



Provider Forum
December 10, 2019
Beth Lackey, MSW, LCSW
Provider Network Director

Provider Forum Agenda

- Provider Council Updates
- Medicaid Transformation Updates
- Member Engagement Department and Member Engagement Information
- Member Engagement Goals of Partners
- Reducing the Risk of Overpayment: Documenting Services
- Utilization Management Updates
- QM Updates
- Credentialing Updates
- Enrollment Updates
- Measurement Based Care
- Value Based Contracting
- PyxHealth



Provider Council Updates

- ▶ New Leadership
 - Beth Brown, Chair
 - Alicia Emmons, Vice Chair
 - Teagan Brown, Secretary
- ▶ Provider Council is an open meeting that occurs Monthly, with the exception of December and July.
- ▶ Provider Council meets at 9:30am in Hickory on the 4th Friday of each month in the Multipurpose room
- ▶ Next Meeting – January 23, 2020 at 9:30am – This is your meeting, the MCO is invited to attend!



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Medicaid Transformation Updates

<https://www.ncdhhs.gov/news/press-releases/legislators-adjourn-without-taking-actions-required-medicaid-managed-care-dhhs>

“With managed care suspended, NC Medicaid will continue to operate under the current fee-for-service model administered by the department. Nothing will change for Medicaid beneficiaries; they will get health services as they do today. Behavioral health services will continue to be provided by Local Management Entities/Managed Care Organizations. All health providers enrolled in Medicaid are still part of the program and will continue to bill the state through NC Tracks.”

Related news articles:

<https://www.northcarolinahealthnews.org/2019/11/20/medicaid-transformation-suspended-indefinitely/>

<https://www.wral.com/nc-s-massive-medicaid-transformation-delayed-over-budget-fight/18778479/>



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Community Support Team – Permanent Supportive Housing

Enhancing Skills to Succeed with Independent Living – cost: \$30.00

When: Tuesday 12/17 from 12:00pm – 3:00pm

Primary Target Audience: North Carolina CST providers (required). ACT, TMS, and LME-MCO staff are also welcome to attend.

This 3-hour webinar meets the new CST service Definition training requirement for *Basics of Psychiatric Rehabilitation and Functional Assessments*. All CST providers are required to complete this training within 90-days of hire.

Please see the link below for registration information and payment.

<http://tinyurl.com/tsop2y9>



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Community Support Team – Permanent Supportive Housing (cont)

Introduction to Profile of Participation (PoP) – cost: Free

When: Wednesday 12/18 from 9:30am – 11:00am

Primary Target Audience: ACT, CST, TMS providers, as well as LME-MCO staff.

This free webinar will introduce the participants to the Profile of Participation (PoP), which is a tool used to guide service providers in obtaining a comprehensive overview of a client's functional independence and participation in activities of daily living.

Please see the link below for registration information.

<http://tinyurl.com/tzr73jf>



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Member Engagement Department

Partners new Member Engagement Department supports members and families with resources, information, and advocacy. If you have members who need extra help navigating the system, refer them to Member Engagement.

Updates:

- The annual member letter was mailed on November 18th. If you get questions have members to call Member Engagement at (704) 884-2666 or email memberquestions@partnersbhm.org
- A Member Portal is available for members to register on the www.partnersbhm.org website (top of screen). They can access information and take screenings now and will be able to see their plan information and message care teams in the future.



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Member Engagement

- The Member Engagement staff are dedicated to building strong partnerships with our internal departments, providers, NCDHHS, external stakeholder groups, and disability-specific advocacy groups to better serve our members with resource needs and continuity of care.



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Member Engagement

We engage with members and families to get input for Partners' operations and we assist members and their families needing:

Information about LME/MCO mailings (*Annual Member Letter mailed in November!*)

- Website screening tool assistance
- Member Portal assistance (*Member Portal now live!*)
- Empowerment or advocacy
- Resources and information
- Help navigating the system or understanding communications they receive
- Guardianship
- Client rights and policy support
- Information on CFAC or other LME/MCO committees
- Help with Psychiatric Advance Directives



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Member Engagement Contact Information

You may contact the department at memberquestions@partnersbhm.org or by calling:

Member Engagement Department (704) 884-2666

- **Director: Allison Crotty** - (704) 884-2564
- **Northern Region** (Surry, Yadkin, Iredell) Beth Brooks — (336) 527-3225
- **Central Region** (Rutherford, Catawba, Burke) *Position posted* — (828) 323-8047
- **Southern Region** (Gaston, Lincoln, Cleveland) Lindsay Green — (704) 772-4271



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Member Engagement Goals of Partners

- Increase Adult and Child members perceived improvements in the following categories by 5% :
 - * ability to deal with problems
 - * ability to deal with social situations
 - * ability to accomplish things
 - * ability to deal with symptoms or problems



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Reducing the Risk of Overpayments: Documenting Services

Provider Webinar, December 10, 2019
William Owens, Program Integrity Director

Objectives of this training...

To enhance compliance and help providers reduce the risk of receiving an overpayment.

Objectives

- ▶ Where do I find the rules for service notes?
- ▶ What must be included in a service note?
- ▶ Is that signature any good?

This presentation is a summary of the requirements outlined in CCP 8C and APSM 45-2. Those sources are superior to any criteria outlined in this presentation.



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Laws, Rules, Regulations, Policies...

- ▶ State Plan
- ▶ North Carolina General Statutes
- ▶ North Carolina Administrative Code
- ▶ Clinical Coverage Policies
- ▶ Service Definitions
- ▶ Records Management and Documentation Manual



NC State Plan, General Statutes, Administrative Code

- ▶ NC State Plan: Title XIX of the Social Security Act requires that North Carolina provide a plan to administer and manage the North Carolina Medicaid Program.
 - <https://medicaid.ncdhhs.gov/notices/medicaid-state-plan-public-notices>
- ▶ NC General Statutes: Chapter 122C-Mental Health, Developmental Disabilities and Substance Abuse Act of 1985.
 - <https://www.ncleg.gov/Laws/GeneralStatuteSections/Chapter122C>
- ▶ NC Administrative Code: Title 10A, Chapters 26, 27, 28 & 29
 - <https://www.ncdhhs.gov/divisions/mhddsas/commission/ncadministrativecode>



NC DHB Clinical Coverage Policies

- ▶ NC Medicaid and Health Choice Clinical Coverage Policies for Behavioral Health
 - <https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies/behavioral-health-clinical-coverage-policies>



Clinical Coverage Policies

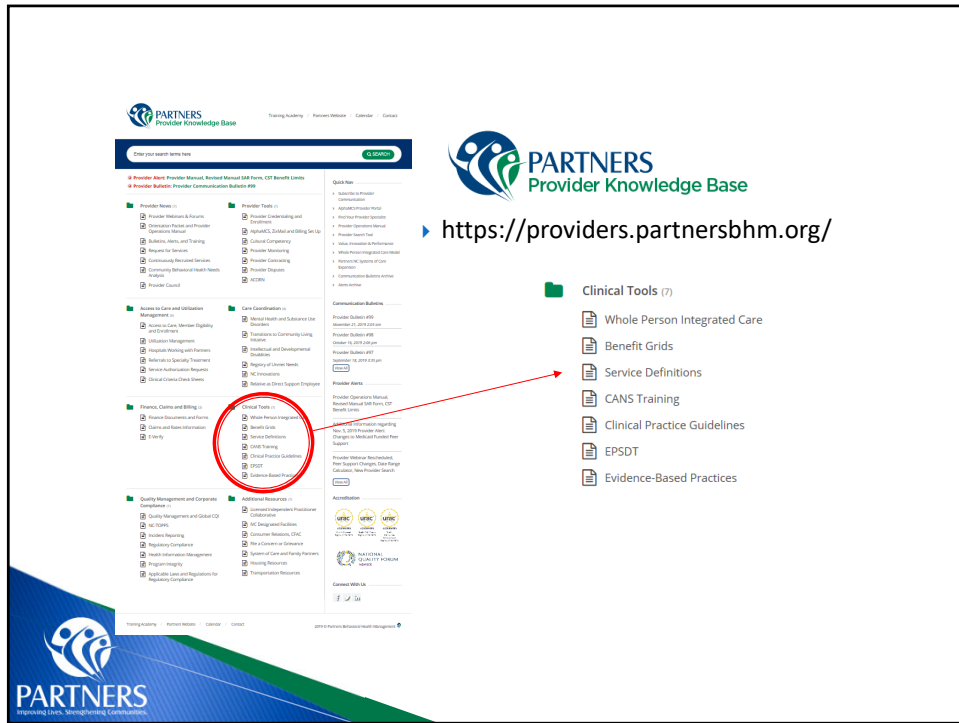
- ▶ 8A, Enhanced Mental Health and Substance Abuse Services
- ▶ 8A-1, Assertive Community Treatment (ACT) Program
- ▶ 8A-2, Facility-Based Crisis Service for Children and Adolescents
- ▶ 8B, Inpatient Behavioral Health Services
- ▶ 8C, Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers
- ▶ 8D-1, Psychiatric Residential Treatment Facilities for Children under the Age of 21
- ▶ 8D-2, Residential Treatment Services
- ▶ 8E, Intermediate Care Facilities for Individuals with Intellectual Disabilities
- ▶ 8I, Psychological Services in Health Departments and School-Based Health Centers Sponsored by Health Departments to the under-21 Population
- ▶ 8J, Children's Developmental Service Agencies (CDSAs)
- ▶ 8L, Mental Health/Substance Abuse Targeted Case Management
- ▶ 8N, NC Health Choice – Intellectual and Developmental Disabilities Targeted Case Management
- ▶ 8-O, Services for Individuals with Intellectual and Developmental Disabilities and Mental Health or Substance Abuse Co-Occurring Disorders
- ▶ 8-P, North Carolina Innovations



NC DHHS Service Definitions

- ▶ State Funded Services
 - <https://www.ncdhhs.gov/divisions/mhddsas/servicedefinitions>
 - Enhanced Mental Health and Substance Abuse Services 2019 effective 11-1-19
 - ACT Policy
 - Facility-Based Crisis - Child
 - Community Support Team (CST) 11-1-19
 - Peer Support Service-Final for Posting 11-1-19
 - Inpatient Behavioral Health-FINAL for Posting 7-1-16
 - IPS-SE for AMH-SAS 1-7-19
 - Transition Management Services-Final for Posting 11-1-19
 - Critical Time Intervention-CTI-Final for Posting 7-1-16
 - Developmental Therapy Service Final for Posting 7-1-16





PARTNERS
Provider Knowledge Base

<https://providers.partnersbhm.org/>

Clinical Tools (7)

- Whole Person Integrated Care
- Benefit Grids
- Service Definitions
- CANS Training
- Clinical Practice Guidelines
- EPSDT
- Evidence-Based Practices

Records Management and

- Records Management and Documentation Manual (APSM 45-2) Chapter 7: Service Notes and Service Grids)

◦ <https://www.ncdhhs.gov/divisions/mhddsas/reports/records-management-and-documentation-manual-rmdm>

Contents of Service Notes

CCP 8C	APSM 45-2
Chapter 7.3.1. Each page must contain:	Chapter 7. Service notes shall include, but are not limited to the following <u>on every service note page</u>
The Member's Name	Name of the individual receiving the service
Service Record Number of Member	Service Record Number of the individual
Member's Medicaid Identification Number	Medicaid Identification Number for services reimbursed by Medicaid



Clinical Coverage Policy 8C

CCP 8C	APSM 45-2
Chapter 7.3.5 Must be a progress note for each treatment, which includes:	
Date of Service	Full date the service was provided [month/day/year]
Name of the Service Provided	Name of the service provided [e.g., Community Support – Individual]
Type of Contact	Type of Contact [face to face, phone call, collateral]
Purpose of Contact	Purpose of the contact [tied to specific goal(s) in the service plan]
Description of Treatment or Interventions Performed	Description of the intervention(s)/ treatment/ support provided.
Effectiveness of Interventions and member's response	Effectiveness of the intervention(s) and the individual's response/progress toward goal(s)
	Place of service [when required by the service definition]



Clinical Coverage Policy 8C

CCP 8C	APSM 45-2
Duration of Service, in minutes	Total amount of time spent performing the service
Signature with credentials, degree and licensure	Signature. - Professionals: Signature, with credentials, degree, or licensure of clinician who provided the service. - For licensed professionals, the full signature denotes the clinician's licensure and/or certification; for non-licensed professionals, the full signature denotes the degree [e.g., BA, MSW] and should also include the individual's professional status [e.g., QP or AP], and any other certifications the person may hold [e.g., CSAC]. - Paraprofessionals, signature and position of the individual who provided the service.



Signature/Date

- ▶ Paper Records = Handwritten Signature
- ▶ When dated signature is required, signature is not valid without the date appearing next to it
- ▶ The date next to a signature must be entered **ON THE DATE THE PERSON SIGNS THE DOCUMENT**
- ▶ Electronic Signature, if date required, must appear next to the electronic one.
- ▶ Electronic Signatures must be under sole control of person using it
- ▶ Only the authorized person can apply a specified signature



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Conclusion

It is the Provider's responsibility to stay abreast of the requirements for delivering the medical services they are credentialed and contracted to provide in the Partners' Provider Network.



Contact Information

How to Report Fraud or Abuse

Help us fight health care fraud and abuse. Reporting Medicaid fraud or financial abuse will not interfere with an enrollee's access to health care. If you suspect billing for a service, a conflict of interest, a violation of Medicaid or Medicare rules, or conduct violation might be illegal, please report your concerns to:

Partners Regulatory Compliance Alert Line at 1-866-806-8777 or
Partners Online Alert Line at <https://partnersbhm.alertline.com>

You do not have to provide your name or contact information. However, we can often conduct a more effective investigation if you let us contact you. Your name will not be shared with anyone investigated.

Note: In rare cases involving legal proceedings, your identity may have to be revealed.

William Owens, CFE
(704) 842-6428

wowens@partnersbhm.org

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Utilization Management Updates

Presented by:

Liza Go-Harris, LMFT - MH/SU UM Manager

Adult Services Benefit Grid Changes IPS SE - YP630

Individual Placement and Support (IPS) - Supported Employment: STATE

- ❖ YP630 (DJ) and YP630 (BC) Benefits Counseling
- ❖ Pass-through of 64 units (16 hours) per fiscal year. Notification SAR required. No clinical information needed.
- ❖ Initial request: Up to 688 units/month (4,128 units) for 180 days. Submit PCP with in-depth Employment Plan and/or Employment Plan.
- ❖ Concurrent request : MH – Up to 8,256 units per 12 months. Submit updated PCP and/or Employment Plan.



12/10/2019

Adult Services Benefit Grid Changes Medicaid PSS - H0038

Medicaid Peer Support Services (Clinical Coverage Policy 8G):

- ❖ H0038 – Peer Supports Individual; H0038 DJ – Peer Supports Individual (DOJ); H0038 HK – Peer Supports Individual (Timely Follow Up); H0038 HQ – Peer Supports Group; H0038 HQ DJ – Peer Support Group (DOJ)
- ❖ 64 Unmanaged units per fiscal year. No authorization required for unmanaged visits. Notification SAR NOT required
- ❖ For over 64 units, submit a Service Authorization Request (SAR).
- ❖ Initial Request: up to 270 units per 90 days. Submit CCA, PCP, and Comprehensive Crisis Plan. Service Order is required on or before the first date of service.
- ❖ Concurrent Request: up to 270 units per 90 days. Submit Updated PCP.
- ❖ Due to the change from unmanaged 83 Peer Support Services (PSS) to Medicaid managed PSS, Partners will allow retroactive Service Authorization Requests (SARs) for dates of service back to 7/1/2019. Partners must receive all Retroactive SARs for Medicaid PSS by 12/15/19.



12/10/2019

Adult Services Benefit Grid Changes CST – H2015 HT

Community Support Team (Clinical Coverage Policy 8A-6) MEDICAID

- ❖ H2015 HT (DJ) - Community Support Team. The new CST service codes will be posted soon.
- ❖ Initial authorization: Pass-through of 36 units for 30 days , once per treatment episode, once per fiscal year. Notification SAR is required for pass-through
- ❖ 1st concurrent request: Up to 128 units per 60 days. Documentation requirements include: CCA, PCP, and Comprehensive Crisis Plan. Service Order is required and is due on or before the first date of service.
- ❖ 2nd concurrent request: Up to 192 units per 90 days. Documentation requirements include: Updated PCP. New CCA or CCA Addendum needed if request exceeds 6 months per calendar year.
- ❖ The new CCA/CCA Addendum for CST requests exceeding 6 months can now be completed by any licensed clinician on the team (clinician must sign, credential, and date the CCA).
- ❖ Partners has posted a Registration of Interest (ROI) for providers who want to deliver the new NC Medicaid Community Support Team – Permanent Supportive Housing Services. Authorization units for Housing needs will be posted soon along with the new CST codes.
- ❖ STATE CST: Providers may now submit a SAR for State-funded members for continued services beyond 6 months. Clinical documents are required to justify continuation of service.



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Child Services Child Focused ACTT H0040- HA-U5

- ❖ For adolescents, ages 12 – 18 years old
- ❖ Adolescents with severe symptoms who maybe recommended for Psychiatric Residential Treatment Facility (PRTF) but may likely benefit from the enhanced team approach and 24/7 crisis interventions
- ❖ Child ACTT is a stand-alone service and other services are exclusionary.
- ❖ Documentation Requirements: CCA, PCP, CCP-Comprehensive Crisis Plan and Service order signed by MD, DO, Ph.D./Psy D, PA or NP
- ❖ Authorization: 1 unit per week
- ❖ Initial and Concurrent request: up to 12 units for 3 months
- ❖ Maximum of 24 units per rolling calendar year



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Acute Services

- ❖ Includes Inpatient Services, Facility Based Crisis Services and Partial Hospitalization
- ❖ Hours of Operation - Effective 12/9/2018
Daily, Monday thru Sunday, 8am-7pm
- ❖ Providers may submit a Manual Service Authorization Request (SAR) by email or Fax, if access to the electronic system (Alpha) is not possible



12/10/2019

Revised Manual Service Authorization Request Form

Partners has revised the Manual Service Authorization Request form and Instructions for Use. This information is located on the Partners Provider Website:

<https://providers.partnersbhm.org/utilization-management/>.



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Electro Convulsant Therapy (ECT)

- ❖ 6 Unmanaged ECT sessions per Fiscal Year
 - Outpatient & Inpatient Combined
- ❖ Notification SAR required for unmanaged visits
- ❖ Authorization required after unmanaged 6 visits (before 7th session)
- ❖ Electroconvulsive Therapy (ECT) Continuation Form required



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Utilization Management Contact Info

CONTACT INFORMATION

UM STAFF

▶ <u>MH/SA UM Workgroup</u>	X 6436	Direct In-dial Number	1-704-842-6436
▶ <u>IDD/Innovations Workgroup</u>	X 2605	Direct In-dial Number	1-704-884-2605
▶ <u>Inpatient Reviewers Workgroup</u>	X 6434	Direct In-dial Number	1-704-842-6434
▶ <u>Appeals Department Workgroup</u>	X 2650	Direct In-dial Number	1-704-884-2650

UM Fax/ Phone Numbers

- ▶ UM MH/SA Faxcore: 704-884-2701
- ▶ Inpatient Faxcore: 704-884-2703
- ▶ Gastonia: 704-866-7727
- ▶ Hickory: 828-325-9826
- ▶ UM Appeals Faxcore: 704-884-2720
- ▶ UM IDD Faxcore: 704-884-2690
- ▶ PBHM Service Desk: 704-842-6431



12/10/2019

Thank You!

HAPPY HOLIDAYS
TO
ALL !!!!



12/10/2019



QM Update

NC-TOPPS Updates

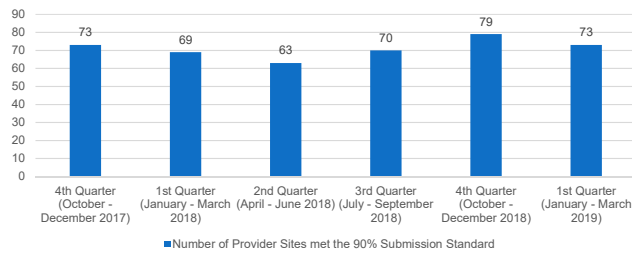
- Monthly CNDIS Validation
- Monthly Provider Webinar
- Quarterly NC-TOPPS System Access Control: Removing Users
- Block Grant POC
- Quarterly Reports



12/10/2019

NC TOPPS Quarterly Summary

NC-TOPPS Superstars Summary Results
SFY 2018 - 2020 Update Compliance
(Based on Initials Submitted During the Time Period Listed)



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1st Quarter FY 2020 Highlights (Based on Initials Submitted January - March 2019):

73 Provider sites met the 90% submission standard.
64 of the 73 Provider sites made 100% submission score.
9 of the 73 Provider sites made 90.9% to 99.3%.
5 Provider sites made it into the 80% range.
15 Provider sites fell below 80% submission.
134 Sites had no requirements for updates.
 Total of 227 Provider sites.

[Source: SFY 2019 Update Compliance by Provider Agency Report: Second Quarter Report | Distributed October 18, 2019 from NCTOPPS]



12/10/2019

NC-TOPPS Quarterly Snapshot Report

NC-TOPPS Quarterly Snapshot Report

1st Quarter FY20 (Based on Episode Completion Interviews July – September 2019) Highlights:

- Decreasing symptoms (Goal: 60%) and improving quality of life (Goal: 50%) have continued to exceed their goals since March 2018.
- Increase In-Person/Telephonic (Combined): All consumers groups for the past three quarters have fell below the goal of 65% except for Quarter 1 (January -September 2019) Adolescent SA was 72.7% and Quarter 4 (April – June 2019) Adolescent SA was 75.0%, and Quarter 3 (January – March 2019) was 66.7%.
- Barriers to Treatment:
 - Ranking 1-7: 1-Strength (Low Percentage) and 6- Area for Opportunity (High Percentage)
 - Transportation
 - Scheduling
 - SA Symptoms
 - Family Issues
 - Treatment Engagement
 - MH Symptoms

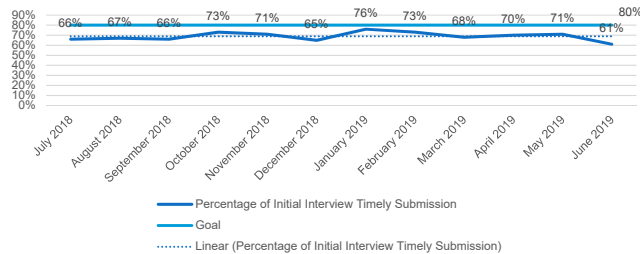
Source: NCTOPPS Simple Query | Date Generated: October 16, 2019



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NC-TOPPS Quarterly Key Performance Indicator Scorecard

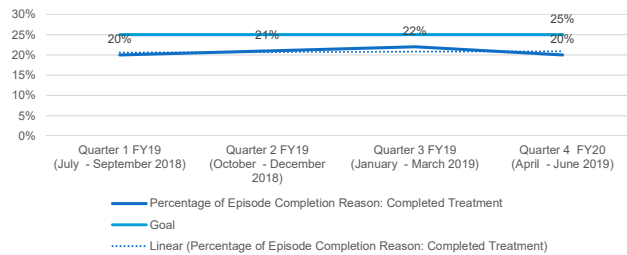
Partners Behavioral Health Management NC-TOPPS Quarterly Key Performance Indicator Scorecard Initial Interview Timely Submission



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NC-TOPPS Quarterly Key Performance Indicator Scorecard

Partners Behavioral Health Management
NC-TOPPS Quarterly Key Performance Indicator Scorecard
Episode Completion Reason: Completed Treatment



12/10/2019

4th Quarter FY 2019 (Based on Episode Completion Interviews April – June 2019) Highlights:

- Initial Interviews Timely Submission: Quarter 4 FY 2020 decreased in April (70%), increased in May (71%) by 1 percentage point and it experienced a significant decrease in June (61%) by 10 percentage points. Both quarters have fell below our goal of 80%.
- Episode Completion Reason, Completed Treatment: Decreased from 22% to 20% (2 percentage points).
- Interview Method, In-Person/Telephone: Decreased from 38% to 37% (1 percentage point).
- Quality Indicator, “Where services helpful with Symptoms?” “Very Helpful”: Increased from 50% to 54% (4 percentage points).

| Source: NC-TOPPS Raw Data Report, NCTOPPS Interview Search Report, Partners BHM Reports Manager (NC TOPPS DUE Based on Claims)
| Generated October 10, 2019 |



12/10/2019



Credentialing

CAQH

- ▶ All clinicians must ensure that their CAQH information is up-to-date:
 - If a provider discloses information in Section C of CAQH "Professional Information", a detailed explanation must be given on the supplemental form. Short and vague answers could result with the application being denied or pended and/or delay credentialing.
 - State release will be available in CAQH once credentialing staff add the clinician to the CAQH Partners roster
 - The state release can be found in the document section in CAQH, sign, date and upload back into CAQH

Re-Credentialing Notices

- ▶ A Re-credentialing notice is sent out at 6 Months and 90 days prior to the expiration of credentialing for each provider (associated clinicians, licensed independent practitioners and agencies).
 - The notice to associated clinicians and LIPs goes to the last e-mail address on file for the clinician/LIP.
 - The notice for agency re-credentialing goes to the agency credentialing primary contact via e-mail as well as to the CEO via certified mail.
- ▶ The expiration of credentialing for each provider (associated clinicians, licensed independent practitioners and agencies) is posted on Partners website and updated monthly. You can find that information at the following link:

<https://providers.partnersbhm.org/provider-enrollment-credentialing>



12/10/2019

Contract Notices

Agencies and LIP's also receive a **contract warning** notice via certified mail at 90 days prior to their credentialing expiration date.

- If Partners BHM has not received a **complete** re-credentialing application from LIPs and agencies **60 days prior to credentialing expiration** then Partners BHM issues a **contract non-renewal letter** via certified mail ending your participation in the Partners BHM network effective the date of the credentialing expiration.
- Partners BHM is required to begin notifying consumers that the provider is no longer eligible to offer services in the network at this point.



12/10/2019

Complete Application

- ▶ The application must be **complete** in order to avoid or stop the contract non-renewal process. A complete application means all attachments are received and correct and the information in the application is correct/accurate and no additional information is needed.



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Credentialing vs. Enrollment

- ▶ Credentialing and enrollment are two different processes and departments within Partners.
- ▶ In addition, enrollment with NC Tracks is separate from credentialing and separate from enrollment with Partners.
- ▶ Providers **MUST** be enrolled in NC Tracks in order to be eligible to apply to join Partners network.
- ▶ Enrollment with Partners (i.e. enrollment in Alpha) **CANNOT** be completed if enrollment with NC Tracks does not match the information submitted and verified through Credentialing.



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Associated Clinicians

- ▶ When initiating credentialing for an agency new to Partners network, be sure to submit the [Provider Change Form](#) to initiate credentialing for the associated clinicians that will provide services with the agency at the same time.
- ▶ The [Provider Change Form](#) lists out all the information needed to initiate credentialing for a clinician



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NPPES

- ▶ National Plan & Provider Enumeration System (NPPES)
- ▶ Addresses, taxonomies, NPI numbers must all match in NC Tracks, NPPES and Alpha.
- ▶ NPPES must have the most current address/taxonomy information for the agency under the NPI# associated with each site.
- ▶ Credentialing will verify that the site/taxonomy in the application are registered in NPPES under the NPI# listed for it.



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NPPES – Making Changes to Information

- ▶ If you need assistance making changes to NPPES:
 - For **individual** NPI numbers:
 - Call: **800-465-3203**
 - 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



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Making Changes to Provider Info

- ▶ For any changes such as name changes, license updates, adding a site, adding services, and updating taxonomy/NPI# to the Partners contract, the provider will need to submit a [Provider Change Form](#) with the specific changes and information listed.
- ▶ The [Provider Change Form](#) is found on the Partners website under the “Provider Knowledge Base” tab at the top of the website. Once in there, go to “Credentialing and Enrollment” tab. When you scroll down the page you will see an actions grid and the [Provider Change Form](#) will be there.
- ▶ Please submit a [Provider Change Form](#) to the credentialing team email (CredentialingTeam@partnersbhm.org) for any changes needed to be made.



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Agency Primary Contact Info

- ▶ Please ensure the primary contact information for the agency is correct in the application.
- ▶ If the primary contact for the agency changes let Partners know by submitting a [Provider Change Form](#) to update the primary contact info for the agency.
- ▶ This will ensure correspondence is not missed and communicated effectively.



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Clinician Insurance Requirements

- Must submit a Certificate of Insurance for the agency's Professional Liability insurance with Partners listed as a Certificate Holder.
- If the clinician is covered under the agency's Professional Liability insurance, please submit either a roster of covered employees or documentation on agency letterhead evidencing that the clinician is covered by the policy.
- In the event the clinician is not covered under the agency's Professional Liability, please submit a Certificate of Insurance for the clinician's individual/personal policy. This certificate must list Partners as a Certificate Holder as follows: Partners Attn: Credentialing Dept., 1985 Tate Blvd. SE, Suite 529, Hickory, NC 28602.



12/10/2019

Agency Insurance Requirements

- ▶ Partners is required to be listed as “additionally insured” under the General Liability coverage.
- ▶ Partners is required to be the “certificate holder” for all required insurance coverage policies for credentialing (General Liability, Professional Liability, Auto Liability, and Workers Compensation).



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Questions?

- ▶ Jason Arenillas, Credentialing Supervisor
 - (828) 325 8142
 - Jarenillas@partnersbhm.org
- ▶ Credentialing Department
 - (704) 842-6483
 - CredentialingTeam@partnersbhm.org

Please be sure to communicate the credentialing information with the credentialing staff/primary contact for your agency, thank you!



12/10/2019



Enrollment & NC Tracks

Danielle R. Clark-Enrollment Supervisor

Enrollment in Alpha

- ▶ Provider Network Enrollment staff verifies that the provider is:
 - Credentialed with Partners
 - Enrolled in NC Tracks
- ▶ If provider is credentialed and enrolled in NC Tracks:
 - Enrolled in Alpha
 - Contract issued
- ▶
- ▶



12/10/2019

If Provider NOT Enrolled in NC Tracks

- ▶ Partners cannot enroll provider in Alpha and cannot issue a contract.



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Common Enrollment Issues for Associated Clinicians

- Practice address is not under Name/Address Tab in NC Tracks.
- License has expired
- Clinician not Affiliated with agency in NC Tracks
- Taxonomy is not loaded in NC Tracks/NPPES
- Taxonomy is not an acceptable billing taxonomy



12/10/2019

Enrollment Cannot

- ▶ Make changes in Alpha until the changes can be verified in NC Tracks.
- ▶ Accept a managed change request as proof changes have been made.



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If Enrollment Status Letter is received

- ▶ Once the manage change request is approved-Please let enrollment staff know, so that changes can be verified.
- ▶ Enrollment staff do not go back and check NC Tracks for changes unless they are notified.



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If you have Enrollment Questions

- ▶ Enrollment group email address is enrollment@partnersbhm.org
- ▶ Danielle R Clark-Enrollment Supervisor can be reached directly at dclark@partnersbhm.org or 828-325-8158



12/10/2019



Measurement Based Care
Everything you wanted to know...

Measurement Based Care

- ▶ We are asking providers to choose a valid and reliable Measurement Based Care Tool.
- ▶ We asked that you start this process 11/1/2019
- ▶ We are asking what tool you have chosen in the Annual Performance Review
- ▶ We understand that this is a paradigm shift
- ▶ We are also continuing to set up individual calls with providers to provide technical assistance



12/10/2019

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Measurement Based Care

- ▶ In **Provider Communication Bulletin #96**, Partners rolled out the implementation date for the use of Measurement Based Care tools as November 1, 2019. As we move towards the implementation date, we received feedback from the Provider Council to host a webinar devoted to this topic. **Partners hosted a webinar regarding Measurement Based Care on Wednesday, October 2, 2019. To view the webinar recording or slide deck, please visit <https://www.partnerstraining.org/training-library/>.**
- ▶ Additionally, Partners wanted to provide clarification to the tools listed in the Communication Bulletin. The tools are not all inclusive or a comprehensive list. As was indicated in the webinar, there are several considerations in choosing the tool that you would like to implement. When selecting a tool, use validated tools.
- ▶ The list provided is not exhaustive



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Measurement Based Care

- + Measurement Based Care (MBC) is the **systematic administration of symptom rating scales**, incorporating the huddle and/or registry in operations
- + MBC is NOT a substitute for clinical judgment
- + MBC **uses the results to drive clinical decision making** at the consumer level and supports to overcome clinical inertia
- + Consumer rated scales are equivalent to clinician rated scales

SOURCE: Fortney et al Psych Serv Sept 2016



HEALTH MANAGEMENT ASSOCIATES

6
9

Measurement Based Care

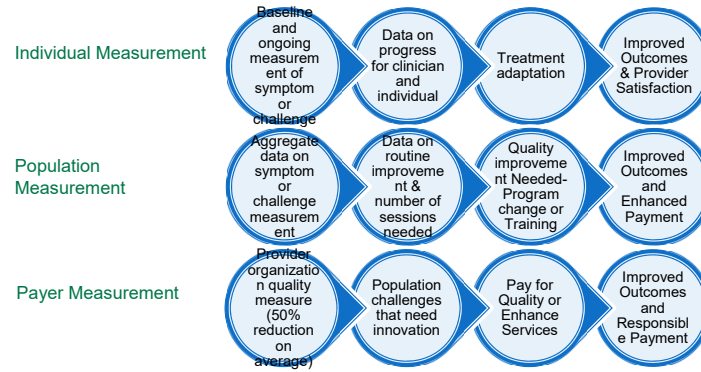
- + Is a change in clinical process not merely a metric.
- + The goal is to improve treatment specifically catching individuals who are not improving or who have improved only a minimal amount
- + Maximizes treatment to get to enhanced outcomes
- + Offers data for organizations to demonstrate value across programs, populations, and providers
- + Supports individual engagement in care



HEALTH MANAGEMENT ASSOCIATES

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Measurement Based Care is more than a QI Metric



ROLLING MBC UP TO NETWORK LEVEL PERFORMANCE MEASURES

Network of Providers

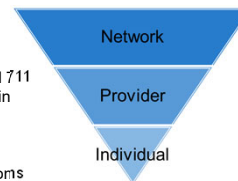
- ✓ Percent with 50% reduction PHQ-9 – NQF 184 and 185
- ✓ Percent reaching remission (PHQ-9 < 5) – NQF 710 and 711
- ✓ 80% of individuals served see a 50% reduction or better in symptoms within X number of weeks.
- ✓ % reduction in psychiatric/medical hospitalizations

Provider

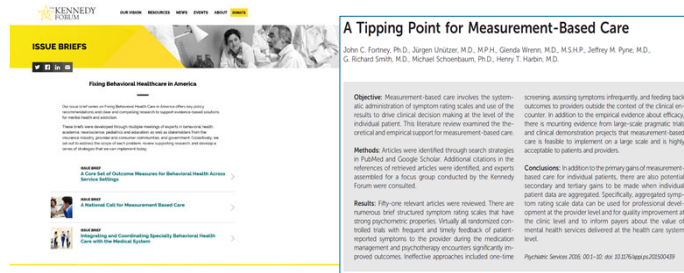
- ✓ 80% of clients have a 50% or greater reduction in symptoms
- ✓ 75% of clients complete treatment in 12-15 weeks (could be by conditions or sub-population)
- ✓ Average number of treatment adjustments is 40 (could be by condition or sub-population)
- ✓ 60% of providers are reaching initial treat to target of 40% reduction in X timeframe

Individual

- ✓ 45% reduction on PHQ-9
- ✓ 60% reduction on GAD-7



Resource: GROWING FOCUS ON MEASUREMENT BASED CARE



Fixing Behavioral Healthcare in America

A Tipping Point for Measurement-Based Care

John C. Forney, Ph.D., Jürgen Unutzer, M.D., MPH, Glenda Wrenn, M.D., M.S.H.P., Jeffrey H. Pyne, M.D., G. Robert Smith, M.D., Michael Schoenbaum, Ph.D., Henry T. Haugan, M.D.

Objective: Measurement-based care involves the systematic administration of symptom rating scales and use of the results to drive clinical decision making at the level of the individual patient. This literature review examined the theoretical and empirical support for measurement-based care, screening, assisting symptoms infrequently and feeding back outcomes to providers outside the context of the clinical encounter. In addition to the empirical evidence about efficacy, there is mounting evidence from large-scale pragmatic, trial, and clinical demonstration projects that measurement-based care is feasible to implement on a large scale and is highly acceptable to patients and providers.

Methods: Articles were identified through search strategies in PubMed and Google Scholar. Additional citations in the references of retrieved articles were identified, and experts assembled for a focus group conducted by the Kennedy Forum were consulted.

Results: Fifty-one relevant articles were reviewed. There are numerous, brief structured symptom rating scales that have strong psychometric properties. Virtually all unmet need, low-level trials with frequent and timely feedback of patient-reported symptoms to the provider during the medication management and psychotherapy encounters significantly improved outcomes. Ineffective approaches included one-time

Conclusions: In addition to the primary goals of measurement-based care for individual patients, there are also potential secondary and tertiary gains to be made when individual patient data are aggregated. Specifically, aggregated symptom rating scale data can be used for professional development at the provider level and for quality improvement at the clinic level and to inform papers about the value of mental health services delivered at the health care system level.

Psychiatr Services 2018; 69:1-12 doi:10.1176/appi.ps.201804019

<https://www.thekennedyforum.org/resources/page/3/>

BH providers only detect 19% of patients who are worsening



GROWING EMPHASIS ACCOUNTABILITY

Resource: GROWING FOCUS ON MEASUREMENT BASED CARE

September 11, 2019 Provider Forum Webinar

<https://providers.partnersbhm.org/wp-content/uploads/2019/09/Master-Slide-Deck-Provider-Forum-9-11-2019.pdf>

June 12, 2019 Provider Forum Webinar

<https://providers.partnersbhm.org/wp-content/uploads/2019/06/June122019ProviderWebinarFullPresentation.pdf>

Link to all past provider forum webinars

<https://providers.partnersbhm.org/provider-webinars-forums/#1568955012184-fc376725-90e0>



Value Based Payment and Contracting

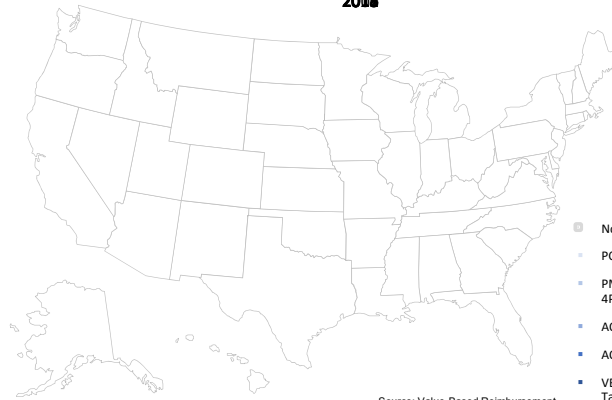
Standard Plan RFP Language p. 168-170 – V. Scope of Service

- ▶ The Department is encouraging accelerated adoption of value-based payment (VBP) arrangements between PHPs and providers, and requiring that PHPs' Provider Incentive Programs be aligned with the Quality Strategy and related measures.
- ▶ Use of VBP and Provider Incentive Programs will align financial incentives and accountability around the *total cost of care* and overall health outcomes and ensure that PHPs and providers are recognized and rewarded for quality gains.



VBP are an accelerating national trend

2018



Source: Value-Based Reimbursement State-By-State: A 50-State Matrix Review of Value-Based Payment Innovation. Change Healthcare, 2018.



12/10/2019

VBP and accountable care: two sides of the same coin



12/10/2019

VBP is Fundamentally a Population Health Tool



WHAT ARE POPULATION GOALS?

What population(s) are you targeting? What is driving their costs and inhibiting their outcomes?

What network provider behavior will drive the outcomes you want?

How can VBP be structured to incent the necessary delivery system performance?

In simple terms

- ▶ Value-Based Payment (VBP) is an emerging payment approach that:
 - Pays for value:
 - Better care
 - Better outcomes
 - Reduced costs
 - Instead of paying for volume:
 - Visits
 - Procedures

What is value?

$$V = \frac{Q}{\$} \times P$$

(Value) (Quality) (Cost) (Population)

The theory behind VBP

Paying for volume (FFS) provides the wrong set of incentives

- ▶ Expensive intervention instead of an inexpensive one
- ▶ Focus on illness, not health
 - Lack of accountability for the wellbeing of the consumer
- ▶ Doesn't promote innovation
 - Inconsistent with virtual and other technological interventions
- ▶ No payment for important parts of the service

The mechanics of VBP

- ▶ Benchmarking: What is the baseline spend against which the future spend will be measured?
- ▶ Risk Adjustment: A change to the benchmark to reflect consumer characteristics (e.g. age, sex, health status)
- ▶ Attribution: How and to whom is the care and wellbeing of the consumer assigned?
- ▶ Predictive Modeling: Analyzing data to create a statistical model of expected future performance or results
- ▶ Stop loss: An upper limit on the amount a provider can lose in a shared risk arrangement



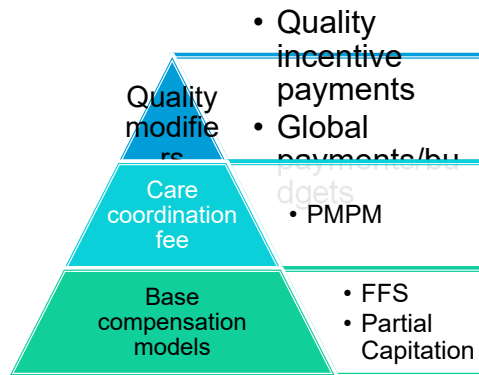
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The VBP stew

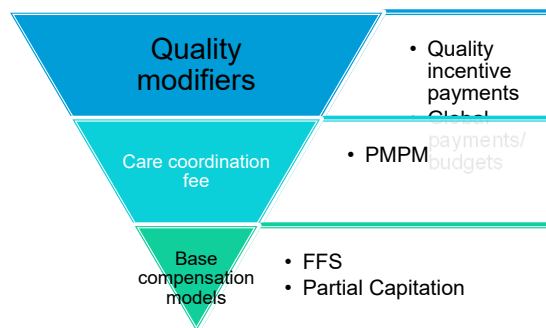


12/10/2019

Another way to think about VBP payment structures



The eventual goal is to flip the pyramid



Standard Plan RFP Language p. 168-170

V. Scope of Service – Quality and Value

- The Department defines VBP arrangements as payment arrangements between PHPs and providers that fall within Levels 2 through 4 of the multi-payer Health Care Payment (HCP) Learning and Action Network (LAN) Alternative Payment Model (APM) framework, which can be found at <http://hcp-lan.org/workproducts/apm-framework-onepager.pdf>.
- The Department requires that by the end of Year 2 of PHP operations, the portion of each PHP's medical expenditures governed under VBP arrangements will either increase by twenty (20) percentage points, or represent at least fifty percent (50%) of total medical expenditures.



Standard Plan RFP Language p. 168-170

V. Scope of Service – Quality and Value

- ▶ PHPs shall have a sophisticated IT infrastructure and data analytic capabilities to support the Department's vision in moving toward value-based payment, including having systems that can support alternative payment arrangement models which require shared savings and/or risk sharing across different provider types, care settings and locations.
- ▶ These systems must have mechanisms to measure quality and costs across attributed populations, share actionable administrative and clinical data with providers in these VBP arrangements, and process payments to providers based on the terms of the contract.
- ▶ The PHP shall complete an APM assessment based on the categories developed by HCP-LAN.
- ▶ The Department will provide specifications on the assessment methodology upon Contract Award.



Health Care Payment & Learning Action Network (HCP-LAN)

► <https://hcp-lan.org/>

Our Goal Statement

Accelerate the percentage of US health care payments tied to quality and value in each market segment through the adoption of shared accountability alternative payment models.

	Medicaid	Commercial	Medicare Advantage	Traditional Medicare
2020	15%	15%	30%	30%
2022	25%	25%	50%	50%
2025	50%	50%	100%	100%



12/10/2019

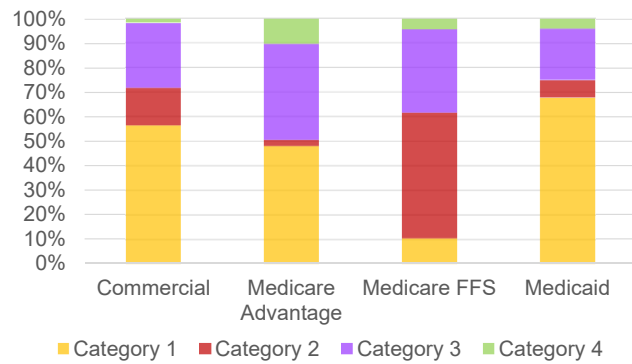
HCP-LAN Framework

Figure 4: The Updated APM Framework

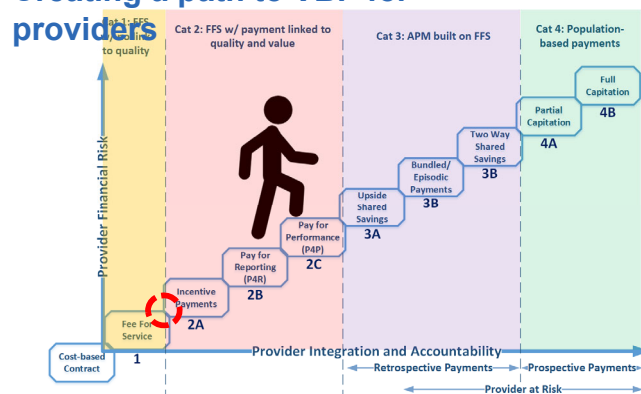
CATEGORY 1 FEE FOR SERVICE – NO LINK TO QUALITY & VALUE	CATEGORY 2 FEE FOR SERVICE – LINK TO QUALITY & VALUE	CATEGORY 3 APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE	CATEGORY 4 POPULATION – BASED PAYMENT
	A Foundational Payments for Infrastructure & Operations (e.g., care coordination fees and payments for HIT investments)	A APMs with Shared Savings (e.g., shared savings with upside risk only)	A Condition-Specific Population-Based Payment (e.g., per member per month payments, payments for specialty services, such as oncology or mental health)
	B Pay for Reporting (e.g., bonuses for reporting data or penalties for not reporting data)	B APMs with Shared Savings and Downside Risk (e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk)	B Comprehensive Population-Based Payment (e.g., global budgets or full percent of premium payments)
	C Pay-for-Performance (e.g., bonuses for quality performance)		C Integrated Finance & Delivery System (e.g., global budgets or full percent of premium payments in integrated systems)
		2N Risk Based Payments NOT Linked to Quality	4N Capitated Payments NOT Linked to Quality



VBP adoption



Creating a path to VBP for providers



Contact Information

- Our next webinar will be in March 2020
- For questions on any of the content provided today, please send to questions@partnersbhm.org
- Next Presenter is PyxHealth and they are going to share about exciting member engagement products Partners is implementing

