Behavioral Health Partnership Oversight Council

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Co-Chairs: Rep. Christopher Lyddy Jeffrey Walter Hal Gibber

Meeting Summary: Dec. 14, 2011

Next meeting: ***Jan. 11, 2012 @ 2 PM in LOB Room 1E***

Attendees: : Christopher Lyddy, Jeffrey Walter, Hal Gibber (Co-Chairs), William Halsey (DSS), Lois Berkowitz (DCF), Lori Szczygiel (CTBHP/ValueOptions), Paul DiLeo, Jennifer Hutchison, Scott McWilliams (DMHAS), Mickey Kramer (Office Child Advocate), Elizabeth Collins, Howard Drescher, George Eason, Dr. Ronald Fleming, Heather Gates, Dr. Steven Girelli, Charles Herrick, MD, Thomas King, Dr. Stephen Larcen, Kimberly Nystrom, Sherry Perlstein, Galo Rodriquez, Janine Sullivan-Wiley, Jesse White-Fresse, Judith Meyers, Catherine Foley-Geib, Dr. Karen Anderson, Dr. Mark Schaefer, Terri DiPietro, Rick Calvert and Daniela Giordano

Chair, Jeff Walter expressed thanks to George Eason for his service on the council. George is leaving the council.

Jeff Walter asked for a motion to approve the November meeting summary. Jesse White-Fresse made motion to approve and George Eason 2nd the motion. All members were in favor of approving the minutes. None opposed. Minutes are passed.

Action Items

Subcommittee Report on Rate meld Summary

Steve Larcen thanked the members of the subcommittee for their input in the process on the Behavioral Health Rate Meld Summary. He explained that the process included determining how the rate meld will impact access, program, program types and levels of care. The mantra going in was "do no harm or as little harm as possible" while trying to blend the fee for service rates with the Husky rates. Several departments, including DCF, DMHAS, and DSS worked to find solutions for unintended consequences of blending rates together. The goal today is for the Council to approve a set of methodologies with certain conditions as the work is not 100% done, there are a few open areas, and rates are not available in some instances. The plan is to continue to work with Departments to satisfy the conditions and find solutions.

BHOC Presentation-12-14-11Final.ppt

Bill Halsey began his review of the work that was done and what the rate methodologies are by providing the following definitions:

Fee/fixed fee - Uniform price paid to all providers for specific service regardless of coverage group
Provider specific rate – Price paid to provider for a specific service that is negotiated between the provider and the payer
Coverage Groups – Husky A, B, C, D
CMS – Centers for Medicare and Medicaid Services
Fee for Service – Traditional age, blind disabled, low income adults

Background on the reason for doing this massive rate meld project

- Project operates under a waiver, which ends at the end of this month. Beginning January 1st providers cannot be paid different rates based on eligibility coverage groups. The process was kept budget neutral.

- Deadline – Federal laws requires DDS to publish its intention to amend the State plan prior to the effective date of the change. In order to publish in the CT Law Journal the deadline to submit to the law journal is 12/15. State plan language becomes available to the public on 12/27. Must submit State plan amendment to CMS by March 31, 2012.

- Melded rates need to be effective January 1, 2011. Will need to have a retroactive adjustment process in place. Must occur in the 1st quarter of calendar year '12 in order to get the federal match.

Rate Meld

Bill Halsey described the rate meld for different Provider types of services. Please see attach spreadsheet.

Behavioral Health
Rate Meld Summary.p

General Hospital Psychiatric Inpatient

- Adult -Put service into comprehensive case rate or discharge rate. Include medical services and impatient adult psychiatric services.
- Child - Provider specific rate, per diem. Pay full per-diem to hospital for acute medically necessary days. Decrease of 15% for discharge delay days. CARES service defaults to HUSKY BHP Rates.

General Hospital Observation

- Default to fee for service methodology based on cost to charges

General Hospital Intermediate

- Based on fixed Fee Meld

General Hospital Outpatient

- ECC defaults to HUSKY rates
- Non-ECC 513 codes converted to 900 codes. Price 900 codes at 75% of Medicare except for group therapy which is priced at 100% of Medicare.

Psychiatric Hospital – Provider specific rate

- Adult - Meld between fee for service and HUSKY. Full per diem paid through day 29, then reduced on day 30.
- Child – Full per diem paid for acute necessary days, then 15% reduction for medically necessary discharge delay days.

Free Standing Mental Health Clinics

- Straight meld. Child –vs.- Adult differential was looked at. Adult fees paid at 95% of child fees.

Child Rehabilitative Services-Fixed fee

Other Freestanding Clinics- Fixed fee

Chemical Maintenance Clinics – Provider specific rate rather than site specific rate

Alcohol and Drug Centers – Provider specific rate except ambulatory detox

Home Health Services- Fee for service fees

Federally Qualified Health Center –No change required under meld

Independent Practioners – Took a meld of fee for service and HUSKY service expenditures. No Child vs. Adult differential

Supplemental Payments- Department plans to use calendar year 2011 performance incentive funds to provide one time supplemental payments for those previously eligible to receive payments.

Provider Performance Initiatives-Plans to submit a proposal to CMS for the implementation of Performance Initiatives for calendar year 2012.

Questions and Answers about presentation included:

Judith Myers asked about points of controversy or anticipated push backs that needs attention.

Steve Larcen answered that areas that are open, not yet resolved between members of the committee and the departments could be an area. For example, when the BHP was implemented by statute there was a provision that inpatient rate and intermediate rate, Partial and IOP would be provider specific. Inpatient provider specific rate is maintained, but there is a change in moving Partial/IOP from provider specific to a fixed fee of blend. More provider specific impact. There are potential solutions for provider specific issue which will be provided today.

All providers have rates calculations in spreadsheet. Impatient rates of reimbursement have not been specific. Once the information is published in the CT Law Journal, people can still comment further before the rates are finalized.

Rick Calvert asked about committee considerations and discussions in comparing products for outpatient care of adults versus children. Different blend of services that goes into child/adolescent care vs. adult care.

Steve Larcen answered that there were a lot of discussions as there are representatives on the committee who do both adult and child work and discussed ways the committee worked to come up with a compromise solution. Overall shift from child to adult was mitigated.

Galo Rodriquez asked about the spreadsheet that shows the providers' impact and commented that children services require more intensive case management and require higher rates.

Copies were distributed.

Dr. Herrick reiterated the issue of Child and Adolescence care being more labor intensive and costs are higher to provide care. Concerns about payments being roughly the same as adults. Question regarding impatient care of discharge delays reduction to 85% on the child side. Is it the responsibility of inpatient unit, are they legitimately motivated by reduction of cost to do this or is delay in discharge really based on other institutions trying to accept these patients that really don't have the services available to take these patients?

Steve Larcen answers that it is both. Depts. sought legal advice on how best to submit this to be compliant. He confirmed that kids services are higher.

Sherry Perlstein asked with regards to revenue neutral does this assume static level of service. Steve answered that the measurement period is a point in time.

Steve Larcen made a motion to approve the rate methodology as presented with the following seven conditions:

1. **General Hospital Adult Services** - continue to consider a per diem rate methodology for adult inpatient psychiatric services provided at general hospitals and share the rates with the hospitals;

2. **Child Impatient Rate** – share with the hospitals the revised calculations for children's inpatient psychiatric services that incorporates the discharge delay adjustment, using the methodology recommended by the Oversight Council;

3. **Impact on provider specific rate for general hospital Intermediate Levels of Care-** in calculating rates for hospital intermediate services, reduce the adverse impact on "outlier" hospitals by adjusting their inpatient rates;

4. **Relating to extending outpatient enhanced care clinic to adult at the three hospitals there is a cost of $185,000.** _submit plans for using performance pool funds to finance hospital enhanced care clinic rates for adult services, for Council review prior to implementing such plans;

5. **Provider specific Rate for the Clinic** in calculating rates for clinic intermediate services, find a way to reduce the adverse impact on "outlier" clinics;

6. **Approve private practioner meld as proposed** with a requirement that in April 2012 the departments provide an "impact on network" review as to whether the rates have

compromised the network adequacy for private providers to see if any adjustments are necessary at that time.

7. **With respect to proposed incentive programs outlined** – Before incentives are submitted to CMS, the plans are submitted to the council for review and comments

Motion was second by Janine Sullivan-Wiley. Jeff Walter called for a vote of the Council to approve the proposed methodologies with the seven conditions. All were in favor.

- ASO implementation is on track for January 1st
- For dates of service on after January 1st claims should be submitted to HP
- Providers who receive payments exclusively from the managed care organizations need to enroll in CMAP network
- Non-emergency medical transportation update - On 1/1/2012 three providers are providing transportation services
- Logisticare has won the right to negotiate a contract on 4/1

Agency Reports

DCF

Dr. Anderson gave an update on the DCF certification process for children's rehabilitation services. DCF regs. published on Dec. 5th in the CT Law Journal outlines provider criteria and service model endorsement process. Programs officially approved by the review board includes: MST and MST families and transition and MST problem sexual behavior; Multi dimensional family therapy and DFT, functional family therapy (FFT) and IICAP.

Value Options

Lori Szczygiel – There are 15 performance standards in the ASO contract. There are penalties for non-performance if standards are not met. There are call standards: phone needs to be answered within 30 seconds. Phones are currently answered within 3 seconds. Standards are in the contract and are set by the State departments. They are negotiated on an annual basis. Performance standards for next year will be revisited with the council

Subcommittee Reports

Coordination of Care: *Sharon Langer, Maureen Smith & Rep. Elizabeth Ritter, Co-Chairs*

See printed minutes

Child/Adolescent Quality, Access & Policy: *– Sherry Perlstein, Hal Gibber & Robert Franks, Co-Chairs*

Sherry gave highlights from the last committee meeting with Commissioner Bob McKeigney:

- Great deal of discussion about Plan changes to voluntary services system, he emphasized the importance of cost containment and standardizing processes statewide.
- Concerns raised by committee included emphasis on new system on means testing for families, to pay part of cost out of pocket or be penalized or excluded if insurance does not cover, frustration when kids fall between DDS and DCF purview who are being excluded from services, Department reduce access to community based congregate care and voluntary services and intermediate care services have long waiting lists, many youngsters are showing up at outpatient level of care and outpatient clinics don't have

capacity to provide required services. High risk families can be harmed by lack of services.

- Confusion about the term community based services

Operation – *Susan Walkama and Elizabeth Collins, Co-Chairs*
Susan explained about the mystery shopper calls to enhanced care clinics and a discussion followed on how to improve calls. Elizabeth mentioned discussion on DSS alert on performing provider enrollments for hospitals and clinics in Medicaid programs. By January 31st hospitals and clinics will need to upload data file. 33 questions were sent to Bill Halsey on issues regarding the new policy. Bill is working on getting the questions answered.

Other Business
This is Liz Collins' last meeting. Jeff thanked her for her leadership on the council and wished her well on behalf of all the members.