Connecticut

Medicaid Managed Care Council

Behavioral Health Subcommittee

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Meeting Summary: January 20, 2004

Chair: Jeffrey Walter

Pharmacy Work Group

The Subcommittee Chair, Departments of Social Services and Children & Families, mental health practitioners, representatives from two of the HUSKY plans and their Pharmacy Benefits Manager (PBMs) met with Senator Harp on January 12, 2004. The group identified key pharmacy issues and recommendations that address the problems. The DSS identified several short-term collaborative initiatives that might relieve the administrative burden:

- Create uniform PA forms across MCOs,
- Develop provider "quick-look" reference for each MCOs BH drug on/off the formulary,
- Assess BH drugs that have high override rate to reassess PA process for specific drugs.

According to DSS, the need for pharmacy cost containment will continue, as Medicaid pharmacy costs now exceed hospital costs. The DSS is planning to streamline the pharmacy process in HUSKY either by mandating, through contract, a single formulary based on the Medicaid FFS PDL or through a carve-out of HUSKY pharmacy services into the Medicaid pharmacy process that now includes a preferred drug list (PDL). The DSS will reconvene the next meeting, upon review of MCO PA data.

Department of Social Services Update

Mark Schaefer provided an update on:

- Behavioral Health Partnership (BHP): Legislators, the 3 agency Commissioners and Secretary Ryan, OPM, last met December 2003 to answer legislative questions about the structure and financial model for the proposed BHP. There was agreement for follow-up meetings to look at utilization management and evidenced-based practices, the initial and revised Mercer (State actuary) report and consideration of rate structure options (HUSKY plans and hospital have submitted data that may cross-validate the financial model). Additional clarification will be sent to bidders for the ASO contract. It is unknown at this time what will evolve from these meetings in the 2004 session. It may be that if legislative action is not taken early in the 2004 session, other pressing issues may overshadow the legislative resolution of the BHP.

- BH Service carve-out: At the January Council meeting, the DSS seemed hopeful that the BH carve-out would occur October 1, 2004, along with the dental carve-out. Settling on a date is reportedly important in configuring the proposed MCO capitation rates, effective July 2004, that needs to be included in the 1915(b) waiver extension approval (April 1, 2004) from CMS.

- The BH Outcome Study report of BH outpatient services is completed. The DSS and Jeff Walter will review the draft report; Dr. Kazdin will be invited to discuss the study results in March. There was a discussion of the barriers that contributed to the limited efficacy of this study that was the first outcomes-based assessment in HUSKY.

Department of Children & Families (DCF) Update

Karen Andersson discussed significant DCF changes associated with the agency internal reorganization.

- There will now be 13 local areas, with 13 area directors, 16 MH program directors and area quality supervisors. This change will create a community-based focus for all DCF mandates throughout these areas in the State (see DCF web site below for details).

- Foster care will move from the Bureau of Child Welfare to the Bureau of BH beginning February 2, 2004, with a greater focus on therapeutic foster care.

- The Exit Plan has been approved by the federal judge, the details of which will be posted on the DCF web site – www.state.ct.us/dcf . The Exit Plan includes 22 outcomes, several of which focus on behavioral health and a reduction of 200 children/youth in residential care by 2006.

- Peter Mendelsson, previously with DMHAS, is the Director of the Bureau of BH. Dr. Lou Ando is now the Director of the Bureau of Quality Assurance. Karen Snyder is the COO of DCF.

Dr. Patricia Leebens and Naida Arcenas (DCF) reviewed the DCF Psychotropic Medication Protocol and formulary that will provide guidelines for approval of BH drugs for DCF children and facilities that provide services under DCF (i.e. the guidelines would be applied to all children in Riverview, a DCF hospital and eventually to children in in-state and out-of-state residential facilities). Dr. Leebens stated that DCF staff that has *in loco parentis* responsibilities for DCF children know the family situation, the safety of the drugs in that environment, but may not have the medical expertise to decide approval for pharmacological interventions. The guidelines, in conjunctions with DCF policy, which will dictate when a child welfare staff person must consult with a nurse and/or physician prior to authorizing the use of a specific psychotropic medication with a DCF-committed child, will assist in improved oversight of the use of psychotropic medication with a child committed to DCF and children treated in DCF facilities. The guidelines will also be helpful to staff in shelter or safe home settings that do not have 24-hour medical staff coverage. Children with BH diagnoses often are either under diagnosed and under-medicated or over-medicated, receiving multiple psychotropic medications. An important aspect of the protocols include baseline and follow-up lab studies for psychotropic drugs, which the DCF hopes that the HUSKY MCOs will reimburse.

The DCF Medication list is an evidenced-based formulary for treatment modalities appropriate for children and adolescents, whereas MCO formularies take into account additional issues. The interface of the DCF formulary and the MCO formulary will include consultation for the DCF client. One health plan, CHNCT, stated that while the MCO oversees BH drugs included in the formulary and drug utilization and reviews the formulary through the Pharmacy & Therapeutics Committee, ultimately a single formulary may be helpful.

Intensive Home-Based Services

There are several different evidenced-based models for Intensive Home-based Services (IHBS). Jeffrey Walter requested DCF and providers using the models give the subcommittee an over view of each model through case studies. Reginald Simmons (DCF central office Substance Abuse Division) and

J. Emmanuel Bowier (a MDFT Clinician in Hartford Behavioral Health) presented information on **Multidimensional Family Therapy (MDFT)**. This therapeutic model, developed by the University of Miami, is based on structural Family Therapy:

- Focus on youth with a primary problem of substance abuse or at-risk for substance abuse that may have co-occurring acting out behaviors.

- Treatment, provided by a two-therapist team, occurs in the home 3-5 times/week for approximately 4-6 months. The Therapist Assistant, as case manager, has daily contact with the youth/family, providing the connection to other community-based support services.

- The interventions focus on the youth, the parent/caregiver and their interactions, as well as others in the youth's environment (i.e. extended family, peers) and systems external to the family (i.e. school, juvenile justice).

- MDFT staff receive intensive 6 months training facilitated by experts from the Center for Treatment Research, University of Miami.

- Currently there are 5 providers practicing in the North Central and Southwest Regions, with a caseload of 7 families per Team. Approximately 49 families can be treated at one time, with about 100 families receiving this intervention in a year. Referral sources include DCF, local systems of care, schools, juvenile justice agencies and out patient providers.

- The DCF, in collaboration with the U. of Miami, will continue provider training through June 2004, followed by development of a quality assessment process in the fall.

Mr. Bowier, an MDFT clinician, provided two case studies that described the essence of the model- identifying the underlying issues that contribute to or cause the substance abusing and acting out behaviors (or at risk behaviors); this discovery becomes a focus of the youth & family interventions. For example one youth was grieving the loss of a parent and another young women's early interaction with her mother created the sense of not being cherished or wanted. The intervention process in these cases worked to help the family and youth communicate these issues more clearly rather than remaining focused mainly on the youth's behaviors and discover and/or refocus on the strengths existing within the youth and family. Randomized clinical trials have demonstrated long-term reduction in substance abuse and functional improvement of highly at-risk adolescents from ethnically diverse backgrounds. The studies have shown MDFT to be more effective and cost-efficient than standard out patient and residential substance abuse treatment.

The presentation clearly explained the components of the model, target population and effectiveness of the interventions. Other models (refer to the power point from Mr. Simmons emailed to the SC after the meeting) will be discussed at the March meeting.

The BH subcommittee will meet **Tuesday March 16 at 2 PM in LOB RM 1A**. Agenda items will include an update from the MCOs and provider on IHBS, case study presentations, update on the pharmacy work group and follow-up on decreasing access to MH services in schools (raised at the MMCC meeting).