Lessons Learned from Behavioral Health Transition into Health Plans

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Transition of Behavioral Health in Health Plans

- Loss of carve out for Behavioral Health
- Behavioral health integrated into 7 health plans and 3 RBHAs
- Systems Integration occurred October 1, 2018
- Payment change from capitated payments to Fee for Service
- Spent over a year preparing providers and plans
- Plans were not ready on October 1
Creating Data to Back Up Provider Complaints

• Previous experience with AHCCCS regarding transitions
• Committee of Council members formed to develop strategies
• Richard Cooper of SPSI (Southwest Provider Services, Inc.) volunteered to help
Transition Issues: Behavioral Health into Health Plans

- Contracting
- Credentialing
- Rates
- Payment - Claims submission and payment
- Implications of switch to fee for service
- Eligibility
Issues Identified by Committee

• Eligibility
• Credentialing
• Coding
• Timely Payment
• Correct rates not loaded (individual provider issue)
Southwestern Provider Services, Inc

- Provider Focused, Workflow Re-Engineering
- Electronic Payor Communication Including Traditional “Clearinghouse” Tools
- Behavioral Health Population Served
  - Supporting 95% of Agencies in the Central GSA (Maricopa County)
  - Managing over 1.1 million claims
Data Monitoring - Introductions

- Scope of Transition
  - Move from a Single Payor to a Ten Payor Model
  - Move from a Block (Capitated) Payment System to Fee-For-Service Model

- Objective - Be Proactive and Avoid the Problems of Past Transitions
Data Monitoring - The Approach

- Consensus on Aggregation and De-Identification of Agency-Specific Data
- Formulation of Metrics to be Monitored
  - Communication Flow with Each of the Health Plan (Claims, Remits, etc.)
  - Monitor Cash Flow
  - Anticipated Problem Areas (Member Eligibility, Provider Setup, Fee Schedule Mgmt.)
  - Identify and Trend Claim Rejections / Denials
Data Monitoring - The Approach

- Detailed documentation of Issues
- Establishing Baseline Information (from Current Data)
- Timely Reporting (weekly updates)
- Health Plan Collaboration
Data Monitoring - Implementation

- Aggregation of Participating Agency Claims & Payment Information
- Web-Based Monitoring Reports available to all
- Health Plan Specific Monitoring
- Sample Reports
- Problem Areas
- Problem resolution
Data Monitoring - Outcome

Today

• At a Pivot Point
  • Continue to Support Struggling Agencies
  • Continue to Build Communication with Health Plans
Data Monitoring - Outcome

Lessons Learned
- Cost Burden of Late Contracting, Credentialing, and Fee Schedule Load
- Earlier & Ongoing Orientation
- Electronic Remittance Reporting

Next Steps
- Build on Lessons Learned
- Improve the Model for Future Implementation (DD October, 2019)
Use of Data with AHCCCS

- AHCCCS required health plans to meet with providers - two series of meetings
- Plans were fined and/or given notices to cure
- AHCCCS investigated complaints regarding eligibility and credentialing
- AHCCCS worked with plans to set up advance payments for providers
- AHCCCS set up committee to review credentialing process
Lessons Learned

• Require that contracts covering scope of work are in place several months prior to go live date
• Require credentialing to be done prior to go live date
• Test claims process prior to go live date
• Require monthly meetings of providers and payors for 4 months prior to go live date
Lessons Learned

- Have data to demonstrate problems early in the process
- Have a plan for transitioning clients who are in mid-course of treatment
- Have reserve funds to cover delays in payment
- Plans and AHCCCS should have process for advance payments
- Advanced provider orientation and education on claims/payment processes
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