Behavioral Health Partnership Oversight Council

Operations Committee

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Co-chairs: Lorna Grivois & Stephen Larcen

Meeting Summary: *April 1, 2011*

Next meeting: **Friday May 13, 2011***(Note date change)*

1. *General Update on Implementation "Go Live" Medicaid BHP Program*

Lori Szczygiel provided an overview of the April 1, 2011 "go live" VO management of the Medicaid FFS population behavioral health services within the expanded Partnership of DSS, DCF & DMHAS.

- VO received 268 calls by noon today. Authorization time is ~ 11 minutes for HUSKY children and ~20 minutes for Medicaid adults, attributed to providers new to this process.
- VO staffing positions are filled (a few held open for the fall).
- VO contracted with McKesson involving the management of clients with medical/MH co-morbidities.
- OP registration was anticipated at 6000 but is ~ 12,000 clients that need to be entered into the system. VO put in ~ 4000 prior to 4-1-11. VO gave 30 days pre 4-1 and 60 days post 4-1 for PA. Providers should check PA approval status before sending in the claim: this information can be found on the VO website, listed by agency: a provider can see all PAs listed in alphabetical order. VO will be able to backdate the PA.
- It was clarified that the 60 day "grace period" does impact provider cash flow, as no claims will be processed until the OP services have a PA in the system. This was not previously clear to providers.

2. IOP Web registration: Conflict between 10 units/ 28 day authorization and actual program operations

IOP providers will receive 10 units over 28 days via 1st web registration and *telephonic* approval is required for the 2nd 10 units/28 day PA. Providers expressed concern on the burden of calling for the 2nd PA as some programs use 10 sessions within 2.5 weeks. DSS stated this was the process in the previous SAGA/ABH system. At this time the Agencies and VO are creating the common parameters for IOP PA (and all services) for all populations; VO provides PA per client need, taking into consideration level of care guidelines and medical necessity. This process will be reassessed and remain on Committee agenda.

3. *Update on process for uninsured: pending eligibility and authorizations*

DSS is reviewing with their legal staff whether PA can be approved for inpatient services (as well as ambulatory services) while program eligibility is pending. Facilities are obligated to accept clients for inpatient care when seen in the ED. This was done under the state-funded SAGA BH program but needs to be assessed under Medicaid. In the meantime VO stressed the importance of ***notifying VO when client receiving services become eligible – need to state this upfront when VO is contacted.*** Clients cannot be put into the web registration system until they are given eligibility for Medicaid. Ms. Collins hoped this clarification is made before next month (May) before YNNH commits to chart review.Detox inpatient providers noted their client may be discharged before Medicaid eligibility is confirmed. DSS to follow-up on this item and report to committee at a future meeting.
Question: when will provider education regarding medical necessity guidelines be provided prior to audits as some providers are anxious about the audits – to be determined by DSS.

4. *Content of OP/IOP web registrations: required fields and use of data*.

The new Connect system requests information for the web registration that is burdensome to providers, although the outpatient PA units have been increased to 90 units. For example, psychotropic meds information is requested that is not readily available when doing the registration and may be obtained through another source. VO stated the questions added came from the national program and there is a 'drop-down' box to indicate meds. Nationally VO views it important to identify medical/MH co-morbidities and be able to analyze prescriber type, capacity to transfer drug maintenance to primary care providers. VO will review measures, consider needed modifications after this CY. Dr. Larcen asked what a reasonable time is for provider alert about new required data (large volume providers need 120 days). VO noted they have 30 days to change reports to the agencies. There is a 365 days claims lag time for Medicaid FFS services so the registration data provides data trends. DSS stated the agencies are reviewing the over 300 VO reports, will determine what is important and can be put on a web dashboard. VO and the agencies agreed to bring future new web registration questions to the Operations Committee.

5. *ECT authorizations*

VO will look at a template of registration questions for outpatient ECT services in the future.

6. *Claims denial reporting implementation*

DSS is tracking weekly HP reports on claims information, including denied claims and reasons, how claims were submitted (batch vs. individual) and will consider resurrecting the early reports from the Rapid Response Team claims summaries that are relevant to this program. HP requires 60 days for report edits. Dr. Larcen noted the usefulness of the RRT reports that allowed provider error corrections that involve less administrative time for HP and providers.

7. *Other*

The Adult quality Committee is interested in LIA utilization data and the Operations Committee is interested in baseline expenditures for LIA. Also suggestion to look at the ABD population along these measures as well. DSS said Qualidigm currently does PA for Medicaid clients for an inpatient episode that includes admission to a medical unit and transfer to Psychiatric unit. DSS wants to amend this contract to ensure VO is alerted to inpatient psychiatric care until the Medical ASO process is

implemented. VO follows up on inpatient service transfer from psychiatric services to medical.