Connecticut
Medicaid Managed Care Council

Behavioral Health Partnership Oversight Council

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Report of the
Connecticut Behavioral Health Partnership Oversight Council

March 2006

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 **September 2005 through February 2006.** 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 Transition. These subcommittees report back to the Council on activities and recommendations related to the BHP program.

The appointed members of the BHP Oversight Council met for the first time in September 2005 at which time the Council further defined its purpose and oversight areas, based on provisions in 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:

- Waiver authority from the Centers for Medicare & Medicaid (CMS) for the change in the delivery system of behavioral health services, granted December

2005.
• ASO contract provisions including the Quality Subcommittee recommendations for initial performance measures associated with financial rewards/sanctions.
• ASO implementation goals and deliverables, including consumer outreach activities, provider network development, utilization management, and service claim interface with EDS. Additional goals, still under development, include establishing Intensive Care Management criteria and creating a Peer Specialist team that will assist members and families by providing support and advocacy in the community.
• Provider reimbursement rate methodology for all services; DCF conversion for intensive home services from grants to fee-for-service.
• Level of care clinical management guideline recommendations from the Provider Advisory Subcommittee, approved by the full Council, and adopted by the BHP agency clinical Management Committee.
• Development of Enhanced Care Clinic (ECC) criteria and implementation process.
• Transitional issues from HUSKY managed care to the "carve-out" of behavioral health services in the BHP program, including payment of outstanding accounts receivable under the managed care system.

Both the Departments of Social Services and Children & Families and the Administrative organization ValueOptions 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 the plan for monitoring the performance of the Administrative Services Organization (ASO) and the quality of behavioral health services provided to HUSKY and DCF Voluntary Services recipients.

• The subcommittee initially recommended targeted performance measures for the ASO that will be associated with fiscal incentives/sanctions. These were adopted by the BHP.

• The subcommittee also reviewed an initial set of fifty performance indicators developed by the Departments' contractor, Health 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 will identify adult service indicators that will be included in the program's performance“report card”.

• The subcommittee collaborated with the Provider Advisory Subcommittee as the latter subcommittee began consideration of guidelines for Enhanced Care Clinics that will serve children and adults.

• The Subcommittee recommended that the BHP agencies streamline wherever possible data that are now collected separately from providers by each agency. The subcommittee has also worked with the departments and ASO to develop a registration form that will be easy for providers to use while supplying essential client information upon intake. Recently the subcommittee began reviewing the ASO criteria for intensive care management.

B. Transition subcommittee has focused on (1) the communication process about the new delivery system with HUSKY plans, providers, and consumers and (2) HUSKY plans' responsibility for payment of claims as the behavioral health subcontractors exit the system.

The subcommittee provided oversight to ensure the enrollment by DSS of an adequate network of providers to replace four separate HUSKY plan behavioral health networks. It was not possible to measure the extent of disruption to consumers at the point of transition to the BHP. This was due to the difficulty in matching the HUSKY network providers to the new BHP network. Subsequent to the transition on January 1, the subcommittee has reviewed anecdotal reports by the ASO and DSS. While it is certain that a number of consumers have faced the need to find new providers, of note is the relatively small number of inquiries and complaints stemming from the network changeover.

The ASO activities directed toward consumer education about the new BHP program and member resources to connect to behavioral health services during the transition have been reviewed and recommendations to strengthen the process were made. During the first two months of the new program, the ASO external call reports do not give evidence of member difficulty in accessing services. Going forward it is important to gather information from various sources to more fully assess any access problems.

Payment of outstanding claims for services rendered prior to January 1 (the so-called “tail”) remains of significant concern to the subcommittee and the Council. The subcommittee has solicited data from providers and HUSKY plans to allow for an estimation of the extent of the problem. Although it is impossible to know with precision the total receivable amount, provider surveys have indicated the amount is likely to be several million dollars. While the managed care organizations believe a part of the outstanding receivables includes claims under dispute, the Oversight council asked DSS to take the following steps toward resolving the issues:

1) Solicit and analyze a sample of disputed claims from each MCO to determine the reasons why such claims have not been paid;
2) Identify a lead person at each MCO with whom providers can work to resolve disputed claims;
3) Require of each MCO the payment of disputed claims that meet the following criteria:

(a) claim met original timely filing standard;
(b) service received authorization, when such authorization was required;
(c) provider was contracted to provide the service;
(d) provider was supplied proof of meeting the first three criteria, including contemporaneous notations in patient record, copy of claims, etc.

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 worked cooperatively with the Clinical Management Committee, mandated under section 96 of the public act, to develop practice guidelines and utilization management criteria that were ultimately adopted by the full Oversight Council.

• The subcommittee also recommended to the Council adoption of guidelines for Enhanced Care Clinics (ECC). The ECC is a new initiative intended to increase access to outpatient therapy and crisis intervention services on a statewide basis. Enhanced care clinic providers will receive higher reimbursement rates for assuring this increased access. The goal of this initiative is two-fold: (1) to improve the network of community-based services that can help children avoid hospitalizations and (2) to significantly improve the percentage of children who receive outpatient care following hospitalization.

D. DCF Advisory Subcommittee: This group works with DCF to identify and address key issues for consumers and providers in the migration of Department-funded services to ASO management. These issues include defining eligibility for the DCF Voluntary Services programs, assuring a smooth transition to a fee-for-service payment method for currently grant-funded programs, and assuring effective interface and coordination of the ASO with the DCF Managed Service System and Community Collaboratives.

The subcommittee, during early BHP implementation, focused much of its attention on establishing the guidelines and process for the transition to the ASO of intensive home-based services. This effort is important because these services, along with the Enhanced Care Clinic, represent a cornerstone of the new service delivery system. In addition, the conversion of intensive home-based services to a fee-for-service model provides a template for the successful future conversion of other DCF-funded programs. As of the date of this report, the Subcommittee has not made a recommendation to the full Council to review the rate for these services because of concern that the proposed rate is inadequate.

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

The subcommittee reviewed and provided suggestions to a comprehensive work plan designed for DSS and the HUSKY plans to follow in assuring that members receive coordinated care and related services. This subcommittee has concluded its work and has referred issues to the Quality Management & Access Subcommittee. The Chair of the Coordination of Care subcommittee has become a vice-chair of the Quality Subcommittee.

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, 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.

Interim provider specific rates were established once DSS received all the HUSKY managed care organizations behavioral rates that were in effect July 1, 2005. Several providers have appealed their rate determinations. The BHP agencies agreed to review interim rates, as well as the application of level of care guideline, after the first quarter of 2006.

As of the date of this report, the Council has not endorsed a rate for Intensive In-home Child and Adolescent Psychiatric services (IICAPS). Further work is needed to assure that the initial rate is adequate.

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 by May 1, 2006. The ECC providers will receive rates for individual outpatient services that are 25% higher than the standard rate schedule. 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.

IV. Consumer Issues

The Council has worked to assure that consumers experience improved access to services and involvement in decisions about how services are delivered under the Partnership. There are several consumer issues that the various subcommittees and the Council have addressed:

- Ongoing effective outreach to the HUSKY and DCF populations about the BHP program.
- Potential service access impact of the rate conversion from grants to fee-for-service on the non-HUSKY, non-DCF families with children with serious emotional disorders.
- Increase consumer participation in the Council and the subcommittees.

V. Council Recommendations

Recommended Revisions to PA 05-280:

1. Add to the Council, as nonvoting ex-officio members, representatives of the State Comptroller, the State Department of Education, and the Office of Health Care Access, to improve coordination and involvement of all relevant state agencies. Clarify that there is one representative from the Department of Mental Health and Addictive Services, which shall have ex-officio status on the Council, consistent with other State Agencies.

2. Expand the Medicaid Council-appointed membership from 16 to 18 voting members with the addition of two (2) HUSKY A or B program enrollees.

3. Require the Departments to adopt procedures allowing providers to submit grievances on behalf of consumers (the current grievance requirement only covers consumers).

4. Provide for annual review of provider rates to allow for adjustments that equal no less than the average of rate adjustments given to the HUSKY managed care plan.

Recommendations to the Departments of Social Services and Children and Families:

1. Develop an expedited process, through active DSS involvement, for payment by the HUSKY plans of outstanding accounts receivable balances for services rendered prior to the beginning of the BHP.

2. Before commencing with any grant conversions, *a*dopt, with Council involvement, a policy to guide the transition of DCF grant-funded services to fee-for-service under the ASO. Such policy should provide for an overlap of grant funding during the transition process.

3. Provide funding for the Council to commission an independent evaluation of the BHP, pursuant to Section 95 of the Act.

4. Provide funding for stipends for consumer representatives to the Council.

5. Consider rate increases to providers for FY 06 with funds available due to the delayed implementation of the Enhanced Care Clinics.

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

Behavioral Health Partnership Oversight Council Members: 2006
*Updated **1/06***

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