

Connecticut
Medicaid Managed Care Council
Behavioral Health Subcommittee
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Meeting Summary: February 13, 2003

Chair: Jeffrey Walter Co-Chair: Donna Campbell

(Next meeting: Tuesday March 18, 2-4PM in LOB RM 1A)

Behavioral Health Partnership (BHP) Update: Mark Schaefer, Ph.D (DSS)

Department of Social Services

Mark Schaefer provided an update on three major projects of the BHP:

- Administrative Service Organization (ASO) procurement process continues with the bidder choice decision expected by late March, a signed contract by May 1, 2003 and phase-in of the HUSKY BH carve-out on October 1, 2003.
- The three agencies have worked together to submit budget options for FY04-05. The Governor's budget will be released at the end of February.
- The Mercer actuarial analysis will be completed in a month and will be available for distribution after that time. The analysis provides a financial model for the phase-in of BH reforms; however the analysis time line may be faster than a realistic phase-in. Dr. Schaefer commented that the analysis supports the carve-out cost perspective of budget neutrality, which is based on BH service utilization trending rather than on actual dollars spent in a given time period. The analysis considers alternative care services that would allow patients to live outside institutions. The actuarial study tries to get at answering the question of whether the financial model makes sense when reform goals, alternative services and dollars needed in the FY04-05 budget are considered. While the study is useful in answering this question, the financial analysis provided estimates that were not appropriate for the development of biennial budget.

DMHAS

Terry Nowakowski reported that the Recovery Program is well underway, with input from the DMHAS Advisory Council. The substance abuse program is in development and provider involvement over the next year is crucial to this process.

The discussion following the updates primarily focused on the actuarial model:

- ✓ The DSS stated the October 1, 2003 HUSKY carve-out time line is still realistic, even with the delay of the bidder choice, although it is possible some aspects of the implementation may be delayed.
- ✓ Impact on the provider community (general and special psychiatry hospitals, outpatient services) was discussed:
 - For the analysis, the departments developed a hospital reimbursement model in which general hospital rates would revert to a TEFRA case rate for acute care. Sub acute days beyond 'medical necessity' related to discharge disposition problems would be exempt from the TEFRA case rate. Hospitals would bill for

these days using a sub acute code. No final decision has been made on rate differences between acute/sub acute, as the latitude for this within the budget is unknown at this time. If the sub acute issue can be solved, the TEFRA case rate may be adequate for hospitals. The intent is to hold hospitals harmless for stays beyond the TEFRA days with the sub acute exemption.

- The scenario for outpatient rates may be: 1) set Medicaid FFS rates higher than the current FFS rates for everyone, in which case providers with more diverse populations (child & adult) may be in a good place even though the rates may be less than those negotiated with HUSKY MCOs; 2) set BH reimbursement rates for those <21 years similar to the HUSKY MCO rates. The actuarial analysis modeled the second of these options. Regardless of which financial option is chosen, the Partnership reforms will result in many more dollars being spent for community services.
- ✓ In response to questions about the rehab options in HUSKY, Dr. Schaefer stated that while the actuarial model supports the economic viability of transitioning services from grants to FFS, the analysis' main weakness is the credible predictions about alternative service growth. Estimates of the unmet need and available provider mix are not clear: the rehab option requires a conservative stepwise approach that will allow the State experience from which to predict service growth in the future. Sheila Amdur noted that other states have not found increased demands for adult services for those with serious emotional disorders because provider-rich services were already in place.

Jeff Walter stated that while recent discussions have been about the financial model, the subcommittee and the Council have discussed integration goals and improving access under a system that no longer will have managed care oversight. Once the financing foundation is understood then more focus can be put on the delivery system. Participants identified the need for consumer and provider input through public discussion of the Mercer analysis and final decisions about the financial plan. Mr. Walter thanked Mark Schaefer for his candor in the discussion.

BH Outcome Study

Judy Jordan reported that the OTR/discharge form match resulted in about 900 forms for the research study; provider payments will proceed now that the form matching process is complete. The Yale research team is in the process of hiring another data staff person to replace the staff that left. This will delay the release of the final report into early summer instead of the spring.

Managed Care Updates

Jeff Walter asked MCOs to comment on any updates from an individual plan perspective.

Health Net/ValueOptions: Linda Pierce stated she has visited providers throughout the state to identify and resolve problems. The implementation of intensive home-based services has been difficult from the plan perspective, in that Ms. Pierce did not have a current list of providers trained in this service and credentialed to provide the service, yet was receiving provider prior authorization requests. The DCF has outlined this service criteria; VOI found differences in service provision among providers and was unclear about how to work within these variations.

Both Anthem and Compicare commented on the intensive home-based services:

- Anthem: The MCO is committed to providing these services and has asked providers to track costs and impact of the home-based services, as the MCO cannot determine short-term outcomes or savings. Dr. Berkowitz commented that while the plan is providing this service, it is unclear what the MCO's role is as BH services transition to a carve-out.
- CompCare, the BH subcontractor for Preferred One, stated that it is hard for the subcontractor to identify savings because there is no basis to predict who, of those using home-based services, would use hospital or ED services. There are two populations that use home-based services:
 - Those hospitalized for more than 60 days and come under the State 100% reinsurance payments. The plan's spending is increased when it approves these specialized outpatient services at a point when the plan is not paying for non-medically necessary inpatient care.
 - Non-hospitalized children with serious BH problems for whom home-based services are authorized in an effort to keep the child in the community, diverting hospitalizations or reducing the hospital LOS.

It was noted that these services are not add-on services, rather one of an array of outpatient services that, when used appropriately, should reduce BH costs for the MCO. Past data from MCOs on cohort groups similar to those now using the home based services could provide service utilization patterns that can be compared with that of the current group. At the least, MCOs could identify higher cost service patterns (i.e. hospital or ED) among the current recipients of intensive home-based services; however this would not support any 'savings' absent a comparison group.

The issues around home-based services was discussed at a 1/31 meeting with Sen. Harp, state agencies, providers, including the YCSC responsible for the statewide ICAP program and MCOs. The DSS has convened a meeting **rescheduled for 3/14 at 2 PM** at DSS to address this. Jeff Walter suggested that the subcommittee convene a work group of MCOs, DSS, DCF, YCSC and home-based service providers to develop a standard information matrix for providers after the 2/18 meeting.

CompCare: Blair MacLachlan presented corrected BH utilization numbers for 2002 in which the recalculation of unique members per month showed that the percentage of members using BH services averaged 12.3% 'penetration' rate. Both Anthem & CompCare noted that when all BH services, beyond those items mandated by the DSS quarterly report, are considered the BH 'penetration' rate is much higher than the % reported in the quarterly data (i.e. Anthem reports >5% in the DSS report compared to 13.6% rate in their inclusive internal report).

Jeffrey Walter requested the plans consider reporting the more inclusive penetration rates to the subcommittee in the future. There seemed to be agreement to do this.

CHNCT/Magellan: Janet Izzo had been asked to comment on the public press articles about the Magellan national company's consideration of filing for Chapter 11. Ms. Izzo stated that Magellan, in an effort to reduce the company's overall debt, is considering the Chapter 11 option (no filing has been made to date) as a reasonable approach to strengthening the company's financial status. Magellan still has adequate operating cash flow and if the Chapter 11 option

was taken this would not affect claims payments. (CHNCT has a non-risk based contract with Magellan in the HUSKY A & B program).

- Anthem CHCS: Lois Berkowitz injected a very positive note with the announcement that subsequent to the Anthem PCP/BH integration pilot, Anthem is initiating a program with CCMC starting March 1 that will address child psychiatry access with PCP & psychiatry phone consultation to promote continuity of care within the PCP system. The CT Child Health Development Institute has provided funds for the evaluation of this project.

The subcommittee participants agreed to meet in March after the Governor's biennial budget proposal has been released. **The March meeting is scheduled for Tuesday March 18, 2– 4 PM at the LOB RM 1A.**