

PAC Minutes from 2/26/10 Meeting

- **Case Rates:** The question came up whether the need for authorizations would be eliminated because it was a time consuming process. VO reported that they are working on creating pass through units to eliminate some of the paperwork, which will hopefully be in effect by April 1st. What the changes will be are:
 - UA's with a service package assignment
 - Expiration dates will still be in effect
 - There will be no unit limitations
 - There will be no minimum hours
 - This will eliminate widget units

Providers expressed that they had either understood or hoped that they would be able to pick from services across service packages and not be pinned down to an actual service package.

- Outcomes will be measured through claims data and TRAG scores.
- Providers are concerned with lawsuits that could reference the service package assignment, but point out the member is not being served at that service level assigned. It was pointed out that Providers can go outside of the service package assignments due to member's choice and resource limitations.
- A concern was brought up that whoever is processing the UA's are inputting incorrect authorization dates. They are inputting the date they reviewed the auth and not the date the auth was requested for.
- **Eligibility and Enrollment** – It was announced by ValueOptions that financials will only need to be completed once a year instead of every six months as previously requested.
 - Lost requests were an issue that was raised as well. ValueOptions did report that they were significantly behind on UA authorizations at times, but earlier this week they finally were all caught up and have hired a new staff member.
 - It was reported by the Providers that there are really no new issues, but fixing the old ones.
- **New VO Process and the NY Office** - Providers seemed to have differing opinions regarding the NY Office and their employees.
 - Some Providers felt the “get to the point” attitude was helpful and the staff was quite procedural, which got the problem resolved quickly.
 - Some Providers feel the staff are rude and obnoxious and not as helpful
- **Complaints** – ValueOptions reported that the number of complaints has dramatically decreased and those outstanding complaints are old complaints, which coincide with what Providers were voicing as well; outstanding issues are old issues.
- **Payments** – Provider wondered if others are receiving spikes and valleys in their payments from ValueOptions? All MH Providers are receiving once a month payments via the blended case rate and therefore this does not really apply to them. ValueOptions did report that staffing patterns probably caused the spikes

- and valleys. ValueOptions also reported that Providers had gotten used to the typical 1 week turn-around time, however, VO does have 30 days to render payment.
- **RDM Redesign** – Kristen Cathey, NTBHA employee, has been attending these meetings in Austin. The following issues have been discussed during the last 2 meetings.
 - The overall focus on the January meeting was service package 1.
 - A high percentage of people are being underserved in package one and the group focused on reasons this may be occurring. The two primary reasons discussed were patient choice (clients are being told that there is a significant time commitment on their part and refusing) and lack of space in other service packages (Lubbock made the comment that where there is no room on their ACT team – SP4 - they are serving them at the SP1 level of care.)
 - Case managers across the state are carrying an average of about 450 clients on a caseload when serving this level of care and in some cases the ration is as high as 900 clients to one case manager. The group questioned what, if any, services are able to be delivered at this level of care with case loads so high. This led to a discussion on what the minimal care for an individual would be when defined for the legislature. The question was discussed briefly but ultimately tabled for a later date.
 - The overall focus on the February meeting was C&A service package 4.
 - A high percentage of children and adolescents are being underserved in package four and the group focused on reasons this may be occurring. One concern with individuals in this package is that children are placed in a package 4 at the onset of treatment when package four is designed to be an aftercare package. Some of the hypothesized reasons this occurs is a lack of resources in more intensive packages, family need, family choice, and continuity of care. The trend of children that are underserved is that that have a higher frequency of crisis and hospitalization services.
 - Medication services information was also presented. Topics included were general medical services overview, 2009 related data, practice guidelines and research. Due to time limitations this presentation was not completed and will be continued at the March meeting.
 - **Local Plan:** NTBHA reported the plan is continued to be drafted. The needs assessments data has been received back, which totaled just over 900 respondents. NTBHA is also conducting town hall meetings with MHA and NAMI across all 7 NorthSTAR counties.
 - **Letter to the NTBHA BOD** – A provider presented a letter that would be given to the NTBHA BOD to clarify what the blended case rate really is and what it really means as well as to clarify that all Providers are within RDM guidelines, but those guidelines are practiced differently within NorthSTAR than in the rest of the State. There seems to be some concern on the part of the Providers that the NTBHA BOD does not fully understand the blended case rate or RDM.
 - The question was raised whether NorthSTAR is better or traditional MHMR is better. It seemed all Providers felt both systems have their

positives and negatives and that both systems could not really be compared. You can't really say one is better than the other.

Next meeting will be held on March 26th at 10am at Green Oaks Hospital
DSHS will be present to give a presentation on STAR PLUS.