Behavioral Health Partnership Oversight Council

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Meeting Summary: **January 16, 2008**
Next meeting: Feb. 13, 2008 at 2 PM in LOB room 1D

Attendees: Rep. Peggy Sayers & Jeffrey Walters (Co-Chairs), Dr. Karen Andersson (DCF), Dr. Mark Schaefer (DSS), Lori Szczygiel (CTBHP/ValueOptions), Sheila Amdur, Ellen Andrews, Rose Marie Burton, Elizabeth Collins, Molly Cole, Thomas Deasy (Comptrollers Office), Anthony DelMastro, Stephen Frayne, Heather Gates, Lorna Grivois, Stephen Larcen, Judith Meyers, Melody Nelson, Sherry Perlstein, Paul Potamiamos (OPM), Maureen Smith, Ramindra Walia, MD, Susan Walkama, Beresford Wilson.
Also attended: Mickey Kramer (OCA), Jean Hardy (Health Net), Joseph Woolston, MD & Katie Balestracci (IICAPS Program), M. McCourt (Council staff)

BHP Report *(Click on icon below to view content of report)*

BHPOC Presentation 01-16-08-b.ppt

Dr. Mark Schaefer (DSS) reviewed the ***current (Jan. 16th)*** status of the HUSKY transition that includes member choice of CHNCT and Medicaid FFS for HUSKY A and CHNCT only for HUSKY B, program delivery changes and application of Medicaid rate increases (see above report for details). Highlights of Council discussion included:

- Pharmacy carve-out will use the Medicaid Preferred Drug List (PDL) that exempts psychotropic and anti-retroviral meds from the prior authorization process.
- The adequacy of the HUSKY provider network capacity was discussed since current DSS analysis shows about 2000 providers are not enrolled in CHNCT or FFS.
    - Further analysis is needed of these 2000 providers in order to assess the disruption impact on members during the transition.
    - Reductions in Primary Care capacity will have an adverse impact on some Enhanced Care Clinics (ECC) as they attempt to implement the PC/BH provisions.
- According to Mr. Frayne (CHA):
    - There are differences in payment rules in FFS versus MCOs (under a waiver) for MD inpatient billing. DSS stated the payment rules will not change with under the transition; DSS is interested in reviewing the scope of problems that may arise.

  - FFS hospital compensation is less than from MCOs and may create a shortfall for the hospitals. DSS noted there was an 18% increase in Medicaid rates to hospitals in the biennial budget but the 'transition' wasn't factored into this and will be further looked at.
  - DSS will do a future assessment of evaluating the cost of managing psychiatric drugs vs. non-managed drugs since DSS manages drugs through EDS.

- Mr. Walter stated that the Coordination of Care Subcommittee will continue to work on the impact of the "transition" on medical/BH service integration.
- DSS reviewed the BHP independent provider network assessed with new methodology. One point was clarified in that while 35 psychiatrists stopped billing for BHP clients, these providers saw one-two clients each.
- Medicaid services for BHP recipients:
  - Over 18 years of age numbers were lower than services for under-18 year recipients.
  - Adult recipients received medication services from MDs more than children.
  - Both adults and children received medication services predominately through clinic providers.

BHP OC Executive Committee recommendation to DSS for SFY 08 rate proposal was presented to the Council for consideration *(Click on icon below to view the recommendations)*

BHP FY 08 Proposal.doc

Motion: It was moved by Stephen Larcen and seconded by Maureen Smith that the Council recommends that the BHP adopt the distributed BHP SFY 08 proposal (*see above).*

Discussion points:

- Regarding #4, hospital incentives to reach average length of stay (ALOS) goals and payments are additive to the 18% "parity" with Medicaid FFS. Dr. Larcen noted that 5 child/adolescent hospitals have been meeting to discus how best to improve hospital ALOS for DCF vs. non-DCF clients and how to improve access for clients with co-morbidities (may be an element for SFY 09 budget).
- BHP was requested to come back with funding recommendations at the February Council meeting.
- The proposed recommendation encourages BHP to take into account not just the 2% increase in the budget (dollars allocated to the 4 MCOs) but the Medicaid budget increases as a whole be applied to BHP program to establish parity.
- Concern expressed that independent providers (IP) 90% Medicare rate increase mirrors the ECC rate when the IP performance is not held to the same standard as ECCs. Mr. Walter stated the IP are small portion of providers and the Ex. Committee thought the 90% Medicare rate was equitable. DSS noted that it is important to keep the IP engaged in the BHP. Families want to continue access to these providers.

Council Action: The motion was carried with one abstention.

IICAPS Program: Access and Outcomes *(Click icon below to view presentation)*

IICAPS Presentation to BHPOC_Handout.p

Joseph Woolston, MD, Director of the Yale IICAPS program and Katie Balestracci, IICAPS program Epidemiologist, presented an overview of this intensive in-home program for children, service utilization, referrals and program outcomes (*See report details above).*

Discussion points included:

- Of the 872 referrals made to IICAPS network between July 1, 2006 and Sept. 30, 2007, 622 became cases, 50 were put on a waitlist and 200 were not opened).
- Of the 522 closed cases between July 1, 2006 and Sept. 30, 2007, 382 (73%) of cases had a planned discharge vs. 140 (26.8%) had premature discharges. The latter had lower scores in pre-treatment problem ratings compared to the planned discharge clients.
    - Mr. Wilson requested demographic data on the premature discharge clients to help understand if there are race/ethnicity differences that would suggest a need to better keep the families engaged. Ms. Balastracci stated this data can be looked at in more detail.
    - Dr. Woolston agreed this important to look at as is the developing methodology to identify "adequate dose" parameters of the IICAPS intervention.
    - There are some families that may require clinical inpatient services despite the family/IICAPS team best efforts.

- Comparing hospital/ED use pre-IICAPS with the IICAPS treatment intervention period, there was a proportional decrease during the treatment phase of patients with psychiatric hospital admissions (43%) and ED visit decrease (30.4%).
- There were statistically significant improvements in symptom severity, functioning and level of main problem severity at the end of the intervention and increased satisfaction with the IICAPS intervention over previous mental health services.
- IICAPS is working with BHP to access 12 month post IICAPS data to further assess outcomes.
- Commercial insurers do not reimburse IICAPS services. The only commercially insured participants are in DCF Voluntary services that are state-only funded.
- Wait lists for IICAPS does impact inpatient capacity. Dr. Woolston stated that rural areas create unique challenges for the IICAPS model and is a funding issue.
- Family income is one demographic that would consider family stress related to poverty and intervention outcomes. IICAPS doesn't have this data.
- IICAPS program continues to need to balance data collection with provider burden. Mr. Walter suggested there are other demographic/outcome data that the Quality Subcommittee could work with IICAPS and BHP to link to the HUSKY database.