Medicaid Managed and Direct Billing for I/DD Providers in Connecticut-Readiness and Impact on Providers

Connecticut Department of Developmental Services

PART 1

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Managed Medicaid History in Connecticut?

- CT used managed care systems to serve most of its Medicaid beneficiaries between 1995 and 2010. IDD enrollees remained in fee-for-service.
- In 2010, CT returned to fee-for-service Medicaid.
- Many states are experiencing the retention of more costly populations (Behavioral Health and IDD) in fee-for-service Medicaid models.
- Now, planning for IDD providers to bill directly to Medicaid (DSS).
- We need to prepare!

Why Managed Medicaid and Direct Billing for Connecticut?

- Accountability
- Data and Analytics are strong when billing claims – can provide reliable outcomes
- Improving Quality of care
- Consumer outcomes
- Stable business environment for providers
- Efficient, effective, and predictable expenditure of public funds
- Flattening of cost-curve for Medicaid

Core DDS Principles

- Approx. 17,000 individuals and families are eligible for a minimum of family support with annual appropriations providing additional scopes of support with waitlists for certain services.
- Family supports on intermittent and emergency basis.
- Greater transition towards community-based residential supports and away from institutional care.
- Greater movement towards competitive employment.
- Self-direction
- Intellectual Disability (ID) partnership created between DSS, DDS and Office of Policy and Management to effect CHANGE.

When you change the way services are paid for – you can change the outcomes and results.

Management of Medicaid Is Different Between States

Some states separate IDD into a separate department with separate funds

Some states combine IDD and Mental Health

Some states combine IDD, Mental Health and Substance Use/Abuse Disorders

Rationale and Catalyst* for ID Partnership to Change Billing Method

1. Expanding community-based services
2. Maximization of Federal Revenue
3. Converting grant funded to FFS rates and possibly results-oriented payment strategies – level of need
4. Managed Care Organization/Admin. Service Org. and Tools
5. Private/Third-party payments
6. Supportive housing models
7. Reducing "unnecessary" residential and institutional use
8. Efficiencies – cost savings focus-lowering cost for providers
9. Monitor and measure individual, provider and program performance
10. Resources for persons on residential wait-list

*DDS Five Year Plan page 11-ID Partnership Seeks Access for IDD Consumers

Goal to Move IDD Providers to Direct Medicaid Billing

STEPS TAKEN

1. The ID Partnership (DDS, DSS and OPM) are providing guidance and oversight of the move to Medicaid direct billing.
2. Move of IDD residential funding to DSS was to start the direct billing process change.
3. Plans to complete the following:
    1. Consider moving DDS rate structure over to DSS;
    2. Policy review and decisions possibly to resolve the disparate rates between providers statewide and other policy matters; and
    3. The "how to" of converting to direct Medicaid billing.
    4. Providers will likely contract with DSS for Medicaid services and receive reimbursement for services from DSS based on utilization.

Synopsis

Changing the way I/DD services are paid/reimbursed and managing the services and supports will lead to greater effectiveness and efficiencies.

Direct Medicaid Billing-So, How Will This Be Done?

- We do not know HOW this will occur today.
- However, we can speculate using the many other states that have changed to Medicaid billing and payments for IDD and Behavioral Health Services.
- You can prepare-let's

  Get started!

DSS May Adopt Managed Health Concerns

- Inappropriate and/or overutilization of certain services (superutilizers)
- High cost services
- Fast access to lower cost services for members
- Better practices leading to improved care
- More cost-effective services and supports with less restrictive levels of care
- Coordinated care leads to decreased costs
- Funds allocated for services not needed – can be redirected to others

IDD and Behavioral Health Conditions Contribute to Higher Costs of General Healthcare

- Chronically ill costs are 75% higher for those with mental illness/IDD—triple that cost if they have a substance abuse disorder
- Persons with disabilities generally have a higher cost for care per person than others.
- 44% of dual eligible (Caid/Care) individuals have at least one mental illness or IDD—if more than one, costs are twice the average for the entire dual population
- It is estimated that over 25% of healthcare costs are driven by behavioral health problems
- ➢ IDD/Behavioral Health/SUD is the KEY to improved care and reduced costs for CT's Medicaid System

Quality Matters in IDD Services: Medicaid Managed Care will Seek High Quality

- Medicaid managed care is being used for IDD in about 20% of the states. It is not new but it is "growing".
- MCOs/ACOs become responsible for the delivery of long term services and supports (LTSS) to people with intellectual or developmental disabilities.
- Quality is becoming more well-defined and measurable using health and functional indicators.

Medicaid Managed Care: Understanding the Context

- Escalating costs – High cost per person with IDD
- Pressure to control costs of Medicaid
- Waitlists for needed services and supports
- Calls for accountability
- Pressures from stakeholders (consumers, providers, payers, etc.) to manage the care
- Integrated care models and payment changes are tools in Health Care Reform to manage care and improve outcomes.

The Four Cornerstones of Managing Medicaid

1. Is it the "right service" or support?
2. Is it at the "right time" in the consumers life?
3. Is the service at the "right frequency, complexity and intensity"?
4. Is the service/support the "right cost"?

Readiness For Managed Care – Business and Clinical Transformation

- Accountability is a central theme of healthcare reform- accountability and stewards of healthcare resources
- Pressure to (connection to ID Partnership top 10)
  - Be effective – Metrics and outcomes
  - Be efficient – Is your cost of care competitive?
  - Focus on measured functional improvements that episodically reduce the level of care needed
  - Adapt to changing revenue methods – emphasis on community-based early delivery of care as more restrictive, higher-cost care, is reduced.
  - Requires sophisticated front and back office functions for sustainability.
  - Manage cost downward.

Provider Questions

- Are you providing a valuable service that no one or others are providing?
- How can you reduce the cost of delivering the care? Outside box thinking is needed.
- Does your organization need to partner or align with other organizations to be more effective and efficient?
- The goal of these partnerships----better care, cost effective care, improved outcomes (Value Based Care)

Provider Concerns?

- What concerns do CT providers have about the potential changes?
- Are these similar/different than consumers and families?
- How quickly can you/your organization adapt and how quickly can you help consumers and families adapt?

Purpose of Medicaid Managed Care Waivers

- Certain types of Medicaid Managed Care waivers are designed to manage the *growth* of Medicaid funding while, at the same time, maintaining high quality behavioral healthcare benefit plans.
- The objective is not to limit services for individuals, but to manage a system so that a person is guided to the *appropriate* level of care.
- A Medicaid Waiver is a mechanism giving the authority and resources to Manage a System of Care (all resources).

SUCCESSFULLY WORKING WITH MEDICAID PAYERS SUCH AS MANAGED BEHAVIORAL HEALTH ORGANIZATIONS

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Develop Partnerships with Connecticut Medicaid DSS When Directly Billing

- Typical Managed Care Organization Departments Include:
  - Administration
  - Finance
  - Medical/Clinical
  - Provider Relations/Network Operations
  - Information Technology and Data Management
  - Claims processing
  - Quality and Compliance
  - Customer Services – Access to Care

Strategies for Providers to Develop Partnerships with CT Medicaid Managed Care Organizations and/or DSS

- Know the Medicaid Service definitions
- Know the Medicaid benefit plan components
- Develop relationship with clinicians in the UM/UR Department (often by specialty)
- Know the Appeals Process and use it when appropriate
- Preferred provider status?
- Relationships with other departments
- Know and use Level of Care Guidelines (e.g. DLA/ICD-10)
- Know Best Practice Guidelines used by the MCOs
- Offer your organizations expertise
- Seek better care and lower costs ideas and share them with the MCOs
- Precision on authorization an treatment guidelines
- Effective denial management

Managed Care and Provider Partnerships

- Providers must change the way in which healthcare is delivered in order to control costs and improve quality
- Payers will focus on the following:
  - Identification of provision of resources and support needed for providers to deliver better quality lower cost care
  - Ability to provide assistance and support to providers during the transition to managing services and payment changes
  - Payers may create report card on providers and determine status levels with various benefits

Sample Preferred Provider Status Characteristics and Benefits

- Use of EBPs and can measure good clinical outcomes
- Evidence of easy access to care
- Administrative efficiency and effectiveness – electronic authorization, claims, low denial rates, rapid revenue cycle.
- Measures consumer experience of care
- System of care/Coordination of Care

- **Benefits of Preferred Provider status**
- Potential for higher number of referrals
- Training
- Technology sharing – e.g. centralized scheduling from MCO to provider 24/7; crisis response shared
- Potential for internal UM

New Levels of Accountability for Providers and Managed Care

- But these we know for sure……
- Accountability for a population (public health model). E.g. the greatest risk for Managed Care are the enrollees that are not engaged in treatment or services. E.g. persons receiving minimum amounts of respite and waiting.
- Renewed focus on Better Care-think functional improvements. Avoid self-serving and conflicting language that limits consumers' potential.
- Providers are going to have to deliver outcome-based care and manage inside alternative payment models with direct billing to Medicaid and may contain different strategies and goals (pay for impact).
- These are "Game Changers"

Potential Impact of these Changes in Connecticut

- Medicaid funds will be re-distributed to serve more IDD consumers/families through decreased rates, individual supports and managed care practices.
- Outcome expectations will increase for IDD providers-measured –think functional adaptations and improvements
- Payers may use measured outcomes as performance requirements moving to alternative payment methodologies (value) and away from fee-for-service.
- Providers will be compelled to integrate care and diversify payer relationships (Medicare, commercial plans)

QUALIFICATION AND/OR CREDENTIALING IS ESSENTIAL

Organizations and Clinicians Must Be Qualified and/or Credentialed: A Measure of Quality

- Designate someone with contract/credentialing responsibility to connect with DSS.
- Review Provider Manual in detail and outline the qualification and/or credentialing process
- The DSS or MCO and providers may outsource credentialing to a Credentialing Verification Organization (CVO)
- Obtain Application, thoroughly complete and submit
- Know the approximate time it may take for credentialing to be completed
- Maintain accurate records for credentialing of clinicians and direct-care staff
- Precision and compliance is important

How Does Managing Medicaid Through a Waiver Lead to Better Care?

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Waiver Management

- The Individual and Family Support Waiver (IFS) and The Comprehensive Support Waiver assists persons with developmental disabilities in Connecticut. Both waivers further set specific dollar limits of services and supports that can be offered based on an individual's assessed level of support need.

Example of Waiver Management State Policy

- Innovations is the common name for the Medicaid 1915(c) Waiver for people living with intellectual and developmental disabilities who are eligible to live in Intermediate Care Facilities. Innovations gives you services and supports to help you live as independently in the community instead of in an institution or group home. The waiver gives you a role in planning and selecting how to receive and maintain community-based services for yourself.
- Innovations funds cannot currently cover everyone needing these services. The number of Innovations participants for state is limited by available funding from the State of ZZZ and the Centers for Medicaid and Medicare Services. If you are eligible for Innovations services but can't get a waiver slot, you are put on a waiting list called the Registry of Unmet Needs.

New Waiver Management Tools that Could Come Into Play

- Initial and Continued Stay Authorizations
- Adjusting the limits on levels of supports
- Provider Network Development and Monitoring – Managed Network creates opportunities for providers in network
- Provider Enrollment and Credentialing
- Quality Improvement Activities
- Payment of Medicaid Claims
- Denial management capabilities
- Sophisticated revenue cycle management
- Evidenced based practices – Practice Guidelines
- Fraud, Waste and Abuse
- Managing for Outcomes
- Pay for outcomes capabilities

Managed Care Organizations MCO's – Quality and Cost Outcomes

- Pennsylvania example: Behavioral Health Choices generated **$4 billion in savings** from 1997-2007.
- Massachusetts example: A **50% reduction** in ED visits and a **71% reduction** in psychiatric admissions for Medicaid enrollees over the 3-year period 2007-2010.
- Colorado example: MCOs operating in CO for 14 years have **contained increases** in their capitation rate to 13.8%, far less than the inflation rate of 44% and the inflation rate of medical care of 82%.
- North Carolina example: MCOs are **reinvesting** $150M in savings into new services 2016-2019.

Medicaid Managed Care – Responsibilities

- Controlling the selection of the professionals and provider organizations in a particular delivery system
- Setting service payment rates, methodologies, limits on level of support needed
- Authorizing services
- Receiving data on service utilization
- Setting best practice policies
- Establishing the framework for the measurement of quality and performance

Managed Care and The Triple Aim

- **Improved Access to appropriate and early services**
- **Better Care**
- **Potential Cost Reduction**

Open Access to Care: The New National Standard

IDD consumers and families need rapid access to support services to reduce or avoid other more complex care.

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What is Open Access?

An engagement strategy whereby organizations offer assessments on the same day they are requested by the consumer, without a scheduling delay or waitlist, resulting in quicker access for the consumer and an eradication of consumer no shows for assessments.

Sounds simple, right?..... It is!!

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Start with the Why

How to determine if Open Access is right for you?

Ask yourself some basic questions and determine if Open Access would be an improvement.

What is your agency's wait time to assessment?

If you were the Consumer, would that be good enough for you?

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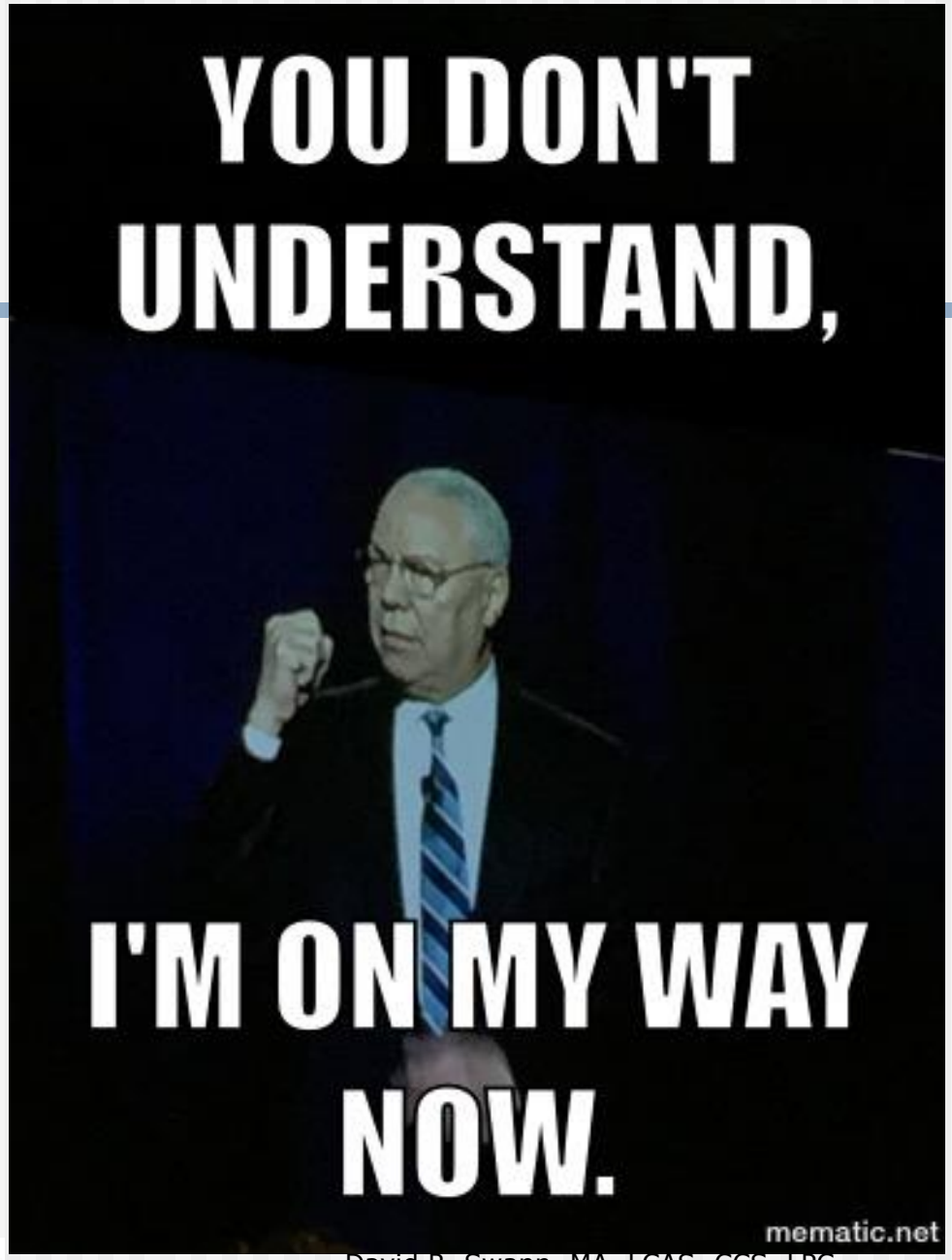

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Better Care-Starting to Define Quality

- Increased focus on Whole-Person, Team-Based Care, through Collaboration or Integration.
- "Medical Homes" and "Health Homes" are becoming the primary focus of integration (team-based) care – connecting the head back to the body. Rationale-it is more difficult to get PH care for IDD consumers.
- Significant movement to "One Stop Shops" integrated healthcare service delivery models.
- How prepared are CT providers for quality improvements like these?

CONTRACTING WITH MANAGED CARE ORGANIZATIONS

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Contracts with Medicaid and DSS

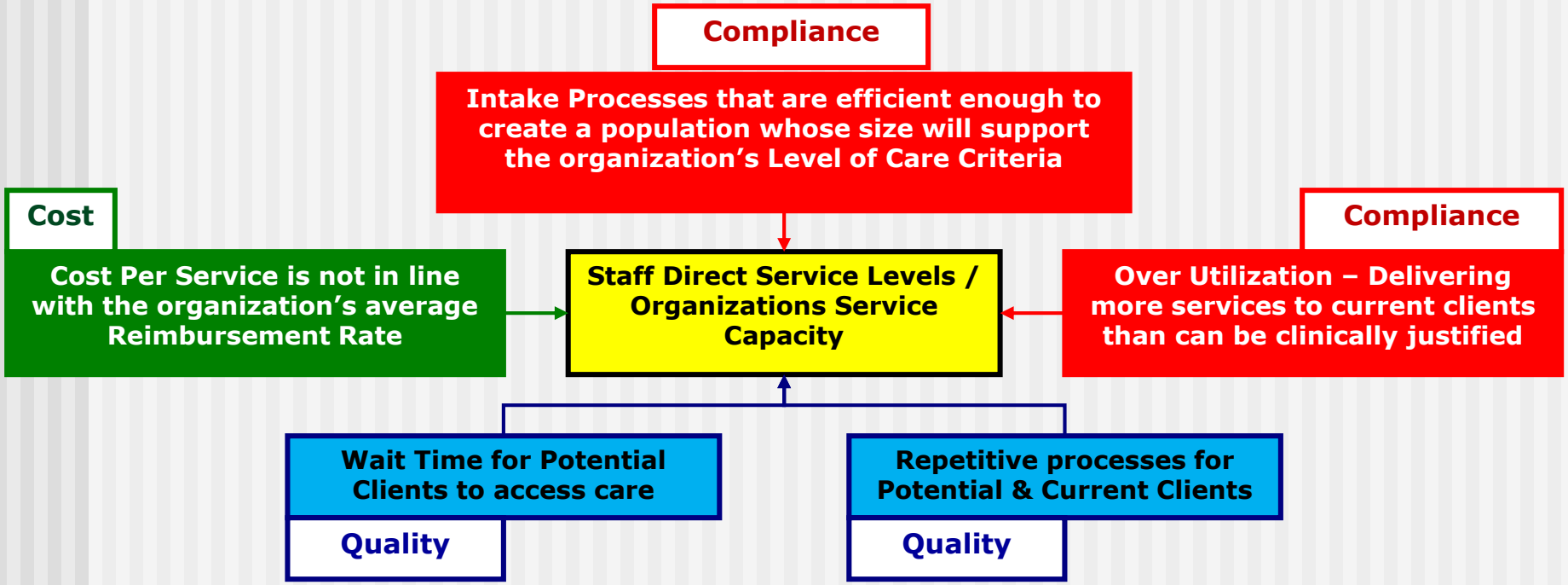
- Begin the relationship first
- Become a member of the provider network through a contract and qualification
- Open or closed networks
- Single Case Agreements
- Get on the "emerging" provider list
- Key is to offer value (quality and costs)
- What is the greatest value you offer?

Do You Know Your Costs?

- To improve efficiencies and reduce health care costs, providers need to understand their costs and change clinical and business practices.
- Pressure on rates and utilization make it essential to know your costs by CPT/HCPCS code, by service and even by staff type. Know costs by length of care.
- To enter into contracts with MCOs, providers need to know their costs.
- Avoid the standoff – Providers demand Medicaid increase rates AND Medicaid demand providers reduce their costs

Understanding Provider Costs and Changing Your Business Practices

Cost drives your organization's productivity goals, which affects several other key areas:



Cost Methodology

Total Cost for Service Delivery

- Direct Service Staff Salary
- Direct Service Staff Fringe Benefits
- Non-Direct Costs (All other costs)

Total Revenue for Service Delivery

- Net Reimbursement actually Attained/ Deposited. *(This takes into account Denial Rate, Self Pay, Sliding Fee Scale, etc.)*

- Divided By -

Total Billable Direct Service Hours Delivered **

- All Direct Service Hours Delivered by Direct Service Staff that are eligible to be billed via a CPT Code or against a Grant.

** Utilizing the common denominator of total Billable Direct Service Hours instead of total hours worked per year assures an apples to apples comparison of an organization's true cost versus revenue per direct service hour.

Cost by CPT/HCPCS Codes Ranked by Highest to Lowest in Frequency

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Cost Versus Revenue Per Code Report

	CPT Code	Total Hours	% of Hours	Average Cost per Code per Hour	Average NET Revenue per Code per Hour	Margin Per Hour	Total Gain / (Loss) for All Hours
1	H2017	360,125.09	13%	$64.69	$56.66	($11.44)	($4,184,876)
2	H0036	323,946.01	11%	$95.61	$4,002.16	$3,906.54	$4,983,378
3	90837	169,431.48	6%	$132.73	$88.12	($55.15)	($8,832,315)
4	H2015	168,190.15	6%	$41.45	$37.62	($11.58)	($3,990,877)
5	90834	158,818.23	6%	$151.52	$80.66	($80.07)	($12,122,687)
6	T2025	144,755.80	5%	$35.89	$30.08	($6.45)	($470,645)
7	H0004	132,410.62	5%	$76.02	$56.21	($35.56)	($1,512,944)
8	T1019	103,314.01	4%	$78.70	$30.11	($48.58)	($4,280,667)
9	T1017	95,977.90	3%	$159.37	$49.27	($110.10)	($7,160,849)
10	90847	79,119.28	3%	$144.74	$70.64	($82.64)	($4,697,771)
	90791	79,039.11	3%	$161.17	$84.37	($85.34)	($6,463,064)
	H2011	77,020.05	3%	$61.09	$45.74	($32.69)	($2,961,007)
	S5150	67,542.91	2%	$63.13	$22.24	($47.18)	($2,166,976)
	90853	66,749.48	2%	$137.31	$98.27	($45.46)	$234,807
	99213	50,256.71	2%	$213.32	$97.80	($169.52)	($8,780,760)
	H0038	36,325.14	1%	$79.69	$59.33	($22.83)	($382,203)
	H2019	33,672.47	1%	$238.05	$79.57	($158.48)	($2,860,791)
	99214	33,330.63	1%	$275.94	$143.69	($153.32)	($4,670,890)
	H2017 HQ	28,591.56	1%	$54.36	$47.87	($8.65)	$24,679
	90885	27,404.72	1%	$45.18	$37.48	($23.74)	($678,659)
	90792	25,911.27	1%	$270.60	$135.15	($150.81)	($3,871,435)
	H0031	25,209.21	1%	$134.37	$90.89	($49.40)	($916,073)
	90832	24,072.05	1%	$149.08	$72.20	($89.88)	($1,909,313)
	T2015	22,303.25	1%	$49.48	$42.99	($6.49)	($34,436)
	H2021	21,727.82	1%	$119.31	$77.70	($41.61)	($514,666)

Top 10 - Total Hours	1,736,088.58
Top 10 - % of All Hours	61%
Top 10 - Total Gain/(Loss)	($42,270,252)
Top 25 - Total Hours	2,355,244.96
Top 25 - % of All Hours	83%
Top 25 - Total Gain/(Loss)	($78,221,040)
Total Gain/(Loss) - All Codes	($106,345,915)

Understanding Provider Costs and Changing Your Business Practices

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Available Hours Per Year	2,080		
Annual Leave Hours/PTO	80	10.00	Days Per Year
Personal/Holidays Hours	88	11.00	
Sick Leave Hours	80	10.00	
Charting/Training/Travel Hours	584	73.00	

Work Days PY	Hours per Day
260	8
Total Budget	BH Standard
$973,000	60.0%

Non-Billable Hours:	832	104.00	Non-Billable Days
Billable Hours:	1,248	156.00	Billable Days

Cost Determination Worksheet
Change the Light Blue Cells Only

OH %	Overhead	Service Cap.
21%	$199,908.37	13,474

Position	Actual / Average Salary	Fringe/ Benefit %	Salary + F&B %	# of Billable Hours F-F-S	Grant	Capped	Total Hours	Base Cost Per Hour	Staff Count (Equals Atleast 1)	Overhead Cost Per Hour	Total Cost per Billable hour	#
MD	$ 112,039.20	29%	$ 144,530.57	685.0	685.0	0.0	1370.0	$ 105.50	1.0	$ 14.84	$120.33	1
Residential		29%	$ -	124.0	0.0	0.0	124.0	$ -	1.0	$ 14.84	$14.84	2
RN	$ 50,296.86	29%	$ 64,882.95	1248.0	0.0	0.0	1248.0	$ 51.99	1.0	$ 14.84	$66.83	3
RN	$ 50,296.86	29%	$ 64,882.95	1248.0	0.0	0.0	1248.0	$ 51.99	1.0	$ 14.84	$66.83	4
Program Manager	$ 49,712.00	29%	$ 64,128.48	499.0	0.0	0.0	499.0	$ 128.51	1.0	$ 14.84	$143.35	5
Center Manager	$ 55,536.00	29%	$ 71,641.44	249.0	0.0	0.0	249.0	$ 287.72	1.0	$ 14.84	$302.55	6
MSW(MH)	$ 40,453.47	29%	$ 52,184.98	1248.0	0.0	0.0	1248.0	$ 41.81	1.0	$ 14.84	$56.65	7
MSW(MH)	$ 40,453.47	29%	$ 52,184.98	1248.0	0.0	0.0	1248.0	$ 41.81	1.0	$ 14.84	$56.65	8
MSW(AD)	$ 40,453.47	29%	$ 52,184.98	1248.0	0.0	0.0	1248.0	$ 41.81	1.0	$ 14.84	$56.65	9
MSW(AD)	$ 40,453.47	29%	$ 52,184.98	1248.0	0.0	0.0	1248.0	$ 41.81	1.0	$ 14.84	$56.65	10
MSW(ACCESS)	$ 45,573.32	29%	$ 58,789.58	1248.0	0.0	0.0	1248.0	$ 47.11	1.0	$ 14.84	$61.94	11
MSW(ACCESS)	$ 45,573.32	29%	$ 58,789.58	1248.0	0.0	0.0	1248.0	$ 47.11	1.0	$ 14.84	$61.94	12
DD INTAKE(ACCESS)	$ 28,454.40	29%	$ 36,706.18	0.0	1248.0	0.0	1248.0	$ 29.41	1.0	$ 14.84	$44.25	13
			$ -	0.0	0.0	0.0	0.0	$ -	0.0	$ -	$0.00	14
Average:	$49,941.32		$64,424.30					$76.38	1.00		$85.34	
Sum:	$ 599,295.84		$773,091.63					$916.59	13.00		$1,109.47	
	Actual Salary Cost w/ FTEs		$773,091.63									
	Total Cost of Program:		$973,000.00									

Screen Print from *Strategic Data Measurement Tools* written by Scott Lloyd

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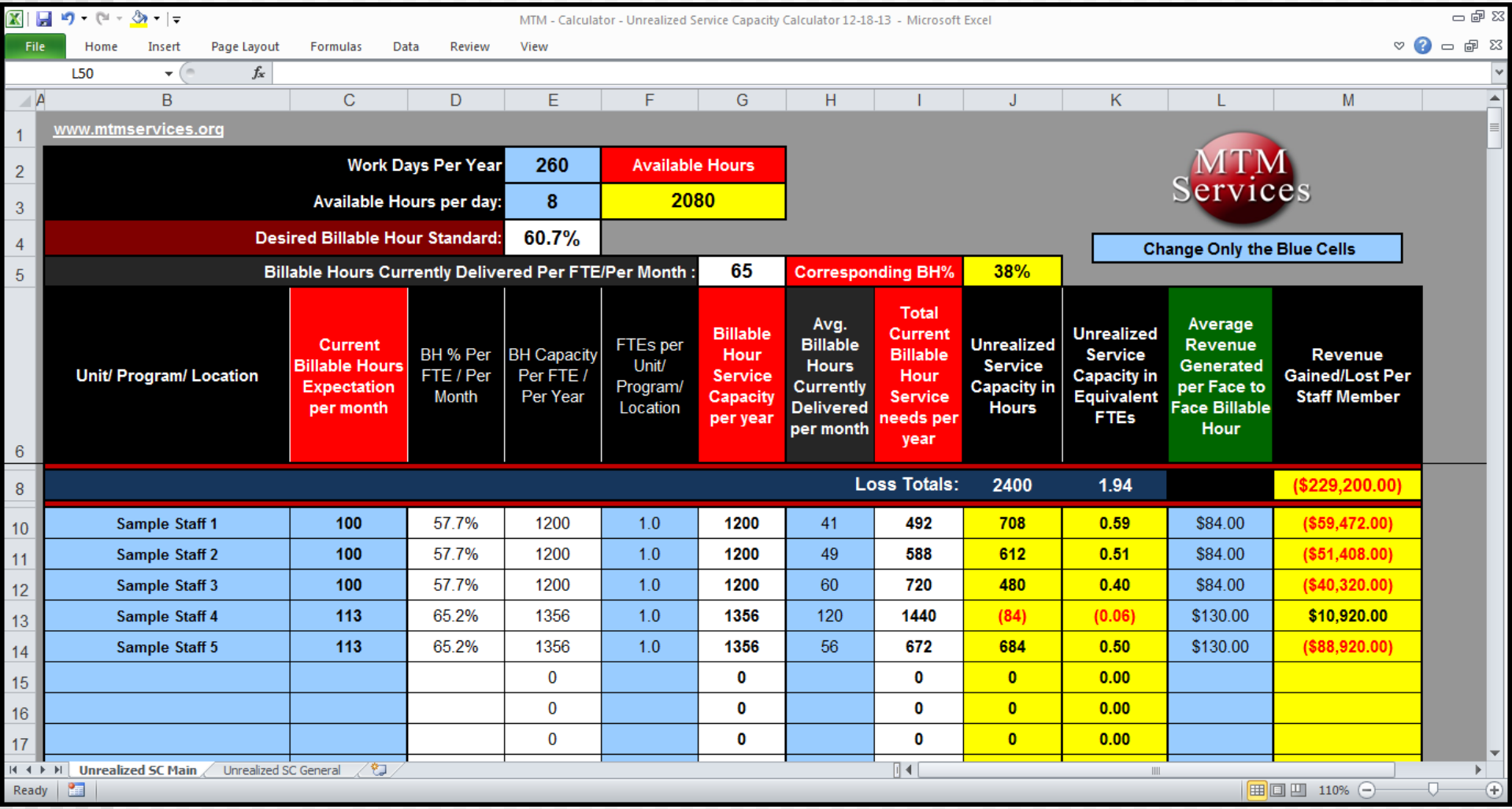
Unrealized Service Capacity?


MTM - Calculator - Unrealized Service Capacity Calculator 12-18-13 - Microsoft Excel

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Work Days Per Year	260
Available Hours per day:	8
Available Hours	2080
Desired Billable Hour Standard:	60.7%
Billable Hours Currently Delivered Per FTE/Per Month :	65
Corresponding BH%	38%

Change Only the Blue Cells

Unit/ Program/ Location	Current Billable Hours Expectation per month	BH % Per FTE / Per Month	BH Capacity Per FTE / Per Year	FTEs per Unit/ Program/ Location	Billable Hour Service Capacity per year	Avg. Billable Hours Currently Delivered per month	Total Current Billable Hour Service needs per year	Unrealized Service Capacity in Hours	Unrealized Service Capacity in Equivalent FTEs	Average Revenue Generated per Face to Face Billable Hour	Revenue Gained/Lost Per Staff Member
							Loss Totals:	2400	1.94		($229,200.00)
Sample Staff 1	100	57.7%	1200	1.0	1200	41	492	708	0.59	$84.00	($59,472.00)
Sample Staff 2	100	57.7%	1200	1.0	1200	49	588	612	0.51	$84.00	($51,408.00)
Sample Staff 3	100	57.7%	1200	1.0	1200	60	720	480	0.40	$84.00	($40,320.00)
Sample Staff 4	113	65.2%	1356	1.0	1356	120	1440	(84)	(0.06)	$130.00	$10,920.00
Sample Staff 5	113	65.2%	1356	1.0	1356	56	672	684	0.50	$130.00	($88,920.00)
			0		0		0	0	0.00		
			0		0		0	0	0.00		
			0		0		0	0	0.00		

Unrealized SC Main | Unrealized SC General

Ready

Expect Payment Methodology Modifications Seeking Greater Value

- Maximizing value

Achieving the best outcomes at the lowest cost.

Move from a supply-driven health care system organized around what staff do and toward a consumer-centered system organized around what consumers need

Converting from Payment for Volume to Payment for Value

- Aligning how we pay for services with the outcomes we are attempting to achieve – better health, better care and better costs.
- Services must be effective in achieving individual outcomes or system-wide outcomes;
- The services are more cost-effective than alternatives that may have been selected;
- The services are "lean", waste (excess costs) have been removed through process improvement activities.

"Value-Based Purchasing" Model

1. Payment Reform is moving from *"paying for volume to paying for value/quality"*

2. VBP requires integration of our clinical, quality and financial information and the ability to track and analyze costs by consumer, provider, team, program, and payor and can operate effectively under fee for service, case rate, and sub-capitation payment models in order to succeed under a variety of Pay for Performance (P4) bonus arrangements.

Value-Based "Shared Risk" Payment Model Core Elements

1. Know cost per service/staff type
2. Identify clinically recommended service mix, frequency and duration per level of care/intensity of need (i.e., DLA-20, ICD-10 CM) to support determination of costs of bundled/episodic care needs
3. Provide outcomes to demonstrate reduction of high/disruptive cost services (i.e., reduction in ER visits)

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Medicaid Managed and Direct Billing for I/DD Providers in Connecticut-Readiness and Impact on Providers

Connecticut Department of Developmental Services

PART 2

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Managed Care and Direct Billing Provider Engagement

- We have seen payment changes take affect in a transition over time.
- Timeframes have been as short as one year and as long as several years.
- Some time is essential but also building capacity by providers to bill during the time.
- Most successful strategies begin with small risk sharing to providers and growing the risk stepwise to a higher level over time.
- Medicaid cost savings goals by states often dictate the amount of time providers are given to develop.
- Providers have varied success rates regardless of the time.

PROPER DOCUMENTATION AND CODING OF SERVICES IS ESSENTIAL

Managed Care Organizations and DSS are Payers

- Payers have the authority to review documentation and codes reported for non-compliance and deny or recoup payments for services when non-compliant.
- Specificity of documentation is critical for both ICD-10 and payment requirements.
- Fraud and waste contribute to Medicaid's escalating costs. CMS will likely require DSS or the MCO to monitor for fraud and waste.
- Level of care is critical to support the service and support needs.

Managed Care Tools-Providers Need to Know-Dependent on Documentation

- Authorizations
- Utilization Review
- Utilization Management
- Quality of Care Reviews
- Peer Reviews
- Post-Payment Reviews
- Claims Denial Management

Authorizations

- Sometimes viewed as barrier to treatment by providers/consumers
- Authorizations will be governed by policy within the DSS or an MCO
- You can ask to see this policy or the DSS/MCO could provide an algorithm or summary
- Master the elements and requirements
- Usually require a diagnosis, level of care assessment (e.g. DLA-20/Supports Intensity Scale (SIS), etc.) and treatment/service plan.

Authorization - Denials

- Avoid the stand-off ("your health plan denied our request saying you did not need this care") vs. "your provider did not substantiate the need for the treatment requested".
- The difference……
- Monitor auth. denials by program, service type and by staff member. Monitor corrections and the success.
- Electronic auth. Requests are rapid and more effective. Will they require electronic transmission? Paper?
- Expect stricter auth. Requirements for higher costs services.
- Watch out for services with no authorization requirements- risk of paybacks is higher.

No Authorization-Potential Liability Problem

- An authorization provides some assurance that the DSS/MCO will pay for the services as long as they are provided in accordance with best practices and/or authorization guidelines.
- Services not authorized can be audited/reviewed and paybacks may a result.
- Watch out for automatic auths or no auths- the auth criteria remains.

Authorization Criteria will Likely Require Medical Necessity

- DSS or the MCO will define Medical Necessity.
- Likely use CMS Guidelines as foundation
- Definition may result in higher and/or lower levels of supports and person-centered plans.

Supports Intensity Scale Sample from an MCO

- A Supports Intensity Scale® (SIS) assessment determines the daily supports a person with intellectual and development disabilities needs to live as independently as possible in the community. Everyone enrolled in the Innovations Waiver will complete a SIS assessment. There is an assessment for adults and an assessment for children.
- A trained intellectual and developmental disability professional conducts SIS assessments. Results from your SIS assessment are used to create your person-centered individual support plan. The SIS also helps set Individualized Budget Amounts to be used for services.

Purpose of Clinical Practice Guidelines Among Medicaid Payers

- Practice Guidelines become more important with the increase of knowledge and range of treatment and supports that is available to mitigate the same disability
- Quality of Care, Access and Cost to determine appropriate or reimbursable care
- Documents concisely what is known about treatment of consumer with an IDD
- Goal is improving the care of consumer
- Parameters are reviewed and update frequently
- Based on valid and reliable clinical evidence

Medicaid Will Expect Practice Guidelines To Be Utilized

- AACAP-Autism and Other Pervasive Developmental Disorders https://www.aacap.org/app_themes/aacap/docs/practice_parameters/autism.pdf
- NICHD-Closing the Gap: A National Blueprint to Improve the Health of Persons with Mental Retardation http://www.nichd.nih.gov/publications/pubs/closingthegap/Pages/sub5.aspx
- NICHD-Traumatic Brain Injury https://www.nichd.nih.gov/health/topics/tbi
- Updated Clinical Practice Guidelines for Concussion/Mild Traumatic Brain Injury and Persistent Symptoms (2015) http://www.ncbi.nlm.nih.gov/pubmed/25871303

Medicaid Will Expect Practice Guidelines To Be Utilized

- National Autism Center - National Standards Project http://www.nationalautismcenter.org/national-standards-project/history/
  - Phase 1 (2009) http://www.nationalautismcenter.org/national-standards-project/history/significant-findings/
  - Phase 2 (2015) http://www.nationalautismcenter.org/national-standards-project/phase-2/
- NICHD-Families and Fragile X Syndrome http://www.nichd.nih.gov/health/topics/fragilex/pages/default.aspx
- AACAP – Practice Parameter for the Assessment and Treatment of Children and Adolescents with Autism Spectrum Disorder (2014) https://www.jaacap.org/article/S0890-8567(13)00819-8/fulltext

Utilization Management (UM)

- UM is the primary tool/process DSS/MCOs use to manage care.
- Are the services medically necessary?
- Are the services designed to meet practice guidelines? Provide results?
- Are the intensity of the services appropriate to the condition?
- Is the consumer responsive to the supports/treatment/interventions?
- Is a lesser level of service likely to produce the same/similar results?

Utilization Management

Utilization management is the process of evaluating the necessity, appropriateness and efficiency of behavioral healthcare services against established guidelines and criteria. UM assesses need and promotes quality care while maximizing the availability of funding to serve a greater number of those in need. This is a more prospective review and attempt to manage healthcare **prior** to delivery rather than after the consumer has received care.

Medical Necessity and UM

- Essential for evaluation/treatment of the illness, condition or disease as defined in DSM or ICD-10 coding manuals
- Expected to improve the condition or level of functioning
- Consistent with national standards of professional practice
- Provided in most cost-effective level of care

Utilization Management Targets

- MCOs and the DSS will usually have a UM Plan and/or UM Operations Manual
- High cost services
- Highly utilized services-overutilization?
- Sometimes healthcare providers and consumers want more than is needed.
- This is often how Medicaid will reduce the overall cost-managing utilization.

Reauthorization Requests

- Beneficial-yes….increases accountability of provider. Benefits consumer. Often stressful for providers.
- Timeframe set by Medicaid/State plan and are in the benefit plan/service definitions of the DSS/MCO.
- When progress is made, the intensity of the service and level of care may decrease.
- When progress is not demonstrated, questions about the care provided may be asked.

Know the Benefit Plans of the DSS/MCOs

- What services and at what intensity are allowed?
- Providers can petition for additions with good clinical support. Avoid requests based on "this is the only service we provide".
- Connect the supports to best practices

Provider Data and Analytics

- Know and measure your utilization – now!
- How many support/treatment encounters does it take your organization to deliver the outcome?
- How does that utilization match to best practices and clinical practice guidelines?
- Need to know this by diagnosis and service.
- Measurement of effectiveness and cost.
- Usefulness:
  - To determine your cost for an Episode of Care (EOC)
  - To determine your effectiveness (e.g. value equation)

Major UM Concern-What Treatment is Not….

- Avoiding modification to service/treatment plans when supports and care are not effective for any reason – keep doing the same thing
- Providing services to support the maintenance of benefits or management of legal concerns.

UM Helps Providers Refocus on Supports and Treatment that Works

- Review caseloads and cases to determine if beneficial treatment levels are being provided.
- Utilize engagement/re-engagement strategies for persons with legitimate needs.
- Does your organization measure supports and treatment improvement – again, think functions?
- Services Effective? Efficient?

Timeframes for UM Decisions – NCQA Standards

- Routine Decisions: 14 calendar days to approve or deny the request
- Expedited Decisions: Three (3) calendar days to approve or deny the request
- Retrospective: 30 calendar days to approve or deny the request.

Types of UM Denials Made by MCOs

- Administrative denials – can be performed by UM Reviewers
- Clinical Denials – UM reviewer sends to highest level clinician reviewer – usually a MD and/or PhD.
- Referral of clinical denials to peer reviewer.
- Peer Review makes an effort to contact the provider for additional information, prior to making a decision.
- Once the Peer Review decision is made, it is sent to UM Reviewer to deny or approve the request.

Managed Care Healthcare Values Needed In the Changing Healthcare Environment

- Under a Managed Care (MCO) or Accountable Care Organization (ACO) Model the **Value** of Supports and Services will depend upon the ability to:
  - Be Accessible (Fast Access to all Needed Services)
  - Be Efficient (Provide High Quality Services at Lowest Possible Cost)
  - Coordinate care with other healthcare team members
  - Utilize Electronic Health Records capacity to connect with other providers
  - Focus on Episodic Care Needs/Bundled Payments
  - Produce Outcomes!
    - Engaged Clients and Natural Support Networks
    - Help Clients Self Manage Their Wellness and Independence
    - Greatly Reduce Need for Disruptive/ High Cost Services

DATA…DATA…DATA AND HOW TO USE IT

Data Analytics: The Challenge for Providers

- "Without data, your just another person (or provider) with an opinion". W. Edward Deming (With DRS edits).
- Providers in a managed care environment must obtain and use data (business intelligence) and minimize opinion and feelings not supported by data.

Medicaid Managed Care Impact on Providers

- Quality outcomes (metrics) and cost efficiencies will become more difficult for "smaller" providers (no clear definition of small).
- Providers may be selected for the network based on outcomes and efficiencies.
- Whole person (team-based) care providers better results and delivered supports without gaps for consumers.
- Providers must be nimble and able to expand scope of services, collaborate with other providers and provide treatment to high volumes of persons.
- Providers must be accountable to the persons in need and demonstrate clinical outcomes.

Overarching Outcomes in Managed Care

1. Services are effective in achieving individual outcomes or system-wide outcomes;
2. Services used are more cost-effective than alternatives that may have been selected;
3. The service are “lean”, meaning that waste (excess costs) have been removed through process improvement activities.

Managed Medicaid Requires Rigid Outcomes to be Met

- 2018 HEDIS Measures for Physical and Behavioral Healthcare
- Coordinated Care
- Integration of Physical/Behavioral/Disability care
- Track Physical and Behavioral Healthcare spending
- Tying payment to outcomes

Maximizing Value for Consumers- The Transformation

- Achieving the best outcomes at the lowest cost.
- We must move away from a supply-driven health care system organized around what physicians do and toward a patient-centered system organized around what consumers need. We must shift the focus from the volume and profitability of services provided—physician visits, hospitalizations, procedures, and tests—to the recipient's outcomes achieved.
- Every local provider offers a full range of services, with a system in which services for particular medical conditions are concentrated in health-delivery organizations and in the right locations to deliver high-value care.

Measure Outcomes and Costs for Every Consumer

- Measure outcomes important to consumers and recipients
- Measure outcomes important to payers
- Measure system outcomes:
  - Delays in accessing care
  - Readmissions to higher levels of restrictive care e.g. institutional care
  - ED and crisis care
  - Costs of care

Know What the DSS/MCO is Being Measured On-Sample Metrics

- Readmission rates for your clients.
- Follow-up after hospitalization or residential care by number of days to access.
- Service engagement and utilization, completion rates
- Length of stay or length of service
- Cost per episode of care
- Follow-up after discharge and stability
- Adherence to plan of care (engagement)
- Coordination of care – linking to all providers
- Cost of care
- Best practice outcomes
- Second service visit within X days

Population Health Data

- Press the DSS/MCOs hard to obtain Medicaid paid claims data for your assigned population. This will inform the provider about utilization and compliance with metrics. Other clinical information is a bonus.
- Example: You must know about a Medicaid enrollee that obtains services for an IDD condition from a non-behavioral health provider so that you can determine if specialty care is needed (Emergency Department Services).

Population Health Data/Analytics Needed for IDD Providers

- Prevalence by condition
- Treated Prevalence by condition
- Rate of hospitalization among consumer population
- Potential opportunity to increase access
- Opportunity to address non-adherence
- Address care coordination among multiple providers
- Risk analysis including cost to clinical patterns
- Data to patient engagement and integrated care outreach
- Top 100 highest cost consumers-better care options

Managed Care Readiness for Behavioral Health Providers

Assess Operational Effectiveness around the following thirteen areas and functions

Transformational Changes Needed to Enhance IDD Providers' "Value" for Managed Care

1. Reduce access to treatment processes and costs through a reduction in redundant collection of information and process variances
2. Develop Centralized Schedule Management with clinic/program wide and individual clinician "Back Fill" management using the "Will Call" procedure
3. Develop scheduling templates and standing appointment protocols for all direct care staff linked to billable hour standards and no show/cancellation percentages
4. Design and implement No Show/Cancellation management principles and practices using an Engagement Specialist to provide qualitative support
5. Design and implement internal levels of care/benefit package designs to support appropriate utilization levels for all consumers
6. Design and Implement re-engagement/transition procedures for current cases not actively in treatment.
7. Develop and implement key performance indicators for all staff including cost-based direct service standards
8. Collaborative Concurrent Documentation training and implementation

Transformational Changes Needed to Enhance Network Providers' "Value" for Managed Care

9. Design and implement internal utilization management functions including:
   - Pre-Certs, authorizations and re-authorizations
   - Referrals to clinicians credentialed on the appropriate third party/ACO panels
   - Medicaid work/volunteer or co-pay requirements (certain states)
   - Timely/accurate claim submission to support payment for services provided
10. Develop objective and measurable job descriptions including key performance indicators for all staff and develop an objective coaching based Evaluation Process
11. Develop public information and collaboration with medical providers in the community through an Image Building and Customer Service plan

Service Options Needed to Respond to Managed Care

- Alternatives to restrictive and high cost care.
- Treat to target approaches-e.g. targeting behavior management.
- Integrated/Collaborative/Coordinated Care.
- Services that reduce the demand, frequency or intensity of professional services.

Transformed Supports and Services

- Internal Utilization Management – right services, right intensity, right time – not just for Managed Care Orgs.
- Producing value –

  1) The services are effective in achieving individual outcomes or system-wide outcomes;

  2) The services are more cost-effective than alternatives that may have been selected;

  3) The service are efficient (less waste) have been removed through process improvement activities (e.g. redundancies, overutilization, etc.

Treat to Target Approaches

- Treatment plans, approaches, frequency and intensity changes as progress or the lack of progress is monitored.

Telehealth and Other Technology-Based Services

- Telemonitoring has added important treatment response data to supports and care. E.g. Smart Housing monitoring lowering the cost in residential care.
- Electronic interface with clinical records where family/guardians can interact are useful as adjunctive to support/treatment encounters and may result in accelerated outcomes.

Technology Can Help Providers Adapt To Managed Care

- What is needed:
  - Electronic Health Record meeting interoperability standards.
  - Electronic Auth/Re-auth/Claims Submission is a must.
  - Data Analytics for BIG data management to inform better care and lower costs.
  - Must assist with ICD-10-CM code application
  - Must analyze denials of auths and claims producing accurate reports on reasons for denials.
  - Must make documentation quick and can be done in collaborative method with consumer.

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