Behavioral Health Partnership Oversight Council

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Meeting Summary: **September 10, 2008**
Co-Chairs: Rep. Peggy Sayers & Jeffrey Walter
Next meeting:* *October 8, 2008 @ 2 PM in LOB Room 1D

Attendees: Jeffrey Walter (Co-Chair), Lois Berkowitz (DCF), Dr. Mark Schaefer (DSS), Lori Szczygiel (CTBHP/ValueOptions), Ellen Andrews, Rose Marie Burton, Elizabeth Collins, Stephen Frayne, Davis Gammon, MD., Heather Gates, Charles Herrick, MD, Sharon Langer, Stephen Larcen, James McCreath, Judith Meyers, Sherry Perlstein, Paul Potamianos (OPM), Maureen Smith, Susan Walkama, Beresford Wilson, (M. McCourt, staff).

Council Administration

- ✓ Elizabeth Collins made a motion seconded by Beresford Wilson to accept the July 2008 meeting summary. Summary accepted without changes.
- ✓ Legislative appointments to the Council: Mr. Walter reminded current members interested in remaining on the Council to contact the Legislator making the appointments for categories as defined in statute.

Subcommittee Reports: *(click icon below each SC for meeting summary)*

Coordination of Care – Co-Chairs: Sharon Langer & Maureen Smith

BHP OC Coord Care SC 9-08.doc

Key areas include new plans' co-management processes, identifying benchmark data and data going forward to assess the effect of co-management, Primary Care/Behavioral Health practice integration initiatives (CHDI) and potential for Medicaid Council's Consumer Access & this SC coordination on certain integration issues.

*DCF - Co-Chairs; Heather Gates & Kathleen Carrier: meetings now on the **4th** Wednesday*

Minutes 7.29.08.doc

The two focus areas are:

- Organizing the family focus groups with family and consultant input into the process. The groups should be held in late fall 2008 with report by the end of 2008.
- Consultation arranged for IICAPS compliance issues.

Heather Gates requested DSS provide the SC with the draft child rehab regulations to the SC for review prior to the 9-23 SC meeting. The regulations will be published for public comment upon

release from the Governor's office.

Operations – Co-Chairs: Lorna Grivois & Stephen Larcen

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Elizabeth Collins reviewed the July meeting topics that included the issues related to Charter Oak Health Plan (COHP) provider participation and rates impacted by member cost share, substance abuse treatment limitations and implementation of tracking mechanism for number of services used within this benefit.

Provider Advisory – Chair: Susan Walkama

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BHP OC PAG SC 8-20-08.doc

- The Subcommittee has reviewed the hospital 23-hour observation level of care guideline from the BHP Clinical Committee with CHA and individual interested hospital representatives. The Council will receive these guidelines prior to the Oct or Nov. meeting for review. Mr. Walter encouraged council members/others to contact this SC to participate in guideline discussion and/or revision. The Subcommittee brings the recommended guidelines to the Council for approval; if revisions are required, the Council will refer this back to the Subcommittee.
- At the Sept 17 meeting, there will be continued discussion of the Enhanced Care Clinic "Mystery Shopper" for timely access to routine appointments and PRTF guidelines. The Council will review the Subcommittee's recommendation for Psychiatric Residential Treatment Facility (PRTF) level of care revisions at the October meeting. Rose Marie Burton explained PRTFs provide step-down or hospital diversion level of care with 24 hour nursing care. ***DSS will discuss the PRTF 2% performance incentive at the October meeting and the interim changes.***

Quality Management, Access & Safety: Co-Chairs-Davis Gammon M.D. & Robert Frank

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Dr. Gammon reviewed Subcommittee issues that included:

- COHP impact on providers, dilution of the network in this rental/PPO captive network
- Complexity of administering the COHP substance abuse benefit
- Subcommittee work group recommendations for BHP member satisfaction survey process (*click on 2nd icon above).*

BHP Agency Reports

BHPOC Presentation 9-10-08-Fi.ppt

The Agencies reported on HUSKY enrollment growth, HUSKY county transition status, BHP

expenditures and numbers of members using different level of services, length of inpatient stay and delayed stays, PRTF performance improvement initiative, Emergency Mobile Psychiatric Services (EMPS) reprocurement schedule, BHP rate increases SFY 08 and details of the Charter Oak Health Plan Behavioral Health (*click on above icons to view report details).*

Points of discussion related to the presentation included:

- ✓ HUSKY A transition: approximately 12% (38,094) of members are in HUSKY fee-for-service (FFS). In Middlesex County 6% of current members changed to one of the "new' plans. (County change from Anthem & FFS is voluntary until November).
- ✓ BHP HUSKY A expenditures increased by $10.4M between SFY 07 & 08. Provider date of payment (DOP) per member per month (PMPM) was lower in 1Q08 and higher in the 2Q08 compared to any other quarter since 1Q06. This reflects the new claims system. A full report on claims is pending further fork with EDS in resolving claims issues.
- ✓ What is the number of children in Residential treatment? DCF stated it is in the Report to the legislators and will be given to the DCF Subcommittee.
- ✓ Pass Group homes are financed by DCF FFS dollars per bed whereas the Group Home 2 expenditures reflect grants to the homes. Slight decrease in 2Q08 maybe related to the grant cycle.
- ✓ Use of Outpatient services for children has increased in 2007 compared to 2006 and expenditures increased from $25.5M in the first 2 Q's 06 to $28M in same periods 2008.
    - The impact of ECCs is reflected in the increase of the number of children that used outpatient services in 4Q07 & 1Q 08.
    - Home based service utilization has about doubled in 1Q08 compared to the 1Q06.
    - Dips in EMPS expenditures may be the result of ECC emergency services provided at the clinic on-site (billed through ECC) versus those provided by that clinic as mobile community-site services. Clinics often give families a choice for the site of the service. The new EMPS contracts require clinics provide a higher percent of mobile community-site services for emergencies.
- ✓ Trend change reason for adult intermediate care reduction is unclear.
- ✓ Inpatient admits per 1000, based on prior authorization, shows that adults have higher number of admits than children (excludes Riverview) but fewer inpatient days/1000 (about 8 days) compared to children (about 14 days/1000). Hall Brooke hospital, now part of St.Vincent's hospital will be able to accept adult patients, while freestanding hospitals like Natchaug can only receive Medicaid payment for "adults" up to age 21 years. Lori Szczygiel will look at the freestanding psychiatric hospitals' numbers for admissions of those over 19 & under 21 years.
- ✓ Child/adolescent inpatient discharge delay days have decreased in 2Q08 to 2600 days compared to 3500 in the 1Q08 and over 3500 days in 4Q07.
- ✓ Placement issues are the main reasons for children's inpatient delay discharges. *Why is there the number of children in discharge delay related to placement issues when Residential treatment centers (RTCs) have open beds and lost $3M in revenue in the past year?* Lori Szczygiel (ValueOptions) stated that information from DCF/VO four times weekly rounds show that a number of children/youth require out-of-state placement for very complex behavioral problems that the CT RTCs are currently not prepared to accept. DCF has been working with RTC providers to identify the 'right size' for RTC system in CT and identify those interested in programmatic changes to accept some out-of-state clients. The outcome of this work will be reported back to the legislative committee.
- ✓ Enhanced Care Clinic (ECCs) contract requirements:

- The *mystery shopper survey* for timely routine appointment begins in October.
- Letters for Primary Care Memorandums of Understanding with a local PCP and ECC are due to DCF by Sept. 22, 2008
- 3Q08 ECC data is the basis of BHP notice of corrective action plan if necessary.
- There was discussion of ECC requirement for timeliness of access for emergency (2 hours), urgent (2 days) and routine services (2 weeks). Systematically quantifying this by definition in ECC triage is not possible. From a hospital perspective, Dr. Larcen encouraged more focus on this for patients discharged from inpatient care that need timely access for psychiatric medication services. From an ECC perspective, the ECC needs improved communication with the discharging hospital about the patient prior to discharge in order to set up an appointment. Both stakeholders could develop standards to address this.

✓ Charter Oak Health Plan (COHP) Behavioral Health services will be administratively managed by ValueOptions and reimbursed by DSS. All BHP providers are enrolled in CT Medicaid (CMAP) Program and would participate in HUSKY and COHP BH services under the BHP letter of agreement. Providers cannot opt out of one program (i.e. COHP). Concerns and questions were raised by the Council members that included:

- *Provider perspective:*
  - The COHP reimbursement design includes commercial-type client cost-share that often is never collected. When co-payments/deductibles are not collected, provider rates will then be below the BHP rates and the floor of the Medicaid rates.
  - There is no out-of-pocket co-pay maximum: for some services, the co-payment may represent 100% of the covered service reimbursement rate. When this occurs for ambulatory substance abuse services, the service will not be counted against the benefit maximum.
  - DSS stated the ECC rates extend to COHP and Medicaid FFS.
- *Member perspective:*
  - Consumer debt may create member disincentives to participate in follow up care. The plan makes low-income members ineligible for "free hospital care".
  - What resources are available for members to calculate their 'full' cost share? DSS identified the BH member handbook, VO member brochure, brief summary of cost share on the back of the member identification card. (*ACS will also inform members of their cost share for COHP).*

The Council suggested DSS work with a task force/subcommittee to assess the COHP BH rate methodology and impact of program rate design on members' access to care. DSS welcomed feedback regarding member or provider hardship.