Transformational Shifts: Integrating Primary & Behavioral Health Care and New York State’s Transition to Medicaid Managed Care

Dr. Peter Campanelli, Psy.D.
Dr. Tony Salerno, PhD
Meaghan Baier, LMSW
Agenda for Presentation

- Why the shift?
- Managed Care 101
- Integrated Care
- Integrated Health & Housing: Challenges and Opportunities
- Managed Care Technical Assistance Center
New York State’s Behavioral Health Managed Care Vision

- Fully integrated treatment where behavioral and physical health are valued equally and patients’ recovery goals are supported through a comprehensive and accessible service system.

- Integration of all Medicaid Behavioral Health (BH) and Physical Health (PH) benefits under managed care.
Why the need for the shift?
Medicaid Expenditures: 2013

$49.1 billion
Social Care
Behavioral
Deficit funded
Safety net
Individual

Programs
Level Of Service
Productivity

Paid for Quantity
- Little risk

Health Care
Integrated
Medicaid funded
Retail
Population

Outcomes
Value Based Payments

Paid for Quality
- Risk sharing

Slide courtesy C.Copeland, 2015
Managed Care 101...
Managed Care: Definition

• An integrated system that manages health services for an enrolled population rather than simply providing or paying for the services

• Services are usually delivered by providers who are under contract to or employed by the plan
Managed Care: Key Ingredients

- Care “management”
  - Utilization management
  - Disease management
- Vertical service integration and coordination
- Financial risk sharing with providers
Managed Care: Goals

• **Control costs**
  – Health care costs growing faster than GDP
  – Reduce inappropriate use of services
  – Increase completion: focus on value

• **Improve service quality**

• **Improve population health**

• **Increase preventive services**: promote health (not just treat illness)
Managed Care: Key Components

- Network of providers created via contracting
- Medical home created with primary care provider functioning as a gatekeeper
- Prior approval required for inpatient admissions, specialty visits, elective procedures, etc.
- Benefits package defined set of covered services
- Contained list of covered pharmaceuticals (Formulary)
- Utilization review practices to manage inpatient admissions and length of stay
How Capitation Works

• Managed Care Organization receives a fixed amount of money each month for each member: Per Member Per Month (PMPM)
• Fixed fee is for a specific time period (typically a month)
• Fee covers a defined set of services (these are the benefits)
• Provider accepts risk for delivering services:
  – Agrees to comply with prior authorization and utilization management practices
  – May enter into pay for performance arrangement
INTEGRATED CARE
So you want a definition for Integrated Care?
“The Body must be treated as a whole and not just a series of parts.”

Hippocrates 430 BC
Defining Integrated Care…

Illustration: A family tree of related terms used in behavioral health and primary care integration. See glossary for details and additional definitions.

Integrated Care:
- Tightly integrated, on-site teamwork with unified care plan as a standard approach to care for designated populations. Consists of organizational integration involving social & other services. “Alitudes” of integration: 1) integrated treatments, 2) integrated program structure; 3) integrated system of programs, and 4) integrated payments. (Based on SAMHSA)

Patient-Centered Care:
- “The experience to the extent the informed, individual patient desires it of transparency, individualization, recognition, respect, dignity, and choice in all matters, without exception, related to one’s person, circumstances, and relationships in health care”—or “nothing about me without me” (Berwick, 2011).

Coordinated Care:
- The organization of patient care activities between two or more participants (including the patient) involved in care, to facilitate appropriate delivery of healthcare services. Organizing care involves the marshalling of personnel and other resources needed to carry out required care activities, and often managed by the exchange of information among participants responsible for different aspects of care” (AHRQ, 2007).

Shared Care:
- Predominately Canadian usage—PC & MH professionals (typically psychiatrists) working together in shared system and record, maintaining I treatment plan addressing all patient health needs. (Kates et al, 1996; Kelly et al, 2011)

Collaborative Care:
- A general term for ongoing working relationships between clinicians, rather than a specific product or service (Doherty, McDaniel & Baird, 1996). Providers combine perspectives and skills to understand and identify problems and treatments, continually revising as needed to hit goals, e.g. in collaborative care of depression (Unutzer et al, 2002)

Co-located Care:
- BH and PC providers (i.e. physicians, NP’s) delivering care in same practice. This denotes shared space to one extent or another, not a specific service or kind of collaboration. (adapted from Blount, 2003)

Integrated Primary Care or Primary Care Behavioral Health:
- Combines medical & BH services for problems patients bring to primary care, including stress-linked physical symptoms, health behaviors, MH or SA disorders. For any problem, they have come to the right place—“no wrong door” (Blount). BH professional used as a consultant to PC colleagues (Sabin & Borus, 2009; Haas & deGruy, 2004; Robinson & Reiter, 2007; Hunter et al, 2009).

Behavioral Health Care:
- An umbrella term for care that addresses any behavioral problems bearing on health, including MH and SA conditions, stress-linked physical symptoms, patient activation and health behaviors. The job of all kinds of care settings, and done by clinicians and health coaches of various disciplines or training.

Mental Health Care:
- Care to help people with mental illnesses (or at risk)—to suffer less emotional pain and disability—and live healthier, longer, more productive lives. Done by a variety of caregivers in diverse public and private settings such as specialty MH, general medical, human services, and voluntary support networks. (Adapted from SAMHSA)

Substance Abuse Care:
- Services, treatments, and supports to help people with addictions and substance abuse problems suffer less emotional pain, family and vocational disturbance, physical risks—and live healthier, longer, more productive lives. Done in specialty SA, general medical, human services, voluntary support networks, e.g. 12-step programs and peer counselors. (Adapted from SAMHSA)

Patient-Centered Medical Home:
- An approach to comprehensive primary care for children, youth and adults—a setting that facilitates partnerships between patients and their personal physicians, and when appropriate, the patient’s family. Emphasizes care of populations, team care, whole person care—including behavioral health, care coordination, information tools and business models needed to sustain the work. The goal is health, patient experience, and reduced cost. (Joint Principles of PCMH, 2007)

Primary Care:
- Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. (Institute of Medicine, 1994)

Thanks to Benjamin Miller and Jürgen Unitzer for advice on organizing this illustration.
What is Integrated Healthcare (IC)?

• It is a coordinated system of care that provides both medical and mental/behavioral health services to address the whole person, not just one aspect of the consumer’s healthcare needs.

• Medical and mental health providers collaborate to coordinate the assessment, treatment, and follow-up of both mental and physical health conditions.

• Integrated healthcare reflects a holistic approach to social work practice that is strengths-based and person-centered. It represents an opportunity to improve care and reduce costs.
2010 Patient Protection Affordable Care Act (ACA)

- Most significant health care reform since the 1960’s
- Major driver of Integrated Care
- Triple Aim of Reducing Cost, Increasing Population Health Outcomes & Improving Pt. Satisfaction with Care
Patient Protection & Affordable Care Act (ACA)

- Insurance Reform
- Coverage Expansion
- Delivery System Redesign
- Payment Reform

Healthcare Reform
• Promotion of the Medical Home and Accountable Care Organizations (aka the homes for Medical Homes)

• Approx. 36 Billion to improve Health Information Technology

• Movement toward incentivizing providers through development of “qualified health plans” and “pay for reporting”

• Expansion of accreditation requirements to including Medical Home and Health Information Exchange standards

• Movement away from fee-for-service to bundled/case based payments

• New emphasis on need to reduce cost while increasing quality and information sharing between providers
Bi-directional opportunities in an integrated system of care

• Two major approaches to optimal integration:

1. Providing the services of a behavioral health specialist in a primary care setting
2. Providing primary care services in a behavioral health setting

• There are a set of competencies needed by social workers and other behavioral health disciplines working in either of these integrated settings
Why is it important?

• The US spends more on health care as a percentage of GDP than any other nation (now about 18%)

• Our health outcomes and health care system rank about 37th worldwide according to the metrics of the World Health Organization and a study conducted in 2010 by researchers from Harvard School of Public Health

• We are 1\textsuperscript{st} in emergency care
  – We are 39\textsuperscript{th} in infant mortality, 43\textsuperscript{rd} in adult male mortality and 42\textsuperscript{nd} in adult female mortality
Why is integrated care important?

- Skyrocketing cost of healthcare
- Fragmented health systems result in unmet healthcare needs
- Persons with mental health problems often don’t get care and those with SMI die significantly earlier than people without serious mental health difficulties.¹
- Many people with mental health problems have co-morbid medical problems.
- Primary care providers manage care for 80% of persons with psychiatric disorders and are the “de facto” mental health care system.²
- Currently 20% of persons in healthcare system use about 85% of resources
- Research reveals that cost-offset is greatest when behavioral and primary healthcare are integrated.³
The 53 year lifespan for people with Serious Behavioral Health Conditions is comparable with Sub-Saharan Africa.

NASMHPD 2006 Study: *Morbidity and Mortality in People with Serious Mental Illness*
Why is it Important?
The Causes are Preventable

Higher Rates of Modifiable Risk Factors:
- Smoking
- Alcohol consumption
- Poor nutrition / obesity
- Lack of exercise
- Unsafe sexual behavior
- IV drug use
- Residence in group care facilities and homeless shelters

Vulnerability due to higher rates of:
- Homelessness
- Victimization / trauma
- Unemployment
- Poverty
- Incarceration
- Social isolation
- Poor effects of psychotropic meds
Research Evidence on Integrated Healthcare

•Studies have shown that integrating mental/behavioral health services and primary care
  ❖ Improves patient satisfaction
  ❖ Improves provider satisfaction
  ❖ Increases adherence to medication
  ❖ Decreases medical utilization among “high users”
  ❖ Improves patient outcomes
  ❖ Reduces healthcare costs
  ❖ Improves patient quality of life
Social work core competencies in an integrated system of care

- Values
- Knowledge
- Skills
• The values, knowledge and skills needed by social workers and other behavioral health practitioners working in integrated settings
• Social work values and perspectives are uniquely aligned with the principles and practice of integrated care
Values

- **System Minded**: Individuals live within complex social, economic, political, cultural and service systems. Human problems and solutions exist within a context. Helping individuals requires an understanding of the context in which they live including the effects of racism, discrimination and poverty.

- **Comprehensiveness**: Social and psychological circumstances interact with health and illness. Mobilizing the full range of health, support and safety net services is key to sustainable and effective health improvement.

- **Cultural Sensitivity**: A person's culture, religious beliefs, sexual orientation, language, acculturation, socio-economic status, gender identity and racial/ethnic identity influences the perception of and engagement in the healthcare system.

- **Whole health**: Systems of care may be fragmented but human beings are not. Quality care means addressing the emotional, physical, substance use, trauma related and lifestyle challenges of individuals.

- **Person centered and self-determination**: The individual's goals and felt need to address mental health, physical health and substance concerns guides the shared decision making process.
Knowledge: What does a social worker need to know?

A. Understanding the interdependence and interrelationship among mental health, physical health and substance use problems
B. Understanding the role of adverse life experiences on a persons mental health, physical health and substance use
C. Understanding the roles and functions of an integrated inter-professional team
D. Understanding the Culture of Primary Care
E. Basic health literacy: common chronic health conditions and health indicators
Skills: What does a social worker need to do in an integrated healthcare system?

A. Engagement, Connecting and Motivation Enhancing Skills
B. Teaching skills: Imparting information based on the principles of adult education
C. Comprehensive Integrated Screening and Assessment Skills
D. Brief Behavioral Health and Substance Use Intervention and Referral skills
E. Comprehensive Care Coordination Skills
F. Health promotion, wellness and whole health self management skills in individual and group modalities
G. Basic Cognitive-Behavioral interventions
Health Homes: One example of a system wide effort to integrate care

- Similar to PCMH but focuses on low-income and people with chronic conditions
- Network of Providers who receive payment to provide care management services to high cost Medicaid enrollees (90% federal match)
- Eligible enrollees must have 2 chronic medical conditions or a serious mental illness or HIV
- Entities receiving grants from SAMHSA’s Primary and Behavioral Health Care Integration Program started in 2009 will now be required to be Health Homes
Health Homes Services

• Comprehensive care management
• Care coordination and health promotion
• Comprehensive transitional care/follow-up
• Patient and family support
• Referral to community and social support services
• Use of health information technology (HIT)
Health Home Structure

- **In House Model**
  - Behavioral Health Agency provides and owns all PC and BH services in one location
- **Co-Located Partner Model**
  - BH agencies arranges for PC to be delivered onsite
- **Facilitated Referral Model**
  - BH agency has processes that will coordinate care offsite (Druss, 2012)
The Future Healthcare Management Models

[Diagram showing various healthcare management models including Health Plan, Accountable Care Organization, Medical Homes, Hospitals, Specialty Clinics, and Clinics]
Who will be the one stop?
Integrated Health & Housing: Challenges and Opportunities
The PROBLEM

People with mental illness die earlier than the general population and have more co-occurring health conditions.

68% of adults with a mental illness have one or more chronic physical conditions.

more than 1 in 5 adults with mental illness have a co-occurring substance use disorder.
Homelessness: One Of Our Most Persistent Public Health Problems

- Approximately 1 million people will spend at least 1 night in an emergency shelter or in transitional housing (U.S. Department of Housing and Urban Development [HUD], 2010).
- In 2013, 610,042 people in the United States were homeless on any given night. Of this group, nearly 20% were individuals with disabilities who had been continually homeless for 1 year or more or had experienced four or more episodes of homelessness in the past 3 years (HUD, 2013).
• Compared with housed individuals, people experiencing homelessness have higher rates of heart, liver, and kidney disease; diabetes; HIV=AIDS; hepatitis C; tuberculosis; and cancer (LeBrun-Harris et al., 2013; National Coalition for the Homeless, 2009; U.S. Department of Health and Human Services, 2011).

• Mental illness and substance use disorders run rampant in this population. Prevalence estimates suggest that 50–70% of people experiencing homelessness have at least one mental illness, and 30%–50% have substance-abuse problems (Folsom & Jeste, 2002).
Estimated Current NYC Need

- Coalition for the Homeless, NYC reports July 2014
  - 56,454 people living in NYC Shelters
    - 8616 single men
    - 2979 single women
    - 44895 people in families
    - 23979 are children in families
- Disparities: African American and Latino disproportionately effected…linked to poverty
- Homeless have significantly higher rates of serious mental illness, SUD, and comorbid physical health problems
As the National Health Care for the Homeless Council (2011) points out, living on the street means greater exposure to harsh weather, violence, and malnutrition. Without a stable place to stay, it is difficult to store medications that must be taken daily, keep wounds clean, and get proper rest. High stress and dangerous environments worsen psychiatric symptoms and lead to increased substance use (Johnson & Chamberlain, 2011).

Within the current definition of integrated care—that is, integrated medical and behavioral health services—recent research suggests that providing a coordinated continuum of primary and behavioral health care (i.e., mental health and substance use treatment) can be particularly beneficial to people experiencing homelessness (Doran, Misa, & Shah, 2013; Nardone, Cho, & Moses, 2012).

Coordinated, collaborative services that target this population’s multiple health conditions, including their mental illness and substance use problems, offers great promise in improving their overall health and functioning (Tsai, Rosenheck, Culhane, & Artiga, 2013; Woltmann et al., 2012).
In the past decade, numerous studies have shown that integrating mental health and substance use treatment improves outcomes for people experiencing homelessness and helps them successfully transition out of homelessness (Clark, Power, LeFauve, & Lopez, 2008; Foster, LeFauve, Kresky-Wolff, & Rickards, 2010; Mares & Rosenheck, 2009).

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The complex, chronic nature of homeless people’s health problems means that competing needs are ever present, requiring collaboration among medical and mental health and social service providers.
SELLING GOOD NUTRITION & HEALTHY LIFE STYLE IS NOT EASY

“Number 11: Thou Shalt Not Eat Carbs. I think I’m gonna have trouble selling that one!”
Social Determinants of Health

- Housing
- Nutrition
- Trauma Informed
- Poverty/Employment
- Integrated SUD
- Wellness Self-management
- Integrated Continuous Access
- Services from people with lived experience
Best Practices in Housing

• Permanent supportive housing is widely recognized as an effective intervention for people with complex health and social needs who experience homelessness and particularly for those who experience chronic homelessness, often accompanied by frequent and avoidable hospitalizations, emergency room visits, and utilization of other crisis services.
Prevention & The New Medical Necessity: An ACA Priority

- Empowers the creation of a public health prevention plan through a panel of federal agencies and prevention experts
- Funds prevention outcome research through a public health fund which increases to $2 billion in 2015
- Includes research on integration of primary care into behavioral healthcare especially in the areas of HIV prevention, obesity (diabetes type II), and smoking cessation
- Provides funding to re-train and strengthen the workforce placing trained professionals in underserved areas.
permanent affordable rental housing linked to flexible support services making available the help people need to get and keep housing in community settings. Permanent supportive housing is an evidence-based practice for persons with mental illness who experience or are at risk of homelessness, as well as those who need a combination of affordable housing and supports for community living in order to leave or avoid long stays in institutional settings (Burt, Wilkins, & Mauch, 2011; Caton, Wilkins, & Anderson, 2007; U.S. Dept of Health and Human Services, Center for Mental Health Services, Substance Abuse)
When targeted to people who have long histories of homelessness, outcomes from permanent supportive housing include high rates of housing stability, reduced mortality, and substantial reductions in the use of hospital inpatient and emergency room care as well as reductions in stays in shelters, jails, and nursing homes.
Permanent supportive housing combines affordable rental housing with case management and other services that support housing stability and facilitate access to appropriate care.

Services in supportive housing are individualized and often focus on helping people manage disabling health conditions and symptoms of mental illness, increase skills for community living, and reduce harmful substance use and social isolation.
• Collaborative care and continuous communication
• Developing protocols for the management of lifestyle issues such as exercise, nutrition and psychiatric management
• Development of Protocols for the healthy management of Chronic Medical Conditions
Prevention: The New Medical Necessity

• Primary prevention: Advocating Actions that avert the onset of disease; example: Nutrition, exercise….type II diabetes
• Secondary Prevention: mitigating debilitating effects of disease once it is diagnosed; example: eye, kidney, vascular damage due to uncontrolled diabetes
• Tertiary Prevention: Attempting to control for acute life threatening events once disease process has progressed beyond secondary stage and has become chronic

➢ Avoiding iatrogenic medication interactions such as weight gain resulting from certain psychotropic medications in patients who are diabetic or pre-diabetic
➢ Teaching people with disabilities how to more effectively monitor and manage their comorbid physical conditions.

NASW NYC Presentation
Conclusion: Integrating Healthcare within Housing

- **It's all about how you define Health care!!!**

  ✓ **Continuity & linkage to community health/mental health care**
  ✓ **Person Centered Planning**
  ✓ **Psycho-educational wellness groups** targeted at specific issues especially brief, repeatable protocols
  ✓ **Cognitive-behavioral** approaches to behavior change
  ✓ **Critical time intervention** especially during crisis
  ✓ **Motivational Interviewing** counseling
  ✓ **Peer Work force** utilization
  ✓ **Trauma Informed** care
NYU Advanced Certificate Program
Integrated Health

Go To:
www. Silver School of Social Work/ Continuing Education

Click onto Advanced Certificate Programs

Watch the Video!!!
Resources for those of us in the middle of the transformational shift…
• Foundational information to prepare for Managed Care
• Support and capacity building for providers
  o tools
  o consultation
  o informational forums
  o assessment tools
• Critical information along each of the domain areas necessary for Managed Care readiness
• Feedback to providers and state authorities on readiness for Managed Care.
• MCTAC will serve as a clearing house for other Managed Care technical assistance efforts
13 Kick Off Events around NYS
Distribution and collection of a Managed Care Readiness Assessment & Agency Benchmark tools

Training Series:
- Contracting
- Revenue Cycle Management, Utilization Management, Outcomes

Online Tools:
- Managed Care Glossary
- Key Terms for Managed Care
- FAQs
- Recorded Webinars:
  - Contracting
  - Change Management
- Outputs to Outcomes online Database for NYS Health Foundation

Tools in development:
- Managed Care Matrix
- Managed Care script
- Managed Care 101 Presentations for front line staff
Managed Care Readiness Assessment

**Content Areas**

- Understanding MCO Priorities
- MCO Contracting
- Communication /Reporting
- IT System Requirements
- Credentialing Process
- Level of Care (LOC) Criteria / Utilization Management Practices
- Member Services/Grievance Procedures
- Medical Management
- Quality Management/Quality Studies/Incentive Opportunities
- Finance and Billing
- Access Requirements
- Demonstrating Impact/Value (Data Management & Evaluation Capacity)
313 MCTAC Readiness Assessments were included in analysis

OMH, OASAS and OMH/OASAS were represented (~30% each)

162 (52%) agencies did not score in the Top 25% in any Factor

There are no statistically significant differences by Region

There are statistically significant differences by Reimbursement

There are statistically significant differences by Agency Type
## Example Agency Readiness Assessment

Introduction. 554 Readiness Assessments were analyzed. 306 were completed. The following data is included in your report:

- **Average Score** – the mean of the population (N=554) in the domain, which could range from 0 - 5
- **Agency Score** – your agency’s individual score in the domain, which could range from 0 - 5
- **Percentile** – your agency’s rank compared to the population, which could range from 0 – 100.

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<th>Average Score</th>
<th>Agency Score</th>
<th>Percentile (%)</th>
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Visit ctacny.com for more information.
Primary Goal: To help behavioral health providers improve their quality of care while lowering healthcare costs.

Achieve goal by:

• Agencies will be able to access standardized outcome measurement tools and metrics (database) designed to facilitate and improve use of evidence-based practices.

• Agencies can determine effectiveness of treatment modalities for prevalent mental health disorders.

• Best practices/model programs will be identified and disseminated.

• Identify clinics and practitioners that are not achieving minimum outcome benchmarks.
Primary Project Activities

- Create assessment database for practitioners and organization decision-makers to identify and access clinical outcome and process measures.
- Create/identify digital platform for clinics to upload and view outcome data and performance metrics.
- Build provider capacity around outcomes and disseminate project tools through trainings and learning collaborative/community.
OUTPUT to OUTCOMES
ASSESSMENT RESOURCE FOR CLINICS

Helping mental health agencies integrate outcome measures into their clinical treatment.

Search Now

WE’VE STREAMLINED THE PROCESS FOR YOU.
Find valid measure options for your clinical case work in less time.
Managed Care Plan Matrix Features

- **An interactive map tool** to search MCOs by county in NYS
- **Contact information** for MCO departments including member relations, provider relations, finance, and case management
- **Authorization procedures** including: pre-authorization, level-of-care determination, quality improvement standards, complaint and grievance procedures, and reauthorization
- **Claims and billing information**: a checklist of required fields across plans, as well as a list of non-standard requirements for each plan
- **Save and print features** for users to keep helpful information handy
Understanding the Impact of Change on the Workforce

• It is not unusual for an organization’s leadership to believe that it is engaged in promoting strategic change and for its workforce to experience it as shock change.

Change Management Leadership: Guiding an organization through rapid and uncharted waters
So basically we need to:
What Participants Can Do to Make the Most of MCTAC Supports

- Designate a project team including:
  - Executive leadership, Finance & Clinic leadership, and Evaluation staff when available
- Complete the **Readiness Assessment** and participate actively in MCTAC activities
- Commit to investing the time and effort needed to assess, diagnosis, improve, and monitor your organization’s operations, business practices, and financial performance
Questions and Discussion

Visit [www.mctac.org](http://www.mctac.org) to view past trainings, sign-up for upcoming events, and access resources.

**Upcoming Events**

- **Tuesday, February 10, 2015**
  Contracting for Managed Care Webinar Overview and Office Hours, 10 am - 12 pm

- **Thursday, February 26, 2015**
  Readiness Assessment Follow-up Webinar

[view more >](#)

**Missed the Kick-off Series?**

View a video recording from the Albany presentation.

[VIEW NOW >](#)

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