# INTEGRATED CARE DC MANAGED CARE READINESS WORKSHOP

## FACILITATING PRACTICE TRANSFORMATION FOR WHOLE-PERSON CARE

*This workshop is hosted by the Department of Health Care Finance, DBH Training Institute, and Integrated Care DC.*



INTEGRATED CARE DC
A learning community for District of Columbia Medicaid providers

**PRESENTED BY:**
**Health Management Associates**

**Tuesday,**
**May 9, 2023**
8:30 am – 3:30 pm ET

Integrated Care DC is managed by the DC Department of Health Care Finance (DHCF) in partnership with the DC Department of Behavioral Health (DBH). This project is supported by the U.S. Department of Health and Human Services (HHS). A total of $3,500,365, or 81 percent, of the project is financed with federal funds, and $810,022, or 19 percent, is funded by non-federal sources. The contents are those of the author(s) and do not necessarily represent the official views of, or an endorsement by, HHS or the U.S. Government.

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# CONTINUING EDUCATION CREDITS

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- The American Academy of Family Physicians (AAFP) has reviewed Integrated Care DC Webinar Series and deemed it acceptable for AAFP credit. Term of approval is from 01/31/2023 – 01/30/2024. Physicians should claim only the credit commensurate with the extent of their participation in the activity. This session is approved for 4.5 Live AAFP Prescribed credits.
- Please wait 15 business days to claim Social Work/Counseling CEUs (4.5 CEU) by visiting the DBH Training Institute (networkofcare4elearning.org).
- **If you would like to receive CME or CEU credit, the evaluation form will need to be completed.**
- Certificates of completion will be emailed within 10–12 business days of course completion.

# PRESENTER DISCLOSURES

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| Faculty | Elizabeth Wolff, MD, MPA<br>CME Reviewer | Jean Glossa, MD, MBA, FACP<br>Presenter | Caitlin Thomas-Henkel, MSW<br>Presenter | Arthur G. Jones, MD, FACP<br>Presenter | Joshua Rubin, MPP<br>Presenter | Debbi Witham<br>Presenter |
|---|---|---|---|---|---|---|
| **Company** | No financial disclosures | No financial disclosures | No financial disclosures | No financial disclosures | No financial disclosures | No financial disclosures |
| **Nature of relationship** | N/A | N/A | N/A | N/A | N/A | N/A |

| Faculty | Barbara J. Bazron, PhD<br>Keynote | Melisa Byrd,<br>Keynote | Bernard Arons, MD<br>Panelist | Yavar Moghimi, MD<br>Panelist | Raymond Tu<br>Panelist |
|---|---|---|---|---|---|
| **Company** | No financial disclosures | No financial disclosures | No financial disclosures | No financial disclosures | |
| **Nature of relationship** | N/A | N/A | N/A | N/A | |

## No financial disclosures

HMA discloses all relevant financial relationships with companies whose primary business is producing, marketing, selling, re-selling, or distributing health care products used by or on patients.

# LEARNING OBJECTIVES

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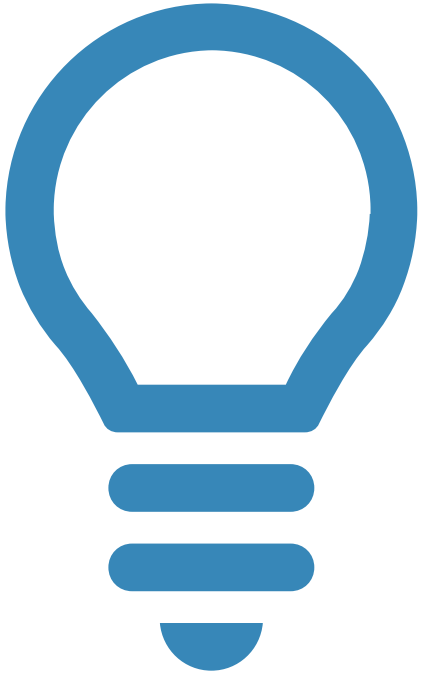

1. Demonstrate the value of the clinical services provided at your organization, and the impact on client outcomes to managed care organizations.
2. Cite the impact of the foundational elements of managed care on behavioral health client services.
3. Describe the opportunities provided by managed care for providers to initiate and expand collaborative team-based care to improve client outcomes.
4. Define effective clinical documentation that demonstrates elements necessary to meet medical necessity and level of care standards of Medicaid managed care organizations

# AGENDA: PART 1

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| | |
|---|---|
| 8:30 – 9:00 | Registration and Networking |
| **9:00 – 9:30** | **Keynote: DHCF and DBH Leadership Perspectives on the Imperatives for Payment and Practice Transformation** |
| **9:30 – 10:30** | **Building Blocks of Managed Care, Part 1: Context and Foundational Elements of Managed Care for Behavioral Health** |
| 10:30 – 10:45 | Group Exercise: Create a Value Proposition for Behavioral Health |
| 10:45 – 11:00 | Break |
| **11:00 – 11:45** | **Building Blocks of Managed Care, Part 2: Planning for Change to Support Managed Care for Behavioral Health** |
| 11:45 – 12:00 | Group Exercise: Sharing Successes and Challenges |
| 12:00 – 12:30 | Lunch |

# AGENDA: PART 2

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| **12:30 – 1:30** | **Panel Discussion: How Can MCOs Support the Integration of Behavioral Health and Primary Care?** |
| 1:30 – 1:45 | Break and Transition |
| **1:45 – 2:45** | **Breakout Sessions**<br>1. Collaborative Business Opportunities for BH Providers (e.g., Consolidations/Independent Practice Associations)<br>2. Prior Authorizations: Documentation for Level of Care Determination<br>3. Plans as Partners: Sharing Actionable Data |
| 2:45 – 3:00 | Break and Transition |
| **3:00 -3:30** | **What Comes Next? Recap of Key Concepts and Provider Training and Technical Assistance Resources** |

# DHCF AND DBH LEADERSHIP PERSPECTIVES

## THE IMPERATIVES FOR PRACTICE AND PAYMENT TRANSFORMATION



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**PRESENTED BY:**

**Dr. Barbara J. Bazron, Director,
Department of Behavioral Health**

**Melisa Byrd, Senior Deputy Director/
State Medicaid Director,
Department of Health Care Finance**

**Tuesday,
May 9, 2023**
9:00 am – 9:30 am ET

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# BUILDING BLOCKS OF MANAGED CARE, PART 1:

# CONTEXT AND FOUNDATIONAL ELEMENTS OF MANAGED CARE FOR BEHAVIORAL HEALTH



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**PRESENTED BY:**
**Josh Rubin, HMA**

**Tuesday,**
**May 9, 2023**
9:30 am – 10:30 am ET

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# PLANNING FOR INTEGRATION: STATE EXAMPLES

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- DBH's contractor, the Aurrera Health Group, conducted a national review of strategies for integrating behavioral health services into managed care and interviewed five states with carve-in experience.
- Its summary report included four key lessons:
  - Support and train behavioral health providers early and often
  - Support provider stability and enrollee access to care
  - Ensure oversight of MCOs specific to behavioral health care
  - Build strong partnership b/t Medicaid and behavioral health teams

Aurrera Health Group. Strategies for Integrating Behavioral Health Services into Medicaid Managed Care Systems.

# DHCF-DBH REQUEST FOR INFORMATION (RFI): MEDICAID BEHAVIORAL HEALTH TRANSFORMATION

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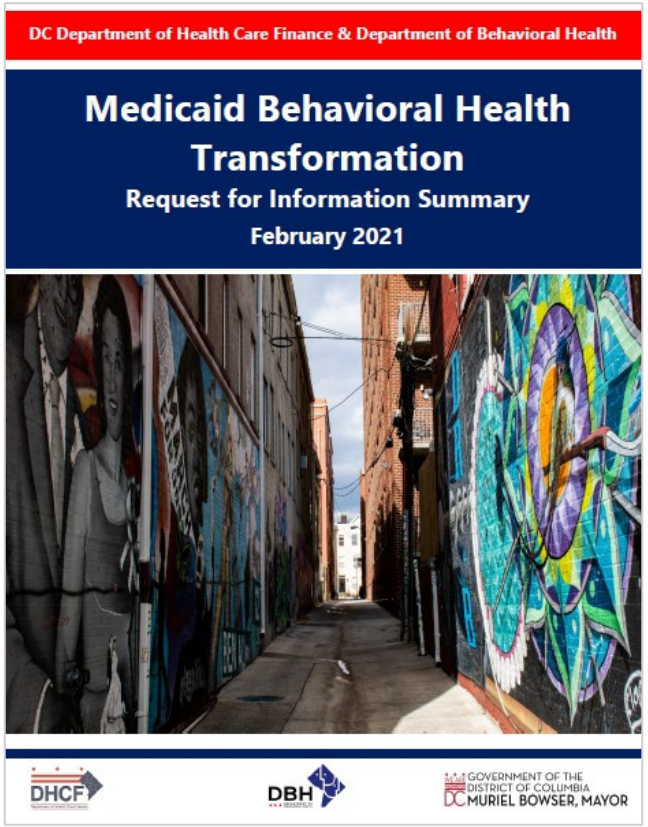
- Overall, respondents were supportive of transforming behavioral health care in the District to achieve a whole-person, population-based, integrated Medicaid behavioral health system that is "comprehensive, coordinated, high quality, culturally competent, and equitable."
- Consensus noted in these areas (16 responses to 21 Qs):
  - Telehealth parity
  - Need for targeted interventions for special needs populations
  - Support for a community-based approach informed by SDOH
  - Funding and focus on improving health equity
  - Defining and measuring success of efforts to integrate care based on specific health outcomes.




DHCF and DBH. Medicaid Behavioral Health Transformation Request for Information Summary, February 2021.

# DHCF-DBH: ASSESSING INDIVIDUAL PROVIDERS' NEEDS FOR TECHNICAL ASSISTANCE (TA)

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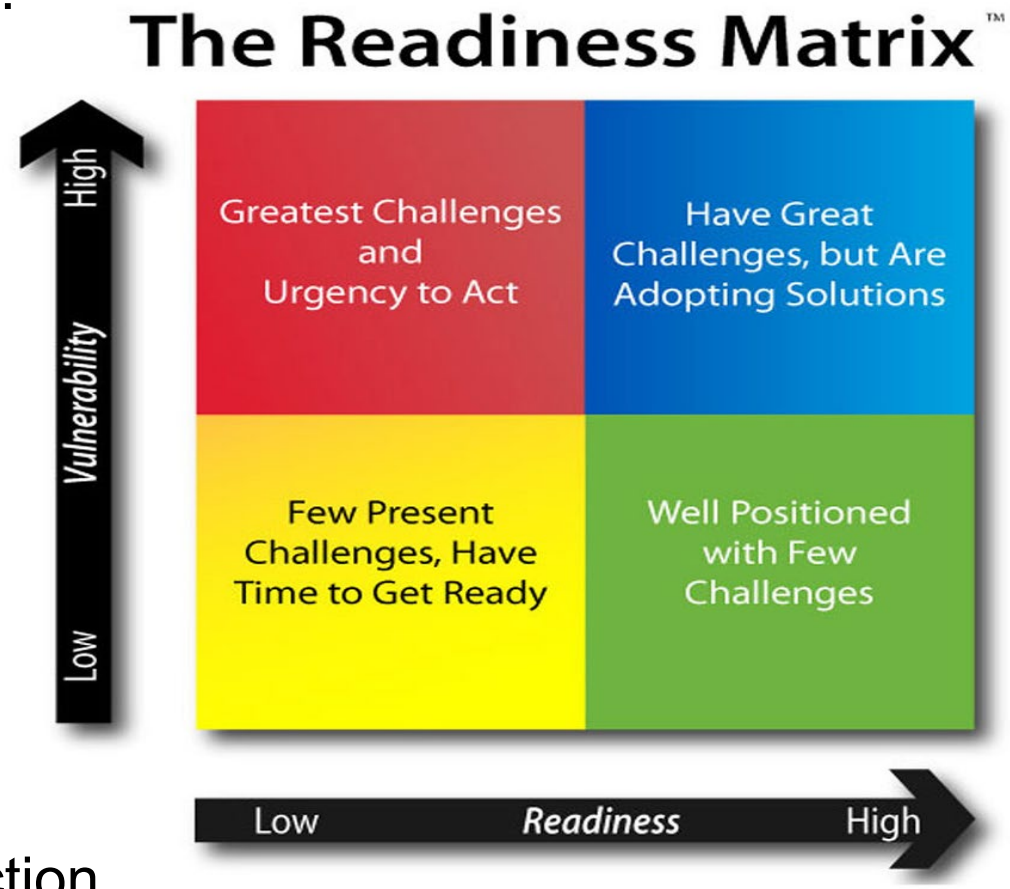
- Assessed the individual needs of providers using:
  - Provider Readiness Survey
  - Revenue Cycle Assessments
  - Provider Assessment on Integrated Care
- Designed the readiness process to:
  - Inform BH providers about the full spectrum of activities and capabilities required for managed care contracting; and to
  - Identify where BH provider organizations would benefit from TA to improve their practice to function effectively within the managed care framework.




Source: DBH Provider Mtg; Readiness 11/4/21

# THE TRIPLE TO THE QUINTUPLE AIM

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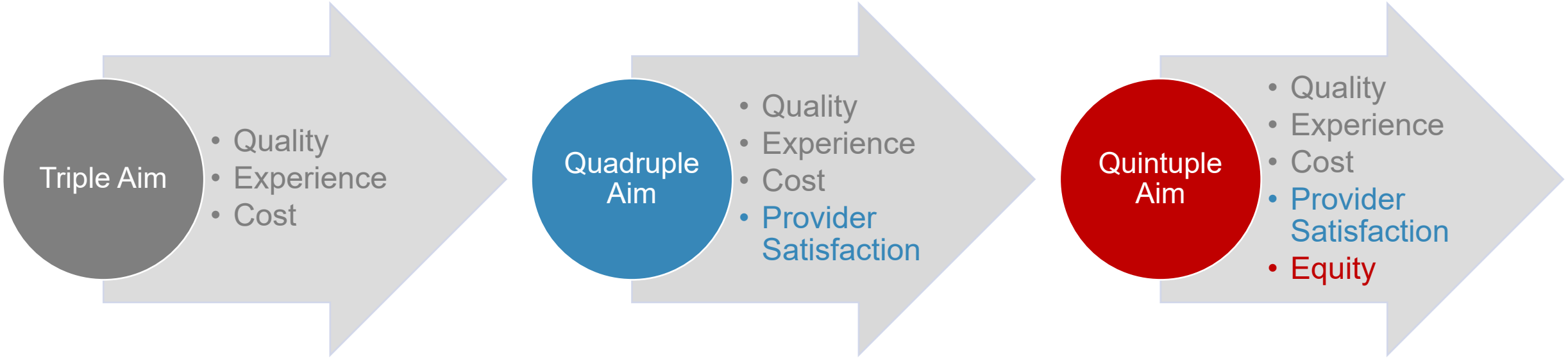


Source: Institute for Healthcare Improvement: www.ihi.org.
Bodenheimer T and Sinsky C, From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider. Ann Fam Med 2014;12:573-576.
Coleman K., Wagner E., Schaefer J., Reid R., LeRoy L. Agency for Healthcare Research and Quality; 2016. Redefining Primary Care for the 21st Century. White Paper. (Prepared by Abt Associates, in partnership with the MacColl Center for Health Care Innovation and Bailit Health Purchasing, Cambridge, MA under Contract No.290-2010-00004-I/ 290-32009-T.) AHRQ Publication No. 16(17)-0022-EF.

# WHAT IMPACTS HEALTH OUTCOMES?

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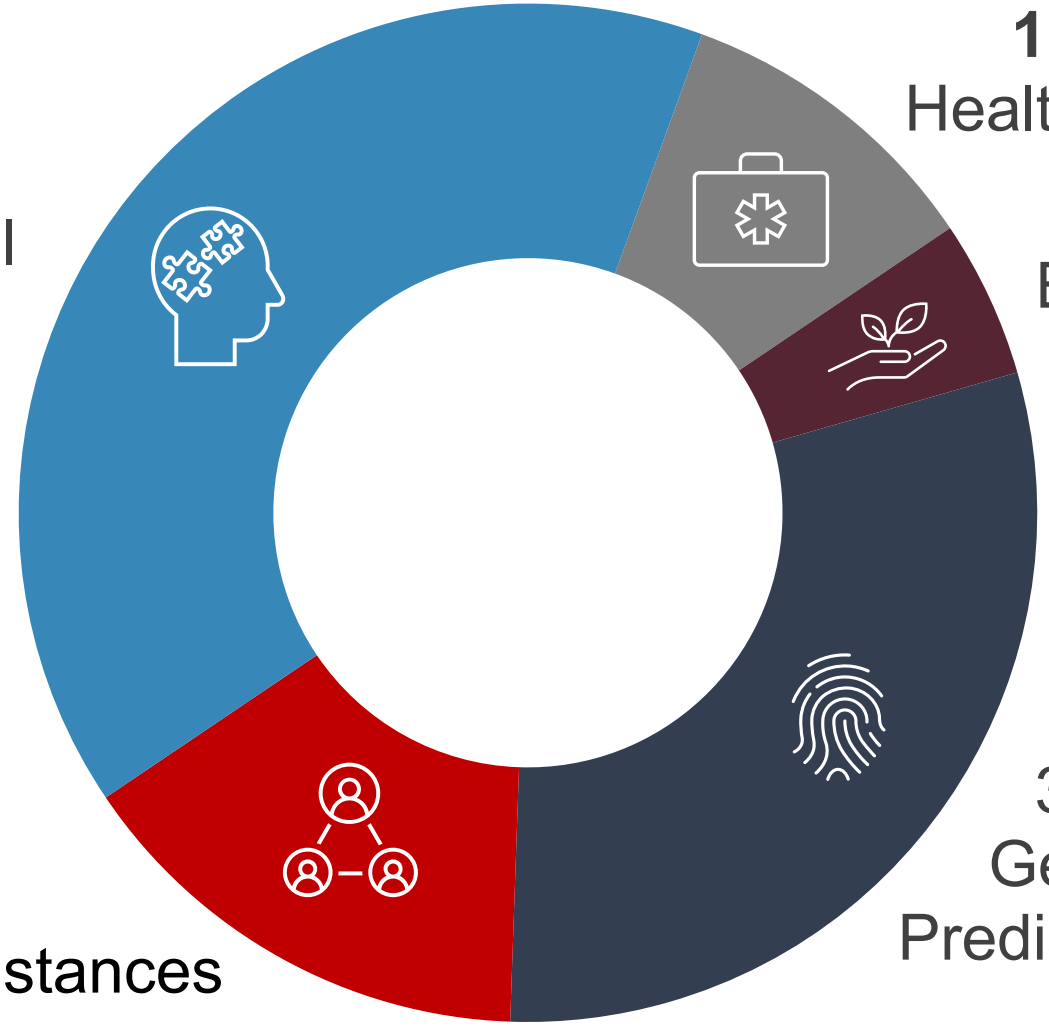


Source: Schroeder, Steven A. *We Can Do Better – Improving the Health of the American People*. N Engl J Med 2007;357:1221-8

# A CONTINUUM-BASED FRAMEWORK FOR INTEGRATING CARE

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| | |
|---|---|
| Case finding, screening, and referral | • Screening, initial assessment, and follow-up<br>• Referral facilitation and tracking |
| Ongoing care management | • Coordination, communication, and longitudinal assessment |
| Information tracking and exchange | • Clinical registries for tracking and coordination<br>• Sharing of treatment information |

Source: Chung, et al. Advancing Integration of Behavioral Health into Primary Care: A Continuum-Based Framework. United Hospital Fund, 2016.

# THE ROLE OF SPECIALTY BEHAVIORAL HEALTH IN AN INTEGRATED CARE ENVIRONMENT

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| Coordinated | | Co-Located | | Integrated | |
|---|---|---|---|---|---|
| Level 1 Minimal Collaboration | Level 2 Basic Remote Collaboration | Level 3 Basic On-Site Collaboration | Level 4 Close On-Site Collaboration | Level 5 Approaching Integration | Level 6 Transformed Integrated Practice |

## The learning imperative for BH providers:

- to integrate into the ecosystem of providers that works with their clients
- to function more like traditional medical specialties

BH integration creates financial underpinnings to make this more possible.

Source: SAMHSA-HRSA Center For Integrated Health Solutions from The National Council for Mental Wellbeing (Accessed 4/27/2023). https://www.thenationalcouncil.org/wp-content/uploads/2020/01/CIHS_Framework_Final_charts.pdf?daf=375ateTbd56.

# INTEGRATION IMPROVES LIVES, REDUCES COSTS

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## RETURN ON INVESTMENT

ROI of $6.50 for every $1 spend

## CONTROLLED TRIALS DEMONSTRATE IT IS MORE EFFECTIVE AND EFFICIENT

70+ randomized controlled trials demonstrate it is both more effective and more cost-effective
+ Across practice settings
+ Across patient populations
+ For a wide range of the most common BH disorders

## BETTER OUTCOMES

Better outcomes for common chronic medical diseases.

## GREATER PROVIDER SATISFACTION

Sources: Unützer J et al. “The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes.” Health Home Information Resource Center Brief. Centers for Medicare and Medicaid Services. May 2013. https://www.chcs.org/media/HH_IRC_Collaborative_Care_Model__052113_2.pdf. See also reference list at end of slide deck.

# UNDERSTANDING BEHAVIORAL HEALTH INTEGRATION

# FEE FOR SERVICE VERSUS MANAGED CARE

## Fee for service

- DC bears the risk and uncertainty
- Incentive to overtreat
- Care is unmanaged
- Less ability to address health-related social needs
- No holistic view of the client
  - Especially problematic for people with multiple chronic conditions
- Individuals & providers as care managers

## Managed care

- MCO bears the risk and uncertainty
- Incentive to keep healthy through preventative care
  - Establishes usual sources of care
- Promotes efficient use of services
- Network adequacy standards
- Quality assurance and improvement function
- External quality review required
- Aggregation structure to incent quality

Source: Medicaid and CHIP Payment and Access Commission, Managed care's effect on outcomes. www.macpac.gov/subtopic/managed-cares-effect-on-outcomes.

# MANAGED CARE OUTCOMES

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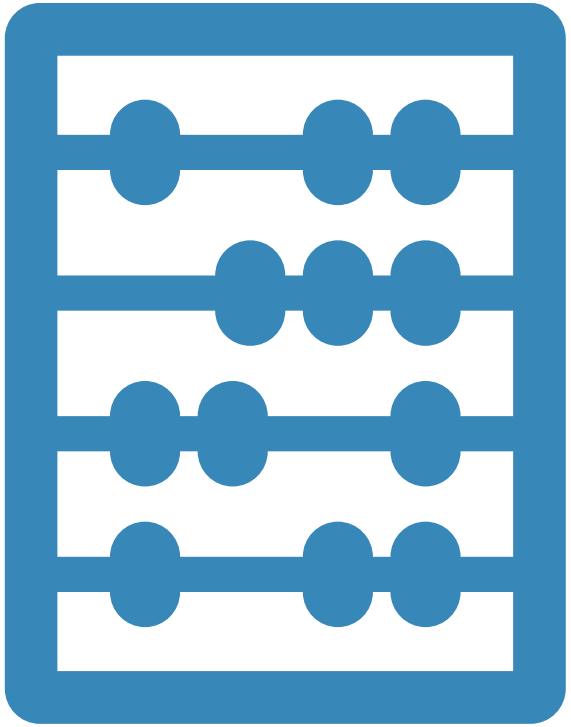
- Higher rates of preventative services utilization
- Reductions in inpatient procedures
  - Fewer inpatient complications
- Reduced mortality rates for specific populations
- Increased maternal care
- Higher patient satisfaction
- Reduced hospital costs



Source: Namburi, N., & Tadi, P. (2022). Managed care economics. In *StatPearls [Internet]*. StatPearls Publishing.

# ALIGNING PAYMENT AND PRACTICE TRANSFORMATION FOR WHOLE-PERSON CARE

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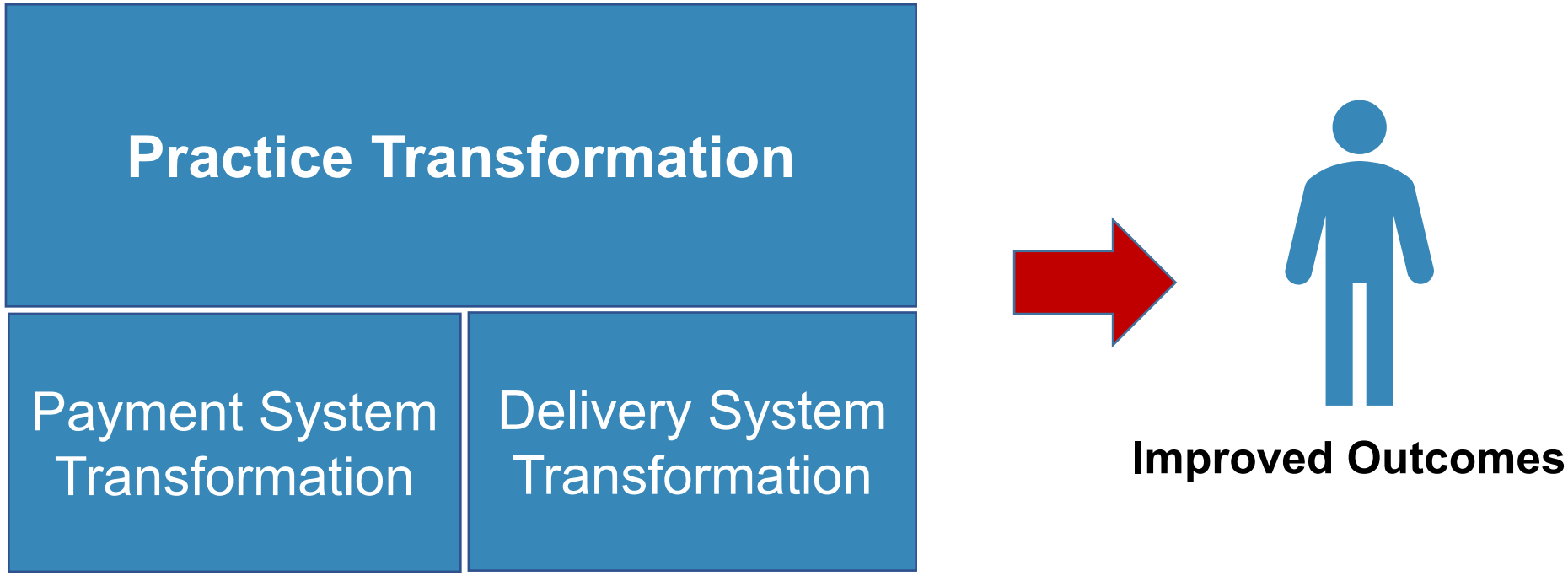
Delivery system transformation and payment system transformation create a financially sustainable model for practice transformation that improves patient outcomes.



# MORE THAN 80% OF THE DISTRICT'S MEDICAID ENROLLEES ARE IN MANAGED CARE

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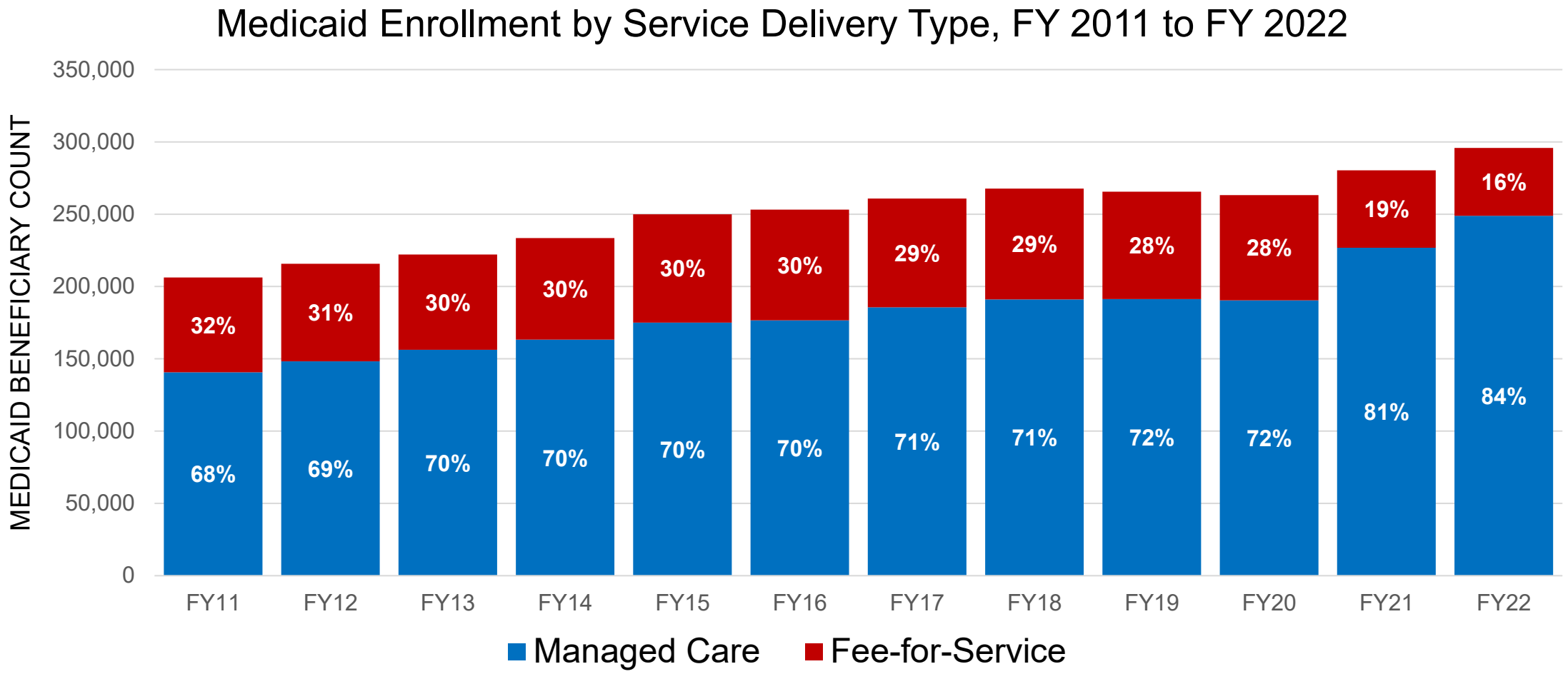


**Source:** DHCF Medicaid Management Information System data extracted in March 2023.
**Note:** Enrollment reflects average monthly.

# COMMUNITY BEHAVIORAL HEALTH: AN HISTORIC PERSPECTIVE

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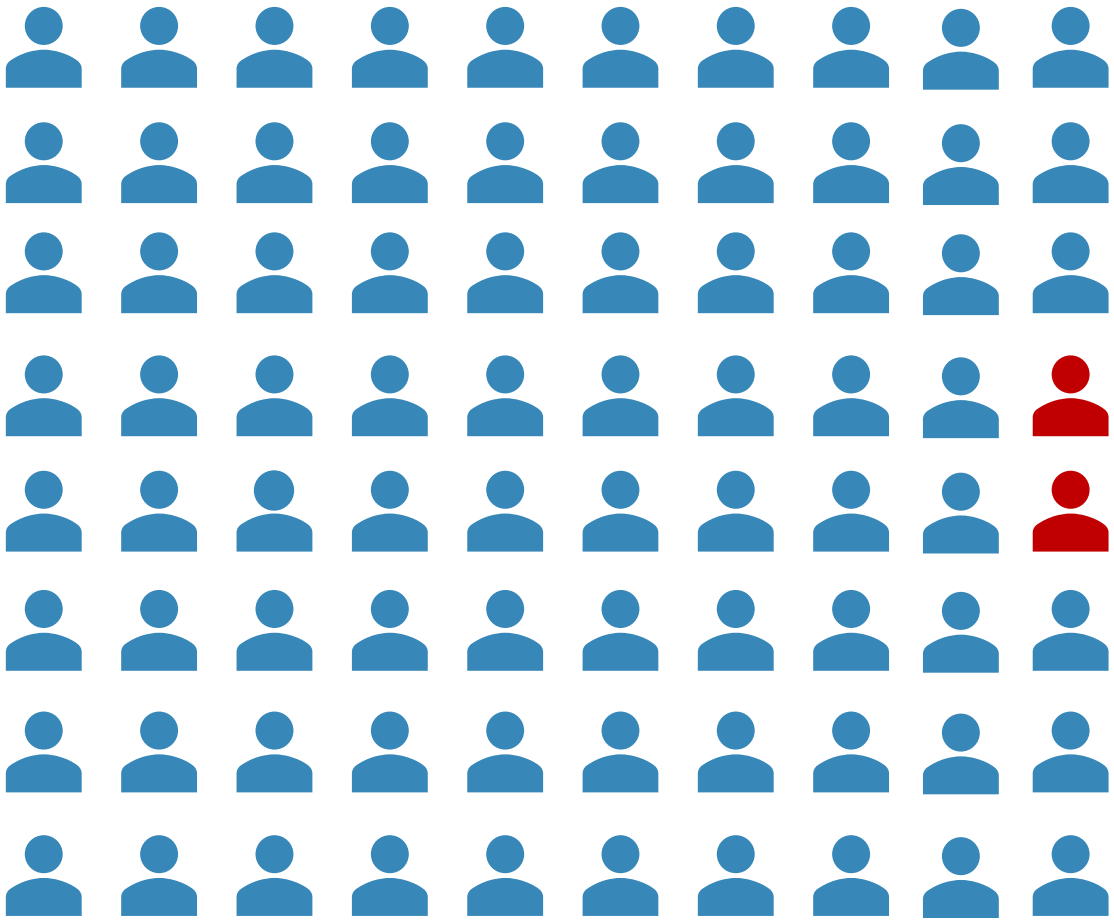
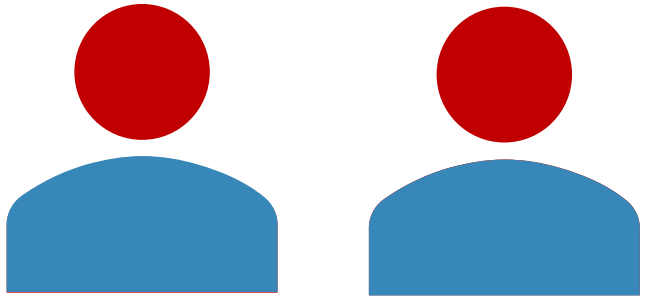
## Served a small portion of the population



## Only tended to a portion of their needs



# BEHAVIORAL HEALTH (BH) ACCOUNTS FOR A DISPROPORTIONATE SHARE OF MEDICAID SPENDING

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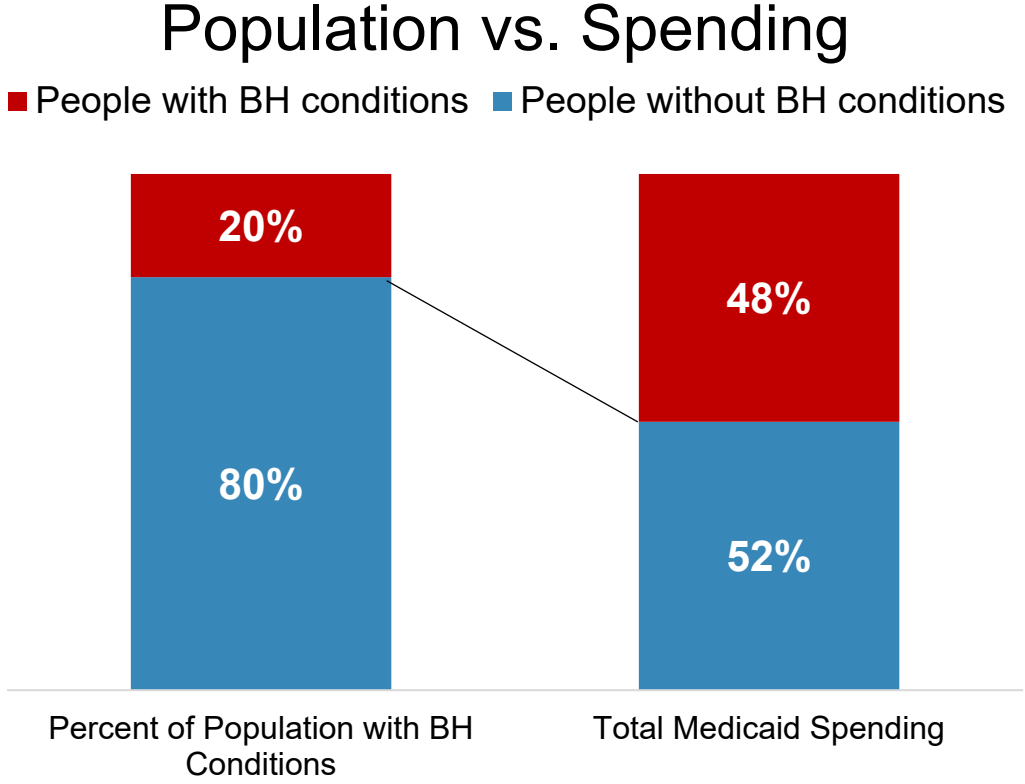
In the U.S., average Medicaid spending per enrollee with behavioral health conditions is nearly **four times** as much as for enrollees without these conditions.


Only 20% of Medicaid enrollees in U.S. have BH conditions, but nearly **half** of Medicaid spending is for enrollees with BH conditions




Source: Medicaid's Role in Behavioral Health, Henry J. Kaiser Family Foundation, May,2017. https://files.kff.org/attachment/Issue-Brief-Medicaids-Role-in-Financing-Behavioral-Health-Services-for-Low-Income-Individuals.

# BEHAVIORAL HEALTH INTEGRATION: FROM CARVE OUT TO CARVE IN

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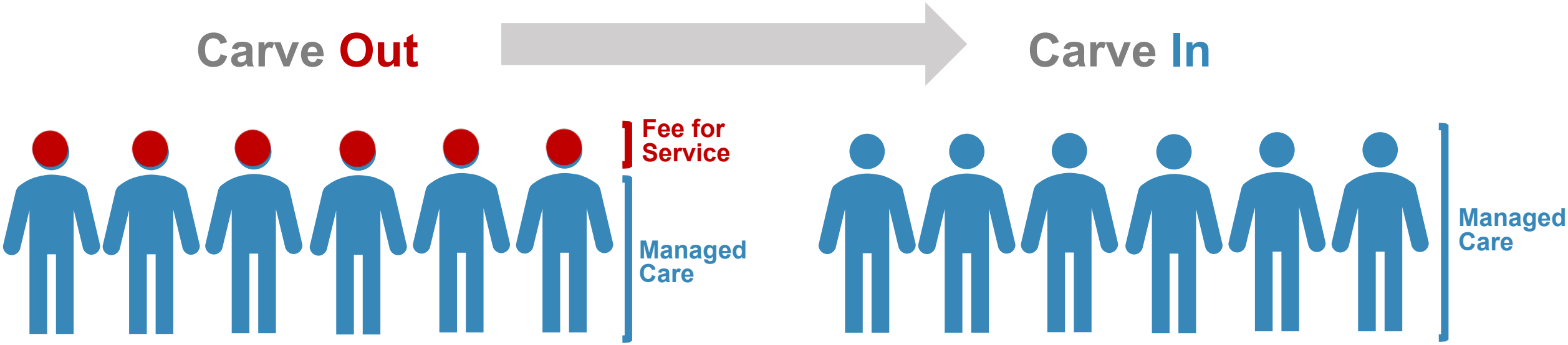


Separate payment methodologies for different parts of the body make whole-person care difficult

# A CRITICAL PIECE TO REMEMBER

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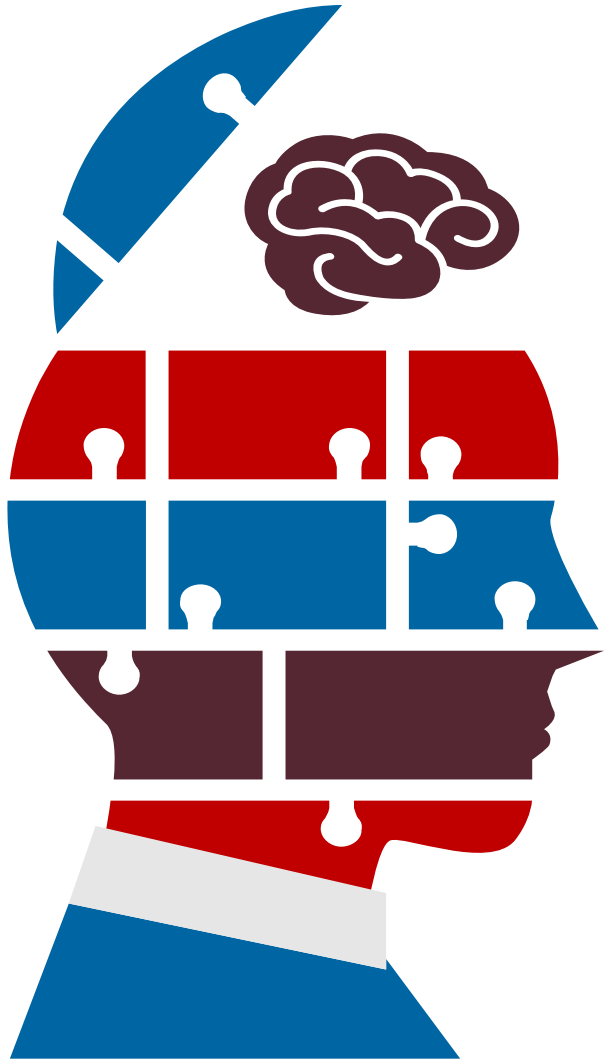

**Integrated funding**

**≠**

**Integrated care**

# YOUR RELATIONSHIP WITH THE MCO AS THE PAYER

# IMPACTED PROVIDERS AND SERVICES

# THE MAJOR STRUCTURAL CHANGE

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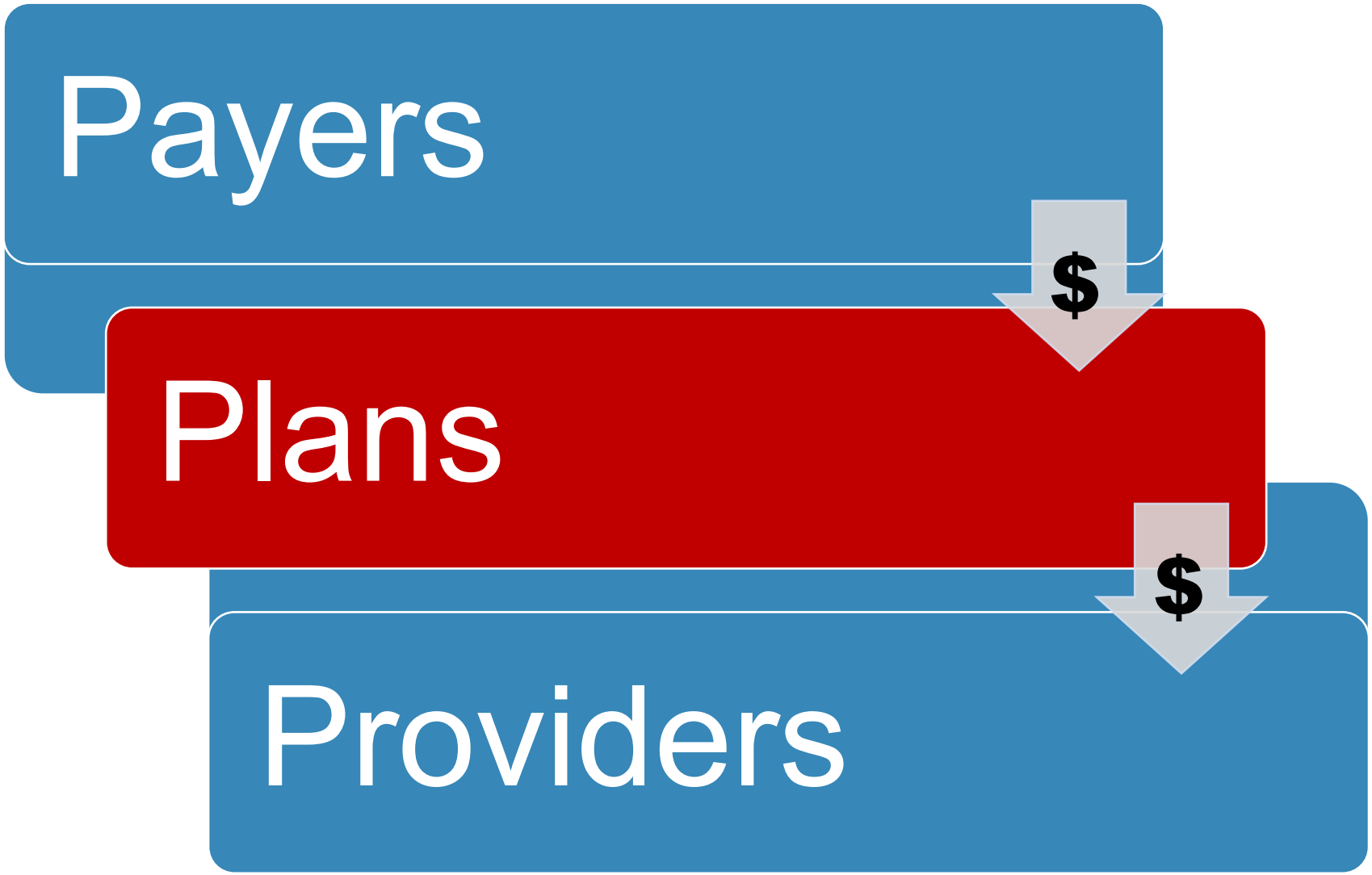

DC Healthcare Alliance Program participants will have full coverage for mental health and substance use disorder assessment and treatment

# DC BEHAVIORAL HEALTH INTEGRATION UPDATES: IMPACTED PROVIDERS AND SERVICES

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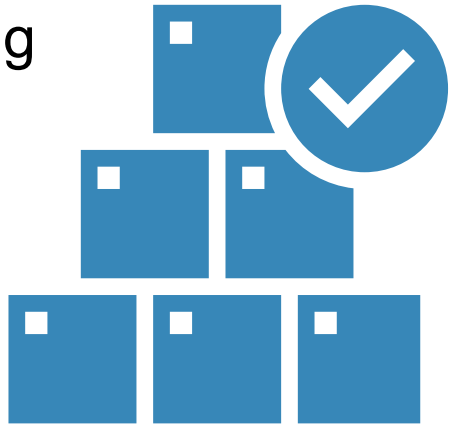
- DBH requires all DBH Certified Providers to contract with each Managed Care Organization (MCO)
  - Fosters beneficiary choice of provider regardless of health plan
  - Facilitates smooth transition process; can retain current provider
  - Ensures providers are preparing as required
- The health plans are no longer allowed to sub-contract Care Coordination and Case Management services

# FOUNDATIONAL ELEMENTS OF MANAGED CARE FOR BEHAVIORAL HEALTH

# FOUNDATIONAL ELEMENTS OF MANAGED CARE

## Key foundational elements include:

- Managed Care Terminology
- Utilization Review & Utilization Management
- Authorization Process
- MCO Priorities (incl. direct input from MCOs)
- Enrollment
- Payment Constructs and Value-Based Payments
  - Capitation (full and partial)
  - Diagnosis-Related Groups
- Contracting
- Quality Improvement vs. Quality Assurance (QI vs. QA)
- Analytics
- National Provider Identifier (NPI)
- Credentialing



# MCO PRIORITIES AND REQUIREMENTS

# DHCF'S PRIORITIES REFLECTED IN MCO CONTRACTS

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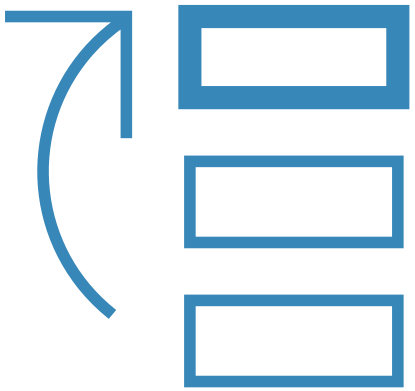
- As DHCF continues to move towards a fully managed Medicaid program, it seeks to transform the managed care program into a more organized, accountable, and person-centered system that best supports the District's Medicaid beneficiaries in managing and improving their health.
- The provisions of the solicitation for the three MCO contracts that went into effect in the District on April 1, 2023 reflect DHCF's vision, mission, and strategic priorities.
- Behavioral health providers who want do business with the DC Medicaid MCOs will benefit from increasing their understanding of the priorities of both the DC Medicaid managed care program and the individual MCOs operating under contract to DHCF.

# MCO PRIORITIES



- Quality monitoring and reporting
- Manage Care
  - Improved health outcomes for members
  - Timely access to high quality services for members
- Manage Costs
  - PMPM
  - Administrative
- Adequate Network
- Authorization
- Utilization Management
- Customer Service
  - Members
  - Funders/regulators (DHCF, CMS)
  - Providers

# HOW MCOS MANAGE COSTS

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- Preventive care for chronic conditions
  - Primary prevention: prevent
  - Secondary prevention: detect and treat early
  - Tertiary prevention: disease management
- Lifestyle changes
- Care management to ensure efficient use of healthcare resources
- Care coordination to enable team-based care across providers
- Data analysis to identify inappropriate utilization

# CUSTOMER SERVICE STANDARDS

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- Each MCO is required to provide an enrollee handbook
  - Benefits provided (amount, duration and scope)
  - How and where to access benefits, including transportation
  - Procedures for obtaining benefits
    - Requirements for service authorizations and/or referrals for specialty care and for other benefits not furnished by the PCP
  - After-hours and emergency coverage
  - Beneficiary rights and responsibilities
  - How to select or change PCP
  - Grievance, appeal, and State fair hearing procedures and timeframes;
  - Toll-free telephone contact information
    - How to access auxiliary aids and services, including alternative formats or languages
  - Information on how to report suspected fraud or abuse.
- Provider network directory in a format specified by DHCF

# THE MCO CONTRACT IS THE MECHANISM FOR ACCOUNTABILITY FOR BOTH MCO AND PROVIDER

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- Parties and definitions
- Scope of services
- Payment adjustments
- Administrative requirements
- Indemnification
- Compliance
- Term and termination
- Representations and warranties
- Assignment
- Amendment
- Notices
- Dispute resolution or litigation
- Audits, monitoring and oversight

# DC ACCESS: 4 STANDARDS

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- Time and Distance Standards
- Timely Access Standards (i.e., appointment wait times)
- Provider to Enrollee Ratio:
  - 1 PCP for every 500 Enrollees (Adults)
  - 1 PCP for every 500 Enrollees (Children and Adolescent) thru age 20
  - 1 Dentist for every 750 (Children and Adolescent)
- Language and Cultural Competency Accessibility

**Appointment Wait Time Standards**

| Provider Type | Appointment Type | Wait Time |
|---|---|---|
| **Primary Care** | New Enrollee Appointment | 45 days of enrollment |
| | Routine Appointment | 30 days of Enrollee Request |
| | Well – Health for Adults 21+ | 30 days |
| | Non-Urgent Referrals | 30 days |
| | Diagnosis and Treatment of Health Condition (*not urgent*) | 30 days |
| **Specialists** | Non-Urgent Referral | 30 days |
| **Pediatrics (EPSDT)** | New Enrollee Appointment | 60 days |
| | EPSDT Examination | 30 days |
| | IDEA | 30 days |
| | IDEA Treatment | 25 days with IFSP |

Source: DHCF. MCO Provider Network Management. MCAC Access Subcommittee Meeting (January 13, 2021).
https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/2021%20Provider%20Relations%20Network%20Requirements%20ppt3-%20MCAC%20Subcommittee%20Mtg%20Jan%2012.pdf.

# PARTNERING WITH MANAGED CARE

# PROVIDER-PLAN COMMUNICATION

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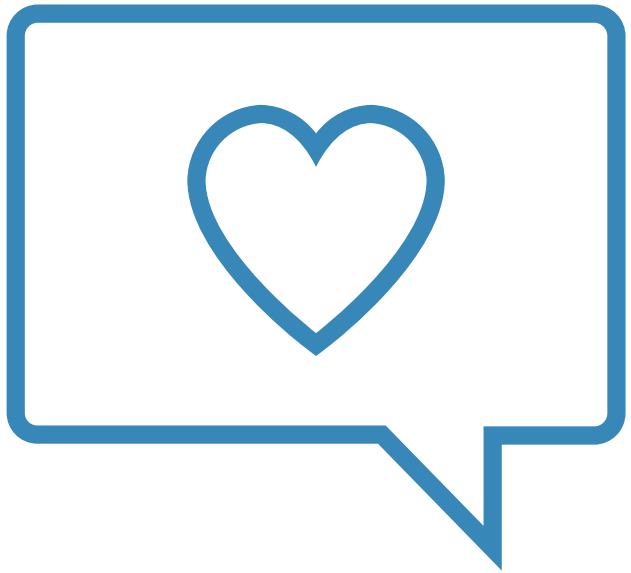
- Plans are part of the patient-centered planning team
- Knowing **who** to contact and **when** is key to smooth collaboration and getting issues resolved
- Some of the plan communication processes and protocols are set by the District; others vary by plan
- Designate a **liaison** responsible for developing relationships with plan contacts



# LIAISON ROLE

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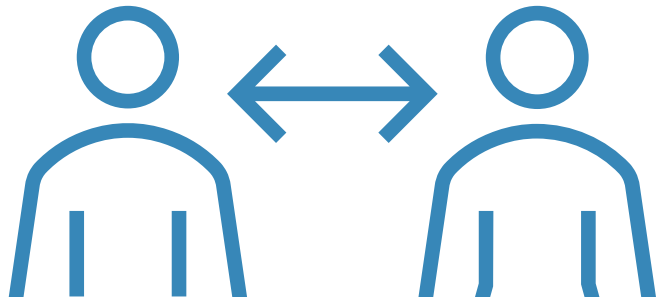
- Know the policies for communicating with and reporting to plans regarding member verification, service authorization, etc.
- Become familiar with plan resources and materials:
  - **Provider manual:** Includes all relevant information on BH services, BH-specific provider requirements
  - **Plan websites:** Contain resources and information



- Keep a record of important plan phone numbers & contacts
  - A telephone tracking log is a good idea
- Track plan reporting and information submission requirements (e.g., for performance reporting) and ensure they are being met

# COMMUNICATING WITH THE PLAN

# COORDINATING THE PRACTICE-BASED CARE MANAGEMENT AND MCO OUTREACH

# CREATING A SUCCESSFUL CARE MANAGEMENT (CM) PROGRAM

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## Seven building blocks to care management

- Joint planning with network providers
- Integrated evidence-based CM
- CM staff working at top of license
- Bidirectional interoperable communication
- Daily analytics monitoring
- Compliance with DHCF's rules
- Payer cost savings and provider VBP performance

**Data and analytics**

**Training and clinical protocols**

# YOUR PLAN COMMUNICATIONS TOOLKIT

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- Designated plan **liaison** within your organization
- A record or database of **important plan phone numbers and contacts**
- Plan **provider manual** (each plan will have one)

# UTILIZATION MANAGEMENT (BEFORE) VS. UTILIZATION REVIEW (AFTER)

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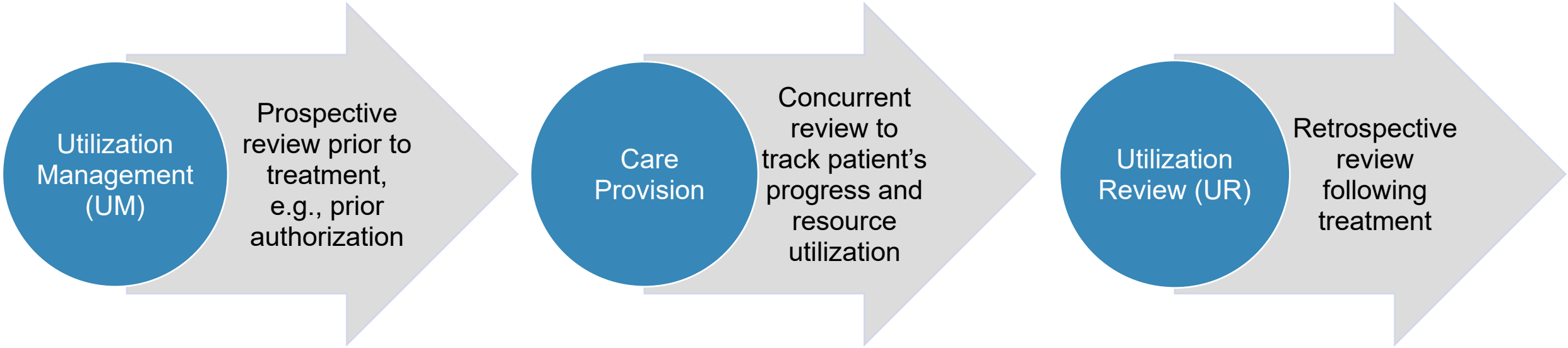
UM and UR are both used to determine whether health care resources are being used efficiently.



# THE BIG THREE UTILIZATION MANAGEMENT GOALS

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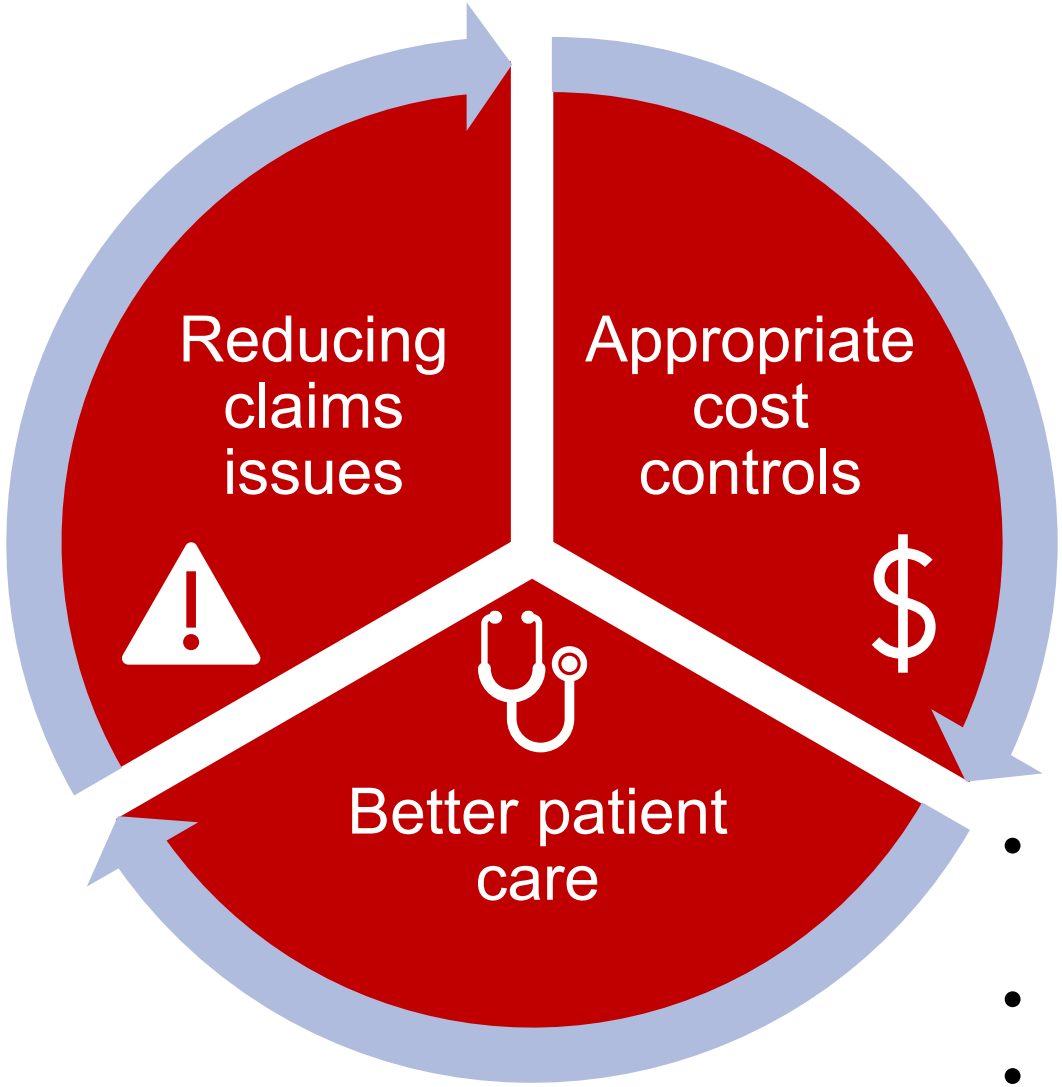
- **Reduction in issues at the claims level**




- **Right care**
- **Right place**
- **Right time**

- **Reduction in inappropriate under and over utilization**
- **Evidence-based**
- **Outcomes measured**

# ELEMENTS OF UTILIZATION MANAGEMENT

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- Pre-certification/Prior Authorization
- Discharge Planning
- Concurrent Planning
- Appeal/Dispute Processes

# AUTHORIZATION

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- The individual is eligible
- Service is part of the approved service plan
- Service is within the established service caps
- It is the most appropriate (most integrated/least intensive) level of care
- Authorization must be provided within timeliness standards
- Meets medical necessity criteria
- In line with best practice guidelines

# LEVEL OF CARE (LOC) CRITERIA

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Six evaluation dimensions:

1. Functional status
2. Co-morbidity
3. Recovery environment (environmental stress and environmental support)
4. Treatment history
5. Degree of engagement
6. Risk of harm to self or others, including potential for victimization or accidental harm

# ASAM LEVEL OF CARE (LOC) CRITERIA FOR SUD

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But how do you determine which level of care is right for your patient?

Look at functioning in each of the six dimensions:

1. Acute Intoxication and/or Withdrawal Potential
2. Biomedical Conditions and Complications
3. Emotional, Behavioral, or Cognitive Conditions and Complications
4. Readiness to Change
5. Relapse, Continued Use, or Continued Problem Potential
6. Recovery Environment

**DC Integration Update**

The *ASAM Criteria* is now the chosen clinical framework for SUD treatment

Mee-Lee D, Shulman GD, Fishman MJ, Gastfriend DR, Miller MM, eds. *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions*. 3rd ed. Carson City, NV: The Change Companies®; 2013.

# ASAM LEVEL OF CARE (LOC) IN SUD TREATMENT

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| | |
|---|---|
| Level 0.5 | Early Intervention |
| Level 1 | Outpatient Services |
| Level 2.1 | Intensive Outpatient Services |
| Level 2.5 | Partial Hospitalization Services |
| Level 3.1 | Clinically Managed Low Intensity Residential Services |
| Level 3.3 | Clinically Managed Population Specific High-Intensity Residential Services (Adults Only) |
| Level 3.5 | Clinically Managed High-Intensity Residential Services (Adult Criteria) |
| Level 3.5 | Clinically Managed Medium-Intensity Residential Services (Adolescent Criteria) |
| Level 3.7 | Medically Monitored Intensive Inpatient Services (Adult Criteria) |
| Level 3.7 | Medically Monitored High Intensity Inpatient Services (Adolescent Criteria) |
| Level 4 | Medically Managed Intensive Inpatient Services |

# DC BEHAVIORAL HEALTH INTEGRATION UPDATES: STANDARDIZED TOOLS – DLA-20 AND CAFAS/PECFAS

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**DC Integration Update**

DLA-20 and CAFAS/ PECFAS selected as standardized tools

**DLA-20:** The Daily Living Activites-20 (DLA-20) is an adult functional assessment tool designed to assess what daily living areas are impacted by mental illness or disability. The tool identifies interventions for functional needs to inform individualized service plans.

**CAFAS/PECFAS:** The Child & Adolescent Functional Assessment Scale ("CAFAS") and the Pre-school & Early Childhood Functional Assessment Scale ("PECFAS") are rating scales for youth ages 6-20 that assess functional impairment attributed to behavioral, emotional, psychological, or substance use disorders.

# DC BEHAVIORAL HEALTH INTEGRATION UPDATES: STANDARDIZED TOOLS – DLA-20 AND CAFAS/PECFAS

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| DLA-20 | CAFAS/PECFAS |
| --- | --- |
| **Requirement:** DBH-Certified providers are expected to complete the DLA-20: | **Requirement:** DBH-Certified children/youth providers to complete the CAFAS/PECFAS: |
| 1. At admission during the assessment process | 1. Within 30 days or by the 4th visit whichever comes first following intake. |
| 2. Every ninety (90) days thereafter | 2. Every ninety (90) days thereafter |
| 3. When a change in Level of Care occurs | 3. During significant events affecting functioning that would impact service intensity and necessitate a treatment plan update |
| 4. At discharge | 4. At discharge |

Source: Government of the District of Columbia. (2023, February 13). *Level of Care Determinizations for Adults in MHRS*. Department of Behavioral Health. https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/COVID-19%20Guidance%20to%20Operators%20of%20Community-based%20Residences_0.pdf

# DC MCO FY2023 BEHAVIORAL HEALTH-RELATED METRICS

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- Follow-up After Hospitalization for Mental Illness (FUH)*
  - 7 day
  - 30 day
- Follow-up After ED Visit for Mental Illness (FUM)*
  - 7 day
  - 30 day
- Screening for Depression and Follow-Up Plan
- Concurrent Use of Opioids and Benzodiazepines
- Use of Opioids at High Dosage in Persons Without Cancer
- Use of Pharmacotherapy for Opioid Use Disorder

*Performance Improvement Projects are required for MCOs/CASSIP/DSNP

# MEDICAL NECESSITY

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- Health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is:
  - In accordance with generally accepted standards of medical practice
  - Clinically appropriate in terms of type, frequency, extent, site, and duration
  - Not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician, or other health care provider

Source: American Medical Association

# JUSTIFYING MEDICAL NECESSITY

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- Consistent with symptoms or diagnosis
- Consistent with generally accepted professional medical standards
- Not for the convenience of the patient, any provider
- Neither more nor less than the patient requires at that time
- Not related to monetary status or benefit
- Documented

# GRIEVANCES AND APPEALS

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- The Health Benefits Plan Members Bill of Rights Act of 1998 guarantees DC health plan members a progressive appeal/grievance process

**Informal internal review**
- 24 hours for emergency care
- 14 days for non-emergency

**Formal internal review**
- 24 hours for emergency care
- 30 days for non-emergency

**Formal external review**
- Procedure established by the Director of the Department of Health

D.C. Law 12-274. Health Benefits Plan Members Bill of Rights Act of 1998. https://code.dccouncil.gov/us/dc/council/laws/12-274.

# OFFICE OF THE HEALTH CARE OMBUDSMAN

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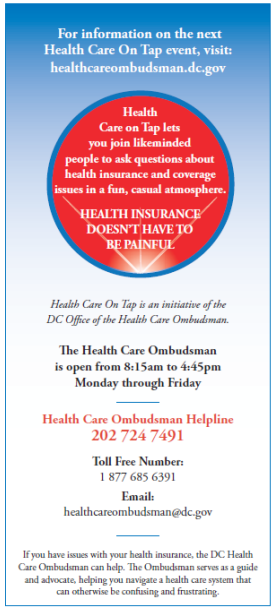
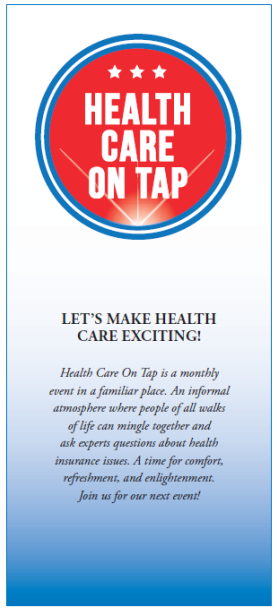
- Established by the Council of the District of Columbia, the Health Care Ombudsman Program assists individuals insured by health plans in the District and uninsured consumers in the District to:
  - Understand their health care rights and responsibilities;
  - Resolve problems with health care coverage, access to health care, or health care bills;
  - Appeal a health plan's decision; and
  - Find other health care resources.
- Website: https://healthcareombudsman.dc.gov

# CHANGE MANAGEMENT FOR BEHAVIORAL HEALTH LEADERSHIP

# THE CASE FOR CHANGE

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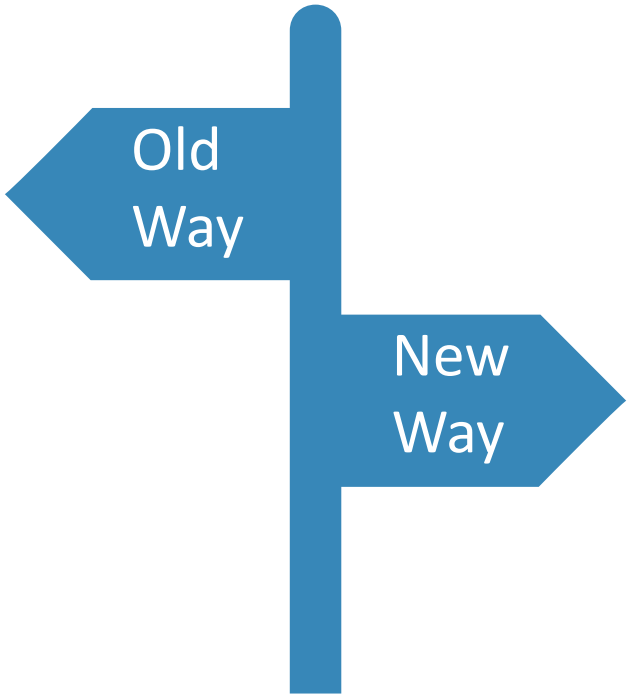


**“It is not the strongest of species that survives, nor the most intelligent that survives.**

**It is the one that is the most adaptable to change.”**

***-Charles Darwin***

# THE SYSTEM HAS BEEN EVOLVING AND CHANGING SINCE IT WAS ESTABLISHED

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**Dorothea Dix: 19th century**
**Moral Treatment**

**Adolph Meyer: Early 20th century**
**Biopsychosocial Treatment**


**Anti-psychotics: 1950s**
**Pharmacologic Treatment**

**Deinstitutionalization: 1960s**
**Community-Based Treatment**

**Recovery Movement: 1970s**
**Person-Centered Treatment**

# THE EVOLUTION HAS BEEN DIRECTIONALLY CONSISTENT

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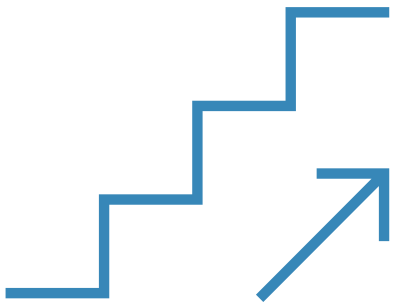

- Government investment and regulation
- Integration
  - Community
  - Other service systems
- Whole-person approach
  - Social Drivers of Health
- Level of complexity
- Respect for the humanity of people with mental illness
- Centrality of people with mental illness and their wants/needs

# SUCCESS FACTORS FOR CHANGE MANAGEMENT

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1. Provide direct and visible leadership
2. Deploy teams to make changes
3. Test changes
4. Coach to support change
5. Make the way unavoidable
6. Allocate actual resources
7. Monitor what you want to sustain and spread
8. Create a culture of improvement

Source: Judge, K. H., Zahn, D., Lustbader, N. J., Thomas, S., Ramjohn, D., & Chin, M. (2007). Factors contributing to sustaining and spreading learning collaborative improvements: Qualitative research study findings by the Primary Care Development Corporation. *New York: Primary Care Development Corporation*.

# QUESTIONS

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# GROUP EXERCISE
# CREATE A VALUE PROPOSITION FOR BEHAVIORAL HEALTH

## *10:30 – 10:45*

# DEMONSTRATING IMPACT/VALUE

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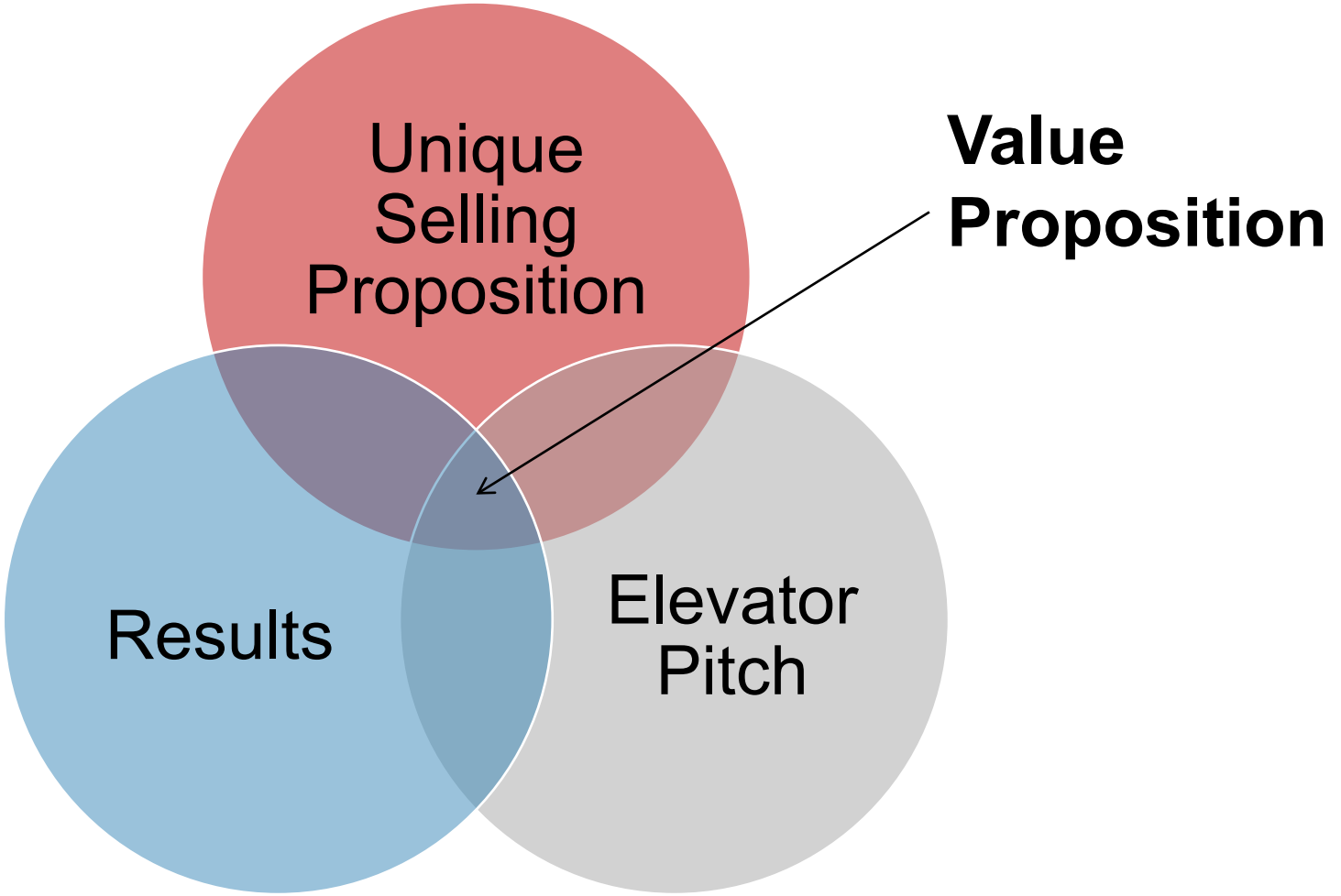

# DEFINE THE PROBLEM/NEED

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***"A problem well stated is a problem half solved."***
***– Charles Kettering, Inventor***

- Is the problem unworkable?
- Is fixing the problem unavoidable?
- Is the problem urgent?
- Is the problem under-addressed?

# DEMONSTRATING YOUR VALUE PROPOSITION IN FOUR BASIC STEPS:

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1. Define the problem/need
2. Evaluate
   a) Unique?
   b) Compelling?
   c) Innovative?
3. Measure
   a) Cost/benefit of services to customers
4. Build

# BREAK

## *10:45 – 11:00*

# BUILDING BLOCKS OF MANAGED CARE, PART 2:

# PLANNING FOR CHANGE TO SUPPORT MANAGED CARE FOR BEHAVIORAL HEALTH



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**PRESENTED BY:**
**Dr. Art Jones, HMA**

**Tuesday,**
**May 9, 2023**
11:00 am – 12:00 pm ET

Integrated Care DC is managed by the DC Department of Health Care Finance (DHCF) in partnership with the DC Department of Behavioral Health (DBH). This project is supported by the U.S. Department of Health and Human Services (HHS). A total of $3,500,365, or 81 percent, of the project is financed with federal funds, and $810,022, or 19 percent, is funded by non-federal sources. The contents are those of the author(s) and do not necessarily represent the official views of, or an endorsement by, HHS or the U.S. Government.

DHCF Department of Health Care Finance

HMA

# SECTION TOPICS

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- Managing the Health of a Population
- Measuring Behavioral Health Quality
- The Move to Value-Based Payments
- Clinically Integrated Networks and the Role of Behavioral Health
- Questions and Answers

# MANAGING THE HEALTH OF A POPULATION

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# Population (Health)care

Dealing with symptoms and disease treatment. Focus on prevention **proactively**.

# Population (Sick)care

Dealing with symptoms and disease treatment **reactively**.

# POPULATION HEALTH: DEFINITIONS AND CONCEPTS

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"The health outcomes of a group of individuals, including the distribution of such outcomes within the group; It has been described as consisting of three components. These are **health outcomes**, **patterns of health determinants**, and **policies and interventions**."

| Population Health Science | Population Health Action |
|---|---|
| Identification and measurement of outcomes | Programs developed and implemented to effectively and efficiently provide care for members of a population in a way that is consistent with the community's cultural, and health resource values (adapted from IHI and AMA). |

Source: Kindig D, Stoddard G ( March 2003) American Journal of Public Health, 93 (3): 380-3

# 3 ELEMENTS OF POPULATION HEALTH

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| Physical Health | Behavioral and Emotional Health | Social Health |
| --- | --- | --- |
| • State of preventive care<br>• Risk for a disease<br>• Presence of a disease/ condition<br>• Multiple conditions | • Base emotional health<br>• Behavioral risk factors<br>• Behavioral conditions | • Food<br>• Housing<br>• Economic stability<br>• Transportation<br>• Education<br>• Employment<br>• Safety/Violence<br>• Caregiver access<br>• Etc. |

# POPULATION HEALTH FOCUS AREAS

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# STEPS TOWARDS ACHIEVING POPULATION HEALTH

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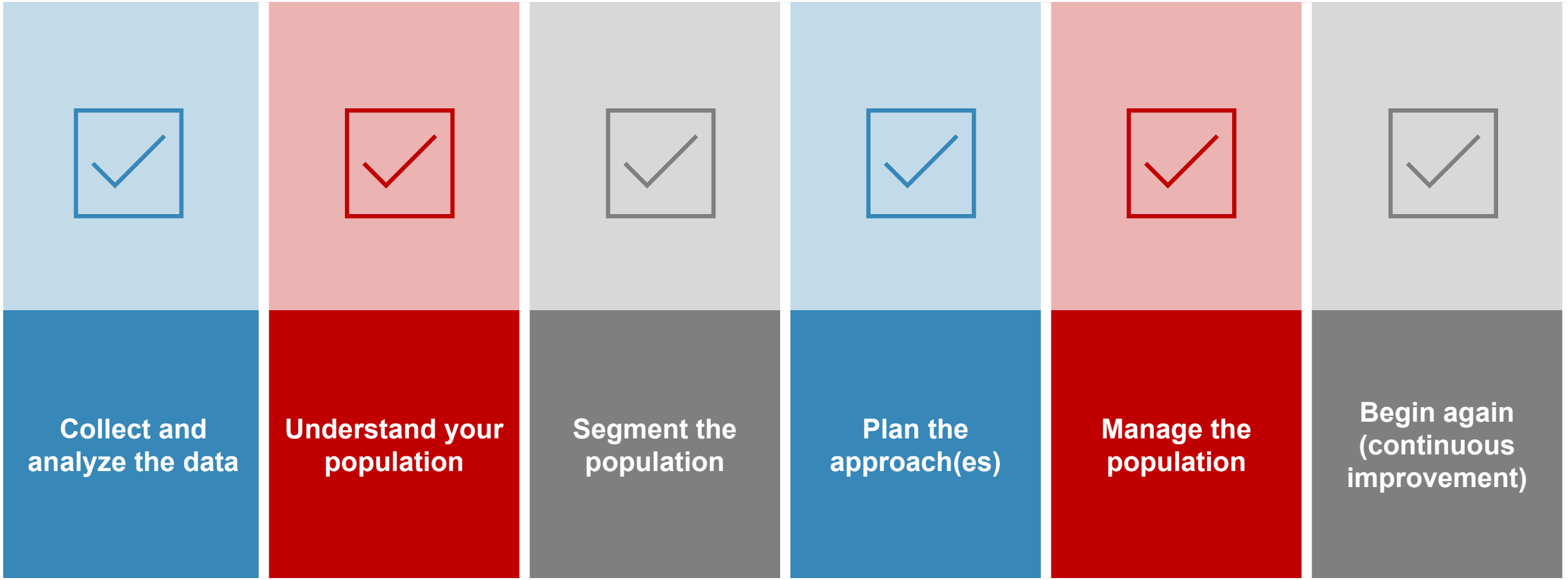

# POPULATION HEALTH ATTRIBUTES

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| | | | |
|---|---|---|---|
| **Member-centric:** *Population-based* | **Data-Driven:** *always* | **Evidence-Based:** *including innovative approaches* | **Comprehensive** |
| **Addressing Health Equity** | **Working with Providers/Plans:** *enabling involving the populations that they serve* | **Incenting Providers:** *using true Value-Based Contracting; this aligns interests* | **Measuring Outcomes and the Tasks that Drive Those Outcomes** |

# POPULATION HEALTH DATA COMPONENTS

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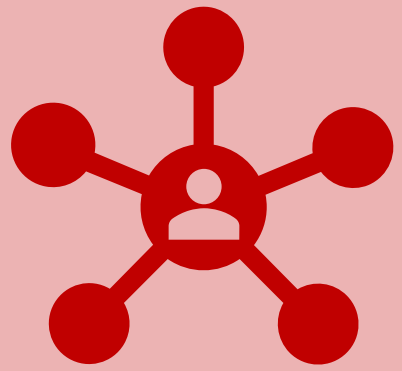
General Population



Attribution: Your Population of Focus

Individual Members of the Population of Focus

# DATA FOR THE GENERAL POPULATION

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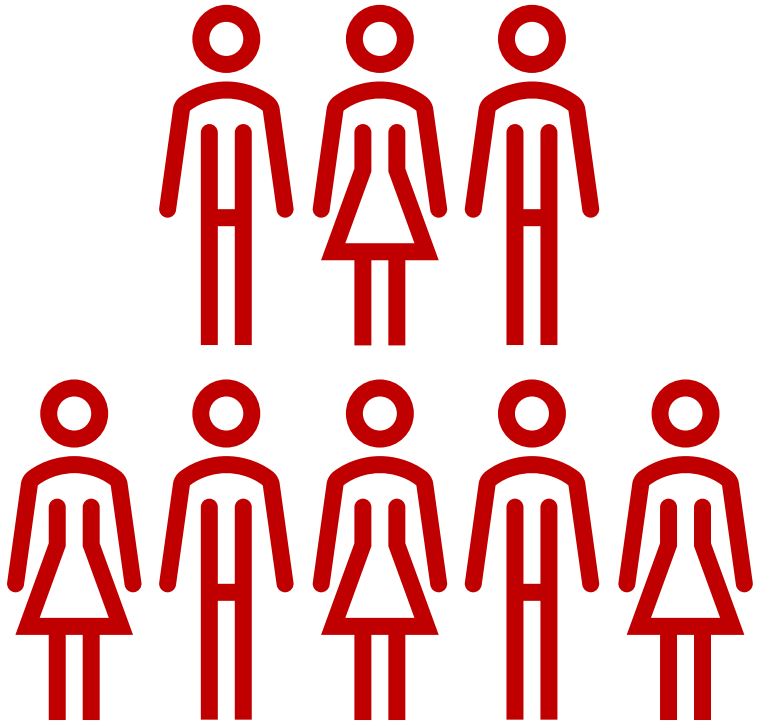
1. Census Data
2. Public Health Data
3. Personal Social Data
4. Accumulated Claims Data



# DATA FOR INDIVIDUAL MEMBERS OF THE POPULATION OF FOCUS

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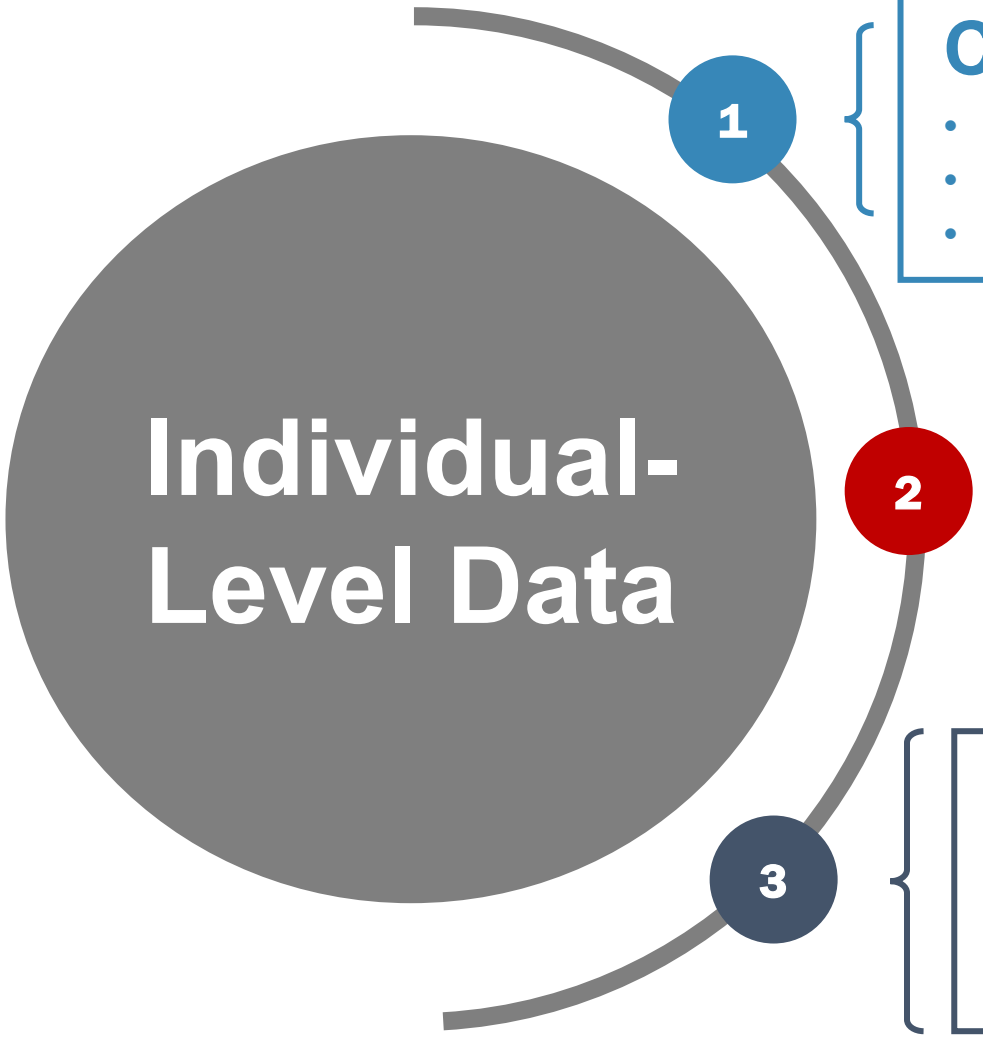


## Claims Data:

- Not timely
- Not precise
- Still the **mainstay**

## Clinical Data:

- EMR
- HIE and ADT
- Pharmacy

## Member-Reported Data:

- Critical (especially for SDoH)
- The Health Risk Assessment

# KEEPING MEMBERS HEALTHY

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1. Prevention
2. Acute Episodic Care
3. Health Risks
4. Stable Physical Condition Management Programs
5. Stable Behavioral Health
6. Stable Social Health





Source: Photo by Alexis Brown on Unsplash

82

# BARRIERS TO A SUCCESSFUL POPULATION HEALTH PROGRAM

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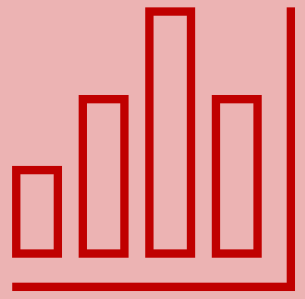
Lack of Data



Lack of Data tools/decision support

Lack of incentive alignment

Provider Culture

# THE CURRENT STATE OF THE DC HIE

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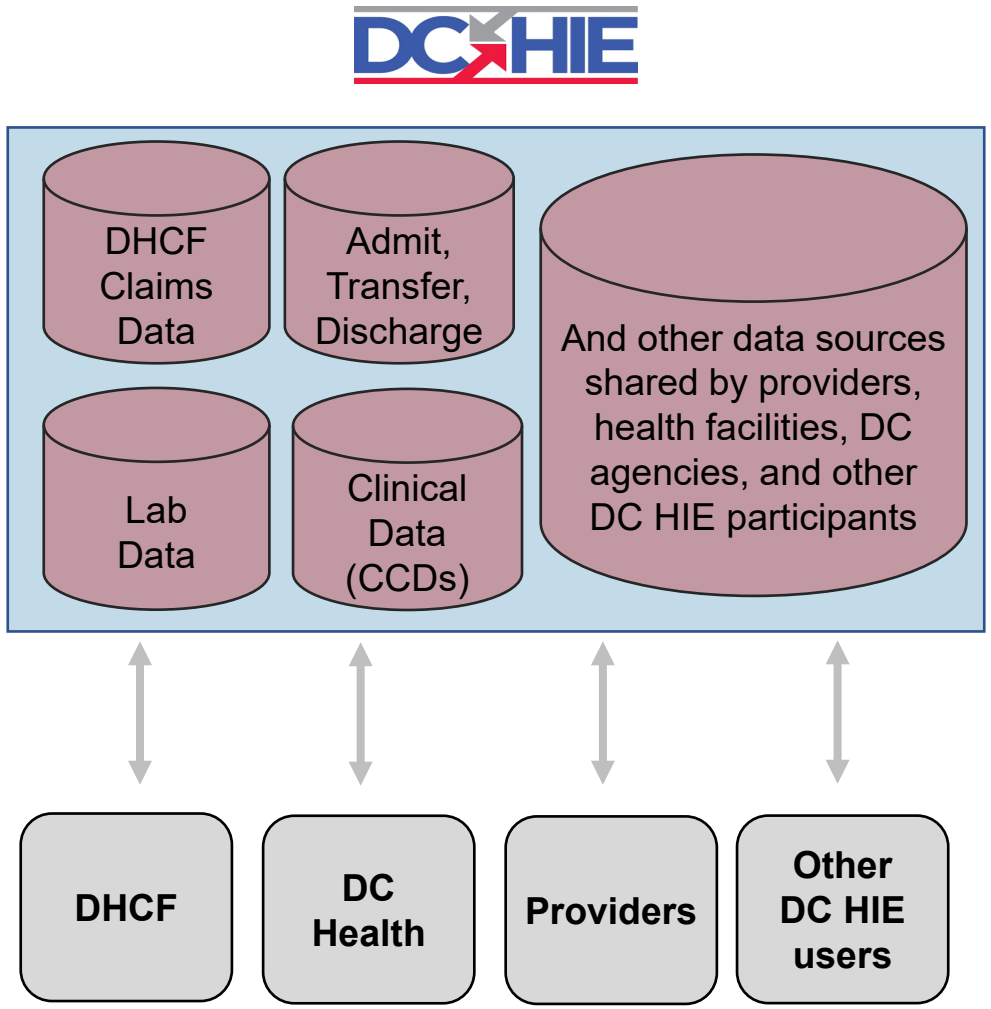
- The **DC Health Information Exchange (DC HIE)** is a health data utility that enables the secure, electronic exchange of health information among participating organizations. DHCF designated CRISP DC to serve as the District's HIE.
- DC HIE users can:
  - View the same content via the same interface, but for different panels – depending on which population they serve
  - View data at the individual-level, panel-level, and in the aggregate from disparate sources
  - Have greater transparency across entities involved in an individual's care delivery



# MEMBER DATA SOURCES- IDEAL STATE

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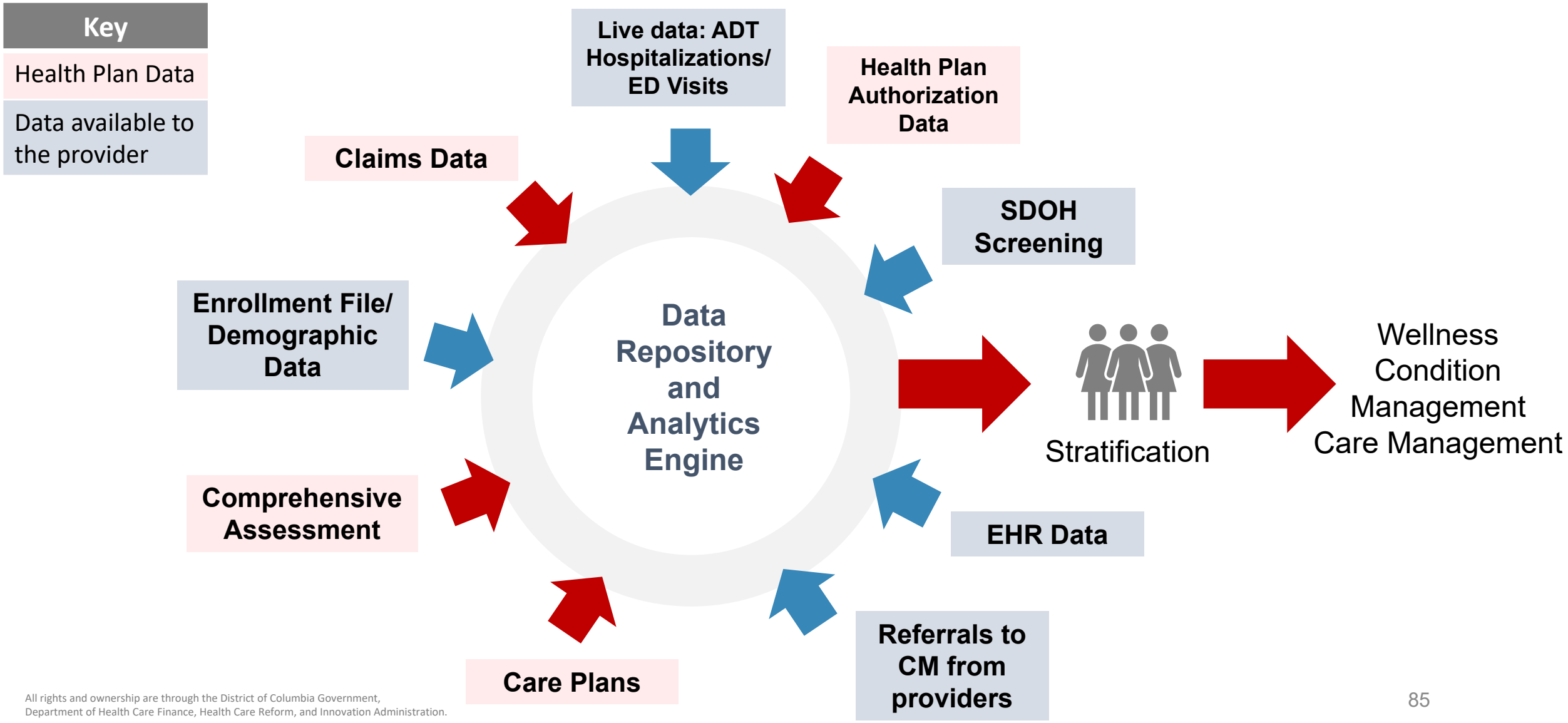

# EMERGING RISK

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| Physical | Behavioral | Social |
| --- | --- | --- |
| • One or two conditions that are not stable<br>• Condition management programs<br>• ER and hospital utilization | • Unstable condition<br>• ER and hospital utilization<br>• Low adherence to prescribed medications | • Unstable life situation coupled with PH or BH issues |

# DYNAMIC RISK STRATIFICATION

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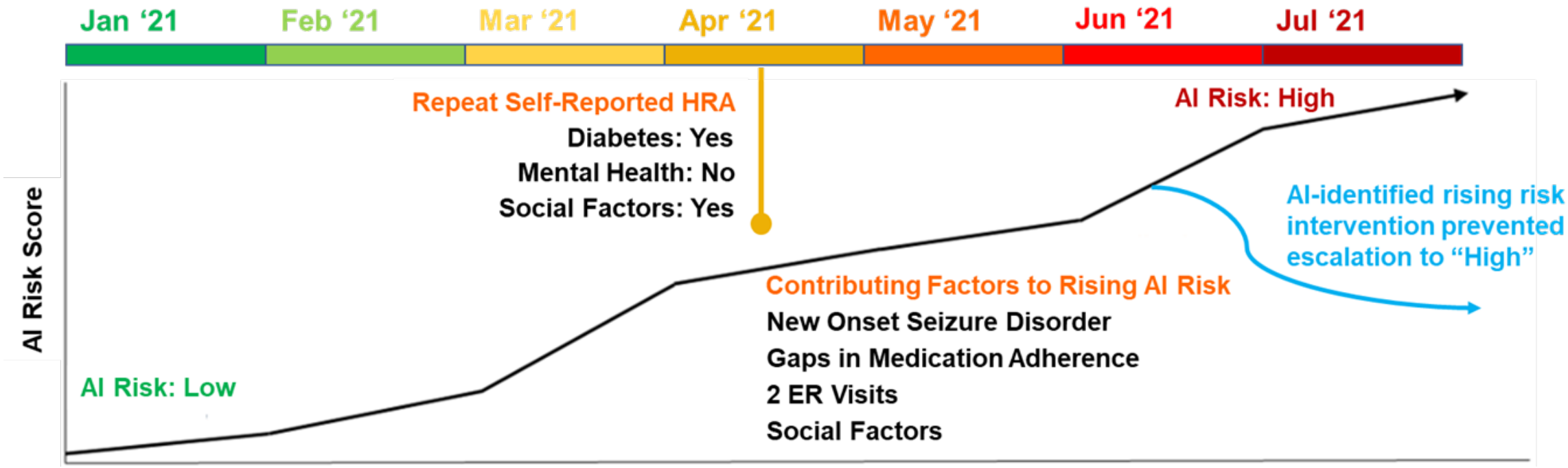


Source: Medical Home Network, 2021.

# MEASURING BEHAVIORAL HEALTH QUALITY

# STATES' COLLECTION AND USE OF MEDICAID BH PERFORMANCE MEASURES: 2022

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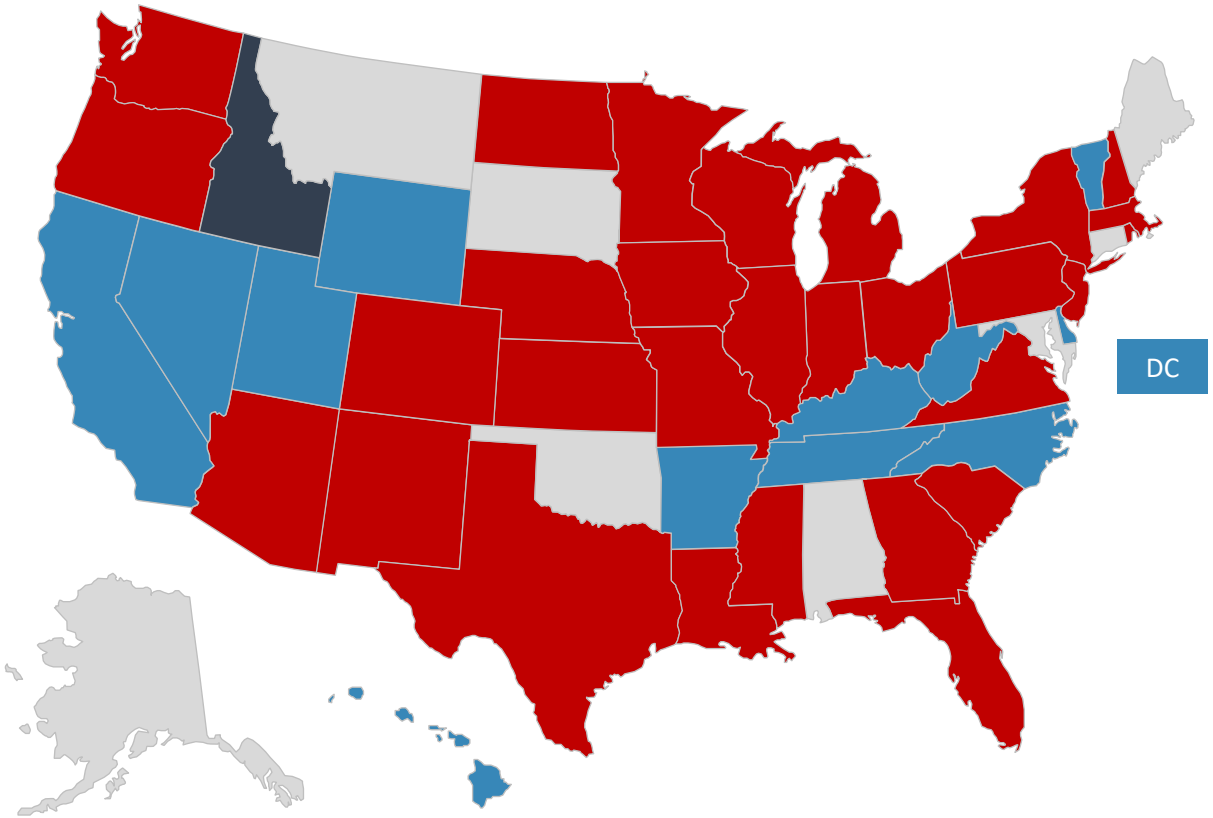
Collects Metrics

Uses Metrics in Payment

Does Not Collect Metrics

Does Not Manage BH




Source: National Academy for State Health Policy: State Use of Behavioral Health Performance Measures in Medicaid Managed Care Contracting. April 2023

# IMPROVING POPULATION HEALTH OUTCOMES

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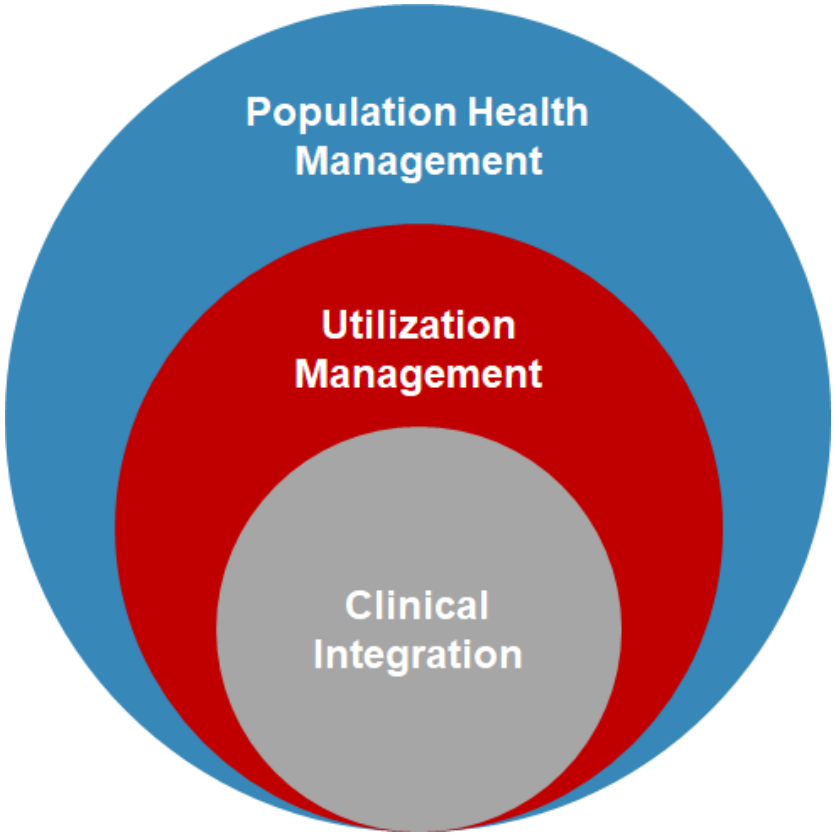


## Population Health Management: Provider and plan activities

- Data aggregator and analytics
- Stratify population by health risk
- Individualize care plans
- Care management
- Promote patient engagement

**Data-driven quality of care**

## Utilization Management: Provider and plan activities

- Standardize utilization of resources
- Cost containment
- Managing risk and outcomes

**Accountable care**

## Clinical Integration: Primarily provider-driven activities

- Provider integration
- Patient-centered medical home
- Referral management
- Patient access
- Team-based care

**Coordinated care**

# DHCF BEHAVIORAL HEALTH HEDIS METRICS FOR MCOS

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Screening for Depression and Follow-Up Plan

Follow-Up After Hospitalization for Mental Illness

Follow-Up After Emergency Department Visit for Mental Illness

# Screening for Depression and Follow-Up Plan

- The percentage of members 12 years of age and older who were screened for clinical depression using a standardized instrument and,
  - if screened positive, received follow-up care within 30 days of a positive depression screen finding.

## Follow-Up After Hospitalization for Mental Illness

- The percentage of discharges for members ages 6 and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider. Follow-up visits that occur on the same day as the IP discharge do *not* count. Follow-up is reported:
  - within 30 days after discharge
  - within 7 days after discharge.

## Follow-Up After Emergency Department Visit for Mental Illness

- The percentage of emergency department (ED) visits for members ages 6 and older with a principal diagnosis of mental illness or intentional self-harm who had a follow-up visit for mental illness. Follow-up visits *can* occur the same day as the ED discharge. Follow-up is reported:
  - within 30 days of the ED visit (31 total days)
  - within 7 days of the ED visit (8 total days)

# OTHER NCQA HEDIS BEHAVIORAL HEALTH METRICS

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- Follow-Up Care for Children Prescribed ADHD Medication
- Antidepressant Medication Management
- Metabolic Monitoring for Children and Adolescents on Antipsychotics
- Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia

# OTHER NCQA HEDIS BEHAVIORAL HEALTH METRICS (CONTINUED)

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- Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications
- Follow-Up After Emergency Department Visit for Substance Use
- Follow-Up After High-Intensity Care for Substance Use Disorder
- Initiation and Engagement of Substance Use Disorder Treatment

# VALUE-BASED CARE

# DEFINING VALUE-BASED CARE (VBC) AND ALTERNATIVE PAYMENT METHODOLOGIES (APMS)

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- Under VBC arrangements, providers are reimbursed based on their ability to improve quality of care in a cost-effective manner, or to lower costs while maintaining standards of care, rather than the volume of care they provide.[1]
- Alternative payment methodologies (APMs) refer to payment approaches that incentivize providers for delivering high-quality, cost-efficient care, such as bonuses for achieving specified quality and cost benchmarks, or shared savings for delivering services at a lower cost.[1,2]
  - APMs can apply to a provider type, clinical condition, care episode, or population
  - APMs vary by complexity and risk[1,2]

[1] Centers for Medicare & Medicaid Services. Fact Sheet. Value-based Care State Medicaid Directors Letter (September 15, 2020). https://www.cms.gov/newsroom/fact-sheets/value-based-care-state-medicaid-directors-letter.
[2] Health Care Payment Learning & Action Network (HCPLAN or LAN). Updated APM Framework. https://hcp-lan.org/apm-framework.

# VBP SPREAD IN MEDICAID

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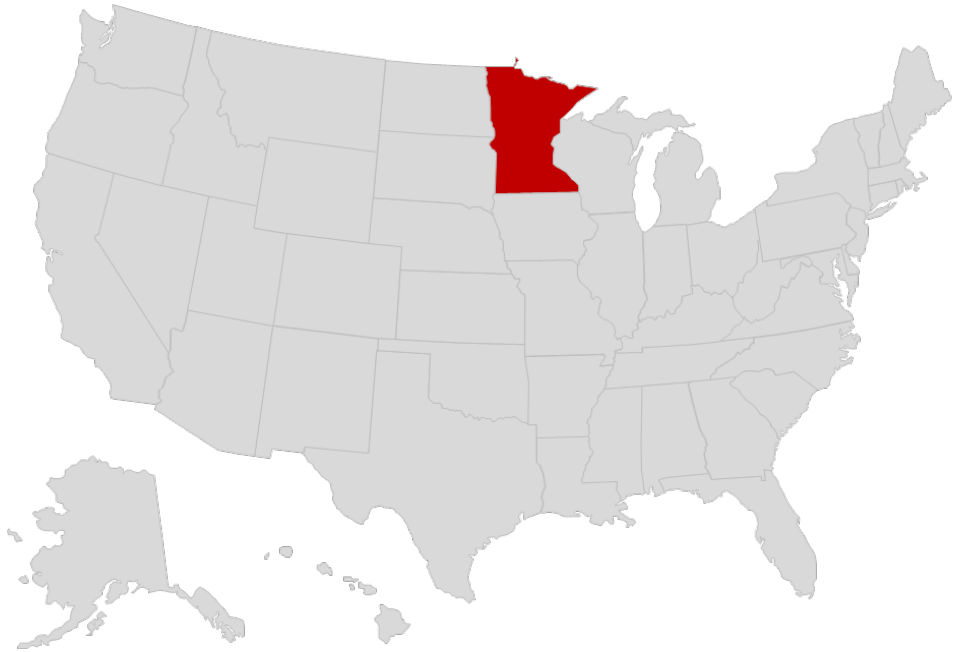
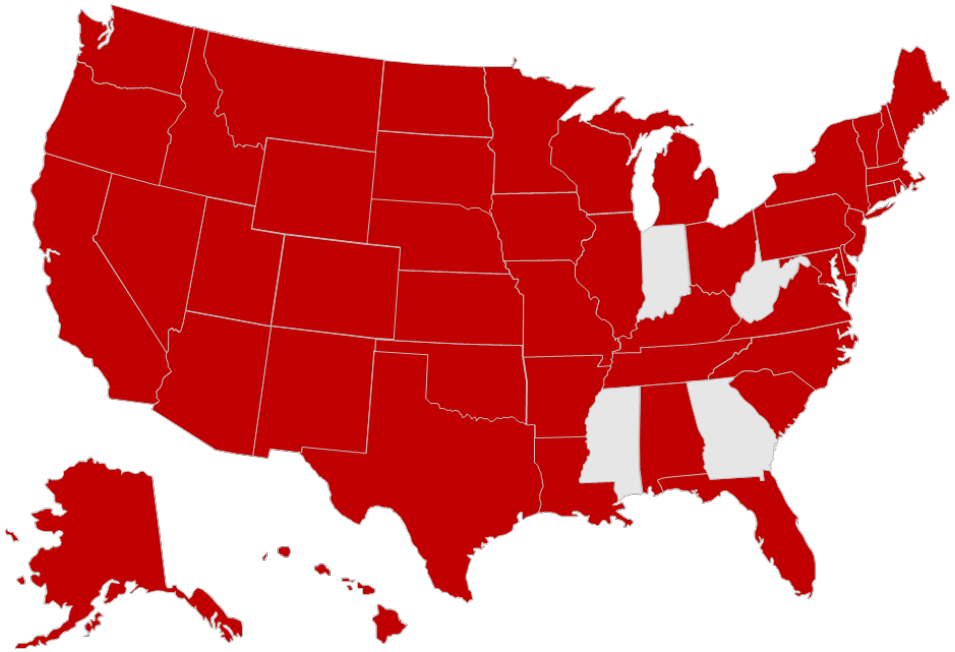
2008



2019



Value-Based Reimbursement State-By-State: A 50-State Matrix Review of Value-Based Payment Innovation. Change Healthcare, 2019.

# THE GLIDEPATH TO MORE ADVANCED ALTERNATIVE PAYMENT MODELS (APMS)

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| Pay for Performance | Upside | Upside and Downside | Bundled Care | Capitation |
|---|---|---|---|---|
| » Usually, quality-gap based | » No risk for provider | » Begins risk for providers | » Provider risk is specific but high in cases | » Typically, as a percent of premium for full capitation |
| » Was around for decades | » Can be with or without "quality gates" | » Real financial alignment | » Alignment of finances | » Partial arrangements also exist |
| » Does not really align finances in a meaningful way | » Begins alignment of finances | » Requires two-way data connections for success | » Almost always procedure based | » High financial alignment |
| » No risk for provider | | | » Some interesting disease-based arrangements exist | » *"Bill Aboves"* may exist |

Less Complex → More Complex

# PROVIDER ENGAGEMENT

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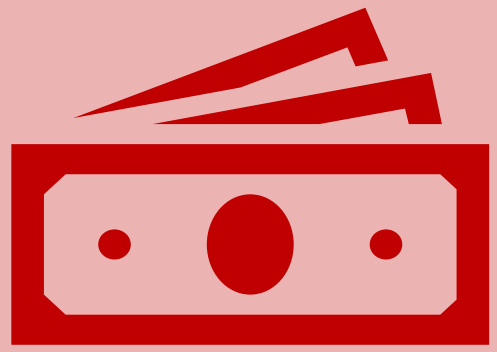
**The best population health management is provider-driven, or at least *heavily* provider involved.**



**Value-based contracting is critical to success.**

# HCP LAN FRAMEWORK: ACCOUNTABILITY, INTEGRATION, AND RISK GO TOGETHER

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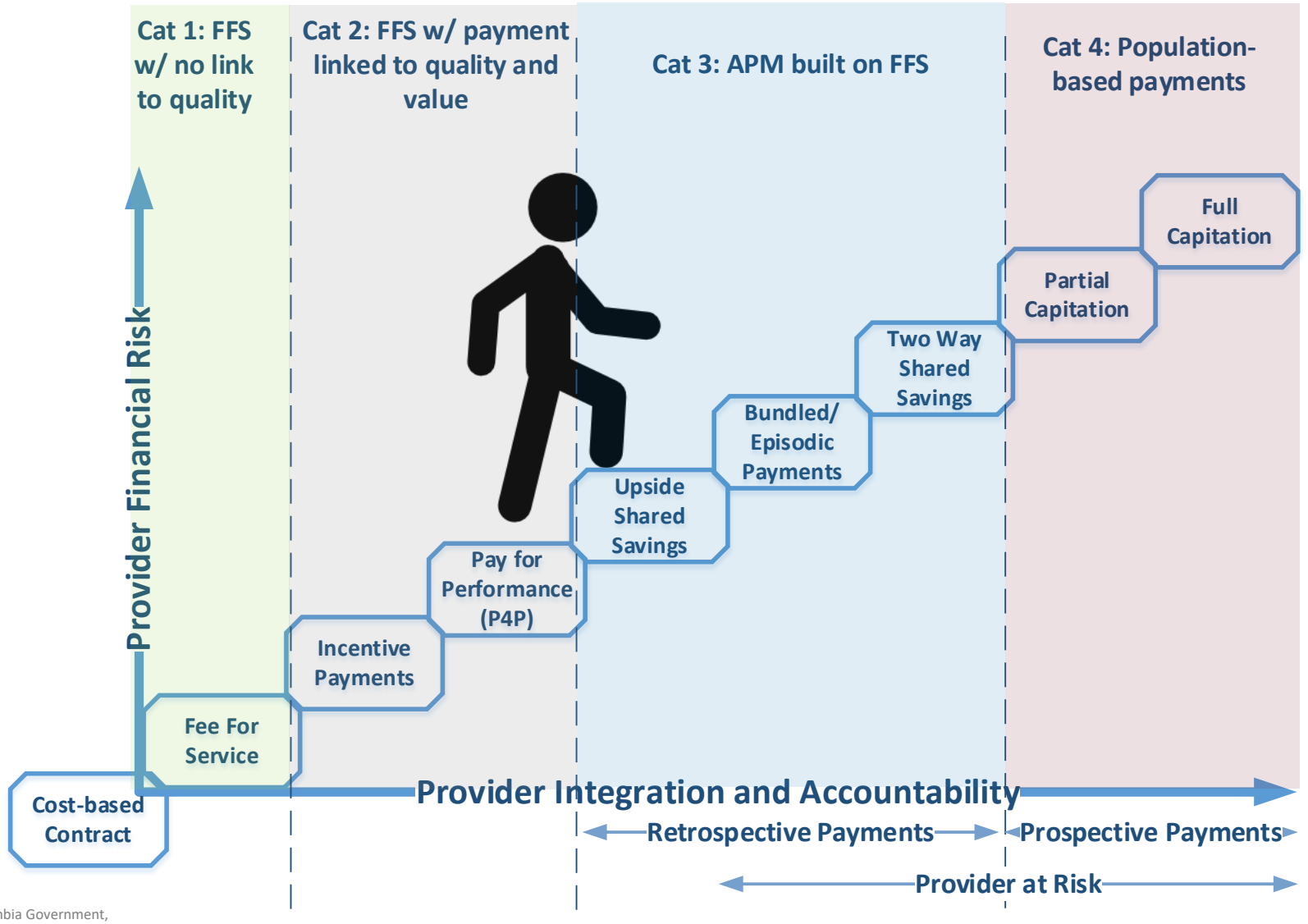


Source: The MITRE Corporation. (2017). *Alternative payment model (APM) framework - HCPLAN*. Health Care Payent Learning & Action Network. Retrieved May 5, 2023, from https://hcp-lan.org/workproducts/apm-whitepaper.pdf

HCP LAN Framework

# CLINICALLY INTEGRATED NETWORKS AND THE ROLE OF BH

# VBP ADVANTAGES PROVIDERS WITH CERTAIN CHARACTERISTICS

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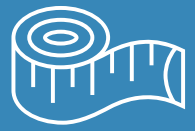
Size



Sophistication

Data Capture and Analysis Capacity

Risk-Readiness

Strong, Strategic Leadership

Administrative Depth

# THE ROLE OF CLINICALLY INTEGRATED NETWORKS (CINS)

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- Enable providers to participate in sophisticated value-based payment arrangements beyond what they might be able to do on their own
- Leverage both size and geographic coverage that the network brings to the payer
- Secure data and the means of analysis to support it
- Facilitate improvement in provider operations, patient satisfaction, and clinical performance for all participants
- Insulate providers from financial risk under VBP arrangements by contracting with MCOs at the network level
- Enable providers to expand their current offerings to their patients and expand their capacity to treat patients in their community

# CIN GOVERNANCE AND COMMITTEE STRUCTURE

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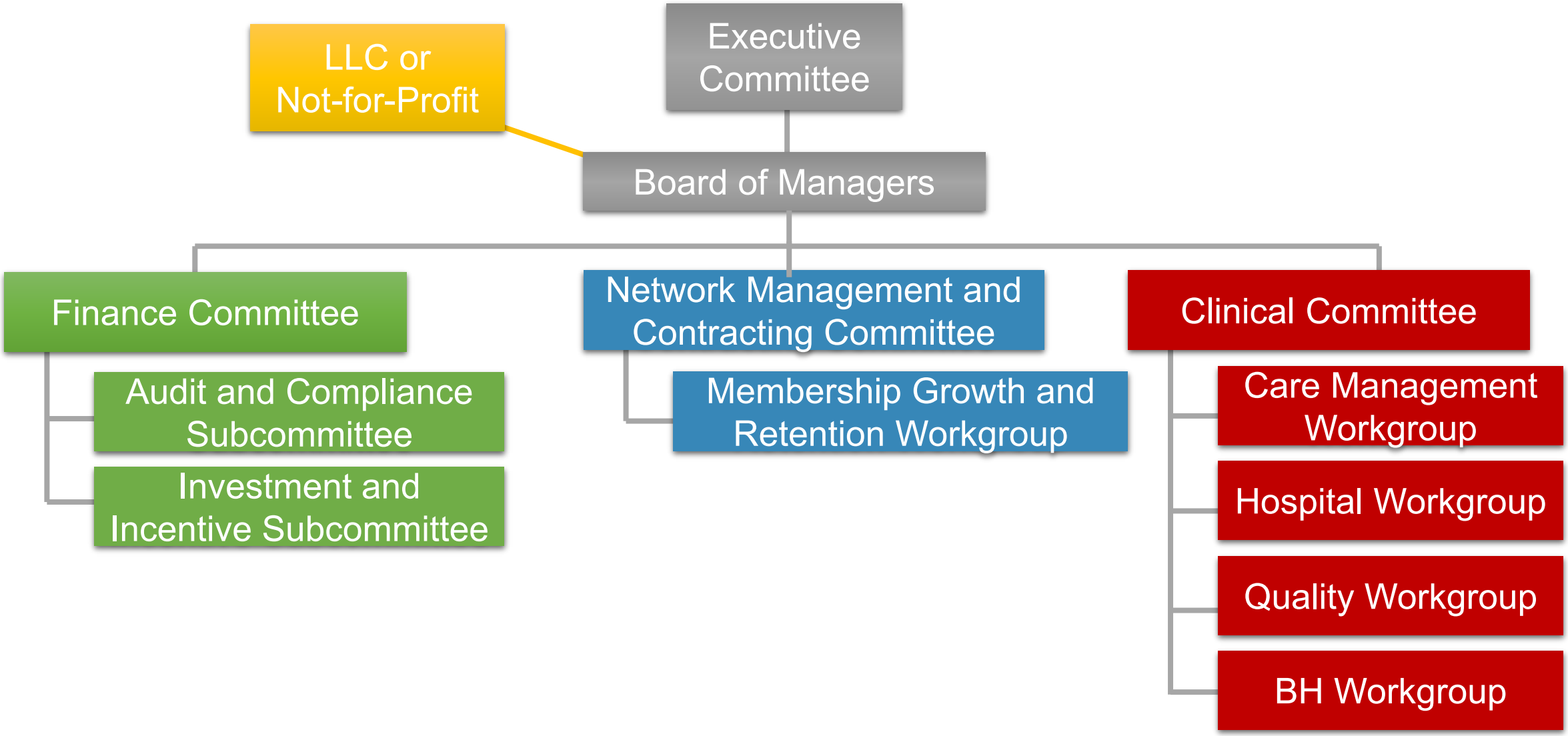

# CONTRACTING AS PART OF CINS UNDER VALUE-BASED PAYMENT

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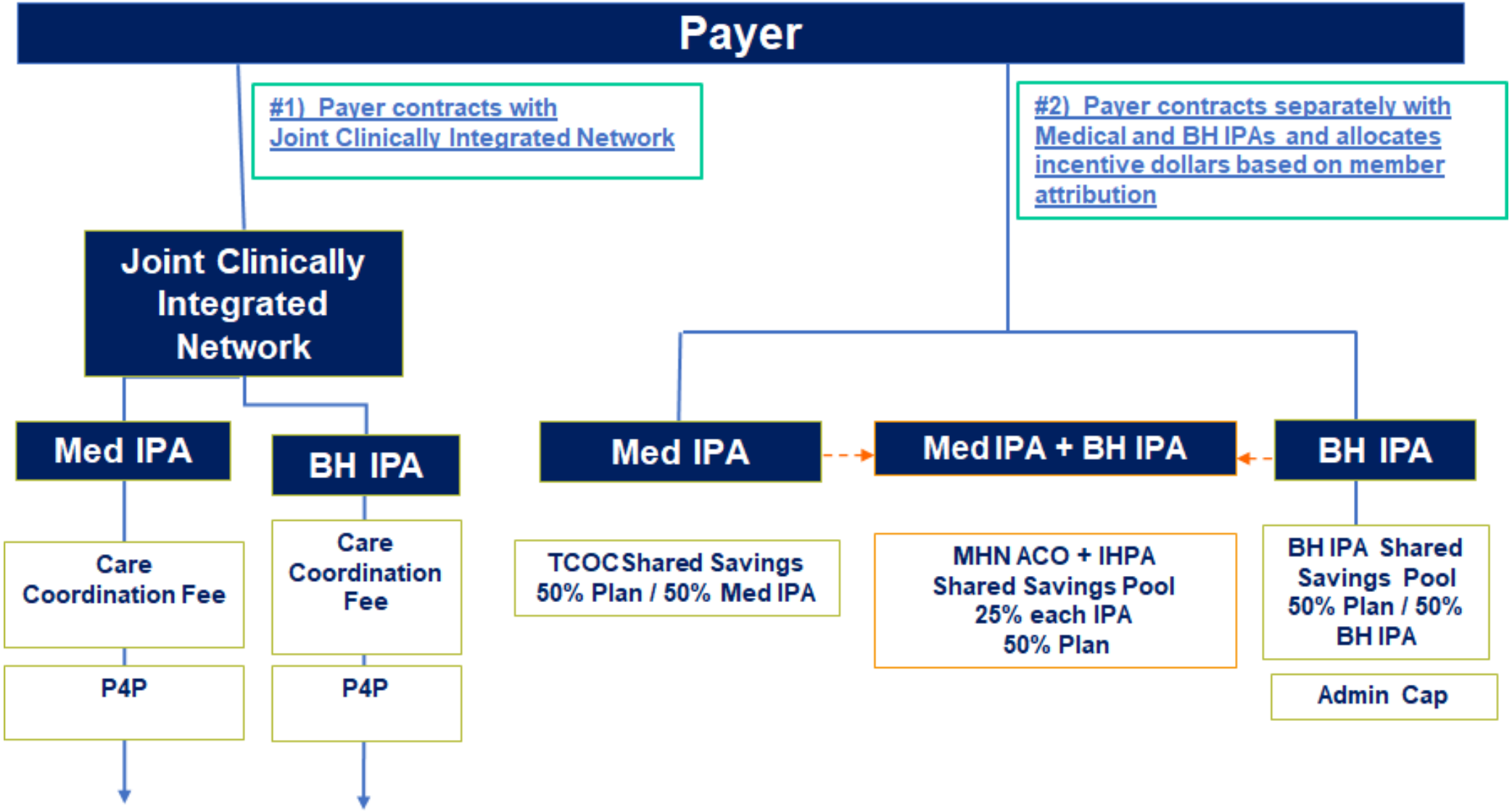

# QUESTIONS

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# GROUP EXERCISE

# SHARING SUCCESSES AND CHALLENGES FROM ATTENDING PROVIDERS

# 11:45-12:00

# LUNCH

## *12:00 – 12:30*

# AGENDA: PART 2

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| | |
|---|---|
| **12:30 – 1:30** | **Panel Discussion: How Can MCOs Support the Integration of Behavioral Health and Primary Care?** |
| 1:30 – 1:45 | Break and Transition |
| **1:45 – 2:45** | **Breakout Sessions**<br>1. Collaborative Business Opportunities for BH Providers (e.g., Consolidations/Independent Practice Associations)<br>2. Prior Authorizations: Documentation for Level of Care Determination<br>3. Plans as Partners: Sharing Actionable Data |
| 2:45 – 3:00 | Break and Transition |
| **3:00 -3:30** | **What Comes Next? Recap of Key Concepts and Provider Training and Technical Assistance Resources** |

# PANEL: HOW CAN MCOS SUPPORT THE INTEGRATION OF BEHAVIORAL HEALTH AND PRIMARY CARE?



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**FACILITATED BY:**
**Dr. Art Jones, HMA**
**Dr. Jean Glossa, HMA**

## Tuesday,
## May 9, 2023
12:30 pm – 1:30 pm ET

Integrated Care DC is managed by the DC Department of Health Care Finance (DHCF) in partnership with the DC Department of Behavioral Health (DBH). This project is supported by the U.S. Department of Health and Human Services (HHS). A total of $3,500,365, or 81 percent, of the project is financed with federal funds, and $810,022, or 19 percent, is funded by non-federal sources. The contents are those of the author(s) and do not necessarily represent the official views of, or an endorsement by, HHS or the U.S. Government.

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# TRANSITION TO BREAKOUT SESSIONS

## *1:30 – 1:45*

| Breakout 1<br>Collaborative Opportunities for BH providers | Breakout 2:<br>Prior Authorizations: Documentation for Level of Care Determination | Breakout 3:<br>Plans as Partners: Sharing Actionable Data |
|---|---|---|
| **Old Council Chambers** | **Room 1107** | **Room 1114** |

# COLLABORATIVE OPPORTUNITIES FOR BH PROVIDERS

## (E.G., CONSOLIDATIONS/ INDEPENDENT PRACTICE ASSOCIATIONS)



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**PRESENTED BY:**
**Josh Rubin, HMA**

**Tuesday,**
**May 9, 2023**
1:45 pm – 2:45 pm ET

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If we take as a given the integration of behavioral healthcare with the medical system, what can we identify as our priorities for the transition?

# SIZE/SCALE/SCOPE

# WHAT SERVICES NEED TO BE IN THE SPECIALTY BEHAVIORAL HEALTH PORTFOLIO?

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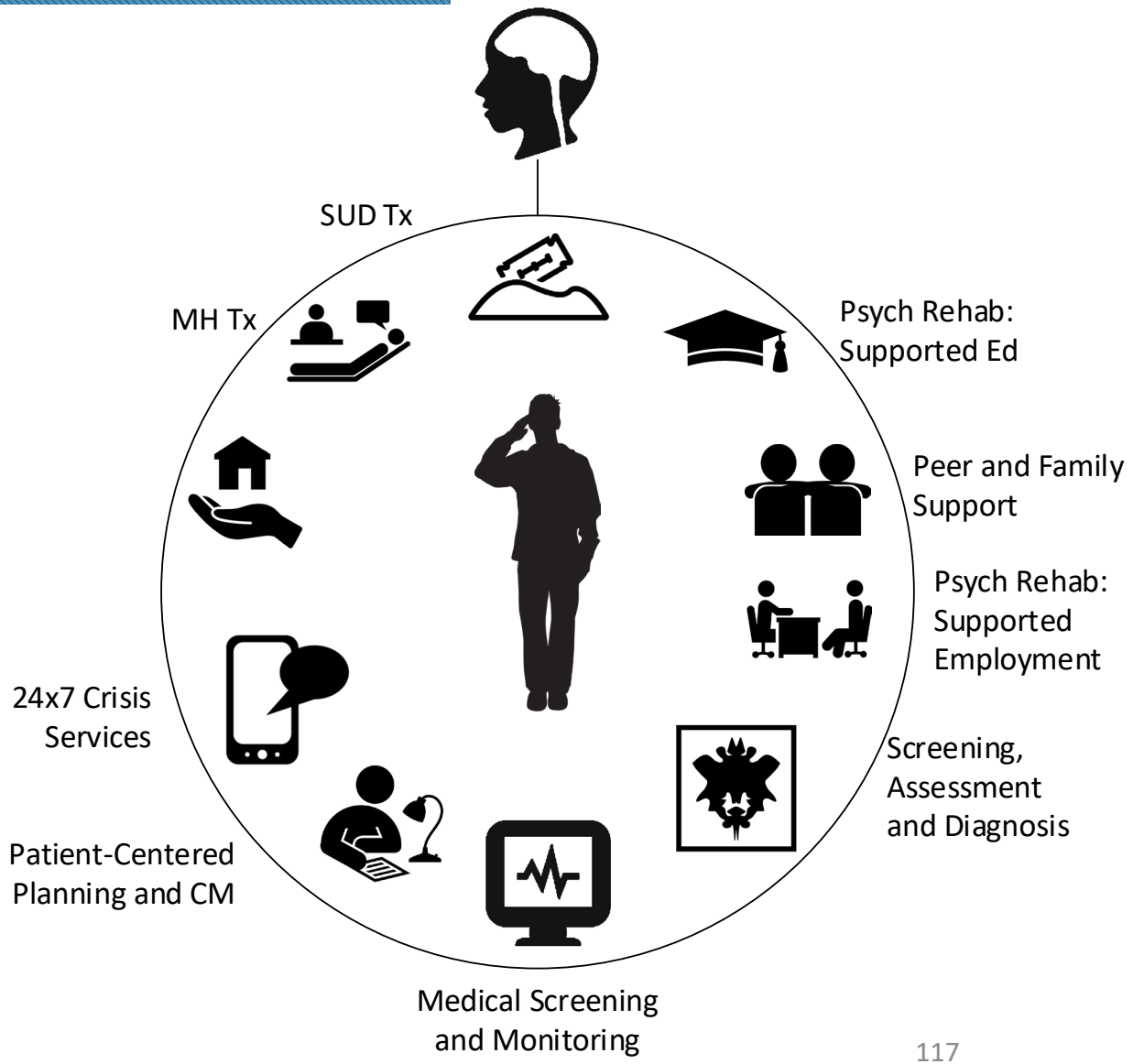
**Basically, CCBHC plus housing**



# OPTIONS FOR BH PROVIDERS

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## Get big

- Vertical integration and expansion can be effectuated either directly through growth or acquisition or partnership

# OPTIONS FOR BH PROVIDERS

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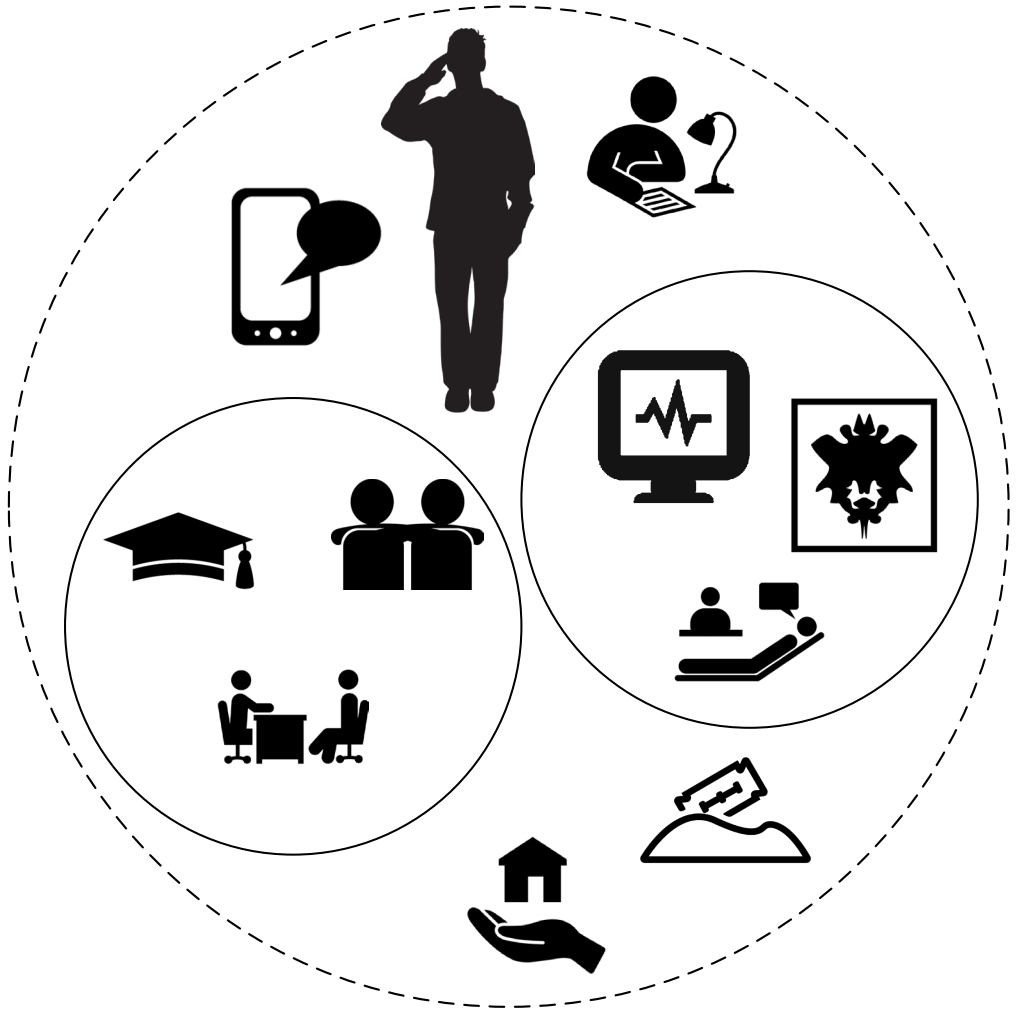
## Seem big

- Independent Practice Associations (IPA) are a way to partner with other agencies in order to offer comprehensive, integrated services



# OPTIONS FOR PROVIDERS

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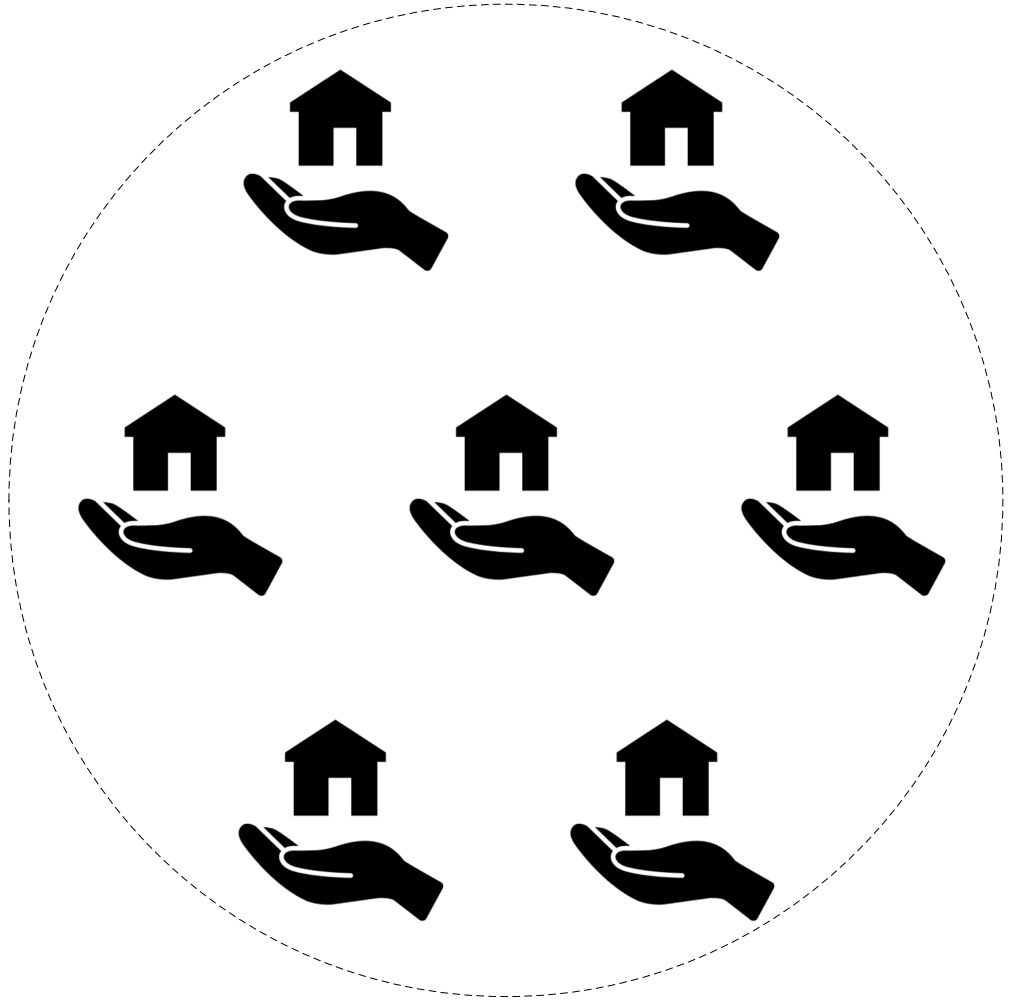
## Become unavoidable

- BH providers can establish partnerships that corner the market and increase leverage for negotiations



# IPA-DRIVEN COLLABORATION

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## Like a Matryoshka doll, IPAs are sometimes made of other IPAs

# TWO PRIMARY OPTIONS

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There are a lot of variations on two main themes:

# BUILD NEW SERVICES TO FILL GAPS

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| Pros | Cons |
|---|---|
| Complete control over the entirety of the service continuum | High percentage of the program portfolio may be prototypes |
| No need to spend the time, money, and energy with mergers and/or IPA affiliations | Reliant on the development of new services, and funding for them. Made more challenging by the need to win procurements for services with which you don't have a history |
| Able to offer a purchaser a comprehensive, integrated service | Development time could be substantial |
| | No administrative efficiencies |
| | No opportunity for collective bargaining with purchasers |

# JOIN/FORM AN IPA

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| Pros | Cons |
|---|---|
| Requires less time, expense and burden than merging | Requires significant time, expense and effort |
| Enables each agency to maintain its own identity, Board, fundraising base, etc. | Does not generate the same kind of economies of scale and efficiencies as a merger |
| Clinical integration leads to better outcomes for consumers | Governance can be challenging and time consuming |
| Enables collective bargaining with purchasers | In order to provide comprehensive and integrated services, other providers would need to be brought in, especially primary care |
| If coupled with an MSO, there can be administrative efficiencies generated | IPA members are liable for the quality of care provided by other members of the IPA, which can be problematic |

# MERGE INTO A LARGER BH AGENCY

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| Pros | Cons |
|---|---|
| Consistency of mission | Mergers are costly, time consuming, emotionally challenging and difficult |
| Enhancement of the service continuum for your clients | Loss of control |
| Access to a much larger and mature infrastructure | Loss of organizational identity |
| Straightforward decision-making and governance process | May generate acrimony among your staff because of a feeling of having been 'acquired' |
| Programmatic economies of scale | Likely no access to attribution |
| May obviate the need for potential additional mergers | |
| Creates negotiating leverage | |

# MERGE WITH A SIMILAR BH AGENCY

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| Pros | Cons |
|---|---|
| Consistency of mission and culture | Mergers are costly, time consuming, emotionally challenging and difficult |
| Programmatic economies of scale | No significant enhancement to the existing continuum of care for your clients |
| Less likely to generate acrimony among the staff because no agency has been 'acquired' | One merger may be insufficient to generate critical mass |
| Straightforward decision-making and governance process | Likely no access to attribution |
| Doubles the resources available for infrastructure | |

# MERGE WITH A HEALTHCARE ORGANIZATION

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| Pros | Cons |
|---|---|
| Substantial enhancement of the service continuum for your clients | Mergers are costly, time consuming, emotionally challenging and difficult |
| Access to a much larger and likely more mature infrastructure | Loss of control |
| Straightforward decision-making and governance process | Loss of organizational identity |
| Obviates any need for potential additional mergers | May generate acrimony among your staff because of a feeling of having been 'acquired' |
| Creates negotiating leverage | Inconsistency of mission |
| Potential access to attribution in a VBP environment | No significant programmatic economies of scale |

# WHILE THERE ARE NO RULES RE MERGERS WITH MCOS…

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## …there are some basic guardrails

- Attribution matters a lot
- FQHCs have some big advantages
  - PPS
  - 340b
  - HRSA grant opportunities
- And some disadvantages
  - Board requirement
  - New Access Point (NAP) requirements
  - Grant restrictions
- They need you

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# What types of movement toward size/scale/scope most benefit the people we serve?

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# What types of movement toward size/scale/scope most benefit our agencies?

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# What, if anything, is lost by the move toward size? What can we do to minimize the loss?

# LEVERAGE

# LEVERAGE COMES IN MANY FORMS

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- Size/scale/scope
- Service value (ability to impact outcomes)
- Cash
- Essentiality for network adequacy
- Attribution
- Population (relationships, community credibility)
- Data

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# What types of leverage are most accessible to you?

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# What are the most effective ways for BH providers to gain the leverage we will need?

# DISCUSSION

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In some ways, the question of when to integrate with the medical system is a question of when we have sufficient leverage to achieve our priorities.

How will we know when that is?

# DISCUSSION

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There is a tension between the value of getting in early and the value of waiting for better leverage.

How do we know we are not waiting too long?

# ATTRIBUTION

# A BIG QUESTION FOR BH PROVIDERS

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How can you be part of an organization that has attribution, infrastructure, and scale in a way that enables you to access integrated medical care and human services for your clients, and provide behavioral health care to a broader population, while maintaining your focus on the population about which you are most concerned?

# SOCIAL DRIVERS OF HEALTH

# BH PROVIDERS HAVE A UNIQUE OPPORTUNITY TO HELP INTEGRATE HUMAN SERVICES & HEALTHCARE

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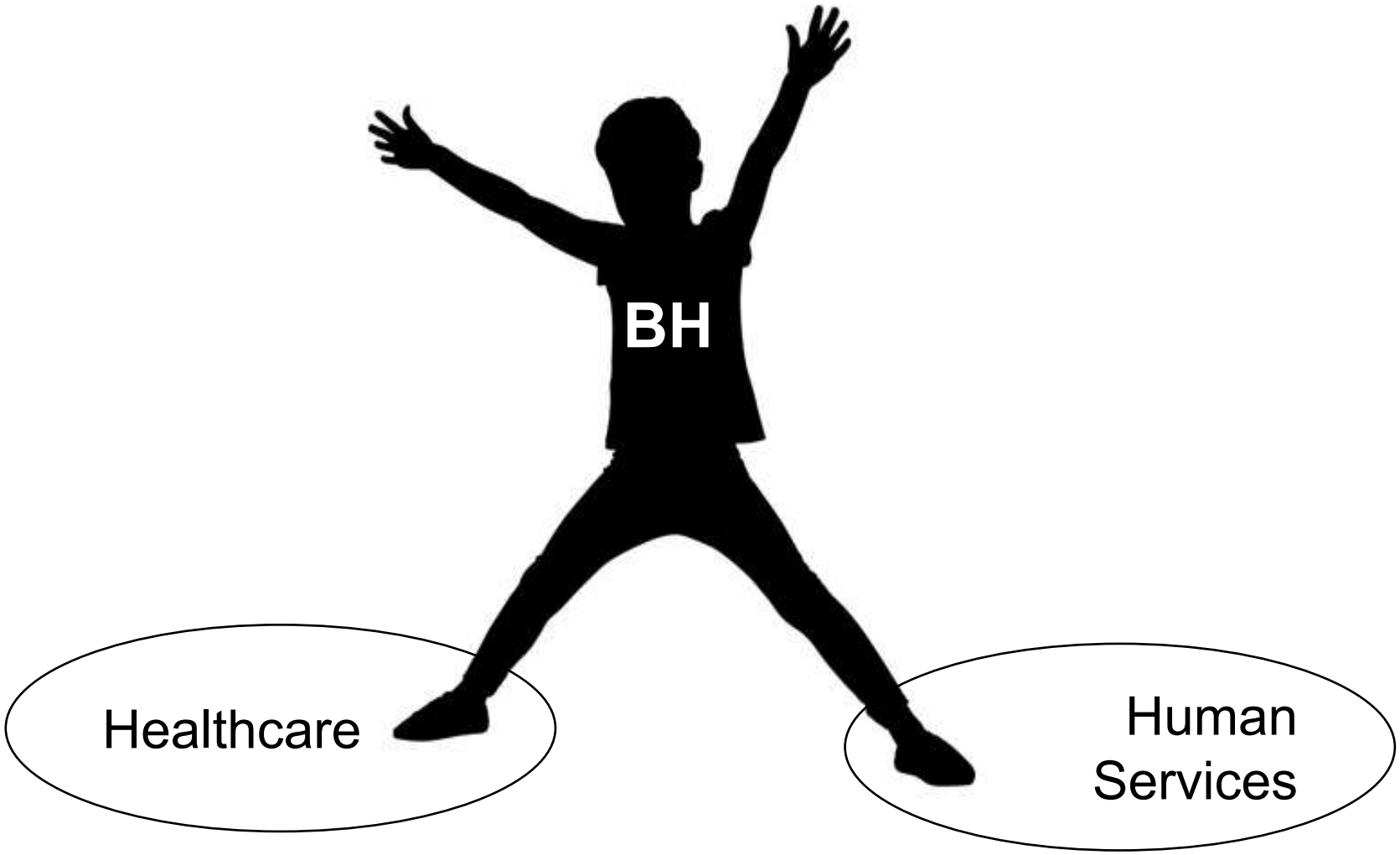

# ANOTHER BIG QUESTION

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If the BH system spans the boundary between the medical and human services systems, how can we leverage that capability to benefit both consumers and providers of behavioral health services?

# IN CONCLUSION

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What is standing in your way?

What are the impediments preventing you from addressing your priorities?

# BREAKOUT SESSION 2: PRIOR AUTHORIZATIONS: DOCUMENTATION FOR LEVEL OF CARE DETERMINATION



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A learning community for District of Columbia Medicaid providers

**PRESENTED BY:**
**Caitlin Thomas Henkel, HMA**
**Debbi Whitham, HMA**

**Tuesday,**
**May 9, 2023**
1:45 pm – 2:45 pm ET

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# BREAKOUT SESSION 3: PLANS AS PARTNERS: SHARING ACTIONABLE DATA



INTEGRATED CARE DC
A learning community for District of Columbia Medicaid providers

**PRESENTED BY:**
**Dr. Art Jones, HMA**
**Dr. Jean Glossa, HMA**

**Tuesday,**
**May 9, 2023**
1:45 pm – 2:45 pm ET

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# BREAK
# TRANSITION TO MAIN ROOM
## *2:45 – 3:00*

# WHAT COMES NEXT?

## RECAP OF KEY CONCEPTS

## PROVIDER TRAINING AND TECHNICAL ASSISTANCE RESOURCES



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**PRESENTED BY:**
**Dr. Jean Glossa, HMA**

**Tuesday,**
**May 9, 2023**
3:00 pm – 3:30 pm ET

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# Key Take-aways

**BH Business Collaborations**
Josh Rubin

**LOC Determination**
Debbi Witham

**Plans as Partners: Sharing Data**
Dr. Art Jones

# WHAT'S NEXT: TRAINING & TECHNICAL ASSISTANCE

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To improve Medicaid providers' readiness to deliver whole-person, integrated physical and behavioral health care.

eHEALTHDC

To support advancement of digital health capabilities of HCBS providers to promote use of EHRs, health information exchange and telehealth.

DC Business Transformation

To expand the business, financial, legal and clinical capabilities of Medicaid providers to deliver patient-centered value based care.

- Register for live webinars to learn and share best practices and earn continuing education credits.
- Request practice coaching for site-specific support to achieve your goals.
- Visit the Learning Library to access on-demand videos, podcasts, and tools.
- Public Forum on Integrated Care: Get updates on integrating behavioral health into managed care. Next meeting: tomorrow, May 10, 2023, 4:00 pm – 5:00 pm.

# CONTINUING EDUCATION CREDITS

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## Continuing education through the DBH Training Institute

DBH TRAINING INSTITUTE
BEHAVIORAL HEALTH EDUCATION & E-LEARNING

- The DBH Training Institute offers behavioral health courses online live and on-demand, including continuing education courses approved by the District of Columbia Board of Social Work and National Association of Alcoholism and Drug Abuse Counselors.
- Eligibility: Free to all providers, consumers, community members, and DBH employees
- Questions? Email dbh.training@dc.gov or call (202) 671-0343.

HMA

## HMA is a registered CME Provider through the American Academy of Family Physicians (AAFP). The AAFP has reviewed the Integrated Care DC learning series and deemed it acceptable for AAFP credit.

- Integrated Care DC offers free learning sessions approved for live AAFP Prescribed credits. Physicians should claim only the credit commensurate with the extent of their participation in the activity.
- Questions? Email support@integratedcaredc.com

# THANK YOU FOR JOINING! BEFORE YOU GO...

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## Sign up for the Integrated Care DC Newsletter

1st and 3rd Tuesday for the Monthly Newsletter and the Mid-Month Update.

## Provide feedback on today's session and inform future sessions

Complete the evaluation in your folder. Required for CME/CE.

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A learning community for District of Columbia Medicaid providers

## Demonstrated Results of Integrated Care:


- Heath, B., P., Wise, Romero., and Reynolds, K. (2013, March). *A Review and Proposed Standard Framework for Levels of Integrated Healthcare.* SAMHSA-HRSA Center for Integrated Health Solutions. https://www.integration.samhsa.gov
- Palmer, A. and Rossier Markus, A. (2020). Supporting Physical-Behavioral Health Integration Using Medicaid Managed Care Organizations. *Administration and Policy in Mental Health 47(2):*316–322. https://doi.org/10.1007/s10488-019-00986-3
- Soper, M. H.(2016). *Integrating Behavioral Health into Medicaid Managed Care: Design and Implementation Lessons from State Innovators*. Center for Healthcare Strategies. www.chcs.org/media/BH-Integration-Brief_041316.pdf.
- Unützer, J. (May 2013). "T*he Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes.*" Health Home Information Resource Center Brief. Centers for Medicare and Medicaid Services. www.chcs.org/media/HH_IRC_Collaborative_Care_Model__052113_2.pdf.