Behavioral Health Partnership Oversight Council

Operations Committee

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Co-chairs: Lorna Grivois & Stephen Larcen

Meeting Summary: May 13, 2011
Next meeting: ***June 3, 2011 @ 2:30 PM***

Attendees:

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1) ***DSS update on Authorization Process for clients with retroactive eligibility***: DSS said a solution to this issue that impacts mental health providers is in progress and pending final policy review and approval. The retroactive eligibility service coverage is in progress.
VO: If you have submitted medical records with claim for this group who was pending and now eligible: call Dr. Steve Moore 263-2102.

2) See ***April 2011 provider alert*** issued on inpatient Prior Authorization responsibility/entity and discussion on this below.

PA 2011-10 - CT BHP
Hospital Medical-Psyc

- Who should do the review when Medicaid client admitted to a *medical unit:* - Qualidigm. VO will do the review for *direct Psych unit* admissions.
- If the patient is *first* admitted to the psych unit, VO does PA and follows the PA even if patient transferred to medical unit: VO will get information from the hospital on reason for medical unit transfer and expected Medical unit LOS.
- If the patient on a Medical unit is transferred to a psych unit and Qualidigm did PA medical: VO asked provider to call VO to inform them so VO can work with provider for next level of care.
- Psych to medical transfer: and have PA for inpatient stay with end date: VO will extend the end date for necessary period of time: but hospital has to notify VO. VO would accommodate back dating VO if hospital hasn't been able to call.

3) Group Home review process: VO will go thru LOC guidelines: want to fill Group Home beds – DMHAS & LMHA make admission determinations. There have been challenges in some parts of the state in referrals to Group Homes. To bill Medicaid, client has to have 40 hours of rehab services/ less than 40 hours, look at lesser billing rate. DMHAS is working with DSS on this.

4) TPL Online process changes: subscriber name and policy ID data elements have been dropped from online lookup. CTBHP comment: this references the last page: HIPPA limits on information on web registration (insurance subscriber #), ***but can access this information on the AVES system.***

5) Detox providers/ scope of authorization reviews. VO reported the PA process time is ~ 22-25 minutes max with ~17 minutes average authorization time. The authorization time has been reduced with template of required information that prepares provider and VO for authorization call.

6) Authorization timeframes summaries:

- Average authorization timeframes by level of care (LOC)
    - Improvement: high volume providers like hospitals needed more staff to do this.
    - FFS populations – represents VO's 'new work' as of April 1, 2011 although LIA has been part of the system. DMHAS noted when GABH started in 1996-97 there were similar administrative issues experienced as those discussed under VO management.
    - Intensive Out Patient (IOP) CCR - 30 patients: 10 pts /week for PA: DSS said they are looking at IOP PA parameters in a manner similar to EDT PA units where there were changes made due to low numbers. DSS said this can be modified and the Agencies will have a decision in 2 weeks.
    - DMHAS will meet with LMHAs to discuss intensive care management: commitment to share discussion with BHP OC. VO hired staff from ABH so there is familiarity with this population. VO is meeting with hospital staff to identify how VO can be most effective. VO made a commitment to work with YNHH ED because of ED adult psych patient delayed stays.
    - VO Intensive Case Management (ICM) vs. ICM ABH (in person CM) & LMHA: 3 levels of coordination of care that creates confusion.
    - After- hours Auth information is received but has less data than that collected during the day, hence VO's call back next day to complete the registration data.

- Claims denial data: related to certain LOC derived from all HP claims data: DSS has to sort out BH data. Dr. Larcen noted this claims report says 70% are paid, 30% not paid by reason for denial.; past reports allowed trouble shooting at billing level.

7) HUSKY & Medicaid LIA & ABD Rate Blend Initiative; related to changes on medical side with State Medicaid conversion from waiver to SPA that will affect provider rates. DSS sent out draft and will go thru rates for each LOC for CTBHP HUSKY, FFS LIA, ABD. The process is intended to identify nuances of rates by LOC: DSS & DMHAS look at each

covered groups' LOC. This is an intricate process. Dr. Larcen said the Operations Committee will convene a small work group comprised of 1 representative from each major LOC category to work on the rate initiative and reports will be brought back to the Committee. Identify rate change options, projected impact. ***Representatives with general interest should contact Steve Larcen with their contact info, LOC area.***

DSS will identify where providers can get Medicare rate information to help providers know "end rate" for Medicaid.

Next meeting agenda will include the transition plan for licensure for Clinics with satellite sites.