Integrated Managed Care
Clinical Symposium –
North Central
(Chelan, Douglas, Grant counties)

Co-Hosted by:
Agenda

• Coordinated Care Overview
• Beacon Overview
• IMC Overview
• Case Management Overview
• Common PA Standards
• How to work with each MCO
• Questions and Answers
Coordinated Care of WA

**Mission Statement:** To be the **highest quality** health plan in Washington, and the **health plan of choice** for members and providers.

- Serving over 250,000 Washingtonians
- Coverage includes Medicaid, Foster Care, Health Benefit Exchange
- 360 Employees statewide with offices in Seattle, Wenatchee, Tacoma & Yakima
- NCQA Accreditation accredited as COMMENDABLE

Embedded Care Management and Member Connections staff in the community, including community health centers, hospitals, jails, and other pilot sites.
Coordinated Care Statewide Coverage
Beacon is Committed to Strong Partnership with Washington State

**Strong Medicaid and Non-Medicaid Experience**

- Implemented the first BH-ASO in partnership in Clark and Skamania Counties in ~90 days
- Manage the crisis system access and coordination contracts with the IMC MCOs, county governments, key providers and other community stakeholders

**Dedicated Local Team**

- BH-ASO staff in Vancouver, Washington
- Expansion plans to hire in North Central

**Military, Commercial, Employer Experience**

- Military contract served out of Bellingham, Washington
- Boeing MHSUD and EAP contract
Our mission is to help people live their lives to the fullest potential. Our vision focuses on improving the health and well-being of individuals coping with mental health and substance use conditions.

Healthier Washington will help people experience better health throughout their lives and receive better—and more affordable—care when they need it.
The BH-ASO Will Provide a Series of Services that Supplement Those Provided by the Managed Care Plan

<table>
<thead>
<tr>
<th>Maintain and Administer Crisis Services</th>
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<tbody>
<tr>
<td>• Maintain 24/7/365 regional crisis hotline</td>
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<tr>
<td>• Provide mental health crisis services, including mobile outreach team</td>
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<tr>
<td>• Administer Involuntary Treatment Act</td>
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<td>• Administer Chemical Dependency Involuntary Commitment Act</td>
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<table>
<thead>
<tr>
<th>Manage SUD and MH braided Funding Benefits</th>
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<tr>
<td>• Proviso funds</td>
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<tr>
<td>• Federal Block Grant (MHBG &amp; SABG)</td>
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<tr>
<td>• Criminal Justice Treatment Account</td>
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<td>• Dedicated Marijuana Account</td>
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<td>• Jail Transition Services</td>
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<td>• State General Funds</td>
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<table>
<thead>
<tr>
<th>Admin support, financial support and miscellaneous</th>
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<tbody>
<tr>
<td>• Behavioral Health Ombudsman</td>
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<tr>
<td>• FYSPRT &amp; CLIP</td>
</tr>
<tr>
<td>• State hospital liaison and Peer Bridger</td>
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IMC Overview
North Central IMC Go-Live

January 1, 2018

Chelan County
Douglas County
Grant County

NOTE: Medicaid members in surrounding counties will remain Apple Health with Apple Health benefits.
## Current State:
Fragmented Financing and Care

<table>
<thead>
<tr>
<th>Financing</th>
<th>Care Delivery</th>
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<tbody>
<tr>
<td>Mental Health &amp; Chemical Dependency</td>
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<tr>
<td>Physical Health</td>
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Limited Coordination
Future State: Integrated Financing = Integrated Care

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<tr>
<td>Physical Health</td>
<td>Integrated Services</td>
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<tr>
<td>Mental Health</td>
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<tr>
<td>Chemical Dependency</td>
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</table>
Two HCA Contracts Cover All Enrollees

Medicaid Covered Services
- Physical Health (e.g. Apple Health)
- Mental Health (MH)
- Substance Use Disorder (SUD)
  - NOTE: MH and SUD = Behavioral Health (BH)

Wrap Around Benefits
- Behavioral Health services **NOT** covered or funded by Medicaid
- These services are funded by General Fund – State dollars
- Examples of services:
  - eg. room & board, sobering services

Enrollees
- Apple Health Medicaid children, families, adults, blind/disabled
- Behavioral Health Services Only (BHSO) members will only receive behavioral health benefits through MCOs. Medical benefits remain Fee-For-Service
What Does Better Look Like?

Better medical care and outcomes for people living with chronic mental illness

Better identification and treatment of behavioral health conditions in primary care

Better integration of fragmented system through care coordination – no falling through cracks

Better inclusion of Social Determinants of Health

Triple Aim

Better health outcomes

Lower total cost of care

Better Patient/Provider experience
Provider Network

### Primary Care
- Integrated Delivery Systems (Confluence)
- Primary Care Clinics (i.e. Columbia Valley Community Health, Moses Lake CHC, Columbia Basin Health Association)

### Mental Health
- State Hospitals--MCOs do not administer this benefit
- Inpatient Psychiatric Hospitals
- Community Mental Health Agencies
- Behavioral Health Providers-Group Practices
- Individual Behavioral Health Providers

### Substance Use
- Substance Use Disorder (SUD)/ Chemical Dependency Agencies
- Inpatient and Outpatient Treatment

### Behavioral Health Administrative Services Organization (BH-ASO)
- Beacon Health- provides crisis service response 24 hours a day/7 days a week/365 days a year and administers non-Medicaid services to non-Medicaid members
Role of the Behavioral Health ASO

![Diagram showing the role of the Behavioral Health ASO in the Continuum of Integrated Clinical Services with an HCA contract and sub-contracts with BH-ASO and Fully Integrated MCOs for Individual Clients.](image-url)
Case Management Overview
Care Coordination with Integrated Managed Care (IMC)

• Community Based Care Coordination (basics plus BH collaboration)
  – Working with PCP and BH providers to coordinate and collaborate
  – Local providers know the patient best
  – *Allied Service Coordination (Community partners)*

• Coordination of BH Services by MCO
  – SUD
  – State Facilities
  – Outpatient Wrap Around Care
  – Justice System
  – BH-ASO Crisis Services
Initial Health Screening:

- Newly enrolled members receive an Initial Health Screening within the first 60 days of enrollment.
  However, many members are difficult to contact.

- Based on screening results and other utilization data, members are referred to Care Management for further assessment.
Examples for CM referrals include:

- High utilized of care
- Difficulty managing a chronic condition
- Psychosocial needs impacting management
- Assistance navigating health plan system
- Gaps in care
Care Management Process

- Comprehensive Health Risk Assessment
- Specialized Assessments, including disease specific, depression, and quality of life
- Goal Setting in collaboration with the member
- Motivational interviewing techniques to encourage the member toward improved health outcomes
- Removal of barriers to care and services including navigating the health plan system
Care Management Levels

Care Management services are designed to support the overall Wellness of enrollees with a focus on improving health outcomes.

MCO’s offer two levels of Care Management Services:

**Care Coordination Services (CCS)**
- Focus on short-term or intermittent needs, such as:
  - Access to care/services addressing social needs
  - Improving clinical outcomes
  - Increasing self-management skills

**Complex Case Management (CCM)**
- Focus on individuals with chronic or complex needs requiring ongoing care management.
  Services include:
  - Person-centered approach to care plan development
  - Utilization of evidence-based practices in screening and intervention
  - Addressing gaps in care
  - Coordination of care across the continuum
  - Designed to meet NCQA Complex Case Management standards
**Advance Directives**

**MCOs** are required to educate and inform employees, providers, and members about a patient’s rights to an Advance Directive.

An Advance Directive gives written instructions about a patient’s medical care in the event that the patient is unable to express his or her medical wishes.

For the State of Washington there are three types of Advance Directives:

- **Health Care Directive/Living Will** - specifies an individual’s wishes about end of life care.
- **Durable Power of Attorney** - names another person to consent to, stop, or refuse treatment if an individual is incapable of doing so.
- **Mental Health (MH) Advance Directive** – allows a person with capacity to state mental health treatment preferences in a legal document that will govern during periods of incapacity (see section below for more information on MH Advance Directive).
Advance Directives

To be valid, a Mental Health Advance Directive must:

• be in writing;
• include language indicating a clear intent to create a directive;
• be dated and signed by the patient, or be dated and signed in the patient’s presence at his or her direction;
• state whether the directive may or may not be revoked during a period of incapacity;
• be witnessed in writing by at least two adult witnesses; and
• conform substantially to the statutory format.
Common Access to Care Standards
**Access Standards**

*All MCO’s* access standards comply with the Healthcare Care Authority (HCA) and the National Committee for Quality Assurance (NCQA) requirements. According to our contracts with HCA and our commitment towards quality improvement, providers must also adhere to these standards.

<table>
<thead>
<tr>
<th>Type of Care</th>
<th>Appointment Wait Time</th>
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<tbody>
<tr>
<td>Preventive Care Appointment</td>
<td>Within 30 calendar days of request</td>
</tr>
<tr>
<td>Second Opinions</td>
<td>Within 30 calendar days of request</td>
</tr>
<tr>
<td>Routine Primary Care</td>
<td>Within 10 calendar days of request</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>Within 24 hours</td>
</tr>
<tr>
<td>Emergency Care</td>
<td>24 hours/7 days</td>
</tr>
<tr>
<td>After-Hours Care</td>
<td>Available by phone 24 hours/seven days</td>
</tr>
<tr>
<td>Office Waiting Time</td>
<td>Should not exceed 30 minutes</td>
</tr>
<tr>
<td>Care Transitions – PCP Visit</td>
<td>Within 7 calendar days of discharge from inpatient or institutional care for physical or behavioral health disorders or discharge from a substance use disorder treatment program</td>
</tr>
<tr>
<td>Care Transitions – Home Care</td>
<td>If applicable, Transitional health care by a home care nurse or home care registered counselor within 7 calendar days of discharge from a substance use disorder treatment program, if ordered by the enrollee’s primary care provider or as part of the discharge plan</td>
</tr>
</tbody>
</table>
Behavioral Health Standards

All MCO’s access standards comply with the Healthcare Care Authority (HCA) and the National Committee for Quality Assurance (NCQA) requirements. According to our contracts with HCA and our commitment towards quality improvement, MCO network of Behavioral health providers must adhere to these standards.

<table>
<thead>
<tr>
<th>Behavioral Health Appointment Types</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life threatening</td>
<td>Immediately</td>
</tr>
<tr>
<td>Non-life threatening</td>
<td>Within 6 hours</td>
</tr>
<tr>
<td>Urgent care</td>
<td>Within 24 hours</td>
</tr>
<tr>
<td>Routine care</td>
<td>Within 10 calendar days</td>
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</table>
Shared Utilization Management Regulations

- FIMC/WrapAround Contracts
- WACs and RCWs
- HCA Provider Guide
- HCA Health Technology Assessment Committee
- NCQA Standards
Medical Necessity

Washington State law defines **medical necessity** as:

- A requested service that is intended to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that
  - endanger life,
  - cause suffering or pain, or
  - result in an illness or infirmity or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction AND
- There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service.
NCQA Accreditation

• All MCOs are required to be accredited by the National Committee for Quality Assurance (NCQA)

• An independent, not-for-profit organization who has developed quality standards for health plans.
  – Accredited health plans today face a rigorous set of more than 60 standards and must report on their performance in more than 40 areas in order to earn NCQA’s seal of approval
  – Includes 14 UM specific standards
Utilization Management

• NCQA Definition of Utilization management:
  Evaluating & determining coverage for and appropriateness of medical & behavioral health care services, as well as providing needed assistance to providers and patients, in cooperation with other parties, to ensure appropriate use of resources.
Types of UM Reviews

- **Pre-Service/Prior Authorization**
  Services in which authorization must be obtained prior to start of service

- **Concurrent**
  Services in which authorization is obtained during a course of care and prior to the end of the episode of care.

- **Retrospective/Post-Service**
  A review conducted after the service has occurred to determine if the services were medically necessary
Emergent Services

• **Psychiatric**

  *A mental health condition in which the patient is a danger to themself, others or is gravely disabled.*

• **Medical**

  *A medical condition that a prudent lay person might anticipate serious impairment to his or her health in an emergency situation*

  The American College of Emergency Physicians has long believed that anyone who seeks emergency care suffering from symptoms that appear to be an emergency, such as chest pain, should not be denied coverage if the final diagnosis does not turn out to be an emergency.
Different MCO’s, similar UM processes

What’s the same?

Types of review:
Pre-Service/Prior Authorization
Concurrent
Retrospective/Post-Service

Standards:
Use of standardized, nationally recognized, evidence-based criteria sets to make determinations of “medical necessity” which is common language.

What may be slightly different?

The method of authorization: Phone/fax/online submissions
The forms that you may see for each MCO may have some slight variation.
The specific services that may require authorization – the variance will be very minor.
Plan Referrals and Prior Authorizations for Coordinated Care
Utilization Management (UM) Processes
UM Tools

- Prior Authorization Tool
- Benefit Grid
- PA Forms
- HCA Provider Guides
- Fee Schedules
- Provider Manual
Prior Authorization (PA)

• Authorization can be requested using a faxed form, provider web portal, or for urgent services/admissions by phone
  • Fax forms
  • Web Portal
  • Phone
    • (844)208-8885
    • All emergent behavioral health admission notifications and reviews are conducted telephonically
Prior Authorization

• Providers can check our authorization requirements by using our online PA code look up tool
Prior Authorization

• Services requiring prior authorization:
  • Planned admissions
  • Psychological Testing (above 2 units, or above 7 units for ABA Centers of Excellence)
  • ECT
  • Transcranial Magnetic Stimulation
  • WISE/PACT- requires notification for program entry and authorization for continuation in program
UM Discharge Planning

Member Needs Assessment to Developing an Integrated Discharge Plan

- Medical needs Resources/Appointments
- Transportation needs
- Basic Needs met: Communication, Food
- Financial Needs: Example is SSI
- Chemical Dependence Needs
- Mental Health Resources Needs

Basic Needs met:
- Communication
- Food
Psychotropic Medication Review

- Review of psychotropic medication use for pediatric members
  - Identify members who may be at risk for harm due to use outside of clinical parameters or higher than recommended doses
  - Behavioral Health Medical Director sends communication to provider about prescribing, options for consultation, and performs follow up
Customer Service

• Call one number for all your needs: (877) 644-4613
• Our hours are 8 am-5 pm, Monday-Friday
  • Our staff are located in Tacoma and Seattle

Average experience for last 12 months:

12 second ASA

0.85% abandonment

- Real-time call volume monitoring to manage staffing levels to ensure less than 3% abandonment and 30 second average speed to answer.
- Evaluate monthly statistics to ensure right-sizing of staffing levels overall.

Average experience for last 12 months:

95% Quality Score

- Quality Audits are conducted for every agent to ensure at least 94% call quality rates.
- Monthly, quarter, and annual quality metrics are evaluated for potential training or process improvement.
North Central
Washington BH-ASO

October 2017
Request for Non-Crisis Services – Authorization Review Process

- Authorizations are granted for the fund(s) for which the individual is eligible
- Authorizations are for a specific number of services/units of services/days and for a specific time period based on the individuals clinical needs
Beacon clinicians are trained to match the needs of the individual to appropriate services, levels of care, treatment and length of stay, and community supports.

Beacon clinicians obtain clinical data from the provider and evaluates this information and references applicable clinical criteria to determine medical necessity of the requested level of care.

Providers should be prepared to provide the following information at the time of the review:

- Demographics
- Estimated length of Stay
- Previous Treatment history
- Diagnosis (inclusive of behavioral and medical)
- Reason for Admission
- Treatment Goals/Treatment Plan
- Specific planned interventions
- Precautions for specific risk behaviors
- Family Involvement
- Barriers to discharge
- Discharge Plan
- Aftercare required upon discharge
To determine the appropriate level of care during a review the CCM evaluate the pertinent clinical information relative to the level of care criteria:

- Medical Necessity/Level of Care Criteria can be found at: http://www.valueoptions.com/providers/Handbook/clinical_criteria.htm
- Substance use criteria are based on ASAM PPC-2 criteria published by the American Society for Addiction Medicine (ASAM)
- To order a copy of the ASAM criteria, please go to the following website:
  - www.asam.org/PatientPlacementCriteria.html
Determination Review Definitions

- Initial Review – Refers to the first review of service
- Concurrent Review – All reviews after the initial review
- Appeal Review – Request for a second review following a denial of service
- Retrospective Review – Review request after an individual is no longer in treatment for that service
- In cases where retrospective review is not available under the guidelines, the provider will be informed of this status
## Determination Timeframes for Initial Review

<table>
<thead>
<tr>
<th>Level of Care</th>
<th>Standard</th>
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<tbody>
<tr>
<td>Inpatient, CSU</td>
<td>12 hours</td>
</tr>
<tr>
<td>Residential</td>
<td>24 hours for MH, 72 hours for SUD</td>
</tr>
<tr>
<td>IOP, Day Supports</td>
<td>Fifteen (15) calendar days</td>
</tr>
<tr>
<td>Outpatient inclusive of Psychological Testing, Clubhouse, Respite Care</td>
<td>Fifteen (15) calendar days</td>
</tr>
</tbody>
</table>
## Determination Timeframes for Concurrent Review

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<tr>
<th>Level of Care</th>
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<td>Inpatient, CSU</td>
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CCM Discharge Review Criteria

The following information may be requested and must be documented:

**Aftercare appointment**
- Date of appointment
- Time of appointment
- Name of specific provider individual is to see
- Where the individual is to go for aftercare appointment

**Individual’s contact information**
- Phone number and address of where individual is being discharging
- Emergency contact information (family, support, social support available)

**Clinical information**
- Date of Discharge
- Diagnosis at Discharge
- Medications with dosages
- Community resources referred
## Determination Timeframes for Appeal Review

<table>
<thead>
<tr>
<th>Level of Care</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient, CSU</td>
<td>Within three (3) calendar days of the receipt of the request for review. Notification: written notice to the provider and the individual within the decision timeframe</td>
</tr>
<tr>
<td>Residential, IOP, Day Supports</td>
<td>Within fourteen (14) calendar days of receipt of the request. Notification: Verbal notice to provider and the individual within the decision timeframe. Written notice to the individual and provider within 72 hours of the verbal notification</td>
</tr>
<tr>
<td>Outpatient inclusive of Psychological Testing, WISE, PACT, Clubhouse, IOP, Day Supports, Respite Care</td>
<td>Within fourteen (14) calendar days of receipt of the request. Notification: Verbal notice to provider and the individual within the decision timeframe. Written notice to the individual and provider within 72 hours of the verbal notification</td>
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</table>
Communicating with Beacon Health Options
Contact Information

- **Customer Service**: General questions regarding referrals, claims, complaints and grievances
  
  855.228.6502 – Monday through Friday, 8 a.m.-5 p.m. PT

- **National Provider Service Line**: General questions regarding credentialing and contracting
  
  800.397.1630 – Monday through Friday, 8 a.m.-5 p.m. PT
  
  Email – Beacon WAASO@beaconhealthoptions.com

- **EDI Help Desk**: ProviderConnect questions, including registration and direct or batch claims submission
  
  888.247.9311 – Monday through Friday, 11 a.m.-3 p.m. ET
  
  Claims Mailing Address:
  
  PO Box 1850
  
  Hicksville, NY 11802-1850
Beacon’s website: [www.wa.beaconhealthoptions.com](http://www.wa.beaconhealthoptions.com)