Connecticut Medicaid Managed Care Council

**Meeting Summary: December 14, 2005**

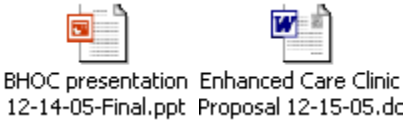
*Co-Chairs: Sen. Chris Murphy & Jeffrey Walter*

*(Next meeting: **January 18, 2006** @ 2 PM in LOB RM 1D)*

Attendance: Sen. Chris Murphy & Jeffrey Walter (Co-Chairs), Rep. Patricia Dillon, Dep. Comm.Stacey Gerber, Karen Andersson (DCF), Dr. Mark Schaefer (DSS), Thomas Deasy (Comptroller's Office), Barbara Parks Wolf (OPM), Sheila Amdur, Ellen Andrews, Paula Armbruster, Connie Catrone, Anthony DelMastro, Heather Gates, Dr. Davis Gammon, E. Collins for William Gedge, Sharon Langer, Stephen Larcen, Judith Meyers, Patrick Monahan, Sherry Perlstein, Janice Perkins (Health Net), Marilyn Ricci, Dana Marie Salvatore, Vicki Veltri, Dr. Ramindra Walia, Susan Walkama, Beresford Wilson, Lori Szczygiel & Lisa Carrico (BHP ASO VOI), M. McCourt (Council staff).

November meeting summary was accepted without revisions.

**Behavioral Health Partnership Update** *(click on two icons below to view the BHP meeting handouts)*




Dr. Mark Schaefer (DSS) and Dr. Karen Andersson (DCF) provided the report. The key Council discussion points were:

• The Administrative Service Organization (ASO) contract execution was completed in November; the Attorney General's office, the BHP agencies and ValueOptions (VOI) have signed off on the contract.

• CMS approval for 1915(b) waiver amendment to "carve-out" behavioral services in HUSKY A is pending. (*Addendum: DSS announced at the Medicaid Council meeting 12/16/05 that CMS notified the department of the waiver amendment approval that morning).*

• BHP providers must be enrolled in Medicaid (CMAP) in order to receive payment for HUSKY A & B BH services after January 1, 2006. EDS has mailed over 800 applications for the CT Medical Assistance Program (CMAP) and 122 have been approved or in process. Many applications were returned to providers for additional information and EDS will follow up on these. EDS has advised providers that enrollment in the BHP will be retroactive to 1/1/06 if their application is approved. (Further discussion on provider recruitment in the VOI report below). In response to questions raised at the Transition Subcommittee, EDS's staff is working overtime to reduce the application processing time to enroll BH providers in CMAP.

• Fee Schedules discussion issues:

- ***School-based Health Centers (SBHC***) proposed rate methodology change from a uniform weighted average to uniform weighted averaged adjusted to pay as fixed percentage of MH clinics (90%) was made for administrative efficiency. The change results in no overall fee reductions, rather an increase for some services. Case management services would be reduced by about a dollar/service. Clarification was provided:

    - SBHC licensed under DPH as a medical clinic will have the adjusted rate.
    - For those SBHC under a child guidance clinic or hospital outpatient license, the fee schedule for BH services within those entities would apply to SBHC.
    - SBHC services that are under a Federally Qualified Health Clinic (FQHC) or as a satellite center will receive the full FQHC rate (includes the wrap dollars).

The rationale for the methodology change was administrative efficiency (not doing individual codes) with no anticipated adverse financial impact on the SBHC. Rep. Dillon requested the BHP provide her office with the justification for the decision for the 90% MH clinic rate adjustment, addressing how this would impact each SBHC, especially those that are not FQHC satellites.

- ***Hospital rate*** letters were sent to the CT Hospital Association (CHA) December 5th and the BHP met with the hospitals to review the rates. The CHA Council representative stated that the rate methodology has no provision for future hospital rate adjustments, although there is the provision for enhanced care clinic rate adjustments. Under the HUSKY managed care program, some hospitals negotiated annual rate adjustments. Dr. Schaefer stated that at the May 2005 BH Committee (the precursor to the statutory BHP Oversight Council) the BHP proposed applying the statutory budget increase to the MCOs (2%) to the BH portion of the program and target these dollars in the care system to improve access to and quality of outpatient services through the enhanced care clinic proposal. CHA stated that the BHP Oversight Council should address rate adjustments going forward after the initial implementation of the BHP program. Mr. Walter stated that rate setting is part of the statutory oversight of this Council (PA05-280) and will be addressed in the Council. By January 2006 all providers will know their rates, and the Council will evaluate the rates and impact on services and make recommendations in the report

required in statute to CT General Assembly (CGA) in March 2006. DCF will also report to the CGA on program costs. Annual rate adjustments may need to be taken up in the 2006 legislative session budget adjustments.

- The non- provider-specific fee schedules are posted at www.CTBHP.com.

- Dr. Schaefer stated that the ***provider specific rates*** for higher levels of BH ambulatory care such as partial hospital (PHP), intensive outpatient (IOP) and extended day treatment (EDT) are still being calculated, but expect these rates will be available by the end of the week of 12/19. The BHP recognizes the short time period left for providers to load the rates in their system; however the rate calculations have been complex. DSS has sent a letter to BH providers notifying them that they must contact DSS/DCF within 30 days of receipt of this letter to identify rate setting errors for their practice. BHP expects many rate questions will arise that may take BHP months to evaluate. If resolution of a provider-specific rate issue results in higher rates, the provider will receive retroactive reimbursement. The intensive home-based IICAPS rates are currently under review at the request of providers.

- ***Enhanced Care Clinics*** **(ECC)** proposal was discussed (*see page two of the 1st handout and 2nd handout above on page 1 of the summary).* The BHP proposal is to establish a subclass of clinics that meet special requirements and are then reimbursed about 25% higher than the standard CT BHP clinic. Higher fees do not apply to hospital outpatient services, PHP, IOP, EDT, emergency psychiatric services (EMPS) or intensive home services (HBS). The general outpatient clinic requirements include:

    - Improve access through emergency assessments for clients in the clinic setting, extension of operation hours, and scheduling follow-up visits within 10 calendar days of referral, with the goal of reducing emergency room BH evaluations/stays and providing timely access to services.
    - Develop coordination of care agreements with primary care practices and have agreements for the medical provider to provide, when appropriate, transitional medication management and clinic consultation for PCPs, thus freeing up limited psychiatric resources within the system.
    - Facilitate clinic-based peer support groups, led by parents/consumers that link families/patients to the

community.
- Adopt one evidence-based practice initiative by 10/07.
- Demonstrate the capacity to identify and manage co-occurring diagnoses, with MH clinics linking clients to a SA clinic as appropriate, or the SA clinic linking clients to MH clinic.
- Create clinic specialty care by 10/07 in at least two areas (i.e. trauma, OCD, eating disorders).

Discussion/questions that were raised included:

✓ Are ECC dedicated to children's services? Dr. Schaefer stated the intent is to identify and fund any of the 130 clinics that qualify, taking into consideration start up costs. There are 26 child guidance clinics, 40 licensed psychiatric clinics that serve child/adult and other clinics that may apply for ECC status.

✓ How would clinics with intensive services such as EDT or EMPS interface these services with routine ECC services? Dr. Schaefer that the intent of ECC is not to have interested clinics use their "special services for targeted populations" in the clinic's ECC proposal, rather identify how the clinic staff would implement the ECC criteria to most of their population. The ECC proposal is evolving and the two Council subcommittees will address the specifics of the ECC's criteria, fair implementation process and of identification of process and outcomes measures.

✓ Measurement of ECC's performance threshold for timely follow up visits, given the current attrition rates is complicated and may unfairly reflect negatively on the ECC efforts. One clinic noted that they have reduced their "no-show" rate by meeting clients where they are (i.e. in the home, at school, in the community). To do this, it is imperative to resolve the federal Medicaid coverage issues. For children, why wouldn't services off-site be a covered Medicaid service under EPSDT?

✓ The audit process will identify problems clinics may experience in meeting the standard criteria. What would be the consequences of not meeting the audit specifications? Dr. Schaefer stated that the VOI registration data and "mystery shopper" process will contribute to the validation of an ECC's performance. The intent is not to reduce ECC clinic rates and access, rather provide clinics with a 4-month probationary period, which allows the ECC to develop and implement a corrective action plan to meet the ECC standards (*similar to the DSS quality audit process of the MCOs).*

✓ Family/community perspective, it is important to:

- Develop achievable provider performance measures that do not have a negative impact on member access,
- Identify successful strategies to reach to clients that 'drop-out' of treatment.
- Involve community groups in determining how data collection will be used.

Mr. Walter, Dr. Larcen and other Council members noted that the BHP Council has consistently and strongly recommended the BHP move the ECC process forward early in 2006 and commended the BHP for doing just that. The details in implementing the ECC proposal require further consideration. Mr. Walter requested the two Council subcommittees, Provider Advisory and Quality Management & Access, meet before the next BHP Council meeting on January 18, 2006, to review and make recommendations for the ECC standards and compliance measurements to the Council in January.

**ASO VOI Implementation Progress Report** *(click on the icon to view the materials presented).*


Lori Szczygiel, CEO, CT BHP VOI, and Lisa Carrico, presented the status of CT VOI staff hiring, provider enrollment and continuity of care service authorizations interface with HUSKY BH subcontractors for January 1, 2006. Key issues discussed were:

- ✓ Staff training has focused on critical issues that need to be ready January 1, 2006. Call center staff will be supported by the NY VOI staff as needed. Staff clinicians are being cross trained on Intensive Case Management (ICM) however implementation will probably be February 1st .
- ✓ Residential and Group home authorization will be implemented Feb. 1, 2006. Currently DCF is meeting twice weekly on this and residential provider meetings have been scheduled January 18 & 19, 2006.
- ✓ MIS set-up is moving forward, with two test cycles for Outpatient and inpatient service authorization, claims submission and payment, as recommended by the Council and Transition Subcommittee.
- ✓ Provider file information is crucial to facilitate response to claims payments January 1, 2006. Provider response has been slow and the BHP will enlist the help of CHA and CCPA to encourage BH providers to submit information about their practice sites, available services, etc.
- ✓ Peer specialist hiring is moving forward, however VOI is now concentrating on training clinical staff that do the prior authorizations (PA) and concurrent review.
- ✓ Continuity of care issues (PA) between the MCO BH vendors and the ASO VOI were raised. There seem to be a difference in provider experience, in that

PA are only to 12/31, while VOI stated that they are compiling reports from the BH vendor VOI and CompCare to put the PA into the ASO system for 1/1/06.

- Outpatient PA would be made only to 12/31 because as of 1/1/06 no authorization or registration will be required for outpatient services until May 2006 for these services.
- All MCOs/BH subcontractor authorizations for EDT, IOP, PHP and IP should extend beyond 1/1/06 when appropriate. CompCare is terminating all authorizations effective 12/31/05; providers would have to call for continued authorizations from CT BHP on or after 1/1/06 for the above higher level services (not outpatient). Ms. Carrico (ASO VOI) stated VOI expects to receive the CompCare authorization report today (12/14/05) in order to assess the volume of PA for higher service levels. ASO VOI does not expect a high volume of continued authorizations on Jan. 1, 2006 from CompCare. (*Addendum: BHP was asked to address this confusing process with a clarification notice on the web site).* A web-based PA inquiry is being prepared for 1/1/06 so that provider can check service authorizations for 1/1/06 and beyond.

✓ CTBHP VOI will contact Mobile Crisis Teams for their provider referral lists, as suggested by Dr. Larcen and the Transition SC. While VOI has aggressively outreached to providers to enroll in the EDS system and BHP program, there has been limited response from psychiatrists. Dr. Larcen had noted that it is crucial to engage MD/APRNs in the program for medication evaluation and management in outpatient after care. Dr. Larcen, at the Transition Subcommittee meeting and at this Council meeting, suggested hospitals could assist in physician outreach. The list of 140 psychiatrists could be sent to the appropriate area hospitals and the hospital could contact them directly. The BHP will consider this. When the provider file information is complete (see above) VOI will then analyze provider-type gaps by geographic unit, which would provide VOI with more focused recruitment.

**CCPA Provider Survey** *(see attached survey document)*


Terry Edelstein, Executive Director of CT Community Providers Association (CCPA) requested providers complete a survey on HUSKY BH receivables to identify the scope of net receivables as of October 31, 2005 and at 30,60,90, 120 days and >120 days:

- Total outstanding accounts receivables (A/Rs) totaled over $4 million, 40.18% ($1.6 M) of which were past 90 days.

- 29.4% A/Rs were over 120 days old
- Most frequent reasons for delayed payments: “claims lost”, “not a clean claim” and “claims not payable under contract”.
- Providers have used multiple strategies for claims recovery including contracting with private consultants to recoup payments.

CCPA will provide more detail to the Transition SC on January 3, 2006 and update the survey as of 12/31/05 for the January BHP Oversight Council meeting.

Subcommittee Reports

*DCF Interface Subcommittee: Chair Heather Gates*


Minutes 11.30 meeting.doc


Minutes 12.14 meeting.doc

Heather Gates stated the SC has been focused on the rate methodology for the IICAP grant to fee-for-service conversion, identification of billable services, client eligibility. The SC will use the IICAPs process as a template for upcoming discussions of other intensive home-based service and also review the residential prior authorization processes.

*Provider Advisory Subcommittee: Chair Susan Walkama*


Child Group Home Level 1 LOC 120805.doc


Recommendations fGroup Home Level 11

Susan Walkama reported on the Subcommittee December meeting. The subcommittee asked DCF questions about the level 1 Group Homes and the discussion led to the above recommendations. Discussion:

- ✓ The intent of recommending global assessments within 60 days was not to delay the assessment but rather specify that the assessment be done no later than 60 days of admission to a Level 1 Group home, as the admission is not predicated on the global assessment.
- ✓ Dr. Karen Andersson (DCF) described the issues in Level 1 group home. The Agency is working on transition plans, to have appropriate clients in this level home (those without significant behavioral problems) in order to provide timely transition of these clients to other appropriate levels of services. Youth in the independent living program that are not succeeding in this placement could then be moved to a Level 1 Group home. Expand Level II to include wrap around services.
- ✓ DCF will meet with providers of Level I group homes to clarify the issues on 12/15/05.
- ✓ It is difficult to transition youth with developmental disorders to the adult system. DCF is working closely with DMHAS to support transition plans, as well as DMR. DCF is looking for family feedback as to what service young adults with developmental disorders need in long term group homes.

Dr. Gammon offered a motion to accept the Provider Advisory Subcommittee Level I Group Home level of care guidelines and the two subcommittee recommendations (*see icon 2 above),* the motion was seconded by Stephen Larcen and approved without changes by Council voice vote with two abstentions.

*<u>Transition Subcommittee:</u> Co-chairs: Dr. Stephen Larcen & Susan Zimmerman*

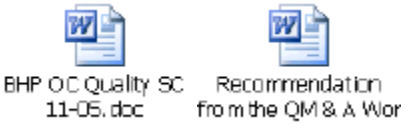

The Co-Chairs reviewed key issues and recommendations to the BHP from the Nov. 29, 2005 meeting (*please see above meeting summary for details):*

- Consumer related topics included:
  - Recommendation that CT BHP VOI repeat the public meetings in January-February; additional consumer forums will be scheduled as requested.
  - CT BHP was requested to develop a one-page flyer about the BHP program that can be sent to providers, family advocates and community programs. This is being done.
  - DCF voluntary services are not formally in the initial BHP program; however DCF has provided training to the consumer call center staff and clinicians about DCF voluntary services and how to connect families to these services.
  - A member FAQ fact sheet is being developed by VOI; the provider FAQ document is completed.
- BH provider issues included:
  - The VOI ASO outreach to providers has been aggressive and has resulted in more than 50% of the 1500 providers are enrolled or in process wit CMAP. The major area of concern is MD group – only 8/145 psychiatrists are in the CMAP process. Dr. Larcen had suggested asking hospitals to outreach to MDs and VOI ASO is following up on EMPS referral providers.
  - Assessing the scope of outstanding receivable is a major issue, the results of which will benefit both the agencies and MCOs in working toward resolving these A/Rs. The CCPA survey (see above) and hospital information will be discussed at the January 3rd Transition Subcommittee meeting.
  - The HUSKY VOI BH subcontractor acknowledged payment delays August – November and will be paying interest on these. David Glazer (VOI) assured the Subcommittee that there will be adequate CT VOI staff to address claims issues.
  - Dr. Larcen recommended and the BHP agreed to beta-test the

system for service authorization, claims processing and payments prior to January 1, 2006. It was also recommended that BHP consider paying all claims for intermediated levels of care during the first 60-days of the transition period, to offset any system payment glitches. Providers would still be expected to obtain service authorizations, but claims processing would not reject claims for absence of the authorization, given the complexity of the service levels covered in this category. The BHP preferred to initially monitor any major problems in this area and provide retroactive payments.

Dr. Gammon reminded BHP of the letter from the CT Council of Child/Adolescent Psychiatry that outlined their concerns bout the reimbursement levels. Since many children have complex clinical issues, the service reimbursement is seen as a major barrier for psychiatry participation in the BHP program.

*Quality Management & Access Subcommittee:* *Chair Dr. Davis Gammon, vice-Chairs Paula Armbruster & Sheila Amdur.*




The subcommittee met in November (see above summary) and on 12-14 preceding the Council meeting. The subcommittee focus includes:

- ✓ Finishing work with CTBHP VOI on the provider registration form that will be implemented in May 2006.
- ✓ Finalizing recommendations on the performance indicators that HSRI is developing for the BHP.
- ✓ Recommendation (*see 2nd icon above*) that DCF and DSS identify how to streamline provider data reporting considering the data being developed in the BHP program. Dr. Schaefer (DSS) noted this is an important focus area that would reduce administrative burdens for the providers and agencies and supports the BHP agencies looking at this. Mr. Walter will review this further with Dr. Gammon and the agencies and put the recommendation on the January BH OC agenda.

**Other Issues**
A letter from the BHP Oversight Council Co-chairs has been sent to the Commissioner of the State Department of Education requesting the Department appoint a representative to the BHP Council.

**Next BHP Oversight Council meeting is Wednesday January 18 (not the 11th) at 2 PM in LOB RM. 1D.**

**For BHP program updates, fee schedules, etc, go to www.CTBHP.com**