Bi-Annual Stakeholder Meeting
May 12, 2014
1. 1:00-1:05 Welcome and Introductions
2. 1:05-1:10 Inspection of Care – Desk Review – Jennifer Brezee, ValueOptions
3. 1:10-1:20 Retrospective Reviews – Jennifer Brezee, ValueOptions
4. 1:20-1:25 ICD 10/DSM 5 updates – Kerri Brazzel, ValueOptions
5. 1:25-1:40 Behavioral Health Homes – Joy Figarsky and Paula Stone, DBHS
6. 1:40-1:55 Episodes of Care: An Update – Dr. Larry Miller, DMS
7. 1:55-2:00 Medicaid Policy Updates – Robbie Nix, DMS
8. Questions

Feedback and additional questions can be sent to ARInspectionofCare@valueoptions.com
## Members of Stakeholder Group

<table>
<thead>
<tr>
<th>ValueOptions</th>
<th>Provider Representatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kerri Brazzel – Project Director</td>
<td>Joyce Cloud, CEO – The Pointe Outpatient Services</td>
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<tr>
<td>Jennifer Brezee – Clinical</td>
<td>Cyndi Coleman - Methodist</td>
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<tr>
<td>Services Manager</td>
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<tr>
<td>Patricia Gann – Provider Relations Manager</td>
<td>Chad Cornelius, Interim Administrator - Methodist</td>
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<tr>
<td>Tara Hernandez - Retrospective</td>
<td>Jannie Cotton, CEO - Professional Counseling Associates</td>
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<td>Team Lead</td>
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<tr>
<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>Trevor Lay - Ascent</td>
</tr>
<tr>
<td>Dr. João Ramos – Medical Director</td>
<td>Ryan Martin, Director of Outpatient Services – Vista Health</td>
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<td>Carl Moore, Clinical Director – Alternative Opportunities/DaySpring</td>
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<tr>
<td>State of Arkansas</td>
<td>Lee Roberson-Koone, Director of Children Services – Counseling Associates</td>
</tr>
<tr>
<td>Anita Castleberry – DMS</td>
<td>Jason Turner, Director of Quality Assurance – Families Inc</td>
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<tr>
<td>Vivian Jackson – DMS</td>
<td>Robert Wright – Mitchell Blackstock</td>
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<td>Dr. Laurence Miller - DMS</td>
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<td>Robbie Nix - DMS</td>
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<td>Marilyn Strickland – DMS</td>
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<td>Paula Stone – DBHS</td>
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<td>Frank Vega - DBHS</td>
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<td>Dixie Wallace - DMS</td>
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<td>Pam Dodson - DBHS</td>
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Desk Reviews
The provider must submit a Corrective Action Plan designed to correct any deficiency noted in the written report of the IOC. The provider must submit the Corrective Action Plan to the contracted utilization review agency within 30 calendar days of the date of the written report. The contractor shall review the Corrective Action Plan and forward it, with recommendations, to the DMS Behavioral Health Unit, the Arkansas Office of Medicaid Inspector General and Division of Behavioral Health Services.

After acceptance of the Corrective Action Plan, the utilization review agency will monitor the implementation and effectiveness of the Corrective Action Plan via on-site review. DMS, its contractor(s) or both may conduct a desk review of beneficiary records. The desk review will be site-specific and not by organization. If it is determined that the provider has failed to meet the conditions of participation, DMS will determine if sanctions are warranted.
The Arkansas Medicaid RSPMI Provider Manual, Section 228.321 addresses Corrective Action Plans. After acceptance of the Corrective Action Plan ValueOptions will monitor the implementation and effectiveness of the CAP at least 6 months after implementation. ValueOptions may opt to monitor implementation of the CAP via an on-site review or a desk review. If implementation will be monitored via desk review, you will receive notice of documentation requirements prior to the desk review.
Retrospective Reviews
In the Spotlight...

Arkansas Health Care Payment Improvement Initiative

For information on the Payment Improvement Initiative, including updates on Episodes of Care and access the Provider Portal click below.

www.paymentinitiative.org

News & Events

» Add your email address to the ValueOptions® Arkansas provider email distribution list in order to receive valuable updates pertinent to Arkansas.

» The Provider Wire is a quarterly newsletter for Arkansas Medicaid Providers. The newsletter often features news, tips, suggestions and interesting articles about providers and programs.

» For the latest ICD-10

For Providers

ValueOptions®Arkansas

In Arkansas, ValueOptions® serves as the Administrative Services Organization (ASO), responsible for assisting the State of Arkansas Department of Human Services Division of Medical Services in administering the state’s mental health care delivery system. Under this agreement, ValueOptions® operates two contracts.

ValueOptions® provides utilization review (UR) for prior authorization through a free, secure, web-enabled system, for inpatient services for beneficiaries who are under 21 years of age as well as for outpatient services for children, adolescents and adults. The organization also provides UR for substance abuse services for
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
### Results so far...

#### 2012

<table>
<thead>
<tr>
<th>Period</th>
<th>Beneficiaries</th>
<th>Outpatient RSPMI Providers Represented</th>
<th>Reconsiderations</th>
<th>Recoupment</th>
<th>Units of Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 1, 2012 to Sept. 30, 2012</td>
<td>150</td>
<td>30</td>
<td>5</td>
<td>80</td>
<td>188</td>
</tr>
<tr>
<td>Oct. 1, 2012 to Dec. 31, 2012</td>
<td>199</td>
<td>36</td>
<td>10</td>
<td>103</td>
<td>630</td>
</tr>
</tbody>
</table>

- 5 Reconsiderations were submitted, 3 were upheld and 2 were overturned upon reconsideration
- 80 beneficiaries received recoupment for a total of 188 units of services
- 10 Reconsiderations were submitted, 9 were upheld and 1 was overturned upon reconsideration
- 103 beneficiaries received recoupment for a total of 630 units of services
2013
January 1, 2013 to March 30, 2013

• 264 beneficiaries
• 34 Outpatient RSPMI Providers represented
• 4 Reconsiderations were submitted, 2 were upheld and 2 were overturned upon reconsideration
• 130 beneficiaries received recoupment for a total of 328 units of services

2013
April 1, 2013 to June 30, 2013

• 264 beneficiaries
• 34 Outpatient RSPMI Providers represented
• 3 Reconsiderations submitted, 2 were upheld and 1 was overturned
• 130 beneficiaries received recoupment for a total of 404 units of services
Results so far...

2013
July 1, 2013 to Sept. 30, 2013

- 262 beneficiaries
- 36 Outpatient RSPMI Providers represented
- 13 Reconsiderations were submitted, 5 were upheld, 6 were overturned, and 2 were partially overturned upon reconsideration

43 Total RSPMI providers have been represented in Retrospective Review
1: Periodic Review of the MTP – not in cooperation with beneficiary

2: Psychiatric Diagnostic Assessment – late or missing

3: Documentation – unnecessary interventions/duplicate notes, etc.
On April 1, 2014, the Protecting Access to Medicare Act of 2014 (PAMA) (Pub. L. No. 113-93) was enacted, which said that ICD-10 may not be adopted prior to October 1, 2015.

The U.S. Department of Health and Human Services expects to release an interim final rule in the near future that will include a new compliance date that would require the use of ICD-10 beginning October 1, 2015.
Adopting DSM-5

- Beginning June 28, 2014 ValueOptions will be moving to the new screens specifically developed to support DSM-5.

- Diagnoses will now have selections for category, diagnosis code and description. A primary diagnosis is required.

- ProviderConnect will accept both DSM-IV or DSM-5 codes.

- If Providers choose to adopt DSM-5, this must be an agency-wide transition and ValueOptions will need to be notified of this change.
### Axis I
- **Diagnosis Code 1**: Description
- **Diagnosis Code 2**: Description
- **Diagnosis Code 3**: Description

### Axis II
- **Diagnosis Code 1**: Description
- **Diagnosis Code 2**: Description
- **Diagnosis Code 3**: Description

### Axis III
- **Diagnosis Code 1**: SELECT...
- **Diagnosis Code 2**: SELECT...
- **Diagnosis Code 3**: SELECT...

- **Is beneficiary pregnant?**
  - Yes
  - No
  - N/A
- **If yes, expected delivery date**

### Axis IV
- **Check all that apply**
  - None
  - Educational problems
  - Financial problems
  - Housing problems
  - Occupational problems
  - Other psychosocial and environmental problems

### Axis V
- **Current GAF Score**: UK
- **Does this beneficiary have an SED/SPMI diagnosis?**
  - Yes
  - No
  - Unknown
- **If yes, date diagnosed**

- **Is the primary focus of treatment a Developmental Disorder or a Pervasive Developmental Disorder?**
  - Yes
  - No
  - Unknown
**ProviderConnect - As of June 28, 2014**

### Diagnosis

Documented primary behavioral conditions are required. Provisional wording conditions and diagnoses should be documented if necessary. Documentation of secondary co-occurring behavioral conditions that impact or are a focus of treatment (mental health, substance use, personality, intellectual disability) is strongly recommended to support comprehensive care. Authorization (if applicable) does NOT guarantee payment of benefits for these services. Coverage is subject to all limits and exclusions outlined in the member's plan and/or summary plan description including covered diagnosists.

#### Behavioral Diagnoses

<table>
<thead>
<tr>
<th>Primary Behavioral Diagnosis</th>
<th>* Diagnostic Category</th>
<th>* Diagnos code</th>
<th>* Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>* Diagnostic Category 1</td>
<td>SELECT...</td>
<td></td>
<td></td>
</tr>
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</table>

**Additional Behavioral Diagnoses**

<table>
<thead>
<tr>
<th>Diagnostic Category</th>
<th>* Diagnosis Code</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>Diagnostic Category 2</td>
<td>SELECT...</td>
<td></td>
</tr>
<tr>
<td>Diagnostic Category 3</td>
<td>SELECT...</td>
<td></td>
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<tr>
<td>Diagnostic Category 4</td>
<td>SELECT...</td>
<td></td>
</tr>
<tr>
<td>Diagnostic Category 5</td>
<td>SELECT...</td>
<td></td>
</tr>
</tbody>
</table>

#### Primary Medical Diagnoses

Primary medical diagnosis is required. Select primary medical diagnosis category from dropdown or select medical diagnosis code and description.

<table>
<thead>
<tr>
<th>* Diagnostic Category</th>
<th>Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>* Diagnostic Category 1</td>
<td>SELECT...</td>
<td></td>
</tr>
</tbody>
</table>

**Additional Primary Medical Diagnoses**

<table>
<thead>
<tr>
<th>Diagnostic Category</th>
<th>Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic Category 2</td>
<td>SELECT...</td>
<td></td>
</tr>
</tbody>
</table>

#### Social Elements Impacting Diagnosis

- [ ] Check all that apply
  - [ ] None
  - [ ] Problems with access to health care services
  - [ ] Housing problems (Not Homelessness)
  - [ ] Problems related to the social environment
  - [ ] Educational problems
  - [ ] Problems related to interaction w/legal system/crime
  - [ ] Occupational problems
  - [ ] Homelessness
  - [ ] Financial problems
  - [ ] Problems with primary support group
  - [ ] Other psychosocial and environmental problems
  - [ ] Unknown

#### Functional Assessment

Please indicate the functional assessment tool utilized or select Other to write in other specific tool. Assessment score for specific tool should be noted in the Assessment Score field.

<table>
<thead>
<tr>
<th>Assessment Measure</th>
<th>Assessment Score</th>
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<tbody>
<tr>
<td>SELECT...</td>
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</table>

<table>
<thead>
<tr>
<th>Secondary Assessment Measure</th>
<th>Assessment Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>SELECT...</td>
<td></td>
</tr>
</tbody>
</table>
Introduction to Health Homes

- Health Homes in Arkansas
- Service Categories
- Client Enrollment Process
- Geographic Coverage & Provider Criteria
- Design Overview: Payment Methodology & Quality Measures
What is a health home?

The Affordable Care Act of 2010, Section 2703, created an optional Medicaid State Plan benefit for states to establish Health Homes to coordinate care for people with Medicaid who have chronic conditions by adding Section 1945 of the Social Security Act. CMS expects states health home providers to operate under a “whole-person” philosophy.

Health Homes providers will integrate and coordinate all primary, acute, behavioral health, and long-term services and supports to treat the whole person.

http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Integrating-Care/Health-Homes/Health-Homes.html
Health Home Model

What health home services are included?

- Comprehensive care management
- Care coordination
- Health promotion
- Comprehensive transitional care/follow-up
- Patient & family support
- Referral to community & social support services

(Use of HIT to facilitate health home services)

http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Integrating-Care/Health-Homes/Health-Homes.html
Health Home Model

Who Is Eligible for a Health Home?¹

Medicaid beneficiaries who:

• Have 2 or more chronic conditions

• Have one chronic condition and are at risk for a second

• Have one serious and persistent mental health (SPMI) condition

¹ Centers of Medicare and Medicaid Services (CMS) Definition: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Integrating-Care/Health-Homes/Health-Homes.html
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Our vision to improve care for Arkansas is a comprehensive, patient-centered delivery system.

**Objectives**
- Improve the health of the population
- Enhance the patient experience of care
- Enable patients to take an active role in their care

**For patients**
- **Population-based care**
  - Medical homes
  - Health homes
- **Episode-based care**
  - Acute, post-acute, or select chronic conditions

**For providers**
- Reward providers for high quality, efficient care
- Reduce or control the cost of care

**How care is delivered**
- Results-based payment and reporting
- Health care workforce development
- Health information technology (HIT) adoption
- Consumer engagement and personal responsibility
- Expanded coverage for health care services

**Five aspects of broader program**
- For providers
- For patients
- How care is delivered
- Objectives
- Five aspects of broader program
Patient Centered Medical Homes

| The PCMH is a team-based care delivery model led by a primary care provider who comprehensively manages a patient’s health needs with an emphasis on health care value. | PCMH supports practices in establishing meaningful change, and incentivizes practices by sharing cost savings |

Health Homes

| In an effort to improve population-based care for targeted populations, integrated care models are being developed to address specific needs for Development Disabilities (DD), Behavioral Health (BH), and Long Term Services and Supports (LTSS). |
| For DD, BH, and LTSS populations, the health home aims to ensure accountability for addressing comprehensive, person-centered needs of individuals served while improving overall population-based care management. |
What a BH health home is...

- A behavioral health agency
- Extra support for people who need an increased level of care management or who face greater challenges in navigating the healthcare system
- Enhanced support for clients who have needs in multiple areas, including DD, LTSS, housing, justice system, etc.
- Opportunity to promote quality in the core provision of behavioral health care
- Encourage providers to work in teams to improve outcomes for the clients
- A way of aligning financial incentives around evidence-informed practices, wellness promotion, and health outcomes

What a BH health home is not...

- NOT a direct provider of medical services
- NOT a gatekeeper restricting a client’s choice of providers
- NOT a physical “house” where all health home activities take place
- NOT an organization that is required to contract with other providers (e.g., medical providers) to serve their clients
To deliver integrated care management in a manner that facilitates quality care and positive outcomes through:

**Providing care coordination**
- Providing clients with integrated care coordination within and across BH, medical health, developmental disabilities, long-term supports, and other systems

**Managing core care delivery**
- Ensuring effective treatment of behavioral health conditions, including pharmacy effects
The new behavioral health system will be conscious of varying severity of needs as well as intensity of care management required for the different tiers:

- **Tier 1 (low-needs)**
  - PCMH care mgmt. adequate for BH care

- **Tier 2 (medium-needs)**
  - BHH required to manage frequent BH services

- **Tier 3 (high-needs)**
  - BHH intensely manages BH & support services

**PCMH** = Primary Care Medical Home; **BH** = Behavioral Health; **BHH** = Behavioral Health Home; 1IP = Inpatient; OP = Outpatient; SOURCE: 2011 Medicaid BH claims (ICD-9 291 – 314 excluding 299 and dementia codes in 294), excludes pharmacy and crossover claims.
This integrated system includes health homes, behavioral health services, independent assessments, and care plans.

**Tier 1**
- PCMH\(^1\) care mgmt.
- Adequate for BH care

**Tier 2**
- BHH\(^2\) required to manage frequent BH services

**Tier 3**
- BHH\(^3\) intensely manages BH & support services

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**Patient centered medical home**

**Behavioral health home**

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1. Patient centered medical home
2. Behavioral health home
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
- Includes 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
  - Aftercare recovery services
- Clinic/Home/Community-Based
  - Psychiatric diagnostic assessment

Tier 3
- Includes 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
  - Residential treatment
  - Therapeutic communities

Existing Services
- Expanded Services
- Proposed Services (including 1915i)

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

Services available to all Tiers
- Acute psychiatric hospitalization
- Mobile response and crisis stabilization
- Acute crisis units
- Substance abuse detoxification
- Intensive outpatient substance abuse treatment

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.
Introduction to Health Homes

Health Homes in Arkansas

Service Categories

Client Enrollment Process

Geographic Coverage & Provider Criteria

Design Overview: Payment Methodology & Quality Measures
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BHH Service Categories

**Comprehensive Care Management**
- Identifying high-risk individuals and utilizing client and population-based data to manage care
- Assessing needs of individuals to develop care plans that incorporate client needs and person-centered goals
- Facilitating interdisciplinary team engagement to ensuring comprehensive needs are addressed
- Coordinating and disseminating information and reports that guide progress of service delivery and outcomes

**Care Coordination**
- Integrating care plans across systems (including behavioral health, medical, developmental disabilities, and long-term supports) and provides input for plan updates
- Supporting and enabling care plan adherence by providing assistance with referrals, scheduling and arrangement for transportation to appointments
- Providing regular check-ins with beneficiary to understand barriers to plan adherence
- Coordinating care across all medical, behavioral health and other treatment plans
- Participating in hospital discharge planning and coordinating transitional and aftercare services
BHH Service Categories

**Health Promotion**
- Arranging for and/or providing beneficiary and family specific health education services
- Educating and supporting beneficiary on self-management plans and routine clinical care
- Coordinating and supporting access to behavioral health care

**Comprehensive Transitional Care**
- Establishing processes to ensure prompt notification of planned and unplanned care (i.e. developing crisis management plans and processes for hospital admissions and emergency department visit notifications)
- Coordinating and sharing transition planning with relevant persons/entities
- Providing regular education on beneficiary access to services and transitional care needs
BHH Service Categories

**Individual and Family Support Services**
- Matching individuals (and families) to support services and advocating on their behalf for participation
- Facilitating awareness of and interacting with service providers to ensure they are meeting beneficiary needs

**Referral to Community and Social Support Services**
- Identifying needs and managing referrals to needed services and supports
- Facilitating access to needed care
- Promoting self-management and increased beneficiary engagement by facilitating access to appropriate community support and wellness programs
- Introduction to Health Homes
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BHH Client Enrollment Process

Notification of Potential Need for BHH:

- Referral by Health Care or BH provider
- Historic Utilization

Independent Assessment

Independent Assessment Report Indicates Need for BHH and Makes Tier Determination

Client Enrolls in BHH
▪ Introduction to Health Homes

▪ Health Homes in Arkansas

▪ Service Categories

▪ Client Enrollment Process

▪ Geographic Coverage & Provider Criteria

▪ Design Overview: Payment Methodology & Quality Measures
BHH Statewide Coverage and Provider Criteria

• **Available statewide**

• **Behavioral Health Home Provider Requirements**
  
  ✓ Baseline - BH Agency Certification (“in good standing”)
  
  ✓ BHH Performing Provider Requirements
  
  ✓ Lead BHH Roles/Functions:
    
    • Care Coordination: Direct interaction with a beneficiary, the beneficiary’s family and his/her other treatment providers for care coordination provision.
    
    • Care Management: Oversight of BHH care coordination provision, facilitation of problem-solving with case issues, reviewing and updating the Integrated Care Plan, and establishing relationships between the BHH and other treatment providers.
    
    • Care Direction: Management of budgetary and operational components and oversight of other administrative duties of the BHH.
BHH Certification Requirements

A BHH provider must be certified by the state and meet the following:

- Possess DBHS BH agency certification to provide services
- Complete state BHH enrollment process and practice transformation activities
- Demonstrate the capacity to provide:
  - Minimum staffing/BHH team composition for BHH panel for established ratios
  - Effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs, and practices, preferred languages, health literacy and other communication needs
  - Access to services and establish Memoranda of Agreements with organizations to facilitate access to services
- Demonstrate capability to utilize EHR/EMR and have the ability to review progress notes, treatment plans, current and past medications, create problem lists, analyze care outcomes and send secure messages
- Provide assurances of enhanced patient access and patient access to the BHH team
- Support the use of evidence-based clinical decision making tools and best practices to achieve optimal patient recovery and resiliency
- Establish and maintain a continuous quality improvement program
- Introduction to Health Homes
- Health Homes in Arkansas
- Service Categories
- Client Enrollment Process
- Geographic Coverage & Provider Criteria
- Design Overview: Payment Methodology & Quality Measures
BHH Payment Design Overview

- Per Member Per Month (PMPM) Fee
- Acuity-based (risk adjusted)
- Performance Incentive Payment
BHH Quality Measures

• CMS Core Health Home Measures
• Process Metrics
• Outcome Metrics
Online

- More information on the Payment Improvement Initiative can be found at www.paymentinitiative.org
Behavioral Health Episodes: An Update
Behavioral Health Episodes: An Update
Dr. Laurence H. Miller
Senior Psychiatrist, DMS
• First performance period ended December 31, 2013

• Payment report came out at the end of April 2014

• If you have not yet done so, you need to review it
If the report shows that you met the commendable threshold, quality metrics, and a volume level of 5 or more episodes. . .

- You should receive payment in May 2014
- The payment will appear on your remittance advice.
If the report shows that you met the commendable threshold but did not meet quality metrics...

- You have 365 days from episode end dates to enter quality metrics in the AHIN portal.

- Look for those episodes that closed between October 2013 and December 2013 and enter quality metrics for those episodes.

- If you meet the quality metrics, you will receive payment after the April 2015 reconciliation report.
Second performance period began January 2014

You will not receive another performance report until July 2014

That report will not only cover Level I and II open and closed episodes but also:
- Level I partial episodes
- Level I Co-paps
- Level II Co-paps

In the meantime, be sure to review specifics of episode entry/exit
Helpful information is available on the APII website:

**ADHD Webinar #4**

- YouTube presentation on timelines, clinical foundation and medications:
  https://www.youtube.com/watch?v=jFXR7OQqmnk

- YouTube presentation on certifications and episode entry/exit:
  https://www.youtube.com/watch?v=DnUhRlIQVj0

- Complete slide deck:
First performance period began April 2014

Third informational report came out at the end of April (contains data from July 2013 through December 2013)

We’re about mid-way through the first 90-day episode
For each patient with ODD-only diagnosis be sure to...

- Complete the quality assessment certification
- Analyze and monitor medication utilization
- Analyze and monitor individual and family therapy visits
- Anticipate episode closure and track remission rate going forward
Helpful information is available on the APII website:

**ODD Webinar #2**

Complete slide deck:
Beginning May 2014, if you do not answer every question on the episode certifications, your entries will not be accepted in the AHIN portal.
<table>
<thead>
<tr>
<th>Who to Contact</th>
<th>Contact Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Paula Stone, LCSW, Assistant Clinical Director of Children’s Services, Prevention and Consumer Affairs</td>
<td>▪ Office: 501-686-9489&lt;br&gt;▪ Cell: 501-246-1858&lt;br&gt;▪ Fax: 501-686-9182</td>
</tr>
<tr>
<td>▪ Dr. Laurence Miller, Senior Psychiatrist, Pharmacy</td>
<td>▪ Office: 501-683-4120&lt;br&gt;▪ Fax: 501-683-4124</td>
</tr>
<tr>
<td>▪ Suzette Bridges, DMS Assistant Director, Pharmacy</td>
<td>▪ Office: 501-320-6177&lt;br&gt;▪ Fax: 501-320-4124</td>
</tr>
<tr>
<td>▪ HP Customer Service Center</td>
<td>▪ In state: 1-866-322-4696&lt;br&gt;▪ Out of state: 501-301-8311&lt;br&gt;▪ Email: <a href="mailto:arkpii@hp.com">arkpii@hp.com</a></td>
</tr>
</tbody>
</table>
Medicaid Policy Updates
Questions?
Thank You!

Presented by ValueOptions, DMS and DBHS

Please send additional comments or feedback to: ARInspectionofCare@valueoptions.com