

May 10, 2002 Meeting Summary

Present: Sen. Toni Harp (Chair), Rep. Vickie Nardello, David Parrella & Rose Ciarcia (DSS), Thomas Deasy (Comptroller's Office), Dr. Victoria Niman for Gary Blau (DCF), David Guttchen (OPM), Paul DiLeo (DMHAS), Patrick Carolan, Janice Perkins (MCOs), Judy Solomon, Lisa Sementilli, Dr. Edward Kamens, Dr. Wilfred Reguero, Irene Jay Liu, Jeffrey Walter.

Also present: William Diamond (Concera Corp.), Mark Schaefer, Martha Okafor (DSS), Karen Andersson (DCF), Sylvia Kelly (CHNCT), Deborah Hine (ABCFFP), Joan Morgan (FirstChoice/Preferred One), Jesse White Frese (SBHC), M. McCourt, (Council staff).

CT Behavioral Health Partnership

Representatives from the three agencies, the Departments of Social Services (DSS), Children & Families (DCF) and Mental Health & Addiction Services presented an overview of the report to the General Assembly on Developing an Integrated System for Financing and Delivering Public Health Services for Children and Adults in Connecticut (see report at www.CTBHP.state.ct.us). This report, presented by Dr. Mark Schaefer (DSS), Dr. Karen Andersson (DCF) and Paul DiLeo (DMHAS) is the culmination of over two years work among the agencies and work groups to consolidate the public mental health system into a more seamless, less fragmented system of care across all ages. The process initially focused on DSS & DCF collaboration; in September 2001 DMHAS joined the partnership that has resulted in a Memorandum of Understanding (MOU) among the three agencies for shared organizational structure and decision-making in the development, implementation and evaluation of the proposed system change.

Programs that will be included in the public MH program are the Medicaid HUSKY A (adults and children) and B programs, Medicaid Fee-For Service (FFS) that include dually eligible adults with persistent serious illness, the General Assistance (GA) BH Program and DCF Voluntary Services program.

Three key objectives to make the goals of improved access to quality services and efficient use of state resources a reality have been identified by the Partnership:

- Administrative integration that includes shared clinical management, claims processing and data management services. A common Administrative Service Organization (ASO) will provide clinical management, including uniform standards for authorization, utilization management and quality assessment indicators. A single claims vendor will process claims (the GA claims system will remain). Data management is the lynchpin of

improving the system of care: The new DSS system will interface with the existing DMHAS data warehouse system. The benefits of this joint purchasing include:

- Elimination of separate funding silos that will allow funds to follow the client through different programs (i.e. GA to Medicaid, back to GA), and levels of care (i.e. residential care to community based care).
- Promote improved transition of youth into adult BH programs.
- Improved access to care for adults and children as their program eligibility changes.
- Improved efficiency, continuity of care and documentation of the efficacy of treatment that is lacking in the current system.
- Service delivery redesign that will address current system problems:
 - KidCare address problems that include numbers of out-of state residential placements, extended residential stays beyond treatment necessity because of unavailable community based placement and care, inappropriate use of ED beds and extended inpatient stays, lack of family involvement in treatment planning and system change planning. There is a statewide commitment to expand care coordination and community based services, including the addition of new services such as the emergency mobile psychiatric service, crisis stabilization beds, additional Extended Day Treatment programs with rate enhancements, and adjustments to residential programs that provide services for those special populations out-of-state as well as appropriate transition to community care.
 - Recovery Management for adults will focus on enhanced case management and care coordination, comprehensive, flexible benefits, integration of adult BH funding streams.
 - Maintenance of the safety net system and consumer assistance in navigating the system of care.

Both programs will have quality measurements, developed through a Robert Wood Johnson grant, that will assess the efficacy and cost-effectiveness of the BH Partnership, reinvestment of dollars into the programs and program improvement.

- Revenue maximization focuses on BH services currently funded by DCF and DMHAS that could be covered under Medicaid if changes were made to the CT Medicaid State Plan. These changes would reduce the burden on the state budget by allowing federal financial participation in funding for BH services.

Highlights of Council comments and questions:

• Currently there are difficulties determining which entity (MCO or Medicaid FSS) is responsible for the cost of BH services. How will the new system address this? The Department noted that currently some children are not in HUSKY and BH claims for these children are processed through Medicaid Fee-For-Service. Also, children in HUSKY B may receive some services through the PLUS program. Specific payment problems should be referred to DSS. Under the new system most BH services will be outside the managed care system (pharmacy and primary care will remain in managed care) and all claims will be paid by DSS: there will be no distinctions between managed care and FSS. Authorization and clinical management will be the function of the ASO, as determined by DCF and DMHAS.

• The data warehouse will contain pharmacy data; it is uncertain at this time if MCO encounter data will be linked to the warehouse. DCF will continue to have access to

psychotropic drug utilization for DCF children.

- The report refers to adults in HUSKY as ‘TANF’; however only about 14,000 are under the TFA category and the remaining adults are parents/caretakers of HUSKY A children. This distinction is important in influencing how services are targeted to the adults. The DMHAS acknowledged this point.

- Jeffrey Walter commented on the concerns raised by the Medicaid Council BH Subcommittee at the BH Partnership presentation:

- o The timeframe is tight for implementation of this complex system change by July 2003.

- o The Subcommittee has been assured the actuarial report, to be available early Fall 2002, will be available to the Subcommittee. Adequate provider reimbursement under Medicaid FFS has been an issue that impacts on service access. This issue has been effectively addressed in HUSKY. It is important to maintain access to services in this system change through a reasonable rate restructuring, taking into consideration the low Medicaid FFS rates.

- o A mechanism must be developed to coordinate BH services with primary care. It is important that the Council and BH Subcommittee continue to receive quality assessment and utilization reports for the new program.

- o The implementation and transition to the Public BH system needs to include all stakeholders’ input, as does the development of the ASO responsibilities.

- Access to child Psychiatry services remains difficult for School Based Health Clinics. Karen Andersson (DCF) agreed, stating that DCF put additional money in this budget year for child guidance clinics to improve child psychiatric service access. The Department is working with hospitals and others to maximize staff utilization and consider other professionals’ participation; the Department welcomes any new ideas that will improve access in this area.

- The CT BH Partnership has looked to other state system reorganization when developing this public BH system.

- Rate restructuring will be done by DSS in consultation with DCF & DMHAS; there has been no decision made about statewide versus regional rates. The three agencies develop the policies for the program while the ASO role is to implement these policies.

- The Centers for Medicare & Medicaid (CMS) approval is required for:

- o Amendment of the current 1915(b) HUSKY waiver, including changes of the Upper Payment Limit associated with the BH carve-out. The waiver will be presented to the legislative Committees of Cognizance for review prior to submission to CMS.

- o Authorization of the ASO costs and contract provisions.

- o Approval of the State Plan amendment that will include the rehab options.

- What are the disincentives for cost shifting from private programs to this public program?

Mark Schaefer (DSS) stated that attention is directed to the underinsured that use the DCF voluntary services program. Since the public BH program will include services unavailable under commercial insurers, both DSS and DCF are mindful of the potential of private sector exploitation. Karen Andersson (DCF) stated that the Department is concerned about maintaining access to these services and would hope that the efficacy of these services, demonstrated through data collection and cost analysis, will encourage private insurers to participate in this model.

More information will be presented in the Fall 2002 about this.

- Senator Harp questioned if there are plans to integrate the Juvenile Justice system into the program. Karen Andersson stated that DCF is working on this, noting that currently adjudicated delinquents outside of the current HUSKY program are ineligible for voluntary services.

Mark Schaefer (DSS) stated that the BH Partnership is committed to ensuring cost neutrality and

providing effective, measurable quality services to the current coverage groups. The departments recognize that those outside the coverage groups with serious mental health needs will eventually find themselves involved in the public system. The challenge is in designing a program that provides access yet doesn't reduce employer benefit responsibility. Redirection of investment in the system may need to be viewed as short vs. long term as this applies to Juvenile Justice. Senator Harp thanked the three departments for their hard work and expertise in designing the public mental health system redesign and the Council and BH subcommittee look forward to continued reports and dialogue as aspects of the program become more developed.

Concera Corporation (formerly Benova) Enrollment Report

William Diamond presented HUSKY call center, received applications and total HUSKY (A & B) enrollment as well as a breakdown of HUSKY enrollment by program and child/adult members:

- HUSKY call center monthly incoming calls peaked in January 2002 at 24, 243 calls, slowed in February and March to 18-19,000 and increased in April to 21,772 calls.
- HUSKY applications received peaked to the highest point in 2 years in January 2002 at 2649/month, decreased to 2200-2300/month during February, March and April.
- Combined HUSKY A & B enrollment is the highest in the history of the program (1998) at 286,255 members as of May 1, 2002. Since January 2001, when adult enrollment at 100-150%FPL began in HUSKY A, adult enrollment numbers have increased by 22,102.
- HUSKY B numbers have also increased by **3864 since August 2001**. Monthly enrollment gains average 430/month, with the higher monthly rates ranging from 500-756 in January through April 2002. The slower growth in HUSKY B may be related to the April changes in the federal poverty level rates, making some B eligibles now eligible for HUSKY A.

Questions about the application-to-enrollment time frame and the process for follow-up of incomplete applications in HUSKY A and B were raised. The Department of Social Services is responsible for following through on incomplete HUSKY A applications sent from Concera to the Department, either through the central DSS presumptive eligibility center or at the regional level. The Department and Concera will provide further information on this process and data on incomplete applications.

Department of Social Services Report

The Department of Social Services has prepared, through William Mercer, CT HUSKY marketing materials that have been sent to over 50 HMOs and State Medicaid Directors across the country in anticipation

of the procurement process for HUSKY A & B for July 1, 2003. The material describes the HUSKY program and CT information on managed care.

HUSKY MCO Quarterly Financial Reports

The health plans report quarterly unaudited financial reports to DSS as well as audited end-of-the-fiscal- year reports. Information presented at this meeting includes audited financial reports from Anthem BCFP and CHNCT and unaudited reports from all plans. In addition to the MCO reports, the Department estimates the medical loss and administrative loss ratio, based on the premise that some of the medical loss ratio reported by MCOs actually includes subcontractor administrative fees that are paid to the subcontractor. The following summarizes the MCO report and DSS estimate based on reapportionment of subcontractor administrative costs for CY 2001:

Period	CY 2001 Total MCO Report	CY 2001 DSS Estimates
Medical Loss Ratio	91.6%	90.0%
Administrative Loss Ratio	8.4%	10.0 %
Margin	- 0.5%	- 0.5%
PMPM medical \$	\$135.16	\$132.76
PMPM Administrative \$	\$12.42	\$14.83

The Department noted significant quarterly fluctuations in the health plan reports, the cause of which is unknown at this time. Overall, the reports show a marginal loss for CY 2001. Council comments:

- The health plans use the standards set by the National Association of Insurance Commissioners in reporting medical/administrative expenditures. The Department will provide the Council with those standards.
- The loss margins are small for CY2001; if, at the end of the year the losses are greater how will the system provide for this? The Department stated that both DSS and the MCOs have projected losses for the coming year. Program costs have increased reportedly related to the change in population mix in that more adults, whose medical costs tend to be higher than children, are enrolled in HUSKY A and rising medical inflation, which includes pharmacy cost increases. The Department has had discussions with the MCOs regarding their estimates for needed funding to continue in the program and the Department has estimated program costs projections. The Department is hopeful that the budget will

include a percentage increase for the program that will be reflected in the rate structure to compensate for real losses.

- Can the Department provide data on HUSKY A adult care costs? The Department stated that the adult rate cells are in the waiver and can be provided at the June meeting. Actuarial analysis shows that adults new to the program incur less costs than those already in the program. Pregnancy costs are lower in the more recently enrolled adults.
- The Department is working on the reporting framework required by Public Act No. 02-3, Sec. 6 for mental health and dental health plans to provide quarterly reports to DSS on the nature of expenditures of their monthly payments applied 1) directly to health provider payments and 2) administrative costs/profit.

Managed Care Resolution of PROBH Outstanding Claims

Health Net: Janice Perkins reported that with the exception of St. Francis and Yale New Haven hospitals, the reimbursement for run out claims is complete. Actual numbers remain unchanged from the 10/01 report.

FirstChoiceCT: Joan Morgan briefly described the background of the health plan's changes: HealthChoice was bought by Wellcare in October 2000 and had an ASO agreement with PROBH up to 3/1/01. CompCare became the full-risk BH subcontractor on March 1, 2001. PROBH was responsible for claims payment up to March 1, 2001: CompCare agreed to assist in the run out claims process resolution. Of the 13,291 claim lines entered, 6,318 have been paid, 6,973 were denied. Reasons for denials included no authorization found (4924), duplicate claim line (2535), service code outside of fee schedule (1144) and code not covered (678). The Department assisted in the resolution of a few reinsurance claims under HealthChoice. All PROBH claims submitted prior to October 15, 2001 have been adjudicated and the last provider payments are being mailed.

Children's Health Council Reports

Judith Solomon provided a preliminary summary of three utilization studies of children continuously enrolled in HUSKY A for one year in FFY 2001. Two reports, Ambulatory Care for children 2-19 years and Dental Care for children 3-19, have been reported in FFY 1999 & 2000. A new report Well Baby Care, used a sample of 2,054 babies born in January-March 2000 and continuously enrolled for one year. Summary of the utilization reports:

	Ambulatory Care(AC)	Dental Care	Well Baby (WB) Care
Utilization Patterns FFY 2001	* 82.4% - Any AC *49.% - well care *32.6%- episodic/ED care * 17.6% No AC	* 45% any dental care * 35% Preventive * 20% Treatment	* 34% >/=5 WB visits * 61% 1-4 WB visits * 5% no WB visits (expected 6 visits in 12 months)

Utilization Differences FFY 2001	*Older teen and AA child <likely to have well care, >likely to have ED care. *AA child >likely to have no care.	TBA	*African Amer (AA), & Hispanic babies <likely to have adequate WB visits compared to white babies.
Utilization Trends FFY 2001	Compared to FFY 1999 & 2000 %: *INCR % well care, *DECR % with no care, *INCR % of ED care rates.	Compared to FFY: *2000, dental care rates unchanged in 2001. *1999, decrease in % children with dental care in 2001.	NA (WB care NOT associated with <ED use or hospitalization for ACSC)

Senator Harp suggested that the MCOs comment, in the future, on approaches to increase and/or account for health care access for these services. The CCHP is working with MCOs on improving adolescent preventive care.

Other

Representative Nardello clarified that the UCONN dental project site at the UNH Dental Hygiene School has been changed to the Hill Health Center as of May 1, 2002. The Department of Social Services was requested to provide the Council with a summary of the dental project costs to date, amount of administrative and direct-service pilot site expenditures and additional costs, if any, in relocating this pilot to the Hill Health Center.

The Council will meet on Friday June 14, at 9:30 AM in LOB RM 1D.