

○ ○ ○ | **Accessing,
Coordinating and
Sustaining Services**

Where Social Services and Mental Health Intersect

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○ ○ ○ | **Introductions**

A little about us and a little about
you...

○ ○ ○ | **What you can expect
today...**

- Overview of relevant changes to treatment system
- What you should and should not expect
- Things you to know & can do to improve outcomes for you, the families you serve and your agency

○ ○ ○ | **The Current System is in Transition**

- Previously, 23 Local Management Entities (LME's) existed to ensure access to publically funded treatment services to individuals with mental health, substance abuse and/or intellectual or developmental disabilities
- Point of entry for individuals with no insurance or Medicaid

○ ○ ○ | **The Transition Has Started**

- Consolidation of LME's to meet requirements to be Managed Care Organizations (MCO's)
- This process has already started
 - Successful implementation at PBH from 2005
 - Expansion of PBH-October 2011
 - Western Highlands Network-January 2012
 - ECBH-April 2012
 - Sandhills & Smoky Mountain Center-July 2012
 - Pathways, Eastpointe, Mecklenburg, Durham, Centerpointe, Southeastern Center-Jan 2, 2013
 - Hot off the press, Wake is officailly partnering with Durham

○ ○ ○ | **MCO's & Waiver**

- A "waiver" allows for approved alternate services from standard Medicaid services.
- MCO's will implement the Home & Community Based Supports (HCBS) (b) & (c) waivers (an expansion of a previous NC waiver through PBH)
- HCBS program permits NC to furnish an array of home & community based supports that assist Medicaid recipients to live in the community & avoid institutionalization

○○○ | **Understanding Some Jargon**

- 1915 (b)(3) & (b)(4)
- (b)(3) employs cost savings to furnish additional services
- (b)(4) allows selective contracting & limits the number of providers

○○○ | **Why the Change?**

- Do or die.
- Either pick a partner or be absorbed by another LME-MCO as of January 2013.

○○○ | **Goals of Waiver**

- Improved access to care
- Predictable Medicaid costs
- Combine management of state & Medicaid services funds at community level
- Increase consistency & efficiency
- Support purchase & delivery of best practice

○○○ | **Goals Cont'd**

- Ensure services are managed & delivered within a quality management framework
- Empower the LME-MCO to build partnerships with consumers, providers and community stakeholders to provide a more responsive system of community care

○○○ | **MCO "Services"**

- Enrollment & monitoring of providers
- Call center
- Ensure consumers with greatest need access care and have treatment plans
- Authorize medically necessary services
- Pay for mh/sa/idd services

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- Provide education to consumers about all Medicaid benefits
- Provide due process (appeals, etc.)
- Service gap analysis & community development
- CCNC collaboration

○ ○ ○ | **MCO Tools**

...the LME is responsible to manage care within the amount provided. They can provide this management by using tools such as:

- Care coordination
- Flexible rate setting
- Managing the provider network
- Utilization management

○ ○ ○ | **Care Coordination**

Per 42 CFR 438.208 Coordination & Continuity of Care

- States must ensure that MCO's...
 - Ensure that each enrollee has an ongoing source of primary care or an entity responsible for coordinating health care services
- Implement mechanisms for:
 - Identifying
 - Assessing
 - Producing a person centered treatment plan for an individual with special health care needs
 - Access to specialists

○ ○ ○ | **Special Healthcare Needs**

Intellectual and/or Developmental Disabilities:
Individuals who are functionally eligible for, but not enrolled in, the Innovations waiver, who are not living in an ICF-MR facility

OR

Individuals with an intellectual or developmental disability diagnosis who are currently, or have been within the past 30 days, in a facility operated by the Department of Correction (DOC) or the Department of Juvenile Justice and Delinquency Prevention (DJJDP) for whom the LME has received notification of discharge.

○ ○ ○ | **Child Mental Health/Special Health Care Needs**

Children who have one of the following diagnoses:

293-297.99	298.8-298.9	300-300.99	302-302.6	302.8-302.9	307-307.99
308.3	309.81	311-312.99	313.81, 313.89	995.5-995.59	V61.21

And a current CALOCUS Level of VI, or who are currently, or have been within past 30 days, in a facility (including a Youth Development Center and Youth Detention Center) operated by the DJJDP or DOC for whom the LME has received notification of discharge.

○ ○ ○ | **Adult MH/SA & Co-occurring/Special Health Care Needs**

Adult Mental Health:

- Adults who have a diagnosis within the diagnostic ranges of:

295-295.99	296-296.99	298.9	309.81
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And a current LOCUS Level of VI.

Substance Dependent:

- Individuals with a substance dependence diagnosis and current ASAM PPC Level of III.7 or II.2-D or higher.

Opioid Dependent:

- Individuals with an opioid dependence diagnosis and who have reported to have used drugs by injection within the past 30 days.

Co-occurring Diagnoses:

- Individuals with co-occurring diagnosis may be a combination of mental health, substance abuse and/or intellectual or developmental disability. The following criteria are required to be considered special health care needs:
 - Individuals with both a mental illness diagnosis and a substance abuse diagnosis and a current LOCUS/CALOCUS of V or higher, or current ASAM PPC Level of III.5 or higher;
 - Individuals with both a mental illness diagnosis and an intellectual or developmental disability diagnosis and current LOCUS/CALOCUS of IV or higher; or
 - Individuals with both an intellectual or developmental disability diagnosis and a substance abuse diagnosis and current ASAM PPC Level of III.3 or higher.

○ ○ ○ | **Care Coordination**

“Care Coordinators manage the person’s care across the care continuum, throughout various care settings, and work in conjunction with the person, providers, payers and others to improve outcomes and make the best use of health care dollars...”

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○ ○ ○ | **MCO Care Coordination & Case Management**

- The Case Management service definition ceases as of July 1, 2012
- Care Coordination has some functions of case management but isn't case management
- Is a politically hot topic because of Session Law 2011-264
- Is a local hot topic because of potential impact on guardianship & residential placements

○ ○ ○ | **What All This Means to You**

- Local authorization of enhanced Medicaid and state-funded services
- Opportunity to engage the LME-MCO regarding service needs/gaps as a stakeholder
- Feedback loop regarding provider quality
- Administrative MCO care coordination for the most at risk adults & children

○ ○ ○ | **Names You or Your Director Should Know**

- CEO
- Provider Network Director
- Care Coordination Director
- Clinical Operations or Utilization Management Director
- Why?

○○○ | **What This Doesn't Mean**

- Unrestricted access to all mental health, substance abuse or intellectual/developmental disabilities services in all counties for all people
- Unrestricted, immediate access to inpatient or out of home placements

○○○ | **Accessing Services**

- The LME-MCO or the individual can make an appointment with a service provider
- The service provider completes an assessment
- The assessment is connected to a treatment plan
- The assessment & treatment plan support a treatment authorization request
- Service is approved or denied by the MCO

○○○ | **Medical Necessity**

- "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem];
- The provider must document how a particular service, product, or procedure will correct, improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.
- <http://www.ncdhhs.gov/dma/mp/8a.pdf>

○ ○ ○ | **Medicaid & Medical Necessity**

- Medicaid covers procedures, products, and services related to this policy when they are:
- Medically necessary and
 - the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs;
 - the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
 - the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

○ ○ ○ | **Medical Necessity**

- Court orders don't determine medical necessity, a quality comprehensive clinical assessment does
- A psychological evaluation is not the same thing as a comprehensive clinical assessment → PE's cost more and should be used in specialized circumstances
- If you consistently order PE's, you are reducing the numbers of state-funded parents that can receive an assessment

○ ○ ○ | **Reasonable Expectations of a Comprehensive Clinical Assessment**

- Chronological general health & behavioral health history (MH & SA) of symptoms, treatment (tx), tx response & attitudes about tx over time, emphasizing factors that have contributed to or inhibited previous recovery efforts;
- Biological, psychological, familial, social, developmental & environmental dimensions & identifies strengths, weaknesses, risks, & protective factors in each area;
- Description of presenting problems, including source of distress, precipitating events, associated problems or symptoms, recent progressions, & current meds;

○ ○ ○ | Expectations cont'd.

- Strengths, protective factors, & problem summary which addresses risk of harm, fxnal status, co-morbidity, recovery environment, & tx and recovery history; strengths-based assessment identifying consumer & family fxnal strengths including natural supports, preferences, needs, & cultural information specific to family;
- Evidence of consumer & legally responsible person's (if applicable) participation in the assessment;
- Recommendation regarding target population eligibility (needed only for state-funded services);

○ ○ ○ | And Most Importantly to You

- Analysis & interpretation of the assessment information with an appropriate case formulation; and
- Diagnoses on all five (5) axes of DSM-IV; & recommendations for additional assessments, services, support, or treatment based on the results of the CCA.

○ ○ ○ | Services = What?

Basic benefit vs Enhanced services

- Basic benefit services are unmanaged visits that do not require prior authorization thru Medicaid (ex. 16 visits if a child, 8 visits if an adult <http://www.ncdhhs.gov/dma/bulletin/0611bulletin.htm#cla>)
- Enhanced services require prior authorization and typically include a community based team approach to treatment

○ ○ ○ | **Examples of Enhanced Services**

- Kids (<21)
 - Intensive In Home (IIH)
 - Multisystemic Therapy (MST)
 - Substance Abuse Intensive Outpatient Therapy (SAIOP)
 - Day Treatment
- Adults (21+)
 - Community Support Team (CST)
 - Assertive Community Treatment Team (ACTT)
 - SAIOP

<http://www.ncdhhs.gov/dma/mp/8A.pdf>

○ ○ ○ | **The Language Barrier**

- What's an emergency or crisis to clinical treatment provider?
- When is something a behavioral health issue vs behavior
 - "Rhondaism" → Behavioral health emergency=Acute, high risk behavior that is a symptom of clinical diagnosis vs
 - Behavioral issue=Individual has a diagnosis but it is not the reason they are behaving or making the choices they are making

○ ○ ○ | **Other Communication Barriers**

- Individual choice despite having a diagnosis
 - A person has the right to make bad decisions within reason
 - Ex. Diagnosed with diabetes and refuse to change eating habits
 - A person has the right to refuse their medication within certain boundaries
 - Schizophrenic ceases meds but is not an acute danger to self or other

○ ○ ○ | **Not All Agencies are Created Equally**

- CABHA (Critical Access Behavioral Health Agency)
 - Required to have clinical & administrative infrastructure (ex. Medical & QM Dir.)
 - Some level of service continuum
 - 24/7/365 MH First Responder (http://www.ncdhhs.gov/mhddsas/ImplementationUpdates/update086/lu86_april2011_final.pdf)
- Licensed Independent Practitioners
- Direct Care Provider (typically IDD svc)

○ ○ ○ | **CABHA Requirements**

CABHAs shall Serve as first responder when any consumer who has been assessed by the CABHA and is receiving services from the CABHA undergoes a crisis.

For purposes of first responder requirements, **crisis is defined as:** a high level of mental or emotional distress, or an episode, which without immediate intervention will foreseeably result in the person's condition worsening, environmental instability or could result in harm to self or others.

○ ○ ○ | **Other Types of Service Providers**

- Licensed Independent Practitioners
- All direct-enrolled Medicaid providers are required to:
 - Coordinate care
 - Provide an individualized treatment plan
 - Enrolled providers shall provide, or have a written agreement with another entity, for
 - Provide access to 24-hour coverage for behavioral health emergency services (<http://www.ncdhhs.gov/dma/mp/8C.pdf>).

○○○ | **What a Provider Can Do**

- Assess
- Request authorization for a service
- Link & coordinate services
- PROVIDE BEST PRACTICE
- Ensure transition to next appropriate service
- Provide information if appropriate releases in place

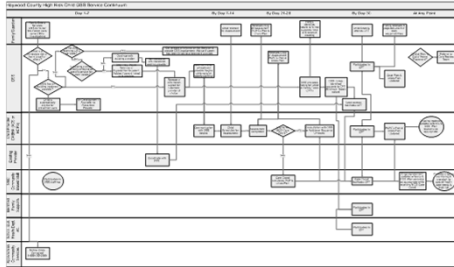
○○○ | **What a Provider Can't Do**

- Fake medical necessity
- Violate service definition requirements
- Drop cases with no transition
- Have an unstable financial model
 - Things providers wished DSS staff knew
 - Things providers wished you knew

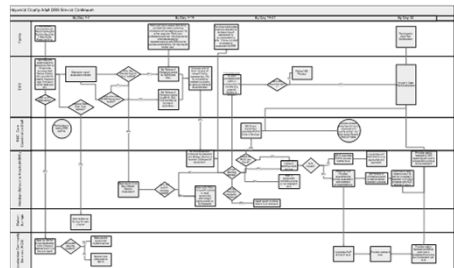
○○○ | **Some Real Life Examples**

- DSS Continuum...
 - Services were fragmented & disconnected
 - Quality & service provision between providers was inconsistent
 - Disconnect between DSS, Providers and LME...

○ ○ ○ Child Continuum



○ ○ ○ Adult Continuum



○ ○ ○ Things to Think About

- Not all providers are created equal
- Quality Assessment
- Best Practice
- Communication flow
- Agreements/MOA's
- Relationship

○ ○ ○ | Did I Mention Relationship?

- Different systems have different agendas
- Different language
- Different priorities
- Where do you meet in the middle?
- Who are the effective changes agents that have to be at the table?

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Questions?

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Thank You...
