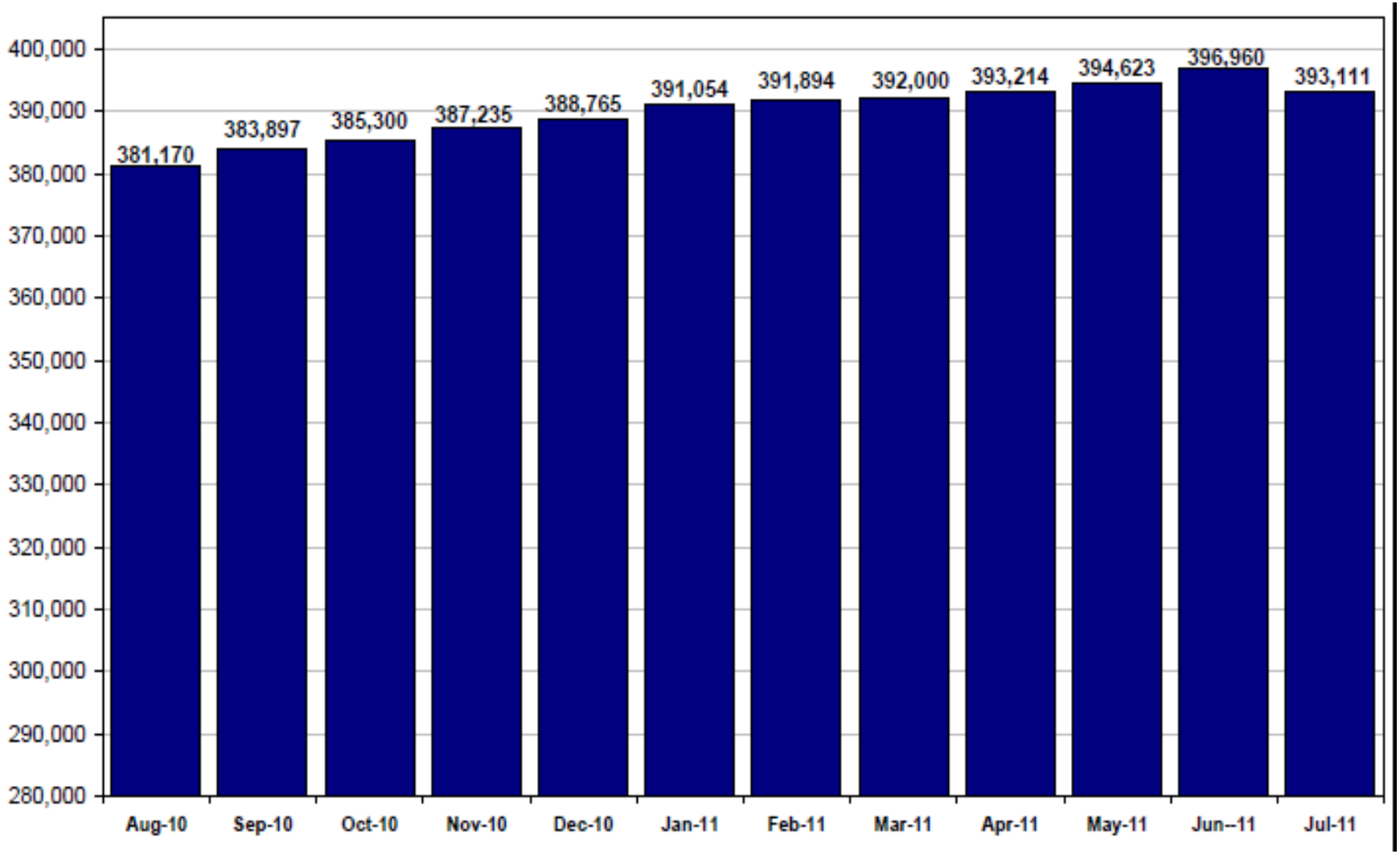
Connecticut BHP
Supporting Health and Recovery

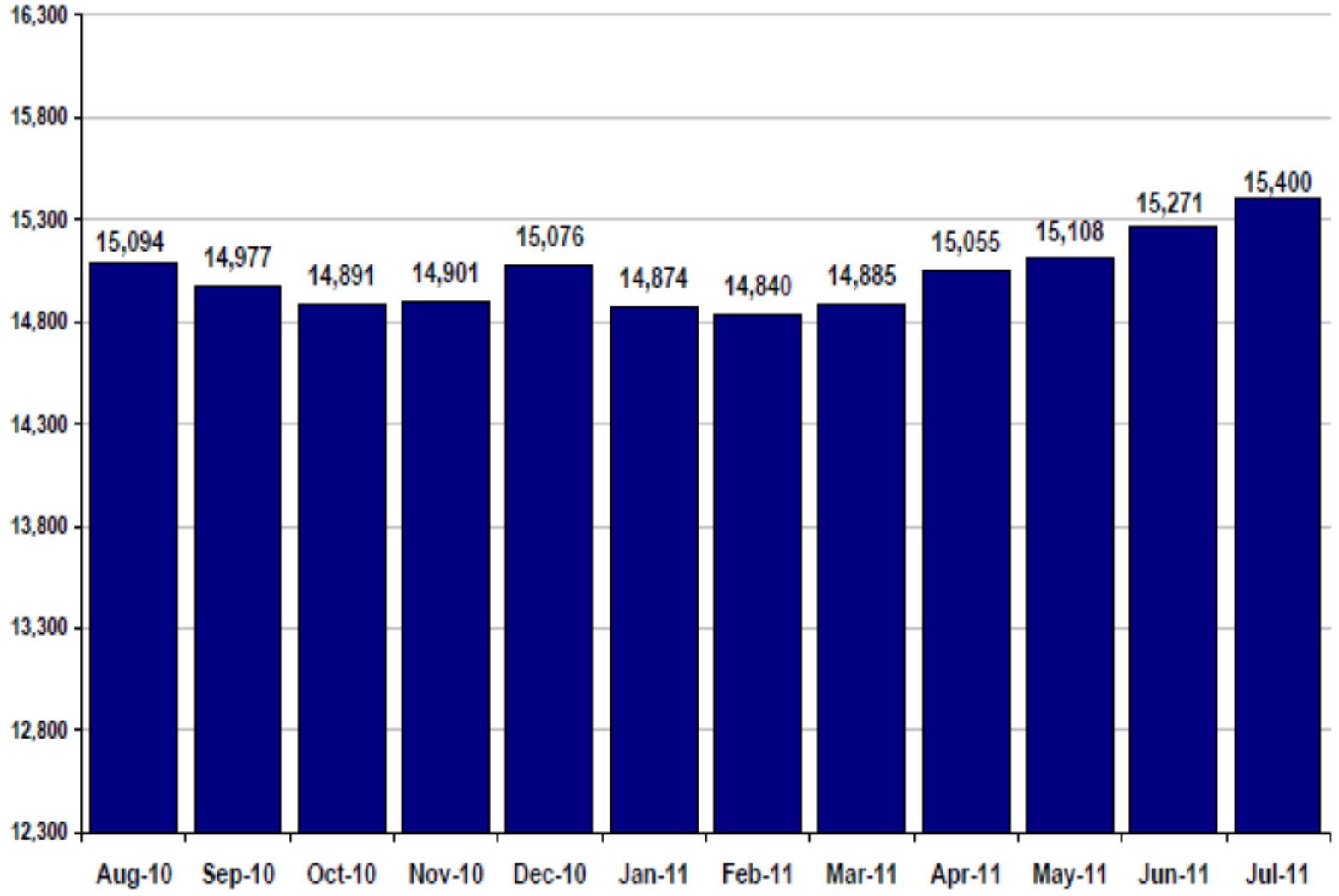
BHP Oversight Council
State Agency Report

July 13, 2011

HUSKY A Enrollment Growth - All



HUSKY B Enrollment Growth - All



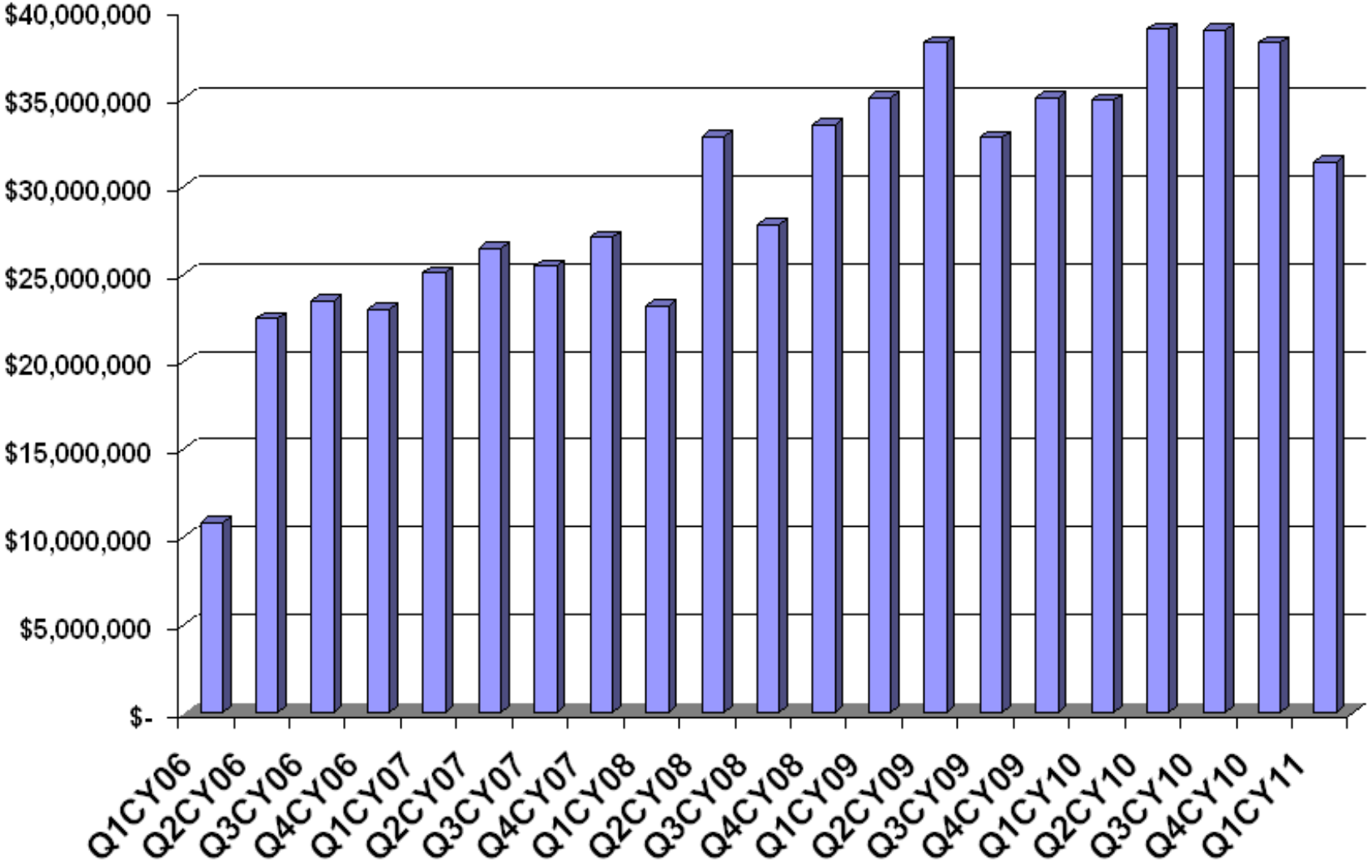
Expenditures

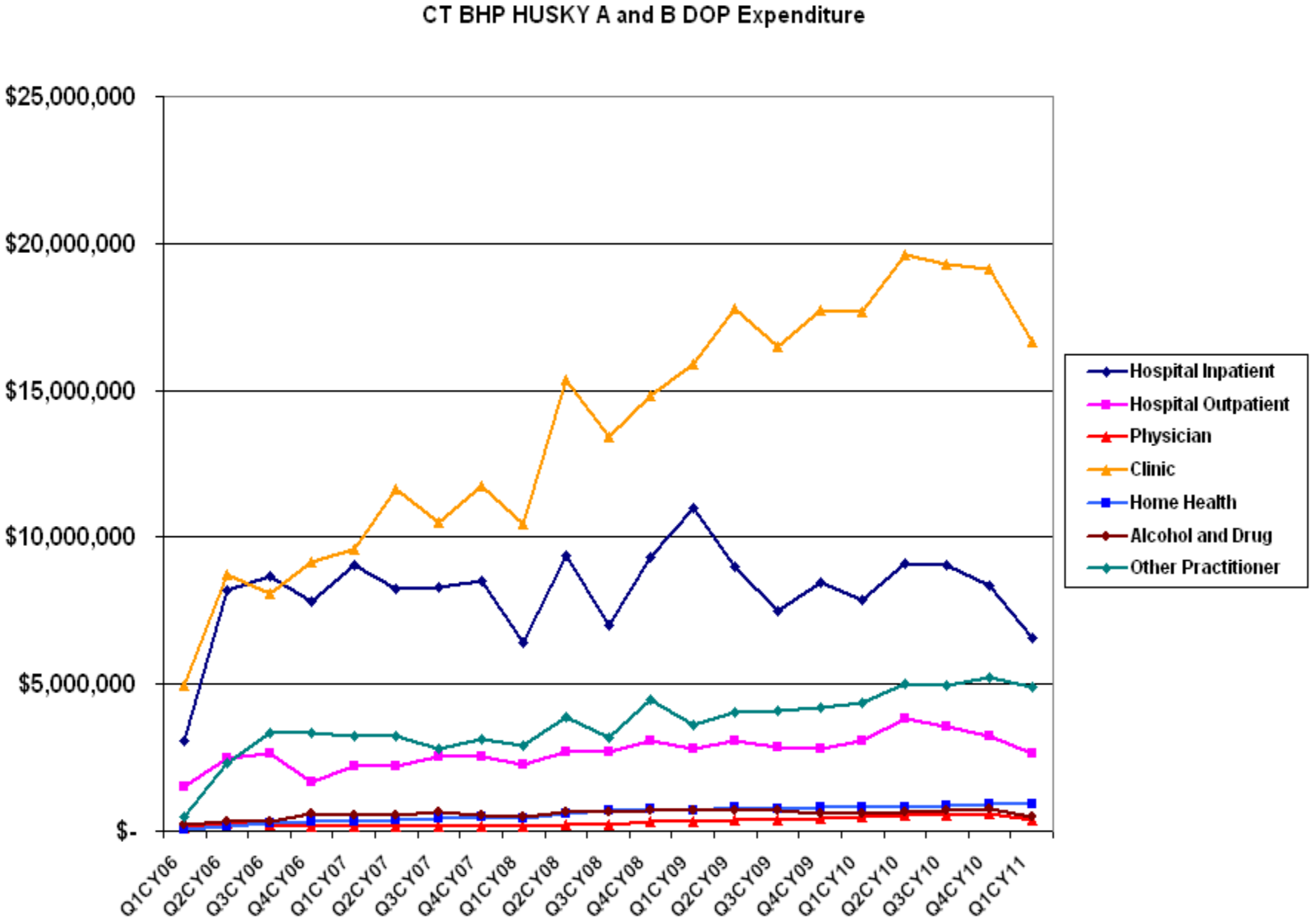
Annual CT BHP DOP Expenditures by State Fiscal Year

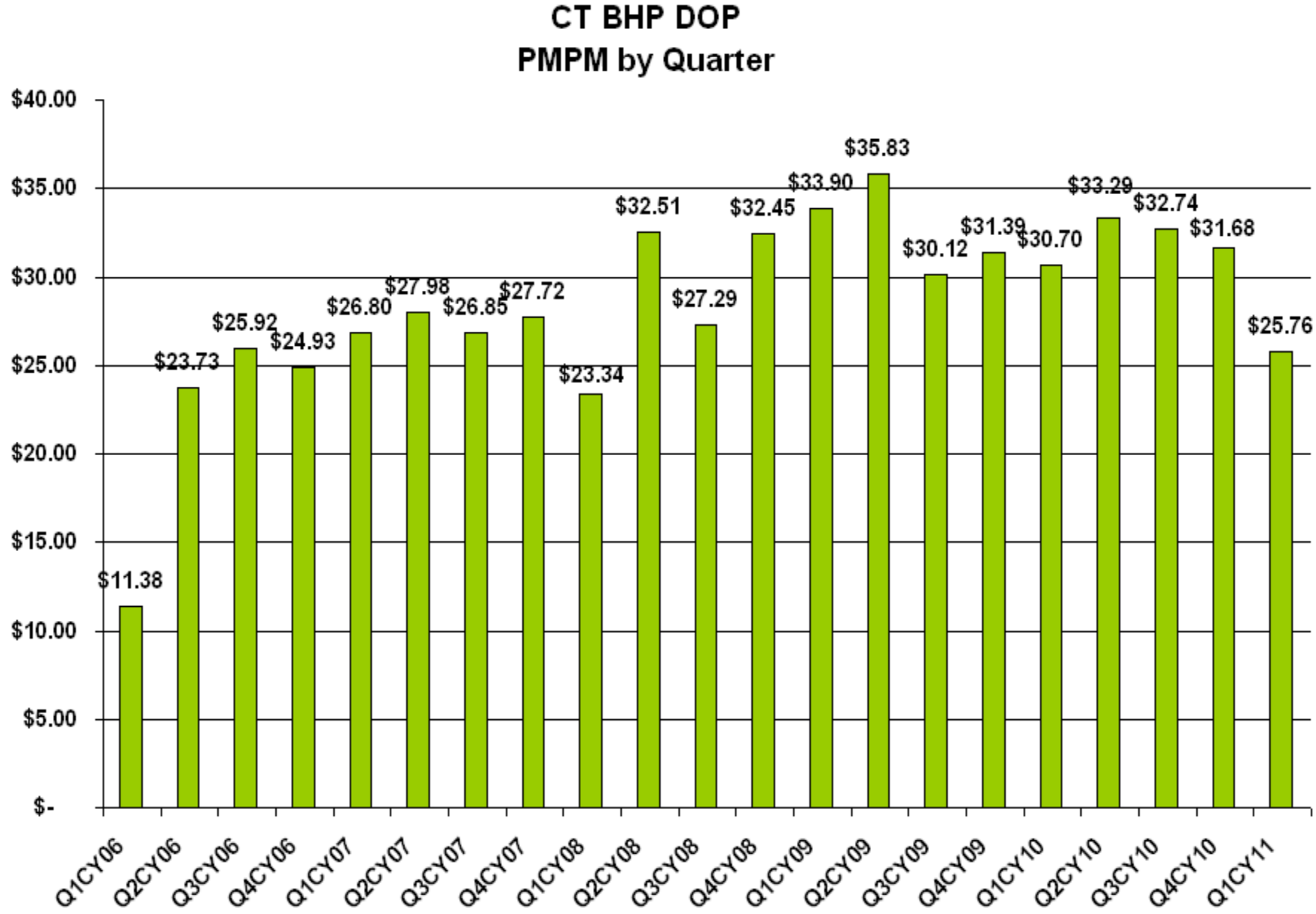
	SFY06	SFY07	SFY08	SFY09	SFY10	SFY11 to Date
HUSKY A	$32,560,572	$94,563,848	$104,931,636	$130,578,440	$137,393,654	$ 105,409,846
HUSKY B	$723,599	$3,389,493	$3,604,812	$3,989,433	$4,321,668	$ 3,150,294

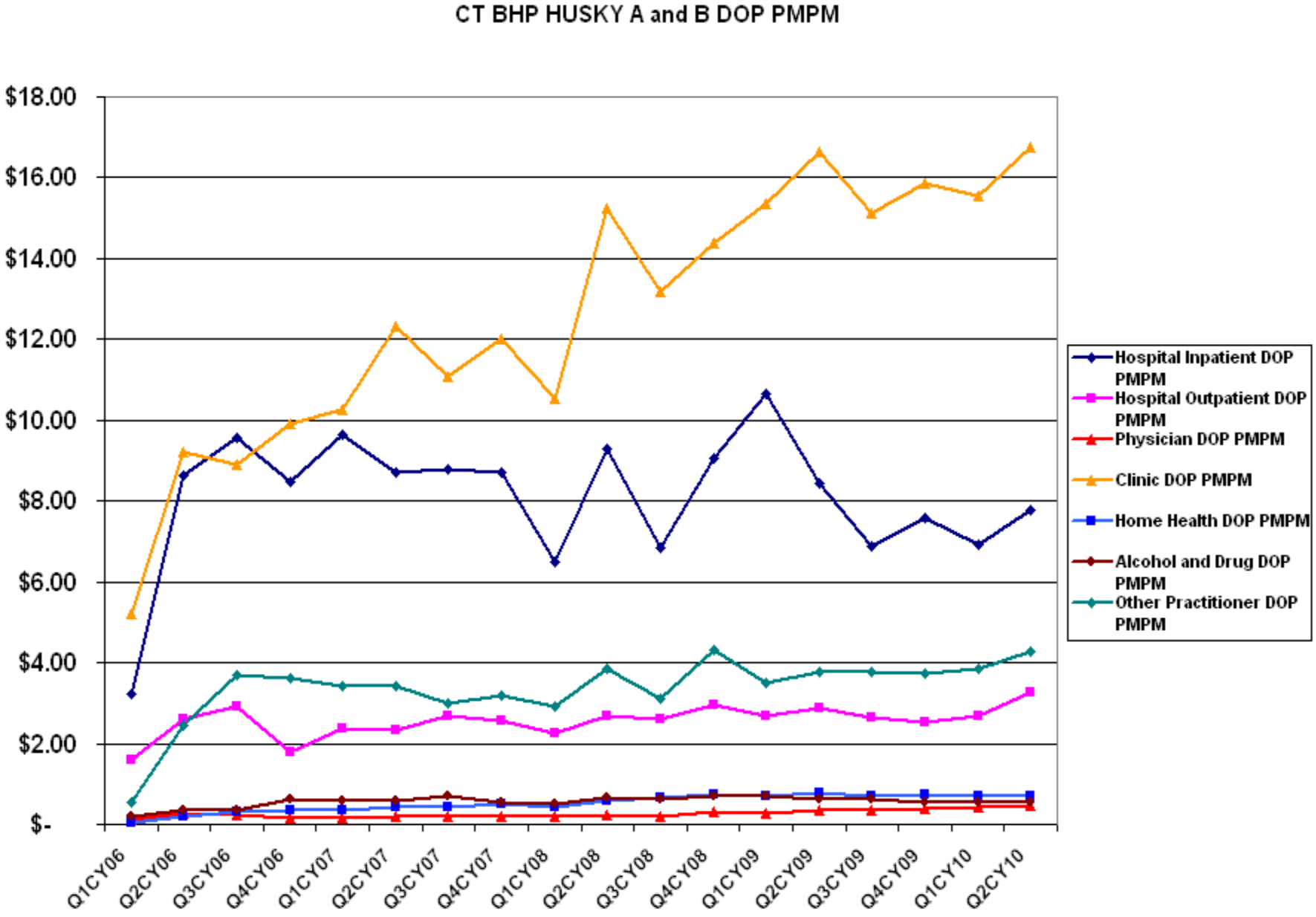
Note: Does not include State Ops

CT BHP HUSKY DOP Expenditures by Quarter




CT BHP HUSKY A and B DOP Expenditure
$25,000,000
$20,000,000
$15,000,000
$10,000,000
$5,000,000
$-
Q1CY06
Q2CY06
Q3CY06
Q4CY06
Q1CY07
Q2CY07
Q3CY07
Q4CY07
Q1CY08
Q2CY08
Q3CY08
Q4CY08
Q1CY09
Q2CY09
Q3CY09
Q4CY09
Q1CY10
Q2CY10
Q3CY10
Q4CY10
Q1CY11
Hospital Inpatient
Hospital Outpatient
Physician
Clinic
Home Health
Alcohol and Drug
Other Practitioner


CT BHP DOP
PMPM by Quarter
$40.00
$35.00
$30.00
$25.00
$20.00
$15.00
$10.00
$5.00
$-
$11.38
$23.73
$25.92
$24.93
$26.80
$27.98
$26.85
$27.72
$23.34
$32.51
$27.29
$32.45
$33.90
$35.83
$30.12
$31.39
$30.70
$33.29
$32.74
$31.68
$25.76
Q1CY06
Q2CY06
Q3CY06
Q4CY06
Q1CY07
Q2CY07
Q3CY07
Q4CY07
Q1CY08
Q2CY08
Q3CY08
Q4CY08
Q1CY09
Q2CY09
Q3CY09
Q4CY09
Q1CY10
Q2CY10
Q3CY10
Q4CY10
Q1CY11

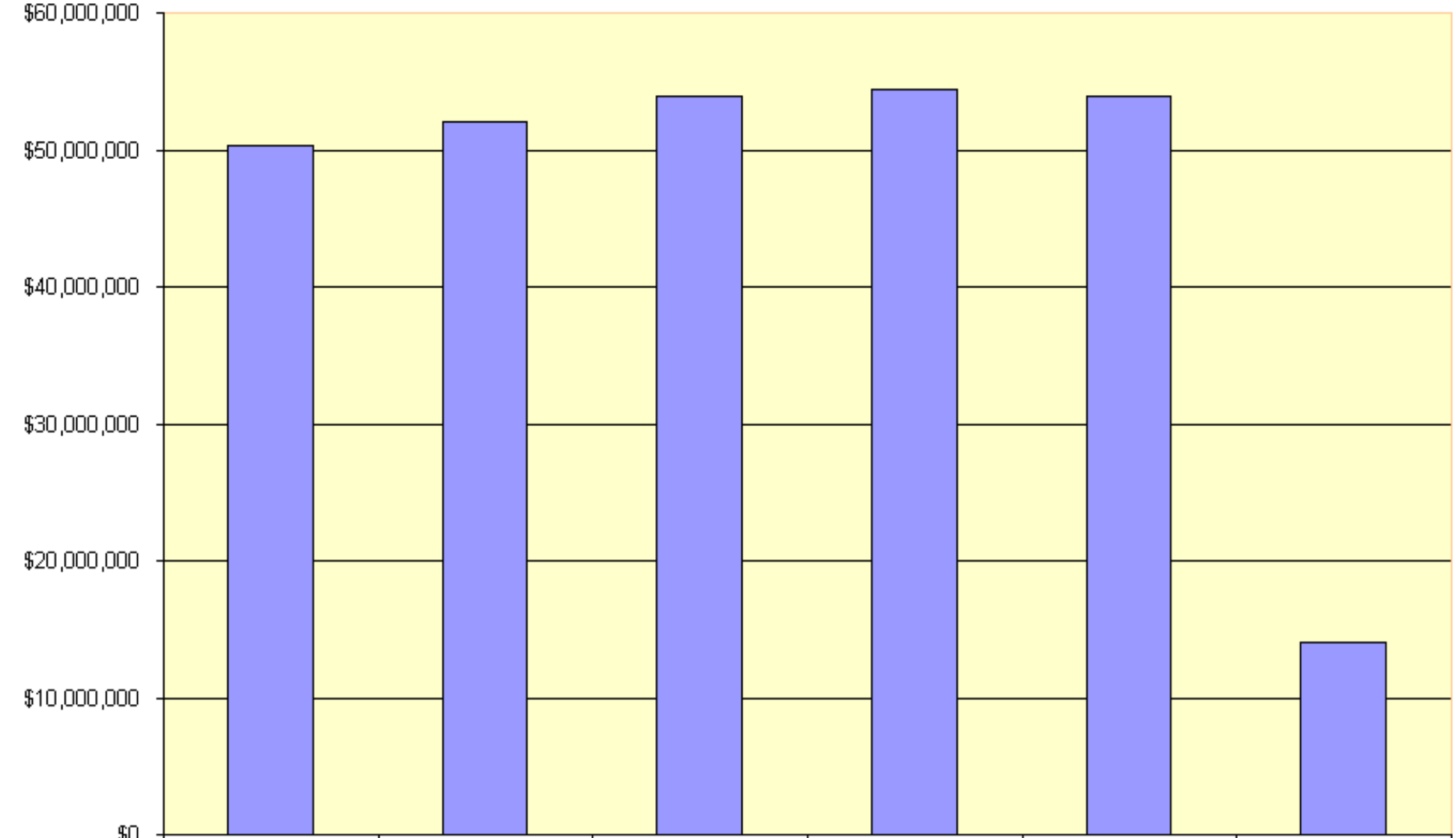

CT BHP HUSKY A and B DOP PMPM
$18.00
$16.00
$14.00
$12.00
$10.00
$8.00
$6.00
$4.00
$2.00
$-
Q1CY06
Q2CY06
Q3CY06
Q4CY06
Q1CY07
Q2CY07
Q3CY07
Q4CY07
Q1CY08
Q2CY08
Q3CY08
Q4CY08
Q1CY09
Q2CY09
Q3CY09
Q4CY09
Q1CY10
Q2CY10
Hospital Inpatient DOP PMPM
Hospital Outpatient DOP PMPM
Physician DOP PMPM
Clinic DOP PMPM
Home Health DOP PMPM
Alcohol and Drug DOP PMPM
Other Practitioner DOP PMPM

DCF Expenditures

Community-Based Services

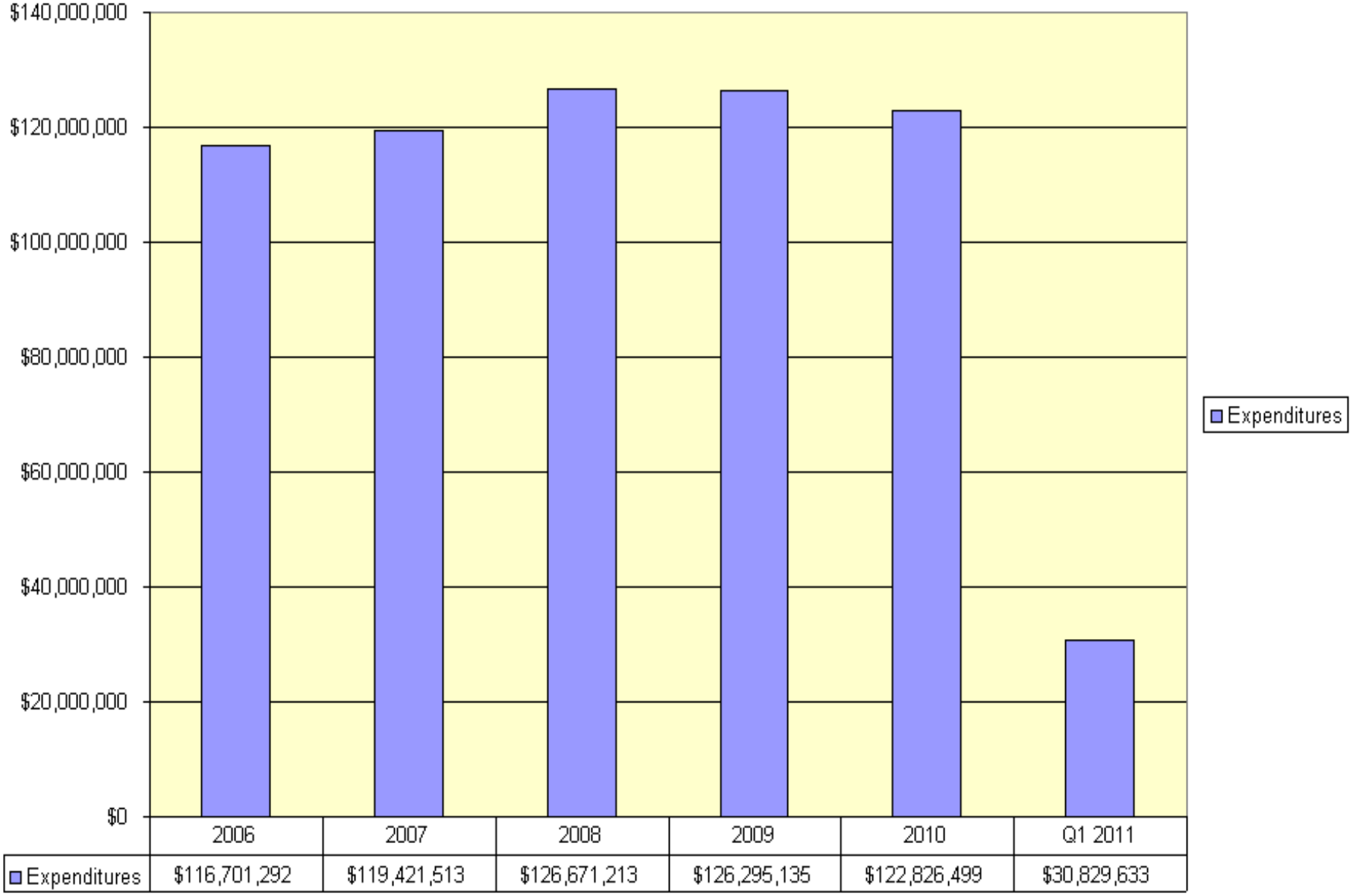
- Crisis Stabilization
- Care Coordination
- Emergency Mobile Psychiatric Services
- Extended Day Treatment
- Home-Based Services
- Child Guidance Clinics
- Outpatient Adolescent Substance Abuse

DCF Annual Expenditures for Community-Based Services thru 3-31-11

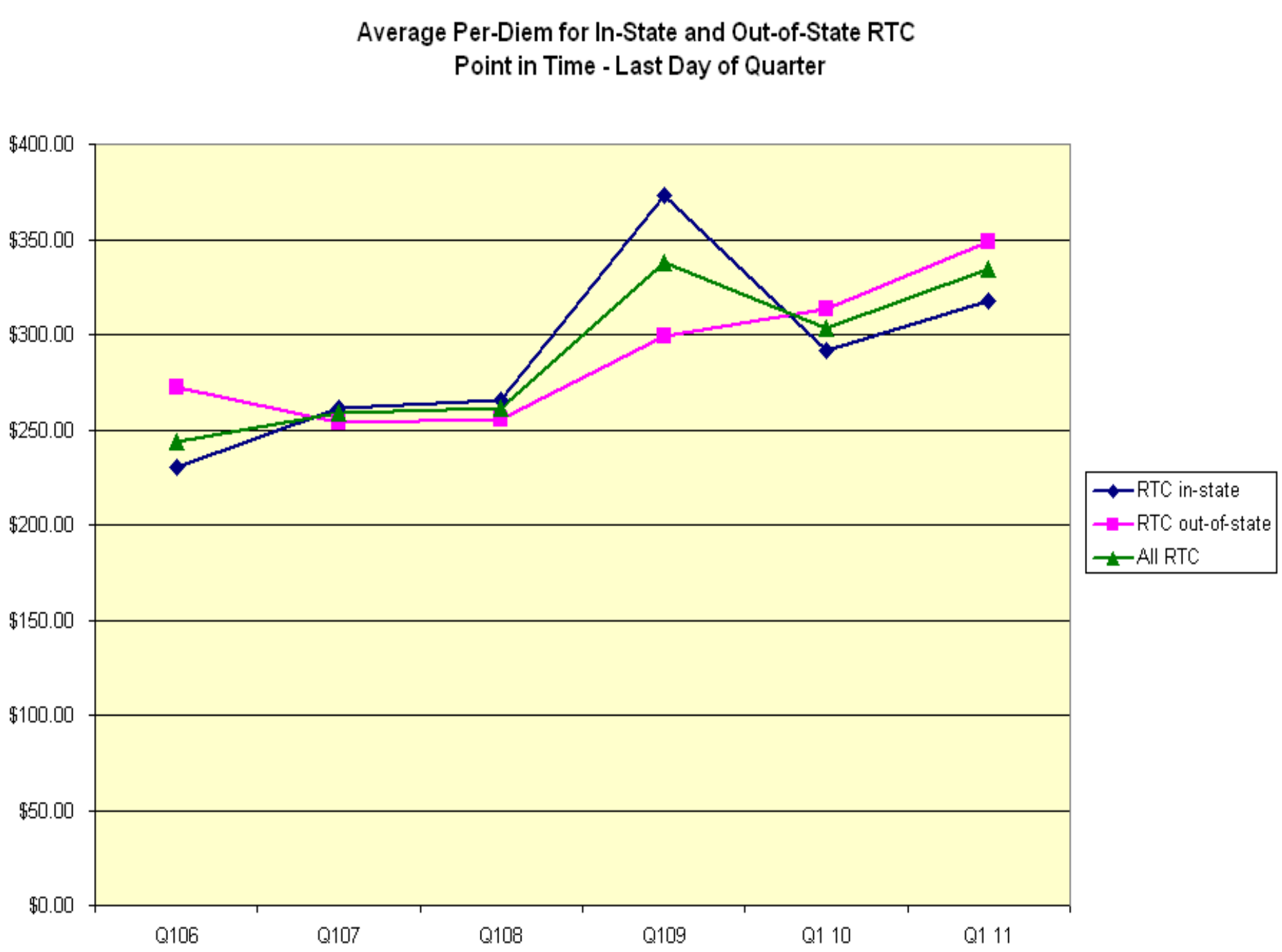


	2006	2007	2008	2009	2010	Q1 2011
Expenditures	$50,279,233	$52,000,841	$53,860,218	$54,459,986	$53,900,526	$13,989,299

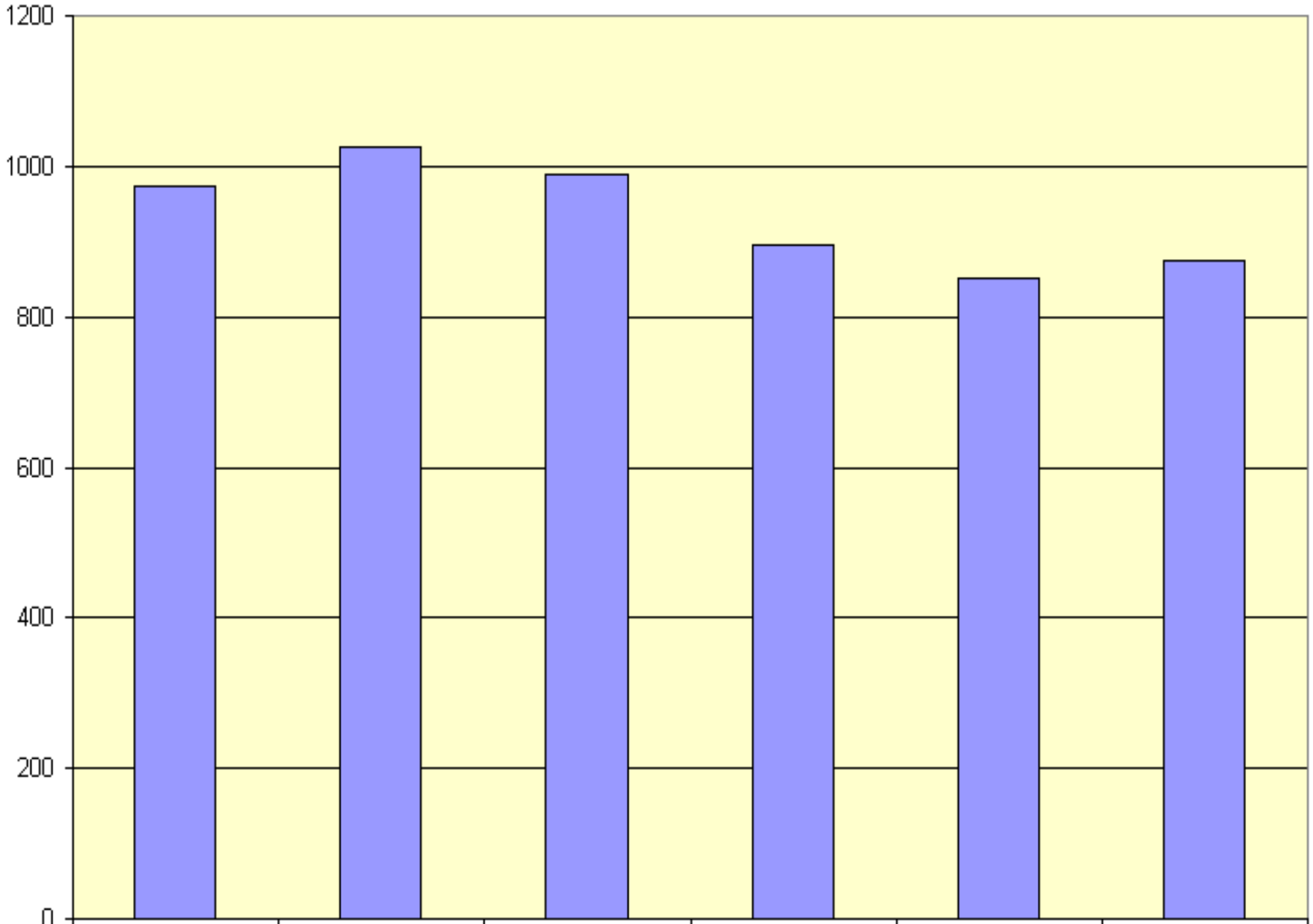
Combined Annual Expenditures - Residential and Therapeutic Group Home



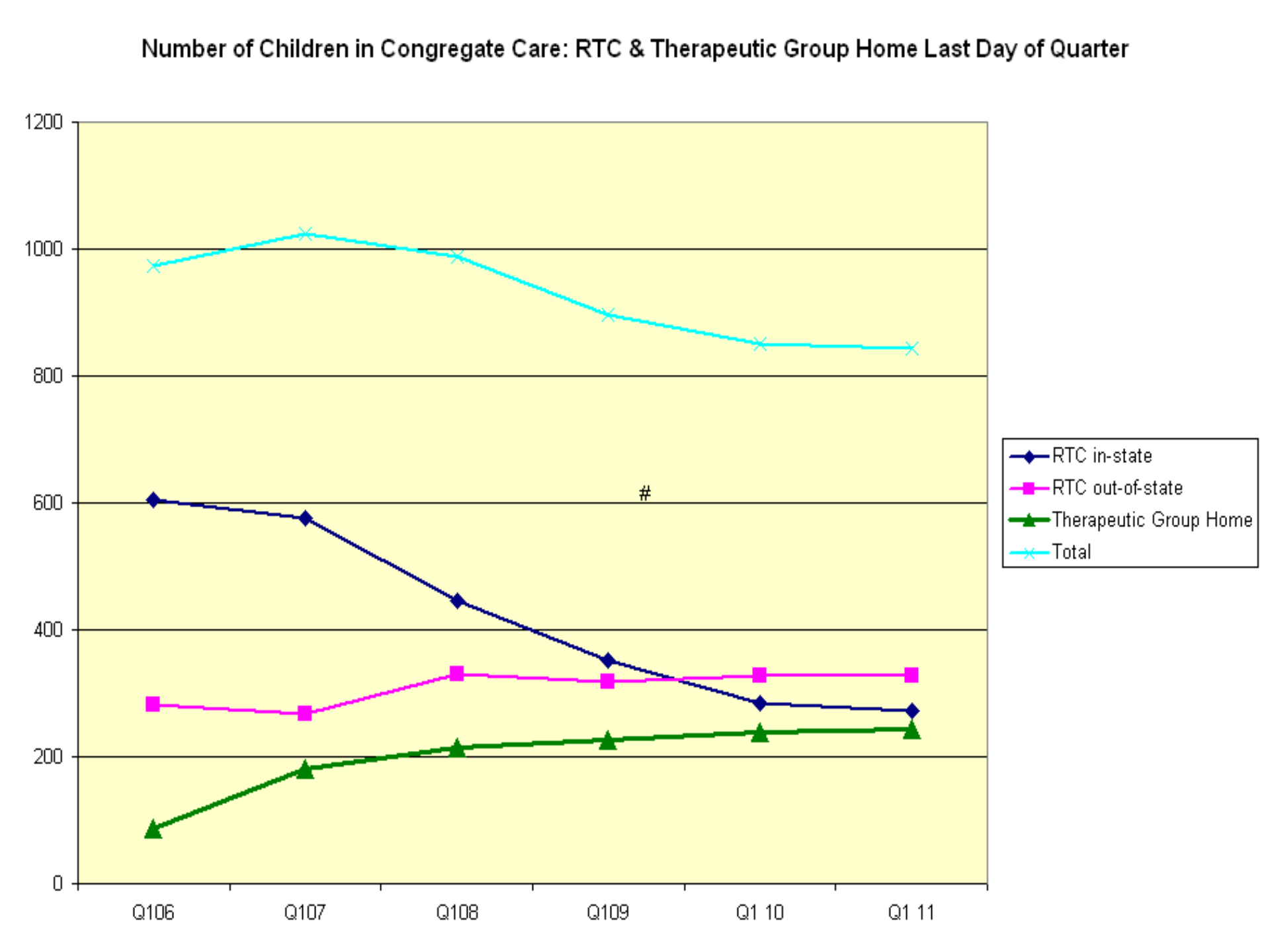
	2006	2007	2008	2009	2010	Q1 2011
Expenditures	$116,701,292	$119,421,513	$126,671,213	$126,295,135	$122,826,499	$30,829,633


Average Per-Diem for In-State and Out-of-State RTC
Point in Time - Last Day of Quarter
$400.00
$350.00
$300.00
$250.00
$200.00
$150.00
$100.00
$50.00
$0.00
Q106
Q107
Q108
Q109
Q1 10
Q1 11
RTC in-state
RTC out-of-state
All RTC

Number of Children in Residential and Therapeutic Group Home Placement as of last day of Q1 during Calendar Year



	Q1 2006	Q1 2007	Q1 2008	Q1 2009	Q1 2010	Q1 2011
# of children last day of qtr.	973	1025	988	896	850	875


Number of Children in Congregate Care: RTC & Therapeutic Group Home Last Day of Quarter
1200
1000
800
600
400
200
0
Q106
Q107
Q108
Q109
Q1 10
Q1 11
#
RTC in-state
RTC out-of-state
Therapeutic Group Home
Total

Coordination of Physical and Behavioral Health Care

Coordination of Care

- In the original adult ASO specific expectations were stated relative to the improved coordination of physical and behavioral health care for FFS and other Medicaid, high risk individuals
- State expected coordination with MCO's, DSS, dental services, and transportation
- Expectation remained that ICM services would be available and would prioritize high risk individuals

Coordination of Care, cont'd

- In the ValueOptions response we proposed the core elements listed previously, as well as a Wellness Care Coordination program which includes:
  - Pilot program for 300 most at risk
  - Health risk assessment/profile for members
  - Identification and stratification of high-risk members for ICM and disease management

Wellness Care Coordination Program Overview and Goals

Medicaid Members Experience

Many challenges…

- 45% of ABD beneficiaries have three or more chronic conditions [1]
- 49% have at least one psychiatric illness [1]
- Often harder to find, engage, and activate
- Often require a different and more intensive intervention set
- Provider engagement is challenging but necessary
- Best served by multi-disciplinary staff located in their community

[1] Kronick, Bella, & Gilmer, 2009

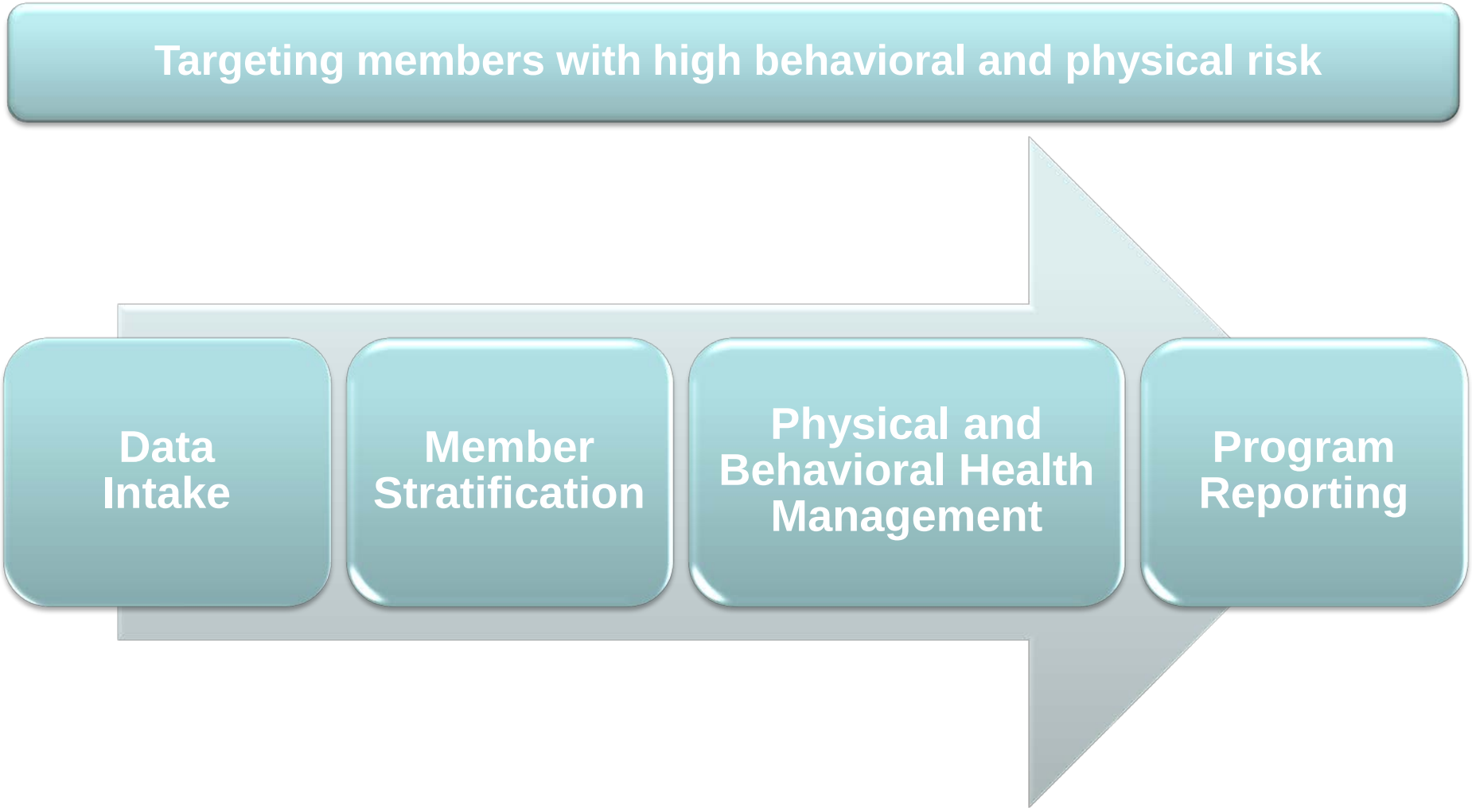
McKesson Health Solutions

Medicaid experience and results – a natural Partner

- $745 million in third-party validated savings across 12 states
- More than 20 years care management experience; 8 years working directly with high-cost, high-risk Medicaid populations including ABDs
- McKesson has never been terminated from a state contract
- Consistently > 90% member satisfaction
- 100% on-time implementations
- NCQA and URAC accredited

An Integrated Care Model

Meeting behavioral and physical health needs



Detailed Outcomes Achieved
Medicaid experience and results

- Clinical Outcomes Achieved
  - 73% increase in annual flu vaccine among heart failure Enrollees
  - 51% increase in annual flu vaccine among COPD Enrollees
  - 86% increase in daily use of ASA or anti-platelet medication among diabetes Enrollees
- Utilization Improvements
  - 33% decrease in admissions for CAD
  - 25% decrease in admissions for COPD
  - 6% book of business reduction in IP admissions
- Net Savings/ROI
  - Texas program: Net Savings $45m after program fees after 5 years
  - Illinois program: Net Savings $303m after program fees after 3 years
  - Book of business ROI > 2.85:1

McKesson and ValueOptions
Partnership for a successful implementation

Comprehensive Implementation Process

- Subject matter experts identified from ValueOptions and McKesson
- Weekly team meetings and focused work-groups
  - Data
  - Identification and stratification
  - Communications
  - Reporting
  - Operations
  - Training
- Shared staff recruitment and interviewing

McKesson and ValueOptions
Partnership for a successful program

Seamless Wellness/Intensive Care Management Team

- Shared training
- Co-located within the ValueOptions facility
- ValueOptions and the McKesson Care Management applications
- Collaborative workflows integration
- BH and PH communication integration
- Creation of referral processes between ValueOptions and McKesson
- Case review meetings with ValueOptions management team (Grand Rounds process)

Program Communications

Engagement beyond the Wellness Care Coordinator

Member Approach

- Communicate at an appropriate literacy reading level with cultural sensitivity
- Describe benefits of the desired behavior
- Provide easy to follow materials to assist in behavior change
- Supplemental self-management educational materials

Provider Approach

- Provider post assessment letters with Practitioner Bill of Rights
- Clinical Alerts
  - Program nurses fax or call *Physician Alerts* to the physician's office if a patient experiences certain sentinel events

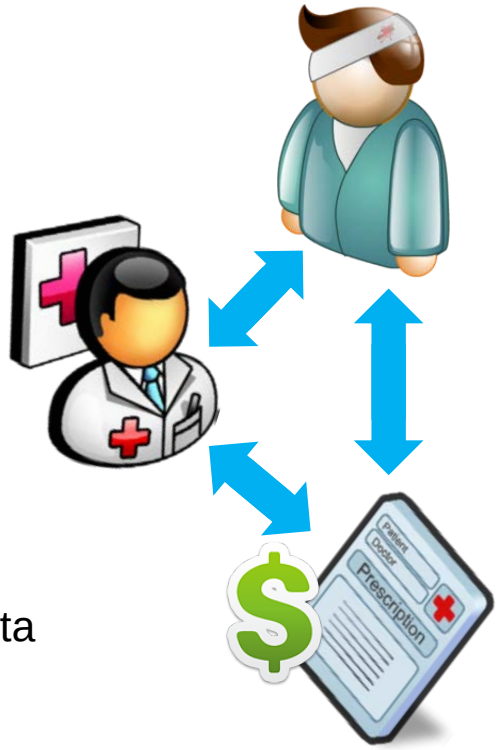
Care Coordination

Data Management

Data Management
Data Collection

Wellness Care Coordination program will utilize the following types of data for the services provided to members & providers:

- **Member Information**
  - Demographics & Contact information
  - Privacy Preferences (HIPAA, etc.)
- **Provider Information**
  - Demographics & Contact Information
  - Specialties, Provider Type Designations
  - Member – Provider Associations
- **Claims & Clinical Data**
  - Facility, Pharmaceutical and Professional Claims Data
  - Lab Results, Care Gaps, Health Metric Information
  - Member reported health information



Condition Identification and Stratification

Program Details
Wellness Care Coordination Program

Member Conditions and Stratification

- From claims, condition identification of:
  - 19 behavioral health / substance use conditions
  - 61 physical health conditions
  - Impact conditions:
    - Physical health conditions: Asthma, COPD, Diabetes, Heart Failure, CAD
    - Behavioral health conditions: Schizophrenia, Bipolar, Depression
  - Stratification of member risk (McKesson / ValueOptions)
    - Identification of gaps in care
      - Example: Diabetes but no A1C test (in claims) in last 12 months
      - Example: Schizophrenia but no follow-up appointment (in claims) after ED or IP admission for schizophrenia
    - Apply CDPS scoring

Program Details

Wellness Care Coordination Program Components

- CDPS
  - Diagnostic classification system developed specifically for Medicaid populations
  - Medicaid programs can use to make health-based capitated payments
  - One component of the stratification process
  - Classifies conditions into 19 major categories – including separate categories for mental health and substance abuse conditions (knowing the prevalence of these conditions is high in Medicaid)[1]
  - Provides separate scoring for adult TANF, adult disabled, child TANF, child disabled
- Each member with an individual risk score
  - Risk Levels: high (~5%), moderate (~20%), low (~75%)
  - Updated quarterly

[1] Original paper (Kronick et al., 2000) is available at: http://cdps.ucsd.edu/cdps_hcfr.pdf

Program Details

Health Management

- Telephonic co-management of 300 members
- Referrals from ValueOptions Intensive Care Managers
- Evidence-based clinical content
- Personalized, integrated care plan for each member
- Follow-up contacts with member to complete care plan goals
- Case coordination / collaboration between medical and BH care managers
- Member and provider communications after assessment
- Clinical alerts to provider(s) as clinically appropriate

Program Details

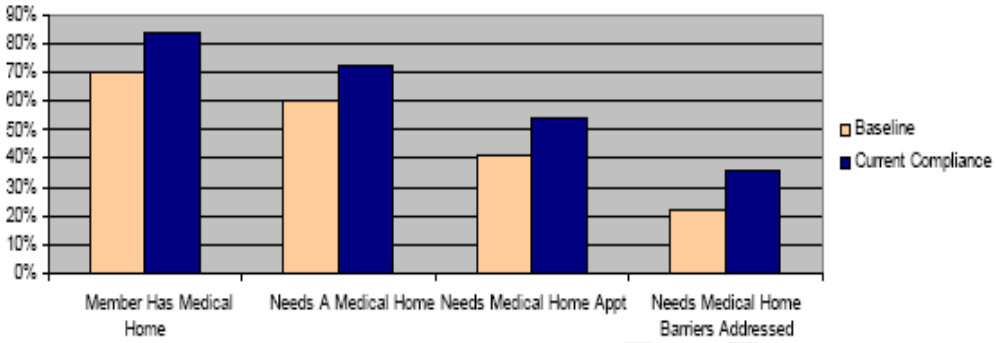
Health Management: Wellness Plan Activities

- Identification of:
  - Barriers / Basic needs
  - Availability / capability of caregiver support
  - Knowledge of condition(s) and self care
- Medical Home existence / proper use
- Medication regimen / adherence / barriers
- Self-management techniques / lifestyle adjustments
- Condition monitoring / preventative testing
- Care coordination and care transitions
  - Referrals to myriad of resources (local, regional or national)

Care Coordination Reporting

Program Reporting
Reporting Overview

- Integrated across program components providing holistic view of Member
- Flexible and comprehensive
- Reports available at client and additional levels
- Graphical representation with narrative text, trending and benchmark comparison data points
- Report Reference Guide
- Secure, web-based delivery
- Support for ad-hoc reporting needs

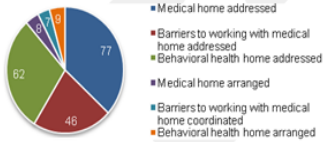


Barriers to Care

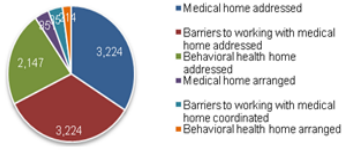
Barriers to Care include those basic resource and care coordination needs that must be addressed in order for the members of our programs to fully participate in self-management of their conditions. These barriers may include basic resources for food, housing and utilities, caregiver and support network needs, functional impairments, transportation for healthcare, and most importantly linking all members to a medical home. Data displayed within this view show interventions provided by our staff in an effort to reduce a member's barriers to care.

	Oct07-Dec07	Jan08-Mar08	Apr08-Jun08	Jul 08	Aug 08	Sept 08	Total	PTD
Barriers to Care								
Medical home addressed	125	211	422	99	48	77	982	3,224
Medical home arranged	20	42	22	5	4	8	101	351
Medical home appointment addressed	125	211	422	99	48	60	965	3,224
Medical home appointment arranged	12	24	2	5	6	8	57	320
Barriers to working with medical home addressed	125	211	422	99	48	46	951	3,224
Barriers to working with medical home coordinated	10	42	22	5	6	7	92	351
Behavioral health home addressed	322	244	233	70	75	62	1006	2,147
Behavioral health home arranged	32	24	23	7	5	9	100	214

Barriers to Care Issues Addressed - September



Barriers to Care Issues Addressed - PTD



Reporting Package
Report Summary

Comprehensive reporting package covering all aspects of the program from enrollment, engagement, clinical outcomes and detailed data extracts

Report	Description
Program Participation	Provide graphical reporting of program participation across the population of Identified Members; will incorporate key program measures.
Enrollment Activity	Provide an accounting of the population throughout the program enrollment and management process.
Program Interventions	Provide detail on all program activity/interventions delivered to the population during the reporting period; to include call, alerts, durable medical equipment, resource referrals and communications.
Clinical Outcomes	Provide self-reported clinical outcomes on key clinical and program indicators.
Member Program Data Set	Provide a member-level program data set including key program dates, member status, member demographic data and clinical information about the member.

Reporting Package
Clinical Outcomes

McKESSON
Empowering Healthcare

Clinical Outcomes

Population Baseline: January 1, 2011 - March 31, 2011
Current Compliance as of March 31, 2011

Bipolar Disorder

Clinical Measure	Initial N	Target	Baseline	Current Compliance	% Change
Guideline Recommended Tests					
Has Fasting Blood Glucose Test annually[19]	259	50% or 10% relative improvement	46%	55%	18%
Has Blood Kidney Function Test biannually[20]	260	N/A	22%	22%	2%
Has Thyroid Function Test Reported biannually	259	N/A	46%	55%	18%
Member is Prescribed Appropriate Condition-Related Medications					
Recommended Mood Stabilizer Prescribed[21]	260	50% or 10% relative improvement	22%	22%	2%

Depression

Clinical Measure	Initial N	Target	Baseline	Current Compliance	% Change
Guideline Recommended Tests					
PHQ9 score not in target range[22]	200	50% or relative improvement	46%	55%	18%
Member is Prescribed Appropriate Condition-Related Medications					
Has Antidepressant Prescribed[23]	200	50% or 10% relative improvement	49%	58%	17%
Has Psychotherapy Prescribed[1]	200	50% or 10% relative improvement	43%	44%	2%
Has Antidepressant and Psychotherapy Prescribed[24]	180	50% or relative improvement	58%	61%	5%

Connecticut BHP
Supporting Health and Recovery

Implementation and Operations Update

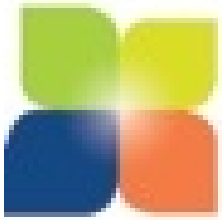
July 2011

IOP Authorization Parameters

- Providers previously received 10 units within 28 days on the initial and 1st concurrent registration
- As of July 5:
  - Providers will receive 10 units within a 14 day period on the initial registration
  - The “provider inquiry” function may be used to extend the time frame for unused units prior to the end of the 14 day auth period (up to 28 days)
  - The 1st concurrent auth will be completed via web registration and pended to clinical staff for review
  - All future continuing requests will be performed telephonically

Level of Care (LOC) Authorization Review Process

- The Departments continue to review the authorization process for all LOCs in an effort to create efficiencies
- Currently Under Review:
  - Acute Inpatient
  - Adult Mental Health Group Home
  - Concurrent and Discharge Review Processes
  - EDT



Connecticut BHP

Supporting Health and Recovery

Questions?