Behavioral Health Partnership Oversight Council

Legislative Office Building Room 3000, Hartford CT 06106
(860) 240-0321 Info Line (860) 240-8329 FAX (860) 240-5306
www.cga.ct.gov/ph/BHPOC

Co-Chairs
Sen. Jonathan Harris Jeffrey Walter

Meeting Summary: *August 11, 2010*

Next meeting: Sept. 8, 2010

Attendees: Sen. Jonathan Harris & Jeffrey Walter (Co-Chairs), Paul Piccone (DSS), Karen Andersson (DCF), Lori Szczygiel, Wally Farrell & Ray Richette (CTBHP/ValueOptions), Paul DiLeo (DMHAS), Thomas Deasy (Comptroller's Office), Dr. Steven Zuckerman (DDS), Uma Bhan, Rose Marie Burton & Dr. Steven Girelli, Rick Calvert, Elizabeth Collins, Howard Drescher (adult rep), George Eason (adult rep), Ronald Fleming (adult SA), Heather Gates, Hal Gibber, Thomas King, Mickey Kramer, Sharon Langer, Stephen Larcen, Patricia Marsden Kisch, James McCreath, Judith Meyers, Randi Mezzi, Kimberly Nystrom, Sherry Perlstein, Kelly Phenix (adult rep), Maureen Smith, Susan Walkama, Jesse White Frese', Alicia Woodsby, (M. McCourt, legislative staff).

BHP OC Administration

- *Introduction of new members*: Dr. Steven Zuckerman (Dept. Developmental Services – DDS), Dr. Steven Girelli (replace Rose Marie Burton, appointed by Sen. Harp), Howard Dresher (adult rep.), Kell Phenix (adults), Ron Fleming (substance abuse rep.), George Eason (adult advocate), Kim Nystrom (Home Care rep.) and Catherine Foley Geib, Judicial Branch appointee.
- The Council Chairs extended best wishes to Rose Marie Burton on her retirement thanking her for her active participation in the Council since 2006. Ms. Burton introduced Dr. Steven Girelli who will be taking her place both at Klingberg and on the Council.
- The BHP OC information materials have been updated to reflect appointment changes and the CTBHP/VO acronyms list was distributed at the orientation meeting prior to the Council meeting. The latter will be expanded upon with member's suggestions.
- *June meeting summary*: Maureen Smith made the motion to accept the June meeting summary, seconded by Thomas Deasy; summary accepted by voting members.
- Randi Mezzy (Legal Aid) offered provider assistance in completing General Assistance and Social Security Disability evaluations. Ms Mezzy presented an overview of the questions, key points to remember and stated she is available to answer provider questions and/or provide basic training at the office site. (*Click icons below for contact # and information).*


DSS W-300a.pdf

Subcommittee Reports *(Click icon below each Committee to view most recent meeting summary)*
Coordination of Care: Sharon Langer & Maureen Smith, Co-Chairs


Coordination Care SC 7-28-10.doc

Committee meeting highlights include a DCF presentation on the new policy for involuntary administration of pediatric psychotropic medications, ValueOptions up-coming Sept. report on psychotropic meds for young children, redefined categories for co-management and ED high utilizers. Re-instatement of HUSKY B Plus medical program was reviewed.

DCF Advisory: Sherry Perlstein & K. Carrier, Co-Chairs


DCF Advisory Comm. 7-10.doc

Focus of the July meeting was on purpose of the Committee, bridging interests of families, providers and DCF. DCF & VO reported on the Foster Care studies: in Sept. DCF and CHDI will review the Outpatient mental Health report. In the future work groups related to this will report on their recommendations to the Committee.

DMHAS Advisory: Heather Gates & Alicia Woodsby


DMHAS Advisory Comm. 7-10.doc

Focus of the July meeting of this new Committee was on the Committee's focus that includes updates on the DSS/DMHAS Administrative Service Organization (ASO) procurement for the Medicaid, non CTBHP population.

Operations: Stephen Larcen & Lorna Grivois, Co-chairs


BHP OC Operations SC 6-18-10.doc

Dr. Larcen reported that there have been Committee meetings related to 1) the General Assistance (GA) conversion to Medicaid – information can be found on the Dept of Mental Health & Addiction Services (DMHAS) website: www.ct.gov/dmhas/gaconversion and 2) CTBHP - the July meeting focused on CTBHP program with a presentation from the BHP Rapid Response Team (contact-http://www.ctbhp.com/RAPID_RESPONSE_TEAM_CONTACTS.pdf) and ValueOptions (VO) Intensive Case Management staff that work with pediatric psychiatric hospitals to reduce delayed discharges to the next level of care.

Provider Advisory: Susan Walkama & Hal Gibber
Susan Walkama reported that the Committee again reviewed the intermediate level of care guideline revisions that addressed consistency of the guidelines and policy; questions were raised at this meeting that require further consideration by CTBHP before the revisions will be presented to the Council for

action.

BHP OC Provider Advisory 7-21-10.doc

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

Quality SC 7-10.doc

The Quality Committee reviewed the VO 2009 consumer/provider satisfaction survey results (*see summary). A* work group of this Committee will make recommendations to the Council regarding a previous suggestion that the 2009 VO ASO report be provided to the CT General Assembly as representative of the CTBHP program evaluation.
Adult *Quality Management, Access & Safety: Chair: Elizabeth Collins* Committee plans to meet 1/11.

Agency reports

BHOC presentation 08-11-10 FINAL.ppt

Department of Mental Health & Addiction Services (DMHAS) *(not in above doc)*
Paul DeLio discussed the process and time frame for the Medicaid fee-for-service (FFS) mental health Administrative Service Organization (ASO) selection and implementation:

- Answers to ~ 140 questions generated by the Request For Proposal (RFP) have been posted on the DMHAS website.
- 6 letters of intent were submitted in response to the RFP
- Final proposals are due to the State on 9-10-10.
- The RFP evaluation team includes 2 members from the Council (Maureen Smith and Sharon Langer) and the two state agencies; the team will convene their first meeting 9/13/10.
- The Agencies expect to announce the ASO selection by 10/11/10, have a contract completed between the two agencies and the successful bidder by 11/1/10 with ASO implementation for the Medicaid population on 1/1/11.

Department of Children & Families (DCF): Dr. Karen Andersson
(*Sides 1-6)* Dr. Andersson (DCF) reviewed the DCF "***One-to-One Care"*** program authorization now placed within the ValueOptions system and service guidelines/goals of protocol changes that provide an opportunity to standardize protocols similar to a level of care guideline.

- The changes target program quality, access and cost efficiency improvement (line item reduction of ~$1M for this service) through ensuring this type of service is available to the appropriate client defined in the protocols.
- Congregate care providers includes sites such as Residential Treatment Centers (RTC), group homes, emergency shelters, safe homes.
- Utilization data: 300 children were served in the last year at the cost of $2M. The protocol changes allow DCF to focus on the small subset of clients that use the majority of resources.

Dr. Zuckerman (DDS) noted it is important to look at these patterns, for example in DDS 40% of their adult clients represent > than 50% of allocated resources.

- While this program does not specifically target ED visit reductions, DCF can track program use and ED visits over time.
- Sherry Perlstein noted this will be an agenda item for the October DCF Committee; since the protocol changes are effective Aug. 16th, it will be useful for the Committee to identify the number of children in an inappropriate level of care where the One-to-One program is being used.
- Shelters may use the program more than the Star Shelters that do one-to-one with their staff.
- Dr. Larcen (Natchaug hospital) applauded the One-to-One program that keeps children in group homes rather than hospitals with this 1-1 care. He stated it is unfortunate this DCF program cannot be applied to pediatric psychiatric hospitals since the intense costly supervision of these children creates a disincentive for a hospital to accept them. Mr. McCreath said it also creates a problem for the discharge facility to accept the child/youth when 1-1 is still needed, often resulting in hospital discharge delays (inpatient days beyond 'medically necessary" days).

Department of Social Services (DSS): Paul Piccone

- *(slide 9)* The State Administered General Assistance (SAGA) population transition and Charter Oak conversion (*slide 14)* to the Medicaid fee-for-service ***expansion program for low income adults (LIA)*** is part of the Health Care Reform bill. SAGA clients are being enrolled in Medicaid through their regional DSS offices based on eligibility requirements (citizenship and income documentation). The 2000 Charter Oak adult eligibles have not yet been transitioned into Medicaid.
  - Under the Medicaid LIA expansion, SAGA clients will receive less management of their BH service compared to the SAGA/ABH program until the new ASO is in place in 1/11.
  - *(slides 8-12)* The SAGA transition requires a provider 'recoupment' process in order to receive federal match for medical and behavioral health service claims dated April 1, 2010 going forward.
    - Some medical providers in SAGA were not enrolled in the Medicaid program; *Hewlet Packard (HP)* is enrolling these out-of-network providers into Medicaid to allow for Medicaid reimbursement for their services.
    - Certain services covered under DMHAS but not Medicaid such as RTC substance abuse care and support services will continue to be reimbursed by DMHAS.
    - Some BH providers under SAGA are now in the process of including Medicaid rules in their systems.

- *(Slides 15-16)* DSS will assess their ability to track utilization changes associated with **increased HUSKY B cost share** changes in the 2010 legislation.
  - Sharon Langer said this is important to look at on the medical services side as well.
  - In response to a provider's question, the BH service rates will be adjusted down minus copays.
  - Mr. Eason expressed concern regarding the burden on the family for the increased HUSKY B costs even with the annual federal limit on out-of-pocket expenditures. The added cost share may force a family to decide their resource allocation for food/meds/services. Randi Mezzi said out-of-pocket expenditures can be deducted from income for the nutritional program (SNAP)

eligibility determination.

- *(slides 17-19)* ***CTBHP Rates and Performance Incentive***

In 2008 the Council approved rate adjustments proposed by DSS for CTBHP that included a 1% across the board provider increase and additional dollars appropriated for provider performance incentives. While the agency was creating a process through the Medicaid management Information system (MMIS) claims system to identify CTBHP claims in the Medicaid system, providers received estimated rate advances in SFY 09 and SFY 10 (*addendum: Dr. Schaefer confirmed the advances were released by June 30, 2010. DSS hopes to have information in Sept on the claims/budget allotments and if any adjustments are required).* The CTBHP utilization reports to date have been based on prior authorization, not actual service claims..

ValueOptions: Hospital Profiling System

Lori Szczygiel, Wally Farrell and Ray Richette presented the internet-based real time dashboard data set on hospital utilization (Provider Analysis Reporting –PARS). Each hospital's utilization by patient age, DCF/non-DCF involvement and region will be available on the CTBHP website: www.ctbhp.com CTBHP and VO have worked with hospitals to identify inpatient access issues and then created a hospital performance-based incentive targeting child/adolescent psychiatric inpatient care says. Dashboard hospital inpatient data is updated daily; the hospital performance incentive data will be run on a different schedule.

The reports show variation and length of stay (LOS) by hospital over time. The data dashboard, supported by a VO biostatician, allows hospitals/CTBHP to query the data to discern possible explanations for the variations within and across facilities and regions.

- The definition of "DCF" children is those children DCF-involved, not just DCF committed.
- VO provided an example of how the data can be used. The average of discharge delay days (DD days) was 38.7 days in 2007 and now ~18 days on average. Recently there is a slight increase in average DD days; the data can be used to identify the reasons for this.
- Hospital specific data example: Yale New Haven Hospital's DD days are driven by 13-18 year old non-DCF children. The hospital and CTBHP can identify the causes and potential solutions to decrease these days.
- The data provides an opportunity for hospitals to share ideas on best practices to reduce DD days.
- Statistical analysis of the PARS data can generate predictors of factors that impact length of stay for pediatric inpatient utilization, which can be applied to future initatives.

Council members commended VO on this data dashboard initiative, expressing appreciation of how the data analysis can improve CTBHP service delivery as well as provide an opportunity for provider feedback.