Behavioral Health Partnership Oversight Council

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Co-Chairs: Sen. Jonathan Harris & Jeffrey Walter

Meeting Summary: *June 10, 2009*

Next meeting: **August 12, 2009 @ 2 PM in LOB Room 1D**
NO JULY MEETING

Attendees: Sen. Jonathan Harris (Co-Chair), Mark Schaefer (DSS), Karen Andersson (DCF),Lori Szczygiel (CTBHP/ValueOptions), Pat Rehmer (DMHAS), Uma Bhan, Rick Calvert, Thomas Deasy (Comptrollers Office), Davis Gammon, M.D., Hal Gibber, Lorna Grivois, Charles Herrick M.D., Sharon Langer, Stephen Larcen, James McCreath, Randi Mezzy, Melody Nelson, Sherry Perlstein, Pat Rehmer (DMHAS),Galo Rodriquez, Maureen Smith (OHA), Susan Walkama, Alicia Woodsby (NAMI),
(M. McCourt,Leg.Staff).

Council Administration

May 2009 Council meeting summary was approved without change by a motion of acceptance by Dr. Gammon, seconded by Susan Walkama and voice vote by voting Council members.

Council Action

Sen. Harris introduced a draft resolution *(see below)* that addresses the Governor's May 28, 2009 budget proposals to close Riverview hospital and freeze DCF Voluntary Services new pediatric intake for the biennium.

Proposed Resolution:
Whereas, as part of a revised budget for State Fiscal Years 2010 and 2011 submitted by Governor Rell to the Legislature on May 28, the Governor proposed closing Riverview Hospital and freezing new intakes to the DCF Voluntary Services Program for the biennium, and

Whereas, there does not exist a plan to assure the provision of care in alternative settings for Riverview Hospital pediatric patients, and

Whereas, the freezing of new pediatric admissions to the DCF Voluntary Services Program will place an undue additional strain on hospital emergency departments, lead to increased discharge delays for children in acute care hospitals, place critical community-based services out of reach of Connecticut families, and result in additional costs to the State.

Therefore, the CT Behavioral Health Partnership Oversight Council strongly urges the Governor and Legislature not to include these two proposals in the final budget agreement.

Council motion: A motion by Melody Nelson that the Council adopt the above resolution was seconded

by Sharon Langer.

Council discussion: No comments were offered prior to the vote. Later in the meeting DCF was asked about this service utilization. DCF stated ~100-125 families/year are in Voluntary Services. While most of these clients receive Residential Treatment (RTC) services there is a growing number that receive intensive home based services, including IICAPS services. Council members expressed concern about the proposed closure to Voluntary Services intake for two years. Where will uninsured or 'underinsured' non-Medicaid families find/afford appropriate treatment for their children with complex needs absent access to the State program that provides services often not covered by private insurance? The significant progress made in improving 'fluid' movement throughout the CTBHP system including more access to community-based services rather than reliance on institutional care would be seriously compromised, affecting non-DCF HUSKY A & B children's access to CTBHP services and a return to increasing discharge delays at higher levels of care.

Council action: Motion carried: the resolution was approved without amendment, by unanimous' yes' vote of Council voting members.

Behavioral Health Partnership Report (Click icon below to view presentations)

june2009BHOC presentation (4).ppt

Council & BHP agency discussion related to report items included the following (*see details of report above):*

- DSS is developing ***agency reorganization plans*** for central office managers and frontline staff in response to staff losses from the Retirement Incentive Program. DSS will update the Council on the plan and the impact on BHP program operations in July.

- The proposed budget ***1% Medicaid rate decrease*** affects all services including BHP providers. A 'level of care' impact analysis will be done; the SFY09 1% BHP rate increase retroactive to July 1, 2008 is in process of being implemented.

- ***State Administered General Assistance (SAGA) Medicaid waiver*** included in the Governor's and Legislative budget proposals was discussed. DSS provided general information on state waiver options:

    - A 1915(b) "choice" waiver provides for a service delivery model of full risk managed care, primary care case management (PCCM), and/or non-risk Pre-paid Inpatient Health Plans (PIHPs).
        - 1115 Demonstration Waiver allows states to negotiate with CMS for the program benefits and coverage populations.
    - A CT 1115 waiver could include all or some of the Medicaid populations: SAGA only, SAGA & Medicaid FFS, which may include long term care 1915(c) population or one large management service for all Medicaid populations. Within the waiver there can be co-existing management models especially with potential migration across programs.
    - States can choose a waiver with financial design that includes:
        - Aggregate cap (Medicaid block grant that locks in state federal dollars based on state 5 year projections): one negative aspect of this approach is lack of flexibility

in responding to increased enrollment and service costs.
    - Per member per month federal match that reduces state exposure if enrollment increases but places the state at financial risk if expenditures exceed projections.
- Waivers cost neutrality; CMS expects states to show savings in other areas of Medicaid to negate cost increases in federal dollars. The SAGA medical coverage Federal match could be ~ $130M. The state would need to find savings or develop other agreements such as using unallocated Disproportionate Share Hospital (DSH) funds to offset the federal costs.
    - The Administration has decided <u>not</u> to give up unallocated DSH funds. Council members stated that states have pursued this option; not doing so would cause savings to be realized through other mechanisms such as service cuts.
    - Savings can come from service reductions and/or cost efficiencies through quality care initiatives, disease management programs and member support, all of which can improve the member's health, lead to best practice management decisions and over time reduce high end service utilization trends. Savings would reflect better care.
    - DSS was asked if savings realized in this biennial budget such as proposal to reduce MCO capitation rates could be viewed as savings in the waiver configuration. Dr. Schaefer noted the timing of incurring such savings is critical in the cost neutrality configuration.

- The Special Needs Plan (SNP) for Medicaid/Medicare dual eligibles is included in the budget proposal. The Governor's (May 28) proposal added an Administrative Service Organization model (ASO) for the Medicaid Aged, Blind, Disabled (ABD) population. Council members commented that:
    - Efficiencies in an ASO model may lead to savings, rather than reliance on Medicaid benefit cuts for savings under this budget deficit crisis. The BHP OC was interested in more information about the projected rates, access, utilization trends and management strategy projections related to the ASO projected savings.
    - SNPs have been shown to be more costly and complicated for members. Using an at-risk model is problematic for Medicaid/SAGA clients in accessing appropriate services. DSS asked for information on problems with SNPs.

- ***SAGA BH & Substance Abuse program*** will remain under the management of DMHAS. DMHAS and DSS are in preliminary discussions about managing SAGA and Medicaid FFS behavioral health services under a waiver. The intended goal is to better manage behavioral services for SAGA & Medicaid FFS clients and coordinate management for those with co-morbidities.
- The last budget proposal from the Governor ***reduces and caps <u>state</u> subsidies for COHP*** in an effort to contain costs and not expand the state obligation for this state-funded program. There can be a potential negative impact on BHP program if COHP members' premium costs increase.
- Budget proposal in both the Governor and Legislature's budget includes a change in ***Medicaid medical necessity*** to that used for the SAGA population. Advocates have serious concerns about what this would mean, given the projected cost savings with this budget item ($4M SFY10 & $9M SFY 11). The basis of the projected savings is unclear.
- Council members were asked to address concerns about other budget proposals that affect the HUSKY population to the Council Co-Chairs.

Behavioral Health Partnership ValueOptions Report *(Please refer to the above BHP report,*

pages 5-22 for utilization details). Highlights of the discussion included:

- Data trends show an improvement in pediatric service access, in particular intermediate levels of care in the community and reduction of inpatient days and delay days in institutional care. The creative and diligent work of the hospital performance incentive group organized by CT Hospital Association, with hospitals, BHP and ValueOptions staff participation has led to significant improvements in reducing inpatient stays, freeing up beds for the increasing number of pediatric admissions. The hospital *readmission rates* have actually gone down, representing thoughtful discharge planning by all participants.

- There has been a dramatic decrease in DCF children's average inpatient length of stay *(pg 9).* While Riverview admissions fluctuate, there has been a decrease in DCF client percent of inpatient days delayed (about 22% compared to ~50% in the 1st two quarters of 2008). ValueOptions does case reviews for Riverview patients.

- Residential Treatment Centers (RTC) average length of stay (ALOS) days has begun to decrease by ~30 days/Q. RTC, DCF and VO staff review RTC client status weekly. RTC discharge delay reasons "awaiting placement' show that over 50% are waiting for Group Homes. Of the Psychiatric Residential Treatment Facilities (PRTF) discharge delay reasons, more than 50% are waiting for RTC placement. Value Options stated that the children in PRTFs are highly complex and securing appropriate placements that meet their clinical needs is a challenge. Dr. Larcen requested data on group homes utilization. ValueOptions noted that this level of care under DCF is "slot driven" with a fixed capacity.

- Home based service pediatric admissions are increasing as had the days/1000 members from 800 in 1Q07 to 1200/1000 members in 1Q09.

- Council raised concerns about maintaining and improving service access in CTBHP that included:
  - The effect of workforce strain and financial sustainability on pediatric home based services access. Important to track wait lists by geographic area.
  - The effect of the state budget deficit and budget changes on the State's ability to continue improvements in access to appropriate levels of services in the program that have been identified in quarterly utilization data to date.
- Slight increase in adult inpatient psychiatric and detox admissions that may be related to increasing numbers of parent/caregivers enrollment in HUSKY. The ALOS remains within the established parameters in the adult 'by-pass" program that allows precertification for 5 days, bypassing an initial concurrent review.

Council Subcommittee Reports (*click on monthly summaries below*)

Coordination Care SC 5-27-09.doc

BHP OC Provider Advisory 5-26-09.doc

Coordination Care SC 5-27-09.doc