

**Heritage Health Behavioral Health Integration
 Advisory Committee Minutes**

Meeting Date / Time	Tuesday, October 11, 2016; 9:30 am – 11:00 am
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>Lisa Neeman welcomed everyone and announced that Director Calder Lynch and Deputy Director Heather Leschinsky would not lead the meeting today as they are in other meetings.</p>	Lisa Neeman
<p>Roll Call: Courtney Mason welcomed everyone and took roll call of the committee members: 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 Gansebom, 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>	Courtney Mason
<p>Review of Minutes: Todd Reckling, CAFCON, stated that he has not been marked as attending the previous few meetings.</p>	
<p>Behavioral Health Workgroup Update:</p> <ul style="list-style-type: none"> • Lisa stated that Medicaid and Long Term Care meets regularly with representatives from the MCOs to work on different implementation topics and projects. • Kim gave an update of the progress of the Behavioral Health workgroup. MLTC is internally reviewing reporting templates. MLTC appreciates input regarding quality of 	Kim McClintick

<p>care and reporting. There is a focus on accountability to the contracts. The health plans have agreed to a general prior authorization form for Medicaid rehab services.</p> <ul style="list-style-type: none"> • Otherwise the Workgroup is discussing topics as they arise and putting out fires. <p>Discussion: Lisa clarified that the prior authorization form being discussed is not for Medicaid outpatient services, just for rehab services. Questions: Is the preauthorization for initial outpatient services not needed? Answer: Lisa stated that prior authorization is not required for initial outpatient services for anyone entering into treatment. However, plans may vary on how they authorize further treatment.</p>	
<p>Review of the Sub-Committee & Service Definitions Comments</p> <p>Lisa reminded everyone that the process of developing the service definitions was created by the MLTC team internally in conjunction with DBH and using Magellan guidelines along with review and input from Dr. Stull. The service definitions have gone in front of the behavioral health workgroup and these have been reviewed for consistency. The BHIAC subcommittee then reviewed them. The service definitions were put out on the public website for review and the 3rd round of criteria review will be completed for the November meeting. The public can offer input on the MLTC website by looking on the left side – clicking the provider issues link – then the medical necessity link – the email address is at top – which is where the public can send comments and feedback.</p> <p>Lisa Neeman introduced Lori Lewis and Angela Parrish as the staff who is going to cover the service definitions that have been vetted and approved by the subcommittee already before presenting it to this committee for review.</p> <p>ASA Community Support Level 1 Service Definition: Question: The first bullet in service expectations – Can that be licensed LMHP or otherwise (LADC)? Answer: Need to identify the scope of practice – if the service is in scope of practice, then acceptable</p> <p>Question: Did you utilize ASA criteria for family therapy, etc? Answer: Yes, we are making changes for all Adult Substance Abuse service definitions.</p> <p>The Services Definitions are completely new and were developed, with the help of DBH, to be as consistent as possible across the various definitions.</p> <p>ASA Outpatient Group Therapy – Level 1 Service Definition: Question: Service expectations and the thought behind requiring an IDI? Requiring both evaluations creates challenges and constraints for Medicaid patients, especially regarding access in rural areas. Answer: MLTC recognizes the high rate of co- occurring incidents and wants to ensure that providers are aware if the patient is suffering from both a mental illness and substance abuse to receive the appropriate treatment. Discussion: It will be difficult for a patient to be seen by an LI and LMHP, especially in rural areas. This may be a scope of practice issue. Members wondered if just a screening would suffice rather than having the IDI; as this is the standardized model. IDI and Substance Abuse Assessment – crippling if Medicaid patients are required to receive both, lack of access in rural areas, difficulty with the time commitment.</p> <p>Question: Do vocational rehab specialist need to be credentialed? We should be clear regarding certification requirements.</p>	<p>Lisa Neeman</p>

Answer: ADC Service Definitions does not clarify.

ASA outpatient Individual Therapy Level 1 Service Definition:

No comment other than stating previously mentioned IDI concerns.

Family Assessment Service Definition:

Question: Are provisionally licensed not considered relevant?

Answer: Will need to look into this and believe that it is considered relevant.

ASA Outpatient Family Therapy –Level 1- Substance Use disorder Service Definition:

Question: Has there been questions on changes/feedbacks thru the committees?

Answer: There has been a lot of feedback on service definitions. Changes have been incorporated throughout the process.

Question: Members have been asked by providers about how to provide questions and comments. Suggested MLTC looks into an easier way for providers to review posted services definitions and send feedback more directly.

Answer: MLTC explained where the link to send feedback was and where the service definitions were posted. However, MLTC would look into making this process more accessible.

Therapeutic Community (Co-Occurring Diagnosis) ASAM Level 3.3 Facility Service Definition:

Question: Not concerned with IDI because this is for co-occurring diagnosis. However, the service definition seems to be very substance abuse focused, rather than co-occurring.

The definition is driven more as a substance abuse service definition.

Rates should reflect those of co-occurring rates.

Answer: Would have colleagues look over and get back on this topic. The relevant programs should be asked for input.

Public comment: This definition does not define mental health and substance abuse.

Assertive Community Treatment Service Definition:

Question: Assessment – not sure what medical the assessment expectations are for the evaluations – it would be helpful if what that means was described.

Requiring licensed staff will increase the costs. Does it have to be a LADC or someone with specialty (LMHP)

Answer: Licensed not required, LMPH would be fine.

Question: Staffing – model set up for 70 patients; concerned that if the definition is for 50 patients there will be problems for rate schedules.

Answer: Fifty is the baseline ACT requirement; it is set up for 50 or 100 patients.

Question: Does it allow for the alternative ACT on the DBH side?

Answer: Staffing identical except for the LADC requirement. Group of 50 needs one RN and if you increase total you will need more RNs. This would match what we are doing now.

Question: Is the intent to have a vocational rehab specialist on the staff? ACT is a good opportunity to get staff training and experience, so it is better to allow lower level staff to participate on the team.

Answer – It has be clear what we have for certification.

Community Treatment Aide (CTA) Service Definition:

Question: Was this primarily intended for children and adults?

Answer: This was intended for children. This definition has not changed significantly. Should be fairly standard to what providers are familiar with.

Conference with Client Service Definition:

Question: Is this a face-to-face conference?

Answer: Depends on the context it is used. Telehealth is allowed for mental health conferences.

Question: What context will this be used for?

Answer: It is used when mental illness diagnostic evaluations are explained to individual.

Question: Children and adults?

Answer: Yes

Question: Does this include school setting?

Answer: No – school based services to include OT/PT and speech - utilizing resources not included in schools.

MLTC is working on school expansions in the future. But there is a difference between school based services and services performed by school staff.

The purpose is not to be a multi-disciplinary meeting, but it is to share the diagnostic evaluation and treatment plan.

Question: Can the parent be at the meetings?

Answer: Parents are allowed to attend and are not prohibited from inviting who they want to be present. However, this meeting is intended for diagnostic testing.

Question: There is a long list of staff. It is not clarified as to needing all staffing or one.

Answer: MLTC needs to clarify that one of the following is required, as opposed to the entirety of the listed staff.

Crisis Outpatient Psychotherapy Service Definition:

Question: Could the state clarify “consent”?

Answer: MLTC has included that coordination of care occurs with client consent with other definitions and will with this definition.

Question: Clarification regarding pending authorization?

Answer: Lisa will get clarification on this.

Question: Can this service be provided in the Emergency Department?

Answer: Will look into this in terms of observation rooms and emergency rooms.

Question: Can this service be performed through telehealth?

Answer: Yes, as long as the patient is not suicidal or a danger to others.

Question: Will this be identified as a cap service?

Answer: No, this is not a cap service.

Question: Can MLTC staff clarify that only one of the following staff is required?

Question: What about Rural Hospitals' ER's without area for a hold (no observation/assessment room)?

Answer: MLTC will need to look into this.

Individual Therapy Service Definition

Question: IDI concern and question about staffing requirements?

Answer: Clarifying statement that only one staff from the list is required, not all of the listed staff.

Electroconvulsive TX – outpatient Adult Service Definition:

Question: The number of providers able to provide feedback is limited. Would be helpful to get feedback from providers whose expertise is in the area of the service definition.

Answer: We welcome all input. We ask that providers share the definitions and how to submit feedback to providers who specialize in the area of the service definition.

Outpatient Family Service Definition:

Question: Could MLTC clarify the timing of IDI? How quickly does the IDI need to

happen? What is the expectation of how quickly the provider needs to see the family?

With Magellan, the provider had to administer the IDI during the first session for the child and within four sessions for the adult.

<p>Answer: MLTC will need to check into this. Comment: There is a concern that requiring it during the first session would be extremely prohibitive. Question: Is the authorization contingent? Answer: Family consent Question: Can MLTC comment on the 60 minute sessions? MLTC might want to adjust as time limitations/requirements are difficult and can impede the quality of treatment. Answer: MLTC is consistent with CPT requirements and explains such in its provider bulletin for family sessions. Question: 90846 – not always an extreme situation – recommends softening that language. Answer: MLTC is not opposed at all and will reconsider.</p> <p>Initial Diagnostic Interview Service Definition: Question: Could MLTC comment on the service definitions on initial diagnostic interview, timing of IDI? Providers may be concerned regarding timing of occurrence. Answer: MLTC commented regarding service definition vs co-occurring sessions. Chapter 20 does not allow flexibility in regards to IDI, and must be done within four sessions for adults. Lori and Angela will look into regulations; if flexibility will be helpful to patients and providers, it needs to be considered. MLTC will look into CMS and federal requirements, as well.</p> <p>Lisa Neeman moved to public comments as time is getting short.</p>	
<p>Action item assignments / Closing remarks: Please send any further comments to the e-mail address so we have them for the November meeting.</p>	Lisa Neeman
<p>Public Comment Period: Comment: Maybe a better question for the technology staff – when will all of the MCOs be publishing the EDI? When will they be ready for testing? Need 4 to 6 weeks to program their system internally. Question: Could MLTC clarify whether Magellan will no longer credential as of October 1. Answer: Magellan will not credential private practitioners but will credential providers if hired in a facility. However, MLTC will double check on that. Question: Is there an audit trail of changes? Answer: There is a two week period to review and send in comments on the posted service definitions. Question: Preauthorization by Magellan MCO – will the preauthorization by grandfathered in? Answer: Preauthorization will continue. Lisa stated they will check this but it is her understanding that pre-authorizations from Magellan will be acknowledged by the new Heritage Health plans for a 90-day period. Request that we post the Service Definitions sooner than later.</p>	Courtney Mason
<p>Adjourn: 11:05 p.m.</p>	Courtney Mason

Next Meeting:

Meeting Date / Time	Wednesday, November 9, 2016; 10:30am – 12:00pm
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