BEHAVIORAL HEALTH TAC REPORT TO THE MAC – MAY 22, 2014

Good morning. I am Sheila Schuster, 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 May 8, 2014. We invited all five (5) of the Medicaid MCOs and their Behavioral Health representatives to attend. Three MCOs were represented and two – Coventry and WellCare – were not in attendance. In addition to the MCO representatives and the four TAC members who were present, we had other members of the behavioral health community in Kentucky, including members of the KY Mental Health Coalition.

A summary of the Behavioral Health TAC report made to the MAC in March of 2014 was disseminated before the meeting and was briefly discussed. The meeting invitation had specifically noted the problems with access to psychotropic medications, particularly Abilify, and the MCOs were asked to provide input from their pharmacy director on this issue.

- The ongoing problems with access to appropriate medications were discussed, particularly with regard to Abilify. Consumers have recently complained that they are being charged $400+ for a prescription of Abilify. Since this appears to be limited to WellCare and they were not present at the meeting, the issue will have to be addressed directly with that MCO to clarify their policy and to address access issues.

PREVIOUS RECOMMENDATION: The requested data for PA's and their outcomes for psychotropic medications – as well as other requests made by our TAC as far back as July, 2013 were approved by the MAC in January and submitted to DMS for response. That response and initial data was received by me from Beth Partin, MAC Chair, late yesterday, May 21st. In a very brief review, I noted that the table prepared by Ms.Guise of DMS regarding Prior Authorizations of services did not address our question, as it creates a single category for Mental Health & Substance Abuse Services and does not break out the individual services. Our question was about specific services and whether PAs were required, as well as whether PAs were differentially required, depending on whether the service was being provided by a CMHC or by a private provider. Obviously, the Behavioral Health TAC has not had an opportunity to read, review or digest the response from DMS nor the data provided. A number of the data tables were illegible and I will contact Erin Hoben at DMS to obtain clean copies for our review. Once that material has been thoroughly reviewed by the BH TAC, further recommendations to improve medication access and to address other issues may be forthcoming.

- There was discussion about the fact that an Open Enrollment Period had begun on May 5th (to end on June 18th) and that the only information that had been made available was through a direct mailing to Medicaid members. Consumers and family members noted that this was <u>not</u> the most effective way to communicate important information to members, particularly those with significant behavioral health issues, who frequently do not open their mail, may not understand the letter or make note of its contents. Communication about the Open Enrollment period should be disseminated as widely as possible to all those who have contact with Medicaid members – their families, support groups, advocates and providers, particularly case managers.

RECOMMENDATION: That DMS immediately post on their website and disseminate basic information about the Open Enrollment Period now underway. This information, at a minimum, should be sent to the MAC members, all of the TACS and to the advocacy and provider groups typically notified by DMS about the MAC meetings. I have attached a copy of the announcement flyer and of the accompanying MCO information that is being disseminated through the KY Mental Health Coalition and other advocacy groups for this purpose.

The focus then turned to the issues which have been at the forefront of concern from the Behavioral Health Community, some of them since Medicaid Managed Care began in November of 2011, particularly with regard to accessing outpatient services. WellCare has begun requiring pre-authorizaton for outpatient therapy visits, creating an access problem. Co-pays of as much as $40 per visit charged by WellCare are also creating access issues for consumers. These will need to be addressed directly with this MCO to resolve the problems. There continue to be concerns around the high denial rates for outpatient therapy services, particularly by one of the MCOs, and the short LOS in the hospital for behavioral health patients, particularly children. Some of the MCOs suggested direct contact with their Behavioral Health director to discuss these situations. Again, a Behavioral Health Ombudsperson would be extremely helpful in expediting consumer communication about these access problems.

- 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 MCOs present indicated a willingness to further discuss this issue and to work toward reducing administrative burdens for all. It was pointed out that other states have achieved consistency of forms and procedures, thus streamlining their system, so we know it can be done!

PREVIOUS RECOMMENDATION: That representatives of the Behavioral Health TAC (or their designees) be invited to attend a meeting of the MCO Medical Directors convened by Dr. John Langefeld (DMS) to discuss this issue of inconsistency of forms and procedures across MCOs, in order to seek some resolution which would reduce administrative costs and burden for providers and facilitate service provision.

- We are pleased to note that apparently all of the MCOs are including Peer Support Services at this point in time, and that it is being included in the CMHC contracts.

- At our meeting in March, we made a request of the MCOs for improved communications and more opportunities for consumers and family members to participate on their committees. It was helpful to have the pharmacy director from Passport Health Plan present to explain their P&T and formulary development processes, including the input of members. The offer of utilizing the network of the KY Mental Health Coalition for dissemination of information and "recruitment" materials was made once again in the May meeting since there had been no

follow-through by the MCOs,. Since then, Passport has made a specific request for consumer participation which will be circulated through KMHC; we are hopeful that other MCOs will follow suit.

➢ Concerns were noted with the low Medicaid rates posted by KY DMS, with providers feeling that they were not sufficient to cover their costs. Comments regarding these rates were made by various provider groups in response to the Medicaid regulations. Unfortunately, the responses to those comments from DMS have been received and indicate that no changes will be made. The members of the Behavioral Health TAC continue to be concerned that if "front-end" services are not sufficiently available because of low rates and, therefore, reduced number of providers, members – especially children and those with significant behavioral health issues – would end up in much more costly treatment settings or being placed out-of-state.

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.

➢ The TAC member representing the Brain Injury Alliance of Kentucky noted these ongoing concerns:

- Following up with local DCBS offices is difficult; would it be possible to have a specific worker assigned to all of the ABI Waiver clients?
- Need to find easier, more streamlined processes for: scheduling appointments to apply for the waiver; clearer financial qualification descriptions; earlier determination of the existence of a disability (now taking months and months);
- More training for Case Managers and anyone else who needs to understand the process, what is required and what programs are available.
- Families need to receive communications that are now being sent directly to consumers who, because of their brain injury with subsequent memory loss and impaired judgment, discard the communications or do not respond to them because they do not understand them.

➢ A new concern was raised about Impact Plus and what the fate of the program would be. Providers are anxious to learn what changes are being contemplated by DMS and DBHDID and what role the MCO's will play. The MCO reps indicated that they had some preliminary information from DMS and that they understood that Impact Plus providers would be receiving further information in the very new future. We understand that providers have been verbally notified that no new children will be enrolled in Impact Plus as of July 1, 2014, but information has not been received in writing to date. This issue will be placed on the agenda for our next Behavioral Health TAC meeting so that we can receive an update. The concerns are: what services will be available to children with intense needs and how will that array of services be most effectively accessed by children and their families?

- 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.