AGENDA

I. **Introductions**

II. **Discussion and Clarification of Pathways, Impacts, and Considerations**

III. **Discussion of Carve-In/Carve-Out Approaches**

IV. **Financial and Timeline Considerations for Carve-In/Carve-Out**

V. **Recommendations and Next Steps**

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2023 PRTF Workgroup

Meeting 2

Agenda

- **Summary of meeting #1 approaches, impacts, and considerations**
- Process mapping and discussion of each approach
- Financial and timeline considerations
- Recommendations and next steps

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Approaches to Inclusion in Managed Care for PRTF

- **Service carved-out of managed care, youth excluded from managed care (status quo-All Fee-for-Service)**
  - Parallels: Individuals who are incarcerated and other managed care exclusions
  - What this means:
    - No MCO resources including care coordination, enhanced services, etc., for member placed in PRTF.
- **Service carve-out of managed care, youth non-excluded (included in managed care)**
  - Parallels: Dental services; Therapeutic Group Home (TGH)
  - What this means:
    - PRTF providers and TGH providers would only be contracted directly with DMAS.
    - The TGH IACCT process and service auth are managed by the Fee-for-Service Contractor (Magellan/KEPRO), all other services (BH and Physical Health) continue to be managed by the MCO.
    - MCOs provide care coordination and member available for enhanced services for member placed in PRTF.
- **Service carve-in**
  - Parallels: ASAM residential services; other non-residential behavioral health services
  - What this means:
    - MCO are fully responsible for member and managing their benefit, including PRTF service as well as all physical and behavioral health.

General Comparison

No MCO Resources Acentra Care Coordination	MCO Care Coordination only	MCO Manages Benefit and assumes full responsibility
Excluded	**Service Carve Out**	**Service Carve In**
• Youth disenrolled from managed care; transition to FFS (currently: Magellan) during PRTF stay • All BH and Physical Health services are authorized and paid through FFS contractors • Re-enrolled in managed care after stay; could be a different health plan; MCO enrollment may take several weeks to occur.	• Youth remain in managed care even if in PRTF; MCO readily available to assist with discharge planning • Health plan remains engaged in care coordination and accountable for other services (e.g., medical) • PRTF auths/claims managed by FFS administrators/DMAS	• Youth remain in managed care regardless of service setting • Health plan responsible for PRTF/TGH network adequacy, utilization management, and payment of PRTF/TGH

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Impacts from Meeting 1

- Care coordination: BH and medical
- Care coordination: FAPT, local government (DSS, CSA)

- Access to residential level of care: timeliness
- Access to residential level of care: proximity for family and in-state/out of state
- Access to specialty services/placements for high acuity youth
- Access to intensive community treatments as an earlier alternative to residential

- Quality of residential care provided in PRTFs (safety, evidence-based model uptake)

- Avoidance of unnecessary residential placements and length of stay

- Outcomes: successful transition to community-based care, clinical outcomes

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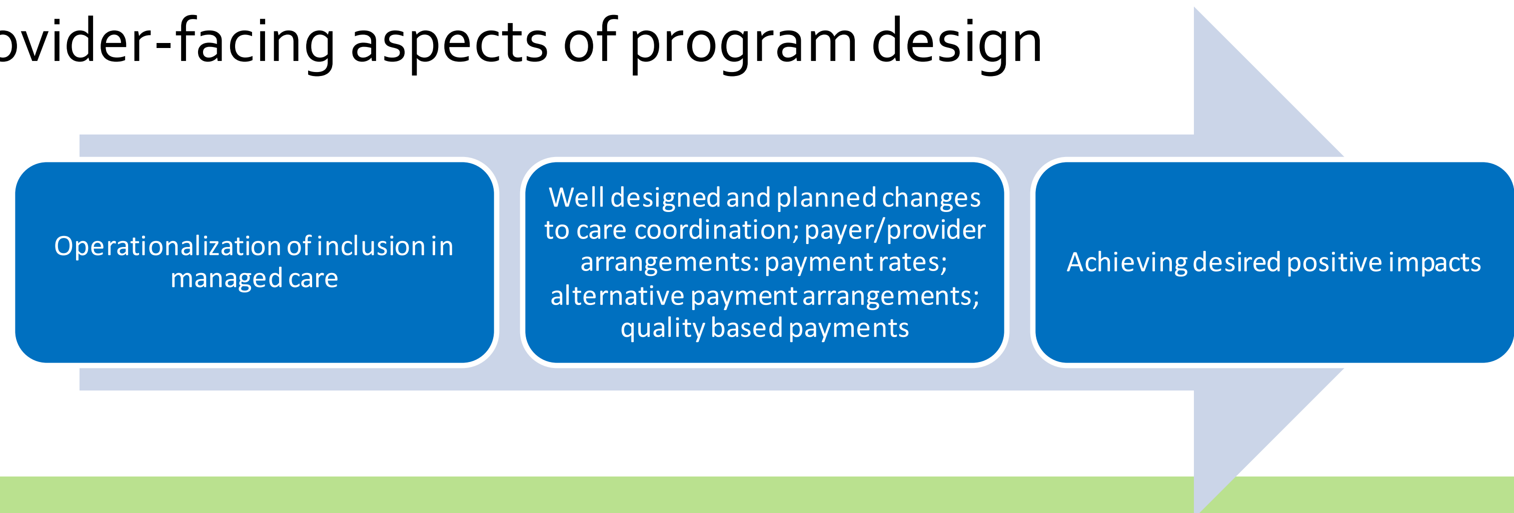
Considerations from Meeting 1

- To achieve desired impacts/avoid negative impacts, the coordination and careful analysis of different options and approaches should be tested and understood
- Components of the process need to be analyzed - how would the process change? Other payers (CSA) was a primary consideration brought up (education component; but also in context of payer order/accountability)
- Granular details of contract language (DMAS-health plans; health plans-providers) all matter
- Considerations raised both in support of flexibility of model but also standardization across health plans for provider-facing aspects of program design



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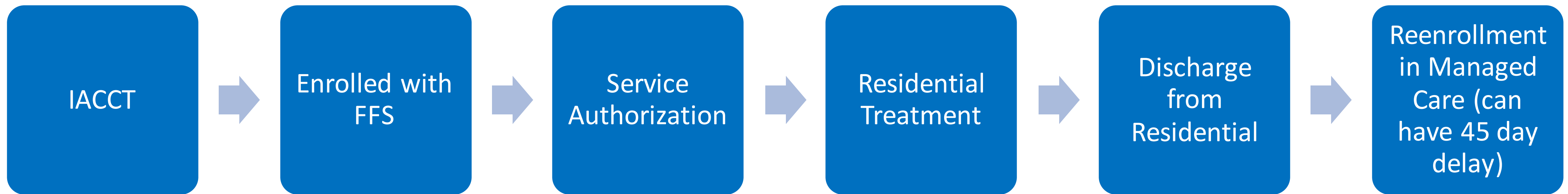
PRTF Process Mapping (excluded/status quo)



Engagement with FAPT team, service planning process milestones can vary based on referral pathways and locality. These milestones are not included here.

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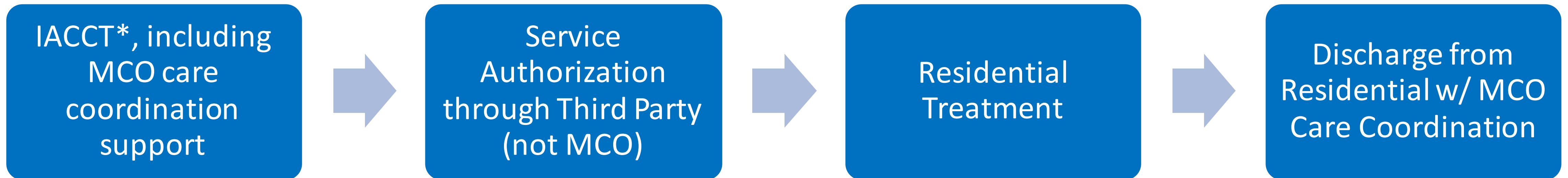
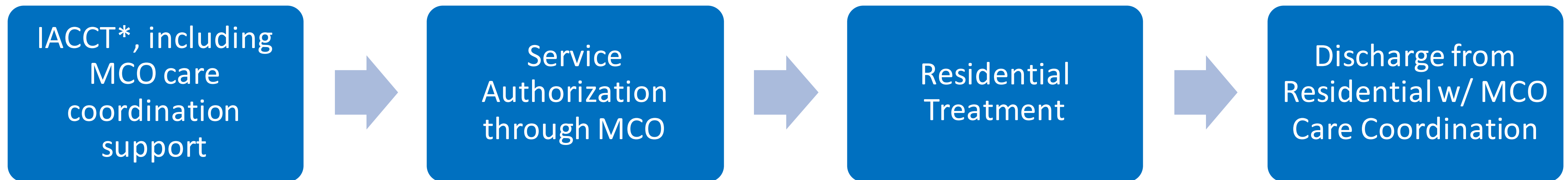
PRTF Process Mapping (managed care service carve out)



Engagement with FAPT team, service planning process milestones can vary based on referral pathways and locality. These milestones are not included here.

**IACCT process would be managed by FFS contractor if parallel to the current TGH arrangement*

PRTF Process Mapping (managed care carve in)



Engagement with FAPT team, service planning process milestones can vary based on referral pathways and locality. These milestones are not included here.

**Role/employer of independent assessor would be a design decision.*

Options and Expected Impact (DMAS initial analysis for discussion)

Desired System Impact	Carve Out	Carve In
Care coordination- BH and medical	Expected improvements	Expected improvements
Care coordination- FAPT, local government (DSS, CSA)	Expected improvements	Expected improvements
Access to residential level of care- timeliness and ease of navigating assessments	No impact	Could impact positive or negative
Access to residential level of care- proximity for family and in-state/out of state	No impact	Could impact positive or negative
Access to specialty services/placements for high acuity youth	No impact	Could impact positive or negative
Access to intensive community treatments as an earlier alternative to residential	No impact	Expected positive (incentive aligned with capitation)
Quality of residential care provided in PRTFs (safety, evidence based model uptake)	No impact	Could impact positive or negative
Avoidance of unnecessary residential placements and length of stay	No impact	Expected positive (incentive aligned with capitation)
Outcomes- successful transition to community based care, clinical outcomes	Some specific expected improvements (care coordination during discharge)	Some specific expected improvements (care coordination during discharge); other potential improvements could be positively or negatively impacted with carve in

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Different Groups for Consideration

- These are groups that should be considered specifically, as the pathways developed would vary.
  - Youth in Medicaid without FAPT/CSA involvement
  - Youth with Medicaid and FAPT involvement
  - Youth with FAPT/CSA involvement but without Medicaid
  - Youth in foster care
  - Youth with primary SUD; comorbid SUD/MH needs

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Funding and Timeline Considerations

Carve Out	Carve In
Costs: administrative changes, system changes, contracting changes (managed care and FFS) MCO administrative costs, case management costs may need to be considered for approximately 700 youth who would be non-excluded **Operational Impact:** Operationally, CSA/DMAS funding relationship around SGF, NGF, and local match could likely continue without significant changes **Timeline:** within 18 months	**Costs:** administrative changes, system changes, contracting changes (managed care and FFS) Rate Study, including study of rate structure, including alternative payment models, value based payments, and study of the service itself With service carve-in, cost impact may include changes in capitation rates with service inclusion- budget authority Analysis would have to take into account existing NGF, SGF, and local match **Operational Impact:** Local match should be reconsidered for appropriateness and feasibility under a carve-in model; and if retained, significant operational changes to process would be needed **Timeline:** 3 years to implementation

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Discussion

- What should the workgroup recommend?
  - Can we achieve consensus between the three broad options (status quo, carve out, carve in)?

- Our flowcharts weren't able to capture intersection with CSA or considerations for a number of specific groups - how can we address this in the report and recommendations?

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