Behavioral Health Partnership Oversight Council

Operations Committee

Legislative Office Building Room 3000, Hartford CT 06106
860) 240-0321 Info Line (860) 240-8329 FAX (860) 240-5306
www.cga.ct.gov/ph/BHPOC

Co-chairs: Lorna Grivois & Stephen Larcen

Meeting summary: Feb. 4, 2011
Next Meeting Friday March 4, 2011 @ 2:30 – 4 PM at VO/Rocky Hill

Agency/ValueOption review of BH ASO implementation for Medicaid enrollees


BHOC-presentation2 -09-11final(2).ppt

Highlights of discussion including slide presentation clarification resulted in the above presentation to the BHP Oversight Council on Feb, 9 (*click icon above to view presentation regarding ASO implementation, existing/open authorizations by LOC, Medicare/Medicaid billing, etc).*

- ✓ *(Slides 2 &3)* identifies current/new State Agency partnerships (DSS, DCF & DMHAS) and 3 distinct coverage groups: HUSKY A & B,Charter Oak & Medicaid Fee For Service that includes ABD, dual eligibles and Low-Income Adults (LIA).
- ✓ *(Slides 4-7)* outline the implementation plan and March 1, 2011 deliverables. *ValueOptions* was selected as the successful bidder for the ASO for the Medicaid FFS coverage groups. *(Slide 8)* Full implementation of ASO management for Medicaid FFS will ***commence April 1, 2011.***
- ✓ *(Slide 7)* shows the responsibilities VO will assume as of March 1, 2011 that include DMHAS RTC bed capacity data, residential detox provider disposition assistance/referral to ABH case managers, contact EDS daily to identify "stuck" BHP members, provide assistance on diversion/coordination with Local Mental Health Authorities (LMHAs) and/or ABH case managers, contact psychiatric hospital units to assist with disposition, referrals and ABH case managers as appropriate.
- ✓ *(Slide 9):* Rates and benefits for 3 distinct coverage groups (HUSKY, COHP, & Medicaid FFS) do not have uniform rates or benefits and there is NO CHANGE to these in the 'new' partnership/ASO for any coverage group. Mr. Halsey (DSS) stated there is no merging of all rates to the current BHP rates.

✓ *(Slide 10)* While all VO authorizations (prior and continued stay) are based on medical necessity, PA care guidelines will be used to assist the ASO by providing typical parameters of duration for a service authorization.

✓ *(Slides 11-17)* provide VO process for open authorizations by level of care for Medicaid FFS members initiated prior to 4/1/11; new prior authorization (PA) or continued stay requests must go through VO. ***Existing authorizations will be honored. New authorizations for services on or after April 1, 2011 will be staggered for high volume services: routine outpatient & Methadone Maintenance.*** VO summarized the process:

- Existing PA/continued stay received prior to 4/1/11 that may extend beyond that date will continue without another PA in the new system.
- New PA for services on or after 4/1 and new continued stay requests will be authorized by VO.

✓ FFS members using BH services will need to be entered into the VO registration system. VO staff will work with high volume (>200 clients) providers to identify clients and do the data entry. VO will give high volume providers notification of this.

✓ VO expects to finalize the eligibility files in March to allow BH member registration prior to April 1 of high volume providers.

✓ VO will provide state wide training for all providers on ***Feb. 28th*** (*Click icon below)*

BHP Provider Forum Invitation - 2-9-11.pd

These will be followed by *trainings specific to service type*, recognizing that some BH providers in the DMHAS system have not worked with VO and their registration/PA systems. VO will be updating their website to reflect information for the additional Medicaid FFS group. www.ctbhp.com. This Committee welcomes DMHAS providers such as Adult Group homes and Home Care providers to attend these meetings and reflect operational issues for these providers new to VO system.

Provider Bypass Program Changes *(Click icon below to view BHP policy change)*

VO Hosp bypass chg 2-11.pdf

(Slide 19) outlines the above changes in the provider (hospital, intensive outpatient -IOP) by-pass programs; 1) hospital program will be slightly modified to authorize 5 days instead of 6 days in the initial authorization for those providers that qualify for the by-pass program, 2) IOP by-pass will terminate March 31, 2011 with transition to the VO registration process April 1, 2011. The changes were made to provide consistency for all populations for these care levels. Lori Szczygiel (VO) emphasized that the hospital by-pass programs ***was never meant to reflect the ideal length of stay***; it was tied to ***administrative efficiency for both VO and providers*** in reducing a continuous stay request.

Dual Eligible Billing Issues *(See Slide 18):*

- The committee suggested DSS add a slide (#18) clarifying Medicare & Medicaid (dual

eligible) authorization requirements thru VO after questions posed by the Committee.

- Medicare/Medicaid billing processes are under the same rules as in Medicaid FFS. The provider manual chapter 9 summary says "***For patients who are dually eligible (having both Medicare and Medicaid coverage), the provider (referencing psychiatric hospital) should request authorization on the day Medicaid coverage becomes primary".*** Providers assert this is problematic in that CTBHP timely filing is 120 days from a new client's eligibility date, not the date of service. The Medicaid eligibility date isn't available to provider. It was suggested this information could be added to the HP website, or expand timely filing process while long term care and other providers are notified of the client's deemed Medicaid eligibility date. ***(Follow up with DSS in March).***

CTBHP Claims Reports: reports currently not being provided (required changes in the system) that had stopped with the 'new' Interchange system in 2008. Mr. Halsey (DSS) will review the previous reporting format to ensure data addresses claim delays/denials reasons that will allow providers to make corrections in their billing departments. (***Follow up in March Meeting****)*