Connecticut
Medicaid Managed Care Council

Behavioral Health Oversight Committee

Legislative Office Building Room 3000, Hartford CT 06106
(860) 240-0321 Info Line (860) 240-8329 FAX (860) 240-0023
www.cga.ct.gov/ph/medicaid

Meeting Summary: March 9, 2005

(Next Meeting: Tuesday April 12 from 2-4PM in LOB RM 1D)

Present: Jeffrey Walter (co-chair), Rep. Patricia Dillon, Mark Schaefer (DSS), Stacey Gerber (DCF), Pat Rehmer (DMHAS), Dr. Orlosky (Anthem), Lynn Childs representative (CHNCT), Janice Perkins, (Health Net), David Smith (Preferred One), Barbara Sheldon & Beresford Wilson (HUSKY Parent rep.), Morgan Meltz (Child advocate), Sheila Amdur (Adult advocate), Susan Walkama (Adult OP), Anthony DelMastro (Residential care), Paula Armbruster, Rick Calvert (Child Guidance Centers), Susan Walkama (OP adult services), Dr. Paul Dworkin (General hospital), Drs Ramindra Walia & Robert Zavoski (Primary Care), Dr. Davis Gammon (Child, adolescent psychiatry), Connie Catrone (School Based Health Centers), William Gedge.(YNHH)

Also present: Karen Andersson (DCF), Michael Starkowski, David Parrella (DSS), Steven Schramm (Mercer).

BH Service Carve-out Update

DSS has been meeting with ValueOptions and DCF Community Collaboratives regarding the contract. The ASO contract will be finalized after the legislative committees of cognizance review the waiver amendment. The Committees will receive the amendment early in April and have 30 days to respond, which may include a public hearing.

Morgan Meltz is the BH committee representative to DSS/DCF ASO contract development team. Ms. Meltz noted that the discussions have highlighted the potential of the restructured system's improvement in access, accountability and data collection and the strengths VOI brings to the process. The DSS noted that key VOI staff was hired, subject to DSS/DCF approval and DSS will provide the Committee with the list.

BH Committee Work Groups

The Coordination of Care group has met and the QA WG will meet in March as will the Provider Advisory WG. The Committee agreed to a recommendation for an additional work group that looks at DCF implementation role and voluntary services in the BH restructuring.

BH Carve Out Budget and Mercer Analysis: Steve Schramm (Mercer) (*see attachment of handout)*

Key concepts were reviewed:

· Waiver amendment "cost neutrality" is based on assumptions of total expenditures in the HUSKY program. States provide CMS with an aggregate ceiling on expenditures that allow states flexibility in meeting policy goals.

· Within this ceiling dollars can be allocated within the programs. In addition the "carve-out" of the BH services from managed care allows for higher growth trends, less administrative costs. The assumptions and policies about increasing BH access and capacity can be realized within these different financial assumptions.

· Reinsurance: "Stop-loss" state reimbursement to HUSKY MCOs for inpatient psychiatric services provided in either an acute or subacute level of care when the length of stay exceeds 15 days or after the 1st 24 hours for administratively necessary admissions. The actuarial analysis required a separate methodology to ensure claims were not double counted. Reinsurance schedule (sec. 3.18 DSS/MCO contract)

Number of days	**State Share**	**MCO Share**
0-15	0%	100%
16-45	75%	25%
46-60	90%	10%
60 and beyond	100%	0%

· The BH carve-out revised estimates were based on three sources:

o BH encounters

o RFI that included supplemental data request from DSS, estimated BH professional services (submitted by only one of the 4 MCOs), adjusted for reinsurance, blended for MCO credibility.

· The base year was SFY03

· Data summarized and analyzed on PMPM basis

· Estimates trended to the carve-out implementation date.

There was extensive discussion with Mr. Schramm about the BH cost estimates. Highlights of questions/comments:

♉ What were the services and professional type services included in the utilization assumptions? What services are expected to increase within the 7.8% increase of utilization trend? Mercer will provider the Co-Chairs with more detail on those services that contribute to the increases in utilization trends.

♉ The utilization trends are not based on the developing level of care guidelines.

♉ There was no mention of new KidCare services in the base year. Mercer stated these would be factored in; they are not in the base year.

♉ The DSS expects to negotiate BH PMPM reductions with each individual MCO. This will be based on the current DSS/Mercer review of each MCO's operations (including BH) related to administration, finance, claims and systems and the MCOs reported experiences. Mr. Starkowski stated that the estimated $79.6M would be from the current MCO BH dollars that will be "carved out" of the MCO PMPM capitation payments. If there are financial gaps, either because all the estimated carve-out dollars are not realized from the MCOs or there is increased service utilization beyond the projected trends, these would become part of the DSS budget deficiencies. DSS stated there is no intention to short-fund the program.

♉ The MCOs will retain program and financial responsibility for HUSKY A transportation, pharmacy and medical service costs.

♉ The legislative committees of cognizance will review the Waiver amendment in the spring, the MCO/ DSS negotiations will occur in the summer 2005 and the BH restructured program would begin November 2005. There was concern expressed that the legislature would be asked to approve the budget and the waiver amendment without knowing the final MCO dollar carve-out.

♉ Riverview costs have historically been `off budget" because of the budget cap. These dollars do receive the 50% federal match.

Provider Rate Methodology

Mercer and DSS reviewed the methodology developed for setting rates and fees (*see attached handout*).

♉ Current HUSKY program provider fees are either subject to uniform fee schedules that vary across the four MCOs or negotiated rates for given services by some providers. The latter varies across MCOs and across providers.

♉ The departments will establish provider specific rates for intensive services and uniform fees for outpatient services, which will be in a range of 50-55% of the Medicare rates.

♉ The departments propose to adjust BH provider rates under the waiver when rate adjustments are appropriated to the MCOs. The Governor's budget provides for 2% rate increase in SFY06 and 0% in SFY07.

♉ The method creates a cost neutral rate for Outpatient services. Intensive BH services will remain in DCF who will set these rates.

♉ Primary care services that apply to BH are under the MCOs. The DSS will check on the reimbursement for PCP that admit patients for psychiatric services and seek a psych consultation.

Detail on the rates and fees by Level of care (provider type and service) will be presented at the next BH Oversight Committee meeting, **scheduled for Tuesday April 12, 2-4PM in LOB RM 1D.**