

Came from Providers

Summary of Issues Related to CMO's and Behavioral Healthcare for Children & Adolescents

The following are issues communicated through various sources, regarding C&A services and the CMO's. The issues are in 4 areas:

1. Financial viability of service providers
2. Service authorization parity & processes
3. Shifting of custody to DFCS in order to receive services and to DMHDDAD for hospitalization and high end care
4. Continuity of care for children in multiple systems

Issue #1: Financial viability of service providers

- Low number of providers enrolled w/ CMO's
Many providers in the public and private C&A provider system are not enrolled with the CMO's. Data indicates that of all C&A providers, **66%, 55%, and 56% are enrolled** with the three CMO's respectively. Of private providers, excluding the CSB's, there are **only 35%, 30% and 30%** of providers enrolled with CMO's.
- Difficulties becoming enrolled
 - Inability to receive applications from CMO's. Time frames from attempts to receive applications to executed contracts ranged from several months to a year and a half. Most providers cited long periods of no communication, unreturned phone calls, and other difficulties in communication.
- Difficulties contracting. Providers indicated that some CMO's want to contract only with their professional staff and not with the agency itself
- Technical difficulties. All three CMO's require different authorization and billing systems. Providers report difficulty receiving technical assistance in establishing and operating the disparate systems, correcting billing errors, etc.
- Costs. Providers report high costs in technology and staffing to accommodate the systems requirements of operating 4 billing systems.
- Inability to recoup costs of service. Providers reported only recovering between **10% and 48% of their costs** for serving CMO children.

Issue #2 Authorization difficulties

- Each CMO has different authorization forms, processes, and standards.
- Providers have reported disparities in authorizations for basic therapeutic services. Each CMO has different authorization standards. Some standard authorizations are considered inadequate. For example, Magellan authorizes only six 15 minute units (1 ½ hours) for diagnostic assessment, Cenpatico authorizes only 1 hour, while these assessments typically take 4-7 hours.
- Providers report unpredictable inconsistencies in authorization, eg. What is authorized this week may not be authorized next week.

- Waiting for authorization can be delayed up to 2 weeks depending on the CMO. If services need to be provided before that, and denials occur, providers have to absorb the costs.
- Providers have reported having services denied categorically which are in the state plan (most recently group skills training).
- Providers report that children in RBWO who are enrolled in CMO's receive less service than those paid by DMHDDAD. Providers report absorbing the costs for the differences.
- DJJ reports CMO kids not getting approved for PRTF level of care.
- PRTF's report that CMO's are authorizing only 3-7 days at a time before requiring reauthorization (except Magellan). Given the time and staff involved in obtaining authorization and reauthorization, this time frame is not viable for PRTF's. Some may begin not to take CMO kids. Costs for CMO kids who must stay in PRTF beyond CMO authorization are shifted to the PRTF.

Issue #3 Shifting custody and costs

- Children in RBWO who are enrolled with CMO's, where the RBWO is not a Core provider, have been absorbing costs for therapy for these children. They will begin not taking children who are in CMO's and, eventually discharging these children. This will cause a significant placement issue for DFCS.
- Children who are not adequately served at the outpatient level will end up in state hospitals.

Issue #4 Continuity of Care

Many children who are enrolled with CMO's are also involved with DFCS. That is, children who are in the child protective services, family preservation, or diversion caseloads have not been taken into custody, but require behavioral health services. (There are approximately 6000 families receiving Medicaid in the CPS caseload statewide). There are also many kids who are involved with DJJ, have court involvement but have not been committed to DJJ custody who are enrolled w/ CMO's. For these children, there is a need for interagency planning for their care. When the behavioral health provider is not a part of the process, as is reported to be the case when the child has CMO coverage, continuity of care is lacking. Other continuity issues include:

- Children may move from parental custody to DFCS custody, and therefore change providers and eligibility from CMO to DMHDDAD. When the providers from whom children are receiving treatment are not also MHDDAD providers, there is a lack of continuity of care. (Some of this movement is due to children not receiving what DFCS and providers believe to be required treatment as stated above).
- Children may go from DFCS custody back to their parents and, therefore, back to CMO coverage. Shifts in coverage cause delays in treatment and potential changes in providers.