Connecticut
Medicaid Managed Care Council
Behavioral Health Subcommittee

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Meeting Summary: September 5, 2002
Chair: Jeffrey Walter

Behavioral Health Partnership (BHP)
Mark Schaefer, Ph.D (DSS) reviewed the current status of the BHP and answered questions from the subcommittee participants:

Update

- While the implementing legislation did not include DMHAS as part of the language (original plan stated that DSS may delegate clinical authority to DCF and DMHAS), the BHP will proceed. The Commissioner of DMHAS is reviewing the impact of the legislation.
- BH claims vendor: DSS is preparing a plan for the MIS change process as a function of Health Insurance Portability and Accountability Act (HIPAA) provisions.
- BH regulations: The Department is planning to review all Medicaid BH regulations, propose update & BHP changes with formal input from providers. Goal in the Partnership is to increase Outpatient access without compromising quality and without increasing administrative burden.
- Mercer actuarial report is proceeding, with the 3 agencies fiscal reports for FY04-05 being sent to the Office of Policy & Management. All agency budgets have draft tools for baseline figures, from which trend assumptions can be derived. The preliminary data show that cost neutrality can be achieved through the Partnership.
- Elements considered in the analysis are DCF voluntary services, HUSKY A children and adults, HUSKY B, Medicaid FFS coverage groups and DMHAS General Assistance BH services (GABH). Model will look at rehab services for children and adults to establish revenue projections, determine potential impact of policies on the overall budget.
- DMHAS has surveyed providers on their readiness to do electronic billing. Terry Nowakowski reported there was **100%** provider survey participation; the majority of the respondents are already doing electronic billing.

Subcommittee questions:

- ✓ *What is the impact of the adult Medicaid optional services cuts, which includes psychologist services, on HUSKY members over 21 years?* Mark Schaefer stated that these services are included within the capitation rates; MCOs can choose to pay these services at this time.

- ✓ *Why a BH carve-out?* DSS stated that the administrative burden would be decreased with a single ASO & claims vendor, which would reduce provider accounts receivable/cash flow problems in the current system. There will also be a 10-15% reduction in administrative costs ($40-60 million among the BH subcontractors). The system will improve efficiencies; the State will hold the ASO contract and own their data. As of July 2003 providers will contract with a single entity.
- ✓ *What is the Department's overriding principle as certain methodologies may result in a dramatic loss of capacity, which may destabilize the system?* Mark Schaefer stated that there is no intent to destabilize the system nor have hospitals bear the burden of the change to the carve-out. There are variables in the approach to general hospital rates; if defaulted to the FFS TEFRA rates, there would be consideration of administrative discharge delay days, additional UM payments to the ASO and assessment of the impact on hospitals. If this results in shorter LOS, case rates may be effective. Reinsurance under HUSKY has grown to $30 million, most of which is attributed to Riverview Hospital. Most hospitals can move children to another level of care in 90 days. Only 2% are left in the hospital after 90 days. In Riverview the stays may last 150 days with discharge to residential care. DCF is actively pursuing non-hospital residential group care. Approximately 30% of the Riverview children are DMR clients defaulted to DCF with BH and cognitive problems. DCF is asking for help in designing appropriate management of the care of these children.
- ✓ *Rate changes may harm the Out Patient providers.* The actuarial analysis is taking into account providers that have rates higher than FFS in Managed Care. The Department is considering a two-tier fee schedule, with higher rates for a 'super clinic' that has no wait times, has SBHC access, after hours and weekend clinic hours and wrap around services for more complex adults and children that require higher rates. More will be known in 4-6 weeks as further analysis of the model is done.
- ✓ *Will Child Guidance Clinic grants from DCF continue?* Karen Andersson (DCF) stated that DCF has consistently said there will be no abrupt change in the grants. The DCF will organize a clinic-based work group to develop a process for the gradual move away from grants.
- ✓ Both DSS & DCF has discussed consumer access concerns with Judith Solomon (CHC) and have taken these concerns into consideration.

Jeffrey Walter thanked DSS, DCF and DMHAS for their willingness to continue to discuss issues of concern among the stakeholders. Future discussions need to focus on the integration of BH and physical health components. Mark Schaefer thanked the providers and advocacy communities for taking part in the process by bringing forward their concerns.

Behavioral Health Out comes Study

The BH OC work group will meet within the next 2-3 weeks to determine an expedited approach to completion of the study. The goal of 3000 matched forms will not be reached; there may be 600-700 matched forms for analysis.

(Addendum: BHOC Work group meeting: The Work Group for the Children's BH Outcome Study met 9/26 and developed this timetable for ending the data collection and analysis phase of the study.

- October 18, 2002: All discharge forms should have been sent to the Health Plans by this date.
- October 25, 2002: Health plans should send all forms to Project Coordinator on or before this date.
- November 8, 2002: All matched sets sent to Yale.
- December 6, 2002: All requisitions for checks to participating agencies sent to DSS Accts Payable.
- November 2002-January 2003: Data entry and analysis
- February 28, 2003: Draft report to Outcome Study Work Group
- The final version of the report is expected to be available in March 2003.

Please call Judith Jordan if you have any questions (8600 424-4984)

BH Non-traditional Services Reports Cont'd

CHNCT/Magellan Janet Izzo provided a summary of 8 months of data for BH services HUSKY A non-traditional services # of sessions were reported that included Case Management (21 sessions for 2 patients) & home care (620 sessions). Other services included sessions for urgent OP (64 sessions), IOP (4675), residential (?) 1276, IOP rehab (3175). In HUSKY B, 102 service units of case management for 13 clients were provided.

Anthem BCFP: Lois Berkowitz, Ph.D, presented more data from the earlier subcommittee presentation:

Non-Traditional Services

Type of Service	YTD 2001 (4/1-12/31/01	YTD 2002 (1Q02)
Case Management	95 authorized services/19 visits/ members	66/15
Home care (including intensive)	7614/408	2011/134
Mobile Crisis/Extended Day	7696/229	3455/105

Dr. Berkowitz described the results of the health plan's random calls to outpatient sites throughout the State as part of their assessment of treatment access among their network providers. The number of facilities that could NOT ACCEPT emergent, urgent or routine cases is documented in these columns.

ABCFP Outpatient Treatment Access Study

Month	# calls to facilities	Did Not Return MCO Call	Unable to See Emergent Cases	Unable to See Urgent Cases	Unable to See Routine Cases	Stated Reasons
May 02	15	4*	8/10 facilities	3/10 facilities	3/10 facilities	-Clinician shortage -Long wait list
June 02	14	5**	3/8 facilities	NA	5/8 facilities	-Lack of needed equipment -Clinician Shortage

						-Long wait list -Need to consider crisis situation
August 02	5		3/5	2/5	4/5	-Staff loss/in process of training new staff -Clinician shortage -Staff have full caseloads

*1 facility no answer: total # responding to query was 10 of the 15 facilities called.
** 1 facility refused to answer access questions: total # responding to query was 8 of the 14 called.

The calls were made into the summer months when some facilities lose trainees, adding new ones in July, yet the facilities generally have fewer service requests during the school summer vacation. Anthem BCFP is updating their provider list and members may see an out-of-service provider that they request to see and/or the MCO finds a provider for the member.

Karen Andersson (DCF) stated DCF is working with hospitals to allow the Emergency Mobile Psychiatric Service Team to see patients held in the ED. The Department is gathering data on the services provided by the EMPS Team. Crucial components of the Team system include case management and follow up of each client seen by the Team.

Further discussion about outpatient access is needed, including processes in place or recommendations for processes that alert the HUSKY MCOs to the lack of emergent and urgent visit outpatient access as well as prolonged wait times for routine services.

The Subcommittee will meet on Thursday October 17 at <u>9:30 AM</u> (*Please note earlier meeting time*) in LOB RM 1B.