Pediatric Behavioral Therapy Benefits Collaborative

5/23/2018

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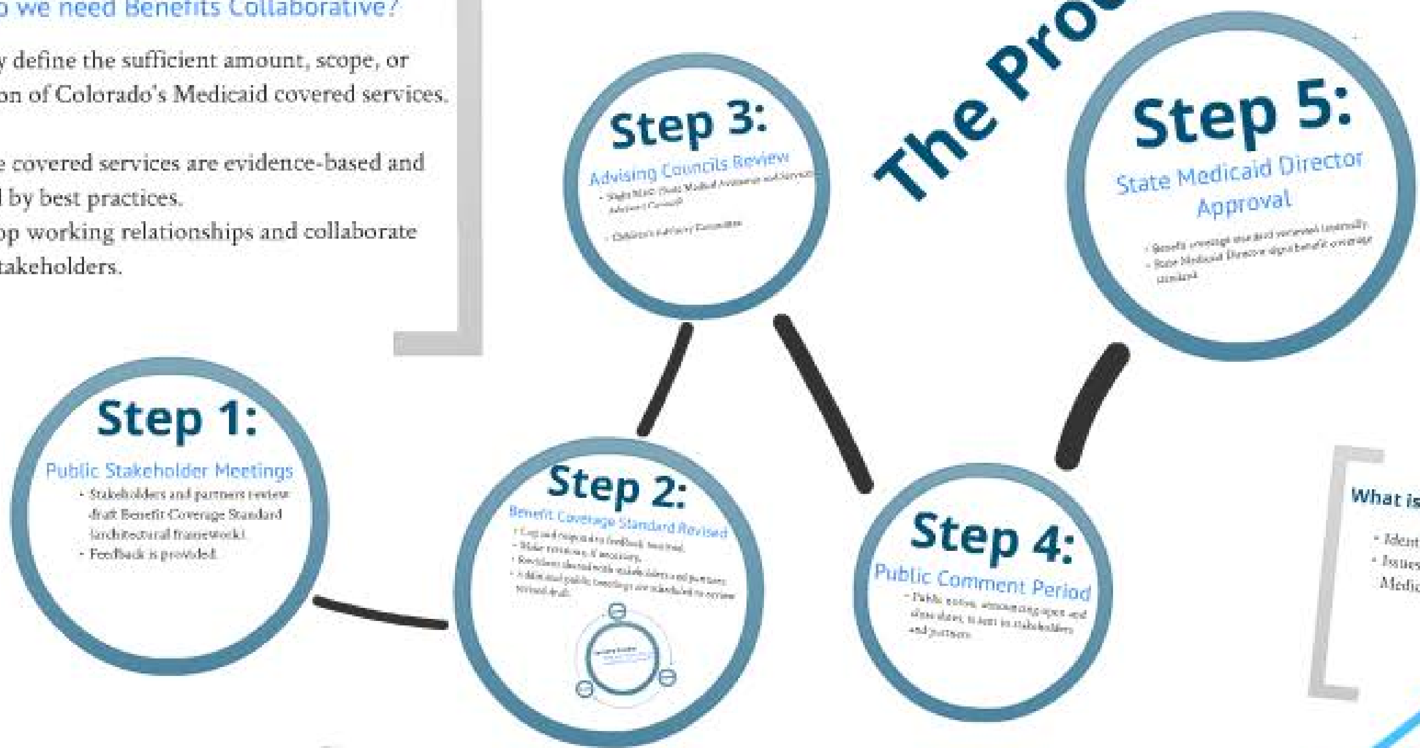
COLORADO
Department of Health Care Policy & Financing

Our Mission

Improving health care access and outcomes for the **people** we serve while demonstrating sound stewardship of financial **resources**

What is the Benefits Collaborative Process?

Benefits Collaborative



Objective

Develop Benefit Coverage Standards

- Objective researchers draft the Benefit Coverage Standards according to evidence-based guidelines and best practices.
- Conduct an extensive review of the medical literature.

Coverage Determination vs. Medical Necessity:

Coverage Determination

- An agency policy about what is covered for the entire Colorado Medicaid population.
  - Example: Weight Loss surgery is covered by Medicaid.

Medical Necessity

- Involves authorizing a covered service for an individual Colorado Medicaid client.
  - Example: Client must be 1) clinically obese, 2) for at least 2 years, and 3) have made a previous attempt to lose weight.

What is a Benefit Coverage Standard?

- Identifies what is covered by Colorado Medicaid.
- Issues coverage determinations for the Colorado Medicaid program.

The Format:

- Brief Coverage Statement
- Services Addressed in Other Coverage Standards
- Eligible Providers
- Eligible Places of Service
- Eligible Clients
- Covered Services and Limitations
- Non-Covered Services and General Limitations
- Requirements
- Billing Guidelines
- Definitions
- References

Purpose

Why do we need Benefits Collaborative?

- Clearly define the sufficient amount, scope and duration of Colorado's Medicaid covered services.
- Ensure covered services are evidence-based and guided by best practices.
- Develop working relationships and collaborate with stakeholders.

Objective

Develop Benefit Coverage Policies

- Subject matter experts draft a coverage policy according to evidence-based guidelines and best practices

What is a Benefit Coverage Policy?

- Identifies what services are covered by Health First Colorado (Colorado's Medicaid Program)
- Defines the appropriate amount, scope and duration of a covered service
- States determination of whether a given service is medically necessary
- Describes the service
- Lists who is eligible to provide and receive said service and where

Benefits Collaborative

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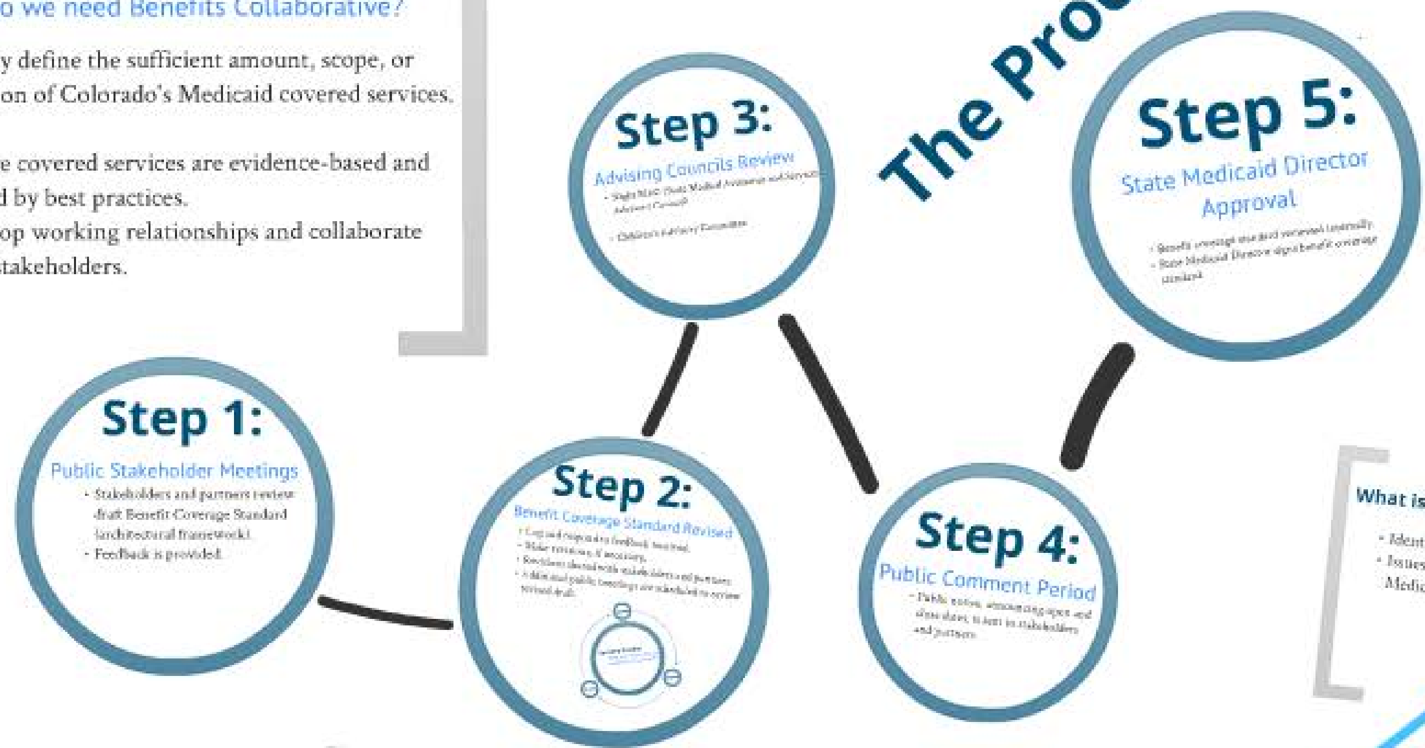

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Step 1:

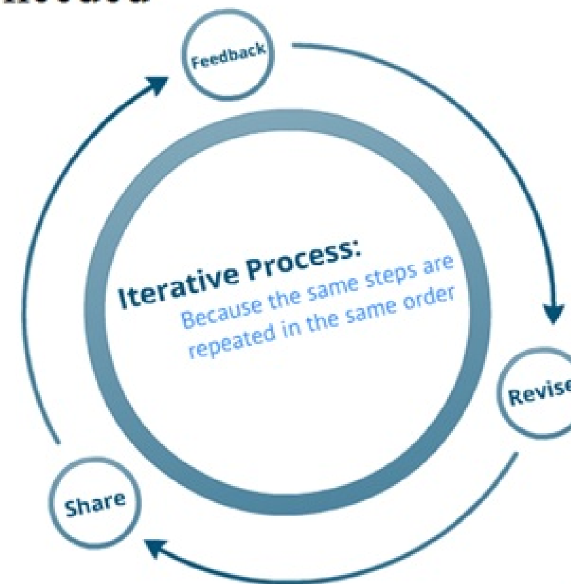
Public Stakeholder Meetings

- Stakeholders review draft Benefit Coverage Policy
- Feedback is provided

Step 2:

Benefit Coverage Revised

- Log and respond to feedback received
- Make revisions, if necessary
- Revisions shared with stakeholders
- Additional public meetings are scheduled to review revised draft if needed



Step 3:

Advising Councils Review

- Night MAC (State Medical Assistance and Services Advisory Council)
  - 42 CFR 431.12
- Children's Advisory Committee

Step 4:

Public Comment Period

- Public notice, announcing open and close dates, is sent to stakeholders and partners before the open date.

Step 5:

State Medicaid Director Approval

- Benefit Coverage Policy reviewed internally
- State Medicaid Director approves

What's My Role Here Today ?

How Do I Participate?

Your Role

Participants Are Consultants

Your role is to provide suggestions for policy improvement based on:

- Evidence based research and data
- Peer reviewed literature
- Knowledge of the population we serve

Guiding Principles

Policy Suggestions Adopted Will:

- Be guided by recent clinical research and evidence based best practices, wherever possible.
- Be cost effective and establish reasonable limits upon services.
- Promote the health and functioning of Medicaid clients.

Our Role

- To seek out the feedback of the population we serve and those that support them.
- To implement suggested improvements that meet the collaborative's guiding principles.
- To foster understanding in the community about how policy is developing, and why.

Ground Rules

Participants Are Asked To:

- Mind E-manners
- Identify Yourself
- Speak Up Here & Share The Air
- Listen for Understanding
- Stay Solution Focused
- Stay Scope Focused

Pediatric Behavioral Therapy

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Proposed Changes to PBT Policy

- Create a new eligible provider type (BCaBA) that can provide and bill for services.

- Improve quality, effectiveness, and consistency, of services.
  - Learn from new PAR process questions rolled out 4/1/2018
  - Plan to hire degreed professional to review PARs and develop additional guidance for reviewers

Why create new eligible provider type?

- Expand limited provider pool
- National certification for BCaBA providers has grown

What is meant by improving quality, effectiveness, and consistency (QEC) of services?

- Quality of current professional knowledge and standards applied to development and approval of care plans
- Effectiveness of therapies as measured by outcomes and met goals
- Consistency of access to quality services for children across the state

Improving QEC – New Provider Questions

- Examples of questions added to the PAR process on 4/1/18
  - Has the child received behavioral therapy services from a different organization in the past 6 months?
  - What screening tool was used to assess the need for behavioral therapy?
- Examples of how these questions may help improve QEC
  - Identify differences across providers and nature of client access issues
  - Identify if certain assessment tools lead to more accurate assessments and outcomes

Improving QEC – Plan to hire degreed professional to review PARs

- Degreed professional would:
  - Review 50-100 previously approved PARs to assess them for quality of: care plan; goals w/in the plan and any previous plans; and the degree to which goals were met.
  - Use information gathered to develop additional training and/or guidelines for PAR reviewing staff.
- Example of how these actions may help improve QEC
  - Reduce instances in which child is discharged by one provider for meeting care plan goals only to begin new care plan with different provider.

Questions for this group

- Creating a new eligible provider type (BCaBA)
  - ➢ Are there other mid-level provider types of which we are not aware and which we should consider including as eligible direct service providers?
  - ➢ How do you anticipate the addition of this provider type will help your organization?
  - ➢ Do you have concerns about the addition of this provider type?

Questions for this group

- Addition of PAR process questions
  - Are the questions added as of 4/1/2018 clear?
  - Can your office answer the questions as written?
  - Do you have additional question suggestions that may help us improve QEC over time?
  - What advice would you give the Department about how to improve the QEC of services across providers? How do you monitor and improve upon quality?

Questions for this group

- Hiring degreed professional to review PARs
  - Do you have concerns about the hiring of a degreed professional to review PARs and to provide further guidance to PAR reviewers? If so, what are they?
  - Do you have advice regarding what the degreed professional should be looking for when evaluating the quality of the care plan, the goals therein and whether those goals were met?
  - If you were advising PAR reviewers, what guidance would you give them that may help to improve QEC over time?

Thank You