Behavioral Health Partnership Oversight Council

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Meeting Summary: Jan. 13, 2010

Next meeting: ***Wednesday March 11, 2010***

Attendees: *Jeffrey Walter (Co-Chair), Mark Schaefer (DSS), Karen Andersson (DCF), Lori Szczygiel, laurie Vander Heide & Dr. Steven Kant (CTBHP/ValueOptions), Thomas Deasy (Comptroller's Office), Paul DiLeo (DMHAS), Candida (Dee) Bonnick, Rose Marie Burton, Elizabeth Collins, Terri DiPietro, Jesse White-Frese`, Davis Gammon, M.D., Heather Gates, Hal Gibber, Lorna Grivois, Nora Hanna, M.D., Thomas King, Mickey Kramer (OCA), Stephen Larcen, Jocelyn Mackey (SDE), James McCreath, Patricia Marsden-Kish, Judith Meyers, Randi Mezzi, Sherry Perlstein, Galo Rodriquez, Maureen Smith,Beresford Wilson, (M. McCourt, legislative staff).*

BHP OC Administration:
Motion made by Stephen Larcen, seconded by James McCreath to accept the December meeting summary as submitted was accepted by the Council voting members.

Subcommittee Reports

Coordination of Care: Sharon Langer & Maureen Smith, Co-Chairs: SC will meet Jan. 27th.

DCF Advisory: Heather Gates &K. Carrier, Co-Chairs: no report for Jan.

Operations: Stephen Larcen & Lorna Grivois, Co-chairs


BHP OC Operations SC 12-11-09.doc

Provider Advisory: Susan Walkama & Hal Gibber, Co-Chairs: Next meeting is Jan. 20th @ 1:30 PM at VO: re-review child inpatient level of care that was re-distributed.

Quality Management, Access & Safety: Chair – Davis Gammon, MD, Vice-Chairs: Robert Franks & Melody Nelson


Quality SC 12-18-09.doc

The Quality & Operations Subcommittees will host a joint meeting 1-15-10 at VO from 1-3:30 for a demonstration of future web-based system migration changes.

Mr. Walter thanked the Subcommittees for their work, encouraged Council members to participate in a Subcommittee and requested all members contact the SC chairs for issues pertinent to their area and have representation to the SC meeting that will address issues of interest.

CTBHP Reports *(click icon below to view presentation)*

BHPOC Presentation 01-13-10 DRAFT.ppt

- ***HUSKY Jan. 1, 2010 enrollment*** (*Slides 4-5)* was reviewed. DSS discussed the Superior Court decision that directs DSS to re-enroll State Medical Assistance to Non-Citizens (SMANC) non-pregnant and non-nursing facility *adults* that had been dis-enrolled Dec. 1, 2010. The loss of about 4800 adults, of which 4500 are HUSKY parents, is reflected in the enrollment numbers.

- ***Citizenship documentation***: HUSKY B eligibles now must provide documents (rather than self-attestation) of US citizenship as required in the Children's Health Insurance Program Reauthorization Act (CHIPRA). This congressional legislation allows states to use the federal Social Security number match to identify citizenship status. HUSKY B eligibles will be enrolled with a 90 day reasonable opportunity period to complete documentation if needed. DSS will be applying this to HUSKY A eligibles by mid-February. Currently HUSKY A members that have not documented citizenship (prior to the SS# match) are not enrolled until such documentation is presented to DSS.

- ***DSS: CTBHP expenditures*** (*slides 7-10)* were reviewed for SFY 06-09 and SFY 10 to date. (*CTBHP began Jan. 1, 2006 –period of claims run out from the previous MCO system and a phase in of authorizations; Feb. 2008 claims system changed: significant increase in enrollment 2009).* There is concern about the trend in increased expenditures however quarterly spikes (*2Q09*) may represent claims processing and payment artifacts.
    - Per Member Per Month (PMPM) costs by quarter (*Slide 9)* adjust for enrollment changes. DSS noted new enrollees seem to have less risk compared to the general lower income population prior to the steady enrollment increases. Using PMPM expenditures, the expenditure trends are less striking with ~$3 PMPM increase.
    - Expenditures by service type (i.e. inpatient, hospital/free-standing clinic outpatient, etc.- *slide 10)* were discussed.
        - Inpatient expenditures variability over the quarters related to new 'Interchange' system, suspension of claims timely filing to 365 days Medicaid FFS; adjust by PMPM costs, expect to see less variability in costs.
        - Hospital outpatient cost is stable compared to free-standing "outpatient". Enhanced Care clinics, begun 10/07 have shown an increase from $8-9M in 2007 to $10-12M in the subsequent time periods. A future analysis of cost adjusted for enrollment changes can answer the question of cost increases relationship to increased volume. DSS noted home based services cost increases far outpace enrollment changes after system change from grant-based services with less flexibility to services paid on fee-for-service basis. DSS said there is need to assess appropriateness of rise in expenditures, noting that under the grant

system these services were capped and limited geographically; under FFS system there is flexibility to meet the demand.

Council comments/questions included the following:

- Does the State take into account Federal Medicaid match (FMAP) now available for IICAPS (an intensive home-based service) under FFS? DSS said that some federal match had been available under TANF Block grant, however new revenue is not part of this.
- Several comments noted the growth in community-based services and reduced reliance on institutional services represents the to-date success of the CTBHP and a positive change for families. It is important to have a detailed look at utilization and expenditures for all levels of care.
- DCF was asked if residential savings can be identified given the decrease in CT Residential Treatment Centers (RTC) bed utilization. DCF commented that while there has been a reduction in bed use, often the costs for RTC complex clients and additional expense of therapeutic group homes offset the RTC costs.
- The agencies will continue to assess cost trends and identify steps that address cost efficiencies and effectiveness. Mr. Walter asked and DSS agreed that more detailed reports would be available that will provide insight into program costs/cost offsets. Mr. Walter stressed the importance of assessing client connection to services and outcomes measures.

➢ ***Other Updates***
- ***Medicaid Care Management Program (CMP)*** plan was reviewed: RFQ was released to the 3 existing HUSKY/Charter Oak Health Plan MCOs for response to non-risk management model for medical care for approximately 25,000 – 30,000 Medicaid eligible single adults in the Medicaid FFS Aged, Blind & Disabled (ABD) program. A Section 1932 Medicaid State Plan Amendment (SPA) is being developed. Behavioral health services will be managed separately by DSS/DMHAS. Mr. DiLeo (DHMAS) said DSS and DMHAS are working on a memorandum of understanding (MOU) for this population. Timeframe: Implement medical component July 1, 2010. DMHAS noted the BH service management may take 8 – 11 months.
- ***State Administered General Assistance (SAGA) 1115 waiver:*** if federal health care reform is implemented, a SAGA waiver is unnecessary, if provisions allow enrollment of SAGA enrollees. The waiver can be built from the Medicaid MCP plan. Behavioral health services for SAGA BHP and for Medicaid dual eligibles can be done under a Medicaid SPA.
- ***Medical necessity definition change:*** Alicia Woodsby, Co-Chair of the advisory committee reported there will be a public forum on the proposed change in early Feb. and the committee plans to draft recommendations in February.

➢ ***CTBHP/ValueOptions Pharmacy Report*** *(In above report see the remaining slides for details).* HUSKY member (child/adult) BH pharmacy data is a VO performance measure. This report is the first of 6 that assess (child and adult) quality efficiency, cost and variability in subpopulation pharmacy use. One of the reports will profile individual prescriber patterns with a comparison to statewide prescribing patterns. The DCF Psychotropic Medication Advisory Council (PMAC) reviews the VO pharmacy reports and makes recommendations for next steps. The first study was done over **5 months** in 2008 (Feb. – June 2008). Result highlights included (*see presentation):*

- 38, 870 child/adult consumers received BH meds during the 5 months and the total BH prescriptions was 207,558 with an associated 5 month cost of $22.9M. Medication costs for child/youth represent 62% of the total cost ($14.2M) while adult consumer costs represent 38% of the total costs ($8.7M).
- Average cost of BH meds for non-DCF children is $554, total 5 month cost of $9.7M compared to average DCF child cost of $1,338, total cost is $4.5M.
- DCF children tend to receive a preponderance of atypical antipsychotic drugs while non-DCF children's most frequently prescribed scripts are primarily stimulants and atypical antipsychotics.
- Adults : 42% of scripts are for antidepressants, followed by mood stabilizers (20%).

Council comments included:

- Dr. Kant (VO) commented that Seraquel prescribing patterns can be looked at (sleep alone vs. agitation, distorted perceptions).
- Judith Meyers referenced a similar 2000 CHDI study with different ages for "children" and that more than half the BH drugs were prescribed by the primary care provider. Dr. Kant noted there are adults in the 18-24 year old group. CHDI also looked at poly pharmacy and hope this will be described in future reports. The last sets of the pharmacy reports will describe prescribing profiles that can be broken out by age/medication, quality, risk management, rationale for script and safe prescribing.
- Maureen Smith asked if a relationship between the PCP prescriber and psychiatrist can be identifies.
- Mr. Wilson asked how this report impacts families and expressed particular concern about the Juvenile Justice population.
- Dr. Gammon noted that BH drug costs consume ~ 30% of the budget: important to look at psychosocial interventions as well as medication costs.
- Dr. Andersson (DCF) said Dr. Janet Williams (DCF) monitors DCF involved children's poly pharmacy and is working with the DCF Medical Director on on-site child evaluation. Dr. Williams will present their findings from this work to the BHP OC.
- Comments on including psychotropic medications in the DSS preferred drug list required prior authorization.. Dr. Schaefer state the intent is to proceed cautiously in making changes, if changes are made at all in the PA process. Alicia Woodsby welcomed an opportunity to discuss specific research studies that identify problems associated with PA of BH meds and access issues.
- Jeff Walter observed that service carve-outs in the HUSKY program such as pharmacy and BH services from the medical part of the system create challenges and opportunities to maintain and improve integration of services that leads to quality, cost effective care.