

**Heritage Health Behavioral Health Integration
 Advisory Committee Minutes 9 06 2016**

Meeting Date / Time	Tuesday, September 06, 2016; 12:30 pm – 2:00 pm
Meeting Location	Nebraska State Office Building 301 Centennial Mall S. Lower Level Conference Room A Lincoln, NE 68509
Conference Line	(888) 820 – 1398 Access Code : 4533256#

Summary:

Topics	Facilitator
<p>Deputy Director Heather welcomed everyone and announced Director Calder was not be attending due to another engagement. Deputy Director Heather continued with the introductions and roll call of the committee members:</p> <p>Tom Adams, Executive Director of National Alliance on Mental illness; Beth Baxter, Regional Admin. Behavioral Health Region Three; Carole Boye, President & CEO for Community Alliance; Dan Claussen, Payer Relations Provider for Nebraska Medicine; Pat Connell, Vice President, Behavioral Health, Compliance, & Government with Boys Town; Jon Day, Executive Director of Blue Valley Behavioral Health; Shannon Engler, Director, Counseling & Mental Health Services of Bryan Health; Wayne Fisher, Ph.D., Director, Center for Autism Spectrum Disorders; Ingrid Gansobom, Regional Administrator for Behavioral Health Region Four; Tamara Gavin, Deputy Director, Behavioral Health Services, DHHS, Div. of Behavioral Health; Sherri Haber Administrator, DHHS, Div. of Children & Family Services; Lori Hack, Compliance Officer, Magellan Behavioral Health of Nebraska; Topher Hansen, NABHO; Cynthia Harris, Deputy Director, Office of Consumer Affairs with DHHS, Div. of Behavioral Health; Jan Henderson, Health Services Business Office Manager, Ponca Tribe of Nebraska; Adam Proctor, UnitedHealthcare Community Health Plan; C.J. Johnson, Regional Admin. Behavioral Health Regional Health Region Five; Christine Johnson, Behavioral Health Support Foundation; Patti Jurjevich, Regional Admin. Behavioral Health Region Six; Lori Lundquist Wall, Ph.D. Nebraska Psychological Association; Julie Rothacker, NTC; Julie Scott, Justice Behavioral Health Specialist, Office of Probation Admin.; Kathy Seacrest, Regional Admin., Behavioral Health Region Two; Carole Matyas, Wellcare; Alecia Stevens, QDDP Coordinator, DHHS, Div. of Developmental Disabilities; Todd Stull, M.D. Chief Clinical Officer, DHHS, Div. of Behavioral Health; Mike Vance, Ph.D. Director, Behavioral Health Services, Children’s Hospital; Barbara Vogel, Acting Regional Admin., Behavioral Health Region One; Mark Ward, Omni Behavioral Health; Mona Zuffante, Tribal Health Director, Winnebago Tribe of Nebraska.</p>	Heather Leschinsky
<p>Behavioral Health Workgroup Update:</p> <ul style="list-style-type: none"> Kim gave an update of the progress of the Behavioral Health workgroup and stated they met on August 25th. with all the Plan and Dr. Stole and Shelly Nickerson from the State pharmacy. At the meeting the general discussions were on behavioral health services, justifications for the reporting the Plans will need to do. There is a lot of reporting the Heritage Health Plans are scheduled to do and the group continues to go 	Kim McClintick

over the criteria. There will be another meeting scheduled for September 8th and there are 13 more criteria to go through and the group is very close to completing the criteria.

- The workgroup will be going through the prior authorizations and many providers have voiced a concern about going from one behavior health plan to having to do three different prior authorizations. There has been several questions and the group is looking at forms from other States to streamline the process that works for everyone.
- Indian Health Services was also discussed in the workgroup and there has been concerns with Indian Health Services regarding behavior health services.
- Overall the workgroup is doing well and getting a lot accomplished and Kim encouraged the committee members to call or attend in person if possible these workgroups.

Discussion:

Question: What are the goals of the medication requirement and prior authorization identification/discussion during the workshop?

Answer: Kim responded that the Plans have the right to use their own criteria and own authorization, however in the workgroup we are trying to work together to try to find one that would meet everybody's needs and there is no guarantees this will happen.

Statement: Currently the prior authorization is very arduous; time consuming; not efficient and hard to follow. The providers do not want a system more complex and hard to follow.

Kim followed up with a question, asking if he has talking mainly about the Injectables? No, he was addressing authorizations in general.

Deputy Director Heather asked if he was asking about Magellan Behavioral Health or Magellan Rx. He was asking about Magellan Rx and the prescriptions.

Kim reported that the State is looking at changing the prior authorizations and we are cutting out several of the requirements and reducing the requirements.

Deputy Director Heather explained the workgroup has not discussed the prescriptions drugs and the antipsychotic drugs yet. Pharmacy staff consider these drugs exempt from the preferred drug list per statue. At this time the contract states that the Managed Care Plans can manage those formulary outside of the PDL/Nebraska criteria. We will put this as a topic for discuss in our internal meetings along with the oral medications, specifically the antipsychotics, suppressants and convalescents.

Statement: Did you say that the Managed Care Plans do not have to follow State law?

Deputy Director Heather clarified and confirmed that the Managed Care Plans have to follow State laws. The Heritage Health contracts requires the Plans follow the preferred drug list and cover the drugs on the PDL in the same manner the State covers these drugs. However the drugs that are exempt from the PDL list the Plans have been given the flexibility to manage those outside of the PMP committees. Deputy Director Heather made the distinction that the Plans do not have to follow the Nebraska defined criteria system edits for the exempt drugs but they still have to follow State laws.

Review of the Sub-Committee & Service Definitions Comments

Handouts were provided with the Agenda and is currently posted on the DHHS website.

Deputy Director Heather introduced Lisa as the staff who is going to cover the service definitions that have been vetted and approved by the subcommittee already before

Lisa Neeman

presenting it to this committee for review. There is currently a schedule for the completion of all the service definitions and we anticipate the completion by November 2016. Deputy Director Heather introduced Lisa Neeman as the staff who will be going over the subcommittee comments related to the service definitions.

Lisa gave an overview of work the subcommittees and the workgroups have accomplished with reviewing the service definitions. Lisa indicated the State has been reviewing what Magellan had provided and there has been internal meetings to discuss what service definitions are going to be used for Heritage Health. Then it was taken to the subcommittees with all the Plans to review and once the Plans reviewed it and gave feedback. The information was merged into one document to be reviewed by this committee. Lisa stated fifteen of the service definitions are going to be reviewed at this meeting and there is an email address available for questions and comments regarding these definitions: dhhs.medicaidmhsu@nebraska.gov. Lisa said this email address can be found on medical necessity guideline and criteria page at the following link: <http://dhhs.ne.gov/medicaid/Pages/Nebraska-Medicaid-Medical-Necessity.aspx>.

Statement: Where these definitions included with the Agenda?

Lisa responded yes and can be found on the Heritage Health website. The service definitions are also located on the Medicaid website under provider information and under the bullets labeled – Adult Behavioral Health Services Definitions: http://dhhs.ne.gov/medicaid/Pages/med_provhome.aspx.

Deputy Director Heather informed the committee the State is currently revision Chapter 20 and 35 to the extent to include the service definitions are reflexed in the regulations. The chapters will match the final definitions decided on during this process. The goal is to have those regulations completed by the end of the year. The goal is to have the regulations promulgated on or about January 1st.

Discussion:

Statement: The definitions with three Managed Care Organizations involved is hard for the providers to accept and follow.

Deputy Director Heather stated the definitions that are developed during the workgroups are the ones the Managed Care organizations will have to follow.

Lisa introduced Angela Parish, who went through each of the fifteen criteria and the comments from the workgroup.

- Annual supervision by a psychologist or an LIMHP - comments were made on the staffing regarding LIMHPs having supervision.

Discussion:

Question: This criteria is for outpatient?

Answer: Angela responded, Yes.

Statement: It is really difficult in the rural areas when the LIMHPs and the LMHPs cannot diagnose. Will send comment to the email.

- Adult Substance use disorder Addendum – Subcommittee looked at staffing for APRN and LIMHP and LADC and are considering to add LIMHPs and LADC.

Discussion:

Question: State is considering to add LMHPs also?

Answer: Angela responded, Yes.

- Adult Substance use disorder assessment – State comments to add PLADC, LIMHP and LMHP that is in their scope of practice.
- Dual Disorder Residential – APRN was listed as doing the function of the psychiatrist. It is to the extent of if the APRN is qualified to supervise since not all APRN are qualified to supervise.
- Halfway House – no comments. Access to licensed mental health practitioner for the 24/7 requirement was discussed and it was brought up that it could be that the person have to be really a licensed therapist. The group did not think that was the intent the person would have to be responsible for the other staff but it does not have to be a licensed therapist.
- Short-term Residential – no comments.
- Intensive OP – no comments.
- Short Term Residential – APRNs discussed again.
- Social Detoxification – no comments.
- Community Support Mental Health – see general comment on Rehab. Services.
- Day Rehab. – see general comment on Rehab. Services.
- Group Psychotherapy – no comments.
- Medication Management – comment on the APRN scope of practice.
- Outpatient group – comments on the Allied Health services must be prescribed? Should it be a supervising practitioner?

Discussion:

Angela reported the overarching concern that was brought up in the workgroup was for SPMI members that are not progressing and they have reached their rehabilitative potential but they continue to have services for maintains in an outpatient setting that basically is considered maintenance. According to CMS, maintenance is not covered by Medicaid. The State is following the CMS regulations on rehabilitation if the member is no long meeting medical necessity, Medicaid will not pay for the service. Also, a provider had made a comment indicating that a face to face visit is not paid for when the member is inpatient at the hospital and is transferring back to rehabilitation, however coordination has to be done and can be accomplished via phone and telehealth rather face to face visit.

Statement: Where should I make comments for example we have had issues with getting services approved before the member's conditions worsen.

Deputy Director Heather explained the reason for this exercise of Medicaid taking back the definition and streamlining the definitions from the different books of definitions used in the past. State is working together with DBH to accomplish a close alignment that falls under the medical necessity criteria.

Deputy Director Heather recommended for the committee members to send in all their comments and the State will definitely review and if they apply to the rule making process in a few months we may use those comments. Medicaid generally have to follow the Rehab. Option services directed by CMS rules regarding the MRO services, which can be found in the Medicaid Rehab. Option services. Whatever transpired in the past that allowed services to be paid for under maintenance services will no longer be covered by Medicaid because the State would like to continue to qualify for all federal funding.

Statement: I am concerned with these changes the members are not going to get all their services approved. Would we have to have multiple IDI for various services?

Answer: Deputy Director Heather Deputy Director Heather stated she heard that the multiple requirements that an IDI occurred before the services are rendered I think I heard you said that is redundant and at times maybe not necessary and

<p>put trauma or trauma type services on the consumer. Deputy Heather stated that one IDI would cover more than one service.</p> <p>Angela stated that staffing ratios if not specifically addressed in the service definitions will then be left up to the facilities in order to give each agency the flexible to develop their own staffing ratios.</p> <p>Statement: The transient population we work with, would the State consider being flexible with the numbers and formulas with participation? Quality and outcomes should be used as the guideline to how things are going and the MCOs should be able to adjust based on the outcomes or lack of outcomes. We have to be careful removing the supports the members have led to relapses and the members moving to higher levels of care and as payers this should be considered in the decisions to add or remove services.</p> <p>Answer: Deputy Director stated the goal of integration is to achieve the type of treatment/improvement in care and to address the gaps providers are voicing as a concern. In the past behavioral health and Medicaid were in different silos, and the motivation to keep that member healthy was not clear and now we are coordinating these definitions to achieve the best results. It will be best to keep the member at the lowest level, least restrictive service possible and stabilized.</p> <p>Statement: Is it possible to review the Day service in increments of 15 minutes instead of 5 hours? Members are not always willing to attend for the full 5 hours.</p> <p>Answer: Deputy Director Heather stated at what point would there be a cut off and still call it a day service? Medicaid staff are directed to use the CMS definition of Day treatment to insure alignment with Medicaid federal funding/rules.</p> <p>Lisa Neeman encouraged the committee members to submit all comments within two weeks, in order for the comments to be incorporated and posted to the medical necessity page on the DHHS website for 60 days prior to finalizing the definitions.</p>	
<p>Action item assignments / Closing remarks:</p> <p>Deputy Director Heather closed with a reminder to visit the DHHS website and gave instructions on how to get to the page to view the definitions that will be the posted. Staff will also be sending an email with the definitions to all the committee members. There are also action items for research that staff will bring forward once completed to all the committee members via email and discussion at the next meeting.</p>	Heather Leschinsky
<p>Public Comment Period: None</p>	Heather Leschinsky
<p>Adjourn: 2:30 p.m.</p>	Heather Leschinsky

Next Meeting:

Meeting Date / Time	Tuesday, October 11, 2016; 9:30 pm – 11:00 pm
Meeting Location	Nebraska State Office Building 301 Centennial Mall S. Lower Level Conference Room A Lincoln, NE 68509
Tentative Agenda Topics	Definitions/Behavioral Health Criteria