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LIP Collaborative Webinar November 8, 2018

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Odds & Ends about the webinar:

- ◎ Roanna Newton, Provider Network Account Specialist, is your moderator for today's webinar.
- ◎ The audience is in "listen only mode, you can only hear us talking, but you can't talk with us through the phone in an interactive way.
- ◎ You may submit questions from today's webinar to:

questions@partnersbhm.org



NC Health Connex:

REMINDER!

- ◎ NC HealthConnex
- ◎ **All** providers must be enrolled or have a State approved extension by June 1, 2019
- ◎ If you don't, you won't get paid.



- ◉ Handouts with information pertaining to NC Health Connex will be uploaded to the Partners BHM webpage under the webinar tab.
- ◉ Link for Provider webinar:
- ◉ <https://providers.partnersbhm.org/provider-webinars-forums/>



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Acorn Tool Providers:

- Please make sure to read your Acorn contract agreement, these agreements will appear in your performance monitoring tool.
- There are requirements in the contract and reporting expectations that you need to be aware of.



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Acorn Tool Providers: Reminder

- ⦿ Please do **NOT** fax your Acorn surveys to Clinical Informatics!! This incurs an additional cost to Partners BHM above and beyond our contracted agreement with Clinical Informatics. Partners BHM has paid this surplus fee, but **WILL NOT** continue to do so.
- ⦿ Any providers that continue to fax surveys will be financially responsible for the cost associated with Clinical Informatics processing fees.



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LIP Survey Results:

- ⦿ Only 10 people completed the survey
- ⦿ Only 2 participants (20%) have an EHR, 80% do not.
- ⦿ The 2 chosen EHR's: Valant & Valant Med
- ⦿ 33% of LIP's want the EHR to be:
 - User Friendly
 - Easy to Implement
 - Reasonable cost



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Challenges for EHR Implementation:

- ⦿ Transitioning from paper to digital
- ⦿ The time involved
- ⦿ Learning the billing piece.
- ⦿ Finding a good work flow for the digital pieces. Transitioning to new forms or trying to implement MCD approved ones to ensure no difficulties with monitoring.



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**Let's hear about the 1115
Waiver...What's going on with
that?**

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1115 Waiver

1115 Waiver Status

- On Oct. 24, 2018, the federal Centers for Medicare and Medicaid Services (CMS) approved North Carolina's 1115 Demonstration Waiver application submitted November 2017.
- The approval is effective Jan. 1, 2019 through Oct. 31, 2024.
- The amended waiver is the result of collaboration among DHHS, beneficiaries and their families, advocates, health care providers, health plans and associations, lawmakers and other stakeholders throughout North Carolina.



Vision for North Carolina's Medicaid Managed Care Program

- August 9, 2018 the RFP for the Medicaid Managed Care Prepaid Health plans was released
- In 2015, the General Assembly directed the transition of Medicaid to a managed care structure.
- In managed care, DHHS will oversee all aspects of the Medicaid and NC Health Choice programs. However, PHPs will directly manage certain health services, assume financial risk and contract with providers to provide services for beneficiaries.
- This RFP reflects three years of collaboration with and extensive feedback from beneficiaries, clinicians, hospitals, counties, health plans, elected officials, advocates and other stakeholders to design the managed care program.
- DHHS hosted listening sessions across the state, reviewed more than one thousand written public comments and released 15 policy papers on different aspects of the program.
- This RFP is the largest procurement in DHHS history. It clearly communicates DHHS' requirements and defines the standards that PHPs must adhere to in contracting with DHHS. All plans will be subject to rigorous oversight by DHHS to ensure strong provider networks, a full range of benefits, accountability for quality and outcomes, a positive beneficiary experience and timely payments to providers among aspects of a successful managed care program.



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Why an 1115 Waiver?

- Fundamentally, the waiver provides North Carolina with federal authority to implement Medicaid managed care and phase certain populations into managed care over time.
- Under the waiver, North Carolina has further federal authority to incorporate the following innovative features into its new managed care delivery system, further enhancing the program's ability to deliver on the state's transformational goals



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Transformational Goals of the 1115 Waiver

- Behavioral Health Integration, Tailored Plans and Specialized Health Homes
- Opioid Strategy
- Healthy Opportunities Pilots

<https://files.nc.gov/ncdhhs/CMS-1115-Approval-FactSheet-FINAL-20181024.pdf>



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Behavioral Health Integration and Tailored Plans

Description

North Carolina will **integrate physical, behavioral and pharmacy benefits** into both Standard Plans and Tailored Plans. **Tailored plans** will provide:

- Integrated physical, behavioral and pharmacy benefits to people with a serious mental illness, serious emotional disturbance, severe substance use disorder, intellectual/ developmental disability or a traumatic brain injury
- A specific, more intensive set of behavioral health benefits that are not available in Standard Plans (as approved in the 1115 demonstration waiver)*
- Care management through a specialized behavioral health home model designed to meet beneficiaries' complex needs

Impact

Supports the State's goal to provide managed care beneficiaries seamless access to coordinated care and benefits through one managed care plan and to ensure those with serious behavioral health conditions get the care they need.

*Individuals eligible for Tailored Plans may elect to enroll in either Standard Plans or Tailored Plans, but will only have access to the more intensive behavioral health benefits in the Tailored Plans



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Opioid Strategy

Description

As part of the State's comprehensive strategy to address the opioid crisis, North Carolina will (1) increase access to inpatient and residential substance use disorder treatment by beginning to reimburse for substance use disorder services provided in institutions of mental disease (IMD), and (2) expand the substance use disorder service array to ensure the State provides the full continuum of services.

Impact

Strengthens the State's approach to improving care quality and outcomes for patients with substance use disorders, including by decreasing the long-term use of opioids and increasing the use of medication-assisted treatment (MAT) and other opioid treatment services.



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Healthy Opportunity Pilots

Description

- North Carolina will implement within its Medicaid managed care program a groundbreaking **pilot program** in two to four regions of North Carolina to improve health and reduce health care costs.
- Working with managed care plans, these pilots will **identify cost-effective, evidence-based strategies** focused on addressing Medicaid enrollees' needs in five priority areas that drive health outcomes and costs: **housing, food, transportation, employment and interpersonal safety**.
- The State will increasingly **link pilot payments to improvements** in health outcomes and efficiency.
- North Carolina will use a **rigorous rapid-cycle assessment strategy** to evaluate pilot performance and tailor service offerings to those with demonstrated efficacy.

Impact

Overall health is driven by many factors beyond the four walls of a hospital or clinic. The Healthy Opportunities pilots leverage federal funding to ensure the most efficient and effective managed care program and to strengthen work already underway in communities to improve population health.



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Goal of Medicaid Managed Care: Create an Innovative, Integrated and Well-Coordinated System of Care

- ◎ This RFP procures Standard Benefit Plans, which will provide integrated physical health, behavioral health and pharmacy services to the majority of Medicaid and NC Health Choice beneficiaries with lower intensity behavioral health needs.
- ◎ Beginning in 2021, most individuals with a serious mental illness, a serious emotional disturbance, a severe substance use disorder, an intellectual/developmental disability or a traumatic brain injury will receive integrated physical health, behavioral health, pharmacy services and I/DD services through Behavioral Health Intellectual/Developmental Disability Tailored Plans (BH I/DD Tailored Plans), an integrated specialized managed care product.
- ◎ BH I/DD Tailored Plans will be procured later through a separate process, and this population will continue receiving benefits through a combination of Medicaid Fee-for-Service and LME-MCOs as they do today until BH I/DD Tailored Plans begin.



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Ensure PHPs maintain strong networks...

- The RFP contains specific standards around network adequacy, including time and distance and appointment wait time standards. In addition, Medicaid beneficiaries will receive adequate and timely coverage of out-
- of-network services (that have been pre-approved) if the PHP is unable to provide coverage within network on a timely basis.
- DHHS will closely monitor PHP Network Access Plans, which must demonstrate that the PHP has a network with the capacity to serve the expected enrollment.
- The Access Plan will be submitted annually and whenever there are substantial changes.
- To assist members in obtaining covered services from network care providers, PHPs will produce, monitor, and maintain consumer facing network care provider directories that are compliant with content requirements outlined in the RFP.



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<https://files.nc.gov/ncdhhs/RevisedWebcastQuestionSummary-FINAL-POSTING-FOR20180712.pdf>

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Next Steps

RFP evaluation and award:

- DHHS has received bids from potential PHPs and this has closed as of October 19, 2018.
- DHHS will first review offers to determine that they are in the proper form and include all required documents. The Evaluation Committee will then screen the offers to determine if the minimum qualifications have been met.
- The Evaluation Committee will evaluate proposals meeting the minimum qualifications and develop consensus ratings, ultimately developing an award selection that is aligned with state law, and will provide supporting documentation for their selection.
- DHHS will submit the contracts to the Federal Centers for Medicare & Medicaid Services for its approval.
- PHP contract awards are anticipated to be announced in February 2019.



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RFP #30-190029-DHB Bid Opening
Prepaid Health Plans
October 19, 2018 at 2:00 PM

Bids were received from eight offerors.

OFFEROR NAME
Aetna
AmeriHealth Caritas North Carolina
BCBSNC – Healthy Blue
Carolina Complete Health
My Health by Health Providers
Optima Health
United Health Care
WellCare Health Plans



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Anticipated Timelines

Now and ongoing. Care providers may be contacted by potential PHPs who wish to initiate contract discussions.

- **February 2019.** NC will award contracts to the selected health plans to be PHPs in managed care.
- **Summer 2019.** PHPs must have contracted with enough care providers for their network to meet DHHS standards.
- **July 2019.** PHPs must have all call centers operational and all relevant staff located in North Carolina.
- **July-September 2019.** Managed care will start in two phases. For regions of the state in Phase 1, this will be the window in which beneficiaries select a PHP.
- **November 2019.** The Medicaid managed care program will launch in regions in Phase 1.
- **October-December 2019.** For regions of the state in Phase 2, this will be the window in which beneficiaries select a PHP.
- **February 2020.** The Medicaid managed care program will launch in regions in Phase 2.



For more information as this transition occurs, please see this website:
<https://www.ncdhhs.gov/medicaid-transformation>

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Provider Payments

- **Rate floors/ceilings**
 - PHPs will comply with Department-established rate floors for certain in-network providers
 - PHPs and providers can mutually agree to different rates through PHP/provider contract
 - Department will monitor PHP/provider contracts to determine if rate ceilings need to be established
- **Department will hold PHPs to prompt pay requirements**
- **Out-of-network services will be covered if PHP provider network is unable to provide necessary services covered under the contract, subject to prior authorization**
- **Out-of-network provider of emergency or post-stabilization services will be paid no more than Medicaid fee-for-service rates**



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Rumors about Medicaid Managed Care

Providers must sign a contract with a plan NOW to continue serving Medicaid patients in the future

You may have heard...



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Rumors about Medicaid Managed Care

FALSE

Providers must sign a contract with a plan NOW to continue serving Medicaid patients in the future

TRUE

- PHPs must contract with DHHS
- PHPs must be licensed by the state
- PHPs must have their provider manuals, contracts and contracting policies and procedures approved by DHHS
- Medicaid Fee-for-Service program will remain operational to serve excluded populations – although a smaller program.



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Before PHP contracts are awarded

Pre-Award Period

Build relationships with health plans

Understand contract terms, conditions, payment and reimbursement methodologies

Contracting Guidance

- **Letters of intent**
Non-binding indication of health plan and provider's intent to enter into contract negotiations
- **"Any willing provider"**
PHPs must contract with providers willing to accept reimbursement unless "objective quality" concerns
- **Department-approved contracts**
Mandated clauses and specific provisions



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Partners Vision and the 1115 Waiver Transition

Partners Vision: Culture of Collaboration

The Partners approach fosters strong collaboration and delivers quality care.

We believe in and are committed to:

- ✓ Maintaining collaboration
- ✓ Enhancing our collaboration as we seek participation of the best thinkers at all levels of the system to achieve effective care and raise the level of healthcare for all populations served
- ✓ Focus on specific outcomes, network accountability and re-investment in our providers and communities

1115 Transformation is a new lever that allows enhancement of our culture to improve performance of provider organizations and ultimately, population health.

Partners Vision & 1115 Waiver: Key Components

Partners is well positioned for the State's system transition and is actively evaluating and designing our role in preparation for the transformation.

Value Based Payment

Improved outcomes
Improved cost
Leveraging our provider's expertise and innovation
Improving the total network
-raise all boats

Innovation

Whole Person Care
Evidence Based
Collaborative Care with Peers and Social Determinants of Health (SDOH)

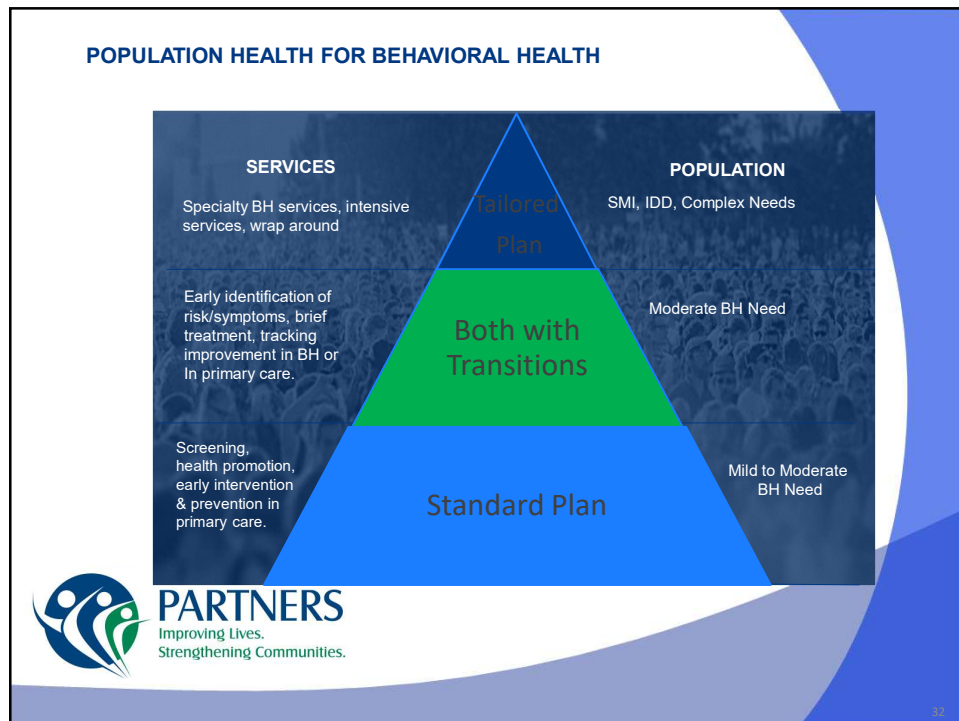
Population Health

Provide network solutions that support population health across the full continuum of care

Health Plan Partner

Shares mission and values
Believes in collaborative approach
Offers infrastructure to enhance current models and system of care





Are you ready?

- ◎ The National Council of Behavioral Health has a great readiness assessment tool that is relevant in 1115 waiver planning.
- ◎ As an organization, assessing your strengths and weaknesses can assist in your focus and planning efforts.

https://www.thenationalcouncil.org/dl.php?file=/var/www/vhosts/thenationalcouncil.org/public_html/wp-content/uploads/2013/01/Provider-Readiness-Assessment.pdf



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1115 Waiver Planning

- ◎ Partners has constituted a CEO Roundtable Discussion regarding 1115 waiver planning
- ◎ This Roundtable connects directly to the Provider Council as the chair of the Provider Council sits on this group
- ◎ The roundtable consists of large and small providers, across all disabilities, local, regional and statewide provider representation
- ◎ The purpose is to gain stakeholder input and planning to prepare for an 1115 waiver transition



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Credentialing Update



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LIP FAQs

LIP FAQs

- ◎ All applicants must ensure that their CAQH information is up-to-date
 - You **must** complete *and upload* a state release/authorization specific to Partners in CAQH
 - This form can be found in CAQH
- ◎ We receive a number of questions that fall into two categories, which will be the focus of the remainder of this presentation:
 - Insurance
 - National Plan and Provider Enumeration System (NPPES)



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Insurance Requirements

- ◎ Partners must be the **Certificate Holder** on all required insurance policies.
 - It is not necessary for Partners to be listed as an additional insured on these policies for LIPs.



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Insurance Requirements (cont)

- ◎ You must complete the *Partners Behavioral Health Management Insurance Affidavit for Contracted Providers* form if:
 - 1-You do not transport consumers (waiver of automobile coverage)
 - 2-Your number of employees exempts you from the requirement of carrying Workers Compensation coverage (Workers Compensation waiver)
 - 3-You rent your office space and your landlord holds the General Liability policy covering the property (General Liability coverage waiver)
 - Please note: you **must** be able to produce a copy of this policy/certificate of insurance (COI)
 - As this policy is not held by the applicant, the coverage limits (\$1mil occurrence/\$3mil aggregate) do not apply
- ◎ You can obtain this form by contacting Partners' Credentialing Department at CredentialingTeam@partnersbhm.org or (704) 842-6483



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NPPES

- ◎ Addresses, taxonomies, NPI numbers must all match in:
 - NC Tracks
 - NPPES
 - Alpha
- ◎ Inconsistencies among these databases will not stop your credentialing application from being processed but **will** prevent you from billing
- ◎ For practices with multiple site addresses:
 - Partners staff can only see the first site address in NPPES.
 - You will need to print screen shots for all other site addresses and submit them along with your application materials



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NPPES – Do I need an organizational NPI?

- ◉ If you contract with Partners using a Tax ID other than your Social Security Number:
 - The practice/agency/organization associated with that Tax ID must have an organizational NPI number
 - The organizational NPI number must be enrolled in NC Tracks.



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NPPES – Making Changes to Information

- ◉ How to make changes to information in NPPES:
 - For **individual** NPI numbers:
 - Call: **800-465-3203**
 - Ask for “**role request**” to gain access to NPI information
 - For **organization** NPI numbers:
 - Call **866-484-8049**
 - Select the option called “**Identity & Access**” (I&A)
 - Ask for guidance in processing a “**role request**” to gain access to organization NPI information
 - For all changes related to the organization NPI, you will likely need to have your W-9 handy when you call.
 - Partners cannot process your credentialing application until your current practice site address (associated with your organizational NPI) is entered in NPPES



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WHAT'S IN YOUR COMPLIANCE TOOLBOX?



This Photo: iStockphoto.com

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WHAT'S IN YOUR COMPLIANCE TOOLBOX?

DEPARTMENT OF PROGRAM INTEGRITY

Michael Bomar MSW, LCSW,
AHFI
Supervisory Clinical
Investigator

OUR MISSION

- ◎ Ensure compliance, efficiency, and accountability to stakeholders and consumers by:
 - Detecting and preventing fraud, waste and program abuse.
 - Ensuring that Medicaid and State dollars are paid appropriately by pursuing recoupment of provider overpayments and identifying avenues for overpayment cost avoidance.



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Program Integrity Actions

Combat Medicaid Provider Fraud and Abuse



Eliminate and Recover Improper Payments



Educate Providers on Medicaid Program
Integrity Issues



Provider Bulletins

- ⦿ Provide timely information
- ⦿ Adjustments in definitions forthcoming
- ⦿ Trainings (Partners Training Academy)
- ⦿ Reminders i.e. Documentation, Claims Submission



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NC Clinical Policy Definitions

- ⦿ Change from year to year
- ⦿ Coincide with other statues/regulations (cited) - Not always all inclusive of what is required
- ⦿ Be familiar with the particular definition of services you provide
- ⦿ Give your input!



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Records and Documentation Manual (i.e. APSM 45-2)

- ⦿ Descriptive of the required components of clinical records
- ⦿ Detailed lists of components of a clinical note for respective services
- ⦿ Often overlaps and/or referred to within several Clinical Coverage policies.



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Other Tools

- ⦿ Provider Manual
- ⦿ Develop Internal Compliance Plan/Program
- ⦿ Regular Self Audits
- ⦿ Utilize Provider Network Specialists!
- ⦿ Sign up for alerts via email with DHHS



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24 Hour Crisis Planning

Clinical Coverage Policy 8C (CCP 8C)

- ⦿ All enrolled providers are responsible for ensuring access to 24 hour crisis coverage
- ⦿ Enrolled providers shall arrange for coverage in the event that he or she is unable to respond to a beneficiary in crisis
- ⦿ Coverage shall include the ability for the beneficiary to speak with a licensed clinician on call either face-to-face or telephonically



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Clinical Coverage Policy 8C (CCP 8C)

- ◎ Coverage may be provided by the beneficiary's provider and/or via a written agreement with another entity



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24 Hour Coverage

Includes:

- ◎ Weeknights/weekends
- ◎ Vacations
- ◎ Absence from the office for an extended time
- ◎ During and after business hours



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24 Hour Coverage

Beneficiaries, clients and/or legally responsible person must be informed of process for accessing after hours services

- ⦿ **Must be informed in writing**
- ⦿ **If the provider is the primary responder, the beneficiary must be given the provider's number as well as the phone number of a back-up person if provider is unavailable**



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24 Hour Coverage

- ⦿ **Providers should differentiate between medical and behavioral health emergencies when directing people to call 911**
- ⦿ **Provider are responsible for responding to behavioral health emergencies**



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What is Crisis?

- An inability to safely cope with a range of emotions and impulses
- A perception or experience of an event or situation as an intolerable difficulty that exceeds the person's current resources and coping mechanisms.
- Disrupted equilibrium or the failure of one's traditional problem-solving approach which results in disorganization, hopelessness, sadness, confusion, and panic.



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Emergent Situations

Any one of the following:

- ⦿ Consumer has a moderate or severe risk related to safety or supervision, or
- ⦿ Consumer is at moderate or severe risk for substance abuse withdrawal symptoms, or
- ⦿ Consumer presents a mild, moderate, or severe risk of harm to self or others, or
- ⦿ Consumer has severe incapacitation in one or more area(s) of physical, cognitive, or behavioral functioning related to MH/IDD/SA problems.



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Risk of Potential Harm to Self or Others:

Assessment Scale should indicate:

NONE, no current ideation (*within past 30 days*)

MILD, current ideation only to hurt self or others
(*within past 30 days*)

MODERATE, ideation with EITHER plan or history
of attempts to hurt self or others

SEVERE, ideation AND plan, with EITHER intent or
means to hurt self or others



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GUIDING PRINCIPLES FOR CRISIS WORK

Services are congruent with the culture, gender, race, age, sexual orientation, health literacy and communication needs of the individual

- Rights are respected
- Services are trauma-informed
- Recurring crises signal problems in assessment or care
- Meaningful measures are taken to reduce the likelihood of future emergencies



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HIGH RISK CRITERIA

- Not appearing for appointments and at risk for inpatient or emergency treatment
- Crisis service has been provided as the first service in order to facilitate engagement with ongoing care; or
- Discharged from an inpatient psychiatric unit or hospital, a Psychiatric Residential Treatment Facility or Facility-Based Crisis



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Accessible Crisis Resources

A good crisis plan needs to be available to ALL who will need it in a crisis!
With permission, upload to a computer for greater accessibility to:

- ⦿ Individual in crisis
- ⦿ Legal Guardian/Family
- ⦿ Service Providers...Peer Support Specialists, First Responders, Mobile Crisis Team, NC Start, residential providers
- ⦿ LME-MCO Call Center and Care Coordination personnel
- ⦿ Emergency Department personnel
- ⦿ Physician
- ⦿ Law Enforcement
- ⦿ Others as needed

*For individuals with a substance abuse diagnosis, the consent must meet the requirements set forth in 42 CFR Part II (Subpart C § 2.31)



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Documenting of Acknowledgment of 24 Hour Crisis Coverage

Consumer Name: _____
DOB: _____
Record #: _____

[Practice Header Here]
Consumer Acknowledgement
24 Hour Behavioral Health Crisis Coverage

In the event of a behavioral health crisis after business hours please call **[Practice name & phone number.]** Crisis calls will be returned within **[]** minutes. In the event of a medical emergency please call 911 or have someone take you to your nearest emergency room. Should your provider not be available after business hours, you will be instructed to call **[]**; the person/agency with whom there is a written agreement to provide coverage in your provider's absence.

I acknowledge that I have received a copy of my provider's 24 hour/ after-hours behavioral health crisis coverage number/information. I understand that this information indicates how to access support for after-hours behavioral health crises only.

Signature of Consumer /Legally Responsible Person (Relationship) _____

_____ Date

Signature of Provider _____

_____ Date

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Signature of Provider

Date

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6 STEPS TO WRITING A CRISIS PLAN

Step 1: Date of the Initial Crisis Plan or the Date of the last Revision

Step 2: Basic Essential Information about the Individual, including:

- > Identify the person needing a crisis plan
- > Date of Birth
- > Address and phone number
- > LME-MCO information
- > Living situation
- > Employment information/assistance



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Essential information to include...

Communication barriers, language, preferences

- > **Legally Responsible Person information**
- > **Insurance information**
- > **Diagnoses**
- > **Medications (dosage, frequency, reason for change, prescription date, pharmacy)**
- > **Medical problems and allergies, if any**



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6 STEPS TO WRITING A CRISIS PLAN

Step 3: Identify the Supports for the Individual

- List the individuals that should be called in the event of a crisis
- Indicate the calling order
- Provide contact information
- Indicate if a consent to release information to that person exists



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6 STEPS TO WRITING A CRISIS PLAN

Step 4: Crisis Follow Up Planning - Include which team member is the primary contact to coordinate care

- Indicate who will be visiting the consumer in the hospital (this should be the consumer's preference)
- Indicate who will organize and lead a review/debriefing following the resolution of the crisis, and within what timeframe this will happen



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6 STEPS TO WRITING A CRISIS PLAN

Step 5: Identify and Attach Additional Planning Documents

- Advanced Directives (Health or Mental Health)
- Living Will
- Health Care Power of Attorney
- Advanced Instructions for Mental Health Treatment
- Behavior Plan
- WRAP Plan
- Suicide Prevention and Intervention Plan



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6 STEPS TO WRITING A CRISIS PLAN

Step 6: Description of General

Characteristics/Preferences to include:

- What the individual is like when they are feeling well
- What a good day looks like and how they interact, appear and behave
- Early warning signs including significant event(s) that may increase stress and trigger onset of crisis
- Anniversaries, holidays, change in routine, alcohol/drug use, off medications, medical problems, family/marital conflict, noise, isolation, weather, etc...
- Known/effective strategies (how others can help, how they can help him/herself)
- Focus on preventing the targeted behaviors and on the least restrictive measures
- Match the strategy to the behavior
- Consider what occurs just before, during, and after crises
- Specific relapse prevention strategies



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6 STEPS TO WRITING A CRISIS PLAN

Step 6: Description of General Characteristics/Preferences (Cont'd)

- Response /Stabilization Strategies (Include how client can help self and what others can do)
 - Focus on natural and least restrictive measures (Back-up support, crisis respite, etc.)
 - Consider alternatives to hospitalization
 - Match the response to the level of behavior
 - Include special strategies that reflect client's intervention preferences
 - Include who should be notified of the crisis
 - Include provision of support while inpatient and plan ahead for discharge



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6 STEPS TO WRITING A CRISIS PLAN

Step 6: Description of General Characteristics/Preferences (Cont'd)

What's Working /What's Not

- Acceptable/unacceptable treatments that have/have not worked in past
- Preferred /non-preferred treatment facilities, medications, etc...
- How others (i.e. staff, family, professionals) should interact with client during a crisis (i.e. listening to music, going for a walk, having a conversation, not having a conversation, peer counseling, being touched, not being touched, etc...)



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Partners Behavioral Health Management Expectations

One Page Crisis Plan

- ◎ Part of the Person-Centered Plan (PCP)
- ◎ Documented Consumer Acknowledgment of Crisis Plan
- ◎ Updated as needed, and after crises occur
- ◎ Reviewed and updated at least annually
- ◎ Full PCP uploaded into Alpha CM



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Partners BHM Expectations

Comprehensive Crisis Plan

- ◎ Stand alone document
- ◎ Updated as needed, and after crises occur
- ◎ More actively reviewed and revised because of unstable condition and high needs
- ◎ Uploaded into Alpha CM for access by MCO and crisis providers



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Reference

**NC Division of Medical Assistance Clinical Coverage
Policy 8C 7.4**

Records Management and Documentation Manual

www2.ncdhhs.gov/dma/mp/8C.pdf



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Network Develop Plan

Four Work Groups:

- ⦿ **Prevention and Education**
- ⦿ **Quality Monitoring and Management**
- ⦿ **Social Determinants**
- ⦿ **Treatment**
 - **Accessing Care**
 - **Adult Services**
 - **Children and Families**
 - **Dual Diagnosis**
 - **Evidenced Based Practices and In Lieu of Service Definitions**



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Prevention and Education

Goal	Progress
Goal 1: To promote community awareness of behavioral health services and criteria for service eligibility, four articles will be written and published in the Behavioral Health Focus (BHF) by 6/30/19.	Qtr 1: Developed plan to and publish first article in November issue for Hunger and Homeless Awareness week.
Goal 2: To promote awareness of behavioral health stigma, in our catchment area, Public Relations' campaigns will include 4 community speaking engagements/presentations by 6/30/19.	Qtr 1: Partners' helped sponsor 5 events in September for National Recovery Month. Sept 28-Gaston County Recovery Month Celebration and Candlelight Vigil; Sept 28-Iredell County Walk for Recovery; Sept 29-Catawba County Recovery Rally; Sept 29-Burke Rally for Recovery; Sept 29-Surry and Yadkin County Hope Fest for Recovery.
Goal 3: Increase consumer support group presence within Partners catchment area by three new groups by 6/30/19.	Qtr 1: Group working on a current listing of support groups in the catchment area and potential for partnering on efforts.



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Quality Monitoring and Management

Goal	Progress
Goal 1: All Partners' providers will enroll in Health Connex or have an approved extension by 5/31/19.	Qtr 1: List of Health Connex resource links from the state website was made available to providers.
Goal 2: Consumers "episode of completion" reason is "completed treatment" based on NC Topps data for 25% of consumers by June 30, 2019.	Qtr 1: Plans developed for a link for the Health Connex website to be placed on Partners website.
Goal 3: Treatment effectiveness/consumer satisfaction will increase by 55% by June 30, 2019.	Qtr 1: Not started
Goal 4: Develop or obtain software with capability to provide the data analytics and predictive modeling to meet Partners identified needs by June 30, 2019.	Qtr 1: Reviews of software are being conducted.
Goal 5: Identify barriers and develop plan to reduce barriers to consumers missing follow up appointments by June 30, 2019.	Qtr 1: Not started



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Social Determinants

Goal	Progress
Goal 1: In partnership with the North Carolina Housing and Finance Agency (NCHFA) and Reinvestment In Communities (RIC), develop 2 small homes in Gaston County.	Qtr 1: Application delayed, to be submitted in January.
Goal 2: Expand inventory of affordable apartments in catchment area by 6/30/19.	Qtr 1: Not started
Goal 3: Coordinate at least one workforce summit in Gaston County by 6/30/19 to educate local businesses about hiring people with MH/SUD and criminal backgrounds.	Qtr 1: Met with Gaston Chambers Workforce Development 9/25/18. Processed services, discussed educating business on benefits of hiring those w/disabilities, and identify possible businesses for employment submit.
Goal 4: Engage at least 3 providers through the provider council on the benefits of participation in regional homeless Continuum of Care Committees by 2/1/19	Qtr 1: Attended Provider council meeting 9/28/18. Identified 2 new providers to invite to lunch and learn.
Goal 5: Research at least 2 new transportation options.	Qtr 1: New flex route began October 1, 2018 in Burke County



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Treatment

Accessing Care

Goal	Progress
Goal 1: Access-Collaborate with 60 In Network Providers to adopt protocols to obtain preventive physical care and annual physical data for behavioral health consumers by 6/30/19.	Qtr 1: Determined need for survey instead of RFI. Delays in drafting survey.
Goal 2: Access-Implement three strategies to increase access to psychological evaluations by 6/30/19.	Qtr 1: Obtained list of in-network providers from Provider Network, updating for providers who had not previously responded. Out of Network still needed. Obtained feedback internally from Care Coordination departments.
Goal 3: Access-Partners will increase Behavioral Health Urgent Care capacity by 50% through development of one additional center by 6/30/19.	Qtr 1: Request for feedback made, other facilities toured for comparison. Initial conversations with Mike Welch. Obtained and shared new laws for group review.



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Treatment

Adult Services

Goal	Progress
Goal 4: Adult-Partners will develop and release at least one RFP designed to increase capacity for and access to comprehensive substance use disorder services throughout the Partners catchment area by 6/30/19.	Qtr 1: 9/11/18 reviewed the results of the 2018 needs assessment. Reports manager could not give data needed. Revised activity to reflect IT request to build a report to obtain data that will be used to assess capacity.
Goal 5: Adult-Develop transitional housing program for adults diagnosed with substance use disorders in Partners northern region by 6/30/19.	Qtr 1: Identified a need to continue a contract with Oxford House for development in Northern Region. Contracted and Oxford house looking for property in Mt. Airy.



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Children and Families

Goal	Progress
Goal 6: Child-Increase capacity for residential treatment facilities to treat children/adolescents diagnosed with problem sexual behaviors by one facility by 6/30/19.	Qtr 1: Decision made to go with RFP. Consulted with EBP workgroup. Recommendation was to let providers submit EBPs relevant to service. RFP posted 9/5/18. Met with potential providers on 9/17/18.
Goal 7: Child-Develop and implement one Level II Residential Treatment home in Burke County for boys ages 10-15 with MH/SU diagnosis by 6/30/19.	Qtr 1: RFI posted 8/22/18. On 9/5/18, withdrew RFI to review rates based on provider feedback.
Goal 8: Child-Develop one residential treatment facility for adolescents with substance use disorders by 6/30/19.	Qtr 1: Not Started



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Treatment

Dual Diagnosis

Goal	Progress
Goal 9: Dual Diagnosis-Develop and implement one dual diagnosis (IDD/MH/SU [ASD]) 3-4 bed residential group home that serve adults ages 18-35 by 6/30/19.	Qtr 1: ROI posted 7/3/18. RFP posted 8/29/18. 9/20/18 RFP Responses received and sent for review.
Goal 10: Dual Diagnosis-Develop and implement one dual diagnosis (IDD/MH/SU [ASD]) 1 person placement (IAFT) serving ages 12-17 by 6/30/19.	Qtr 1: ROI posted 7/3/18; RFP posted 8/29/18. 9/20/18 RFP Responses received and sent for review.
Goal 11: Develop one Dual Diagnosis (IDD/MH/SU-ASD) Level III Residential Treatment Facility that serves female children ages 12-17 by 6/30/19.	Qtr 1: Not Started



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Treatment

Evidenced Based Practices/In Lieu of Service Definitions

Goal	Progress
Goal 12: Evidenced Based Practices/Service Definitions-Fully implement two previously approved In Lieu of Service Definitions by 6/30/19.	Qtr 1: 7/3/18-Identified Long Term Community Supports (LTCS) and Young Adults in Transition(YAT) to implement. Met with potential providers of LTCS on 8/13/18. Providers participating are all current providers of residential levels of service-Family Living and Supervised Living. YAT to be implemented as a pilot project with Sipes Orchard Homes and Youth Villages. 8/27/18-Sipes Orchard Homes submitted complete credentialing application for YAT.
Goal 13: Develop an alternative definition/payment for at least two new services by 6/30/19.	Qtr 1: Identified Intercept and Family Partners as services to obtain approval for alternative payments.
Goal 14: Evidenced Based Practices/Service Definitions-Implement an enhanced rate for two Evidenced Based Practices by 6/30/19.	Qtr 1: 7/3/18-prioritized Trauma Informed Comprehensive Clinical Assessments (TICCA). 8/22/18-met with Family Net regarding their use of TICCA's.

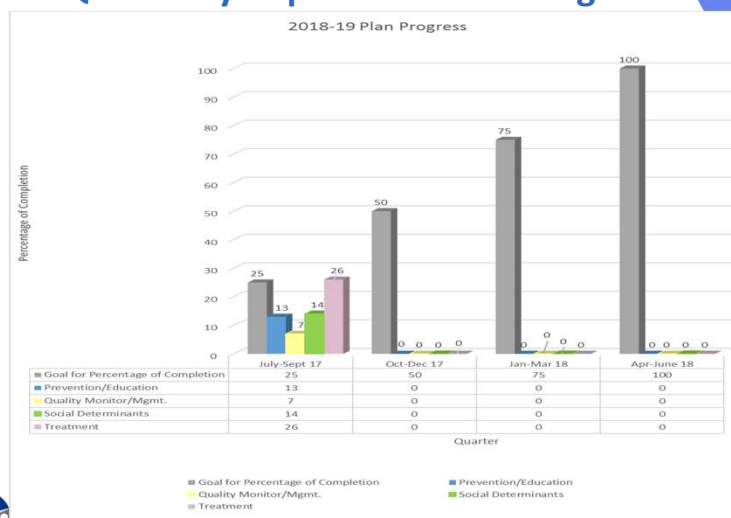


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Qtr. 1: July-September Plan Progress



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Note: First quarter percentages may be significantly lower than 25% due to goals being added during the 2018 Needs Assessment final report and planning session in September. Implementation of new goals did not begin in the first quarter.

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Contact Information

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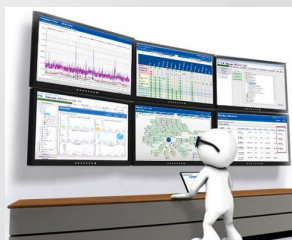


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Performance Monitoring



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Provider Performance Reporting



Strategic Planning Goal: Improve Provider Performance

PERFORMANCE SCORING METHODOLOGY



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What will determine the composite score?

- The composite performance score will factor in performance in the 4 weighted performance categories on a 0-100 point scale
(Quality+Resource Use+Clinical Practice+Promoting Interoperability=)

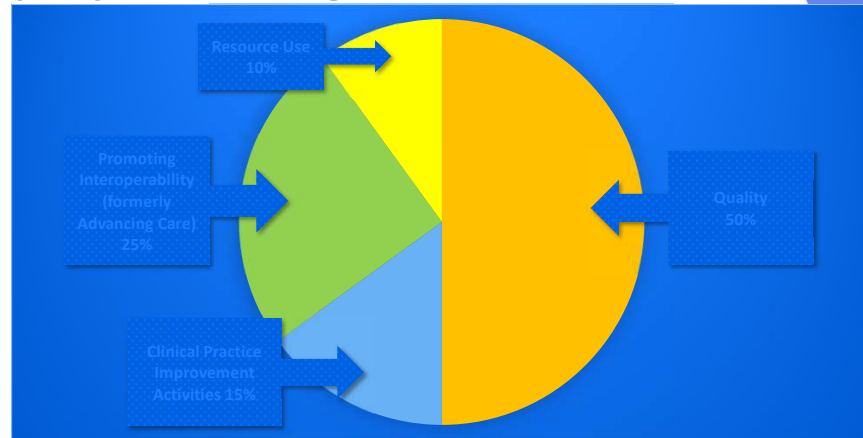


Performance Score

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Year 1: Performance categories and proposed weights



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Performance Measure Scoring

Measure Met = 1 Point

Measure Not Met = 0 Points

Measure N/A = 1 Point



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Performance Category Scoring

Performance Category	Maximum Points Possible	Percentage of Overall Score
Quality: category consists of 9 performance measures (5.55 points each)	50 points	50%
Promoting Interoperability (Advancing Care): category consists of 3 performance measures (8.33 points each)	25 points	25%
Clinical Practice Improvement: category consists of 5 performance measures (3.00 points each)	15 points	15%
Resource Use: category consists of 3 performance measure (3.33 points each)	10 points	10%



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Performance Score Reporting

- Providers to receive their performance score with an opportunity for input
- Upon a 30 day review of the performance score, Partners will publish provider performance



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Quality Performance Measures (50%)

Quality # 1

- ⦿ Sanctions/POC: Partners has issued 2 or more consecutive Plans of Correction against the Network Provider for the same or substantially similar findings within the 3 year credentialing cycle and/or re-credentialing cycle

Quality # 2

- ⦿ Sanctions/POC: The Network Provider has failed to implement a Plan of Correction Issued by Partners and the time for so has expired



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Quality Performance Measures (50%)

Quality # 3

- ⦿ Sanctions: Partners has issued 2 or more sanctions or administrative actions against the network provider in a consecutive period of time

Quality # 4

- ⦿ Sanctions: The Network Provider has failed to remit an identified overpayment to or enter into an approved payment plan with Partners within the designated time frame



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Quality Performance Measures (50%)

Quality # 5

- Quality of Care: Partners BHM has logged quality of care concerns or other serious grievances about the network provider that have NOT been satisfied in requirement timelines.

Quality # 6

- Monitoring: If Provider Overall Score 85% and above, then measure is met



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Quality Performance Measures (50%)

Quality # 7

- Provider provides a service that requires a fidelity review and is in compliance with fidelity score

Quality # 8

- If the provider has a performance measure regarding ambulatory follow up in their contract and they are meeting the standard as indicated in their contract, then measure is met

Quality # 9

- Provider maintains PBHM accreditation standard, if required



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Promoting Interoperability Performance Measures (25%)

Promoting Interoperability # 1

- ⦿ If Provider has established connectivity to NC HealthConnex, then measure is met

Promoting Interoperability # 2

- ⦿ If Provider is submitting information to the NC-SNAP database, then measure is met

Promoting Interoperability # 3

- ⦿ If Provider is submitting information to the Rapid Resource for Families database, then measure is met



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Clinical Practice Improvement (15%)

- ⦿ If NCTOPPS initial interview submissions are in compliance with timely submission requirements (70% or higher), measure is met

- ⦿ If NCTOPPS episode completion reason (completed treatment) score is in compliance (25% or higher), measure is met



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Clinical Practice Improvement (15%)

- ⦿ If NCTOPPS in-person & telephonic episode completion interview submissions are in compliance with timely submission requirements (65% or higher), then measure is met

- ⦿ If Provider is participating in the ACORN tool, then measure is met



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Clinical Practice Improvement (15%)

- ⦿ If Provider has implemented a patient-centered behavioral health model, then measure is met



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Resource Use (10%)

Resource Use # 1

- If Provider has met the PBHM standard (80%) for overall claims approval rate (State funds), then measure is met

Resource Use # 2

- If Provider has met the PBHM standard (80%) for overall claims approval rate (Medicaid B funds), then measure is met

Resource Use # 3

- If Provider has met the PBHM standard (80%) for overall claims approval rate (Medicaid B funds), then measure is met



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Provider Performance Reporting

- Questions?
- Comments?
- Suggestions?

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