

Smooth Transitions: Overview of State-level Behavioral Health Integration Efforts

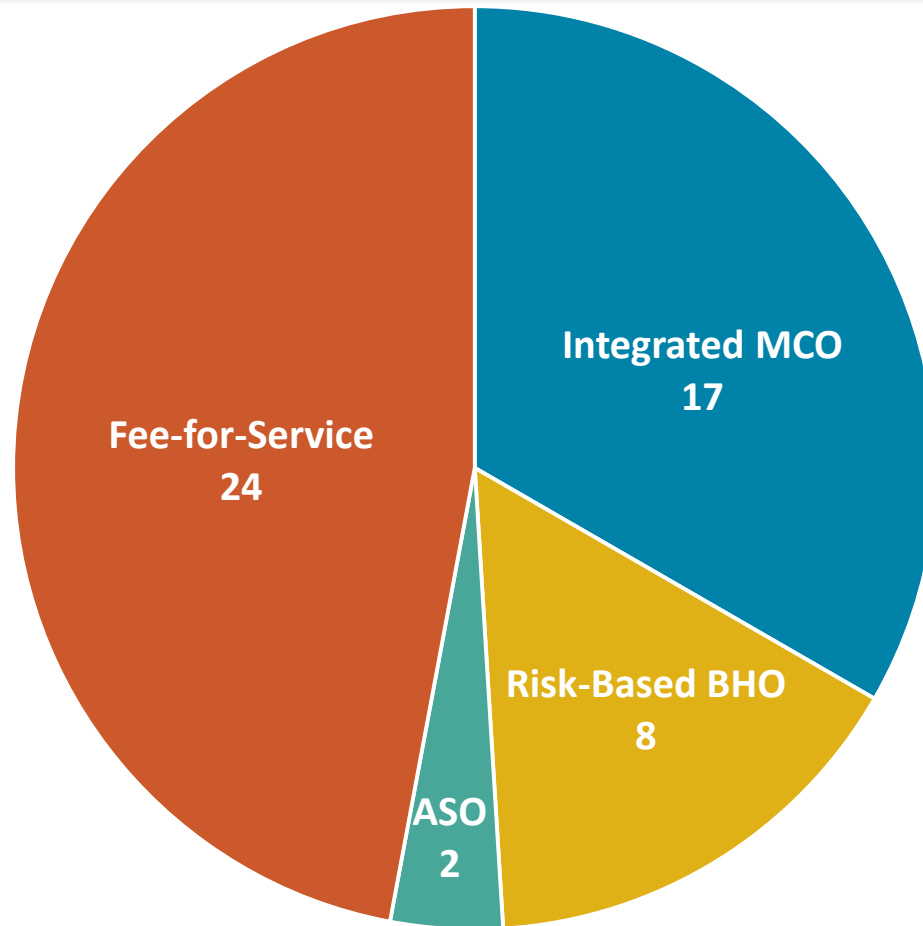
WASHINGTON BEHAVIORAL HEALTH INTEGRATION CONFERENCE

Advancing Integrated Care: The Road to 2020

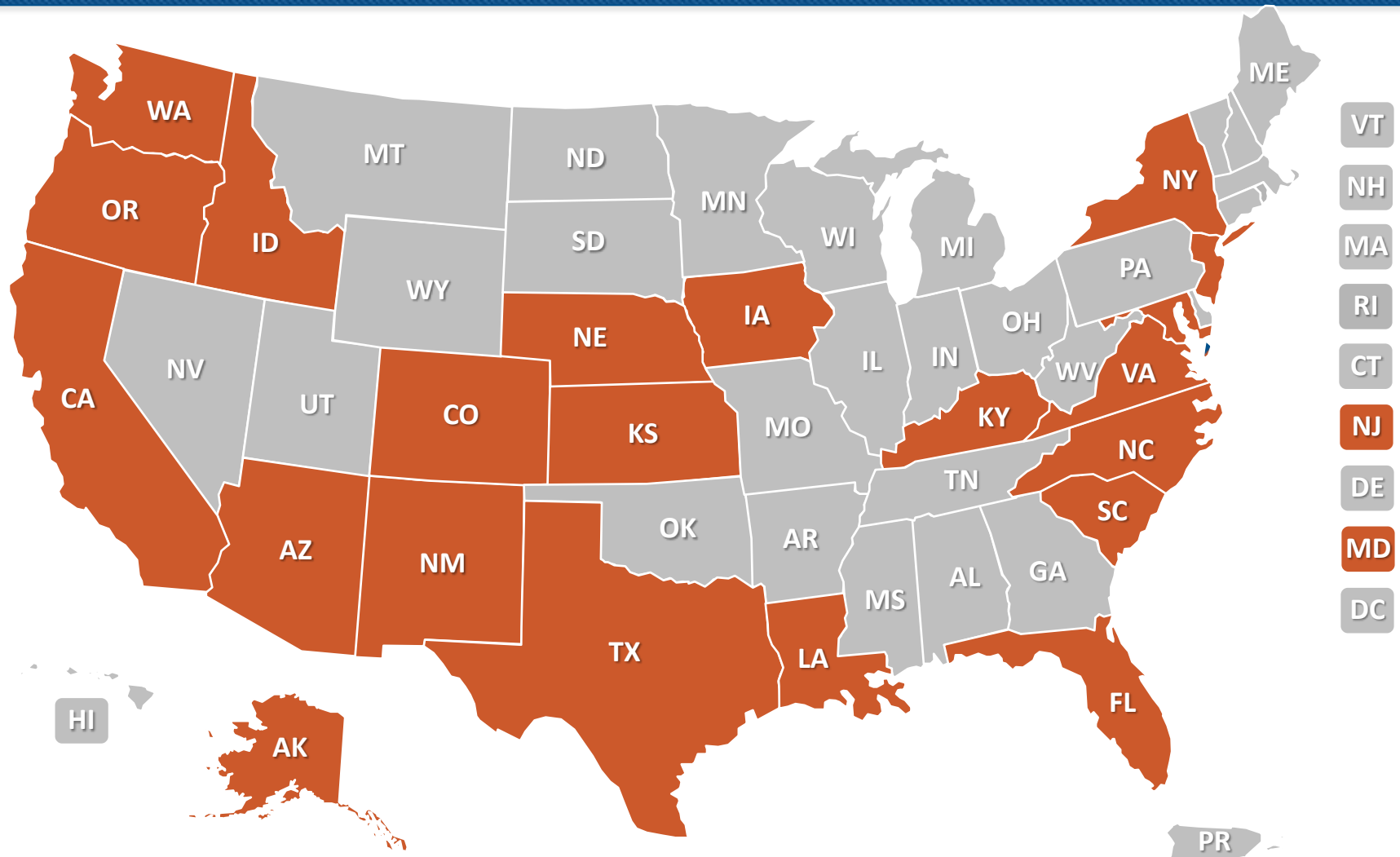
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Overview of State Approaches to Mental Health/Substance Use Disorder Service Delivery



Hot Spots for Behavioral Health Delivery System Reform



Key Policy Considerations for MH/SUD System Redesign

Design Issues	Transition Issues
<ul style="list-style-type: none">• Existing infrastructure• Carve-in vs. out• One vs. many plans• Connection to other reforms• Integration of non-Medicaid funding streams	<ul style="list-style-type: none">• Provider readiness• Plan readiness• Stakeholder involvement• Concerns about redirection of funds• Minimizing service disruption• Ensuring system stability



Integrated Care: Strategies to Ensure a Smooth System Transition

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Washington Behavioral Health Integration Conference
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Honor System History

- Recognize extensive work that has gone into building programs – especially community based services
- Bring forward things that are working well and can work in the managed care structure
- Build on existing infrastructure and fold components of that into the contract with managed care organizations
- Engage and communicate frequently and in multiple ways (town halls, trainings, calls, website)

Build in Continuity Protections

- Include a “stay in place” period of time during which services and providers stay in place for members
- Use this time to ensure providers are successful in contracting/becoming part of managed care organization networks, and members transition
- Be flexible wherever you can: sharing care management between CMHCs/MCOs; limiting network for specialized MH services; initial deemed credentialing based on license

Be Visible/Accessible At Launch

- Create frequent and accessible opportunities for providers and members to ask questions and give feedback
 - Rapid response calls
 - Website with frequent updates
- Be visible to providers and members, and let them see and hear the MCOs receiving and acting on questions, concerns and suggestions
 - Commit to specific contacts/timing
 - Document the issues/resolution

Guide And Hear From MCOs

- Develop a clear, succinct management report that provides real-time, actionable information on the most important issues
 - Members are getting services
 - Claims are being paid timely and accurately
 - Concerns are being surfaced and addressed; compliance with program requirements achieved
- Huddle frequently to collectively review the results and guide resolution; run to the danger and model resolutions that support members and providers

Stay Connected & Course Correct

- Keep in touch with stakeholders – both directly (meetings with large groups or focused groups) and indirectly (keeping information and material available and accessible)
- Ensure plans regularly connect with stakeholders, including members using mental health services and their families
- Bring feedback from both state and plan stakeholder efforts to business meetings between state/plans
- Make adjustments as needed based on feedback



UnitedHealthcare Community & State
KanCare integration whole person health approach



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KanCare Medicaid/Chip Program

“June 2012: The State of Kansas awarded three contracts for the states Medicaid program, KanCare. Amerigroup Kansas, Inc., Sunflower State Health Plan, and United Healthcare of the Midwest, Inc.”

- The State expects KanCare networks to include all current Medicaid providers.
- The State will conduct readiness reviews of each contractor prior to implementation.
- Clean claims must be processed within 30 days. A pay for performance measure establishes a standard of 100% of clean claims processed within 20 days.
- Targeted case management for people with more intensive mental health support needs can be delivered by CMHCs or MCOs
- The statutory and specialized system role of CMHCs will be maintained
- Contractors will use established community partners to deliver care and services.
- Health homes will revolve around consumers' core providers

KanCare Medicaid/Chip Services

Heart, lung, and heart/lung combination transplants for adults

HCBS waiver services

Dental

Physical Health

Non Emergency Transportation

Bariatric surgery

VISION

Behavioral Health

SUBSTANCE USE

Pharmacy

Special Health populations

Nursing Facilities



KanCare Medicaid/Chip Program

Part of the MCO contracts includes the requirement to provide additional, previously non-covered services (Value Added Services) to beneficiaries at no cost to the State

- Value added benefits are individualized by each MCO
- Each MCO must offer an adult dental benefit

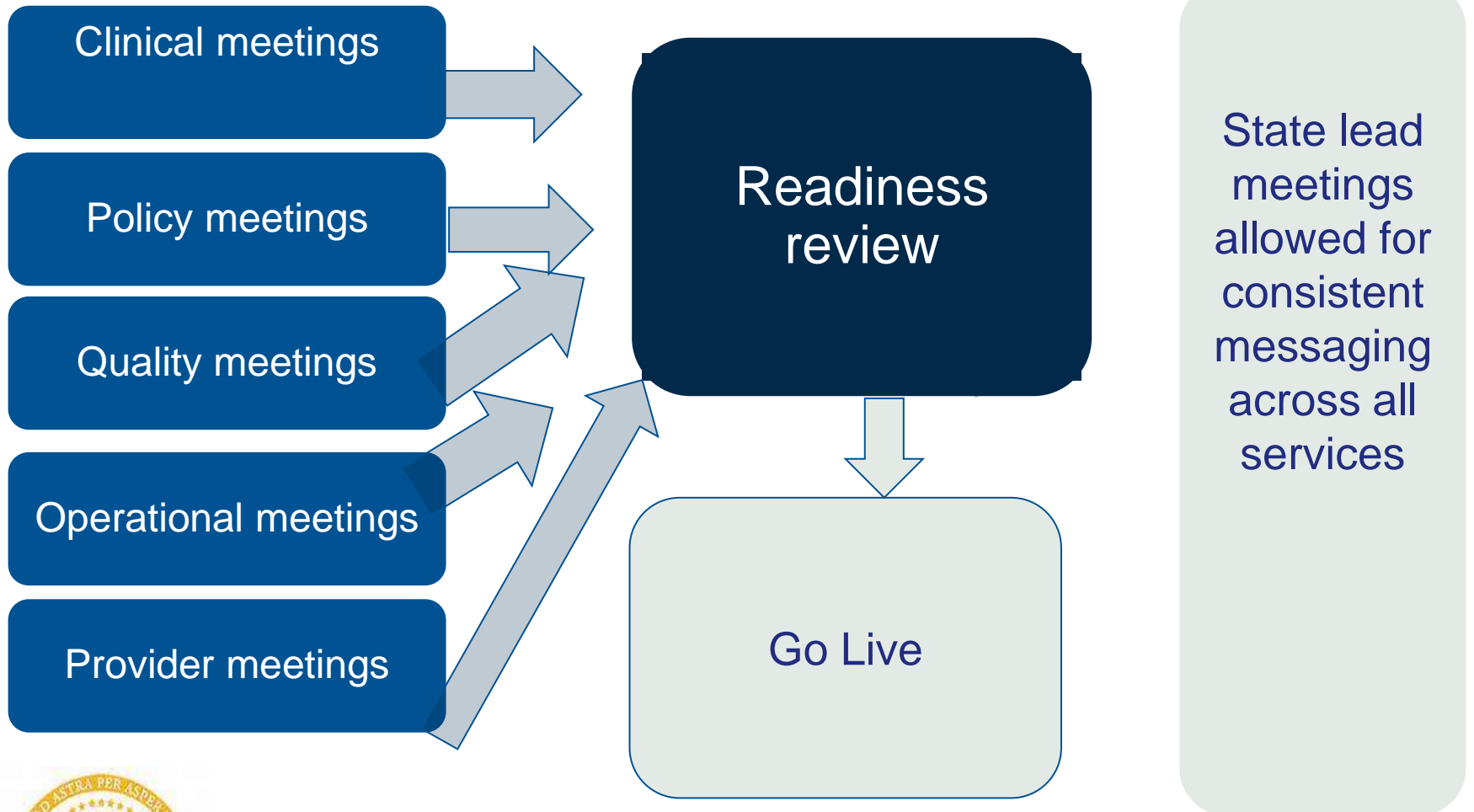
Other value added services includes;

- Rewards programs for healthy behaviors,
 - Gym memberships
 - Activity memberships
- Additional respite care for certain beneficiaries,
- Mental Health First Aid training
- Behavioral health peer supports
- Career development services for people with disabilities.



Pre implementation

State lead meetings

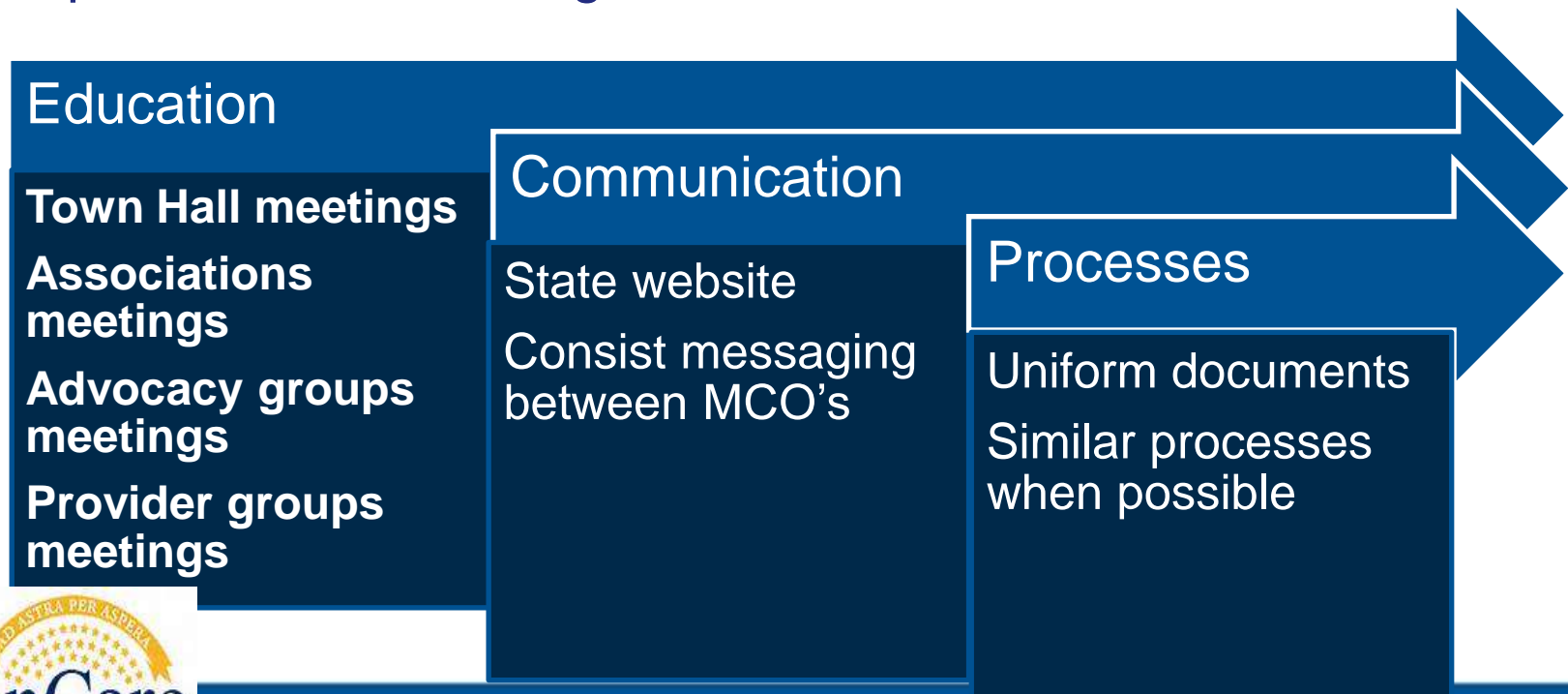


Pre implementation response plan

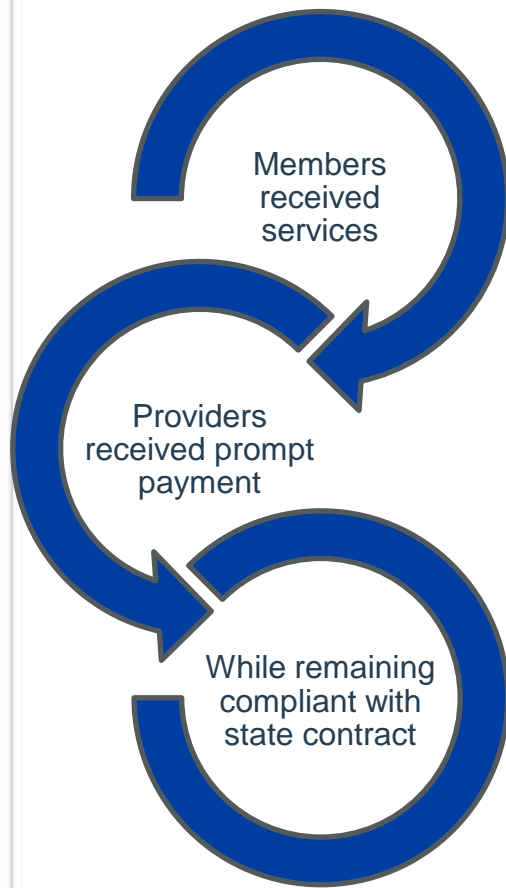
Kansas Department of Health and Environment provided a road map to ensure a seamless transition.

KanCare website:

http://www.kancare.ks.gov/medicaid_reform.htm



Post implementation response plan



Members

- Continuity of care period
- Same care plan
- Same care providers

Providers

- All providers paid as contracted during continuity of care
- Expedited claim processing
- Provider education/communications
 - Individual
 - Group

State and regulatory requirements

- Daily rapid response calls
- Critical issues logs
- Identified contacts for immediate response

Continuity of care period

- First 90 days of implementation
 - Allowed MCO's to listen and learn
 - Current providers shared challenges and success of the system and of the members they served
 - Allowed members to become acclimated to a managed care system
 - MCO specific processes
 - Ability to complete health assessments
 - Resources available
 - Allowed MCO operations to understand state specific processes
 - Allowed state to provide technical support



KanCare First year and beyond



Improving the health outcomes for members

- Timely interventions
- Person centered
- Holistic approach
- Evidence based practices
- Assist members to take responsibility for their health

Improving the quality outcomes for providers

- Data Driven
- Innovation
- Technology enabled
- Evidence based practices
- Incentive based contracts for outcomes

Importance of caring for the whole person

Today's Medicaid populations include an increasing number of individuals with behavioral health diagnoses and social service needs, in addition to existing chronic health conditions. To effectively serve the needs and improve the health of these populations, we must address the whole person.



Almost 1/3 of those with medical health conditions also have behavioral health conditions.

2X

Co-morbid individuals have total expenditures **almost 2x** of those without co-morbid medical and behavioral diagnoses.



Beneficiaries with behavioral health diagnoses account for almost half of total Medicaid expenditures.

Evolving the whole person-centered care model

- Full integration of medical and behavioral care allows for better identification of individuals in need,
- Predictive modeling includes claims data & clinical systems.
- Interventions based on individual needs, Care management, specialized services, community resources and peer supports.
- Empower members to take control of their medical care
- Incentive based contracts for improved clinical outcomes, reduced administrative burdens for clinical outcomes
- Reduction of total cost of care for the state

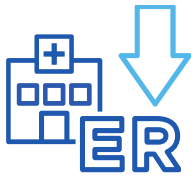


Delivering value

Results from a person centered care model set a strong foundation for improved health outcomes



Reduction of inpatient admissions in targeted populations.



Avoidance of unnecessary ER visits



Member engagement rate

Building healthier communities

As we continue to evolve to whole person care, we will effectively deliver better outcomes for providers, State partners and the people we serve.



Providers:

- Improved relationships resulting ability to remove barriers to care
- Stronger relationships and consistent communications
- Located in and knowledgeable of community and its resources
- Partners in system evolution



States:

- Improved health outcomes for constituents
- Reduced total cost of care
- Coverage for more individuals with complex conditions



Members:

- Improved access to and understanding of care
- Personalized care plan
- Increased engagement

A success story for this model

In 2013 a United Care coordinator began working with Jane who was receiving Traumatic Brain Injury (TBI) waiver services. The care coordinator noticed continued weight loss and she appeared to be growing depressed.

The Care Coordinator discussed this member's needs in a multidisciplinary meeting. Assessments were completed and determined the member was suffering from an eating disorder. The team engaged her in several community resources, but the member was not achieving clinical goals.

The United clinical team determined the member needed inpatient services quickly. The team located a provider who could meet her complex clinical needs. The member worked through each level of treatment quickly and was able to return back to her home community and engage in outpatient eating disorder services, TBI waiver services, as well as Medical and behavioral health services.

The member was able to put the pieces of her life back together by rebuilding her relationship with her adult child and playing musical instruments which was her world before her brain injury. She is currently working part-time through the KanWork program (a program to help people with disabilities gain competitive employment) She is also seeking certification to become a behavioral health peer to share her recovery with others.

