

Medicaid PCP Webinar
Policy Transformation
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Medicaid Policy Transformation

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Developmental Disabilities Services (DDS) Transformation

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Developmental Disability Tiering

- Tier 1:
Individual receives DD services under the Medicaid State Plan (DDTCS, CHMS, therapy, etc.), but does not meet ICF/IID level of care eligibility
- Tier 2:
Individual meets ICF/IID level of care eligibility, but does not currently require 24 hours/day of paid support and services to maintain his or her current placement
- Tier 3:
Individual meets ICF/IID level of care eligibility and does require 24 hours/day of paid support and services to maintain his or her current placement

Therapy Thresholds

- Effective July 1, 2017
- Affects DD clients receiving occupational, physical or speech therapy in four settings (DDTCS, CHMS, private clinic, school)
- Soft cap put in place: Can receive up to 6 units per week (90 minutes) of each discipline without an extension of benefits/prior authorization (EOB/PA)
- A client can receive more than 90 minutes, if it is medically necessary with an EOB/PA
- All DMS-640s still have to be signed by a physician
- Process has revealed children receiving same modality in multiple settings and DDS needs to work with physicians to develop a plan

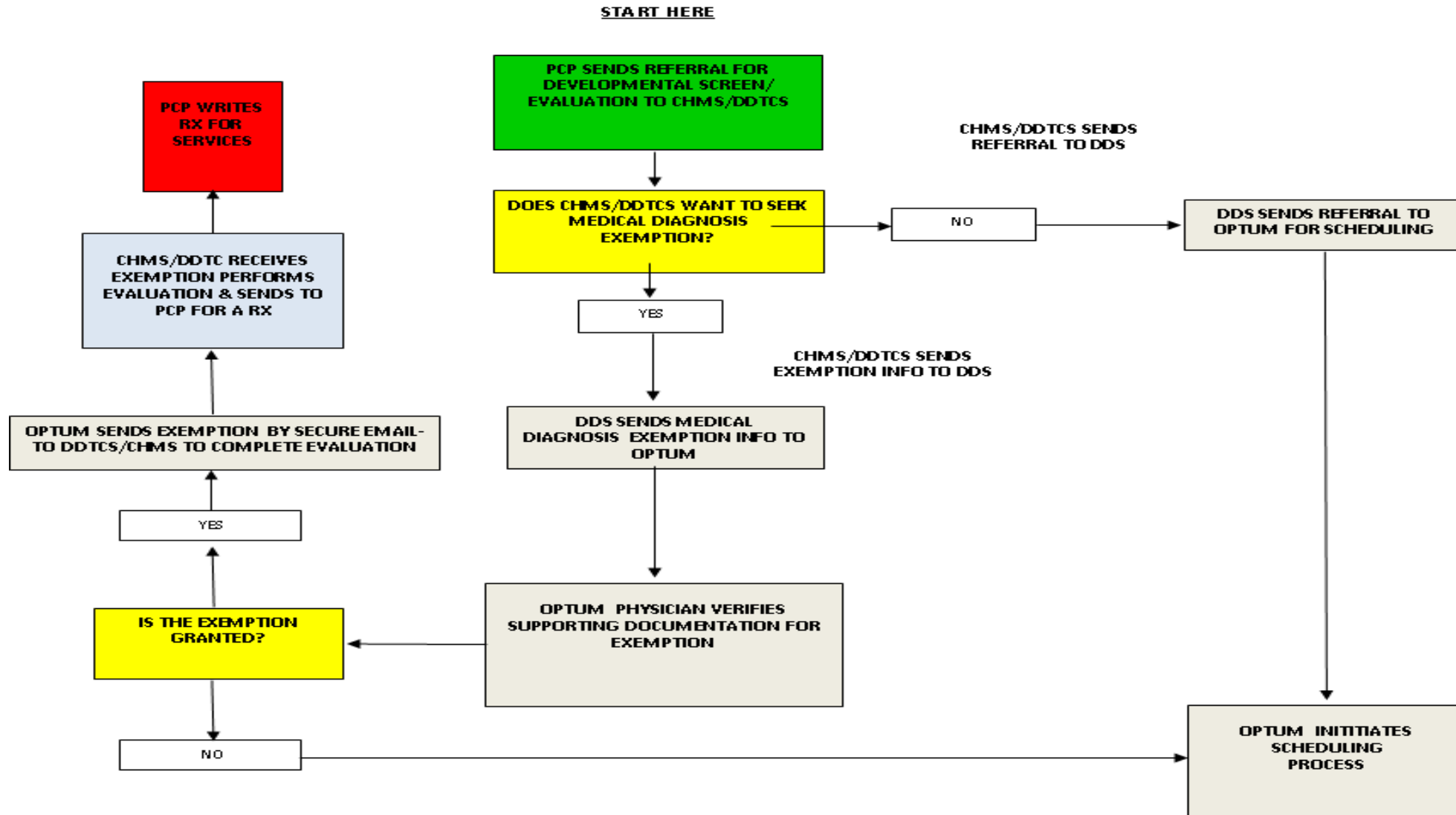
Developmental Screen

- Anticipated effective Oct. 1, 2017
- All new children in a CHMS or DDTCS will have to get a developmental screen to determine if a full evaluation is needed; used as a pre-screening tool
- The facility will coordinate the screen with Optum
- If a full evaluation is not needed—will send you the results
- If a full evaluation is needed—facility will conduct and send you the evaluation and the screen to get a prescription for services

Developmental Screen (cont'd)

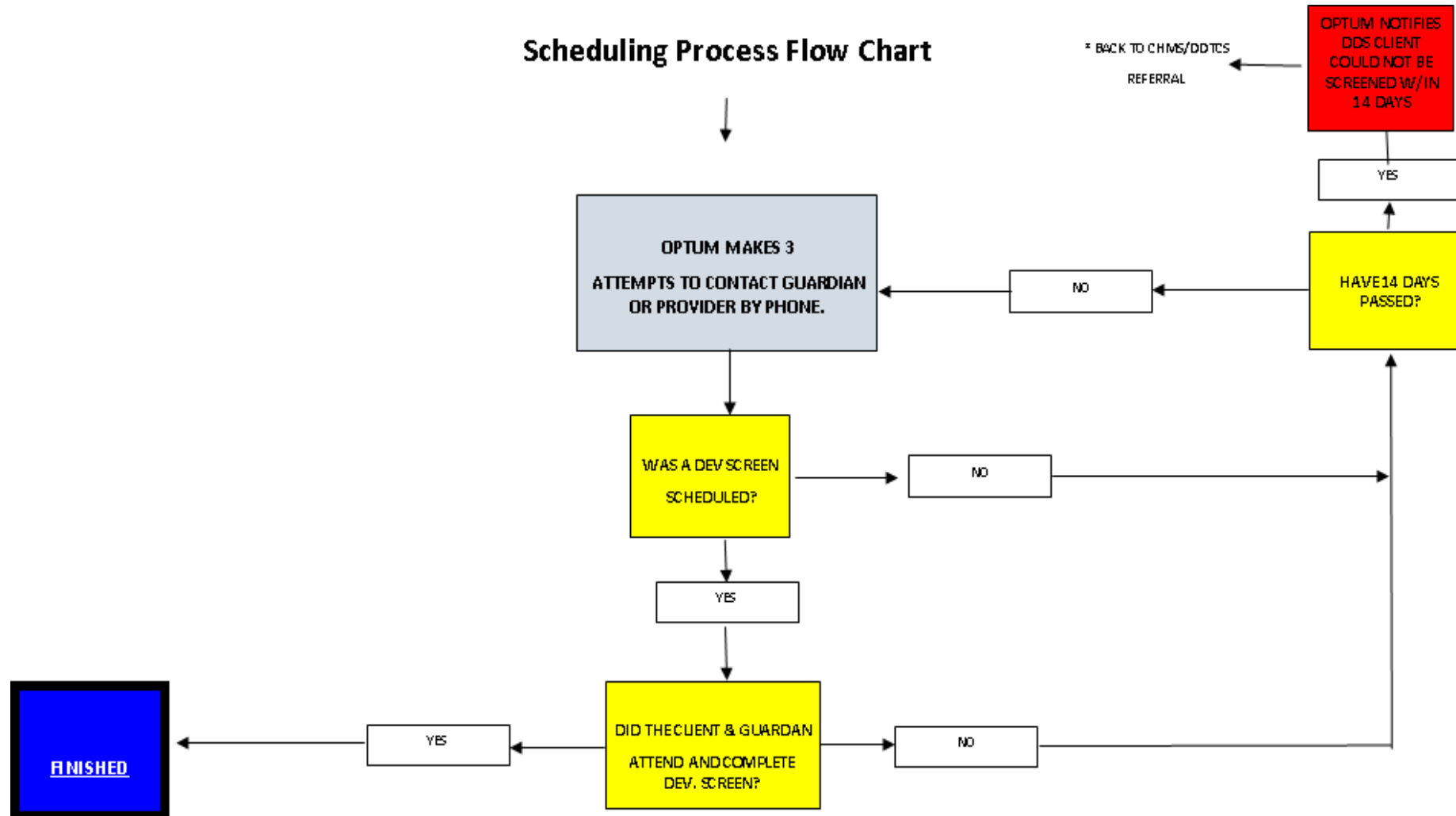
- Can submit medical documentation to Optum to “opt out” of the developmental screen
- A physician will diagnosis any medical condition that is the basis of the medical diagnosis exemption
- The DDTCS/CHMS will coordinate sending in the medical diagnosis exemption paperwork for review and approval by Optum

Developmental Screen Workflow



Workflow (cont'd)

Scheduling Process Flow Chart



Independent Assessment

- Tier 2 and Tier 3 DD beneficiaries will be attributed to a PASSE
- First must undergo an independent assessment (IA)
- Functional assessment designed to:
 - Determine tier (what level/intensity of service is needed)
 - Assist with appropriate plan of care for that client
- Optum will conduct the IA on the Tier 2 and Tier 3 DD population:
 - Current waiver clients (including 500 new from Tobacco Settlement funds)
 - Waitlist clients
 - Clients in a private ICF/IID
 - Clients transitioning into or out of an HDC (not going into PASSE)

Behavioral Health Transformation

Paula Stone
Assistant Clinical Director
Division of Behavioral Health Services

Behavioral Health Program Re-design

- The transformation creates a new three-tiered system of services, care coordination and an independent assessment that will ensure people get the right services in the right setting to meet their needs
- Individuals may access services in Tier 1 without prior authorization or Independent Assessment
- Individuals who need services in Tier 2 or 3 require Independent Assessment prior to receiving services
- Individuals in Tier 2 and 3 will be attributed to a PASSE
- Assessments for current RSPMI clients began September 2017 and projections for 30,000 assessments prior to July 2018
- The RSPMI program will cease to exist July 2018

Behavioral Health Tiering

- Tier 1: Counseling
Time-limited services provided by a qualified licensed practitioner in an outpatient setting to assess and treat mental health and/or substance abuse conditions
- Tier 2: Rehabilitative
Home and community-based services with care coordination including a full array of professional and para-professional services for individuals with higher needs. Services provided by certified behavioral health agency staff members.
- Tier 3: Residential
Services provided in residential setting for individuals with the highest need

Independent Assessment Determines Eligibility for Tier Services

Tier 1 Clinic-Based

- Individual behavioral health counseling
- Group behavioral health counseling
- Marital/family behavioral health counseling (Including Dyadic Treatment for 0-47 months)
- Multi-family behavioral health counseling
- Psychoeducation
- Mental health diagnosis
- Interpretation of diagnosis
- Substance abuse assessment
- Psychological evaluation
- Psychiatric assessment
- Pharmacologic management

Tier 2 Home/Community-Based

- Master treatment plan
- Crisis stabilization intervention
- Home and community individual psychotherapy
- Community group psychotherapy
- Home and community marital/family psychotherapy
- Home and community family psychoeducation
- Individual and group pharm counseling by RN
- Partial hospitalization
- Peer support
- Family support partners
- Behavioral assistance
- Intensive outpatient substance abuse treatment
- Adult rehabilitative day service
- Individual and group life skills development
- Child and youth support services

Clinic/Home/Community-Based

- Psychiatric diagnostic assessment

Tier 3 Home/Community-Based

- Therapeutic Communities

Residential

- Residential treatment unit and center

Crisis Services Available to all Tiers

- Crisis Intervention
- Acute Psychiatric Hospitalization
- Acute Crisis Units
- Substance Abuse Detoxification

New services in **RED**
Existing Services in **BLUE**

Tier 1 Counseling Level Services

- Can be provided by Independently Licensed Practitioner (ILP) enrolled and certified as a Medicaid provider
 - ILP must have community-based office location and can use office space in a medical practice
- Can be provided by a certified Outpatient Behavioral Health agency
 - Service location can be a physician office, behavioral health clinic, health care center, home or school
- Psychiatric diagnostic assessment is not required
- Primary care physician referral is required for children and adults

Primary Care Physician Referral

- PCP referral is not required due to the Independent Assessment and care coordination that will occur upon transition. The Independent Assessment will determine eligibility for Tier 2 and 3.
- The PCP referral is required for all individuals receiving services in Tier 1
- Individuals can receive three Tier 1 services before a PCP referral is required to continue services
- The PCP referral or PCMH authorization will serve as the prescription for those services
- Enrolled agency or independently licensed practitioner

Provider-Led Arkansas Shared Savings Entities (PASSE)

Paula Stone – Division of Behavioral Services

Melissa Stone – Division of Developmental Disabilities Services

What is a PASSE?

The Provider-Led Arkansas Shared Savings Entity (PASSE) is a new model of organized care created by Act 775. Providers will enter into new partnerships with each other and an experienced organization that will perform the administrative functions similar to insurance companies such as claims processing, member enrollment, and grievances and appeals.

- Providers will retain majority ownership (at least 51%) of each PASSE. Under Act 775, the governing body of each PASSE must include several types of providers licensed to practice in Arkansas including a Developmentally Disabled Specialty Provider, a Behavioral Health Specialty Provider, a hospital, a physician and a pharmacist.
- The PASSE is the entity that will be regulated by the Arkansas Insurance Department (AID) as a risk-based provider organization. It will also be accountable to the Department of Human Services (DHS) under federal rules that provide protections for Medicaid beneficiaries. Beginning Jan. 1, 2019, it will pay for all services provided to its members and perform other administrative functions, very similar to an insurance company.

Responsibilities of the PASSE Phase I

Feb. 1, 2018 through Dec. 31, 2018

- Care Coordination is to be provided by the PASSE, which will be responsible for the coordination of care across multiple systems including BH, DD and Medical treatment
- All BH,DD and medical services will continue to be provided on a fee-for-service basis and will be accessed directly through service providers
- PASSEs will build provider referral networks and individuals determined to need Tier 2 and 3 services will be attributed to a PASSE based upon their relationships with providers in those networks

Responsibilities of the PASSE Phase II

January 2019

- The PASSE will become responsible for their attributed clients total cost of care
- The PASSE will receive an actuarially sound global payment to cover the entire cost of care of all services provided to all the members of a PASSE including but no limited to DD and BH specialty services, primary care office visits, hospitalizations, personal care services and pharmaceutical services
- The PASSE will establish provider networks and will establish reimbursement for their provider networks

Service Provider Options for PASSE Participation

- The majority of providers will simply join a PASSE as a participating provider in the PASSE network of providers. Just as in becoming a participating provider for Medicaid or another insurance company, these providers will agree to be paid to deliver a service to a client/patient under the rules established by the PASSE.
- Some providers may join a PASSE under a shared savings financial arrangement. This higher level of commitment might include receiving value-based incentive payments or shared savings bonuses as well as being paid to provide a direct service.
- A small number of providers will help form the PASSE itself as an equity owner in the PASSE. A PASSE may offer different classes (shares) of equity.
- A provider will likely want to be a network provider in all PASSEs to ensure that there is a continuum of coverage for the beneficiaries served.

Medical Neighborhood Report

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Medical Director

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Contacts

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Questions?



Thank you!