

BEHAVIORAL HEALTH TAC REPORT TO THE MAC – JULY 24, 2014

Good morning. I am Valerie Mudd, serving today as the spokesperson for the Technical Advisory Committee on Behavioral Health (BH). Our TAC had its most recent meeting at the Capitol Annex on July 10, 2014. We invited all five (5) of the Medicaid MCOs and their Behavioral Health representatives to attend. All MCOs were represented and all but one – Anthem – had their pharmacy director with them. In addition to the MCO representatives and the five TAC members who were present, we had other members of the behavioral health community in Kentucky, including members of the KY Mental Health Coalition. We also had staff from KY Department for Medicaid Services and KY Department for Behavioral Health, Developmental & Intellectual Disabilities in attendance.

A summary of the Behavioral Health TAC report made to the MAC in May of 2014 was disseminated before the meeting and was briefly discussed.

A number of new items were on the agenda initiated by TAC members and others in the behavioral health community. Input on each was received from the MCOs as well as from staff of DBHDID and DMS.

1. Availability of Assertive Community Treatment (ACT) if the individual is residing in a Personal Care Home (PCH). MCOs stated that Medical Necessity was the criteria; not where the member lived.
2. Question whether an individual who gets ACT services, can they get Therapeutic Rehabilitation services. The closing of so many TRPs is a significant problem. DBHDID will share service standards. All agreed that the full continuum of care is not available.
3. Are targeted case management (TCM) and community support services mutually exclusive? Humana/CareSource indicated that they had changed their procedure here and were approving TCM and community support services.
4. Can someone who does not have an SMI diagnosis get peer support services? Peer support services are not restricted to individuals with an SMI diagnosis.
5. Some individuals who are dual eligible (Medicare & Medicaid) are being denied crisis stabilization services and the CMHC is being told to refer the person to the hospital. What happens if the hospital does not admit the individual? Is this a case of the MCO shifting costs to Medicare and sending members to a higher level of care? Lengthy discussion of these issues with the general consensus being that members who need CSU services are not likely to meet hospital admission standards and need to be seen at the CSU!
6. What is the current status of Impact Plus from the MCO perspective? What is happening with newly-identified youth who need intensive services? The changes in the Impact Plus program were again discussed and the MCOs reported that they are credentialing a number of providers of Impact Plus services who will now be providing these services under managed care. Everyone is anxious to see the Behavioral Health Services Organization (BHSO) regulation and begin the process of being licensed in this new category. While there has been progress made, there are still concerns about the service array for children with intense needs and how accessible those services will be. It was noted that Impact Plus

will be discussed at the July Health & Welfare Committee meeting and it is hoped that more information and clarification will be available then.

➤ The ongoing problems with access to appropriate medications were discussed, particularly with regard to Abilify. We were able to discuss these issues with the WellCare pharmacy director who was present. They do have a “fail first” policy, which consumers, family members and advocates at the meeting did not think was in the consumer’s best interests. Other pharmacy reps reported on their procedures, all of which require Prior Authorization. With regard to injectables, all require a first trial on the oral medication to assure that there are no side effects before the injectable (30-day) would be approved. Pharmacies do have the ability to give a 3-day supply in an emergency, and all pharmacy directors encouraged direct calls to them when problems of access arose.

➤ There was again discussion about the administrative burden experienced by those providers (e.g., CMHCs, private child care facilities, hospitals) who have contracts with all five MCOs, each with its own forms, procedures, criteria, etc. The lack of consistency of forms and procedures creates a huge administrative and resource burden for providers. The TAC will invite MCOs to share their ideas about streamlining procedures and creating consistent forms and will ask for the opportunity to present this information to the MCO Medical Directors convened by Dr. John Langefeld of DMS.

➤ We continue to ask the MCOs to provide information to us about openings and opportunities for consumers, family members, advocates and providers to serve on their committees. These requests would then be circulated through the KY Mental Health Coalition and other forums to recruit interested persons.

RECOMMENDATION: That Kentucky DMS carefully monitor the hospitalization/institutionalization/out-of-state placements of Medicaid members and re-evaluate the reimbursement rates for services such as intensive case management and outpatient therapies in light of this data. Specific data on readmission rates for individuals needs to be tracked and analyzed to get a full picture of what is happening to members with behavioral health needs.

➤ Finally, the Behavioral Health TAC wishes to state again this recommendation made more than one year ago:

RECOMMENDATION: That a Behavioral Health Ombudsperson be established to provide easily-accessed personal responses to consumers who are experiencing difficulty with the Medicaid managed care system. This would allow consumers to share their personal health information (PHI) as they discuss directly with the Ombudsperson the issues that need to be resolved with the MCOs in order for them to access the care that they need.

Thank you for providing this forum to bring forward behavioral health concerns on behalf of Medicaid members.