Behavioral Health Advisory Council Meeting

Wednesday, April 8, 2015
9:30 am – 11:30pm

Charles Ed McFall Boardroom
Lincoln Center
4345 N. Lincoln

Minutes

Present:

Laura Boyd	**Verna Foust**	**Karen Orsi**
Janet Cizek	**Melissa Griffin**	**Randy Randleman**
Traci Cook	**James Hale**	**Traylor Rains Sims**
Charles Danley	**Carrie Slatton Hodges**	**Jeff Talent**

Welcome - *Co-Chairs, Laura Boyd and Jeff Talent*

School-Based Services Acknowledgment - *Co-chairs, Laura Boyd and Jeff Tallent*

- The Co-Chairs publically thanked OHCA and ODMHSAS for their work on the school based services discussion that has gone on during the past few months. This was very important and critical issue to the providers represented by the BHAC. The resolution arrived at was huge for kids in the state and for their service providers.
- Laura Boyd summarized the resolution around school-based services. The fact is that nothing necessarily changes. What is now clear is that if a school system does not want behavioral health services delivered in the school day on their premises then they have the authority and the right to say that, to decline, or prohibit those services in that environment. If on the other hand, the school systems wants to do exactly what they have been doing or they want to engage in those school based services with private outpatient behavioral health agencies and/or LBHP's then they may do so.
- State Department of Education Board Member has been contacted and they are working on getting the information distributed to the Superintendents of each school.
- Any behavioral health services previously provided in a school are still allowable if the school allows them to come in. Services are billed by the rendering provider and not under the school's contract. For requirements/clarification regarding services provided in schools, please refer to OHCA Provider Letter 2015-04.

Fast Facts - *Tony Russell, OHCA*

- See Behavioral Health Fast Facts attachment
- This year there was a 1.6% decrease in the average amount of reimbursement in behavioral health services for clients per month.
- Over the same period, there has been about a 3.3% increase in total members being served.
- This is a reflection of the measures the State implemented over the last 2 years. The State anticipated a growth in the number of persons coming into the program and fewer funds to serve the additional persons so policy changes were made last year that would compensate for this increase. The changes we made are working in the way we had intended.
- A BHAC member asked whether the rehab rule that went into affect in August had any significant impact on the numbers. Mr. Rains-Sims stated that ODMHSAS has seen around

30 million in net savings which is about 10 million in state dollars which is exactly what was anticipated.

- A member of the audience asked if when rehab services were reduced, were any other services affected (i.e. was there an influx or higher admission rates or higher costs associated with higher levels of care? Mr. Rains-Sims responded that the State has not seen any increase in lengths of stay or admissions to inpatient, those have remained the same. There was an increase in the provision of case management. There was some increase since last year in therapy which part of the intent behind the rehab rule change was to align children with services that are more appropriate to their needs. So an increase in case management and therapies was anticipated and accounted for.

ODMHSAS Budget Recommendations - *Traylor Rains-Sims, Director of Policy, ODMHSAS*

- ODMHSAS does not have a final budget and so it is all speculative at this point. The Governor's proposed budget was flat for ODMHSAS. However, due to increases in utilization in the Sooner Care program and a drop in federal match beginning 10/1/2015, ODMHSAS would be left with a shortfall of approximately $10 million in state funds.
- So we want to have the conversation on ways we can address that budget shortfall moving forward. Nothing is set in stone at this point. We are still hopeful at this point that we may get more money. Commissioner White's meeting with the Senate has been pushed back to next week, so we will not get our final budget until close to the end of session.
- We did a lot last year. We addressed the budget with the rehab changes and the 35 hours. Everything that we recommended for the budget last year we have implemented so we would have to come up with something new if we face a budget shortfall this year.
- We have analyzed utilization for psychotherapy (individual, group and family) in an agency setting. The daily limit on H0004 is 6 units a day for individual therapy and those are 15 minute units so that is an hour and a half of individual therapy a day that is allowed. Then there is 2 hours or 8 units of family therapy also allowed on that same day for that client.
- We have seen that some providers will routinely provide 90 minutes of individual therapy no matter the age of the child or adult and will routinely provide those 2 hours of family therapy.
- For individually contracted providers, there is no reimbursement for anything over 60 minutes. It is capped at 60 minutes per the Medicare standards.
- We looked at what it would do if we reduced those daily limits for individual and family therapy for practitioners working in an agency. If individual therapy was reduced to 4 units (60 minutes) family therapy to 6 units (1.5 hours) an estimated savings of $21.8 million could be achieved ($8.4 million state dollars).
- If utilization were to be limited to 4 units for individual therapy and 4 units of family therapy, an estimated savings of $28 million total would be achieved. 5 units of individual a day and 4 units of family therapy a day would save roughly $17.9 million total.
- When the council met a week ago there was a lot of discussion around the appropriateness of 90 minute sessions as routine. The appropriateness of a 2 hour family session with and without client as a standard and the group agreed that 4 for individual and 6 for family was a reasonable limit.
- There was also some discussion that they could bill 1.5 hours of individual therapy and 2 hours of family therapy with client present and 2 hours of family therapy without client present. There is no restriction because those codes are separate they could actually be receiving 5.5 hours of therapy in a day.
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Program Integrity Process - *Kelly Shropshire, OHCA*

- PowerPoint presented by Kelly Shropshire. (See attached)

- Board requested that general trends that look like innocent misunderstandings in behavioral health community be brought to the BHAC meeting two times a year.

Best Practice Issues, Case Management

- Therapist from Poteau in rural Oklahoma encourages board to look into abuse in case management. Clients don't understand the difference between a case manager and a therapist. Therapists can provide case management services but case managers cannot provide therapy.
- What would help to change this? The community needs to be educated about the difference. Case management is an important component but it is not therapy.
- Case Managers who are out there and are not behaving appropriately, you can report them to the Case Management Certification Division at ODMHSAS who has the ability to monitor individual certifications and suspend/revoke if necessary.
- There is a huge need for training/education about case management vs. therapy in the field. Perhaps it could be included as a required component of their CEU for all case managers.
- Case manager need to be better trained to refer to the entire community and not just within their agency.

Other Business

Next BHAC member-only meeting on Wednesday, May 13, 2015 at 9:30 am.
Next public meeting on Wednesday, July 8, 2015 at 9:30 am.

Meeting Adjourned 11:30 am