Connecticut
Medicaid Managed Care Council
Behavioral Health Subcommittee
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BEHAVIORAL HEALTH PRIORITY WORK GROUP

MEETING SUMMARY

APRIL 19, 2000

Jeffery Walter reviewed the items before the work group:

- MCO prior authorization process: plan to outline process on a grid for provider information.
- Training forum for providers, MCOs, consumer advocates will be held in the Fall, 2000 with examples of administrative and clinical `best practices'. Tom Lipscomb, Steve Ruth, Sarah Calatayud, Brook Iead, Angie Harmon, Mark Schaefer, Susan Walkama and Pat Mansfield will work on developing the forum content.
- Case management standards MCO grid will be reviewed and updated. Susan Walkama developed an initial grid from information provided by the MCOs.
- Member transportation: 1) anecdotal reports to the CHIL line and providers describe transportation problems for members accessing health services. Sarah Calatayud (CHNCT) reported on the MCO aggregate data for 1999:
- 400,000 member months, 149,000 rides were provided by the MCO.
- 115 transportation complaints (. 08%) were logged with the health plan. The complaints were aggregated by type, with 90-95% involving delayed pick-up/returns or transportation no-shows and 5% related to vehicle type (i. e. vehicle could not accommodate handicapped rider).
- CHNCT identified certain urban areas where there may be only one carrier under contract with CHNCT, in which there were a greater number of complaints.

2) While transportation issues span across health services, the uniqueness of certain BH services, such as the more intensive levels of care provided daily or several times weekly and child escorts for those under a specific age create challenges in meeting transportation needs. Some facilities that provide more intensive BH services provide transportation for their clients, reimbursed through a MCO/provider contractual line item. The work group identified the following steps to quantify and attempt to resolve the issues:

- MCOs will quantify transportation complaints for 1999 (as CHNCT did), identifying geographic/carrier complaint numbers, develop an action plan to address this with their carrier through future contractual performance standards and report this to the Medicaid Council.
- Pat Mansfield (CCPA) will obtain information through Child Guidance and Family Service associations regarding facility-based transportation, escort availability and the perspective on the issues.

The BH Work Group will meet next on Wednesday June 14, 12: 30 PM in LOB RM 2600.

Behavioral Health Subcommittee

MEETING SUMMARY

April 19, 2000

Chair: Eva Bunnell Co-Chair: Jeffery Walter

Department of Social Services Update

James Gaito provided the following information:

- The BH Outcomes Steering group will meet with Alan Kazdin, Ph. D on 4/26/00 as work progresses on the outcomes study. The projected start date is July 1, 2000, with completion in June 2001. There is funding from the HUSKY reallocated quality incentive money for the administrative study costs to be paid to MCOs and providers.
- At the March meeting PRO BH reported that delayed reinsurance payments to the MCOs has resulted in delayed payments to providers. The Department issued $ 5. 7 million to the MCOs to cover payments submitted from 9/1/99 through 2/29/00. Over the past 17 months, from 9/1/98 to present, $ 15,520,366 in reinsurance has been paid to MCOs for inpatient psychiatric days beyond 15 days.
- The Department has issued a letter to the MCOs of Notice of Action (NOA) policy changes as well as emphasizing existing policy on NOA. The policy change instructs MCOs to send a written NOA for partial denials of care (see April 14 Medicaid Council summary for details). The Department and CT Legal Services have been in discussions regarding the lawsuit filed on due process within the Medicaid program.

Department of Children and Families Update

Karen Andersson, Director, Division of Mental Health, Bureau of Health & Education reported that DCF is working with DSS on plans to enhance all CT children's access to behavioral health services through statewide enhancement of the community-based system of care. The scope of the plan is dependent upon the final State budget, legislation and recommendations from the Governor's Blue Ribbon Commission. The Local Systems of Care, regional DCF offices and consumers are engaged in a statewide assessment of existing services, developing an acuity level ratings and identifying gaps in services needed to provide community-based care to children,

especially some of those currently in residential settings. The needs assessment report should be completed in June 2000. Connecticut adaptation of other state models of community-based care in urban and rural areas is being assessed by DCF.

Legislative Behavioral Health Task Force Update

Legislation enacted in 1999 requested DSS, in consultation with the Departments of Children and Families, Mental Health and Addiction Services, Mental Retardation and Education, to conduct a study of behavioral health services available to children in HUSKY, Part A and B. The agencies were asked to submit recommendations to improve access to and the quality of behavioral health services and potential integration of such services across agencies to the General Assembly February 1, 2000. The Child Health & Development Institute of CT was contracted with to assist in the data collection and analysis.

David Parrella, Director, Medical Care Administration, DSS, reported on the findings of the report that was sent to the General Assembly on February 1, 2000. The following the describes the children using BH services and spending distribution by level of care for 4/1/98 through 3/31/99:

Population:

- 184,000 children <19 years of age are enrolled in HUSKY A and B, representing 20% of all children in CT.
- 12% of HUSKY A children used behavioral health services. HUSKY A covers children up to 185% of the federal poverty level (FPL) without an asset limit. A family of four, with income under $ 31,542 is eligible for the full benefit package with no premiums or co-pays. Children of families with income up to 300% FPL (family of 4, $ 51,150) are eligible for HUSKY B, a state employee health coverage package, with income-based premium costs and some co-pays. Children of families >300% FPL can participate in HUSKY B, paying the group premium rate that ranges from $ 138 to $ 202 monthly per child. Children <300%FPL enrolled in HUSKY B are eligible for HUSKY PLUS, which provides state-funded supplemental coverage for special physical and behavioral health needs.
- 5% of the children in HUSKY A were in DCF custody.
- 55% of hospitalized youth in DCF custody remained hospitalized despite readiness for discharge to a less intensive setting.
- There has been a 40% increase in out-of-state placements over the past three years. In December 1999, of 1268 children in DCF custody, 347 were placed outside CT, many of whom are high-risk children that pose a public safety risk, requiring secure placement and treatment programs not available in CT.
- There has been a 34% increase in parole and juvenile justice court ordered DCF placements in the last three years, (432 of 1268 children in 1999).

Expenditures across agencies for children with serious emotional disorders (SED), totaled $ 207 million of public money:

Agency	Expenditure (in millions)	% Of Total Expenditures
DCF	$ 119. 79	58%
DSS (HUSKY A,B, PLUS)	$ 29. 72	14. 4%
SDE	$ 46. 77	22. 6%
DMR	$ 5. 75	2. 4%
DMHAS	$ 4. 6	2. 2%

HUSKY children served, expenditures for behavioral health services by level of treatment:

Level of Treatment	Numbers of Children	Public Investment
Psychiatric Hospital	1,067 (5%)	$ 41. 1M (20%)
Residential Treatment*	3000 (13%)	$ 104. 2M (50%)
Community/home-based Rx	18,216 (82%)	$ 61. 3M (30%)
Total	22,283	$ 207M

**Includes services in residential treatment facilities, other out-of-home DCF and Local Education placements by Agencies, including group homes, therapeutic foster homes and supervised apartments*.

- A reinsurance provision was implemented by DSS in September 1998 to protect HUSKY A children from inappropriate discharges and provide a financial incentive to MCOs to assist in the development of discharge alternatives. The state (DSS) began subsidizing inpatient psychiatric stays beyond 15 days if there was no place to discharge the child. Originally, the reinsurance costs were projected to be $ 3 million/year; over $ 15 million have been paid to MCOs through 2/29/00 (17 months). Providers and MCOs have been paid; however the inpatient beds remain full and there has not been a proliferation of alternative care programs.

The report outlined critical system issues that include fragmentation of funding and programs across state agencies, an inadequately developed community based infrastructure, inadequate family involvement in program planning and maximizing federal reimbursements. The study recommendations included: the development of a blended funding approach to support a comprehensive, integrated community-based system of care through a Memorandum of Understanding (MOU) between DSS and DCF, development of an administrative structure to manage the expanded system of care model that includes an Administrative Services Organization (ASO) that administers the funds and 5-10 Lead Service Agencies (LSA) that contract with providers and provide care coordination, increasing the Medicaid federal match by $ 14 million, which could be used to further enhance the community-based systems of care and study early intervention and prevention programs for children, youth and transitioning youth-to-adult programs.

Legislation is pending (now in the DSS implementer bill to be taken up in the June special session) that would address the phase-in of behavioral health system change. (Money has been allocated in the budget, since the subcommittee meeting, to enhance community based services ($ 3. 5M) and local systems of care ($ 1M)). The legislative BH Task force continues to meet and a follow-up report is due October 1 that outlines the administrative component.

Transitioning Youth Program

Karen Andersson and Dawn Henschel, Family Representative, No. Central Regional MH, presented the transitional youth program design being developed with DCF and DMHAS. Both agencies recognized the need to design a program that met the needs of youth transitioning out of DCF residential programs, as they often did not meet the strict eligibility criteria of DMHAS adult programs. The program will provide specialized transitional services to young adults aging out of DCF as well as those over age 18 years, enrolled in the DCF voluntary program and remain eligible for DCF voluntary services through ongoing school or work training involvement. The program will also assist youth in emergency shelters transition into a safe living environment, as youth now often end up in adult homeless shelters when they age out of DCF shelters. Youth with SED that age out of their parent's commercial health coverage would be eligible only if they were in the DCF voluntary program prior to age 18 years.

The program will start with 30 youths with the hope to expand to 45 in 2001. As the youth age out of HUSKY at age19, they will be eligible for adult Medicaid and SSI. The program will include apartments with staff on site for case management and support services, helping the clients acquire independent living and social skills. Participation in the program is on a voluntary basis with the following eligibility criteria:

- Youth between the ages of 18-21 years with a history of a major mental illness or in the prodromal phase of such an illness.
- Enrolled in school or a work-training program; assessed to being appropriate for this level of care.

Contracts with private not-for-profit providers and a state-operated Local Mental Health Authority will be developed for the program.

Blue Ribbon Commission on Mental Health: Advocacy Consumer Expert Panel: Dr. Wayne Daily, Assistant Director, DMHAS

Governor Rowland created a mental health commission by executive order to study mental illness in children and adults and make recommendations on how the State can improve prevention and treatment. The Commission is focusing on:

- More effective collaborative work among mental, child welfare and criminal justice service systems.
- Maximization of state agency, academic and private community collaboration in the area of mental health.

- Potential applications of new knowledge in the areas of prevention and earlier identification of mental illness.
- Incorporation of treatment approaches at the community level.

Four expert panels were developed: prevention, treatment, service management and consumer advocacy. A series of hearings for public input will be held in the five regions in May. The Commission will submit a report to the Governor by June 30, 2000.

Dr Daily stated that the Surgeon General's mental health Report identified the national scope of mental health incidence in that 1 of 5 Americans experience a mental health disorder. In CT, 5% of adults (135,000) have severe mental health problems with 2. 6% (66,000) coping with severe persistent mental health disorders. Economically disadvantaged individuals with limited education are 2. 5 times as likely to experience mental health disorders as those of higher income and education levels. While the public perception that mental health is not of general concern, the Surgeon General's report has made it an issue for families, communities and employers.

Eva Bunnel thanked the participants for taking time to update the Medicaid Council subcommittee on the various endeavors that are addressing mental health issues in CT. The Governor's Commission is a vehicle that brings together these initiatives involving children, adolescents, the transitioning youth and the adult. Today's presentation is evidence of the State's attempt to find solutions to service fragmentation, in part driven by fragmented funding, the identification of best practices that can be applied in community-based care and the important role of the consumer and family in creating system changes.

The next meeting of the subcommittee is Thursday June 14 at 2 PM in LOB RM 1A. The BH Priority work group will meet June 14 at 12: 30 PM in RM 2600.