Independent Team Certification and Care Coordination

for Youth Who Receive Residential Treatment

August 19, 2016

DMAS Authority

DMAS has budget authority to make changes to residential treatment services. Item 301.PP of the 2014-16 Appropriation Act states:

> *"The Department of Medical Assistance Services shall make programmatic changes in the provision of Residential Treatment Facility (Level C) and Levels A and B residential services (group homes) for children with serious emotional disturbances in order ensure appropriate utilization and cost efficiency. The department shall consider all available options including, but not limited to, prior authorization, utilization review and provider qualifications. The department shall have authority to promulgate regulations to implement these changes within 280 days or less from the enactment date of this act."*

RTC Project Overview

Mission:

- Transition three of DMAS' most complex programs into models with evidence based treatment approaches, standardized medical necessity criteria, and rigorous program requirements.
- Create a youth and family focused system that will match future Managed Care administration structures, oversight, and contracting requirements.

RTC Project Overview

The objectives of the program changes will be:

- To implement an efficient service model that yields better outcomes to Medicaid individuals using shorter duration and high intensity services.
- To promote care coordination that ensures effective programming and a successful return to the community and home settings.

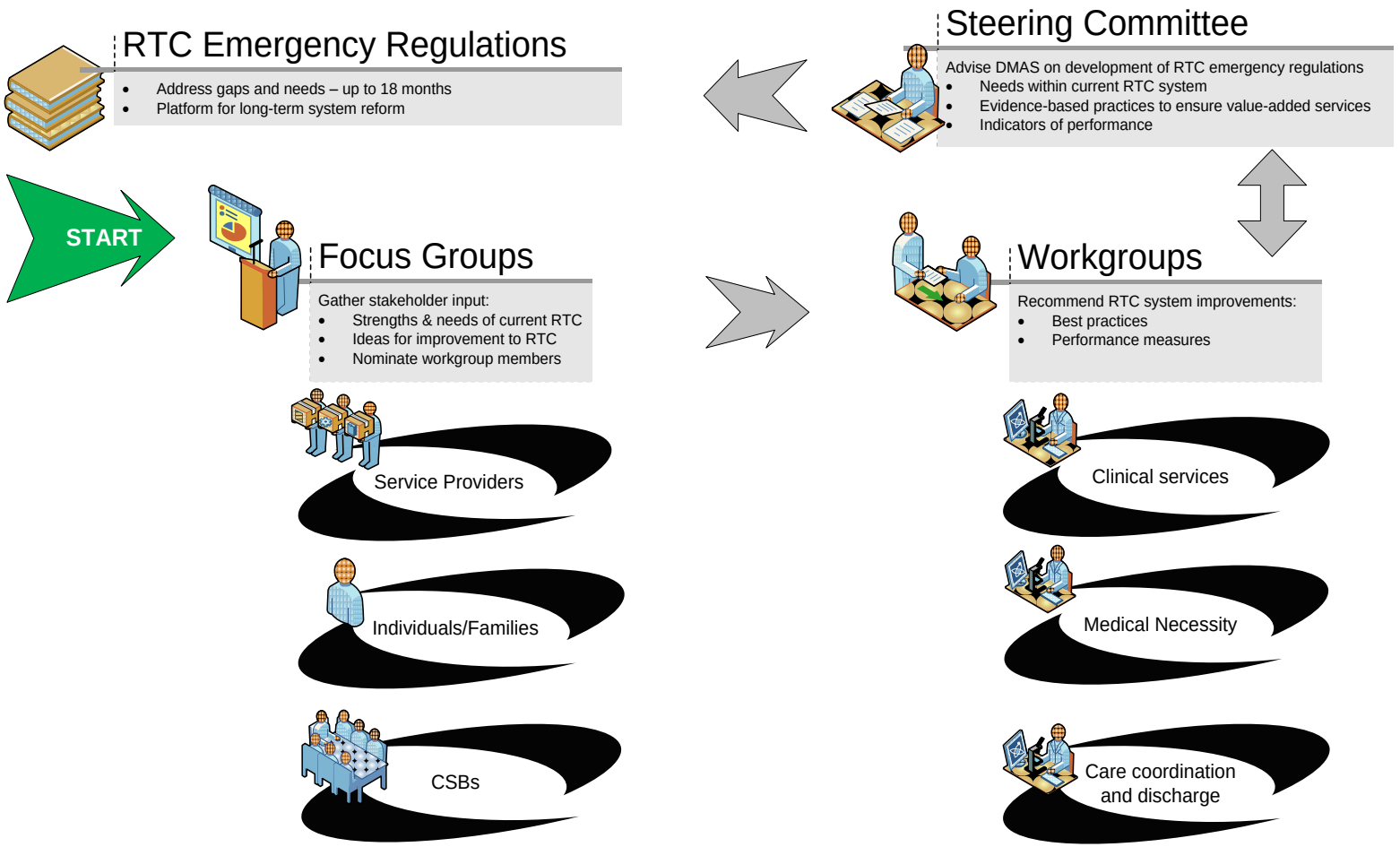
RTC Regulatory Project Focus Groups

- DMAS convened 6 focus groups from September 28, 2015-October 22, 2015.
- Five Distinct Focus Groups Consisted of:
  - Level A Providers: 9/28
  - Level B Providers: 9/28
  - Level C Providers: 9/29
  - Children and Family Services Committee-VACSB 10/8
  - Parents (2 Sessions-NOVA 10/20 and Va Beach 10/22)
- The Focus Groups nominated workgroup members from within the focus groups

RTC Regulatory Project Workgroups

- DMAS convened three workgroups.
  - Five sessions were held from 10/6/2015-10/21/2015.
  - Membership included nominated representatives from focus groups, Providers, OCS, VACSB, DBHDS Licensing, DSS, Parent Advocates, and Magellan.
- Workgroups were organized into three areas:
  - Medical Necessity,
  - Clinical Program Requirements,
  - Care Coordination and Discharge
- Information from the 2014 and 2015 State Executive Council's RTC-Educational Funding workgroups was considered.

PROJECT PLAN



Residential Treatment Focus Groups

Common themes:

- "System" varies widely across the state.
- Effective care coordination is essential but difficult to achieve, i.e., providers, parents, local agencies/CSA, community-based providers.
- Care must be outcomes driven and decisions based on measurable evidence.
- Medicaid's prescriptive program requirements hinder individualized and effective care.

Workgroup Recommendations

Workgroups reviewed current requirements.

Recommendation highlights:

- Reduce prescriptive requirements; examine implementation of individualized service plan; allow justified deviations.
- Require evidence-based/informed, trauma-informed practices.
- Align DMAS, DBHDS, DHP requirements.
- Recognize non-therapy parent activities as “parent involvement,” e.g., psychoeducation.
- Require evidence of discharge planning beginning at admission.
- Consider daily v. weekly requirements (utilization review).

Workgroup Recommendations

Recommendations of the Care Coordination Workgroup include:

- Require the provider to be responsible for care coordination and discharge planning, in collaboration with treatment team.
- Establish specific activities to facilitate discharge: identify and link to community-based services/providers prior to discharge.
- Require Magellan review of discharge plan.

Issues: Level A Group Homes

Workgroups identified the following issues:

- Treatment services require a DBHDS license, but Level A group homes are not licensed by DBHDS.
- Level A and Level B use the same medical necessity criteria.
- The individual must require treatment to be authorized for services.
- Level A group homes are licensed by DSS and do not include treatment as an allowable service.
- Need to work with providers to become DBHDS licensed.

Issues: Independent Team

Workgroup identified the following issues:

- Timely access, process inconsistencies, limits to member choice options, appeal rights concerns, team members may not meet CMS standards in all teams.
- Documented instances when the physician signing the CON has had no contact with the child.
- Current process does not consistently include the individual's MCO or medical home in assessment of need, e.g., for collection of historical information.

Status: DMAS conducted research on how to resolve this issue to promote Building Bridges core values and system of care principles within a managed care environment

Issues: Care Coordination

Workgroups identified the following issues:

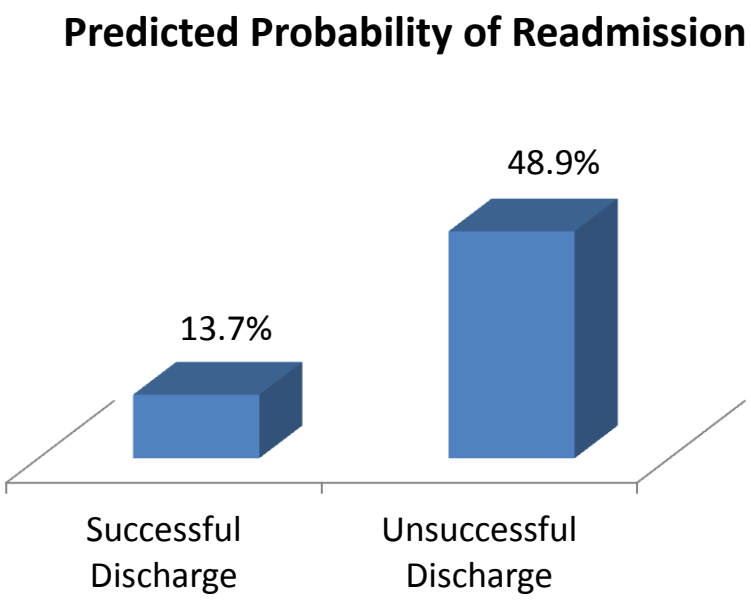
- Ongoing assessment is needed to evaluate progress.
- Providers and local systems do not have a standard way of assessing treatment needs.
- Discharge planning is impacted by local provider engagement and provider knowledge of service availability in each locality.
- Admission and discharge practices are inconsistent. Information is not standardized from treatment providers prior to admission.
- MCO resources are not used, medical home coordination is not used in many cases.

Current Status

- DMAS has drafted and submitted regulatory language to use in the Emergency Regulations.
- DMAS has completed its evaluation of care coordination approaches that will ensure consistent and timely access to care, member choice, coordination with the medical home, and a grievance and appeal process to occur within established CMS requirements.
- DMAS has completed its evaluation of the Certificate of Need Process.

VA Needs Effective Care Management

Successful discharges are predicted to reduce the probability of readmissions by 35.2% *(Magellan Quarterly Report, May 2016)*



NATIONAL RESEARCH SUPPORTS IMPROVED OUTCOMES AND POSITIVE RETURN ON INVESTMENT WITH EFFECTIVE CARE COORDINATION
1. Reduced inappropriate admissions and readmissions.
2. Decreased lengths of stay.
3. Intensive, individualized, and discharge-focused treatment.
4. Improved youth and family functioning post discharge with increased community tenure.

VA Needs Effective Care Management

In focus groups during the Fall of 2015, stakeholders widely expressed belief that good care coordination positively impacts outcomes, but commonly reported that such care coordination is not consistently provided within the current system of care

- 34.5% of high risk members had no paid services prior to the Residential authorization.
  - 28.3% of those received services following discharge.
  - 6.2% of those had no paid services following discharge.

"High Risk" = having spent greater than 450 days in Residential services or having 4 or more initial authorizations for Residential services.

Data Source : Magellan, 9/21/15

WHY	WHAT	HOW	WHO
Improve outcomes for Medicaid members	Single point of entry	Expanded Magellan administrative functions	Medicaid Members
Comply with federal mandates and protect federal dollars	Care coordination and discharge planning		CPMTs & FAPTs

New Process: Independent Team

For individuals eligible for Medicaid at time of admission, team shall include:

- Licensed physician,
- Licensed mental health professional (LMHP) who has competence in diagnosis and treatment of individuals with mental illness;
- Someone who has knowledge of the individual's behavioral health history, service availability in the local service area, and current situation;
- Individual's family or primary caregivers shall be included in the process.

New Process: Independent Team

For individuals who apply and become eligible for Medicaid while inpatient in facility/program, certification shall be made by the team responsible for the plan of care.

Requirements for Independent Certification Teams

- Contract with Magellan.
- Comply with requirements of CFR §441.153 for credentialing and expertise.
- Apply consistent decision-making criteria in line with best practices and Virginia's DOJ Settlement.
- Be subject to quality assurance reviews by Magellan.
- Ensure referral to and coordination with locality-based case managers and CSA teams.

Child & Family Impacts

- Single point of contact for timely assessment of needs and access to necessary services.
- Ensured care coordination.
- Access to the established Medicaid grievance process as mandated by CMS.
- Ensured freedom of choice in service providers as mandated by CMS.
- Ensured care coordination for medical, residential and other behavioral health services.
- Higher probability for improved outcomes.

What Can Localities Expect?

- Localities may chose to become a paid Magellan contractor. Localities will have the right of first refusal to provide this service.
- Reduced administrative burden through partnership with an external independent team.
- Increased collaboration in ensuring effective coordination of care, including commitment to care delivery in the least restrictive setting.

What Can Localities Expect?

- Localities retain authority in determining if a child is eligible for CSA funding. Magellan's referral to the CSA team *does not* make the locality fiscally responsible for the child.
- All children will be referred to the locality.

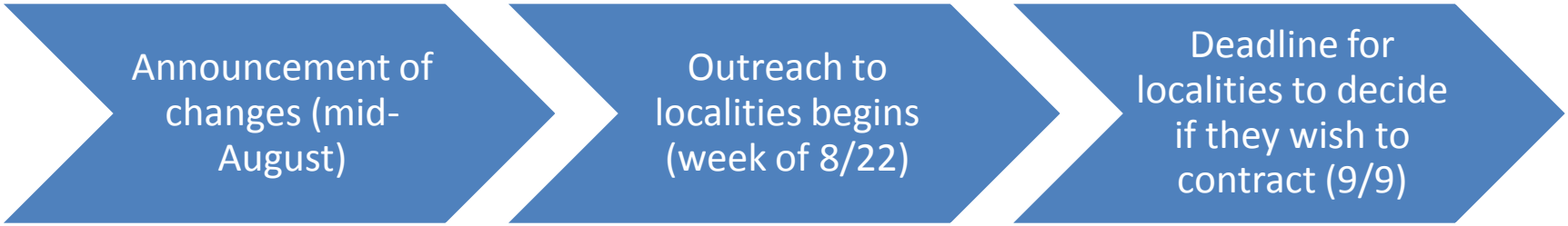
Credentialing/Contracting

- Credentialing is the process used to verify a practitioner's or organization's credentials.
- Magellan credentials providers every three years, in accordance with NCQA requirements.
- The credentialing process includes: Primary Source Verification (PSV) and Regional Network Credentialing Committee (RNCC) review.
- Once the credentialing process is complete Magellan will execute all practitioner/organization contracting documents.
- The Contract documents will include a Magellan Provider Agreement, Medicaid Addendum, and Reimbursement Schedules. All rates will remain the same.

Magellan Care Coordination

- Care Managers coordinate with existing treatment providers for transition planning.
- Planning for discharge at the time of admission.
- Regular communication between FAPT and Magellan.
- Focus on permanency planning and school re-entry post discharge.
- Family support coordinators provide support and education to families to prepare for the child's return to the home/community as well as resource referrals based on their specific needs.
- Developing plans of care when members remain in the community (PRTF diversion) – including safety plans and linkage to other services.

Timeline


Announcement of changes (mid-August)
Outreach to localities begins (week of 8/22)
Deadline for localities to decide if they wish to contract (9/9)

Timeline- Continued

QUESTIONS?