Connecticut
Behavioral Health Partnership Oversight Council

Legislative Office Building Room 3000, Hartford CT 0610
(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: Sept. 8, 2010

Next meeting: **Oct. 13, 2010** at ***1:30 PM in LOB Rm 1E***

Attendees: Jeffrey Walter (Co-Chair), Dr. Mark Schaefer (DSS), Dr. Karen Andersson (DCF), Lori Szczygiel (CTBHP/ValueOptions), Paul DiLeo (DMHAS), Thomas Deasy (Comptroller's Office), Catherine Foley-Geib (Judicial), Mickey Kramer (Office Child Advocate), Uba Bhan, Dee Bonnick, Elizabeth Collins, Howard Drescher, George Eason, Dr. Ronald Fleming, Davis Gammon, MD, Heather Gates, Davis Gammon, MD, Charles Herrick, MD, Thomas King, Sharon Langer, Dr. Stephen Larcen, Patricia Marsden-Kish, James McCreath, Judith Meyers, Kimberly Nystrom, Sherry Perlstein, Kelly Phenix, Galo Rodriquez, Maureen Smith, Susan Walkama, Alicia Woodsby, (M. McCourt, legislative staff).

BHP OC Administration: A motion by Dr. Gammon, seconded by Sharon Langer to accept the August Council summary without change was approved by Council voice vote.

Subcommittee Reports

Coordination of Care: Sharon Langer & Maureen Smith, *Co-Chairs* ***Next meeting 9-22-10***

DCF Advisory: Sherry Perlstein & K. Carrier, *Co-Chairs*
At the Sept. 7th Committee meeting CHDI reviewed their report on *children in mental health Out Patient services*, which has the highest volume of services among the various levels of care. The analysis of OP services identified the challenges of multiple mandates within limited resources. A Learning Collaborative has been organized around data, parent engagement in treatment and how to best balance reporting requirements. Reports from the Collaborative will be presented to the Committee. The full report can be found at: http://chdi.org/publications.php

DMHAS Advisory: Heather Gates & Alicia Woodsby, *Co-Chairs: No Aug. meeting; next* ***9-23-10.***

Operations: Stephen Larcen & Lorna Grivois, *Co-Chairs;* ***Next meetings: Oct.1 - CT BHP, Oct. 22, GA Conversion***

Provider Advisory: Susan Walkama & Hal Gibber, *Co-Chairs:* No Aug. meeting; meeting will be scheduled when the new level of care guideline & procedural clarification on intermediate LOC are done.

Child/Adolescent *Quality Management, Access & Safety: Chair – Davis Gammon, MD, Vice-Chairs: Robert Franks & Melody Nelson:* ***Next meeting 9-17-10.***

Adult *Quality Management, Access & Safety: Elizabeth Collins & Howard Drescher (to meet 1/1/11)*

Agency Reports*(Click icon below, R click, select 'presentation', then 'edit' to see slide number)*

BHOC Presentation Final 09-08-10.ppt

Dept. of Mental Health & Addiction Services (DMHAS)

(Slides 1-4) Paul DeLio (DMHAS) reviewed the SAGA transition to Medicaid Fee-for-Service (FFS):

- ✓ Effective Apr. 1, 2010 SAGA members were transitioned to Medicaid (Low Income Adults - LIA) as part of the Affordable Care Act Medicaid expansion provision. Clients will have access to the Medicaid benefit package that is broader than that under the state funded SAGA program. DSS informed the population about the change/benefits prior to the transition. Dr. Schaefer (DSS) reviewed what the change mean to this population that includes:
    - Clients will no longer use their CHNCT card, rather the Medicaid grey Connect card
    - Clients will have access to Non-emergency medical transportation (NEMT) and home health services that was not part of the SAGA benefits.
    - DMHAS will continue to provide MH non-Medicaid covered services through the ASO ABH.
    - Provider service reimbursement is retroactive to April 1, 2010 as is reimbursement to SAGA members for out-of-pocket expenses.
    - DSS is working with non–Medicaid SAGA providers to enroll in CTMAP for member continuity of care and assist members to obtain a new primary care provider as needed.
    - HP (formerly EDS) provides customer service to these clients in program transition.
    - The transition of band 1 Charter Oak Medicaid eligible members is more complex and will be phased in.

- ✓ DSS/DMHAS issued a Request for Proposal (RFP) to procure an Administrative Service Organization (ASO) for the clinical management of the Medicaid FFS coverage groups and Charter Oak program. The agencies received 6-7 letters of intent to respond; proposals are due 9-10-10 and the agencies expect to begin contract negotiations with the successful bidder by Nov. 1 with implementation of the ASO early January 2011.

Council comments included:

- Family representative were concerned about confusion among Medicaid FFS and SAGA clients in this transition. DSS stated the HP center is assisting SAGA members; there have been no changes in the existing FFS program. DSS is concerned about intermittently enrolled SAGA members that do not receive notices (i.e. transient homelessness). Dr. Schafer encouraged advocates, providers to refer transitioning SAGA members to the HP customer services: **1-866- 409-8430** or in the Farmington area: **1-860-269-2031.**

- The State Plan Amendment on allowable BH group size for therapeutic groups *(slide 4)* will be sent to providers. Providers can discuss other questions about Medicaid reimbursement for group services with DSS/DMHAS.

Dept. of Social Services

✓ (*Slides 5-7)* Enrollment: HUSKY A enrollment growth has been ~30,462 from 9/09 to 8/10 while HUSKY B (children only) has seen a reduction in growth since Dec. 09. DSS is working on FFS enrollment reports – Medicaid dual eligible (Medicaid/Medicare) vs. non-dual eligible. *Council questions included:*

- Why is HUSKY B enrollment declining – are increased cost shares creating a disincentive? DSS suggested the economic downturn may make more families HUSKY A eligible. While outreach opportunities are limited by financing, recent policy changes proposed by CTVoices will enhance enrollment; presumptive eligibility for HUSKY B children and a possible 'express lane' process for HUSKY A/B.
- Programs and service expenditures are increasing; is this related to the economy? DSS noted Medicaid programs target different populations that reflect the economy. For example HUSKY A and SAGA (now LIA in Medicaid) changes are sensitive to economic downturns while enrollment based on disability related eligibility is flat.

✓ *(Slide 9)* SFY 09 Rate Adjustment update: the SFY 09 rate package has been updated with SFY 09 date of service utilization. DSS stated there was a slight increase ($2.4M) above the approved amount that may necessitate a modest adjustment to the hospital floor rate to address the added expenditure. The rate package will not be finalized until the EMPS retroactive rate increase is completed.

- Dr. Larcen suggested some percentage of the additional expenditure might be based on enrollment increase.
- Sharon Langer stressed the importance of including a footnote about enrollment increase in CTBHP utilization/expenditure reports and program annual reports.

✓ *(Slides 10-15)* While HUSKY B expenditures have had a slight change, there has been a steady increase in HUSKY A CTBHP expenditures since 2007 despite a reduction in pediatric inpatient days. The PMPM date of payment (DOP) by quarter (*Slide 14)* methodology controls for enrollment changes. In addition the new CTBHP indicator on claims will show services/service volume and unduplicated client data. The October claims-based report will include PMPM date of service (DOS).

Dept. Of Children & Families (DCF)

✓ *(Slides 16-22)* Dr. Andersson (DCF) reviewed DCF expenditures through June 30, 2010. Community based service expenditures have been fairly flat but the congregate care - Residential Treatment Center (RTC) and Group homes - expenditures for 2010 are projected to be $130M.

- The number of children in congregate care has decreased but increased expenditures are due to reliance on out-of-state (OOS) RTC services for specialized treatment programs not available in CT.

- DCF has released a RFA for specialized RTC in CT that if successful can move some OOS clients back to CT. . ValueOptions and DCF have tracked the RTC length of stay (LOS) trends for OOS services; there is longer LOS in the OOS facilities but DCF noted that some facilities in the South charge lower per diem rates than CT.
- Therapeutic group homes are at capacity.
- Group home ALOS varies by type of home, ranging from 9 months to 2 years. Based on national data a reasonable LOS goal range can be 6-18 months. CTBHP/VO administration (ASO) responsibilities now include RTC/group homes.

Council members commented there has been a remarkable shift in the system of care has led to a reduction in reliance of institutional care, a major goal of the CTBHP. This success needs to be articulated to stakeholders.

✓ *(Slides 23-33)* A grant-funded ***Foster Care Pilot Project*** broad goal was the connection of behavioral health services with child welfare system. The project was designed to address higher foster care disruption rate of children with a history of behavioral health treatment prior to this first time foster placement. Specific program goals were to prevent foster care disruption by working with the families to maintain continuity of health care and immediately assess DCF client BH needs and beneficial family supports. The pilot results showed a lower disruption rate in the target intervention group than baseline data. While there was no defined relationship between the intervention (BH/support services) and disruption, the foster family/client interaction of offering support may have contributed to the reduction of disruptions for these DCF children. DCF offices would keep the child in their school (CGA legislation), place the child n foster care near their home and maintain medical/BH service provider continuity.

Council comments included:

- Commended DCF/VO for undertaking this important project that attempts to preserve the foster parent/child relationship; DCF was encouraged to pursue this project. DCF would like to continue this program within available resources and gather more data on intervention outcomes.
- Family representatives said removal of a child from their home is traumatic. Trauma interventions and foster care support would generally be needed.
- While some programs/initiatives discussed at the Council may not be a formal part of the CTBHP program, there often is a link to this program and as such members find it helpful to receive information on these initiatives.