Transitioning to Carved-In Managed Care

A National Perspective

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Stated goal of managed care transitions

"Efficiency"

- Streamline administration
- Incentivize value/outcomes
- Better integrate care

And, ultimately:

reduce state Medicaid expenditures

How well are states doing?

What we do know:

- Financial integration ≠ clinical integration
- Apparent efficiency can be gained by cost-shifting
- Shifts to managed care offer significant opportunities for clinical & service delivery innovation…
  - …For organizations that are sophisticated enough to take advantage
  - Data & quality reporting must be structured to enable this analysis

Managed care transition: 4 case studies

Where were they before? (And did it matter?)

Fee-for-service	Managed BH

*Management was administration-only (ASO)

Big picture: what results do providers report post-transition?

- **Patient access/outcomes:** ranges from neutral to worse
- **Provider pay:** neutral: rates remain low; opportunities for flexible payment arise
- **Burden on providers:** worse
- **State-level savings:** range from neutral to better

Challenges, opportunities & advice

- Provider networks
- Service delivery
- Payment
- Claims, billing, administration
- Data & reporting

Provider networks

- Fears about MCOs failing to contract with providers largely have not been realized
  - **W. Virginia:** the MCOs "have been desperate to contract with BH"
- Contracts require MCOs to contract with all existing providers or establish robust network adequacy standards
- Network adequacy has been a challenge in some places
  - **Florida:** niche providers, crisis stabilization, some orgs in high-saturation areas have had difficulty getting included

Advice: network adequacy

- Require MCOs to contract with all existing CBHOs for at least the first year (Florida) or longer (W. Virginia)
- Educate plans about the continuum of care, need for highly specialized services/providers

Provider credentialing

- Default: all MCOs will have different standards/processes for credentialing providers in their network
  - On top of state-required processes for licensing
- Administrative burden tied to number of MCOs in your region
  - **Florida**: 3-7 MCOs/region
  - **Kansas**: 2-3 MCOs/region
- Advance advocacy needed to ensure uniform credentialing process/stds for all MCOs

Advice: credentialing

- Develop streamlined methods for credentialing providers *as organizations* rather than as individuals (as in W. Virginia)
  - **Florida** cautionary tale: individual credentialing of all providers under different processes for each MCO
- Require MCOs to recognize the state's licensing standards for behavioral health services as necessary and sufficient for entry into the network
- In contracts, specifically address care delivery by peers, paraprofessionals, etc.

Service array: challenges

- Financial integration ≠ clinical integration
- Service definitions, utilization parameters may vary by MCO
- Need to closely examine financial incentives for service delivery & setting
  - **Florida:** inpatient hospital detox paid for by Medicaid, detox in a non-hospital setting is not → incentive for MCO to divert patients into non-hospital settings
  - **Kansas:** State mental health hospital care is not paid for by Medicaid → incentive to send patients to inpatient settings

Service array: opportunities

- Opportunity for flexible service delivery
  - In-home care
  - Wraparound services
  - School-based services
  - Telehealth
- Must be able to demonstrate impact, return on investment
- Reality: these innovations have not been the norm to date

Advice: service array

- Upfront considerations: where are the potential places in the system for cost-shifting to happen?
  - Residential
  - Hospital / IMD
  - Other non-Medicaid services (e.g. jails)
- Require MCOs to adopt uniform definitions of services, qualified providers
  - **Kansas:** MCOs must have the same benefits as the prior PAHP, same service definitions, utilization parameters, processes, etc.

Medication access

- Traditional Medicaid: single P&T committee
- MCOs each may have their own P&T committee, unique formularies, utilization requirements
  - **Kansas:** Formulary reviews, P&T committee meetings technically open to the public but typically conducted behind the scenes
- Patients' access to medications may vary based on which MCO they're enrolled in
- Provider burden of filling out prior authorizations, fail-first paperwork, etc.

Advice: medication access

- Require all MCOs to use a common, state-developed formulary…
- …that includes open access to all FDA-approved mental health and addiction medications
- Use of standardized forms for requesting prior authorization, specified timelines for review and approval of requests, protocols for “prescriber prevails,” generic substitution, etc.

Utilization reviews

- Providers report greater use of concurrent review
- Adds to administrative burden
- Can conflict with providers' determination of necessity of service
  - Medical necessity definitions vary
  - Often not inclusive of or adaptive to BH services/supports

Advice: utilization reviews

- Adopt standard, statewide medical necessity criteria
- Work with state to ensure robust parity enforcement re: NQTLs
  - Medical necessity criteria
  - Formulary restrictions
  - And more…

Payment rates: challenges

- Providers generally report rates are low
  - **Florida:** state sets FFS rate, MCOs may set rates above or below
  - **W. Virginia:** MCOs agreed to pay 105% of FFS; some clinics negotiated up to 110%
  - **Kansas:** rates have remained the same
- Rate issue is no different from status quo
- Broader issue: stagnation of rates over decades, loss of provider purchasing power

Payment rates: opportunities

- Greater flexibility in financing/payment mechanisms
  - Subcapitation
  - Bundled rates / case rates
- Supports flexibility in service delivery, avoids need for prior authorization, other utilization controls
- Used successfully by some orgs in Florida, W. Virginia, Kentucky
  - The “exception, not the norm.”

Advice: payment rates

- Include language in MCO contracts setting payment rates at or above current levels
  - Including any relevant language on subcapitation/cost sharing
- Advocate with your state for rate increases
  - CCBHC demonstration holds promise
- Develop org. capacity to participate in flexible payment models
  - Service delivery, cost reporting
  - Data analytics
  - Population health

Prompt payment of claims

- Providers report difficulties with prompt payment of claims, for example:
  - **Florida:** Increasing incidence of disputed claims
  - **W. Virginia:** System “glitches” result in lower payments; requires appeals, reconciliation process
  - **Kentucky:** Some plans are months in arrears, providers burning through reserves/credit lines
  - **Kansas:** Challenges to “clean claims” & proper submission delay prompt payment
- Results in accounts receivable issues, cash flow problems

Advice: prompt payment

- Build prompt payment timelines into contracts
- Establish clear, uniform definition of “clean claims”
- Deal with the question of interest
  - Interest should be paid if claims are delayed.
  - But interest charges can delay claims; tracking & reconciling requires extra admin time.

Claims processing

- Mismatched technology is a major administrative burden for providers
  - **W. Virginia:** submission of reversals by U.S. mail
  - **W. Virginia:** payment via paper check instead of EFT
  - **Florida:** reconciling claims via telephone
- "Clean claims"
  - Increase in disputed claims reported in all states
- Local vs. remote call center staff
  - High call center turnover, lack of familiarity with local contracts

Advice: claims processing

- “Get good at claims.”
- Require MCOs to use timely, efficient, user friendly processes for authorization and billing; monitor the burden on providers
- Consider requiring MCOs to collaborate on common authorization, billing and credentialing processes/protocols
- Data collection/tracking by state:
  - Monitoring of timely payment not just on clean claims but on all claims; monitor number of disputed claims

Data reporting

- Alignment of MCO/Medicaid reporting with block grant reporting has been a challenge
  - **W. Virginia:** providers forced to double-report so the state can receive needed info for block grant $
  - Service units issue/definition
- EHRs not linked with MCO technologies
  - **W. Virginia:** MCO paper/fax/phone requirements
- On broader level: challenges with tracking BH spend in capitated arrangements

Advice: data reporting

- Consider requiring standardized forms for data reporting
- Build data/cost tracking structures to enable analysis of:
  - Total BH spend
  - BH utilization
  - Reduced costs elsewhere in system attributable to BH services

General advice

- Contracts are key
- Need to educate plans that have not had experience in BH
- Dealing with risk: have a plan in place to protect providers if MCO's costs come out above the PMPM rate
- Address incentives to cost-shift into non-Medicaid services

Questions

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