NEW JERSEY HUMAN SERVICES

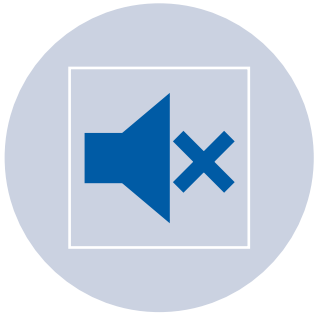
Behavioral Health Integration Advisory Hub Meeting

April 25, 2024

1-2:30 PM EST

Please update your display name on Zoom to include your name and organization. Thank you!

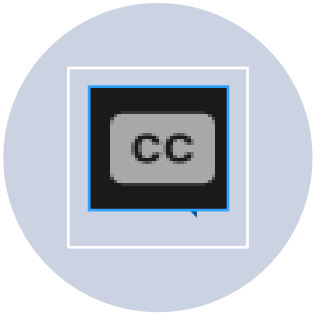
Housekeeping



All attendees will enter the meeting on mute.

To use the “Chat” function, click the speech bubble icon at the bottom of the screen.

Use the “raise hand” function if you wish to speak.



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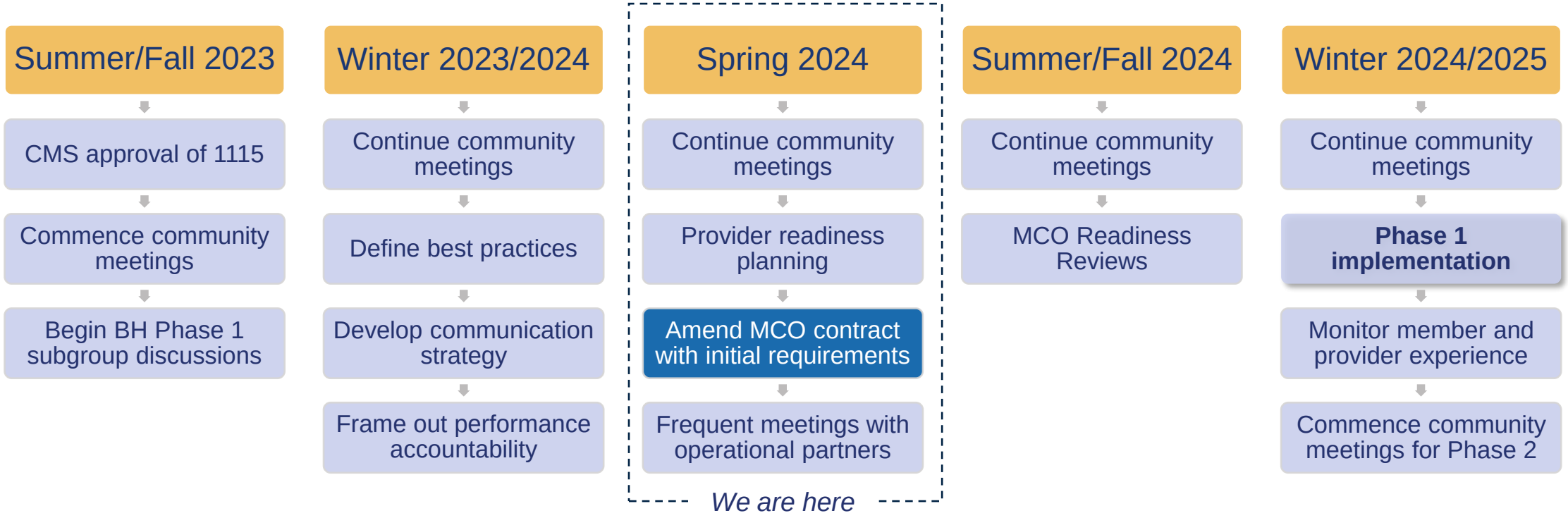
Agenda

- Recap last Advisory Hub meeting and share updates on potential policy changes for enrollment / credentialing and prior authorizations
- Discuss MCO integrated care management and quality monitoring
- Provide updates on provider and member engagement

North Star Principles

Serve people the best way possible.	We will **provide high quality services** our members need in the right setting and at the right time by improving access and supporting individuals through evidence-based methods.
Communicate with clarity and concern.	We will **increase integration** through improved care coordination, strong payer-provider partnerships, and broader electronic health record integration between physical and behavioral health providers.
Explore new ways to solve problems.	We will strengthen our current innovative approaches to whole-person care models and culturally competent care, and introduce new "best practice" opportunities that **improve outcomes**.
Work closely with our stakeholders.	We will collaborate with our **community stakeholders** and aligned systems to raise awareness and provide support, with a shared commitment to respect, dignity, equity, and inclusion.
Show people we care.	We will make **empathy, positive energy, and collaborative focus** our hallmark, internally and externally, with focus on the strengths, resources, challenges and needs of the people we serve.

Recall | Timeline for Phase 1 of BH Integration



Detail follows

Process to develop MCO contract standards, semiannually in July and January

1

- DMAHS gathers feedback from members, providers, and MCOs on current processes
- DMAHS analyzes feedback and incorporates into new draft contract

2

- Draft contract is shared with MCOs
- MCOs review and provide feedback on proposed changes

Current stage for July 2024 contract

3

- DMAHS incorporates feedback from MCOs
- Both parties agree and sign
- Contract sent to Centers for Medicare and Medicaid Services (CMS) for final approval

Contract standards and guidance used for MCO policy changes

Type	Description
Contract standard	• Policy changes **explicitly written into contract** • MCOs **required to comply** or face penalties • Typically used for policies that **do not change frequently** (e.g., domains of quality metrics that are required)
Guidance	• Policy changes **referenced in contract** but detailed in **external document** • MCOs **required to comply** or face penalties • Typically used for policies that **change more often** (e.g., specific details on which quality metrics are required)

Provide updates on enrollment / credentialing and prior authorizations

Credentialing | Key takeaways from February Advisory Hub

Feedback

- Opportunity to better **clarify Medicaid enrollment vs. MCO credentialing/ enrollment processes**
- Strong desire for **one universal form** for all MCOs
- Emphasis on clear process for **facility level credentialing**
- Push to reduce **credentialing processing timelines**

Policy updates

- Reduce credentialing process turnaround time **from 90 to 60 days** for "clean applications"
- Working with MCOs to **streamline credentialing forms**
- Require **new MCO report** on credentialing performance and timelines to monitor adherence to standards
- Working on **clarifying facility level credentialing**

Prior Authorization | Key takeaways from February Advisory Hub

Feedback

- Significant concern around **minimum durations** of services and **timely authorization processes**
- Consider differences in member needs for **court-ordered prior authorizations**
- Consider that **administrative burden** creates **hiring / retention issues** for providers

Policy updates

- Ensure MCO **consistency with current prior authorization** policies for FFS to reduce provider disruptions
- Reduce **turnaround time** for non-urgent authorizations
- Establish **minimum initial authorization durations** for key BH services
- Define **standard fields required** for "complete" behavioral health prior authorization request
- Require **new MCO report** on prior authorization performance to monitor adherence

Discuss MCO integrated care management and quality monitoring

Policy Priorities for Behavioral Health Integration

Ensure access and continuity for members

- Covered services
- Eligible populations / providers
- Provider networks & member access

For discussion at today's Hub meeting

Promote a positive provider experience

- Provider credentialing / enrollment
- Rates
- Billing & claims

Enable streamlined, coordinated care delivery

- Prior authorizations (PA)
- **Integrated care management**
- Telehealth
- PCP & BH provider coordination
- **Quality monitoring**

MCO Integrated Care Management | Definitions

Care management

- Describes set of **goal-oriented and individualized steps** to ensure members receive **effective and supportive care**
- Involves **prevention, continuity of care, and care coordination** of all service providers and member's community

Roles in care management

- **MCOs:** State requires all MCOs to offer integrated care management to all eligible members
- **Providers:** Provider groups can, but are not required to, offer care management
  - Examples of provider orgs: CCBHC, behavioral health homes
  - Even if members have provider-led care management, MCOS are still required to offer care management

Source: Care Management Workbook

MCO Integrated Care Management | Goals

State requires MCOs to offer integrated care management to all eligible members to:

- Ensure **access** to clinically appropriate and member-centered services
- Enable **continuity of care** and **timely authorization** of services
- Drive **integrated, well-coordinated** care and strong **outcomes**
- Provide members with an **advocate** and **clear point-of-contact** to support them throughout all stages of member journey

Source: Care Management Workbook

MCO Integrated Care Management | Process

1 Integrated Care Management Enrollment

How do members enroll in MCO care management?

- MCO representative engages all newly enrolled members to fill out **initial health screen**
  - If members meet criteria, they are assigned MCO care manager for a face-to-face **comprehensive needs assessment** (CNA)
- MCO care managers initiate CNA with members with an identified referral event (e.g., unplanned hospitalization)
- Community providers can refer a member in their care for MCO care management at any time
- Members and caregivers can request MCO care management

2 Integrated Care Management Delivery

What are MCO care managers' qualifications?

- MCO care managers are **registered nurses or BH specialists** with, at minimum, a Bachelor's degree

What are the key activities of MCO care manager?

- **Care plan**: Uses CNA & member goals to create plan
- **Plan implementation**: Facilitates care plan via referrals, care coordination, communication
- **Plan analysis**: Gathers feedback on care effectiveness
- **Plan modifications**: Modifies strategies to meet member goals

Source: Care Management Workbook

Case study: Amira

Amira has a **diagnosis of bipolar disorder** and **Multiple Sclerosis (MS).** She meets regularly with her **PCP for MS symptom management** and, per his recommendation, **enrolls in outpatient behavioral health services at** a provider organization that **offers care management**.

As a **new MCO member, Amira also receives outreach to fill out a screening for MCO-led integrated care management.** She meets criteria and is connected to an **MCO care manager, Phil.** Phil conducts a **comprehensive needs assessment** to determine appropriate level of care management and **checks in with Amira quarterly**. Phil also ensures that Amira is enrolled in all necessary services and creates a plan to **coordinate with all her service providers** (PCP, neurologist, BH provider, and BH provider organization care manager) to ensure treatment goal alignment.

Phil has consent from Amira to coordinate with her BH provider organization care manager to lead interdisciplinary team meetings to share data and **update all of her providers on her treatment goals** and progress. Amira's provider care manager also takes on a more case management role and helps Amira schedule and attend her appointments.

Amira's story is an example of how **provider and MCO care managers can work together** to coordinate integrated physical and behavioral health care to support positive member outcomes.

MCO Integrated Care Management | Overview of proposed BH-related policy changes

1 Integrated Care Management Enrollment

Identification of members in need

- Potential expansions to initial health screening and list of indicators that would initiate care management outreach to ensure all members with BH needs have an opportunity to complete an assessment

Comprehensive needs assessment (CNA)

- Potential expansions to CNA to capture all members with BH diagnoses
- Members with a primary BH need for care management based on CNA to be enrolled with care manager with BH expertise

2 Integrated Care Management Delivery

Delivery and staffing model standards

- Delivery
  - MCOs required to assign care manager with BH expertise to members with primary BH needs for care management
  - Any physical health / BH integration model is acceptable (e.g., 1 CM covers both physical health and BH needs vs. co-managed by 2 different CMs) as long as all member needs addressed
- Caseload
  - Defining reasonable caseload requirements with differentiated care levels based on member severity

MCO Integrated Care Management | Discussion questions

1. How can we encourage member engagement in **initial MCO outreach to complete screening**?
   - What strategies should we consider to effectively engage difficult-to-reach populations (e.g., individuals with serious mental illness, members with BH diagnosis experiencing homelessness)?

2. How can **providers and MCO integrated care managers best communicate** to improve health outcomes for members?
   - What frequency of outreach seems efficient for MCO care managers to communicate with providers?
   - How should providers and MCO care managers share data?
   - What other strategies can help ensure a positive member experience and avoid duplication when a member is assigned multiple care managers (e.g., MCO and provider care manager)?

Quality Monitoring | Overview

Quality monitoring involves assessment of BH integration outcomes to ensure accountability for integrated care.

BH Integration Quality Report: With BH integration, MCO plans will be required to complete an annual BH integration quality report and live presentation based on template and guidance provided by DMAHS. Following components are required:

- **Member satisfaction** with provider access; timeliness of care; disparities and inequities in care; and quality of care
- **Provider satisfaction** with MCO enrollment & credentialing; payment concerns; appeals process; utilization management; and access to training and resources on cultural competency
- **Quality or outcome measures** related to BH and physical health integration

Quality Monitoring | Jamboard discussion

Recall: Goals of BH integration

1. Improve access to services with a focus on member-centered care

2. Integrate behavioral health and physical health for whole person care, with potential to improve healthcare outcomes

3. Provide well-coordinated services for members in the right setting, at the right time

For discussion: What are key priorities for evaluating progress toward each of these goals?

Link to Jamboard to share ideas

Examples of types of feedback to share in Jamboard:

- Member health or social outcomes, including for specific groups of members
- Access to care
- Disparities
- Outcomes that assess how MCOs are managing integrated care

Quality Monitoring | Discussion questions

1. What is your **experience today** with **surveying processes** from managed care or state entities (e.g., member or provider satisfaction)? Any **strengths to preserve** and **key challenges or opportunities for improvement** with quality reporting for BH integration?

2. What **components of member satisfaction** are most important to capture? Are any dimensions missing:
   - Provider access
   - Timeliness of care
   - Healthcare disparities
   - Quality of care

3. What **components of provider satisfaction** are more important to capture? Are any dimensions missing:
   - Network management and enrollment
   - Payment concerns
   - Appeals process
   - Utilization management
   - Access to training / resources on cultural competency and responsiveness

4. How can we improve **provider and members response rates** to satisfaction surveys?

Discuss provider and member engagement

Provider Forums | Overview

Overview

Goals of provider subgroup forum:

- Share information
- Invite high-level feedback on provider type-specific policy implications
- Support provider readiness

Provider forums kicked off in March

- Provided overview of BH integration, and discussed credentialing/ enrollment and prior authorization
- MCO representatives shared processes
- Provider FAQs to be shared on BH integration webpage

Provider subgroups

Date of Meeting	Provider types included
March 21, 2024	• MH independent clinicians – includes Psychiatrists, Psychologists, Advanced Practice Nurses, and Licensed Clinical Social Workers • SUD independent clinicians – includes Licensed Clinical Alcohol and Drug Counselors and MH clinicians who provide SUD services
	• MH outpatient hospital or clinic services • SUD intensive outpatient • SUD outpatient clinic services – including Ambulatory Withdrawal Management
March 26, 2024	• MH Partial Hospitalization and MH Partial Care in an outpatient clinic
	• SUD Partial Care

Provider Forums | Key takeaways

Overall

- Desire for **standardization and streamlining** processes across MCOs
- Request for **resources and support for providers**, including guidance document, trainings, and dedicated MCO representatives

Enrollment / credentialing

- Lack of clarity regarding **individual vs. facility** credentialing
- Continued push for **standard form and streamlined process** across MCOs, including for facilities
- Questions from providers **already contracted** with MCOs:
  - Whether further credentialing required for Phase 1
  - If contract terms can be re-negotiated

Prior authorization

- Push for **standard definition** of medical necessity and **minimum service durations**
- Push for standardization in **information requested and submission process** across MCOs, including ability to request/track PA **electronically**
- Need to clarify processes for **formerly incarcerated / recovery court individuals** (e.g., IME involvement, special program codes)

Provider Forums | Next steps

- Will publish **provider FAQ** document on BH integration webpage
  - Department of Human Services | Behavioral Health Integration Stakeholder Information (nj.gov)

- Plan for **additional forums** in the summer and fall
  - Likely to be **topic-specific** (e.g., enrollment and credentialing, prior authorization, billing and claims)
  - Will **solicit questions from attendees** prior to the session
  - **Additional details** will be shared in coming weeks

- **For discussion:** Do you have any feedback or suggestions for future provider forums? Please respond in the chat or email DMAHS.BehavioralHealth@dhs.nj.gov

Member Engagement

- Member engagement will include individual interviews, focus groups, a virtual member-centered meeting, and member communications
- Individual interviews and focus groups will explore members' current experiences accessing and navigating care to guide policy priorities and refinements
- Member-centered meeting and communications will share information about what members need to know about the transition to integration
- Pursuing partnerships with organizations to guide this strategy, and welcome input from members of Advisory Hub

Next Steps

June Advisory Hub

Planned agenda

- Billing / claims
- Update on member + provider stakeholder engagement
- Other key policy areas and topics to be determined

Thank you!