Behavioral Health Partnership Oversight Council

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Meeting Summary: **May 14, 2008**
Co-Chairs: Rep. Peggy Sayers & Jeffrey Walter

Next meeting dates: Wed. June 11th & July 9th, 2 PM at the LOB

Attendees: Jeffrey Walter (Co-Chair), Dr. Karen Andersson (DCF), Dr. Mark Schaefer & Rose Ciarcia (DSS), Lori Szczygiel (CTBHP/ValueOptions), Sheila Amdur, Ellen Andrews, Richard Calvert, Molly Cole, Connie Catrone, Thomas Deasy (Comptrollers Office), Anthony DelMastro, Stephen Frayne, Heather Gates, Lorna Grivois, Mickey Kramer (OCA), Sharon Langer, Stephen Larcen, Judith Meyers, Sherry Perlstein, Maureen Smith, Susan Walkama, Beresford Wilson, Annetta Caplinger (CARES Unit). (Mariette McCourt Council staff).

Council Administration

- The April BHP OC meeting summary was approved without changes.

- PA08-95: Changes the appointing authority to the BHP OC to CT General Assembly (CGA) leadership, maintaining CGA Committee Chair/Ranking member or designee appointments and ex-officio members. The statute adds an additional two hospital representatives and two parents of children served by the BHP program. The appointments are effective October 1, 2008. (*Based on the legislation there is a total of **34 appointed voting members**, 12 ex-officio appointed members*).

- ***BHP OC independent evaluation of the BHP program***: an ad hoc committee worked with Jeff Walter and the BHP agencies to develop the RFP, review the bidder responses and select an applicant. The University of South Florida Research & Training Center for Children's Mental Health, under the direction of Mary Armstrong, PhD was chosen as the independent evaluator. Mr. Walter thanked Judith Meyers, Molly Cole, Dr. Davis Gammon, and DSS and DCF for their work on the evaluation process. The consultant's final evaluation report will be completed May 2009.

Council Subcommittee Reports *(Click on icon below each subcommittee to read most recent meeting summary)*
Coordination of Care, Chairs: Connie Catrone & Sharon Langer

BHP OC Coordination Care SC 4-23-08.doc

Key agenda items include transportation services & problem resolution, tracking HUSKY plan/ValueOptions co-management – there was a reduction in 1Q08 of cases referred by health plan to

VO and pharmacy - Mercer study report remains pending and feedback from independent pharmacists on new pharmacy 'carve-out' system. Sharon Langer agreed to Co-Chair the SC.

DCF Advisory SC: Chairs: Heather Gates & Kathleen Carrier
Three SC focus areas included 1) Residential Treatment Center (RTC) authorization process, 2) IICAPS retro payment process and rules: DCF was requested to provide statewide IICAPS financial status in fall, 2008 and 3) consumer/family focus groups process to be done in SFY 09.

Operations SC: Chairs: Lorna Grivois & Stephen Larcen PhD


BHP OC Operations SC 4-18-08.doc

Two issues outlined by Stephen Larcen: 1) ***DSS has revised timely filing period of BHP claims to one year for the claims 10/1/07 – 9/30/08.*** DSS requested providers send information to Dr. Schaefer regarding TPL claims rejected based on timely filing rules prior to 10/1/07 in order assess the magnitude of the problem; 2) ED delays: the Chair requested more information on ***data in Region 5*** related to discharge delays and which hospital (s) Region 5 children with BH diagnosis are admitted.

Quality Management, Access and Safety SC: Chairs: Davis Gammon, M.D. & Robert Frank, Ph.D.


BHP OC Quality SC 4-18-08.doc

The Subcommittee Chairs were asked to confirm with BHP the presentation format of ValueOptions and Mercer Consumer-Provider Satisfaction Survey results to the Council.

Behavioral Health Partnership Report
Department of Social Services (DSS) (Click on icon below to view report details)


BHPOC Presentation 5-14-08 Draft TLC.pp

The report includes HUSKY A/B enrollment update and care coordination during the program transition, CTBHP expenditures, FFS and BHP rate implementation, case management changes (to targeted case management-TCM) in compliance with federal regulations effective March 2008, Interchange claims system implementation and ASO performance targets. Discussion related to the topic include:

HUSKY Enrollment

- HUSKY A enrollment increased by 3,136 members since April 2008. Since June 2007, enrollment increased by 21,991.
    - HUSKY A <19 enrollment increased by 1,659 members since last month and since June 2007, enrollment increased by 10,625 members.
    - HUSKY A > 19 (adults/caregivers) increased by 1,477 members since April; enrollment has increased by 11,366 members since June 2007 (the month before adult income-eligibility was increased to 185% FPL, providing 'family coverage' in HUSKY A).

- HUSKY B enrollment has decreased since April 2008 and has 924 less members than in June 2007.
- HUSKY A enrollment in health plans and Medicaid FFS as of May 1, 2008 is: CHNCT – 94,466, Anthem – 188,321 and traditional Medicaid FFS – 38,118, down from 44,154 in April 1, 2008. DSS noted that HUSKY A members can 'opt out' of a plan, including choice/default FFS, at any time.
- Rose Ciarcia reviewed activities that minimized care disruption for members changing out of Health Net & WellCare during the "transition phase":
    - Exiting plans provided ACS with files of members with 'special needs' (i.e. high risk pregnancy, hospitalized, in case management or disease management, in CTBHP program). ACS then matched these clients with their new plan or FFS. For FFS clients:
        - ValueOptions is working with Dr. Zavoski on co-managing current BHP clients.
        - DSS has referred high risk pregnant members from the two exiting plans to Healthy Start.
    - While DSS has no case management structure for HUSKY FFS members, the expanded DSS medical unit will provide member case management 'as time permits' (their primary responsibility is review of health plan denials) and HUSKY Infoline assists members with provider contact, transportation and general program information. If FFS continues 'for a length of time', DSS recognizes the need to identify pregnant women in HUSKY FFS, assess pregnancy risk, case management needs and send out children's well care reminders.

HUSKY A & B Expenditures in BHP

- ***BH expenditures*** by quarter have been increasing under BHP program that began January 2006. Compare 4Q06 expenditures ($22.9M) with 4Q07 ($28.5) there was about a $5.5M increase in expenditures. The 1Q08 expenditures decreased, thought to be a function of claims processing errors associated with the new claims system (InterChange) for which payment issues should be resolved by August 2008. There has been a steady increase in Date of Payment (DOP) PMPM per Quarter from 2Q06 ($23.73) to 4Q07 ($29.15).
- An increasing trend in ***community-based service*** expenditures over the past 6 years is related in part to additional community-based (CB) service development/expansion. These services include Emergency Mobile Psychiatric Services (EMPS), crisis stabilization, Extended Day Treatment (EDT), home-based services and family support teams.
    - Judith Meyers suggested looking at trend data over time *before* as well as from the BHP program to provide a better assessment of service changes to the community based system, one of the goals of the BHP program. DCF agreed to look at historical data.

Addendum 5-28: Dr. Andersson proved a brief historical perspective on trends in CB expenditures:

- *In 2001 we had $ 3 million to support Community based services annually (used primarily to support Outpatient Clinics for Children, family advocacy and EDT).*
- *In 2003 we had $14 million (KidCare allocation) to support community based services annually: EMPS, Care Coordiation, enhanced EDT, limited In-home).*
- *Currently as the graph indicates (see above report) we have approximately $ 56 million ($13-14 million expended each quarter) to support EMPS, Care Coordination, Extended Day Treatment, Intensive Home Based Services, Outpatient Clinics for Children.*

    - Sharon Langer recommended that expenditure data reports include numbers of HUSKY members served, by service type, even though this data is in separate utilization reports.

- Dr. Andersson reviewed DCF ***Out-of-Home*** expenditures that include Residential Treatment Centers (RTC), Therapeutic and PASS (Level 1) Group Homes. RTC expenditures have been decreasing (>'blips' seen in the graph due in part to payments made in the month following when the services were delivered): per calendar year RTCs serve 2000 children/year with annual costs of $125-130M/year.
    - Dr. Andersson stated that PASS GH slots (112) coupled with the expansion of Therapeutic GH (currently 50 in operation with 5 more being added in the near future) have contributed to community-based placement of children/youth previously housed in RTCs. More children/youth are now being stabilized in the community through home-based services than in the past.
    - The State's challenge is meeting the needs of the child/youth with serious complex health needs currently sent to out-of-state RTCs rather than in-state settings because of Ct's lack of highly specialized services required for these patients. DCF will provide a report on out-of-state services in a summer 2008 meeting.
    - Sheila Amdur stated it is important to look across State systems at where opportunities for family early interventions and care coordination have been missed that may contribute to later more serious health needs.
    - Dr. Andersson briefly described the ASO phase 1 study of foster care disruption and mental health service use that identifies predictors of children not stabilized in foster care and then identify and develop strategies to improve continuous placements rather than frequent placement changes. Sixty percent (60%) of children/youth seeking RTC services have had numerous foster care placements. Mickey Kramer (Office Child Advocate) noted the importance of also looking at the characteristics of the foster care provider, not just the complex needs of the DCF child/youth. Dr. Andersson said DCF is meeting with foster care parents to identify how to best match the child/youth with foster parents and the level of support that would help foster families maintain that setting for the child/youth.
    - BHP was asked about Court Support Services (CSSD) involvement in BHP program and the Council. DSS stated while the Governor's budget for bringing CSSD into the BHP (100-200 youth/quarter) was not implemented when the Executive and Legislative Branches agreed to adhere to the 2007 session biennial budget provisions for SFY 09, as of Jan. 1, 2008 BHP is paying claims for CSSD youth eligible for BHP program. Adding non- HUSKY A/B BHP eligibles into the program will depend on the SFY 10-11 biennial budget decisions.

CTBHP and Medicaid Fee-For-Service (FFS) Rates *(see last 4 slides in above document)*

Discussion included the following topics:

- Medicaid ***FFS clinic rates,*** updated May 2008, were effective as of Jan. 1, 2008. DSS decided to make rates effective January 2008 instead of July 1, 2007 because of the need to get CMS approval for supplemental payments and implementation of Enhanced Care Clinic (ECC) rates. ***CTBHP rate changes*** do not require a state plan amendment and were effective July 1, 2007 with the exception of MD, other practitioners and home-based services.
- Enhanced Care Clinic (ECC) extension to FFS and supplemental payments are contingent on CMS approval of the State plan amendment. DSS had done Upper Payment Limit (UPL) calculations for hospitals; calculation for clinics is underway. DSS received CMS questions last week and DSS response to the questions will start the 90-day clock for a CMS decision. Stephen Larcen stated

that Medicare UPL configurations do not include a mechanism that recognizes children's special services. This could allow DSS to consider presenting this aspect of the program as a "special case" to CMS.

- Home-based services should now be covered under FFS; however there may be implementation delays for the rate increases in the BHP program.
- FFS rate codes expect to be placed on DSS website: www.ctdssmap.com & BHP codes at www.ctbhp.com . FFS rates will be paid prior to web rate posting in order not to delay payments.
- FFS retroactive adjustments are expected to be made in May and June, first for hospitals and long term facilities, followed by the balance of FFS adjustments, with the exception of clinics, the following week. BHP adjustments are expected to be made by July 08 for all but MD and home – based services.

Targeted Case Management (TCM): DSS is meeting with CMS at the end of May and will report at the June meeting. {*Both the congressional House and Senate have passed bills with moratoria on Medicaid regulations that include (TCM}.*

CARES Unit Update: *(click on icon below to view presentation, CARES data)*

Cares Update May 2008 - LOB Presentat

Annetta Caplinger, Director of Operations at IOL, provided the update for the first 5 ½ months of the CARES Unit operation (from 10/15/07 – 3/31/08). Discussion points included:

- Impact of CARES unit on CT Children's Medical Center (CCMC) Emergency Department (ED) was seen during the first 5 ½ months of the implementation of the CARES unit:
    - Of the 894 children evaluated for BH problems at the CCMC ED during these 5 ½ months, one-third (293) of the patients were transferred to CARES Unit. The mean wait time in the ED for disposition has been reduced from 14.7 hours to 4.7 in the 1st Quarter and 5.8 hours in the 2nd Quarter, consistent with national goal of 6 hours limit in an ED.
    - The average length of stay (ALOS) in the CARES unit was 2.5 days; 15 patients stayed from 6 – 29 days. These 'outliers' needed access to specialized Residential Treatment Centers (RTCs) or appropriate inpatient settings related to the severity of the presenting behavioral problem/diagnosis. Timeliness of access to specialized services has shortened since the initial start-up of the CARES program through CARES team collaboration.
    - Of the children admitted to CARES:
        - On average 50% were admitted inpatient; some because of unavailable inpatient pediatric psychiatric beds. Higher ED admissions to inpatient during the summer are related more to biological-based diagnoses whereas the March – May high volume is thought to be related to school stressors.
        - Those not admitted to a CARES bed but admitted to the CARES program received an evaluation and connection to outpatient services with an average ED stay of 3 hours. Six/seven children come directly from the community to CARES: these children are often involved in IOL community programs.
- Admission to the CARES program benefits the child/family in that evaluation/discharge planning can be done in a quiet environment where practitioners can take time to do a thorough evaluation and appropriate intervention that is difficult to do in a busy pediatric ED.

- Some patients may be readmitted to the CARES program as part of their discharge plan.
- Given the early success of the CARES program, it would seem appropriate to extend these high expertise services to the communities and school areas where the children live and learn. Mr. Wilson asked how Emergency Mobile Psychiatric Services (EMPS) work with CCMC. Ms. Caplinger replied that EMPS is part of the CARES team, participating with CTBHP/VO in morning rounds. EMPS can directly triage to CARES without using the ED.
- How can the CARES beds be better used as CARES 'inpatient' bed census is lower than projected numbers? Ms. Caplinger outlined the challenges in her presentation and steps that could result in the CARES program reaching its census goals that include the CARES administrative oversight group consider additional outreach to community organizations, providers and neighboring EDs to facilitate community use of the CARES beds and program and review screening/triage practices of ED patients to assess diversion potential.