Connecticut
Medicaid Managed Care Council
Behavioral Health Subcommittee

Legislative Office Building Room 3000, Hartford CT 06106
(860) 240-0321 Info Line (860) 240-8329 FAX (860) 240-8307
www. cga. state. ct. us/ph/medicaid

Meeting Summary: September 23, 2003

(Next meeting: Nov. 18, 2 PM, LOB RM 1A)

Department of Social Services Update

Dr. Mark Schaefer provided the DSS update:

- ✓ The BH Outcomes Study data is being coded and a final report will be sent to DSS in November 2003.
- ✓ Redesign of the HUSKY programs based on 2003 legislation (PA 03-3) for HUSKY A & B is in the planning stage.
  - The HUSKY A (Medicaid) benefit package would be changed to one similar to the State Employee non-gatekeeper point of enrollment (POE) plan with cost sharing by families at or above the 50%FPL. Under an 1115 waiver authority that requires legislative as well as CMS approval, the federal requirements for EPSDT services would be eliminated and access to BH community-based services would be limited.
  - HUSKY B (SCHIP) program benefit package would be similar to that of the largest commercial CT HMO and would require an amendment to the State SCHIP plan, rather than a waiver. Increased cost sharing will be applied.
- ✓ Pharmacy ($1.50) & medical care ($2.00) co pays, which will include BH services, will be applied to adults in HUSKY A, Medicaid fee-for-service (FFS) and the SAGA (***pharmacy co pays only***) program beginning **November 1, 2003**. *Services cannot be denied for failure to pay co pays.* However, legislation requires DSS to allow pharmacies to deny prescriptions to those with 6-months of unpaid co pays. Initially thought to require waiver authority, DSS preliminary discussions with CMS may allow this under a state plan amendment IF the State can identify categories of recipients that could be held accountable for the co pays.

  See www.ctmedicalprogram.com/bulletin/pb03_89.pdf for provider bulletins.
- ✓ Behavioral Health Partnership status was discussed. Since legislation did NOT allow the BHP funds be placed into special accounts within DSS & DCF, all work on the BHP has stopped, including progress on developing the adult rehab option and the OPM work groups looking at ED holds, inpatient capacity, etc. What this means:
  - Unless the BHP can progress, HUSKY BH services will remain as they are, with financial incentives for institutional care rather than dollars directed toward the development of CBS. The service 'grid-lock' throughout the system will continue.

- The carve out of the HUSKY BH services, which includes an Administrative Service Organization (ASO) that has the potential to reduce current administrative cost, redirect services to CBS, measure the efficacy of the BH services provided and identify service gaps, will be on hold.
- Benefit restructuring of the HUSKY programs will include BH services if HUSKY remains an integrated program; non-institutional services will be more limited in the new benefit package. The DSS will continue to have limited management of BH services, as the main MCOs that contract with DSS have the primary responsibility for their subcontractors. An ASO management system would allow more direct State agency management.

Subcommittee participants requested that conceptual concerns about the failure of the BHP to move forward be communicated in a letter to the Medicaid Council Chair and then to legislative leaders.

Unfortunately family representatives were not able to be present to offer their perspective and concerns: staff will contact FAVOR for family input. The agency representatives commented that families of children are very concerned about the possible loss of the structural reforms and comprehensive system development. The adult response has been minimal, perhaps because they have less engaged in the policy process compared to families.

Department of Children & Families

Dr. Karen Andersson and Ann Adams described the current status of KidCare:

- ✓ KidCare systems of care components will continue: home based intensive services, partially funded by the Community MH strategy Board funds and HUSKY MCOs, care coordination, emergency mobile crisis system (EMPS), two crisis stabilization 8-bed units and expansion of extended day care services. It is uncertain if the therapeutic mentoring program will be implemented in face of the $1M KidCare budget reductions.
- ✓ There are two recent reports on KidCare available:
  - The independent evaluation of Phase One of KidCare, performed by the Child Health & Development Institute of CT and the Human Services Research Institute, can be found at: www.chdi.org.
  - The quarterly KidCare report to the GA for April-June 30, 2003 that describes the FY 03 Kid Care activities can be found at: www.ctbhp.state.ct.us.
    - There were 4500 face-to-face EMPS meetings over the past year, of which 60% were non-DCF children, 30% had private insurance and only 12% of those seen and followed for crisis intervention required hospitalization.
    - 710 families received care coordination on average for 6 months and 77% did not require hospital level care while involved in intensive CBS and care coordination.
    - Intensive home based treatment, which served 380 eligible children with almost 1000 family members participating in treatment, helped avert hospital and residential admissions.

- Two crisis stabilization programs (8 beds each) assist youth in crisis that do not require hospitalization but need comprehensive BH evaluation. Wheeler Clinic with UCONN and the Children's Center in Hamden provide the two programs.

Other

A provider asked if the was a reason for BH service authorizations limited to 9/30. The 3 BH subcontractors present stated they have not applied such restrictions. Providers were reminded to address problems to Rose Ciarcia (DSS) rose.ciarcia@po.state.ct.us.