# Connecticut
# Medicaid Managed Care Council

## *Behavioral Health Oversight Committee*

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**Meeting Summary: April 12, 2005**

**Co-Chairs: Sen. Chris Murphy & Jeffrey Walter**

(Next meeting Tuesday May 10th @ @PM in LOB RM 1D)

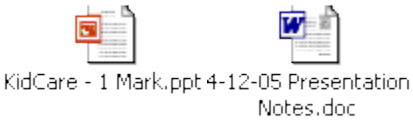
**Present:** Sen. Chris Murphy, Jeffrey Walter (co-chairs), Rep. Patricia Dillon, Mark Schaefer (DSS), Stacey Gerber (DCF), Lauren Siembab (DMHAS), Paul Potamianos (OPM), Dr. Orlosky (Anthem), Janice Perkins, (Health Net), David Smith (Preferred One), Beresford Wilson (HUSKY Parent rep.), Morgan Meltz (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), 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 Snyder, Karen Andersson (DCF), Michael Starkowski, David Parrella (DSS), Steven Schramm (Mercer).

# Waiver Financials

Prior to the presentation by Steve Schramm (Mercer), the Department of Social Services (DSS) reviewed the rationale for the carve-out of Behavioral Health services in HUSKY that includes less fragmentation of BH services within the system, improved data collection and analysis, direct State agency oversight over the Administrative Service Organization (ASO), increase access to community services and over time, less reliance on institutional care.

Mr. Schramm (Mercer) provided more information on the three questions from the March meeting, the BH carve-out estimates and provider rate/fees proposed methodology (*the meeting handouts were email on 4/13, added here for reference to Committee questions. The word doc. is added if the power point doc cannot be accessed).*




Discussion of follow up questions:

1) Rate setting allocation is grouped into three categories (pg 2-3 in above doc.):

- Inpatient BH, which is identified by revenue code.
- Outpatient/Professional, which is traditional non-inpatient BH codes, providers & settings with BH diagnoses.
- Other professional/other includes non-inpatient non-BH specific codes, providers and settings with BH diagnoses.

Mr. Schramm noted that the allocation process is not precise and is quite complex. It is not just the setting (i.e. clinic), but also a combination of the setting, diagnosis, service and code that defines the allocation. (T*here were 2 other handouts with more detail on major categories, encounter submission guide. The hard copies can be obtained in LOB RM 3000 or through mark.schaefer@po.state.ct.us).*

2) Review of allocation of the estimated 7.76% increase in service categories (pg. 4): Mr. Schramm reiterated that the assumed 7.76% service increase represents the upper boundary of the total dollar risk of the program submitted in the waiver amendment, not the actual service utilization changes. The assumption that 80% of the increase is related to inpatient services is a reflection of the weighting associated with inpatient that has a disproportionately large effect on the percentage distribution. The State goal to gradually move an increasing proportion of services toward non-institutional care remains; the 80% is not projected actual service changes in FY06.

3) The programmatic changes between the base year (FY03) and contract year (FY06) did not appear to be reflected in the budget assumptions (pg. 4). Mr. Schramm and DSS stated that three key services were identified within the 3 data sources that were used to develop the adjustments from base year to contract year: home-based services (HBS), Mobile crisis (EMPS) and case management (CM). It was noted that EMPS & HBS had grown considerably within these time frames and yet there was no adjustment for these services. Agency responses included the following points:

- Overall the percentage of dollars identified with these services total 1% of BH total dollars; therefore Mercer did not believe there should be an adjustment of the "bucketing" of these 'in lieu' services. Mr. Shramm stated he would review this.

- The waiver includes conversion of any of these services from grant DCF dollars to Medicaid fee-for-service dollars that can be claimed under Medicaid EPSDT and are included in the waiver 7.76% upper boundary. Those services that remain in the DCF grant are not part of the waiver 7.76%. Going forward HBS may remain under EPSDT or under TANF.

- The expectations that EMPS is 'in lieu' of other services; however the service may actually result in identifying more members that require services. EMPS may connect members to less costly services and ultimately reduce BH costs if one assumes the service provides an earlier intervention for children with the identified problems.

- The State plans to enhance clinic funding, resulting in a growth of Community-based services (CBS) over time. DSS proposes that the 2% MCO per member per month rate (PMPM) increase would be reflected in the BH carve-out rate increase (about $1.6M), for enhanced clinics (see pg 13).

# BH Carve-out Estimates

The agencies were asked to clarify the budget information presented at the March Committee meeting (pgs. 5-7) including the financials for the ASO:

✓ The $19.76 HUSKY MCO BH PMPM represents a $15-22 PMPM range. It does not include the estimated HUSKY MCO BH administrative amount of $1.48 PMPM.

✓ The PMPM administration amount represents a cross over from MCO to ASO; however this, like the PMPM BH final amount, <u>is subject to individual MCO negotiation with DSS</u>.

- ✓ Mr. Starkowski stated that while the ideal scenario would include the above exact dollar amounts subtracted from the MCO PMPM rate, the reality will be reflected in the final negotiation with the MCOs. However the finalized negotiated amount does not impact the projected budget for the BH program, which begins October 1, 2005.

- ✓ The ASO administrative estimates are higher than the current administration costs in the four MCOs. Sen. Murphy requested an explanation of this and the percentage of ASO dollars at risk.

- The ASO administrative costs are estimated at $8.5M, which is 4.25% of the $200M+ BH budget for HUSKY A, B & DCF voluntary services. This is the starting point amount for the DSS/DCF ASO contract negotiations. It represents the upper boundary in the waiver amendment.

- The agencies will withhold 7.5% from the monthly ASO payments, paying the ASO for successfully achieving the contract performance measures at the end of the year. The total amount that the ASO is at risk for in performance goals is about $600,000.

- Dr. Schaefer (DSS) outlined the benefits of a single ASO:

  - The DSS & Department of Children & Families (DCF) will be negotiating a contract with the ASO that has a broader scope of responsibilities and activities than had been negotiated in the HUSKY managed care contracts.

  - More in depth comprehensive quality reports and analysis than is in the current MC system,

  - More comprehensive case management system under the ASO:

    - ASO intensive care management (14 managers) will be provided by clinicians with 5 years clinical experience for strategic, short- term assistance to members in navigating the BH system. This would include post-institutional connections to appropriate levels of ambulatory BH services, identification of members with high service utilization (i.e. repeat Emergency Department (ED) visits, repeat hospitalizations, etc) and work with the family/adult to optimize their treatment options.

    - ASO trained family and adult peer specialists will work with the intensive care manages in family/adult education and outreach to engage the member in treatment, navigate the BH service system and connect to community supports.

- ASO unit system mangers will work with the KidCare collabortives, the DCF Managed Service System (MSS), to develop local area plans, identify service gaps, recruit community-based services and provide technical assistance to local entities to promote their participation in the service network. The system mangagers will allow DCF to determine their client's discharge care connection, arrange for pre-discharge appoints in outpatient service prior to discharge and follow up on client's connection to care.

There was extensive discussion about the various care coordination systems within the program. The Committee Co-Chairs key comments/requests:

✓ Sen. Murphy expressed concern that a 2-tiered care coordination system may be confusing to members and that financial support and reliance on ASO care management may deter dollars needed to build the DCF levels of care coordination. DCF stated that the ASO **intensive care management** helps members understand the BH system and connect to appropriate levels of care in a timely manner while the **local care coordinators** work with the individual family/member over a longer time period. The Department of Mental Health and Addiction Services (DMHAS) has used intensive care management in their ASO for the State Administered General Assistance (SAGA) BH program. The ASO identifies 'outliers' with no consistent BH service use or repeat inpatient admissions. Over the past 5 years DMHAS has seen positive results in the reduction of 'outliers' and plans to reduce the number of ASO intensive case managers.

✓ Mr. Walter requested a Committee work group(s) review the coordination of the MCO/ASO case management CM) as well as the coordination of the various levels of CM within the DCF system with the ASO intensive CM and the MCO CM. (*Both the Coordination of Care and DCF work groups addressed this at subsequent meetings).* The DCF will provide a flowchart on this as well (*reviewed at both work group meetings* -

*See the flowchart discussed in the two work groups:* )


ICM workflows-4.xls

# Provider Rates

The Agencies reviewed the rate methodology proposals for provider specific rates for inpatient, PHP, IOP & EDT. (P*lease see pgs 9-13 of above document & this attachment for the information presented)*

IP, GH-PH OP, & ECC
OP Fee Schedules 04

Dr. Schaefer noted in the discussion that:

- ✓ The rate calculations are based on provider specific MCO rates as of March 1, 2004. Some of these rates have increased since that time. DSS could recalculate the proposed rates at the request of the Committee; however this would require new information from the MCOs on member months and utilization.

- ✓ There are two options for creating the freestanding MH clinic rates:

    - Option A includes using the uniform Medicare methodology; as Medicare includes a greater breathe of codes (exempting medical management, testing and group therapy as the Medicare method under funds these service codes).

    - Option B would use a simple weighted average based on SFY03 utilization (could be updated).

- ✓ General & psychiatric hospital OP proposal blends rates across MCOs across provider type, and weighted average calculated across MCOs. The Committee may have concerns about blending the rates across provider levels, rather may prefer separating out rates by provider level.

Agency BH Accountability *(see pages 13-14 in the first KidCare doc)* was briefly reviewed: Mr. Walter requested further discussion at the May meeting. The work groups provided brief updates. There will be more discussion on this at the May 10th meeting, at 2 PM in LOB RM 1D.