Connecticut
Medicaid Managed Care Council
Behavioral Health Subcommittee

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Meeting Summary: June 20, 2002
Chair: Jeffrey Walter Co-Chair: Donna Campbell

CT BH Partnership (BHP) Update

Dr. Mark Schaefer (DSS) and Terry Knowakowski (DMHAS) discussed the BHP progress:

- In spite of budgetary constraints, the BHP planning is moving forward. The Mercer actuarial analysis, to be completed this summer, will provide the basis for the rate structure for the programs. Preliminary signs indicate that no new dollars will be needed; indeed the reform will allow greater access to new federal dollars through the rehab option.
- ACS (formerly Benova) is the single point of entry for all HUSKY members. Information about the BH carve-out will be included on the membership cards. HUSKY band 1 & 2 will require statutory changes.
- Statutory language in the implementer bill is expected to allow DSS to allocate responsibility for clinical management to DCF & DMHAS.
- The Centers for Medicare & Medicaid (CMS) approval is required for:
    - Amendment of the current 1915(b) HUSKY waiver, including changes of the Upper Payment Limit associated with the BH carve-out. The waiver will be presented to the legislative Committees of Cognizance for review prior to submission to CMS.
    - Authorization of the ASO costs and contract provisions.
    - Approval of the State Plan amendment that will include the rehab options.
- The rehab option goal is to move more children & youth into community-based services that currently do not receive federal match funding. Need to distinguish those residential facilities that can claim 100% of 24 hour care (PRTF) to Medicaid versus the PNMI treatment centers. It is necessary to distinguish levels of residential care/therapeutic intensity level. At present, out-of-state residential placements are in PNMI's that cost 30% less than the instate PRTF facilities. There are children currently hospitalized that could go to an appropriate level PRFT. Implementing the rehab option is contingent on the actuarial cost analysis.

Subcommittee participants:

- Strongly expressed the importance of provider input into the carve-out process. Mark Schaefer stated that DSS will be looking to organize provider input into the regulations that will be applied to the carve-out. DMHAS has a provider advisory council and may consider smaller working groups to address the BHP. Providers will be surveyed about the rehab option once the Mercer report has been reviewed. In

addition, Mark Schaefer has met with non-profit provider organizations (i.e. CAN, CCPA) in May, soliciting comments.

(*Addendum: 1)Find the FRI for the BH ASO on the CTBHP web site www.ctbhp.state.ct.us 2) those interested in the DSS Bidders Conference for the BH ASO FRP, Claims vendor will receive meeting date information and the RFP by* ***writing*** *to Kathleen Brennan, Contract Administration, DSS, 25 Sigourney St, Hartford, CT 06106, indicating the Bidders Conference of interest.)*

- The carve-out is complex and the timeframe is tight (July1, 2003) in order to set rates, create claims & eligibility system. Mark Schaefer stated that EDS is working with DSS to develop a work plan.

BH Outcomes Study

The steering committee met to review study operations; Judy Jordan has met with 13 Child Guidance clinics for staff training, provided MCO staff training, is developing a monthly status report of provider participation which allows identification of clinics that have higher rates of usable matched sets, their study process in order to assist those with lower numbers. This report will be circulated to DSS, DCF, Sen. Harp, and agencies. Currently there are now 773 acceptable sets. Ann Bonney has sent a letter to the CEO's of the Child Guidance clinics about the study, 'best practices' & the payment process. Jeffrey Walter stated that identifying a key study person in each agency is most important. The MCO's will have care managers include the study in their reminders to providers.

There have been changes in the Value Options OTR forms that apply to either commercial clients or do not apply unless an OTR is submitted beyond the pass thru 20 sessions. Magellan changes apply to commercial clients only. The intent of the Subcommittee was to assess the OTR's after the study, reach collective consensus on changes in the forms.

MCO Report on Alternative Services Utilization

FirstCHoice/CompCare

Blair MacLachlan, consultant to CompCare, reported on the types of services and member utilization: Total service events were 74,087, with 11,859 total alternative services. Alternative service members totaled 1,242, with group psychotherapy, home nursing & home behaviorist visit and case management services the higher utilized services. The impact of the utilization of these services has resulted in a 51.99% decrease in Reinsurance reimbursement over the past year and a decline in Riverview Hospital admissions (six months with no admissions) and number of children in Riverview decreased from 11 to 4 in February 2002.

Anthem Blue Care/ValueOptions

Lois Berkowitz described alternative service utilization noting increased use of intensive home care and case management services and a reduction in ED days. Home care visits, for both health plans, bridge the transitional period of hospital discharge and outpatient care. (Dr. Berkowitz will provide the subcommittee with a copy of the data presented.)

Health Net/ValueOptions and CHNCT/Magellan will present information in September.

MCO Assessment of Wait Times for Outpatient (OP) Services

Jeffrey Walter had requested the MCO's describe their experience with timeliness of outpatient

services, as 'wait times' for appointments have been described in past meetings as increasing, even for urgent care.

CompCare reported that their members have same day or next day access to all OP services including EDT, PHP, IOP, in home alternative services and case management. Psychiatric appointment wait times may be as long as a week. Blair MacLachlan stated that the health plan began recruiting a large number of private practice providers when treatment wait times increased last summer when the student interns left their placements. Additionally, the plan uses 'One Time Agreements" with non-participating providers who call for authorization after seeing the member for the first two free visits, allowing members in rural areas to continue with chosen providers.

Anthem BCFP

Lois Berkowitz reported that the plan has used more out-of-network providers in this past year than over the last 10 years. The plan is engaged in a large project to recruit providers, assess who is taking Medicaid clients. There is a long wait list for emergent, urgent and routine care; more children are sitting in hospitals that require child psychiatric services.

The other health plans will provide this information and findings from their internal 'mystery shopper' calls at the September meeting. Dr. Schaefer (DSS) stated that the MCO contract requires adequate access to services for emergent, urgent and routine care and follow up post-hospitalization appointments.

Other sources of information would be DCF data from clinic reports. Staff was requested to obtain information from DCF regarding wait lists, & acuity level, psychiatric evaluation wait time.

HUSKY BH Utilization Data

The group agreed to look at data already reported to DSS by the BH subcontractors, as data other than 'penetration rates' is available to assess the status of BH care in the HUSKY program. Staff will request the list of MCO-reported BH data indicators from DSS for discussion at the September meeting.

The Behavioral Health Subcommittee will meet Thursday September 5 at 10 AM in LOB RM 2A.