Healthier WASHINGTON

Best Practices/Lessons Learned in Preparing Behavioral Health Providers for Integrated Managed Care

March 2018

Introduction

Xpio Health is a technology and behavioral health care consulting firm that provided technical assistance to behavioral health providers in the Southwest Washington (SWWA) and North Central regions during their transitions to integrated managed care (IMC).

Xpio has submitted reports identifying challenges, recommended solutions, and lessons learned/best practices from the early and mid-adopter regions. Additionally, the Washington State Health Care Authority (HCA) has received feedback from North Central behavioral health providers based on their recent experience transitioning to the IMC model.

This document compiles the lessons learned/best practices from Xpio's experience in SWWA and North Central, as well as the experience of providers in the North Central region, to help inform and improve the transition process for future IMC regions.

Contact information, communication, and collaboration

1. Managed Care Organization (MCO) collaboration to try to streamline requirements as much as possible is very beneficial.
2. It is a best practice to set up a workgroup, alliance, or collaborative that consists of Medicaid behavioral health providers, so that HCA, consultants, MCOs, etc. can easily distribute information and communicate with the key providers who are most significantly impacted. This could be set up by the providers themselves, the Behavioral Health Organization (BHO), the Accountable Community of Health (ACH), etc.
3. Routine, ongoing conversations with HCA and MCOs/Administrative Service Organizations (ASOs) is very beneficial.
    a. "Drop in" meetings from MCOs can be disruptive, but scheduled meetings can be priceless in obtaining specific information about specific tasks.
4. MCOs should be clear early on in the process about the names of their organization and parent organization(s) as well as their portal names (i.e. Anthem vs. Amerigroup vs. Availity vs. Payspan).
5. MCOs should be clear early on about the clearinghouse(s) they use.
6. Each MCO and the ASOs should provide a contact list with their employees' photos, email addresses, phone numbers, and areas of expertise.

Billing/payment and technical assistance

1. Bringing on a consultant to provide technical assistance to Behavioral Health Agencies (BHAs) was extremely helpful (e.g., setting up 837P for claims reporting, testing claims submission process, training BHA staff, assistance with electronic health records

implementation, etc.). For some providers, the transition would have been very difficult and problematic without this assistance.

2. Make the technical assistance available at least six months prior to go-live and through at least the first two months after go-live.
3. It is critical that BHAs are upfront and clear about what payment methodology works best for them, and they should work with each payer to identify invoicing procedures (if applicable) prior to implementation in order to avoid payment lag.
    a. Payment will not be the same as the BHO/Regional Service Network (RSN) payment schedule, so BHAs need to prepare for those differences. The BHOs usually use one method for all funding sources, and providers are often used to getting a lump sum payment once or twice a month. New payment methodology may vary between capitated (MCOs), cost reporting (ASO), block grant (ASO), and some fee-for-service (FFS) (ASO for specialized funds).
    b. Ideally, providers should have reserve funds so that they have enough cash flow in the early months while they are in the process of submitting claims/invoices, etc.
    c. MCOs/ASOs may initially offer FFS contracts, but that methodology may not work for BHAs that are used to the capitated rate system of the BHO.
4. MCO/BHA contracts should allow adequate time so that BHAs obtain claims and reporting requirements early on and have adequate time/resources to clarify understanding of requirements and configure/test their data systems before the transition date.
5. It is important to conduct claims testing early so there is time to identify and correct claim rejections and reconfigure BHA/MCO data systems as needed.
6. BHAs should ensure that they understand the difference between submitting claims (requesting payment) and submitting encounters (reporting service).
7. BHAs should ensure that they understand clearinghouse procedures relating to claims/encounters submission.
8. Ongoing support (i.e., ongoing support contracts between the BHAs and a consultant) after the transition supplements agency teams and provides the extra resources to address the additional workload of a major technology project.

Data reporting, retention, and tracking

1. The MCOs/ASOs should be upfront with BHAs about the amount of data they will need in order to satisfy their contracts with HCA and what requested actions BHAs will need to manually track and report.

   a. For example, the ASO needs specific client data in order to enter the person into ProviderOne or HCA reporting that was initially in the state uploads. Daily crisis notes are also required to be shared with the ASO, which is a process change.

2. All existing BHO-contracted providers should use the Qualis Self-Assessment Toolkit that was specifically designed to assess Washington State BHO providers' capacity to transition to the MCO model. If you do not have this assessment or have questions about it, email Samantha Zimmerman: Samantha.Zimmerman@hca.wa.gov.

3. BHAs may need assistance to preserve historical clinical information and documents to meet Washington records retention regulations, if they are moving to a new system as part of the IMC transition.

   a. By law, BHAs must keep clinical documentation preserved and accessible for up to 10 years. While most EHR vendors provide for the import of select client data into their EHR systems under the conversion provisions, only current open active clients and modest data sets like active diagnosis and demographic data is included. Other information like progress notes, medication, clinical records, releases of information, and other scanned documents or paper documents are typically not included. Thus, all BHAs need a solution for obtaining and storing this information.

Other lessons learned/best practices

1. BHAs looking to switch to a new electronic health record (EHR) system should explore what other BHAs in the region are switching to and try to coordinate these efforts/implement the same system, if practicable.

   a. In SWWA, all seven BHAs that received technical assistance contracted with the same EHR system (CareLogic). This model substantially improved individual BHA data autonomy, provided HIPAA and CFR 42 Part 2 compliance, and substantially reduced cost by implementing all BHAs together on the same system – both by sharing implementation resources and by leveraging reports/forms/other configurations that could be shared across the BHAs.

   b. These BHAs have formed a local user group to share system experiences and collaborate on solutions to processing or procedural challenges.