Behavioral Health Partnership Oversight Council
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Report of the
Connecticut Behavioral Health Partnership Oversight Council

March 2007

I. Introduction

This report of the **Behavioral Health Partnership Oversight Council** is submitted to the General Assembly as required by PA05-280. This report is for the time period of **March 2006 through February 2007.** The Council is a collaborative body established by the General Assembly in 2005 to advise the Departments of Social Services (DSS) and Children and Families (DCF) on the development and implementation of the Connecticut Behavioral Health Partnership (BHP). The agencies have statutory authority to implement an integrated behavioral health services system separate from the Medicaid Managed Care Program for HUSKY Part A children/parents/caregivers, HUSKY Part B children, and children enrolled in the DCF voluntary services program. The Council consists of legislators, consumers, advocates, health care providers, representatives of managed care plans, and state agencies. The Council has five working subcommittees: Coordination of Care, DCF Advisory, Provider Advisory, Quality Management and Access, and Operations. These subcommittees monitor activities of the BHP and report back to the Council with findings and recommendations.

The Council defines its purpose and oversight areas based on provisions in the authorizing legislation for the Partnership (PA 05-280):

The Behavioral Health Partnership shall seek to increase access to quality behavioral health services through:

1) *Expansion of individualized, family-centered, community-based services;*
2) *Maximization of federal revenue to fund behavioral health services;*
3) *Reduction in the unnecessary use of institutional and residential services for children;*
4) *Capture and investment of enhanced federal revenue and savings derived from reduced residential services and increased community-based services;*
5) *Improved administrative oversight and efficiencies; and*
6) *Monitoring of individual outcomes, provider performance, taking into consideration the acuity of the patients served by each provider, and overall program performance.*

The Council's areas of oversight responsibility include:

- Review/comment on the contract between DSS and DCF and the administrative services organization (ASO) to ensure ASO decisions are based on clinical management criteria developed by the clinical management committee that includes two members of the BHP Oversight Council.

- Review the delivery of behavioral health services to ensure maximum federal revenue.

- Review and make recommendations to the State agencies and the legislature based on the BHP program reports on services, finances and outcomes and the achievement of program goals. The BHP Oversight Council may initiate and/or conduct an external independent evaluation of the BHP program.

- Review and make recommendations on plans of the State agencies and the Administrative Service Organization to provide for the equitable statewide delivery of individualized, family-driven, community-based and culturally competent services in the Behavioral Health Partnership Program.

- Consumer grievance procedures, developed by the BHP agencies, shall be submitted to the BHP Oversight Council for review and comment.

- Review all proposals for initial service rates, reductions to existing rates and rate methodology changes. The Council may recommend acceptance of the rates or forward Council rate-specific recommendations to the General Assembly committees of cognizance (Human Services, Public Health and Appropriations).

- Review and comment on policies related to the coordinated delivery of both physical and behavioral health services for the covered populations.

The Council and subcommittees met monthly during the period of this report. The focus was on reviewing and commenting on plans for implementing the BHP on January 1, 2006 that were submitted by the state agencies and their Administrative Service Organization (ASO) subcontractor, ValueOptions. The Council reviewed plans and *commented on or* made recommendations related to the following:

- Distribution of a 2% across-the-board rate increase to all BHP providers, retroactive to January 1, 2006
- Request to DSS that additional funds be allocated to provider rates equal to the average rate increased given to HUSKY MCOs for 2006
- Request that eligibility to participate as Enhanced Care Clinics (ECCs) be extended to hospital-based clinics
- Oversight of outpatient registration processes and formats

Both the Departments of Social Services and Children & Families and the Administrative organization ValueOptions Inc. (VOI) have been responsive to the Council and Subcommittees requests for information and suggestions and/or recommendations originating from the dialogue

at the Council or Subcommittee level.

II. Council Subcommittees

A. Quality Management and Access subcommittee works with the Departments to determine, and provide oversight to, the plan for monitoring the performance of the Administrative Services Organization (ASO) and the quality of behavioral health services provided under the Partnership. The subcommittee concentrated on providing input into, and oversight of, the following areas during the past year:

- Refinement of the targeted performance measures for the ASO that are associated with fiscal incentives/sanctions.

- Refinement of quality indicators developed by the Departments' contractor, Human Services Research Institute (HSRI), for children's services. These, and others to be developed later, will constitute a "report card" of BHP performance. The indicators relate to access to care (including outpatient appointment following inpatient stay and improved access to care through operationalization of Enhanced Care Clinics), coordination of primary care and behavioral health care, and outcomes of care. The BHP agencies have yet to develop adult service indicators to be included in the program's performance "report card".

- Development of the web-based outpatient care registration system to enable collection of key data elements for future quality studies.

- Review of ASO performance targets, including reducing emergency department lengths of stay and discharge delays, reducing prolonged inpatient stays due to placement delays, and a new study to examine the correlation between disruptions in foster care placements and behavioral health disorders for DCF-involved children.

- Provider and consumer satisfaction surveys conducted by VOI

B. Operations Subcommittee:

This subcommittee changed its name during the past year from the Transitions Subcommittee. This represented a shift in focus from the "transition" to the new delivery system to the monitoring of the effectiveness of the ongoing "operations" of the Partnership. Monthly reports with detailed operational agendas were submitted by CTBHP/VOI and the Department of Social Services (DSS) for review and comment by the Subcommittee.

A comprehensive reporting system was developed to identify children and adolescents in acute care beds awaiting a community based placement. There was a cooperative effort between Value Options and the providers to ensure the accuracy of the "Discharge Delayed Status" patients

and to develop solutions for those children and adolescents who posed unique placement problems and therefore were in an acute care setting for an inordinate amount of time.

The Subcommittee reviewed reports starting in July 2006 that showed although there was not a decrease in the number of BHP members in hospital emergency departments (EDs) there was a preliminary trend that suggests a decrease in the number of days that members stayed in the EDs. This issue will continue to be monitored by the Committee as the period of highest demand (January through June) is experienced.

Ongoing oversight was provided by the subcommittee to ensure an adequate network of providers, and tracked potential disruption to members with the implementation of a new network. Provider issues discussed at monthly meetings included topics such as timeliness of Pre-certification and Concurrent Review (CCR) process, streamlining of service registration and authorization processes, and troubleshooting of systems issues that impact timely payment. Improvement in this process was noted following additional training for providers and development of Value Options staff. A Rapid response Team was also implemented to provide more timely outreach and follow-up to providers regarding the authorization process and assistance in management of administrative denials of payment.

The Committee worked closely with the legacy MCOs and DSS to track the resolution of disputed outstanding claims for services prior to January 1, 2006. Most providers provided documentation on these outstanding claims, and for those providers who did submit this data, resolution was reached with the MCOs on these outstanding claims. The majority of denials of these claims were generated by problems encountered by both providers and MCOs in the administrative processing of the claims rather than disputes regarding Medical Necessity determinations.

C. Provider Advisory Subcommittee is responsible for reviewing clinical criteria for all levels of care and services offered under the Partnership and managed by the Administrative Services Organization.

The subcommittee has continued to review and make recommendations on the BHP Clinical Care Guidelines. New guidelines to be added include case management, group home, home health care, and in-home levels of care. In addition, the subcommittee has reviewed the Enhanced Care Clinic criteria and worked with DSS to clarify the required standards and develop mechanisms to measure performance outcomes.

D. DCF Advisory Subcommittee: The DCF/ASO Committee has met regularly during the course of the last year. Committee meetings have been well attended by providers as well as family members. Staff from DCF and DSS have attended all meetings and continue to be very responsive to requests for information and follow through outside of the formal meetings. The committee has received presentations from DCF and VOI involving such areas as:

1. voluntary services, a change to the referral process for residential and group home placements (Central Placement Team);
2. Local Area Development Plans;

3. DCF Partnership Table of Organization;
4. VOI local system management function and the role of the VOI peer support specialists;
5. DCF funded care coordination and in-home services; and the
6. Enhanced Care Clinic review process.

The Subcommittee also received a presentation from FAVOR, a family advocacy organization under contract with DCF to provide family advocacy to support and grow the family movement.

The majority of the committee work, however, has been devoted to providing oversight of the implementation of Intensive In-home Child and Adolescent Psychiatric Services (IICAPS) and the conversion of funding for this program from grants to fee-for-service under the CT BHP. The subcommittee has worked closely with the Departments on the IICAPS program because it is the first service to be converted from DCF grant funding to fee-for-service under the Partnership. The Council recognizes that the process and methodology for this conversion will serve as a model for future DCF service conversions.

The initial focus was on the rate-setting methodology and the rate set as a result. Providers expressed concerns about assumptions of the methodology and continue to do so. These issues are not resolved at this point in time. In addition, there was concern about the adequacy of the transition period associated with grant funding and the conversion. As a result of advocacy by the committee the grant funds were extended through June 30, 2006 to assist providers with the transition. Providers were also allowed to retain surplus funds to offset potential loses in the new fiscal year.

Effective July 1, 2006, DCF grant funds that were not converted to the BHP were distributed to providers by formula to cover travel costs and to cover uninsured clients. Providers have raised concerns about the formula, but it remains in force pending a review by DCF of travel-related data.

As a result of an agreement between the subcommittee and the Departments, a work group process was launched in July to examine the assumptions of the rate-setting methodology, clarification of the Yale University model (on which IICAPS is based), the grant allocation process, the technical issues associated with billing for the service, and data elements to be collected. These were all to inform the rate-setting process to be reviewed and revised in the spring of 2007.

The subcommittee has also engaged the Departments, and VOI, in a review and resolution of other implementation issues, including timeliness of authorizations, rejection of claims due to coding issues, problems with commercial insurance rejections and submission to EDS as a secondary payer, and lack of final billing guidelines. These issues collectively have the potential of causing financial losses for providers unless they are resolved.

A report will be presented to the Oversight Council at its March meeting that will describe in detail the issues and process over the course of the last fifteen months. It is unclear at this point whether or not a new rate will be established that will be satisfactory to sustain the program.

However, there have been efforts to address provider concerns on an interim basis that keep the program moving forward.

E. The Coordination of Care Subcommittee is responsible for working with DSS, DCF, ValueOptions and the four HUSKY plans to identify and address key issues in assuring coordination of HUSKY members' behavioral health benefits under the Partnership with benefits maintained within the health plans. The issues identified at this time include coordination with the MCOs and primary care providers, pharmacy, and transportation.

Given the importance of the interface between the ASO and the HUSKY plans in terms of access to care, the Oversight Council asked that the Coordination of Care Subcommittee continue to meet. There are yet no quality indicators to track how care is being coordinated, and the goal of the Subcommittee is to develop indicators that then can be monitored for cross-sector coordination. Three major initiatives are underway in each of the primary areas:

- Pharmacy—DSS worked with the Subcommittee to develop a study that would determine if HUSKY members have reasonably prompt access to prescribed medications. The Mercer Consulting group will complete a study this spring regarding timely prescription drug access.
- Transportation—DSS in concert with the ASO and the MCOs and their transportation vendors is conducting a review of access, timeliness, and availability of required non-emergency transportation. Tracking indicators that will allow review of these issues are being developed.
- Primary care and behavioral health—significant initiatives are underway to increase the availability of expert mental health consultation in primary care practices. These include Enhanced Care Clinic requirements that will be implemented over time to develop outreach and consultation to primary care practices; the Child Health and Development Institute's grants for pilot programs to link behavioral health and primary care; and ongoing coordination between VOI and MCOs of children with complex medical conditions.

III. Provider Rate-Setting

The public act (sections 92 and 100) sets forth the criteria and process for DSS and DCF to use in establishing initial reimbursement rates, and making subsequent rate adjustments, under the Partnership. The Act requires the Departments to submit initial rates and changes in methodology they use to establish rates to the Oversight Council for its review. The statute also provides for a process of legislative review if the Council does not accept the Departments' rates or methodology changes.

During the development of the Partnership, the Council reviewed and accepted the methodology for establishing provider-specific rates for intensive levels of care, including inpatient, residential, IICAPS (home-based services), partial hospital and intensive outpatient services. This methodology is based on a weighted average of each provider's HUSKY rates in force on July 1, 2005. Due to the complexity involved in establishing a rate for the formerly grant-funded IICAPS, the Council has asked the

Departments to study the adequacy of the initial rate and return to the Council with data to support the continuation of the rate or adjustment to a new rate. This report is expected in March or April of this year.

The Council also reviewed and approved outpatient rate schedules for clinics and independent practitioners. The Council accepted these rate schedules based on an agreement with the Departments that the Enhanced Care Clinic would be implemented during the first year of the program. The ECC providers have been granted rates for individual outpatient services that are 25% higher than the standard rate schedule, effective October 1, 2006. This enhancement is intended to enable providers to improve access to outpatient and crisis intervention services.

The Council also recognized the need to work with the Departments to create a mechanism for providing future rate adjustments. The Council recommends annual adjustments to provider-specific rates and standard rate schedules at least equal to the average of capitation increases given to the HUSKY plans. For FY 07, the Departments agreed to distribute a combination of across-the-board rate increases as well as increases targeted to specific services, such as Enhanced Care Clinics and IICAPS. Increases were also given to those providers of Extended Day Treatment, Partial Hospital, and Intensive Outpatient Services whose initial rates were significantly below the average for all providers. The total FY 07 increases equaled the $3.67 million associated with the 3.88% rate adjustment that HUSKY plans received for the same period.

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IV. Consumer Issues

Increased consumer access, satisfaction and involvement in the workings of the Oversight Council are among the important goals of the program.

Value Options has conducted a consumer satisfaction survey, the results of which will be presented to the Council soon. The Council also plans to hold its own informational hearing this spring to solicit consumer input, feedback and suggestions regarding the effectiveness of the program.

The Council has also endeavored to increase consumer participation on subcommittees and the Council itself. However, consumer involvement has not improved perhaps because meeting times and locations are inconvenient. The Council will seek funding to provide stipends to assist consumers with such out-of-pocket expenses as travel and childcare.

V. Council Recommendations

The Council, based on its oversight of the CT BHP during the past year, recommends the following actions:

1. Annual provider rate increases that are no less than the average of the annual rate increases granted to participating managed care organizations under the HUSKY program.

2. Change the deadline for the Council to submit its annual report to November 1 (it is now March 1) and the period that the report covers to be the state fiscal year.

3. Provision of stipends for consumer representatives on the Council to enhance consumer involvement in subcommittee and full Council meetings.

4. Funding in the amount of $200,000 for the Council to commission an independent evaluation of the BHP (pursuant to section 95(f) of the original authorizing legislation).

5. Funding to DSS for the purpose of providing technical and administrative support to the Council.

6. Change the deadlines for timely filing of BHP claims to make them the same as the Title XIX fee for service program. (Currently 120 days for BHP and 360 days for Title XIX).

7. Before commencing with any further grant conversions, the Departments should adopt a policy, with Council involvement, to guide the transition of DCF grant-funded services to fee-for-service under the ASO. Such policy should provide for a significant overlap period of grant funding during the transition process.

8. Conduct a review of state statutes and departmental policies to identify opportunities for reducing duplication among existing children's mental health advisory groups.