Connecticut Behavioral Health Partnership: Oversight Council

Rate Meld Subcommittee: Interim Report

October 12, 2011

The Rate Meld Subcommittee has met two times since the last Oversight Council Meeting on September 23rd and October 6th. At the September 23rd meeting we reviewed a revised analysis of all clinic based services, including outpatient, chemical maintenance, PHP/IOP,EDT, case management and IICAPS.

On October 6th we reviewed the memo outlining the rate methodology for all other Medicaid behavioral health services including general hospital inpatient and outpatient, psychiatric hospital, alcohol and drug centers, private practitioners, and home health services. No data was provided on the impact of the meld for these levels of care or provider groups. As a result, the Subcommittee deferred making a recommendation regarding the overall rate meld methodology pending a review of this data. We expect to meet again prior to the November Oversight Council meeting to review this data, and the Subcommittee's requested analysis of some alternative rate meld methodologies prior to making any recommendation to the Oversight Council.

Based on the Subcommittee's work to date there are several issues and concerns that the committee has identified, and some specific alternatives that we would request the Council ask DSS and its partner agencies to provide the committee:

1. Given that for most levels of care, BHP rates for HUSKY members are higher than the Medicaid rates for the adults served in the Medicaid ABD and LIA programs, the overall impact of the meld is a shift in funding and revenue from programs that serve children and their families to programs primarily serving adults. For the clinic analysis this shift totals about $965,000. For all other providers in the program there is likely a similar shift for outpatient levels of care. Given that the majority of this shift ($600,000) is for ECC providers, there is also concern about continued ability to meet ECC standards with a reduction in reimbursement levels.

2. While there are modest shifts for those providers with a mix of child and adult services, there is more marked shift for child only providers, and a masked shift at the program specific level. Several committee members were concerned that less revenue for these child serving programs would impact access over time as program budgets are adjusted to reflect actual revenues.

3. Provider specific rates for PHP and IOP are eliminated under the meld. This impacts providers that negotiated higher rates prior to July 2005 and the implementation of the BHP, and was a key provision in the authorizing legislation for the BHP. DSS is concerned that these provider specific rates can not be justified under the scrutiny of CMS review of the rates established under a revised state plan.

4. With the addition of adult services to the BHP, there are certain services that BHP reimbursed under HUSKY that are not reimbursed under Medicaid, most specific example is emergency mobile crisis services (EMPS) which will be reimbursed for children but not adult. Given the budget neutral constraint for the Subcommittee we recommend that there be a review of all adult services and this issue be addressed during the next rate increase process or implementation of the dual eligible initiative.

5. Inpatient care for children under the BHP has paid providers for discharge delay days at the same inpatient rate under the rationale that these patients are using inpatient beds that are staffed at one level of cost. The meld proposes to implement a 15% rate reduction for all discharge delay days. DSS has agreed to reinvest the savings from this initiative in the base inpatient rate so that providers are generally held neutral overall. The inpatient providers have worked with the BHP in a collaborative manner to reduce discharge delay days by more than 60% over the past three years. There are concerns by providers how this adjustment is calculated, and what provisions there are to protect providers should changes in State policy or service capacity for children under the care of DCF change our current experience with discharge delays.

6. The rate meld methodology proposes to maintain the case rate approach to reimburse for adult inpatient care in general hospitals. There was consideration of implementing a per diem approach, with a 15% reduction for intermediate acute stays greater than 29 days. Concerns about budget neutrality prevented this idea from being included at this time. Further discussion with general hospital providers about the expected utilization under a per diem may result in a reconsideration of this decision.

7. Given that the four general hospital enhanced care clinics were not previously eligible for reimbursement for adults in ABD or LIA Medicaid programs, the rate meld requires that three of the hospitals currently treating adults in HUSKY elect either to meet the ECC requirements or elect to only treat children. DSS is proposing to fund the expansion of the ECC rate to adults from the incentive pool used to support chidren's inpatient care. The five hospital members present at the Subcommittee had concerns about any reduction to the incentive pool for children, and recommends that an incentive pool be funded from savings realized in the adult Medicaid programs.

Subcommittee Recommendations:

1. Given the shift in resources from children to adult services in outpatient levels of care, the Subcommittee recommends that an analysis be provided showing the impact of a rate for services provided to children and services provided to adults, for outpatient, PHP and IOP levels of care. This approach should also be calculated for independent practitioners.

2. The calculation of discharge delay day adjustment for inpatient care should reflect data from the six hospitals that provide both child and adolescent services separately from the two adolescent only providers, given the differences in case mix, and likely impact of discharge delay days for those providers.

3. The impact of extending the ECC reimbursement adults served at the three general hospitals needs to be quantified, and determination of source of funding for this expansion further discussed.

4. The general hospital members of the committee would be interested in reviewing the adult per diem rates as part of evaluating the feasibility of this approach should DSS and its partners deem this a viable approach.

5. The Subcommittee will review the data for the above requested analyses prior to making a recommendation to the Oversight Council at the November meeting.