Behavioral Health in the Emerging World of Managed Care

Opportunities and Threats

PRESBYTERIAN MEDICAL SERVICES
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NEW MEXICO MANAGED CARE

BACKGROUND

- New Mexico Medicaid began Managed care in 1996 – BH Carved out as Single payer
- Implemented new Medicaid Managed Care Program January 1, 2014 – "CENTENNIAL CARE" - Single 1115 Waiver (Replaced 6 -1915 waivers)- BH carved back in
- Four Key Principals
    - Comprehensive Service Delivery / *Care Coordination*
    - Personal Responsibility
    - Payment Reform
    - Administrative Simplicity
- Four (4) Managed Care Organizations were awarded Contract
- All Members are "Risk Stratified"

MANAGED CARE OPPORTUNITIES

OPPORTUNITIES - RISK STRATIFICATION

- All Enrollees require a Health Risk Assessment (HRA)
- HRA places Enrollees in 3 Risk Levels
  - Level 3 –Medically Fragile; Excessive ER use***; MH or SA condition causing "high functional impairment; SA dependency***; Significant cognitive deficits; requiring assistance with 2 or more ADLs or IADLs
  - Level 2- Co-Morbid Conditions; Frequent ER; ***MH or SA condition causing "moderate" functional impairment***; Assistance with 2 or more ADLs
  - Level 1- All others

» A Comprehensive Needs Assessment and Care Plan for which Care Coordination activities are prescriptive and are required for all Level 2 and Level 3 Enrollees

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MANAGED CARE OPPORTUNITIES

OPPORTUNITIES -CARE COORDINATION

» 500,000 Enrollees

- Level 2 (15%) = 75,000 enrollees; 650 staff
- Level 3 (5%) = 25,000 enrollees; 500 staff
- **50% are L2 or L3 due to BH diagnosis**

- Care Coordination Staffing Requirements
  - Level 1 – 1:500
  - Level 2 – 1:75
  - Level 3 -- 1:50

- MCO Care Coordination Staffing requirement approximately 1300

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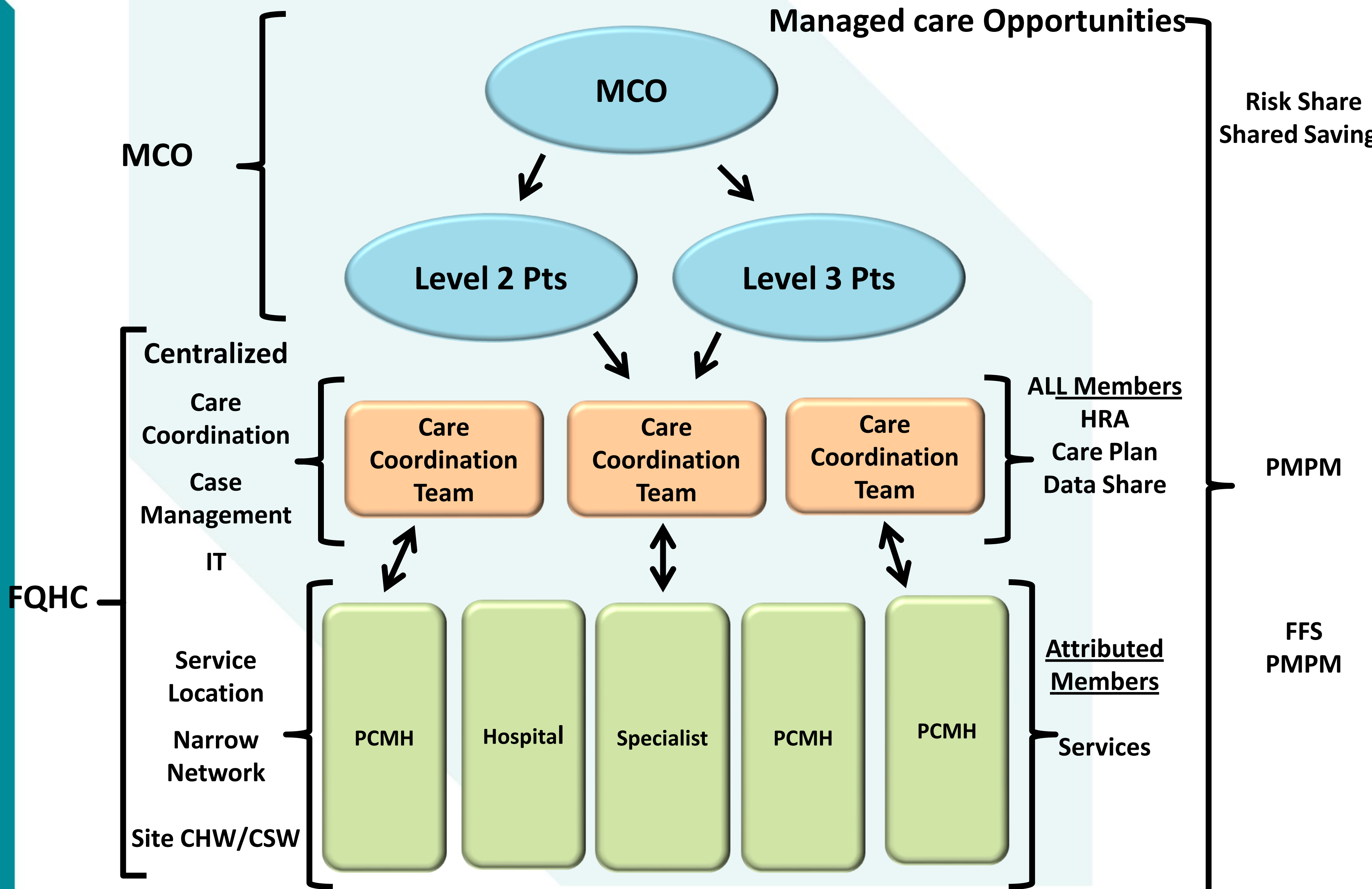

Managed care Opportunities
MCO
MCO
Level 2 Pts
Level 3 Pts
Risk Share
Shared Saving
Centralized
Care Coordination
Case Management
IT
Care Coordination Team
Care Coordination Team
Care Coordination Team
ALL Members
HRA
Care Plan
Data Share
PMPM
FQHC
Service Location
Narrow Network
Site CHW/CSW
PCMH
Hospital
Specialist
PCMH
PCMH
Attributed Members
Services
FFS
PMPM

BH IN AN EMERGING MANAGED CARE WORLD

THREATS

- Behavioral Health Service Delivery Environment
  - Model needs a complete Community Based System of Care
    - Psychiatry
    - Therapy (Indiv, Group, Family, Intensive Out-Patient, Assertive Community Treatment, Multi-Systemic Therapy)
    - Psycho-Social Rehabilitation
    - Comprehensive Community Support Services
    - Residential Treatment
- Staff
  - Licensed / Unlicensed Staffing
  - Staff training documentation

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THREATS

- Assessment Requirements
  - Services based on State Plan
  - Reassessment Requirements
  - Service Eligibility (Medical Necessity)
- Service Plan Requirements
  - Goals Measurable
  - Clients own words
- Progress Note Requirements
  - Golden Thread
- Very few fully integrated E.H.Rs
- Patient Protection and Affordable Care Act Requirement (PPACA) / CMS

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THREATS

- Patient Protection and Affordable Care Act Requirement (PPACA) / CMS
  - Managed Care Organizations/State Medicaid Agencies are required to conduct "Integrity Audits"
  - Amended section 1903(i)(2) of SS Act to provide that financial participation in the Medicaid program shall not be made to an individual or entity to whom a …. Pending investigation of a *credible* *allegation* of fraud exists as determined by the State…

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THREATS

- Prior to the passage of the PPACA the threshold for payment suspension was "RELIABLE *EVIDENCE* of fraud"
- CMS then revised its regulations to comport with PPACA provisions providing that states must "suspend all Medicaid (Medicare) payments to a provider after the agency determines there is credible allegation of fraud for which an investigation is pending…

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THREATS

- CMS recognized this new language creates a “substantive difference between the threshold level of certainty/proof and further indicated “State Medicaid agencies will be forced to withhold payments, in whole or in part, on providers more than ever before.

- CMS indicated that relief from the payhold enacted by State Medicaid agencies can be granted by:
    a) Good Cause criteria determined by the State
    b) “providers may request, and must be granted, administrative review where State Law so requires”

New Mexico has no such LAW

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THREATS – NEW MEXICO EXAMPLE

- 2 Community Mental Health Providers had significant Whistleblower complaints
  - Concern around CPT upcoding (CMS rounding violation)
- State hired Public Consulting Group to conduct state wide Integrity Audit (15 large BH providers with a statewide foot print. PMS 2nd largest outpatient BH provider)
- February 2014 – Unannounced on site audits with list of “Random” users – 150 visits
  - Audit covered 3 areas
    - Clinical Documentation
    - IT
    - Enterprise
- All files were scanned and given to PCG representative on site.

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THREATS – NEW MEXICO EXAMPLE

- Audit Scope – Behavioral Health visits paid by Human Services Department both Medicaid and Non Medicaid State General Funds
- Audit Period July 1, 2009 – December 31, 2012 (3.5 years)
- PMS paid BH claims during audit period = 36,000,000
- After Internal Review of Audit files we believed our outcome would be typical of other audits conducted by Managed Care Organizations

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THREATS – NEW MEXICO EXAMPLE

- June 2013 – HSD meets with 15 provider organizations and PCG
  - Presents PCG findings – Error rate as determined by PCG for all providers was 3X national average of 8-10%
  - Results presented in Summary Form only and data was de-identified
  - Informs all 15 providers that <u>this error rate constitutes a "credible allegation of fraud"</u> and that all agencies had been referred to the Medicaid Fraud Control Unit (MFCU) and each organization's Medicaid provider numbers have been suspended until:
    - A Good Cause request was submitted and approved by HSD

    Or

    - MFCU has determined there is insufficient evidence
- Financial impact to PMS was 1,800,000 per month

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THREATS – NEW MEXICO EXAMPLE

- June 26 2013 – PMS submits “Good Cause” request for payment hold release
- July 2013 – HSD informs PMS:
  - Our “Good Cause” had been partially approved for Non-Behavioral Health Services – payhold remained in effect for BH Services
    - Financial impact to PMS now $900,000-$1,000,000 per month
  - That we were 1 of 3 agencies that were being placed in “temporary management” status for our Behavioral Health Services – remaining 12 providers were being “Transitioned” to Arizona CMHC organizations that had already been vetted and contracted by HSD.
- August 2013 – PMS meets with HSD and Arizona CMHC – determines a “supplemental good cause” is warranted

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THREATS – NEW MEXICO EXAMPLE

- September 2013 – HSD provides PCG audit to PMS
  - Audit indicates PMS error rate = 27%
  - Audit calls for repayment of claims based on extrapolation formula of 4,500,00.
  - PMS reviews audit findings; disputes audit findings and gathers supporting documentation for many missing or incomplete items
  - HSD indicates that are unwilling to accept additional audit material
- September/October 2013 - PMS enters into Settlement negotiations
- October 30, 2013 – PMS settles for $4,000,000 and has its Medicaid/Non-Medicaid number restored

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LESSONS LEARNED

- Cash Management – “Disaster Planning”
- E.H.R enhancements / customizations – “Golden Thread”
- Training requirements – Electronic tracking
- State Regulation / Administrative process
- Recognize the changing environment

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