Behavioral Health Partnership Oversight Council

Operations Committee

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Co-chairs: Lorna Grivois & Stephen Larcen

Meeting Summary: ***March 4, 2011***
Next meeting: **April 1, 2011 2:30 – 4 PM at VO, Rocky Hill**

Attendees;

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VO Update on April 1, 2011 Implementation: Lori Szczygiel

DSS, DCF & DMHAS reviewed VO readiness for the April 1, 2011 ASO to assume management of behavioral health services for the additional populations in the Medicaid low income adult (LIA) and Aged, Blind & Disabled (ABD) dual and non-dual eligibles. Twenty domains were assessed:

- ✓ 1-4 domains address infrastructure: built all new eligibility files for provider auths, adding group homes.
- ✓ #5: policy procedures – working with DMHAS on security privacy HIPAA.
- ✓ 6-7: staff training materials that are comprehensive and inclusive. VO has added 70 new staff with one more position to fill. Staff space being added.
- ✓ 10-11: new 'Connect' platform (registration) has been tested with no IT problems. Developed a new PA for home health care that should be on the website next week.
- ✓ 12-20: UM included ICM program revisions, UM descriptions, provider orientation given to 350 providers and there will additional service specific workshop for home health, group homes, new IOP and outpatient providers. VO has met with Home health professional association as well as other home health providers not in the association. Calendar is on web site: www.ctbhp.com
Paul DiLeo (DMHAS) will do the Community meetings with VO.
- ✓ 15: system integration: ABH and local mental health authorities (LMHAs) will use resources for those most at risk.
- ✓ 16-17: member inquiry & provider appeals – slight changes have been made on the web. The master authorization parameters are also on the web. VO will look at future on-line provider appeal process at the request of the participants.
- ✓ VO has assumed responsibility for obtaining data on DMHAS RTC detox bed availability, possible referral to ABH and ED volume. Four VO staff will begin entering high volume adult practices in the registration system.

Discussion points included the following:

- Hospitals have numbers of initially uninsured patients admitted for BH inpatient services that now require retro authorization for services when patient deem eligible. VO said they cannot do 'pre-cert' for members not yet determined eligible in the system.
    - YNHH noted that since 1/26/11 there were 180 admissions of uninsured patients to adult MH with only 13 denied benefits – most were LIA eligible which necessitates retro PAs. This increases administrative work for both the hospital and VO. This suggests that the retro eligibility may be a more significant volume factor than previous DSS experience.
    - Dr. Larcen noted the timely file for retro eligibility is based on when eligibility is granted; this information isn't found in the AVES system. DSS was asked to consider a 1 year timely filing for the CTBHP population subset that receives retro authorization and has a 120 day timely filing requirement.
- Access VO grid on their web page to view time lines for registration, new IOP web form. IOP will have initial auth for 10 visits, and one web-based concurrent review before telephonic review.
- For high volume patients currently receiving BH services, the goal is to stagger the authorizations so the plan is for members with:
    - 0-1 year continuous service: receive PA for 90 Units (one year)
    - >1 year to 3 years continuous service: PA for 45 Units (6 months)
    - > 3 years continuous service PA over 6 months for 26 Units.

The start date for the PA is 4-1-11. Chronically ill patients with several years of service may only use 4 units because they are seen only one time a month. VO will start with a 6 month review that is more an internal process to assess service use, client needs; will reassess process.

Claims Denial reporting

William Halsey (DSS) said DSS is involved in a parallel process to VO's testing for 4-1-11 start date by testing the claims system. HP produces numerous reports on denials: need to identify reports that allow tracking trends in claims denials that are meaningful to providers. As in past reports, Dr. Larcen said duplicate denials had to be discounted as these often are eventually paid, but initially denied vs. true denied claims that need to be tracked.

IOP/EDT Issues

Dr. Karen Andersson (DCF) briefly reviewed the issues discussed in the ***DCF Advisory Committee***. After numerous analyses, DCF determined that a conversion of EDT services to FFS process was not doable - grants were still needed. There was an assessment of the analysis of EDT programs that had been allowed under managed care to bill for EDT services at the IOP rate. A change in the reimbursement for services in an EDT program that would eliminate the unorthodox processes, resulted in 4 of 14 providers experiencing an unexpected revenue loss. DCF re-did the analysis after the 3-1 DCF meeting, taking into consideration DCF Committee suggestions. This will be sent to the EDT program providers and those that find the DCF analysis does not meet with their program data will meet with DCF to review the differences. In response to questions, VO stated they give PA for services/member that meet the level of care guidelines and medical necessity; the PA was not based on type of program (i.e. independent IOP program vs. EDT program with IOP and EDT services.) The changes were to be implemented 4-1-11: the agencies (DCF & DSS) were asked to postpone the start date until the analysis process is complete.