NEW JERSEY HUMAN SERVICES

Behavioral Health Integration Provider subgroup meeting

March 26, 2024

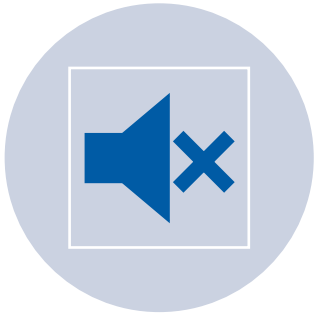
9:30-11:00am

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

Agenda

- Introduce BH integration and progress to date
- Discuss provider experience, priority policy areas, and considerations for BH integration program design
- Answer FAQs and explore further opportunities to engage

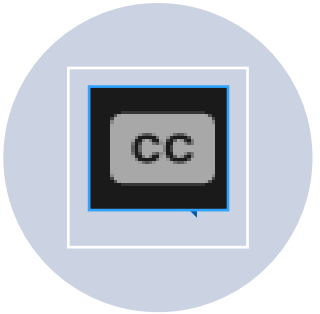
Housekeeping



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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Facilitator introductions

Shanique McGowan, LCSW
Behavioral Health Program Manager, Division of Medical Assistance and Health Services (DMAHS)

Logan Kelly, MPH
Senior Program Officer, Center for Health Care Strategies (CHCS)

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.

BH integration introduction

NJ FamilyCare overview

Fee-for-service (FFS)

- **Traditional Medicaid** model
- **Providers bill state** Medicaid directly for specific services
- Currently, **most BH services** are billed under FFS for the **general population**

Managed care

- Medicaid model that involves **member enrollment in health plan**
- NJ has **5 managed care organizations** (MCOs): Aetna, Fidelis, Horizon, United, Wellpoint
  - **~95%** of NJ FamilyCare members are in MCO
- MCOs receive funding from state to **coordinate member care** and **offer special services** in addition to regular NJ FamilyCare benefits
- MCO **responsibilities** include provider network management, care coordination and care management, utilization management, and quality assurance

How BH Integration will work: Phase 1

	Phase 1 – Outpatient BH Some MCO integration exists today for mental health (MH) and substance use disorder (SUD) services
Provider group	**Discussions began *Fall 2023* for implementation in *January 2025***
A	• 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
B	• MH Partial Hospitalization and MH Partial Care in an outpatient clinic
C	• MH outpatient hospital or clinic services • SUD intensive outpatient • SUD outpatient clinic services – including Ambulatory Withdrawal Management
D	• SUD Partial Care

Future phases:

Residential Services

Opioid Treatment Programs (OTP)

Other BH Services

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Timeline for BH Integration

Summer/Fall 2023	Winter 2023/2024	Spring 2024	Summer/Fall 2024	Winter 2024/2025
CMS approval of 1115	Continue community meetings	Continue community meetings	Continue community meetings	Continue community meetings
Commence community meetings	Define best practices	Provider readiness planning	MCO Readiness Reviews	**Phase 1 implementation**
Begin BH Phase 1 subgroup discussions	Develop communication strategy	Amend MCO contract with initial requirements		Monitor member and provider experience
	Frame out performance accountability	Frequent meetings with operational partners		Commence community meetings for Phase 2

BH integration stakeholder forums

	Advisory Hub	MCO Quarterly	Provider Forums	Member Forums
Launch date	• October 2023	• November 2023	• Today	• May 2024, 1 virtual and 3 in-person options
Meeting cadence	• 1x every 2 months	• 1x per quarter	• Spring and Fall, 2024 • Additional forums scheduled as needed	• Spring and Fall, 2024
Attendees	• MCOs, providers, member advocacy groups	• MCOs	• Providers	• Members
Goals	• Share BH integration **progress updates** • Gather **feedback on key policy areas** for BH integration	• Share BH integration **progress updates** • Work with MCOs to **understand current processes** & **finalize new standards**	• Share BH integration **progress updates** • Gather feedback on **provider-specific challenges & concerns** to inform program design • Answer **provider questions** and ensure provider **readiness**	• Share BH integration **progress updates** • Invite **member perspectives & experiences** • Answer member **questions**

Priority policy areas

BH integration opportunity and challenges

Goals of BH integration

- Improve **access** to services with a focus on **member-centered** care
- Integrate behavioral health and physical health for **whole person care**, with potential to **improve healthcare outcomes**
- Provide **well-coordinated services** for members in the **right setting, at the right time**

Potential challenges for providers, to address through program design

- **Enrollment:** Potential administrative burden to complete enrollment and credentialing processes across MCOs
- **Care delivery:** Providers to learn new prior authorization processes; providers to coordinate with MCO care management
- **Billing:** Concerns around inadequate rates, and delayed / inaccurate payments
- **Supporting integrated care:** Integrating behavioral health and physical health within managed care will take time and require new ways of working

Transition period policies for Phase 1 integration

Type of policy	Proposed policy changes *(non-exhaustive)*
Provider network	• Require out of network and "single case" contracting of Medicaid-enrolled providers as necessary until full credentialing is complete
	• Require contracting with "any willing qualified provider" for first 24 months and until contracted network meets requirements statewide
	• Require MCOs to recruit all active fee-for-service BH providers, otherwise provide reason
Prior authorization	• For initial transition period, 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)

Policy priorities and areas of focus for today's meeting

Ensure access and continuity for members

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

Focus areas for today

Promote a positive provider experience

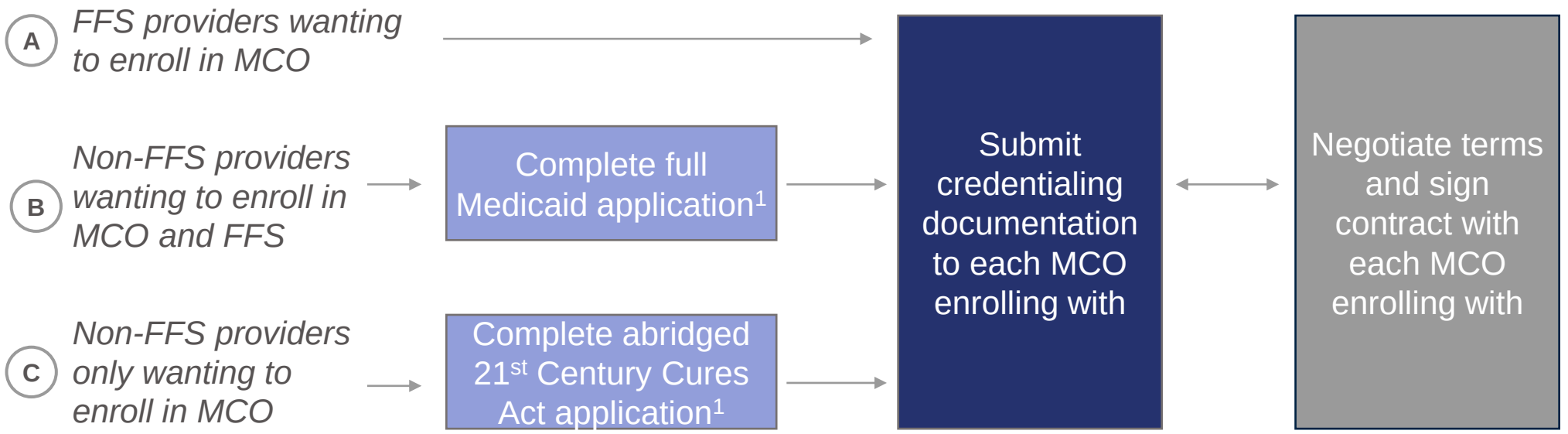
- **Provider enrollment & credentialing**
- Rates
- Claims

Enable streamlined, coordinated care delivery

- **Prior authorizations**
- **Care management** *(time-permitting)*
- Telehealth
- PCP & BH provider coordination

Provider enrollment & credentialing | 3 distinct processes for providers to complete

Process	Medicaid enrollment	MCO credentialing *(focus for today)*	MCO contracting
Managed by	DMAHS and third-party vendor	MCOs	MCOs
Purpose	To register as FFS and/or MCO Medicaid provider with the state	To vet provider qualifications & credentials	To enroll with MCO and bill for services
Process			



1. Go to https://www.njmmis.com/providerEnrollment.aspx

Provider enrollment & credentialing | Current MCO credentialing requirements

	Provider type	MCO credentialing requirements
Eligible for CAQH[1]	Physicians (e.g., MD, DDS, DMD, DPM, DC, and DO)	All MCOs require
	Full license BH providers (e.g., LCSW, LCP, LMFT, LCPC)	All MCOs require
	Nurses (RN, RNFA, APN)	All MCOs require
	Licensed Social Workers (LSWs)	Some MCOs require
	Licensed Associate Counselor (LACs)	Some MCOs require
	Licensed Associate Marriage and Family Therapy (LAMFTs)	Some MCOs require
Not eligible for CAQH[1]	Peer Counselors	No MCOs require
	Office Based Addiction Treatment (OBAT) Navigators	No MCOs require

1. CAQH: Council for Affordable Quality Healthcare; Source: MCO comparison template submissions

Provider enrollment & credentialing | Current process for CAQH

CAQH platform

CAQH is a third-party platform that **streamlines enrollment / credentialing** process for providers

- Providers create online profile
- MCOs pull data from CAQH profile to meet credentialing/enrollment data requirements

Information & documentation collected

Profile information:

- Education
- Professional Training & specialties
- Practice Location
- Hospital Affiliation
- Professional Liability Insurance
- Employment information & professional references

Required supporting documents:

- State medical license(s)
- Drug Enforcement Administration (DEA) Certificate
- Malpractice insurance face sheet
- Summary of any pending / settled malpractice case(s)
- CV
- Signed attestation
- Written protocol (for NPs only)

Sources: CAQH Credentialing Frequently Asked Questions (bcbstx.com), CAQH Approved Provider Types List (bcbstx.com); CAQH ProView Provider User Guide

Provider enrollment & credentialing | Feedback and discussion

Stakeholder feedback

- **Streamline credentialing across MCOs** to reduce provider burden and limit confusion
- **Allow facility level credentialing** wherever possible to reduce provider burden
- **Need support** and guidance in filling out CAQH form

Proposed policy changes

- **Mandate CAQH or NJ Universal Physician Application** for eligible provider types and create **standard supplemental form** to use across MCOs
- Reduce required timeline for MCO decision on provider credentialing to **60 days for "clean applications"**
- Require MCOs to **report on credentialing approval/denial rates** and **timelines**

Discussion questions

1. What parts of the **credentialing data collection and submission process** would most **relieve provider burden** if standardized across MCOs?
2. For providers **using CAQH** today: how much does this **help streamline** the process? How much **additional paperwork** do you often complete for credentialing beyond CAQH?
3. For eligible providers **not using CAQH**: what **prevents** you from using it, and what would **enable** you to do so?

Provider enrollment & credentialing | MCO FAQs

We have **representatives from each MCO** here to answer questions on **provider enrollment and credentialing.**

Frequently Asked Questions (FAQs)

1. Do I need to **independently credential/enroll** with the MCO?

2. If I operate under a **facility level credential, am I allowed to independently** render / bill for services?

3. What information do I need to **submit to credential with MCOs**? How do I complete the process?

What **other questions** do you have? Please enter into the chat.

Prior authorization (PA) | Current MCO requirements

	FFS	MCOs
MH and SUD outpatient counseling[1]	Not required	No MCOs require
MH partial hospitalization	Required	All MCOs require
MH partial care		
SUD intensive outpatient		
SUD partial care		

1. Includes MH outpatient hospital or clinic services and SUD clinic services

Prior authorizations (PA) | Feedback and discussion

Stakeholder feedback

- Support **consistency and transparency** in all PA policies
- Focus on **timely** authorization processes to ensure **access to care**
- Consider that **administrative burden** creates **hiring/retention issues** for providers
- Consider PA only for **high-cost services at risk for fraud / abuse**

Proposed policy changes

- Require **transition period of auto-approved PA**
- MCOs to work with providers on **retroactive authorization if member meets medical necessity** criteria
- Require **annual MCO training on ASAM criteria** to ensure consistent application
- Working with MCOs to finalize standards regarding **turnaround time** for urgent and non-urgent services, **minimum authorization durations**, **PA request fields, & PA reporting**

Discussion questions

1. For **providers enrolled** in managed care: How do you see **PA request requirements vary** across MCOs? Are there certain **services that are challenging** to receive a timely decision today?
2. For **providers not enrolled** in managed care: **What questions or concerns** do you have about PA requirements?
3. What **other policies** would you prioritize to streamline the PA process?

Prior authorizations (PA) | MCO FAQs

We have **representatives from each MCO** here to answer questions on **prior authorizations**.

Frequently Asked Questions (FAQs)

1. How do MCOs ensure members receive **necessary care in a timely** manner?
2. What **methods of submission** do you allow for PA requests (e.g., electronic, fax, telephonic)?
3. What can providers do **to ensure timely prior authorization** approval?
4. How can **providers learn more** about prior authorization process with MCOs?

What **other questions** do you have? Please enter into the chat.

MCO Care Management | Overview

Goals

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

- Ensure **access** to clinically appropriate and patient-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

Standards

State **defines care management standards** with different requirements for:

- **General population**
  - Assessed for comprehensive, whole-person care needs with integrated physical / behavioral health care management when needed
- **Specialty populations**
  - Managed Long Term Services & Supports (MLTSS)
  - Division of Developmental Disabilities (DDD)
  - Division of Child Protection and Permanency (DCP&P)

1. Care Management Workbook

MCO Care Management | Process

Enrollment

Identification of members in need

- All new members receive initial health screening (IHS)[1]
- Existing members re-assessed with a trigger episode[2]

Comprehensive needs assessment

- MCO conducts comprehensive needs assessment (CNA) for identified members to determine a care plan and appropriate care level

Delivery

Delivery activities:

- Care plan development: CM uses CNA & member goals to create plan
- Plan implementation: CM facilitates care plan via referrals, care coordination, communication, etc.
- Plan analysis: CM gathers feedback from team on care effectiveness
- Plan modifications: CM modifies strategies to meet member goals

Monitoring

Outcomes monitoring

- MCOs responsible for reporting on population-based outcomes and member satisfaction to the state
- Future reporting requirements include BH-specific annual report on quality/outcomes, member satisfaction, provider satisfaction, and health equity

1. DCP&P (Division of Child Protection and Permanency) and DDD (Division of Developmental Disabilities) automatically qualify for CM, skip this step 2.Examples of Trigger events - Unplanned hospitalization: ER visits (2 or more), exacerbation of chronic condition and/or disability, and mental health hospitalization Source: Care Management Workbook

MCO Care Management | Discussion questions

1. What are important **policies and considerations for integrated care management to support whole person care** for people with behavioral health conditions, including related to:
   - Enrollment?
   - Delivery?
   - Monitoring?

2. What is currently **working well and not working well** when:
   - Members have MCO-designated care management?
   - Providers and MCOs **both deliver care management** to the same member?

3. How can **providers and MCOs best coordinate** when MCOs are delivering care management to members?

Q&A and resources

Open Q&A

Opportunities to engage

- Next provider subgroup meetings – *details to come*
  - Provide updates on BH integration progress
  - Review key managed care processes
  - Discuss provider training / readiness
  - Facilitate Q&A with MCOs

- Provider trainings
  - Aetna
  - Fidelis
  - Horizon
  - United
  - Wellpoint

Quick reference guide for each MCO: Department of Human Services | NJ FamilyCare Health Plans

Thank you!