

# OHCA Behavioral Health Advisory Council Meeting

February 8, 2006

## Minutes

### Council Members

Debra Andersen, Dept of Health; Dennis Auld, OK Drug & Alcohol; Al Friedman, RRBHS- CMHC Directors Rep; Carrie Slaton-Hodges, ODMHSAS; Jim Igo, Randy Jarman, DaySpring; Integris; Mary Maple, Counseling Center Of SE OK; John Mayfield, OSASA; Charlotte New, Mental Health Assn.; Bob Mann, DOC; Teresa Peden, NAMI; Karrie Utterback, Stepping Stones; Laurel VanHorn, OPA; Dean Williams, Co-Chair CMHC Directors Rep; Brian Wolff, ORALA; Sharon Worsham, OK Psych Hospital Assn; Peter Zuniga, Consumer Co-Chair

### Additional Attendees

Vonnetta Allenbaugh, Bill Willis CMHC; Elizabeth Ashton, Transitions, Inc.; Sara Barry, NorthCare; Jana Brewer, Red Rock BHS; Cindy Coapland, Jim Taliaferro CMHC; David Collins, Grand Lake CMHC; Becky Cox, Grand Lake CMHC; Milton Evans, SOFS; J. B. Fancher, Griffin; John Ford, Lend-a-Hand; Vera Ford, Lend-a-Hand; Tambra Gravett, Stepping Stones; Michael Hall, Stepping Stones; Mariam Harris, BWCHC; Lissa James; Gregg Johnson, Multi-County Coun; Joni Jones, Red Rock ; BHS; Valerie Lewis, Cornerstone; Dan McCullough, Drug Recovery; Kyle McGraw, OKDHS; Kathrine McGrew, Stepping Stones Consumer; Valerie Myatt, Stepping Stones; Chris Perry, CREOKS; Bill Piatt; Professional Health Care Providers of OK; Monte Newcombe; Central OK Family Med Ctr; Morna Pederson-Rambo, DaySprings; Sandy Pruitt, Hope CMHC; Van Rhodes, ODMHSAS; Kevin Rodgers, OCCY; Lisa Schoaps, Stepping Stones; Sonny Scott, NAIC; Joe Smela, Drug Recovery, Inc.; Tracy Spurgeon; Missi Webb, Griffin; Suzanne Whittlesey, OUHSC; Lisa Williams, More Youth & Family; Rebecca Wilson, Family & Children's; Dan Alcorn, ODMHSAS

### Support Staff

Nichole Burland, OHCA; Mike Fogarty, OHCA; Kelly Freeman, OHCA; Nico Gomez, OHCA; Jennifer King, OHCA; Sami Kilgore, OHCA; Glenn Lane, OHCA; Vera Mann, OHCA; Kirk Nicholson, OFMQ; Kelly Pensoneau, OHCA; Heather Poole, OHCA; Jolene Ring, OHCA; Debbie Spaeth, OHCA; Kimrey Suttles, OHCA

Handouts:   Agenda for House Medicaid Reform Task Force Members and Advisory Board  
TEFRA Brochure  
Best Practices Conference Brochure  
Emergency Summit on Mental Illness, Substance Abuse, and Criminal Justice Brochure  
Oklahoma Medicaid Pharmacy E-Prescribing Survey  
Oklahoma Medicaid Pharmacy Update- Fax Blast  
FDA report – ADHD drug linked to liver problems  
Medicaid Commission Rejects Limiting Medicaid to Provide Services to Children in the  
Child Welfare System  
Department of Corrections letter

## Welcome

Dean thanked Sharon Worsham for catering.

Minutes

Accepted as written

Additions to agenda

None for this meeting

The council's drug & alcohol position has been filled by, Dennis Auld, Exec Dir of the Oklahoma Drug and Alcohol Professional Counselors Association.

## Medicare Part D

Kelly Pensoneau -  
Part D Update –

Part D is up and running, going fairly smoothly comparatively. Twenty other states have had to pull back duals temporarily and paying for all meds for a couple of months through appropriations. Transition in Oklahoma has been smoother due to efforts of OHCA staff.

Enrollment problems – Call the Senior Health Insurance Counseling Program – 800-763-2828. OHCA pharmacy staff has also made themselves available to answer questions and point people in correct direction.

Q. – Do have good communication with Social Security on problems?

A. – Pretty much know when problems occur because members call OHCA. Can answer questions, however can't counsel people.

Most people know to call the SHICP office.

Q. – Is there a brochure to hand out?

A. – None that is known of.

In CMS computer system there have been some computer glitches – which doesn't recognize some members on Medicare and Medicaid Part D– all dual eligibles should have a plan. Wellpoint has contract with CMS, for those members who aren't currently showing in the system, Wellpoint will pay for 2 wk supply of what meds on – This 2 week period should give CMS enough time to find out what is happening with computer glitch.

Q. – on state operated mental health centers – have glitch and don't know if eligible for extra help- state operated pharmacies are helping with medication costs- form from CMS to recoup medication costs plus administrative costs for helping people with enrollment into Part D. Is this form specific to agency or is it within each facility to do form. Can send form to Kelly for clarification.

A. –All dual eligibles should have been in a plan as of January 1<sup>st</sup>, this appears to be a way to go back and recoup monies the agencies put out for those dual eligibles that were not in a plan as of January 1<sup>st</sup>. Whether this is specific to a particular agency, would need to contact CMS for directions on how to use the form. This form is not OHCA driven.

Q. – for those clients at hospitals who are Medicare exhausted and Medicaid is in suspense, even if eligible for Medicaid, Medicaid will not pay this for population in an IMD– CMS says can bill for meds once benefits exhaust however don't have proof have Medicaid because Medicaid is in suspense – how do they enroll them in Part D.

A – Not sure if have to have Medicaid, just show Medicaid eligible. Go through extra help, applications available online.

## Emergency Summit

Teresa Peden – Over 400 participants attended the Summit of which 75-100 were DOC staff. The Summit brought together judges, district attorneys, legislators, and blue ribbon task force members. Also had key note speaker from New York, national experts on data related to jail diversion, Dr. Stedman. This Summit made national news in national newspapers, on consensus website, SAMSHA Behavioral Health newsletter, in NAMI headlines for NAMI national as well as the Corrections newsletter. The DOC adopted resolution regarding the need to move people with mental illness into community and to appropriate treatment. This groundbreaking resolution adoption is what drew the attention of the national media. The DOC wants to look at more EBP for this population. Since the Summit more importance has been placed on the efforts of the mental health division at the DOC. General consensus of the Summit was the need to develop alternatives to continuing to lock people up. See the handout for highlights of the reports from each area of the state.

Q. – What will happen with the deaf and blind population?

A. – NAMI will have meeting later in February on this issue.

## OHCA Web Review –

Vera Mann

Domain name has changed to – [www.okhca.org](http://www.okhca.org). Now have major area of contents for Members and Providers. On right side of page have update information, resources, and fast facts. Have contact info, calendars, publications and research info across the top of the page. Have access to information from past Behavioral Health Advisory Council meetings through the Behavioral Health page under the Providers area. Also have access to additional information as a provider or member by accessing the respective content areas. The rules and fees schedules for Behavioral Health can be accessed through the Behavioral Health page under the provider section.

## Outpatient Behavioral Health Claims Update

Kelly Freeman- Per the reports done for the analysis, the average claim time from date of service to submission to payment for: OPMHC's - 23 days, for CMHC's – 41 days and DMHSAS MH Centers – 26 days. Using Medicaid on the Web would improve length of time from submission to payment. Claims processed for OPMHC's – 1,177,000 plus, of these original claims 72,000 denied on first submissions for various reasons, most were paid on second submission. This is approximately a 5.8% denial rate on first time original claims. For the CMHC's there was a 6.9% denial rate on original claims. For the DMHSAS MH Centers there was a 4.6% denial rate on the original claims.

**Q.** Is substance abuse included in any of these numbers? **A.** This is everything billed if your provider type is either an 110, 111, or 118. **Q.** What if agency is a substance abuse provider type?

**A.** Substance abuse is included in the 118 provider type. Clarification on provider types – 110 – Private providers, 111 – CMHC's and 118 – Contracted agencies (contracted through DMHSAS). Adjustments, if necessary, include both positive and negative aspects. Positive adjustments are done when an agency has been under paid for services, negative adjustments are done when over paid. The sources for adjustments include -1. agencies request, 2. internal audits (done by OHCA), 3. external audits (done by OFMQ), 4. Systems issues (i.e., adding new procedure code or rate). Adjustments made for OPMHC's – of 1.2 million paid, recouped only 18,000 claims, which is 1.6% of money paid out was recouped, for CMHC's – of 700,000 paid, recouped 27,000, 3.9% was recouped, and for DMHSAS MH Centers – of 73,000 paid, recouped 1,5000, 2.3% was recouped. SEE HANDOUT for additional information. If have questions regarding adjustments, call Kelly at 522-7098, if calling on the 800#, Kelly is option #6.

## **Family PsychoEducation EBP – Kimrey Suttles**

EBP are services for people who have experienced serious psychiatric symptoms and have demonstrated positive outcomes in multiple research studies. The Substance Abuse and Mental Health Services Administration along with the Robert Wood Johnson Foundation are sponsoring a project to research, identify and promote the use of EBP's across the nation in an effort to improve health care quality. Six practices have been recognized as demonstrating a solid evidence base. Those practices include: Assertive Community Treatment (PACT)[implemented 2000]; Integrated Dual Disorders Treatment[2003]; Illness Management & Recovery[2006]; Family Psychoeducation[2006]; Supported Employment[2005] and Medication Management Approaches in Psychiatry.

The EBP philosophy- people want services that help them with symptom management and moving forward in their lives. These services are more about knowledge, individualization, personal choice and recovery than about rigidity or mandatory.

What is Family Psychoeducation? A partnership between the consumer, the family and practitioner working together as a means of communicating information about illness and working toward recovery. This is not Family Therapy- in Family Psychoeducation the object of treatment is the disorder or illness, not the family. The family is considered part of the team along with the consumer. Also is not just education, but rather an intervention with the objective of enhancing coping skills of the consumer and family. There is direct and ongoing guidance, inter-family support, problem solving and modeling; all in assisting to develop individualized coping strategies and skills.

Why focus on Family Psychoeducation? Consumers are generally interested in the support of their families and families are generally interested in being part of a consumer's recovery. Families play an important role in providing support. In this model the concept of "family" is broadly defined, it doesn't have to be someone living in the household; it can be any supportive person. Consumers can also participate in a multi-family group without having their own support person and still benefit from the process by receiving support from group members and their family members.

Objectives of Family Psychoeducation for Consumer – Reducing symptoms, preventing relapses, rehabilitation so consumers can achieve maximum level of functioning and best possible outcomes, provide foundation for recovery; maximize ability of family members to assist in consumer's recovery.

Objectives of Family Psychoeducation for Family – Engage assistance in supporting treatment and rehabilitation, provide knowledgeable support; alleviate suffering of family members by validating their feelings and supporting them in their efforts to support the consumer's recovery.

Evidence-based benefits for participants - Increased understanding of their illness, development of skills, reducing family stress, reducing relapses and community re-integration, forming social network.

Outcomes of Family Psychoeducation – In over 16 controlled studies, involving over 5000 consumers and their families, there were up to 75% lower relapse and rehospitalizations rates; increased functioning in community, especially in area of employment; reduction in negative symptoms; less stress and improved coping skills in families; and a decrease in doctor visits.

Who benefits from Family Psychoeducation - Most effective for schizophrenia, however with modifications being developed and tested for depression, bi-polar disorder, borderline personality disorder, and obsessive compulsive disorder. This practice usually replaces individual supportive

treatment, however integrates well with other EBP's and has been successful with -inpatient, outpatient, partial hospitalization and day treatment programs.

Core elements of Family Psychoeducation – Partnership (joining) of consumer, family and practitioners in education, problem solving, interactional and structural changes and multi-family contact.

Stages of treatment in Family Psychoeducation – The first stage is joining (partnership). These are generally weekly (one hour) sessions with family, meeting usually for a minimum of three sessions, followed by one day education workshop and ongoing sessions.

First year focus is on – relapse prevention, year two focus – rehabilitation, year three – network formation and recovery.

Q. How do these relate to NAMI's family to family?

A. Nothing contradictory about these two. Family Psychoeducation provides clinical intervention and skills training done by mental health providers. NAMI's family to family would be a good resource for families who are new to NAMI.

Q. What is the degree level of the co-trainers?

A. Master's level licensed therapists.

Q. Are there any programs in Oklahoma doing these practices?

A. Not sure if anyone in Oklahoma is providing this service at this time.

Q. If going to be provided by Master's level therapists, will there be billing opportunities?

A. Currently looking at billing under family therapy.

Suggestion – included professionals in training to build bonding in co-training that facilitates long term recovery. NAMI will have provider training in March to include two family members, two consumers and a professional.

## **Update on Reconsiderations/Appeals**

Heather Poole

In the rules changes, tried to make rules more consistent with federal statute requirements. There are specific areas where provider appeals are required, i.e., nursing homes, PASSAR screenings and recipient appeals; however provider appeals are not required. One area that OHCA was allowing provider appeals was in Behavioral Health in regards to the reconsideration process. Once the reconsideration process ended then the final denial was being appealed to the ALJ. This process has been modified, while there is still the opportunity for a paper review of denials of PA's there will no longer be appeals to the ALJ.

The portion being changed will make rules more consistent bringing Behavioral Health in line with other departments of the OHCA. As of July 1<sup>st</sup>, when new contracts take effect, the new appeal portion will be in effect. Providers will still have access to OHCA to ask for resolution on issues. Recipient appeal process is still in place. If concerned about recipient ability to make appeals, the recipient can give permission to have appeal done on their behalf.

Q. – Just relates to auth denial, not SURS audits process.

A. – Correct. Appeals process in OHCA rules 317:2-1-1.

Q. – When recipient is appealing do they have to appear in person?

A. – Yes

Q. – Who can represent recipient in appeal?

A. - Anyone can be the recipient representative.

Q. – Will OFMQ replace the reconsideration procedure with another procedure to have an internal check and balance against an individual reviewer?

A. – Don't know answer, can only answer for OHCA.

Q. – Any info on length of time from request of hearing to the hearing taking place.

A. – In new process – recipient appeals by federal statute need to be decided within 3 months.

Heather can be contacted at 405-522-7562.

## **Behavioral Health Collaborative Update**

Debbie Spaeth & Carrie Slaton Hodges

Single payor process – Nothing set in stone, will be bringing consumer/providers to table to get input. Developing uniform screen tool so all providers (Medicaid, DMH) will have same document. Screening document will check needed services including – mental health, substance abuse, domestic violence, trauma and considering adding gambling addiction. If a need is identified, the data is entered into system, the system will then identify providers in the consumers' area and an appointment will be scheduled for them. The collaborative will be adding children's assess tool. Everyone will go through same process. Consumer and provider then decide what services are needed and where they want to get those services. Collaborative is also discussing development of a provider report card which will assist the consumer in their choice. Hope is to help navigate through process with less turn downs for consumers. Providers will have access to assessment when provider is chosen by consumer. Collaborative is also considering doing standardized training/certifications for assessors. If not Medicaid recipient, private providers can do assessment and link to providers where consumers are eligible to be served.

Q. – Will there be education standard for assessors?

A. – Yes, still in process, but currently required to be licensed individual to do assessment and don't see that changing with new process.

Q. – Will this be a single point of entry or will each agency be trained in this process?

A. - Lots of ideas on best approach to the many options being discussed, ideas are being discussed and input requested at this time to discover how to proceed. No final decisions have been made. This system would utilize assessors at agencies and do standard training of assessors who met the certification requirements.

Q. - One requirement would include being licensed. Is that any license?

A. – This still need to be decided. The current standard for people doing clinical assessment is a MHP licensed or under supervision for licensure. In the proposed Medicaid rules, in the substance abuse area, have included the LADC's in those criteria. The DMH rules state the person doing the assessment also is a MHP.

Q. – How will this system know which agency has an appointment available at any given time as this information changes minute by minute?

A. – The agency assessors will be online with the system and will report through the online system. This will be a web-based live system that providers would keep updated with available appointments for assessments.

**Suggestion – Have a centralized area for Q & A – possibly on the web.**

Q. – How are going to know which agencies have openings

A. – all agencies will be online with this system, daily schedule will be kept on the system. Will be a web based system.

Q. – Some people will need to keep slots open per contract restrictions.

A. – This will be for the 800# only.

Q. – Two processes, screening - can it only be done by one person

A. – That's what trying to discern – need input from providers.

Single point of entry will bottleneck the system.

Q. – is this concept like the ISIS system?

A. – No, supposed to be one system, the CDC will go in with treatment plan updates to have regular reports and updates.

Q. – will this be a separate system for schedule

A. - No will be only for assessments

Q. – screening process only wouldn't require a clinician.

A. – Screening can be staff member, however assessment needs to be licensed person.

Q. – Caution what definitions read, need to be done by clinician.

A. – in screening process.

Q. – Will the assessment meet the requirements of the accrediting bodies?

A. – Has been considered, however still need additional input from providers. The current piece that has been developed does meet all the requirements of the accrediting bodies; however the down side of this is that it is quite a large assessment.

Q. – In the assessment process – need to have a tool to determine if getting accurate information from the consumer.

A. – The screening instrument – just wanted a basic screening tool, not an in depth tool. The goal is to have the assessors trained and have ability to assess what difficulties the consumer is having and make determination in assessment on a number of different areas. Would then be able to use the assessment tool to link up and locate services for the consumer, based on what information they get from both the consumer and the assessment tool.

Q. – Where will the level of care decision be made?

A. – This is another discussion point – still seeking input from providers. Have given thought to putting an initial plan development on services needed.

Q. – Are there committee meetings around this subject?

A. – There are many committees meeting on the collaborative as there are many aspects of the collaborative. **Suggestion** – people with additional input could come to these meetings to give that input. The initial committee has decided to solicit input from providers and consumers.

Q. – With the difficulty in sharing information between providers, where is the benefit to the provider of collaborating with other providers?

A. – This is the benefit of the single payor system, all of the information will be in the same system. There are still many questions that need to be answered which is why seeking input from providers.

Q. – Who specifically has had input into all of this?

A. – OHCA, DMH, advocacy groups, some consumers and information from a previous provider workgroup. Will be taking work done in past, review it and start to bring some momentum to it and ask for input.

Q. – What opportunity for providers are there in the future for agencies or provider to give input in a public forum.

A. – Starting this process in phases, and have just started a CMHC workgroup which has met once, as just one piece of the collaboration.

Q. – How do providers know of the workgroups or DMH meeting and are they open to providers?

A. – Debbie will start posting them on the OHCA website and yes they are open to providers.

## **Rule Changes Update –**

Debbie Spaeth

Q. – On the reconsideration process, per Ms. Poole, there would be no change, however in the handout of the rules it states that as of July 1<sup>st</sup>, providers could not ask for reconsiderations, which is a major change.

A. – Legal doesn't see this as the huge change that it is; they see it as taking away the formal process to appeal from the provider and give it to the recipient.

Q. – Arkansas had this type of issue and had to enact an emergency rule through the legislative process to stop the process because it wasn't consumer friendly.

A. – Knew legal dept was moving this direction at some point in time with the rules, to make all rules standard across the board concerning appeal process, however didn't know until the day after that legal had gone to the OHCA board with an emergency rule and that it had passed. This left no time for BH to meet with providers, get input and discuss. Suggested take concerns to Heather Poole.

Medicaid Update for 2006

Mike

Mike complimented the group on their efforts. Recommended the council take time to read the strategic plan and annual report.

Legislative Update for 2006

Nico Gomez

Task force recommendations – last 6-7 months worked weekly with eight house members on Medicaid reform task force, sharing information with them that can be found in both the annual report and strategic plan. It's been a worthwhile endeavor for OHCA, sharing information with those house members they previously did not have, changes some of their preconceived beliefs on Medicaid which will hopefully help in the long term. Now have a more informed Legislature. From these meetings came some recommendations, some of which closely match OHCA's strategic plan – Adopt a patient empowerment reform model, Establishment of health savings accounts for participants, Electronic Medical Records/E-Prescribing, Disease Management, Purchasing Pools, Emergency Room Utilization, Tiered Reimbursement for Nursing Facilities, Long-term Care Medicaid Lookback Period, Planning for Future Long-term Care needs, Accountability Measures, Phase out Medicaid Benefits, Funding, Extend Medicaid Benefits to Certain Persons, and finally, Preventive Wellness Programs for Children. Beginning Legislative session, many bills being considered – OHCA tracking some (see list).

Next meeting            May 10, 2006 (Catering - Laurel VanHorn)

Agenda Items for next meeting – Update on MH transformation grant.

Update on psychologists providing services to adults.

Children's and Adult collaborative.

Additional clarification of today's topic.

Report from licensing board on LADC's