Bi-annual Stakeholder Meeting

November 19, 2013
November 19, 2013
1pm to 3pm
Victory Building

Bi-annual Stakeholder Meeting

Agenda

1. 1:00-1:05 Welcome and Introductions—Anita Castleberry, DMS
2. 1:05-1:15 Updates to Payment Improvement Initiative
3. 1:15-1:30 Policy Updates – Robbie Nix, DMS
4. 1:30-1:35 Inspection of Care – Jennifer Brezee, ValueOptions
5. 1:35-1:45 Retrospective Reviews – Jennifer Brezee, ValueOptions
6. 1:45-2:00 Overview – Behavioral Health Transformation – Paula Stone, DBHS and Anita Castleberry, DMS

Feedback and additional questions can be sent to ARInspectionofCare@valueoptions.com
Members of the focus groups

<table>
<thead>
<tr>
<th>ValueOptions</th>
<th>Provider Representatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kerri Brazzel – Provider Relations</td>
<td>Joyce Cloud, CEO – The Pointe Outpatient Services</td>
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<tr>
<td>Jennifer Brezee – Clinical Services Manager</td>
<td>Chad Cornelius, Interim Administrator - Methodist</td>
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<tr>
<td>Patricia Gann – Project Director</td>
<td>Jannie Cotton, CEO - Professional Counseling Associates</td>
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<tr>
<td>William Henley- Retrospective Team Lead</td>
<td>Pam Dodson, Clinical Director – Ascent</td>
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<td>Nicole May – Executive Director</td>
<td>Jim Gregory, CEO – Counseling Clinic</td>
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<tr>
<td>Melissa Ortega – Project Director</td>
<td>Ryan Martin, Director of Outpatient Services – Vista Health</td>
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<td>Carol Moore, Clinical Director – Alternative Opportunities/DaySpring</td>
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<td>Lee Roberson-Koone, Director of Children Services – Counseling Associates</td>
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<tr>
<td>State of Arkansas</td>
<td>Jason Turner, Director of Quality Assurance – Families Inc</td>
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<td>Anita Castleberry – DMS</td>
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<td>Vivian Jackson – DMS</td>
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<td>Dr. Laurence Miller - DMS</td>
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<td>Robbie Nix - DMS</td>
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<tr>
<td>Marilyn Strickland – DMS</td>
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<td>Paula Stone – DBHS</td>
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<tr>
<td>Frank Vega - DBHS</td>
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<tr>
<td>Dixie Wallace - DMS</td>
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Updates on Payment Improvement Initiative
Medicaid Policy Updates

Robbie Nix
Robert.Nix@arkansas.gov
501-320-6427
Effective December 1, 2013

Inspection of Care Manual Policy

Review Tools/Checklists that ValueOptions® will use during Inspection of Care of RSPMI and Inpatient Psychiatric Services for Under Age 21 Providers
RSPMI DNKA Policy

• Minimum standards for RSPMI providers to use when discharging beneficiaries

• Non SMI / Non SED
  – Beneficiary misses professional appointment without notifying provider within 14 days:
    • Facility must notify beneficiary (in writing, electronic contact or by telephone) that they will be discharged within 90 days if they choose to not reschedule.

• SMI / SED
  – Beneficiary misses professional appointment without notifying provider, the facility must accomplish follow-up in the following order twice in the 90 day period prior to discharge:
    • Telephone or electronic contact no later than 7 calendar days after missed appointment
    • Letter to beneficiary, family members or other responsible parties with 14 calendar days of the missed appointment if no response to telephone or electronic attempt

• No later than the 90th day after the last failed appointment, if all efforts to engage the beneficiary in treatment have been unsuccessful, then an official letter must be sent to the beneficiary explaining the reasons for discharge and advising the beneficiary that services are available in the future upon request
RSPMI DNKA Policy

• Reduces administrative burden if beneficiary returns for care

  – If beneficiary returns following a discharge for dropping out of services, but prior to the expiration of the Psychiatric Diagnostic Assessment (PDA), then the beneficiary may resume treatment and be readmitted with:
    • Mental Health Professional Intervention and/or Pharmacologic Management
    And
    • Periodic Review of the Treatment Plan occurring within 14 days of reentering care

  – All other treatment planning timelines will resume
RSPMI DNKA Policy

- RSPMI Stakeholders group has reviewed proposed policy and provided comments/questions which led to changes
- Plan to begin promulgation process for policy at end of November, first of December which entails the formal public comment period
- For copies of proposed policy, please contact Robbie Nix at Robert.Nix@arkansas.gov or 501-320-6427
Inpatient Psychiatric Criteria Policy

• For Acute Inpatient Mental Health and Residential Treatment Services

• Includes:
  – Admission Criteria
  – Exclusion Criteria
  – Continued Stay Criteria
  – Discharge Criteria

• Will be placed in Inpatient Psychiatric Services for Under Age 21 Manual
Inpatient Psychiatric Criteria Policy

• Policy is currently being finalized internally within DMS

• Once final approval is obtained internally within DMS/DHS, the promulgation process will begin
Behavioral Health Transformation

• Includes:
  – Multiple State Plan Amendments (SPAs)
  – Provider Manual Overhaul
  – Payment / Reimbursement Overhaul
Inspections of Care – IP/OP
http://arkansas.valueoptions.com
Welcome to ValueOptions® Arkansas Provider Online Services!

ProviderConnect

Login or register with ProviderConnect, an online tool that allows you to update your provider profile, request inpatient and outpatient authorizations and more. ProviderConnect is easy to use, secure, and available 24/7.

ValueOptions®, the Administrative Services Organization (ASO) for the Arkansas Division of Medical Services (DMS), provides utilization and quality control peer review for outpatient behavioral health services to qualifying Arkansas Medicaid beneficiaries. ValueOptions also is the Administrative Services Organization (ASO) which provides utilization and quality control peer review for inpatient psychiatric services for Arkansas Medicaid beneficiaries under the age of twenty-one.

Inpatient utilization and quality control peer review activities include the following:

- Certification of Need and determination of medical necessity for admission
- Continued stay and quality of care for inpatient psychiatric treatment by providers who are enrolled in the Arkansas Medicaid inpatient psychiatric program
- Care coordination in connection with admission diversion
- Discharge planning
- De-institutionalization for beneficiaries meeting predefined benchmarks
http://arkansas.valueoptions.com
For Providers: Focus Groups: Inspection of Care:

**Presentations**

- 10-31-13 Proposed IOC Revisions to Inpatient Psych
- 10-31-13 Proposed IOC Revisions to RSPMI
- 09-09-2013 Updates to IOC Notification
- OP CAP request
- IP CAP request
- Proposed DNKA Policy 07-08-13
- Proposed OP IOC Facility Tool Checklist 07-08-13
- Proposed IP IOC Facility Tool Checklist 07-08-13
- IOC INPT Clinical Record Review Checklist
- 05-06-13 Proposed revision to Inpatient IOC Report
- IOC OP Clinical Record Review Checklist
  - Proposed IOC revisions to RSPMI
  - Proposed IOC revisions to Inpatient Psych
  - 04-08-13 Proposed revision to Outpatient IOC Report
  - Proposed OP – IOC Policy Revisions
  - Proposed INP – IOC Policy Revisions
  - Proposed DNKA policy
Retrospective Reviews
Timeline for Retrospective Reviews

- Review completed by ValueOptions within 45 calendar days
- Adverse findings
  - Adverse determination letter sent to provider and beneficiary. DMS notified of findings
- No adverse findings
  - Determination letter sent to provider.
Reconsiderations and Appeals

ValueOptions sends provider/beneficiary Notification of Adverse Findings

Reconsideration is submitted within 30 days

Retro reviewed by second psychiatrist

2nd psychiatrist's upholds initial denial

Reconsideration is not submitted

Recoupmont sent to HP

Provider or beneficiary have the option to file an appeal with the Office of Hearings and Appeals within 30 days after the initial denial or reconsideration denial

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Results

*see Retrospective Review Results under “Presentations” Section of IOC Focus Group on arkansas.valueoptions.com
## Results so far…

<table>
<thead>
<tr>
<th></th>
<th>1&lt;sup&gt;st&lt;/sup&gt; Quarter - 2012</th>
<th>2&lt;sup&gt;nd&lt;/sup&gt; Quarter - 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 50 beneficiaries</td>
<td>• 100 beneficiaries</td>
<td></td>
</tr>
<tr>
<td>• 25 Outpatient RSPMI Providers represented</td>
<td>• 27 Outpatient RSPMI Providers represented</td>
<td></td>
</tr>
<tr>
<td>• 3 Reconsiderations were submitted, all three were overturned upon reconsideration</td>
<td>• 1 Reconsideration was submitted, the denial was upheld upon reconsideration; but overturned upon Appeal</td>
<td></td>
</tr>
<tr>
<td>• 14 beneficiaries received recoupment for a total of 39 units of services</td>
<td>• 29 beneficiaries received recoupment for a total of 122 units of services</td>
<td></td>
</tr>
</tbody>
</table>
## Results so far…

<table>
<thead>
<tr>
<th>3&lt;sup&gt;rd&lt;/sup&gt; Quarter - 2012</th>
<th>4&lt;sup&gt;th&lt;/sup&gt; Quarter - 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>150 beneficiaries</td>
<td>199 beneficiaries</td>
</tr>
<tr>
<td>30 Outpatient RSPMI Providers represented</td>
<td>36 Outpatient RSPMI Providers represented</td>
</tr>
<tr>
<td>5 Reconsiderations were submitted, 3 were upheld and 2 were overturned upon reconsideration</td>
<td>10 Reconsiderations were submitted, 9 were upheld and 1 was overturned upon reconsideration</td>
</tr>
<tr>
<td>80 beneficiaries received recoupment for a total of 188 units of services</td>
<td>103 beneficiaries received recoupment for a total of 630 units of services</td>
</tr>
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</table>
## Results so far…

<table>
<thead>
<tr>
<th>1st Quarter - 2013</th>
<th>2nd Quarter - 2013</th>
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</thead>
<tbody>
<tr>
<td>(January 1, 2013 to March 30, 2013)</td>
<td>(April 1, 2013 to June 30, 2013)</td>
</tr>
<tr>
<td>• 264 beneficiaries</td>
<td>• 264 beneficiaries</td>
</tr>
<tr>
<td>• 34 Outpatient RSPMI</td>
<td>• 34 Outpatient RSPMI</td>
</tr>
<tr>
<td>Providers represented</td>
<td>Providers represented</td>
</tr>
<tr>
<td>• 4 Reconsiderations were</td>
<td>• 0 Reconsiderations submitted</td>
</tr>
<tr>
<td>submitted, 2 were upheld</td>
<td>as of 11/18/2013</td>
</tr>
<tr>
<td>and 2 were overturned</td>
<td></td>
</tr>
<tr>
<td>upon reconsideration</td>
<td></td>
</tr>
<tr>
<td>• 130 beneficiaries</td>
<td></td>
</tr>
<tr>
<td>received recoupment for</td>
<td></td>
</tr>
<tr>
<td>a total of 918 units</td>
<td></td>
</tr>
<tr>
<td>of services</td>
<td></td>
</tr>
<tr>
<td>**43 total # of RSPMI</td>
<td></td>
</tr>
<tr>
<td>providers represented</td>
<td></td>
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<tr>
<td>since 7/1/2012</td>
<td></td>
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</table>
Trends...

• **Periodic Review of Master Treatment Plan**
  – Not in cooperation with beneficiary

• **Psychiatric Diagnostic Assessment**
  – Late or missing and services provided

• **YOQs**
  – Missing
Overview – Behavioral Health Transformation
Building a healthier future for all Arkansans

Behavioral Health Transformation
November 19, 2013
This integrated system includes health homes, behavioral health services, independent assessments and care plans.

**Tier 1**
- **PCMH** provides care mgmt. adequate for BH care
- **BH provider** performed by PCMH

**Tier 2**
- **BHH** required to manage frequent BH services
- **Care mgmt.**: Performed by BHH

**Tier 3**
- **BHH** intensely manages BH & support services
- **Care mgmt.**: Performed by BHH

**Population by Tier**
- **Tier 1**: Total: ~90,000
  - 70% youth
  - 30% adult
  - 17% IP
- **Tier 2**: Total: ~10-15,000
  - 82% youth
  - 18% adult
  - 17% IP
- **Tier 3**: Total: ~5,000
  - 72% youth
  - 28% adult

**Core Spend by Tier**
- **Tier 1**: 79% OP, 21% IP
- **Tier 2**: 83% OP
- **Tier 3**: 44% OP, 56% IP
<table>
<thead>
<tr>
<th>Tier 1</th>
<th>Tier 2</th>
<th>Tier 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services Available</td>
<td>Tier 1 Services</td>
<td>Tier 1 and 2 services</td>
</tr>
<tr>
<td>Access</td>
<td>No Prior Authorization or Independent Assessment required</td>
<td>An Independent Functional Assessment and Independent Care Plan is required to access services</td>
</tr>
<tr>
<td>Clinician Driven Diagnostic Evaluation</td>
<td>A clinician driven diagnostic evaluation is completed and drives treatment</td>
<td>A clinician driven diagnostic evaluation is completed and drives treatment</td>
</tr>
<tr>
<td>Psychiatric Diagnostic Assessment</td>
<td>Psychiatric Diagnostic Assessment is available to bill, but not required</td>
<td>Psychiatric Diagnostic Assessment is available to bill and required</td>
</tr>
<tr>
<td>Care Management</td>
<td>Care is Managed by the Patient Centered Medical Home</td>
<td>Care is Managed by the Behavioral Health Home</td>
</tr>
<tr>
<td>Crisis and Acute Services</td>
<td>Immediate Access to Crisis and Acute Services are Available and based on Clinician’s judgment and evaluation</td>
<td>Immediate Access to Crisis and Acute Services are Available and based on Clinician’s judgment and evaluation</td>
</tr>
</tbody>
</table>
Preliminary: new behavioral health services to be offered

BH client population

Tier 1

Clinic-Based
- Individual behavioral health counseling
- Group behavioral health counseling
- Marital/family behavioral health counseling
- Multi-family behavioral health counseling
- Psychoeducation
- Mental health diagnosis
- Interpretation of diagnosis
- Substance abuse assessment
- Psychological evaluation
- Psychiatric assessment
- Pharmacologic management

Tier 2

Low-needs services +...

Home/Community-Based
- Master treatment plan
- Home and community individual psychotherapy
- Community group psychotherapy
- Home and community marital/family psychotherapy
- Home and community family psychoeducation
- Partial hospitalization
- Peer support
- Family support partners
- Behavioral assistance
- Intensive outpatient substance abuse treatment
- Aftercare recovery services

Clinic/Home/Community-Based
- Psychiatric diagnostic assessment

Tier 3

Medium-needs services +...

Home/Community-Based
- Individual life skills development
- Group life skills development
- Child and youth support services
- Individual recovery support
- Group recovery support

Residential
- Planned respite
- Residential treatment unit and center
- Crisis residential treatment
- Therapeutic communities

Health Home services available in Tiers 2 & 3
- Care management (Tier 2)
- Intensive care management (Tier 3)
- Wraparound facilitation (Tier 3)

Crisis services available to all Tiers
- Acute psychiatric hospitalization
- Mobile response and crisis stabilization
- Acute crisis units
- Substance abuse detoxification

1 Services are cumulative; any service available in Tier 1, will also be available in Tiers 2 and 3. Similarly, any service available in Tier 2 will also be available in Tier 3.
Client Journey – George

**Diagnosis**

At George’s primary care visit, the nurse screens for mental health and substance abuse issues and identifies signs of depression and excessive alcohol use. George’s physician prescribes medication and begins to provide medication management.

**Tier 1: Treatment and Coordination**

George is also referred for additional Tier 1 services, including individual behavioral health therapy to address depression and substance abuse. While receiving Tier 1 services, George’s care is coordinated by his PCMH.

**Referral**

After receiving Tier 1 services for over a year, George has a relapse, and his symptoms worsen. George also loses his job and his living situation becomes unstable. With input from George, his therapist, and physician, George’s care coordinator refers George for an independent assessment.

**Independent Assessment**

A face-to-face independent functional assessment with George confirms that he has a functional impairment that requires care management through a behavioral health home and confirms the need for Tier 2 services.

**Tier 1: Treatment and Coordination**

George now manages his depression through regular medication management and occasional clinic-based therapy appointments in Tier 1; his care is coordinated through his PCMH.

**Independent Assessment and Transitional Planning**

It has been a year since George’s last independent assessment. Since then he has gained employment and a stable living situation. The reassessment confirms that he is ready to transition out of the health home. After an interdisciplinary team meeting with George and his providers, transitional planning occurs to transition George’s care to his PCMH.

**Tier 2: Treatment and Care Management**

Through a behavioral health home, George receives care management. He also utilizes peer support services and intensive outpatient substance abuse treatment through a Tier 2 provider.

**Independent Care Plan**

The independent assessor develops an initial individualized care plan that is supplemented with input from George, and specifies the types of services, including aftercare recovery support, that he will need to maintain stability and make inroads to recovery.
Client Journey – Liz

**Diagnosis**
Liz, age 44, has been receiving Medicaid services for the last ten years from various providers. She has been diagnosed with schizophrenia and has substance abuse issues. Liz has recently been hospitalized. Liz also has a history with the criminal justice system and is at risk of returning to jail if she relapses.

**Crisis and Referral**
Liz begins treatment with a new behavioral health provider after relocating. She has been self-medicating and does not have a place to live. After a few months of therapy, medication management, and PCMH care coordination, Liz stops showing up for appointments. Therefore, her behavioral health provider refers her for an independent assessment.

**Independent Assessment**
The PCMH Care Coordinator and Liz’s therapist work with Liz to schedule an appointment for an independent assessment. The face-to-face independent functional assessment confirms that she has a functional impairment that requires care management through a behavioral health home and confirms the need for Tier 3 services.

**Independent Care Plan**
The independent assessor develops an individualized care plan that is supplemented with input from Liz, and specifies the number of visits, therapy sessions, and other support services, including Peer Support and Recovery Support, that she will need to maintain stability and make inroads to recovery.

**Independent Assessment**
Liz has continued to receive Tier 3 services and works closely with her behavioral health home. It has been a year since Liz’s last independent assessment, she receives an assessment which indicates her functional need to continue to receive Tier 3 services and Care Management through a Behavioral Health Home.

**Mobile Crisis Team**
The Mobile Crisis team is able to stabilize Liz. She is then transported to an Acute Crisis Unit where she stays for two days. She is able to avoid hospitalization due to her health home’s assistance and management of additional services.

**Crisis**
Liz presents in the community in a crisis situation. Her family members reference the crisis plan they developed with the health home. Instead of calling the police, a neighbor calls Mobile Response and Crisis Stabilization.

**Tier 3: Treatment and Care Management**
Liz works with her Health Home Care Coordinator and behavioral health provider to determine that Medication Management and Individual Recovery Support Services, which includes housing support and assistance with her budget, would increase her quality of life and assist in managing her stress. She also continues to work with her PCMH.
Client Journey – Ben

**Identification**

Ben’s school performance is average, but lately his first grade teacher has noticed out of the norm acting out and an inability to focus in a classroom setting. Ben’s teacher shares his concern with Ben’s parents. His parents have also noticed the issues at home.

**Diagnosis**

Ben’s parents bring him to his PCMH. The provider completes an evaluation and diagnoses him with Level I ADHD with no comorbidity.

**Tier 1: Treatment and Coordination**

The PCMH completes a Quality Assessment and initiates a trial of first line stimulant medication to treat the symptoms of ADHD. Ben sees his physician every three months to ensure the treatment is on track.

**Continuing Care Certification**

After twelve months of treatment, Ben’s physician, and family agree that treatment is going well. The PCMH therefore completes the Continuing Care Certification and the course of treatment by the PCMH continues.

**Family Engagement**

Ben’s family is engaged in treatment and he continues to reside with his family including one sibling. His teacher has reported some improvement in his behavior over the past few months.
### Treatment in Current System

Annie has been in foster care for 6 years and has had 7 placements. She received a trauma screen at the outset of treatment and the results were used to develop treatment interventions. She has been diagnosed with Bipolar Disorder and presents with oppositional symptoms. She has been receiving behavioral health services for 5 years.

### Referral

With the Payment Improvement Initiative system transition, Annie is referred for an independent assessment due to her complex diagnosis, multi-system involvement, and high utilization of services informs the need for an independent functional assessment.

### Independent Assessment

A face-to-face independent assessment identifies that Annie has recently been expelled from school, attempted suicide, and ran away from her foster home. These functional issues along with her clinical history and interviews with her foster family indicate that she would benefit from Tier 3 services and Wraparound through a behavioral health home.

### Independent Care Plan

Annie’s independent care plan, which was driven by the independent functional assessment, outlines Annie’s need for Child and Youth Support Services and Psychotherapy.

### Independent Assessment

It is now time for Annie’s annual independent assessment. Therefore, her behavioral health home care coordinator works with her foster parents to schedule her an independent assessment. The re-assessment shows that Annie has made strides, but would still benefit from Care Management and support services. Therefore, she transitions to Tier 2.

### Transitional Care Services

Annie is discharged after six weeks. Her behavioral health home works diligently to coordinate support services, including Child and Youth Support Services, and Behavioral Assistance, to keep her in a community setting. In addition, the health home establishes a crisis plan to more effectively handle crisis situations.

### Discharge Planning

The PRTF and Care Coordinator work together to complete an abbreviated assessment of Annie to guide her discharge plan. They work with the foster parents and her school to prepare for her return by arranging for identified home and community based services.

### Residential Treatment

After multiple crises, Annie is admitted in to a psychiatric residential treatment facility (PRTF). While Annie is receiving residential services, her behavioral health home insures that her foster parents are able to attend family therapy sessions.
Questions?
Thank You

Presented by
ValueOptions, DMS and DBHS

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