NEW JERSEY HUMAN SERVICES

Behavioral Health Integration Advisory Hub Meeting

July 26, 2024

11-12:30 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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Recall | Timeline for Phase 1 of BH Integration

Phase 1 planning throughout 2023-2024

Phase 1 go-live Jan 1, 2025

We are here

2023	Jan-Feb ‘24	Mar-Apr ‘24	May-Jun ‘24	Jul-Aug ‘24	Sep-Oct ‘24	Nov-Dec ‘24	2025
Waiver approved	Submit Jan ‘24 contract to CMS			Submit Jul ‘24 contract to CMS			Submit Jan ‘25 contract to CMS
Begin Phase 1 program design	Develop Jul ‘24 contract standards and program guidance for Phase 1 services			Publish Jul ‘24 program guidance; Develop Jan ‘25 contract standards and guidance for Phase 1 services			
Launch stakeholder forums	Advisory Hub	Advisory Hub	Advisory Hub	Advisory Hub	Advisory Hub	Advisory Hub	Continue stakeholder engagement with Advisory Hub, members, and providers on Phase 1 implementation, Phase 2 design
	MCO Quarterly	Provider forum	MCO Quarterly	Member interviews	MCO Quarterly	Informational webinar	
					Member focus group		
	Gather best practices and learnings from past integration efforts		Develop readiness plans, tools, and resources for MCOs/providers		Conduct MCO readiness reviews and monthly provider trainings		Monitor Phase 1 implementation
CMS milestones	Program design	Stakeholder engagement	Readiness & implementation				

Agenda

- Provide update on BH Promoting Interoperability Program (PIP)
- Gather feedback on network adequacy and member access updates
- Share updates on quality monitoring
- Review stakeholder engagement plan

Behavioral Health Promoting Interoperability Program (BH PIP)

- Is a milestone-based incentive payment program for behavioral health facilities to
  - Encourage the adoption of certified health information technology among the substance use disorder and mental health providers
  - Promote integrated behavioral health system that includes providers of all types caring for patients to access clinical information to enhance care quality
- Federally matched funding approved for a period of five years through the extension of 1115 New Jersey FamilyCare Comprehensive Demonstration Waiver
- Administered by the New Jersey Department of Human Services (NJDHS), the Division of Medical Assistance and Health Services (DMAHS), in collaboration with the Division of Mental Health and Addiction Services (DMHAS)
- The program launched on July 1, 2024

BH PIP: Technical Assistance and Incentives

- New Jersey Innovation Institute (NJII) Healthcare is the leading state partner to support the facilitation of healthcare technology necessary to participate and will assist the BH facilities with education, eligibility verification, milestone attestation and incentive payments
- The qualified BH facilities have an opportunity to receive up to $47,500 in financial incentive payments to invest/ upgrade in IT infrastructure through the six milestones
- For assistance or more details about BH PIP, please visit the link https://www.njii.com/healthcare/behavioral-health-bh-pip/
- Email any questions at bhpip@njii.com

BH PI Program Milestones and Payments

Milestones	Incentive Payment
Milestone 1 (Participation)	$5,000
Milestone 2 (Go-live)/ Milestone 2 (EHR Upgrade)	$20,000–tier 1 $7,500–tier 2
Milestone 3 (HIE Connection)	$7,500
Milestone 4 (PMP Connection)	$5,000
Milestone 5 (Behavioral Health electronic consent management system)	$5,000
Milestone 6 (Integrated Telehealth Services)	$5,000

Gather feedback on network adequacy and member access updates

Policy Priorities for Behavioral Health Integration

Ensure access and continuity for members

- Covered services
- Eligible populations/providers
- ☆ Provider networks and member access
- Telehealth

Promote a positive provider experience

- Provider credentialing/ enrollment
- Rates
- Claims processing and timely payments

Enable streamlined, coordinated care delivery

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

☆ To discuss today

Confirmed transition period policies for Phase 1 integration

Type of policy	Policy changes (non-exhaustive)
Provider network	• Allow out of network and “single case” contracting of Medicaid-enrolled providers as necessary while full contracting and credentialing is completed
	• Require contracting with “any willing qualified provider” for first 24 months and until contracted network meets requirements statewide
	• Require MCOs to engage all active fee-for-service BH providers for participation and report on progress to State
Prior authorization	• For initial transition period (first 90 days), existing prior authorization requests must be submitted to MCO for tracking purposes but will be automatically approved
Rates	• FFS rates will serve as “floor” during transition period (e.g., MCO rates cannot fall below FFS rates during this period)

Detail | Confirmed Policies (I/II)

Non-exhaustive

Topic	Standard
Credentialing	Mandate use of CAQH option & integration of all CAQH elements into MCO credentialing process
	Required MCO turnaround 60 days (vs. 90 days) and notification of status to provider within 30 days
	Require quarterly reporting on credentialing acceptances, rejections, and timelines
Network access and adequacy	Require MCOs to contract with all active FFS providers for Phase 1 services or provide a reason and evidence of attempted out-of-network agreement by the date set by DMAHS
	Require MCOs to contract with “any willing qualified provider” for first 24 months
Billing and claims	Align BH claims processing timelines with MLTSS standards
	Require minimum weekly payment cadence for claims (vs. bi-weekly)
MCO staffing	BH Medical Director must be hired full time
Quality strategy	Require new BH annual quality report
Court ordered services	BH court ordered services must be covered by MCO, incl. involuntary inpatient psychiatric stays

Detail | Confirmed Policies (II/II)

Non-exhaustive

Topic	Standard
Prior authorization	PA not permitted for OP MH therapy/SUD counseling
	During first 90 days of rollout, PA request will be auto approved
	Require minimum of 5-day auto-approval for withdrawal management/detox for alcohol, opioids, and benzodiazepines for ambulatory and residential withdrawal management
	Require written notice of urgent determination within 24 hours of decision
	PA staff for behavioral health must be available 24/7
	Require annual training on ASAM and competency/inter-rater reliability testing
	Establish minimum initial authorization durations • Acute Partial Hospital: Minimum 14 days • MH Partial Care: Minimum 14 days • SUD IOP and Partial Care: Minimum 30 days • Short-term residential: Minimum 14 days • Long-term residential: Minimum 60 days
	Require new BH-specific quarterly PA report

Network | Potential Policy Opportunities

Previous Advisory Hub feedback

Important to ensure

- Continuity of care
- Accuracy of provider network information
- Access to telehealth and transportation
- Measuring access beyond traditional adequacy standards, including equity lens

Potential Policy Opportunities

- Ongoing monitoring of network adequacy standards to ensure equitable member access is being maintained; enhancements to be made if/as applicable
- Exploring mechanisms for members to flag provider directory errors
- Strengthening DMAHS' monitoring of MCO outreach to inactive providers and relevant directory updates
- Bolstering DMAHS auditing of directory/network, including regular comparisons of provider network files and directory, audits, and live reviews with MCOs
- Expanding ways MCOs can address cultural competency needs through provider network (e.g., MCO report on languages spoken by providers and racial and ethnic demographics of providers in network)
- Improving MCO telehealth reporting to monitor telehealth network and utilization
- Ensuring non-emergency transportation for all members

Network adequacy | Discussion questions

1. What feedback do you have on the potential policy opportunities?

2. What are some ways MCOs can ensure cultural competency through provider networks?

3. Are there any other considerations for supporting member access to care that are not addressed in these proposed policy updates, such as concerns for monitoring networks for specific services?

Share updates on quality monitoring

Quality Monitoring | Recall plan for BH integration quality report

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 to DMAHS with the following components:

- Member satisfaction
- Provider satisfaction
- Quality and outcome measures

In April Advisory Hub, members gave feedback on ways to measure the following BH integration goals to improve overall member health

1. Member access
2. Whole person care
3. Care coordination

Quality Monitoring | Stakeholder feedback informed BH integration metrics for annual quality report

Non-exhaustive

Stakeholder feedback	Sample of proposed quality and outcome metrics (Claims based)
Ensure health equity	• Required disaggregation of outcomes by demographics (e.g., Race, Gender) • Housing status
Prioritize primary care and prevention	• PCP visits for members with BH needs • Primary dental appointment for members with BH needs • Blood pressure under control for members with BH needs • EKG for members with BH needs screened for CV disease/high blood pressure • Smoking cessation supports • Metabolic monitoring for children on antipsychotics
Improve screening rates	• Social need screening and follow-up • Depression screening and follow-up • Prenatal/postpartum depression screening
Coordinate care with thorough follow ups	• Follow up post ER/high intensity care/hospitalization for SUD or mental illness • Medication adherence for members with BH diagnosis • ER/acute hospital utilization • Plan all cause readmission

Quality Monitoring | DMAHS is proposing standardized member and provider satisfaction surveys

DMAHS is proposing standardized surveys to implement for member and provider satisfaction

- Overall goal to avoid duplication and limit survey length to address member/provider burden and ensure high response rates
- For member satisfaction, goal is to use a nationally recognized survey (CAHPS ECHO) for members with a BH diagnosis
- For provider satisfaction, goal is to centrally administer a standard, state-designed survey and route responses to MCOs so that providers only need to complete the survey once

Quality Monitoring | Overview of proposed provider satisfaction survey

Importance of provider survey

- Space for providers to give feedback on their experience with MCOs
- Opportunity for state and MCOs to take action based on what categories providers highlight as significant to them and areas where they face challenges

Categories to be reported on

- Network and enrollment
- Utilization management
- Payment
- Appeals
- Training and resources

Quality Monitoring | Provider survey modeled after peer states to evaluate satisfaction across key metrics

Structure

- Survey will consist of 11 questions total
- Providers will score 1-5 for each question across each MCO
- 1-2 questions regarding overall satisfaction followed by a space to areas of concern
- Optional field for free form comments at the end of the survey

Logistics

- Survey will be posted on DMAHS website annually and available to providers for extended period of time
- MCOs will share results in quality report; DMAHS will share results publicly
- For more immediate concerns, providers to refer to the resource account
- Survey is anonymous with an optional comment section to identify self with contact information for outreach

Quality Monitoring | Draft provider survey questions

Network and enrollment

Overall satisfaction with MCO's credentialing, contracting, and network management?

Concerns with the following?

- Credentialing
- Contracting
- MCO's provider facing staff

Utilization management

Overall satisfaction with the MCO's UM process?

Concerns with the following?

- Support from UM staff (availability and responsiveness)
- Prior authorization submission
- Prior authorization timeliness
- Clarity or reason for denial
- Peer to peer review

Payment

Overall satisfaction with how MCO processes claims?

Concerns with the following?

- Timeliness of initial claims processing
- Accuracy of payments
- Resolution of claims disputes/issues

Appeals

Overall satisfaction with the appeals process (if you have used it)?

Concerns with the following?

- Timeliness of appeals
- Decision clarity

Training and resources

Overall satisfaction with the training and resources provided by the MCO?

Concerns with the following?

- Provider orientation and onboarding materials
- Provider manual
- Cultural competency materials and sessions
- MCO language assistance

Review stakeholder engagement plan

Plan for remaining 2024 stakeholder meetings

	Advisory hub	Provider engagement	Member engagement
Upcoming dates	• September • November	• September–December	• August (individual interviews) • September (focus group) • November (member centered informational meeting)
Description	• Provide updates on BH integration initiatives, and gather feedback on priority policies	• Launch “go-live ready” training series the first week of each month • Facilitate provider readiness forum and self assessment	• Explore members’ current experiences accessing and navigating care

Member engagement | Next steps

Member engagement will include individual interviews, focus groups, and a virtual member-centered meeting

Started individual interviews and will continue through the summer and recruiting 5-10 participants for a focus group in the fall to explore members' current experiences accessing and navigating care to guide policy priorities

Currently pursuing a partnership with the Regional Health Hubs (RHH) for their support late 2024 and early 2025 to facilitate additional interviews and focus groups

For discussion: Would you like to help us connect to members who may be interested in participating in an interview or focus group?
Please respond in the chat or email DMAHS.BehavioralHealth@dhs.nj.gov

Provider Education | Next steps

Topic-specific FAQ documents to be published on BH integration website over the next few months

- Provider FAQ document on prior authorization to go live: Link published shortly
- Enrollment/credentialing guidance forthcoming

“Go-live ready” training series will include topic-specific educational information and provider readiness training for the first week of each month; MCOs to assist in facilitation

- September: Enrollment and credentialing
- October: Prior authorizations + NJSAMS
- November: Claims
- December: Office hours
- *Providers to also participate in MCO-specific trainings on website

Provider readiness forum and self-assessment forthcoming

For discussion: Do you have any feedback on the proposed provider training topics?
Please respond in the chat or email DMAHS.BehavioralHealth@dhs.nj.gov

September and November Advisory Hub | Next steps

September topics

- Claims
- Prior authorization & NJSAMS use for SUD prior authorization requests
- Telehealth policies

November topics

- Readiness review updates for MCOs and providers
- Final feedback on implementation before go-live

For discussion: What priority topics should we add to the September/November advisory hubs? Please respond in the chat or email DMAHS.BehavioralHealth@dhs.nj.gov

Thank you!


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