DSS and DCF report to the

Behavioral Health Partnership Oversight Council

February 11, 2009

Child Psychiatric Inpatient Hospital Care

Utilization and Discharge Delays

CY2007 – CY2008

Overview

- The Departments of Children and Families and Social Services, ValueOptions and eight of Connecticut's private general and psychiatric hospitals have worked together to support the reduction of unnecessary inpatient days
- Hartford Hospital/IOL, Hospital of Saint Raphael, Manchester Memorial Hospital, Natchaug Hospital, Saint Francis Hospital, Saint Vincent's Hospital (inc. former Hall-Brooke Hospital Inpatient), Waterbury Hospital, Yale New Haven Hospital

Overview (continued)

- Efforts include:
  - the development of a performance incentive program for general and psychiatric hospitals focused on hospital length of stay
  - a performance target under the ValueOptions contract focused on the reduction of discharge delay days within the inpatient system

Overview (continued)

  - the introduction of hospital specific quality improvement initiatives and provider analysis and reporting by ValueOptions, and
  - stepped up efforts in DCF area offices to facilitate timely discharge
- These initiatives have helped assure that incentives were aligned across all participants in the system reform

Overview (continued)

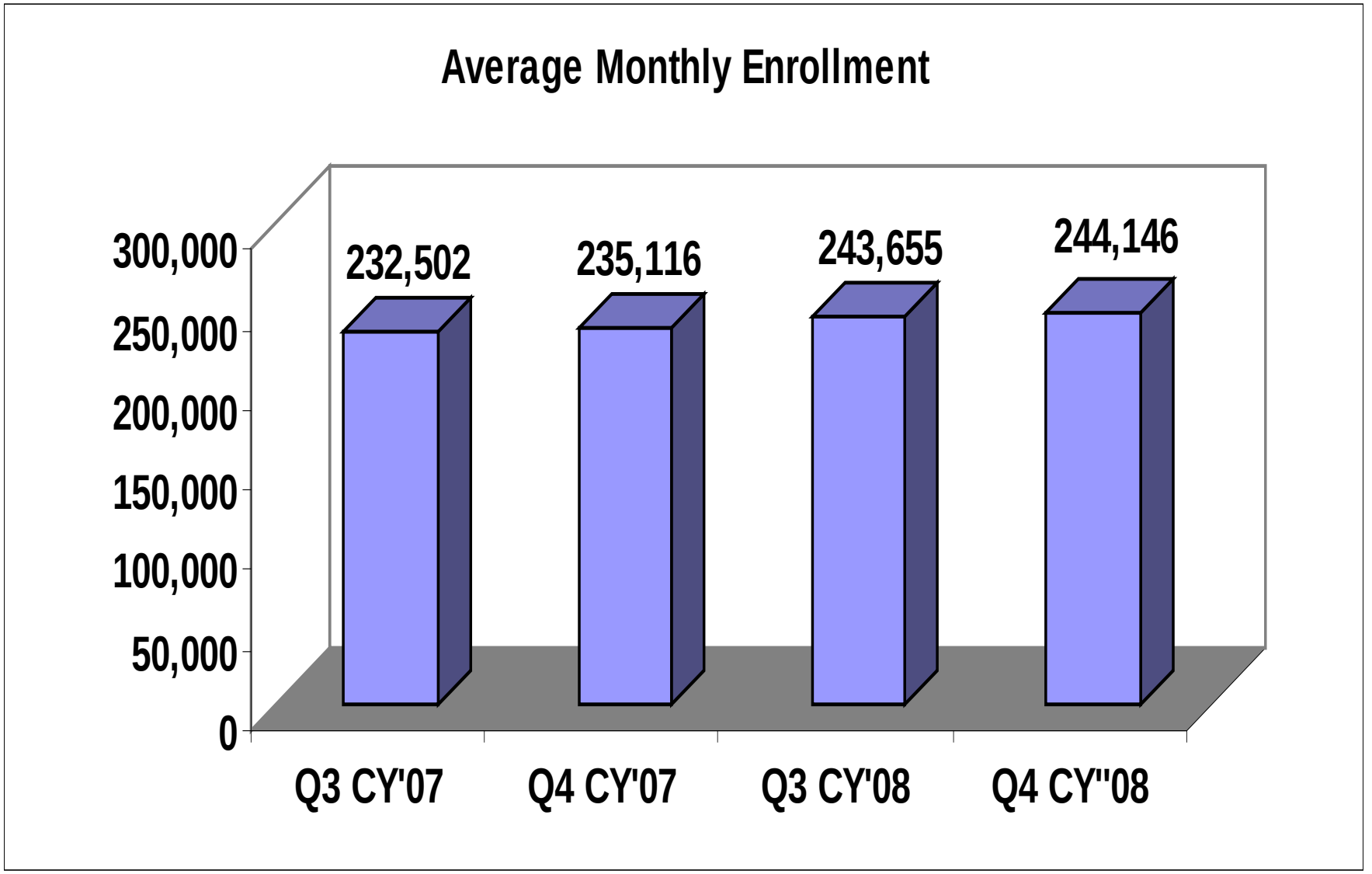
- Results have been positive
  - Child psychiatric inpatient hospital days have declined from 43,493 days in calendar year 2007 to 38,917 days in 2008, a drop of more than 4,500 days (10.52%)
  - During this same period, the average monthly enrollment of children in the BHP increased 4%, from 231,635 to 241,325

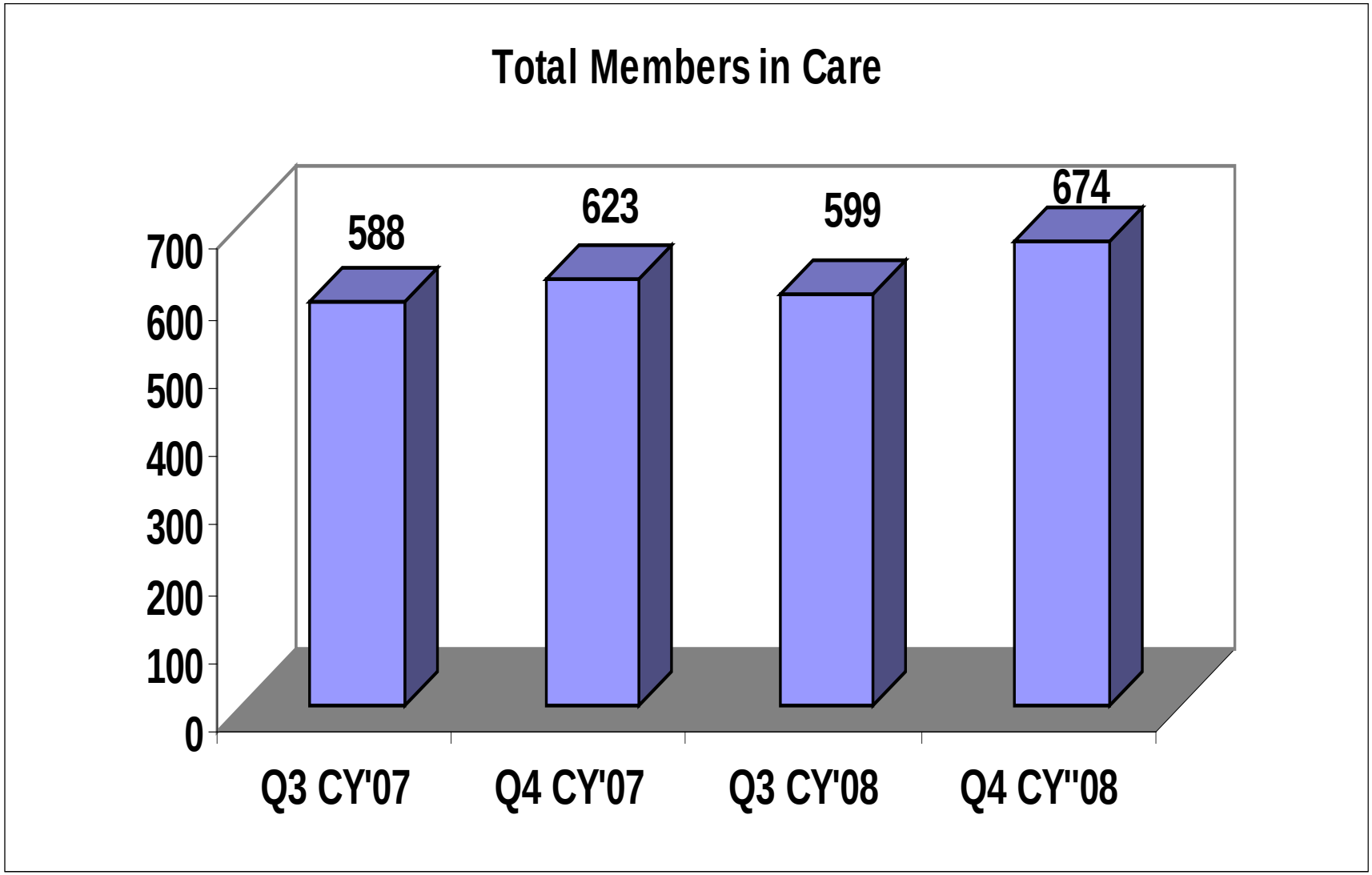
Overview (continued)

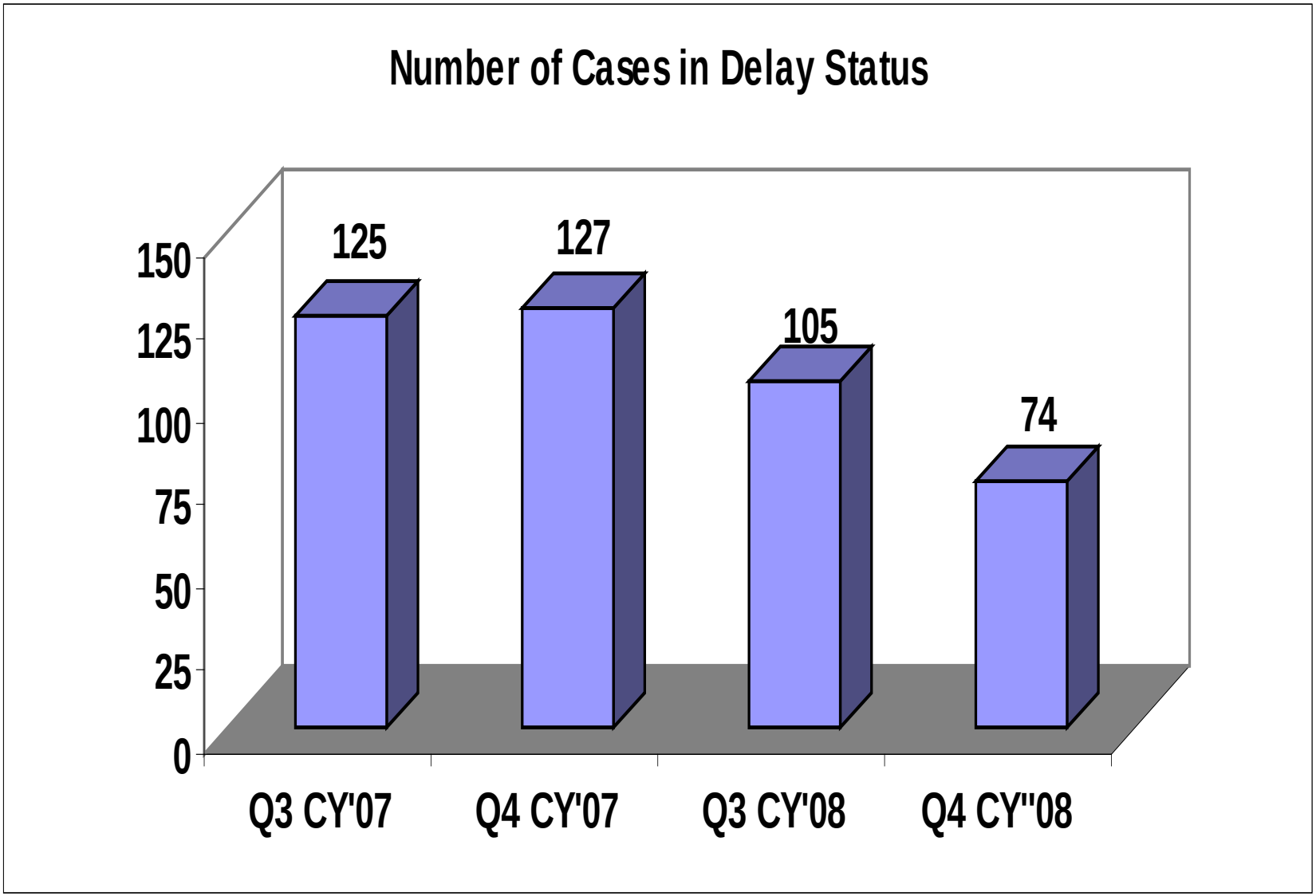
- Reduction is not due to a decline in admissions, which have increased over the period in question
- The majority of the reduction appears to be due to a reduction in the problem of discharge delay--a reduction in both the number of discharges that experience a delay and the average length of delay
- A reduction in acute LOS (about 3%) has also been an important factor contributing to the reduction in authorized days

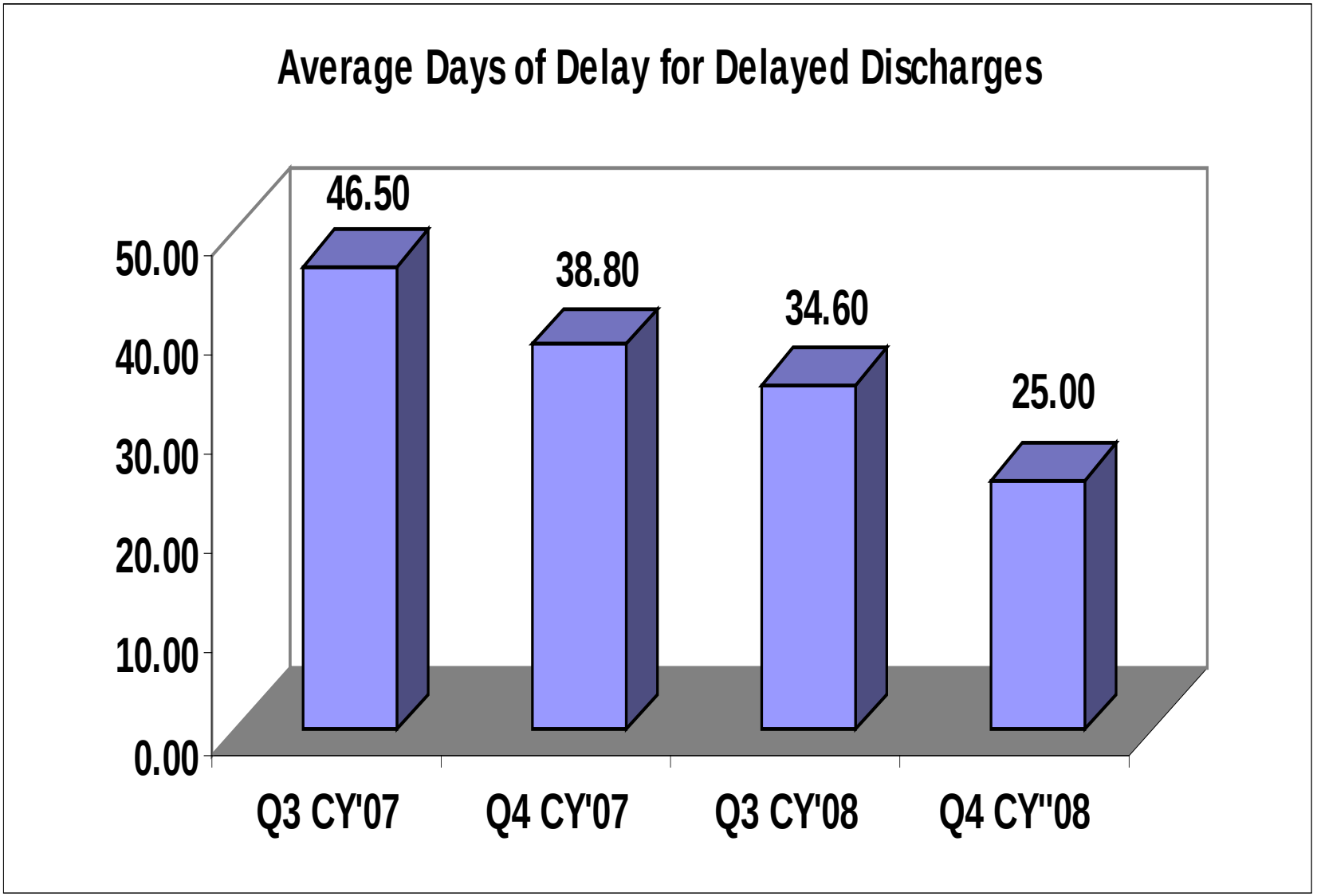
Overview (continued)

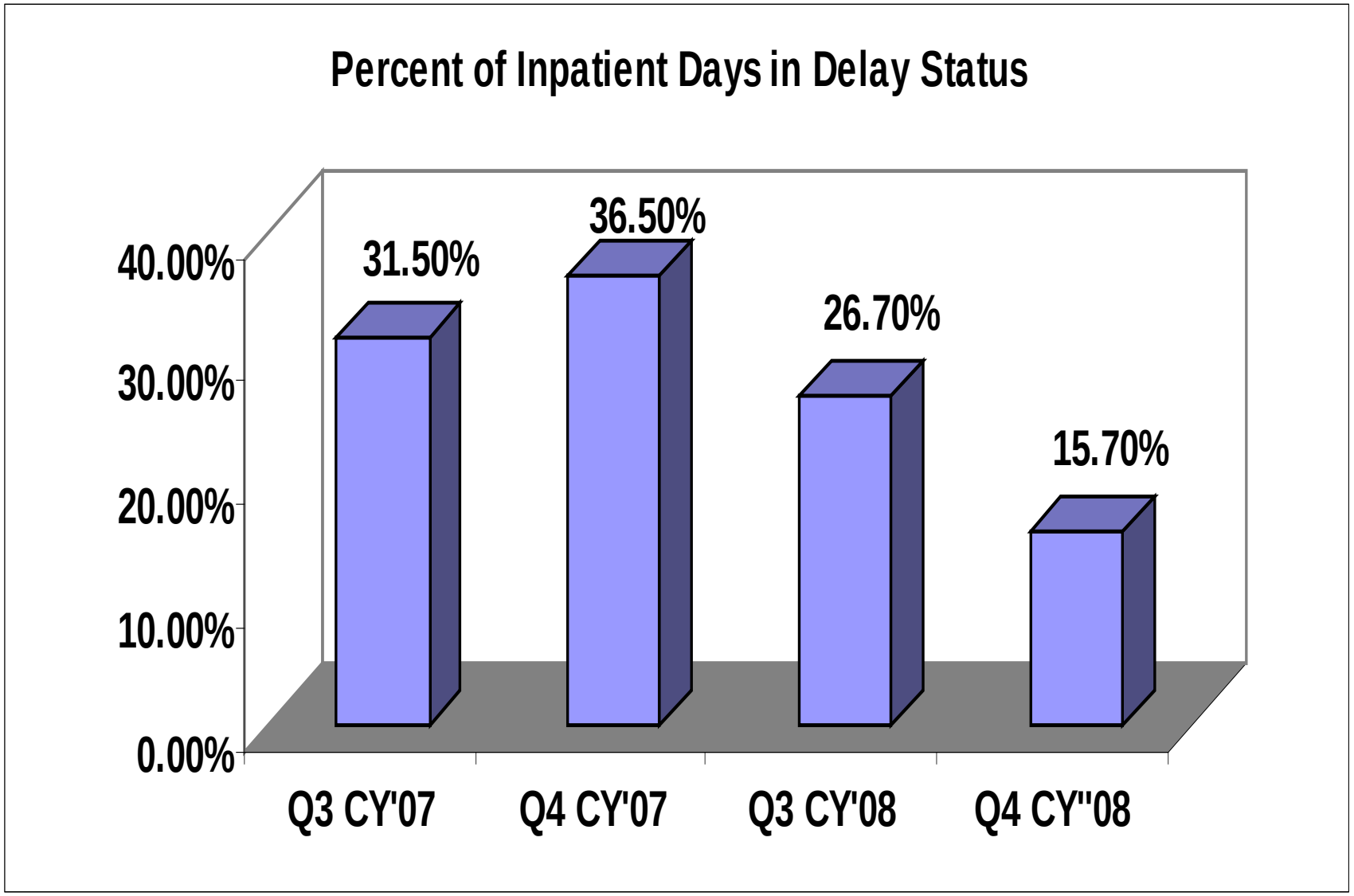
- The following charts provide a comparison between Q3 and Q4 of 2007, when discharge delays were first reliably tracked, and the same quarters the following year
- Improvements in the management of discharge delays are much in evidence in this comparison

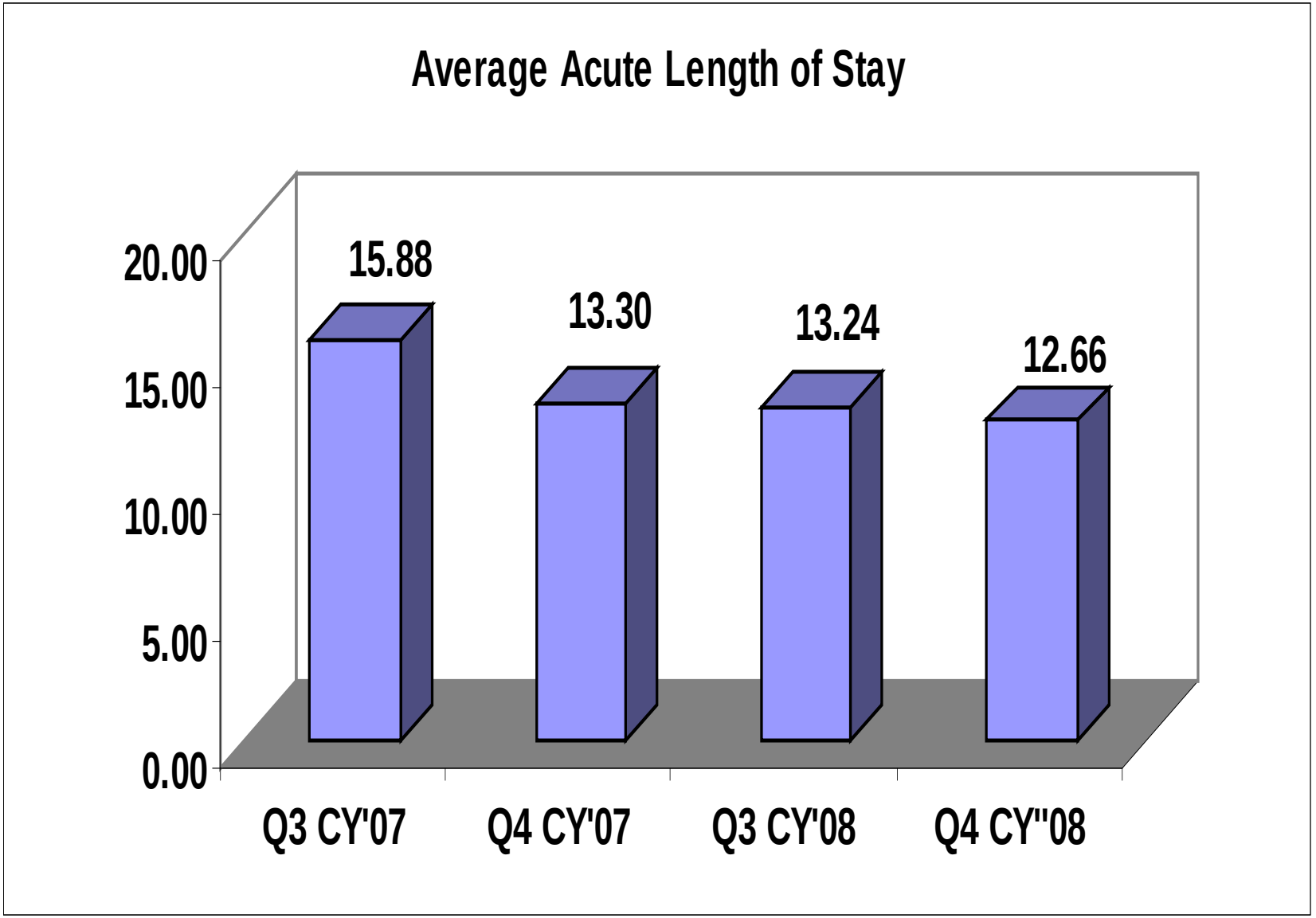

Average Monthly Enrollment
300,000
250,000
200,000
150,000
100,000
50,000
0
232,502
235,116
243,655
244,146
Q3 CY'07
Q4 CY'07
Q3 CY'08
Q4 CY''08

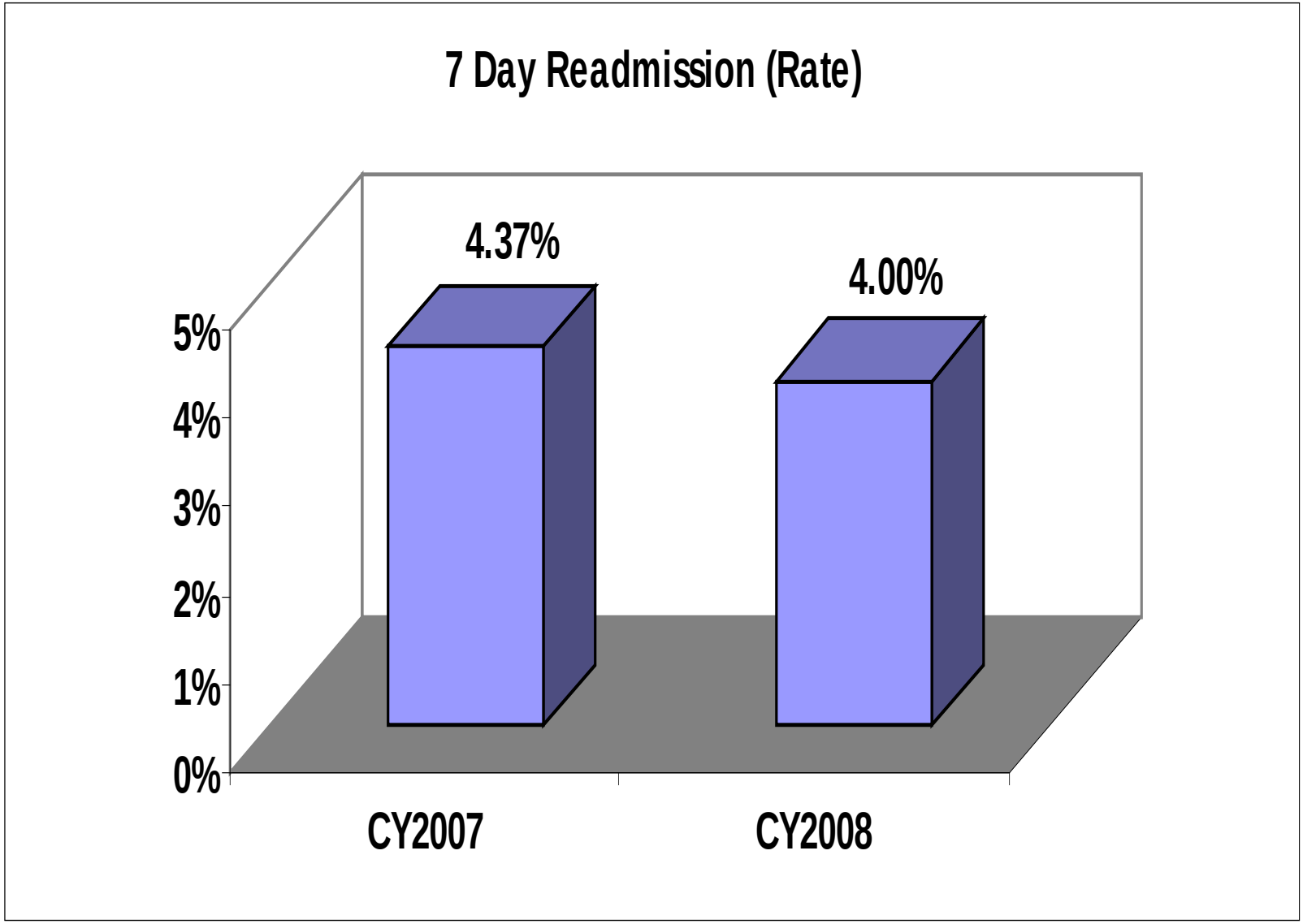

Total Members in Care
700
600
500
400
300
200
100
0
588
623
599
674
Q3 CY'07
Q4 CY'07
Q3 CY'08
Q4 CY''08

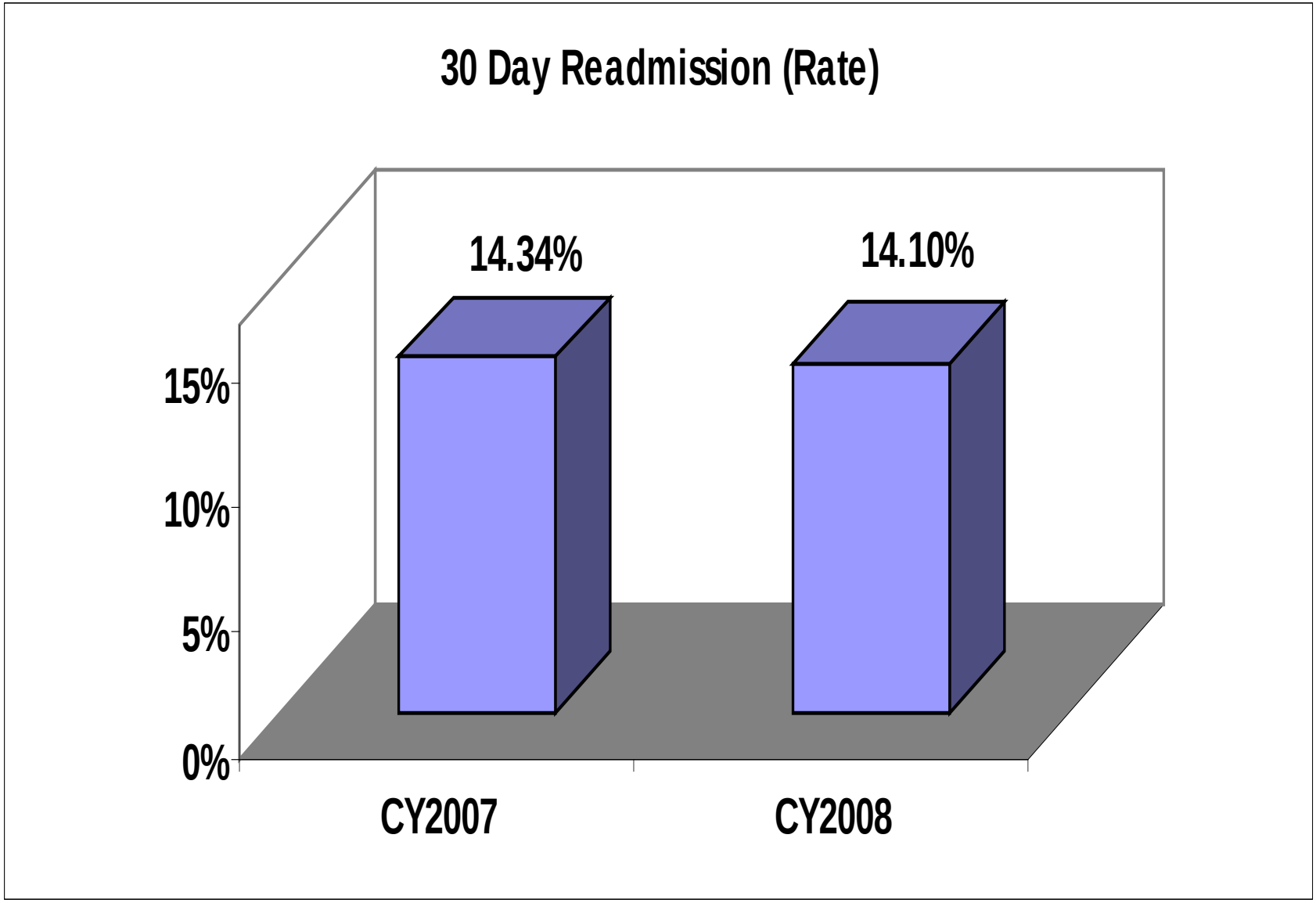

Number of Cases in Delay Status
150
125
100
75
50
25
0
125
127
105
74
Q3 CY'07
Q4 CY'07
Q3 CY'08
Q4 CY''08


Average Days of Delay for Delayed Discharges
46.50
38.80
34.60
25.00
50.00
40.00
30.00
20.00
10.00
0.00
Q3 CY'07
Q4 CY'07
Q3 CY'08
Q4 CY''08


Percent of Inpatient Days in Delay Status
40.00%
30.00%
20.00%
10.00%
0.00%
31.50%
36.50%
26.70%
15.70%
Q3 CY'07
Q4 CY'07
Q3 CY'08
Q4 CY''08


Average Acute Length of Stay
20.00
15.00
10.00
5.00
0.00
15.88
13.30
13.24
12.66
Q3 CY'07
Q4 CY'07
Q3 CY'08
Q4 CY''08


7 Day Readmission (Rate)
4.37%
4.00%
5%
4%
3%
2%
1%
0%
CY2007
CY2008


30 Day Readmission (Rate)
14.34%
14.10%
15%
10%
5%
0%
CY2007
CY2008

Governor's Recommended Budget SFY 2010-2011 Biennium

DSS and DCF Provisions with Implications for CT BHP

CT BHP Rates

- No rate increases in either SFY10 or SFY11
- Also no rate increases for HUSKY MCOs

Methadone Maintenance

- Rates above the CMS approved upper payment limit (UPL) will be reduced to the upper payment limit ($85.53 per week) or by 3%, whichever rate is higher
- Rates that are currently below UPL will be reduced by 1%

Medical Interpretation

- Eliminates for the biennium the initiative to amend the Medicaid state plan to include foreign language interpreter services as a covered service under the Medicaid program
- DSS will continue to require providers to cover the cost of interpreting services

Medical Necessity Definition

- Replaces current outdated medical necessity definition under Medicaid with the definition that has been in effect for State Administered General Assistance January 2005
- Revised medical necessity definition combines the concepts of medical necessity and appropriateness as is done in Medicare and under most public sector and commercial health care programs
- Proposed definition incorporates the principle of providing services which are "reasonable and necessary" or ‘appropriate" in light of clinical standards of practice

Psychotropic Medication

- Adds psychotropic drugs to the PDL
- Provide physician detailing/outreach to reduce use of off-label anti-psychotics in children and other areas of high cost prescribing that present high clinical risk and/or limited effectiveness
- Require prior authorization for certain drugs regardless of whether the drug is on the PDL

Eliminate Automatic 30-Day Pharmacy Supply

- Currently when a recipient presents at the pharmacy with a new prescription that requires prior authorization (PA), the pharmacist can immediately (at the point of sale) dispense a 30 day supply without going through the PA process.
- On subsequent fills of the same medication, if no PA is requested and obtained, the claim will deny because the prescriber must be contacted to request and receive prior authorization.

Eliminate Automatic 30-Day Supply

- Under this proposal, this first 30 day fill without prior authorization will be eliminated. This is consistent with the department's policy prior to the pharmacy carve-out
- This change will not eliminate the 5 day "emergency" supply when the prescriber cannot be contacted or DSS' contractor cannot complete the prior authorization within the required timeframes

Cost-sharing

- A total of 44 states impose co-payments under their Medicaid programs.
- DSS proposes co-pays not to exceed 5% of family income on allowable medical services (excluding hospital inpatient, emergency room, home health, laboratory and transportation services).
- Under federal rules, co-pays for FPR009 can range from $0.50 to $5.70, depending on monthly family income and size, and are indexed annually based on inflation

Cost-sharing

- Co-pays for pharmacy services will be capped at $20 per month
- Consistent with federal rules, exemptions for:
  - certain children under age 18
  - individuals at or below 100% of the federal poverty level
  - SSI recipients
  - pregnant women
  - women being treated for breast or cervical cancer, and
  - persons in institutional settings

Premiums for HUSKY A Adults

- Proposes to require a monthly premium, not to exceed federal maximum levels
- Premium amounts determined on a sliding scale, up to 10% or 20% of the cost of the service, depending on the individual's family income
- Consistent with federal rules, exemptions include
  - certain children under age 18
  - individuals with income at or below 100% of the federal poverty level
  - pregnant women, and
  - individuals in hospice

Governor's Proposed Budget for DCF

- Recommended Closing of High Meadows
  - Closing Proposed for February 2010
  - DCF currently evaluating impact and reviewing clinical needs of the population

Governor's Proposed Budget for DCF

- Loss of funding for new programs
  - Uncommitted Wrap Dollars
  - Selected Child Welfare Programs

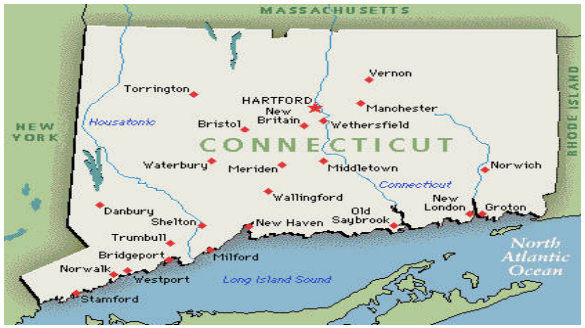
- CT BHP Evaluation

Governor's Proposed Budget for DCF

- No COLAs for Providers
  - DCF recognizes the challenges facing providers
  - Department has begun dialogue with Provider groups to discuss immediate and future impact on service delivery

Connecticut
Department of Social Services

HUSKY Transition: Update



February 6, 2009

Voluntary Transition

9/08 -11/08

- Voluntary transition of HUSKY A members from departing Anthem BlueCare Family Plan and from Traditional Medicaid began Sept. 1, 2008

- State's 3 contracted health plans receiving members: *Aetna Better Health; AmeriChoice by United Healthcare; Community Health Network of CT.*

Mandatory Transition

- Mandatory enrollment originally scheduled for December, delayed to ensure MCOs had sufficient providers.
- Letters sent to 56,900 households in late December with enrollment deadline of 1/28.
- Reminder mailing in January, encouraged HUSKY A members to select a plan; extension of deadline to 1/30.
- PCCM option mailing sent separately to target population.

Mandatory Transition

- Last 2 weeks in January, HUSKY Infoline made outbound calls to more than 20,000 families who had not yet chosen
- January 30, approximately 25,000 households (62,000 individuals) that had not chosen were defaulted into Aetna or AmeriChoice

Plan Assignments

- Members who did not choose a plan by 1/30 were assigned into one of the two new plans.
  - This was done to develop sufficient critical mass in the two new MCOs more quickly to ensure viability.
  - Arizona, Delaware, Illinois, and New Mexico also did this for their new plans when they re-procured their contracts.
- Default plan assignments were well under 85% threshold (of Aetna's and AmeriChoice's capacity in each county) established by DSS.
- CHNCT has received written notification that they are above 90% in Windham County

Transition Care Coordination

- MCO Medical Directors' input was solicited as to what data should be sought from the prior plan for transitioning members
- Bimonthly data exchanges include information for members who:
  - Are in case management, including pregnancy
  - Are in disease management
  - Are inpatient
  - Have existing prior authorizations
- For members transitioning from TM to a plan, the MCOs receive data for members who are:
  - Pregnant
  - Receiving home health care
  - Have a recent inpatient stay

Transition Care Coordination, continued

- Beginning in March, all plans will routinely be receiving dental, behavioral health and pharmacy utilization data of their members.
- Protocols for referrals between the plans, and the Behavioral Health Partnership and Benecare are in place.
- The Behavioral Health Partnership and the plans refer members requiring co-management (medical and behavioral health services) to each other.

Coordination for HUSKY members with prescheduled NEMT trips (e.g. dialysis, therapy)

- **Members switching from Anthem to Aetna or AmeriChoice:**
  - will continue to receive NEMT from LogistiCare
- **Anthem members switching to CHNCT**
  - Logisticare passed prescheduled trip information to CTS, CHNCT's NEMT vendor
- **TM clients switching to the MCOs**
  - Logisticare will continue to provide services for those in their service area that switch to Aetna or AmeriChoice
  - Arrangements were made with FirstTransit to transfer info to LogisitCare or CTS

Primary Care Case Management (PCCM) Membership

- 104 HUSKY A members have enrolled in PCCM effective February 1
  - 90 in the Waterbury area
  - 14 in the Willimantic area
- Members who are current patients of the PCPs, and family members of these patients, were informed about PCCM
- Enrollment continues in PCCM, and members can switch at any time

PCCM Pilot Areas

- **Waterbury**: 4 practices, including:
  - 16 Pediatricians
  - 8 Internal Medicine physicians
  - 6 Internal Medicine / Pediatric physicians
  - 7 Nurse Practitioners (family, children, and obstetrics)
  - 1 Certified Nurse Midwife
  - 4 Physician Assistants included in these practices
- **Mansfield/Windham:** 3 practices, including:
  - 5 Pediatricians
  - 2 Family Medicine physicians
  - 4 Nurse Practitioners (for adults and families)

Questions?