Ohio | Governor's Office of Health Transformation

BH Care Coordination

Introductory webinar

January 31, 2018

Introduction to today's webinar

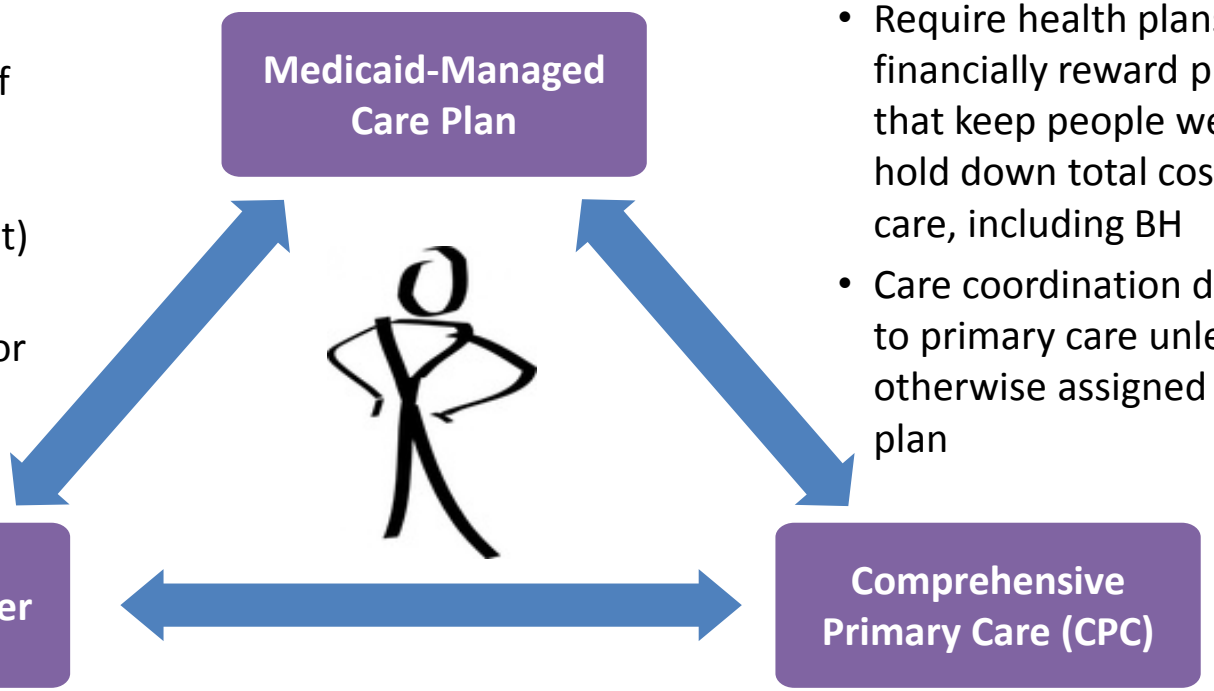
- Over the past 6 months, Ohio Medicaid and Ohio MHAS have been working closely with a group of primary care and behavioral health providers and the Medicaid-managed care plans to develop an innovative behavioral health (BH) care coordination program designed to meet the needs of Medicaid members with severe BH conditions
- The work group has made significant progress toward designing a high-quality program for these members, but additional input is required from you to ensure optimal program design and rollout
- The purpose of today's session is to share information about the program design and discuss next steps

Agenda for today's webinar

- **Overview of BH Care Coordination program**
- Key design decisions
- Timeline and path forward
- Question and answer

Our goal is to fulfill the “Model 2” promise

- Require health plans to delegate components of care coordination to qualified BH centers (“Model 2” commitment)
- Care management identification strategy for high-risk population

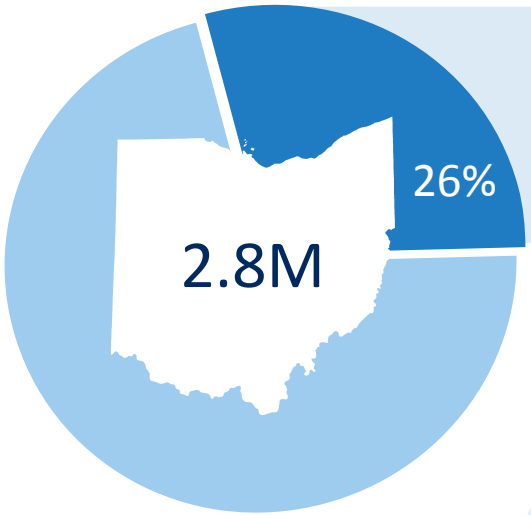


- Require health plans to financially reward practices that keep people well and hold down total cost of care, including BH
- Care coordination defaults to primary care unless otherwise assigned by the plan

- Mutual accountability
- Alignment on care plan, member relationship, transitions of care, etc.
- Common identification of needs and assignment of care coordination

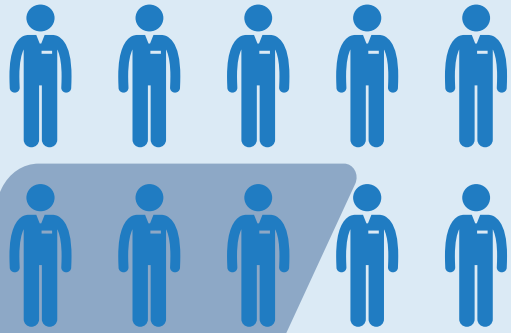
Relationship of BH Care Coordination with BH Redesign

Total Medicaid population



Primary BH population[1]

How can the State, MCPs, and providers best support members with BH needs?



70% of members with BH needs are being appropriately managed through primary care

30% Currently receive more intensive support or are eligible for additional services under BH Redesign[2]

5-10% of the BH population require intensive care coordination

1 Members who have been diagnosed with and treated for a BH condition
2 "Currently receiving intensive support" is defined as those currently in health homes or receiving TCM, but not those receiving CPST; "Eligible for additional services under BH redesign" includes those eligible for ACT and IHBT, but not SRS

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Overview of BH Care Coordination program

Members matched with qualified BH entities

Qualified entities form a care team, supporting the members and being held accountable for both behavioral and physical health outcomes

Benefits of BH Care Coordination for members

- **Relationship with the provider best equipped to serve member needs** through advanced member-provider matching
- **Assistance with fighting substance use disorder** through increased communication and collaboration with recovery services
- **More integration between physical and BH care providers** through new tools to facilitate data sharing and increased presence of care coordinators
- **Enhanced chronic condition management** through care coordinators and expanded role of provider in developing comprehensive care plans
- **Support for member choice** through member-focused care model
- **Enhanced access to specialty providers** by reducing barriers to scheduling appointments
- **Reduced inpatient and ED admission frequency** through greater utilization of preventative health programs such as depression screening
- **Improved treatment adherence** through measurement of treatment adherence and increased member follow-up
- **Fewer disruptions to care** through increased collaboration between PCP/CPC/MCP/qualified entity before and after member handoffs
- **Improved recovery supports** through enhanced collaboration between providers

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Defining the target population

In partnership with clinicians, we have developed a claims-based definition that focuses on identifying individuals who have a BH condition and a high likelihood of either

- Significant utilization of BH services
- An adverse event (e.g., attempted suicide) as a result of the BH condition

Illustrative heat map of BH population as a function of members' BH and physical health needs

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Claims-based definition of target population

Target population

Group 1: Diagnostic criteria only

Or

Group 2: Diagnostic and utilization criteria

Criteria

Presence of the following diagnosis[1] …

- Schizophrenia
- Bipolar disorder with psychosis
- Major depression with psychosis
- Attempted suicide or self-injury
- Homicidal ideation
- Substance use with pregnancy or 1 year postpartum

OR a claim with a procedure for

- Injection antipsychotics

1 or more BH-related utilization

- Inpatient visit
- Crisis unit visit
- Residential facility visit
- Rehab facility visit
- Medication-assisted treatment for substance use
- Partial hospitalization (members under 21)

AND presence of one of the following diagnoses[1]

- Bipolar disorder without psychosis
- Major depression without psychosis
- Other depression
- PTSD
- Substance use
- Conduct disorder
- Personality disorders
- Psychosis
- ODD
- Eating disorders

For both Group 1 and Group 2 members, there will also be a referral channel (with appropriate MCP review) to provide faster access than is available through claims review

1 Diagnosis in primary field on the claim

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Overview of provider eligibility requirements

Provider type	• Classified as both an 84 (comprehensive) and 95 at the TaxID level • For type 84 providers, comprehensiveness is defined by a provider's ability to administer 4 core services[1] — BH counseling and therapy — Mental health assessment — Community psychiatric support treatment — Pharmacological management • Ability to provide crisis management support and/or establish an agreement with another provider to deliver those services
Commitment to integration	• Each provider site must have a stated commitment of collaboration with a CPC or Medicaid-enrolled primary care provider • Additional activity requirements related to coordinating with the full panel of members' PCPs, aligned with CPC approach • No additional commitment required if BH provider has an ownership or membership interest in a primary care organization where primary care services are fully integrated and embedded
Tools	• Capacity to share data with ODM and contracted managed care plans (MCPs) • Consent forms must contain the elements necessary to support the full exchange of health information in conformance with federal and state law, including recent changes to 42 CFR Part 2 • Ability to use e-Prescribing capabilities • Electronic Health Record (EHR) • Ability to send, receive, and use the continuity of care documents
Personnel	• 1 individual who serves as key point of contact for MCPs/State to discuss performance • Identification of a care team, including — Case managers to lead care coordination relationship, serving as primary point of contact for member and family — Registered nurse(s), to consult and coordinate with member's other medical providers • Specific staffing ratios will not be mandated, but a recommended range will be given to providers
Minimum attributed members	• *To be defined as care model, team and resources are defined*

1 Current definition is based on Ohio Health Homes requirements

Approach to attribution

Attribution is …

- Matching members with a qualified entity best positioned to deliver care by
  - Identifying opportunities to connect members not currently in care with entities that best meet their needs
  - Preserving continuity of care in cases where relationships already exist with qualified entities

Attribution is not …

- **Not** a limitation on member choice
- **Not** a gatekeeper restricting choice of provider when utilizing other BH services

Attribution: Guiding principles

In developing an approach to attribution, we followed 6 guiding principles

- **Honor member choice.** At any point, a member may elect the qualified entity of their choosing
- **Maintain continuity of care.** Where there is evidence of an existing relationship with a qualified entity, assign a member to that entity
- **Reward high performers.** The State may use attribution as an opportunity to signal to providers the benefits of good performance by giving preference to providers that achieve success on engagement and outcomes
- **Build in points of integration with CPC.** When a member does not have a visit-based relationship with a qualified entity, attribute to the qualified entity where the member is attributed for CPC
- **Consider geographic proximity.** In cases where a member does not have a visit-based relationship with a qualified entity, attribute to the qualified entity closest to them best positioned to provide appropriate care
- **Consider provider specialty.** In cases where a member cannot be attributed based on a visit-based relationship, prefer those providers whose specialty best matches member needs (e.g., pediatric providers, providers who specialize in SUD services)

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Activity requirements

Initial outreach and engagement	• Perform initial outreach to member, including an explanation of program benefits and other necessary enrollment activities • Begin building a trust-based relationship and understanding of member preferences and goals
Care plan	• Create an integrated care plan within 30 days of member engagement, supported by – Comprehensive assessment of BH needs, taking into account its interaction with physical and social needs – Input from member, CPC/PCP, social support system, MCP, and other medical providers
Ongoing relationship and engagement	• Check in regularly with member to support treatment adherence, and make updates to the care plan as necessary • Provide additional high-touch support in crisis situations • Educate the member and his/her family on independent living skills with attainable and increasingly aspirational goals
Transitions of care	• Ensure successful handoff between care providers by – Establishing relationships with EDs and hospitals – Monitoring admissions and discharges – Communicating about transition needs such as transportation, medication restrictions, etc.
Engagement with and access to appropriate care	• Support scheduling, including same-day and 24/7 access • Reduce barriers to adherence (e.g., transportation) for both medical and BH provider appointments • Define care team members, roles, and qualifications required to support the member • Engage directly with member's medical and BH providers to support updates to care plan • Stabilize crises by gathering information from member, CPC/PCP, social support system, MCP, and other medical providers and formulating a response for immediate intervention and/or stabilization
Engage supportive services	• Facilitate access to community supports, including scheduling and follow-through • Communicate member needs to community partners and other social resources
Population health management	• Continuously identify highest risk members and align with organization to focus resources and interventions

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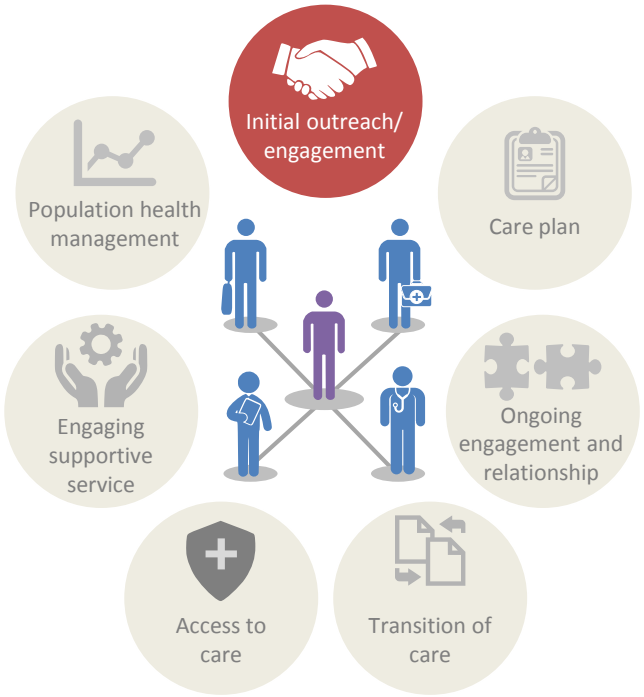
Role of qualified entity, CPC/PCP, and MCP: Initial outreach and engagement

Qualified entities support members through care coordination activities



Role of qualified entity

- Leads initial member outreach, including education on program benefits and necessary enrollment activities
- Leads initial outreach with member's CPC/PCP to share information regarding program participation and care plan development
- Builds trust-based relationship to understand member's preferences and goals and begins engaging with family or social support system (e.g., schools, youth services)

Role of CPC/PCP

- Shares physical health information relevant to program participation and development of the care plan
- May identify members who meet the claims-based definition for program participation

Role of MCP

- As needed, provides data to BH entity to assist with identification of highest risk members, including timely updates regarding patient utilization of behavioral and physical health services

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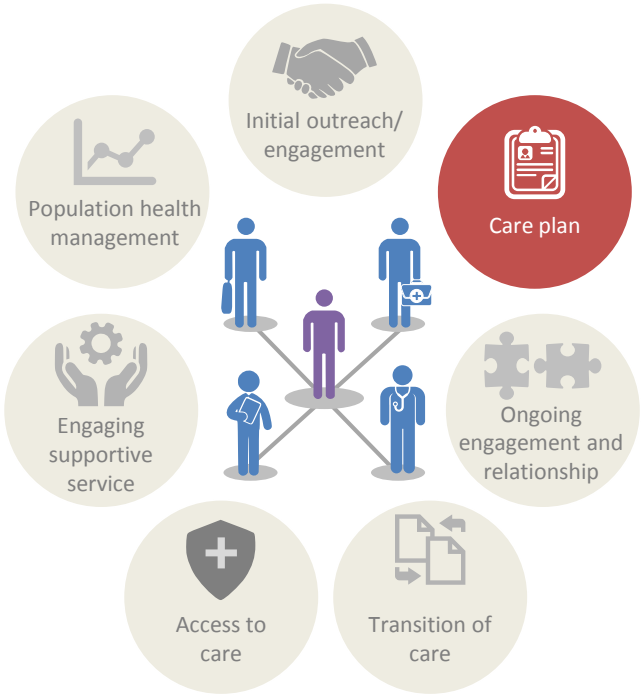
Role of qualified entity, CPC/PCP, and MCP: Care plan

Qualified entities support members through care coordination activities



Role of qualified entity

- Lead for creating and maintaining integrated care plan, including leading outreach to CPC/PCP to incorporate inputs for physical health section
- Develops specific inputs for BH section of care plan

Role of CPC/PCP

- Provides input to integrated care plan by developing section for members' physical health needs

Role of MCP

- Provides input to care plans as necessary

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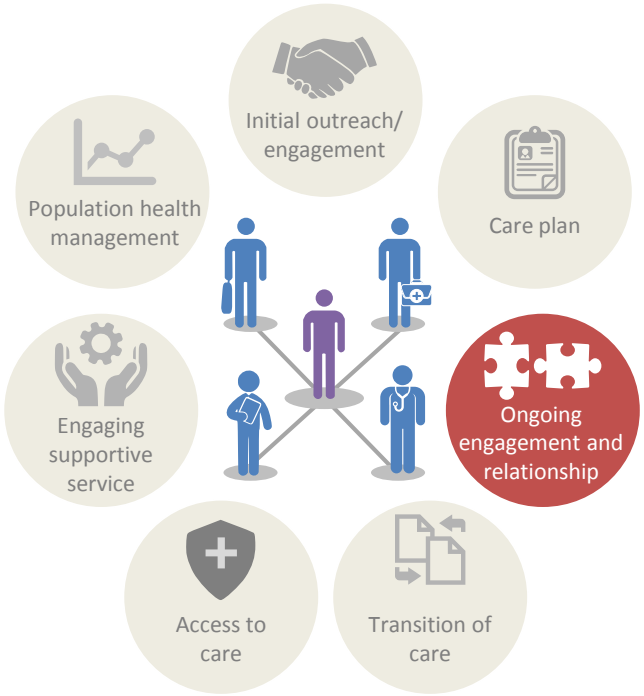
Role of qualified entity, CPC/PCP, and MCP: Ongoing engagement and relationship

Qualified entities support members through care coordination activities



Role of qualified entity

- Primary point of contact for member communication about behavioral and physical health needs
- Leads member and family education on BH, including self-care and adherence to treatment plan
- Leads follow-ups with member on BH care and updates the care plan and PCP/CPC as appropriate

Role of CPC/PCP

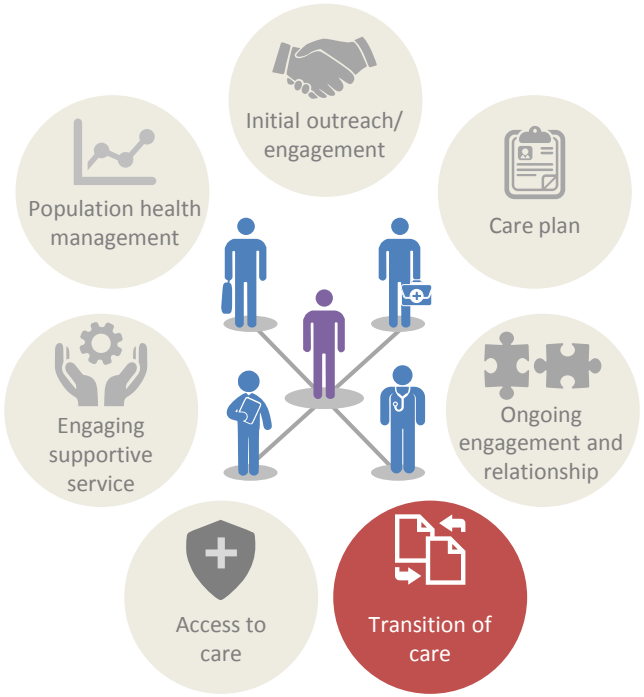
- Educates member and their family on physical health, self-care, and treatment adherence, with understanding of BH conditions
- Provides information to members related to their physical health needs
- Leads follow-ups with member on physical health care and updates the care plan and qualified BH entity as appropriate

Role of MCP

- Notifies members regarding program eligibility as necessary
- Educates members, families, and other social supports about the program and benefits of program participation

Role of qualified entity, CPC/PCP, and MCP: Transition of care

Qualified entities support members through care coordination activities



Role of qualified entity

- Leads outreach to CPC/PCP after major BH events (e.g., inpatient stay) and discusses implications for physical healthcare
- Follows up with CPC/PCP following major physical health related events and discusses implications for behavioral health care as well as transition needs (e.g., as transportation, medication restrictions, etc.)
- Establishes relationships with EDs and hospitals, and monitors admissions and discharges. Accountable for focus on admissions and discharges related to behavioral health treatment

Role of CPC/PCP

- Leads outreach to qualified BH entity after major physical health events (e.g., inpatient stay) and discusses implications for BH care
- Follows up with qualified BH entity following major BH events (e.g., inpatient stay) and discusses implications for physical health care
- Accountable for focus on admissions and discharge for physical-health-related treatment

Role of MCP

- Answers questions related to eligible benefits to support transitions of care (e.g., questions about potential providers to refer to)

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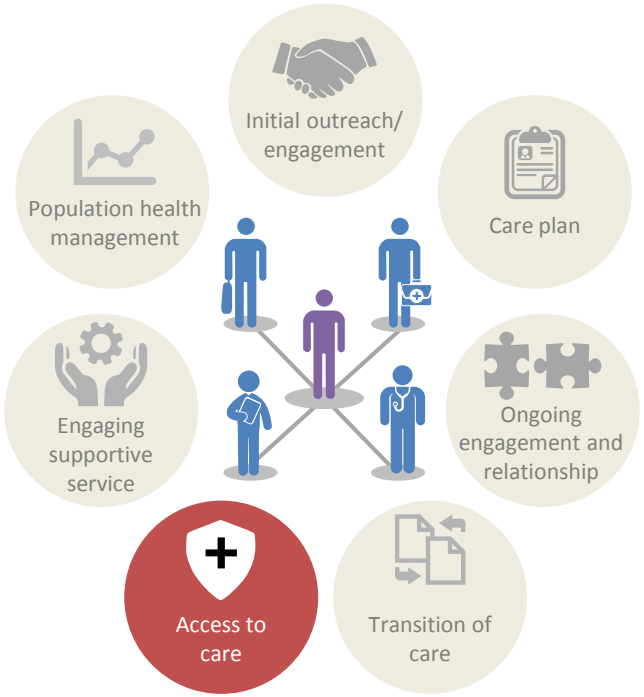
Role of qualified entity, CPC/PCP, and MCP: Engagement with and access to appropriate care

Qualified entities support members through care coordination activities



Role of qualified entity

- Leads scheduling with guidance from CPC/PCP, works with member to reduce barriers to attendance for appointments
- Leads follow-ups with CPC/PCP to understand implications from ambulatory or acute encounters (e.g., treatment adherence)
- Engages directly with member's physical and other BH providers as well as community resources to support care, including updates to care plan
- Accountable for referral decision support and scheduling for BH care in IP, OP, and ED settings
- Stabilize crises by gathering information from member, CPC/PCP, social support system (e.g., schools, youth services), and other medical providers and formulating a response for immediate intervention and/or stabilization

Role of CPC/PCP

- Provides primary care
- Supports scheduling with guidance from qualified BH entity and works with member to reduce barriers to attendance
- Follows up with BH care coordinator to understand implications for physical health from BH encounters (e.g., medication management)
- Accountable for referral decision support and scheduling for PH care in inpatient, outpatient, and emergency settings

Role of MCP

- Addresses challenges to appropriate access to care, and escalates to State as appropriate

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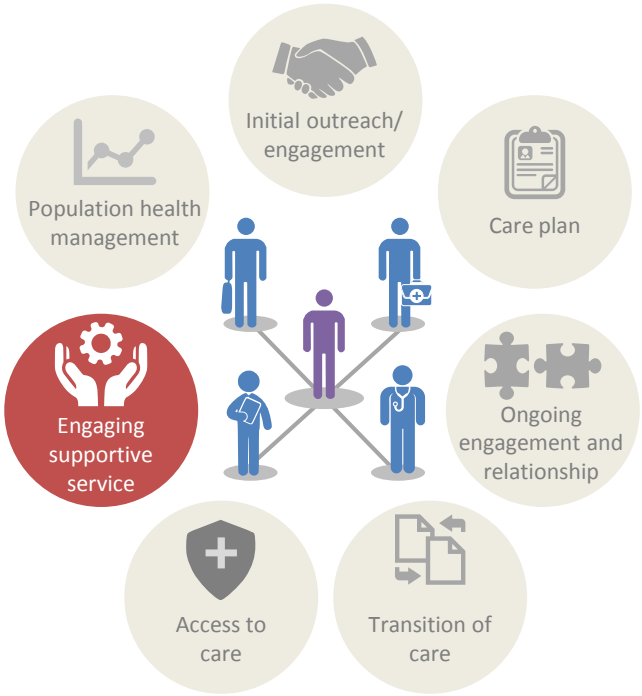
Role of qualified entity, CPC/PCP, and MCP: Engage supportive services

Qualified entities support members through care coordination activities



Role of qualified entity

- Facilitates access to community supports by working with supportive services partners to address member needs

Role of CPC/PCP

- Engages with supportive services as required to support physical health care

Role of MCP

- As needed, provides information regarding relevant supportive services

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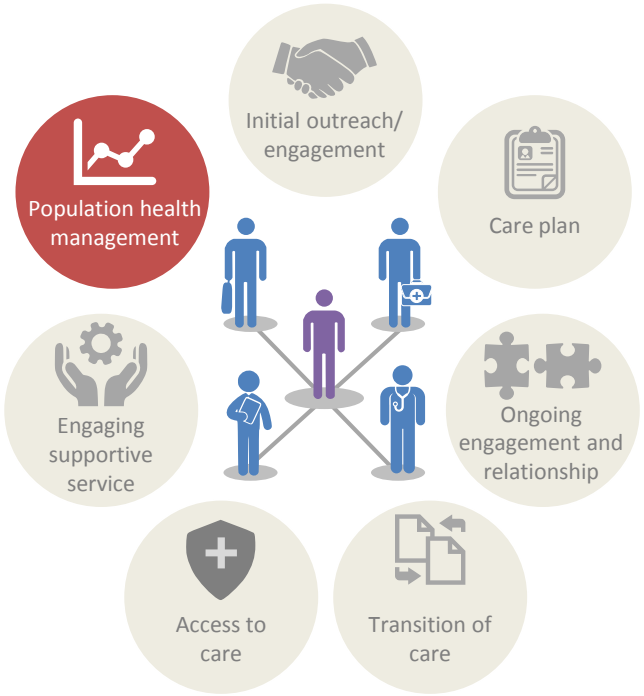
Role of qualified entity, CPC/PCP, and MCP: Population health management

Qualified entities support members through care coordination activities



Role of qualified entity

- Continuously identifies highest risk members and aligns resources and interventions accordingly

Role of CPC/PCP

- As needed, provides input to BH entity to assist with identification of highest risk members, including timely updates regarding changes in physical health condition(s) and/or level of acuity (e.g., uptick in inpatient stays for physical health conditions)

Role of MCP

- As needed, provides data to BH entity to assist with identification of highest risk members, including timely updates regarding patient utilization of behavioral and physical health services

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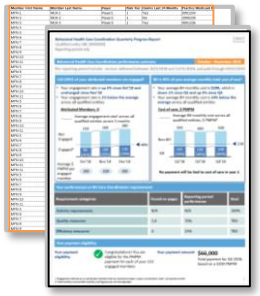
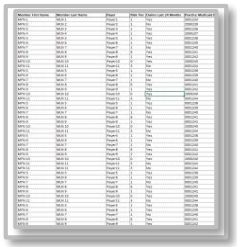
Overview of quality and efficiency measures

Measures		Example measures
To determine eligibility and payment	Adult health	• Adult BMI assessment
	BH	• Follow-up after ED visit for alcohol and other drug dependence, total, 7-day and 30-day
	Pediatric health	• Adolescent well-care visits
	Women's health	• Prenatal and postpartum care – timeliness of prenatal care
	Efficiency	• Ambulatory care – ED visits
For informational purposes only	Engagement and treatment adherence	• Percentage of members engaged
	Social determinants	• Percentage of members with employment income
	Opioid risk factors	• Use of opioids at high dosage

Overview of reporting

Report type	Format	Description
Performance report	 *1 PDF file* *1 .csv file*	▪ Provider-level summary of performance and member-level detail that will include information such as – Member engagement – Performance on quality and efficiency measures
Attribution file	 *1 .csv file*	▪ Provider-level summary and a member-level detail that will include information such as – Member-level demographic information – Clinical data flags regarding chronic conditions

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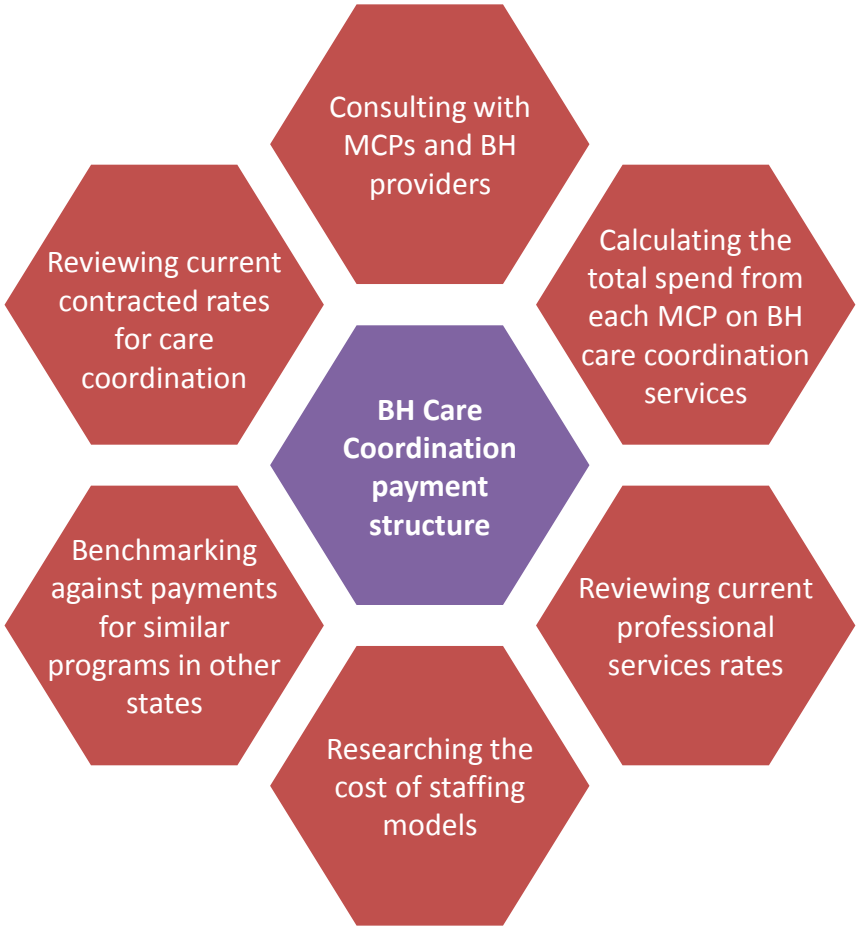
BH Care Coordination payment structure

Overview of payment structure

- Qualified providers receive a comprehensive monthly activity payment (PMPM) to compensate for care coordination activities performed
- PMPM is contingent on demonstrating engagement with attributed members, with ODM defining what constitutes sufficient engagement
- After year 1, there are 2 additions to the payment structure
  - Starting year 2, PMPM will be contingent on providers meeting thresholds on quality and efficiency metrics
  - Additional outcome-based incentive payments may be added in subsequent years
- For the members in the target population, the PMPM is inclusive of all care coordination activities. The payment structure for the rest of the BH population will remain unchanged

Key considerations for defining payment level



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BH Care Coordination – qualified entity enrollment process

Initial engagement with potentially qualified entities	Provider enrollment	Intensive engagement with enrolled entities	Performance period
January-May	***June-August***	***Sept-October***	***Oct 1 onwards***
• Hold introductory webinars for potentially qualified entities • Launch provider readiness assessment • Notify potentially qualified entities of eligibility to enroll (May-June) • Share initial data with potentially qualified entities (e.g., attribution ranges) (May-June)	• Open online enrollment (June-July) • Evaluate entities based on eligibility criteria and inform of status (July-August) • Hold additional webinar sessions to assist entities with capacity planning	• Share detailed data (e.g., attribution numbers, member profiles) with enrolled entities • Hold webinar sessions to assist qualified entities with understanding attribution files	• Exact timing o be determined — Payment begins — Reporting begins

Next step: Provider readiness assessment

- We are asking all potentially qualified entities to complete a readiness assessment
- Potentially qualified entities are those entities that meet the provider type requirement for program participation:
  - Classified as both an 84 (comprehensive) and 95 at the Tax ID level
  - Comprehensiveness for type 84 is defined as ability to administer: BH counseling and therapy, mental health assessment, community psychiatric support treatment, and pharmacological management
  - In addition, the entity must have the ability to provide crisis management support and/or establish an agreement with another provider to deliver those services
- It is important that each entity takes the time to ensure the appropriate staff complete the assessment, as it will inform the State's approach to program design and support during implementation. This assessment is non-evaluative
- The assessment contains 4 sections
  - Provider information (e.g., number of sites, Medicaid IDs)
  - Existing commitments to integration with PCP
  - Provider tools
  - Personnel
- By Friday, February 9, all entities that we have on file as meeting the type 84 and type 95 designation will receive a unique link to a provider readiness assessment
- We ask that all the potentially qualified entities complete all sections of the assessment by March 2, 2018
- If you do not receive a link to the assessment by close of business on Friday, February 9 and you believe it was an error, please e-mail BHCareCoordination@medicaid.ohio.gov

Questions