Behavioral Health Partnership Oversight Council

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Meeting Summary: **December 12, 2007**
Co-Chairs: Rep. Peggy Sayers & Jeffrey Walter
Next meeting: Wednesday Jan. 16, 2008 at 2 PM LOB Room 1D

Attendees: Rep. Peggy Sayers and Jeffrey Walter (Co-Chairs), Dr. Karen Andersson (DCF), Dr. Mark Schaefer (DSS), Lori Szczygiel (CTBHP/ValueOptions), Comm. Christine Vogel (OHCA), Sheila Amdur, Ellen Andrews, Rose Marie Burton, Connie Catrone, Elizabeth Collins, Thomas Deasy (Comptrollers Office), Anthony DelMastro, Stephen Frayne, Davis Gammon, M.D., Heather Gates, Stephen Larcen, Judith Meyers, Randi Mezzy, Melody Nelson, Sherry Perlstein, Maureen Smith, Susan Walkama.
Also attended: Mickey Kramer (OCA), Jean Hardy (Health Net), Annetta Caplinger (CARES Unit), M. McCourt (Legislative staff).

BHP OC Administration
The November BHP OC meeting summary was accepted without changes.

BHP OC Subcommittee Reports

Provider Advisory: Chair Susan Walkama

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BHP OC PAG SC 11-14-07. doc.doc

Susan Walkama presented the CARES program Level of Care (LOC) guidelines (*see above)* approved by the Provider Advisory Subcommittee for the BHP OC consideration. Prior to the LOC guideline discussion Annetta Caplinger from the Child& Adolescent Rapid Evaluation and Stabilization (CARES) program that is a collaboration between CCMC and the Institute of Living/Hartford Hospital described the CARES model. This clinical program, modeled after the New York Presbyterian Hospital Comprehensive Psychiatric Emergency Program, was created in response to the growing volume of pediatric psychiatric patients that remain in the CCMC Emergency Department (ED) for multiple days. CARES unit can provide immediate psychiatric evaluation and secure observation of children between five and seventeen years of age. The CARES program goals are:

- Primary goal: Stabilize the patient in a crisis situation and coordinate resources for the patient to return to the community within 72 hours.
- Secondary goal: provide placement for patients that would be held in the CCMC ED for more than

6 hours when an inpatient bed is not readily available.

Admissions to the CARES program come from the CCMC ED, other EDs in the north central region of the State as well as from the community IF they are screened by the local Emergency Mobile Psychiatric Service (EMPS) teams. From Oct 15 through Nov. 30, 2007 there were 80 admissions to the CARES program from CCMC ED.

Motion: Susan Walkama made the motion, seconded by Davis Gammon, MD. to accept the CARES LOC guidelines presented to the Council.

Discussion points that addressed the CARES program and other service issues in the BHP program:

- ✓ Important for CARES to track:
  - The level and combination of community-based services that are being used for those not admitted to an inpatient unit. Dr. Andersson (DCF) stated the agency is looking at existing Hartford area providers, wait lists, etc.
  - The ED "referral source". Ms. Caplinger stated the CARES program does track where the child/adolescent comes from (i.e. home, school, etc); while schools represent 17% of the referrals these children are the least likely to be admitted inpatient. CARES will be working with the schools regarding managing school crises. Susan Walkama stated the Wheeler Clinic EMPS program has provided information to the local education systems in their service area about the use of EMPS, which should be the first call the school makes prior to sending the child/youth to the ED.
  - CARES utilization by race, ethnicity, family income, health coverage. Demographic, length of stay in the CARES program and disposition data (i.e. percent of patients that start in the ED versus the community that participate in CARES program, percent of patients admitted to the hospital and percentage referred to community services) is being collected. The first quarter data can be provided to the Council.
- ✓ Rep. Sayers recommended that teachers receive education on recognizing a child/youth in pre-crisis, management of behaviors associated with this and available resources such as EMPS.
- ✓ Family members may be confused about where to turn for help when there is a crisis: EMPS, ED or CARES program. Ms. Caplinger stated that CARES is not a walk-in crisis program as there are limited (6) beds. Children/youth appropriately referred to CARES can be evaluated with their families is a secure place.
- ✓ Dr. Andersson reported DCF has been in the process of redesigning the EMPS service as well as identifying select EMPS teams for enhanced funding. *(DCF will report on this to the Quality Subcommittee Jan. 18).* Dr. Larcen stated that as part of this redesign, EMPS needs to be linked to every hospital in the state. Dr. Andersson said DCF has requested Mr. Frayne (CT Hospital Association – CHA) to bring their ED physicians together with BHP to learn about the CCMC/BHP ED intervention model and hospital interest in this type of support.
- ✓ Sheila Amdur reminded the Council of the longer term goal for CT: develop a broader screen of all children for mental health needs and potential crises. At this point the State is focused on evaluation/triage as part of the change process for behavioral health services.

Council Action: The Cares Unit LOC guidelines were approved with one abstention.

<u>Coordination of Care</u>: Chair Connie Catrone (Click on icon below for last meeting summary)


BHP OC Coordination Care SC 12-10-07.do

Meeting highlights:

- Reviewed Logisticare transportation client satisfaction survey with 80% of respondents satisfied with transportation experience, 89% satisfied with Logisticare customer services. The client call reminders for transportation date reduced BH no-shows from 6% to 4%.
- Pharmacy carve-out in January 2008: SC thought the Mercer temporary supply study could inform about issues for the carve-out. MCO pharmacy screens have been adjusted to reflect HUSKY policy.
- HUSKY transition: major concern on the impact on primary care/BHP system integration relationship, continued co-management of cases, member information about the transition and potential limitation to health care access, in particular, vulnerable HUSKY members such as DCF children.
- HUSKY FFS members continued access to BHP services, since FFS members currently do not have access to BHP program. (*DSS stated HUSKY FFS members will have access to BHP services*).

DCF Advisory: Co-Chairs Heather Gates & Kathy Carrier

Next two meetings devoted to 1) 12-18, IICAPS coding, rate structure, 2) Jan. 15, RTC authorization process linked to payment and BHP OC family focus groups.

Operations: Co-Chairs Lorna Grivois & Dr. Steve Larcen (click on icon below for 11-16 meeting)


BHP OC Operations SC 11-16-07.doc

Meeting highlights:

- Pre-cert and concurrent review (CCR) completion is taking less time than in Oct. & Nov.
- SC will continue to receive information on the CARES Unit operations.
- BHP proposed regulations: issues included EDs now contacting CTBHP/VO, inpatient bed tracking now required, clarify secondary claims timely filing is 120 days from primary payer EOB, not date of service.
- New claims system, ***Interchange,*** to start Jan. 26, 2008, will not require entering a PA number, thus reducing claims administrative errors. Provider trainings on the system will be provided. It was suggested that BHP pay special interest to independent providers, some of whom feel isolated from information about program changes.

Quality Management & Access: Chair: Dr. Davis Gammon, Co-Chair Robert Franks


BHP OC Quality SC 11-16-07.doc

(*Click on icon above for last meeting summary).* Dr. Gammon reported that the complexity of the CCR process will be discussed at the Dec. 14th meeting, the subcommittee made a case to look more in depth

at data including client demographics, ethnicity and at-risk sub populations. Speaker Amman and Sen. Slossberg have expressed an interest in working on how best to coordinate behavioral health within the school systems.

BHP 1st Annual Evaluation: CY 2006

Annual Report Presentation to BHPC

Legislation in 2005 required the BHP agencies report to the legislature on the first year of the Behavioral Health Partnership program. The complete report can be viewed at www.ctbhp.com under *publications.* Judith Meyers, CEO of the Child Health and Development Institute of Connecticut prepared the report and reviewed highlights for the Council (*click on icon above to view presentation).* The report concluded that based on BHP contract requirements and associated standards and performance targets, the first year of the BHP was successful. The first year BHP experience drove major initiatives in 2007 that address:

- The ongoing problem of "gridlock" in inpatient and emergency department settings: to reduce discharge delays related to inadequate discharge planning and inadequate community-based treatment options.
- Improving the quality of services delivered through shared information about individual provider and facility performance.
- Local area development plan improvement that would identify performance and accountability results that are needed for building a comprehensive community level system of care.
- More fully meet the assessment and treatment needs of DCF children.

Council discussion highlights:

- ✓ DSS stated there needs to be further analysis of child/adolescent psychiatry participation in BHP. The Quality Management & Access SC and BHP will be assessing barriers to participation in the BHP program. Adequate psychiatric participation is critical to the expansion of community-level care.
- ✓ Historic comparison of behavioral health expenditures with 2006 data suggests evidence of growth in community-based services (CBS). ***The Council requested quarterly BHP expenditure reports by type of service.***
- ✓ Program performance targets 2007:
  - The ASO has minimal control of ED utilization. BHP agencies have addressed this through redesign of the EMPS system, implementing Enhanced Care Clinics for timelier community-level care service access.
  - Hospital discharge delays that impact ED delays have led the ASO to work with providers on effective discharge planning processes. DSS is working with hospitals to identify disincentives to admit complex children and overcome these.
  - BHP plans to measure delays for services outside ED/hospital and additional density analysis of enrolled BHP network. BHP will do a re-run of geo-access reports (who is actually seeing the patient) to further identify access issues. ***The Council suggested breaking out network providers by pediatric vs. adult services.***
  - DSS was asked if the BHP has identified a quantifiable goal in decreasing "grid lock".

DSS described clinical issues that drive improvement in this area including

- Coordinating primary and BH care through the second round of the ECC RFP.
- Implementing evidenced based practices
- Timely access to all levels of services and ensuring provider network adequacy.

BHP Agency Report

BHPOC Presentation 12-12-07 Final.ppt

HUSKY Enrollment

Dr. Mark Schaefer reviewed HUSKY enrollment as of December 1, 2007:

- ✓ Total HUSKY A enrollment (312,119) increased in Dec. by 3,302 compared to Nov. 2007
- ✓ Under 19 year old enrollment (214,044) increased by 1,772 in Dec. 2007 compared to 11/07.
- ✓ HUSKY A adult enrollment (98,075) grew by 1,530 in Dec. 2007 compared to Nov. 2007.
- ✓ HUSKY B enrollment decreased by 253 in Dec. compared to Nov. 2007. HUSKY Plus medical decreased from 305 to 288 between Nov. and Dec. 2007.

HUSKY program transition changes (Click icon above to view presentation)

The Governor has made FOI language a condition for HUSKY MCO contracts. In December, Anthem and Health Net did not agree to this and signed non-risk transition agreements effective 12/1/07 through 2/29/07. CHNCT and WellCare remain full risk through 12/31/07 and then will sign non-risk contracts effective 1/1/08 through 6/30/08.

The new FFS Medicaid fees will become the new "floor" for the HUSKY rates. At this time it is unclear whether the provider network will be adequate for the programs with the two commercial/Medicaid plans leaving the program.

Council comments based on the initial announced transition changes (CHNCT, WellCare participation in HUSKY A & B and FFS as a 3rd option for HUSKY A Medicaid):

- ✓ Pharmacy carve-out Jan. 25, 2008 will place the management of pharmacy in HUSKY A & B under the Medicaid preferred drug list (PDL) system: no Prior Authorization (PA) for psychotropic medication and certain HIV drugs. There is a 5 day temporary supply requirement.
- ✓ New Medicaid MMIS system, ***Interchange,*** will be in place as the same time as the above carve-out.
- ✓ Sheila Amdur expressed strong concern about the plan to shift a significant number of HUSKY A members (> 250,000 – 81%) and B members (68%) to one of the two participating plans or FFS within a very short time period of 2 months. This system is unprepared to manage such a 'transition". The burden on current and new members to 1) make such a choice (or be defaulted into FFS that has no member service support) during this 'transition period (the program is expected to change again post re-procurement) and 2) determine if their regular source of health care provider is participating in one of the options leaves the potential for confusion and limited access to health care services. DSS cannot predict the adequacy of the provider networks at this time.

- ✓ It is so important to have primary care remain 'connected' to BHP. If members lose their primary care provider, their care will be disrupted and any collaboration with BHP (i.e. new ECC BH/PC coordination will be difficult, at best.
- ✓ *Will BHP providers know what option the member is enrolled in as of March 1, 2008?* DSS replied:
    - Members have a State Medicaid "Connect Card" to identify as them as members of Medicaid HUSKY & SCHIP (although current HUSKY members use their health plan card and may not locate their Medicaid card.
    - The Automated eligibility system AEVS will continue to operate and be updated during the transition.
    - Members that choose one of the plans or FFS will eventually have a card specific to their chosen option.
- ✓ *How will the transition program changes be communicated to members and providers?* Notices will be written to both outlining the changes, choice options. In addition DSS expects to meet with medical societies to describe streamlining of the program and encourage providers to participate. Suggested notices are sent to BHP advising them of the changes.
- ✓ According to DSS, the Governor has set the time frames for the changes that are to be done with as little impact as possible to client health care access. The department reserves the right to take action to avoid any calamities. It would be useful to develop a roster of BHP clients and their PCPs.

Addendum: Subsequent to this meeting there have been further HUSKY program changes:

- ***HUSKY A (Medicaid) members will now have a choice of enrolling in CHNCT or Medicaid fee-for-service (FFS) by April 1, 2008. HUSKY B member 'choice' is CHNCT only.***
- ***At the end of December WellCare informed DSS they will not continue in the HUSKY program beyond 3-31-08. At this time, Anthem, Health Net and WellCare will leave HUSKY March 31, 2008.***

Other BHP Initiatives

- ✓ Selection of successful ECC candidates in the 2nd round of the ECC RFP should be done in early ***January 2008***.
- ✓ Ongoing BHP activities involve the SFY 08 budget. Without the analogous MCO percent increase the BHP is now considering increases greater than 2%.
- ✓ Other strategic investment options are being considered.
- ✓ In response to Commissioner Vogel's question about availability of a daily inpatient bed tracking, DSS stated that only 3 hospitals participated in this. The proposed BHP regulations require these reports; however the BHP is reviewing public comments to the regulations before putting this requirement into policy. Bed tracking is an efficiency tool; it doesn't address the underlying discharge delays reasons.