BHP Operations Sub-committee - Minutes

DATE AND TIME OF MEETING: Date May 3, 2019 Time: 2:30 - 4:00 Location: Hartford Room - Beacon	Internal	External	Recorder: Jen Kurowski OperationsMtgAgenda5-3-19.doc Operations Subcommittee sign-	Draft	Final
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TOPIC	DISCUSSION/RECOMMENDATION
1. IICAPS	• Bill H. mentioned that we are not changing rates or payments. Not making any changes to the LOC guidelines. Jean/Joe did confirm that ASD/ID/IDD/SUD cannot be the primary dx. ○ Bill will confirm whether this is indicated in the guidelines. • Bill read an excerpt from the LOC guidelines and asked if anyone has a different understanding (assessments not to occur more frequently than every 60 days per Jean/Joe when asked what is a reasonable # of assessments a child should receive while in episode of care). ○ Bill mentioned that they have seen many notes saying "observing child", which prompted this question above. They are trying to put some intentional documentation and observation behind that observation rather than such a vague notation like "observing the child". ○ Heather G. suggested that all IICAPS providers should respond to this information via survey monkey. Terri D. agreed that this would be an effective means of obtaining this information from the providers. ○ Bill clarified that the question should be "If someone is submitting observation as a billable code, what documentation should accompany this"? ○ Need to speak with the network on this. ○ State Plan for rehab services was amended. Trying to plan out a process for this amendment, which was just approved. ○ Bill explained that Yale says their staff composition may look different than other providers. ○ Related to the spa, we need to amend the spa because IICAPS is problematic and will need to amend it if we want to keep IICAPS going. Potentially some unrelated things we would like to do within the amendment. Bill says this issue must be resolved in order to keep this particular model going. Not interested in blowing this up. For the benefit of providers, we need to be very clear about billing instructions, such as with H2019. • Next steps – Bill and Stephney should determine how to proceed. Bill would like to do this communication through the IICAPS network meeting (next meeting is on 6/10 from 1-3p.m.). Will distribute this list in advance so they can be prepared to respond. Bill needs to check with Jean/Joe on one thing before he distributes the list. ○ Ben S. asked if this is an open meeting that he can attend. ▪ Heather offered to check on this.

2. Integrated Care for Kids (InCK) Federal RFP	• Due June 10th
	• Received 11 statements of intent. Clifford Beers selected to be the local lead organization. They will have access to our Medicaid state claims data and hopefully for other states as well.
	• Risk stratification: rating of 1 – low risk, rating of 2 or 3 – enhanced care; target population is pregnant women of any age and children under age 21.
	• Running data on New Haven, Bridgeport, and Hartford and will need to compare longitudily all the kids. There will always be an opt-out but every child is to be tracked in all these locations and across multiple domains (health care, school, food, housing, etc.).
	• This is a 7 year grant with 2 years of planning. Need to implement alternative payment model in year 4; working with Mercer on this. This should not interfere with the PCMH+
	• Attribution model; in New Haven will likely need to expand the attribution logic we are using for PCMH+
	• Heather asked with regard to the PCMH+ program: Has there been any thinking with how the state might develop a rate and payment methodology for kids and families who have significant behavioral health conditions?
	  ○ We are required to do a root cause analysis. Will determine how to risk stratify. Even if we don't get this grant, there is value in having this in CT. We will be building a roadmap on how to do this and how to pay for it. At this point, we will be able to make projections on how to proceed with this and where is the best location for this service. Would then determine if the care coordination model has fidelity.
	  ○ Heather asked if we get the grant, could the timetable be accelerated? Bill is not sure how we would implement this outside the grant and have fidelity to the grant.
	  ○ Bill said it was mentioned at the Behavioral Health Oversight Council (BHOC) that we are researching what we can do with individuals with SUD. If we could get a demonstration waiver, that would be an option.

3. Alternate Payment Models	• Bill commented that DSS would like to hear from the council if they feel there are other areas that we should look at, such as we should consider whether is it time to look at ECCs.
	• Terri asked if we will ever see any change in ECCs before we get to the alternate payment model?
	  ○ Bill says the state agency reps involved here or in the ECCs would support the idea of creating a value based model and then letting that play out in terms of a path into it and out of it based on outcomes. It would be beneficial to come up with a more streamlined approach. Bill would like to move towards outcomes, not just access. This gets complicated in terms of whether the entire agency would be an ECC or just the site.
	  ○ Terri commented that the thing that stops her from opening a new site is that she would need to have 3 addresses and three numbers. This is an access issue with relation to how many locations are allowed. Heather weighed in on this and agreed that this is an artificial and old construct that does not align with current services and current delivery models. Bill agreed and said we should do this under a value based framework, but Heather said it depends how it is setup. Heather commented that we need to get more concrete on how we start looking at rate structures. This would be a good discussion following BHOC on 5/12.
	• Heather commented that we should give some thought to the terminology we use and what it means. Bill suggested a safer term is value based.

	• Bill said we need to consider what outpatient providers need in their toolbox to keep patients out of the hospital. Need to think of routine outpatient as similar to primary care. Need to ensure the outpatient providers have the capacity to meet the needs. • Bill recommends that we pick one project to work on and go all in. Heather suggested that this would be a great conversation to have with folks at the trade associations. • Ellen Andrews asked for clarification on whether this is a provider risk model and does this cover total cost of care? Bill said this is not a discussion on a risk model and this is not shared savings per the formal definition within a value based payment model. Bill explained that the plan is to create a platform to develop a value based reimbursement model.

4. Follow-up on Tele-health	• Bill explained that the area of focus right now is BH and individuals that are planning to or have gone under surgery in a non-continuous state and we feel some of the pre- and post- can be done via telehealth and for some folks who are home-based. Applicable for providers with multiple sites. Bill explained how the hub and spoke would work and provided some examples of situations that would qualify for tele-health. This is real-time face-to-face interaction.
	• Bill said we are also considering the thought of under what circumstance would we be comfortable with an adult member getting services in their home with a clinician? This would not include the initial evaluation. Some of the responses included:
	  ○ Kelly P. suggested that Agoraphobia might be one situation where this could be helpful. Or perhaps someone with immune deficiency.
	  ○ Someone would need to certify that the person is unable to go to the office and would need home-based care.
	  ○ Heather said it seems sensible that with today's technology, we should be able to provide tele-health services.
	  ○ David B. mentioned that we need to be careful of discrimination.
	  ○ Christie S. said initial evals need to be done face-to-face.
	  ○ Tyler B. mentioned that providers should be able to weigh in on whether the member should be able to receive services via tele-health and should depend on medical necessity.
	• Bill read the current statute on this, which indicates that this can't be done simply for the convenience of the member or the provider. Some of the responses included:
	  ○ Erika Sharillo commented that there would need to be a clinically indicated reason.
	  ○ Ben S. asked if the state were asked to change the definition of medical necessity, what would be the impact to the state? Bill said this is simply a matter of providing examples right now for tele-health.
	  ○ Terri encouraged the group not to get too stuck on the definition of convenience.
	  ○ Heather suggested that the definition should be as broad as possible so that the decision can be left to the provider.
	  ○ Kelly P. commented that some things can only be truly observed via face-to-face interactions.
	  ○ Tyler B. commented the providers are professionals and should be allowed to determine the frequency of tele-health visits vs. face-to-face. Linda R. agreed with this positon.

	○ Sabrina T. said she doesn't feel it's necessary to have additional documentation on this. • From a commercial standpoint, no additional documentation needed; provider initiates the electronic medical record at the start of the session; providers given certain details to review with the clients prior to the session such as lighting, location, confidentiality, etc. This does not have a separate authorization process. • Valerie at OHA mentioned that she is surprised that they have not received any denials on the tele-health for the commercial carriers. OHA is looking at this. • Heather asked about timeframe? ○ Bill said this will need a state plan amendment. He is trying to get a call with CMS to talk this through. ○ Bill will make edits and let the legal department know DSS is ready to talk through this. ○ Heather mentioned that this is on the agenda for the executive committees and will be discussed next week at BHOC with a request for timeframe. • Ben S. acknowledged DSS for taking the provider input on this and feels this will be substantially better for providers than what was discussed about a year ago.
5. New Business and Announcements / Adjourn	• Going forward, we will proceed with WebEx with registration for next meeting in order to have a better handle of who is joining remotely. • Meeting adjourned at 3:58 p.m.
6. Upcoming Meetings	• September 6, 2019 at 2:30 p.m. in Beacon Health Options' Hartford Room, 3rd Floor, Suite 3D, Rocky Hill, CT