Connecticut Medicaid Managed Care Council

BHP OC **Meeting Summary: February 15, 2006**
(Next meeting: Wednesday March 8, 2006 @ 2 PM in LOB RM 1D)

Attendees: Sen.Chris Murphy & Jeffrey Walter (Co-Chairs), Rep. Peggy Sayers, Rep. Patricia Dillon, Paula Armbruster, Connie Catrone, Anthony DelMastro, Dr. Davis Gammon, Heather gates, Sharon Langer, Patrick Monhan, Pat Naylor, Sherry Perlstein, Dana-Marie Salvatore, Dr. Stephen Larcen, Vicki Veltri, Dr. Ramindra Walia, Susan Walkama, Beresford Wilson.
Also Attended: Mark Schaefer (DSS), Karen Andersson (DCF), Lori Szcyzgiel (VOI-ASO), Pat Rehmer (DMHAS), Cheryl Carotenuti (SDE), Thomas Deasy (Comptroller Office), barbara park Wolf (OPM), Robert Diaz (WellCare/PONE), Janice Perkins (HealthNet), Dr. Razia Hashi (Anthem), M. McCourt (Council legislative staff).

Behavioral Health Partnership (BHP) Agencies' Report

The Administrative Service Organization (ASO) provided the report. Highlights of Lori Szczygiel (CEO, ValueOptions, CTBHP) report:

- CTBHP is in the process of testing the full service claims cycle.
- The web-based outpatient registration system development is in process with review and input from the BHP OC Quality Management & Access Subcommittee.
- Key staff have been added and openings remain for Intensive Care managers and case managers. CTBHP will host a job fair in early March and continue to actively recruit for a psychiatrist.

- The phase in of the utilization management process continues:

    - Phase 1: Residential & Group Home new admission prior authorizations (PA) and concurrent review began February 1, 2006.
    - Phase 2: Inpatient/acute care, including 23 hour inpatient, PRFT's will begin March 1, 2006. New admissions will require PA and providers need to either fax a modified concurrent review form for patients in treatment between 3/1-3/15/06 or call the ASO either on the discharge day or 3/15/06, which ever comes firsts.
    - Phase 3; Interim level care (i.e. residential detox, PHP, IOP, intensive home services) will be followed by Phase 4: Outpatient services May 1, 2006.

- Provider network development update:

    - 1300 credentialed providers including 80 RTC & Group Home providers and 150 new providers have been loaded into the network system.
    - Initially CTBHP reported that 900 providers identified through the MCO claims cross match with the Medicaid provider system (CMAP) could not be found. As of 2/13/06 that number has been reduced to **53 providers**. While CTBHP continues to actively search for these providers' contact information, it is

estimated that over 10% may be in group practices or within clinic systems. It was suggested that CTBHP match these providers with the Department of Public Health (DPH) list of licensed providers.

- CTBHP will provide the Transition SC and Council with an updated list of provider types in the system in March. Mr. Walter and Vicki Veltri suggested that in order to assess the adequacy of the provider network, it would be important to identify providers both by discipline and geographic distribution.

• Transitional Disruption Analysis report: Initially 11,000 members were receiving BH services from non-credentialed Medicaid (CMAP) providers. Under the new service delivery system providers outside the CMAP system would not be reimbursed for services beyond a certain time. A more recent analysis with the added credentialed providers showed that 1100 clients are receiving services from non-credentialed (CMAP) providers, many of whom may have completed treatment. Ms. Sczyzgiel will reassess client impact in light of the further reduction in the number of non-credentialed providers.

• Consumer activity:

- In five weeks the call volume has significantly increased from 1200 calls to 4300 calls, 73% of which are from members.
- Four complaints have been logged, with 2 remaining open related to their provider not in network.
- The disruption analysis addresses issues of members already receiving services. The concern expressed in the Transition SC and by Council members is the adequacy of outreach to the overall population about the BHP program. DSS does not believe public service announcements (PSAs) are cost effective nor needed based on the VOI call content. The BHP will continue outreach activities including local community meetings.

Managed Care Organization (MCO) Claims Run Out Report

Dr. Larcen, Co-Chair of the Transition Subcommittee, reviewed the outstanding claims issues related to the managed care system. CT Community Providers Association (CCPA) and Dr. Larcen provided updated reports on outstanding claims (A/Rs) by time period:

• Total outstanding receivable submitted to CCPA by 30 small to large multi-service agencies as of December 31, 2005 total approximately $3.9 million. Between 10/31 and 12/21/05 $166,672 claims had been paid. Sixty-nine percent of the A/Rs fall within 90 days to <365 days while 31% are outstanding for more than 365 days.
• Seven hospitals submitted A/Rs of $7,038,090, of which 38% are <60 days old, 50% are > 60 days and 12 % are more than a year outstanding. DSS noted that claims aged 30-90 days are part of the claims tail runout.
• More than ¾ of the claims belong to VOI, the BH vendor for three of the largest HUSKY plans. Of the hospital A/Rs, 33% belong to Anthem, the largest MCO, 9% to CHNCT, 15% to Preferred One, the smallest MCo and 43% to HealthNe, the second largest MCO.

Council members expressed continuing concern that the unpaid claims issues under managed care presents a threat to access in the BHP program going forward. While unpaid claims resolution is critical to the new program success, time spent discussing these critical issues diverts the Council's attention from looking at the new delivery system as it unfolds.

Various representatives in the Council presented their perspective:

- ✓ Provider perspective: legitimate claims for services provided within a contract to eligible members should be paid. Are payers holding to technical deficiencies versus the basic principle to pay these claims? DSS responded that while the computer system works with built-in logic steps, the provider appeal process brings the human element to the process. There are timely appeal periods for each plan for "clean" claims. The claims report from DSS /MCO seems contrary to the above claims reports. DSS stated the MCO report only includes those claims in the payment process. Council suggestions:
  - o Convene a subgroup of the Council to work with DSS on a fair plan to address the large amount of dollars outstanding.
  - o Analysis of claims not paid for services provided to learn what the problems are, both to resolve the A/R issues and apply what is learned to the new system. DSS commented that there will be a process in place going forward to track claims submitted/paid, identify providers that are having issues with claims payment and VOI & EDS (Medicaid payer and BHP payer) will provide technical assistance as needed.
- ✓ DSS perspective: DSS recognizes accountability through contractual obligations both for the MCOs and providers in the claims area. Given that, DSS stated they have made a commitment to a fair and objective process to resolve the claims issues. The agency needs to define this process internally before reporting back to the Council and considering working with a sub-group of the Council.
- ✓ Legislators commented that while they do not have the information to make a judgment about what has 'gone wrong', there was an explicit expectation that the agency provide the legislators with steps the agency will take to resolve the problem in the next 2 weeks, as there is too much money outstanding. Sen. Harp, Rep. Dillon and Rep. Sayers certainly want to see the resolution plans as the General Assembly is in the midst of the budget process and needs this information.
- ✓ Managed Care plans present each committed to working with providers, as they have been doing, to resolve outstanding claims. They have not heard the detail outlined in the reports, from all their providers. The plans expect to do this as they will have an ongoing relationship with all stakeholders.
- ✓ Consumer perspective: concern that lack of payment for services rendered will impact the financial stability of the provider community and directly impede access to services.

Subcommittee Reports

DCF Subcommittee: Chair – Heather Gates: the focus of the subcommittee recently has been on

rates and grants to intensive home program ICAPs providers. The CCPA survey of ICAP providers will be reported to the SC and then brought to the Council with recommendations.

Provider Advisory Subcommittee: Chair – Susan Walkama: the subcommittee has developed Enhanced Care Clinics (ECC) standards based on Council recommendations. The SC is awaiting feedback from the BHP on how facilities will treat the ECC application versus the individual offices. Additional criteria have been developed for acute care guidelines for Riverview, specifically the DCF/Riverview admission criteria. This arose out of concern that children in community-based treatment be ensured access to Riverview inpatient services.

Mr. Walter asked DSS when the RFA for the enhanced Care Clinics will be released. Dr. Schaefer stated there is a draft of the RFA, but the BHP want to be sure it "is right" before releasing it. A notice of the RFA for the ECC will be published in the newspaper and will on the CTBHP website with links to the DSS site. Given the tight time line, the BHP is unsure if the ECC start time will be May 1, 2006. The agencies are committed to implementing ECCs that will focus on improving access as soon as is feasible.

Quality Management & Access Subcommittee: Chair – Dr. Davis Gammon: The Subcommittee has reach consensus on a number of HSRI performance indicators at the January 20th meeting. DSS/DCF received a grant to develop performance management system and the subcommittee is the stakeholder group advising the BHP on measure. Some ECC measures will be included.

Transition Subcommittee: Co-Chairs- Dr. Stephen Larcen & Susan Zimmerman (FAVOR): Dr. Larcen noted that discussion related to consumer outreach and the outstanding were discussed earlier.

Behavioral Health Partnership Oversight Council Report to the CGA The chairs of the Subcommittees will meet February 16th to review the report parameters and a draft will be sent to the Council for review prior to the March 8th meeting.

Other
Comments from the Council included:

- ✓ Increase in consumer representation on the Council
- ✓ Begin ongoing reports on service utilization by number of services, type as compared to the managed care system.
- ✓ Council may consider what role it will have in applying recommendations from the VOI/EDS claims analyses to providers so that the cycle of unpaid claims is significantly diminished.

Next meeting: Wednesday March 8 at 2 PM in LOB RM 1D

Co-Chair/ legislator letter sent to DSS Commissioner related to claims issues

February 21, 2006

Patricia Wilson-Coker, Commissioner
Department of Social Services
25 Sigourney Street
Hartford, CT 06106

Dear Commissioner Wilson-Coker:

We are writing as the Behavioral Health Partnership Oversight Council co-chairs and Council representative of the legislative Public Health Committee to request the Department's assistance in resolving outstanding claims payment issues for behavioral health care services rendered to HUSKY members prior to January 1, 2006.

There was lengthy discussion at the most recent Oversight Council meeting about the critical importance of bringing providers and HUSKY Managed Care Organizations (MCOs) together regarding this issue. There was much agreement that, without the Department's intercession, unpaid claims disputes among the parties are not likely to be resolved.

The scope of the problem is of such magnitude (possibly as high as $12 million) that it threatens to thwart our efforts to keep all parties (particularly service providers) focused on assuring the success of the fledgling Partnership.

We request that the Department immediately take the following steps:

(1) Solicit and analyze a sample of disputed claims from each MCO to determine the reasons why such claims have not been paid;
(2) Identify a lead person at each MCO with whom providers can work to resolve disputed claims;
(3) Require of each MCO the payment of disputed claims that meet the following criteria:

(a) claim met original timely filing standard;
(b) service received authorization, when such authorization was required;
(c) provider was contracted to provide the service;
(d) provider supplied proof of meeting (a) – (c), including contemporaneous notations in patient record, copy of claims, etc.

I am sure you will agree with us that service providers should not be denied payment strictly on technicalities. Your department's help will assure that such a result does not occur as the book is closed on the former behavioral health program's business. We request to meet with the Department prior to the March 8th BHP Oversight Council meeting to hear about your plans to address the unpaid claims issues.

We thank you in advance for your assistance in this matter.

Very truly yours,

Jeffrey Walter
Co-Chair of the Council

Senator Christopher Murphy
Co-Chair of the Council

Representative Peggy Sayers
Chair, Public Health Committee

CC Michael Starkowski
David Parrella
Dr. Mark Schaeffer
State Senator Toni Harp