Behavioral Health Partnership Oversight Council

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Quality Management, Access & Safety Subcommittee

Meeting Summary: July 18, 2008
Co-Chairs: Dr. Davis Gammon & Robert Franks
Next Meeting: September 19, 2008 @ 1 PM at VO in Rocky Hill

Attendees: Davis Gammon, MD & Bob Franks, PhD (Co-Chairs), Mark Schaefer (DSS), Lois Berkowitz (DCF), Laurie VanDer Heide and Ann Phelan (ValueOptions), Sandra Cohen (Wheeler Clinic), H. Felton-Reid (R&C), Melody Nelson (Family Representative), Susan O'Connell (CHR Health), M. McCourt (legislative staff).

Charter Oak Health Plan (COHP) Implementation(Click on 1st icon for DSS report to MMCC July 11 on implementation timelines COHP, HUSKY transition & dental carve-out, 2nd icon DSS July report to BHP OC that includes COHP BH services, etc.)


MMCC HUSKY Charter Oak Update0


BHPOC Presentation 7-9-08 Final.ppt

Dr. Schaefer (DSS) reviewed the COHP status and BH services (see 2nd icon above). Key discussion points include:

- DSS is finalizing contracts with the 3 MCOs for the next HUSKY transition and start up of COHP; over the next few months, starting in September, Anthem and HUSKY FFS members will be moved into one of the 3 at-risk MCOs. These MCOs will also cover COHP members.
- The enrollment plan for DCF children, currently enrolled mainly in Anthem, has not been decided.
- CTBHP: DSS will administer COHP behavioral services alone within the BHP infrastructure (not with DCF since the COHP members are adults) with a possible consultative agreement with DMHAS.
- ValueOptions will provide customer services, UM support and limited quality reporting as compared to CTBHP reports. DSS position is to share COHP data with both Oversight Councils although there is no current legislative mandate to do so.
- BH providers, enrolled in the CT Medical Assistance Program (CMAP), can bill DSS for COHP services. All CTBHP providers will be notified about COHP. Rates will be based on CTBHP rates subject to client co—payments. (*See 2nd icon for COHP benefits, client deductibles & co-pays/type of service).*
- Substance abuse services are limited: this non-parity of benefit is a compromise in an attempt to

manage costs (approximately $20/PMPM for BH) within the premiums.

- Issues as they affect providers were highlighted:
    - Free-standing clinics will collect the visit co-pays.
        - Some services (i.e. group therapy rates are less than the $35 co-pay, so the clinic would collect the co-pay, not bill for the service).
        - A clinic could waive a client's co-pay; service reimbursement rate will be adjusted for the co-pay. Providers are concerned that the negotiated rate for CTBHP will not apply to COHP (COHP wasn't developed when rates were negotiated) and lack of client payment of co-pays will reduce services rates.

    - Hospital concerns were outlined: that included:
        - Client's 10% co-insurance is discounted from the inpatient BHP per diem rate. Hospitals will lose revenue if clients fail to pay their co-insurance.
        - With COHP small employers may, in the future, forego offering employee insurance programs. The balance of commercial vs. Medicaid reimbursement will shift.
        - DSS noted that the intent of COHP is to cover uninsured adults that currently self pay for hospital services and hospitals may not receive many of these payments.

    - Providers will need to identify what portion of a BH benefit has been used, what is left for remaining services. While VO can identify # visits PA, claims processing may not correspond directly to that as previous claims within the benefit may have been billed and paid. Further discussion in the Operations SC to identify how providers can best manage this with the client.

BHP Client Satisfaction Surveys (Click icon below for VO Consumer Satisfaction Survey Results)

Final Quality and Access Committee Jul

Laurie VanDer Heide (VO) provided back ground on two client satisfaction surveys: 1) Mercer customer service (VO) satisfaction survey and 2) FactFinders, contracted by VO, survey of member satisfaction with CTBHP services. This sample was stratified for 5 levels of care with about 50 clients/strata. Both VO and the SC discussed changes/additions for a future survey. Bob Franks will convene a work group in August to discuss how best to measure client satisfaction and functional outcomes of treatment, two very different measurements. This group will report back to the SC in September.

Information from other CTBHP areas that would be helpful in assessing the program includes follow up of 'high utilizers/outliers" and crisis plans implementation: who needs the plan, percentage that had a plan and percentage that did not.

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