

Meeting Summary: November 8, 2002

Present: Sen. Toni Harp (Chair), Rep. Vickie Nardello, David Parrella & Rose Ciarcia (DSS), Thomas Deasey (Comptroller Office), Barbara Parks Wolf (OPM), Gary Blau & Dr. Victoria Niman (DCF), Dr. Ardell Wilson (DPH), Jeffrey Walter, Irene Jay Liu, Dr. Edward Kamens, Lisa Sementilli, Phyllis Rotella-Sodaberg, Patrick Carolan and Janice Perkins (MCOs).

Also present: Mark Schaefer (DSS), Hilary Silver (DSS), Karen Andersson (DCF), William Diamond (ACS), Deborah Hine and Lois Berkowitz (Anthem BCFP), Sylvia Kelly (CHNCT), Joan Morgan (FirstChoice/Preferred One), Jack Huber (Qualidigm), M.McCourt (Council staff).

Behavioral Health Partnership: Mark Schaefer, Ph.D. (DSS)

Dr. Schaefer reviewed the BH Partnership goals that provide overarching planning and policy development for mental health services to Medicaid fee-for-service clients, HUSKY A & B adult and child members, HUSKY Plus clients, State Assistance (SAGA) population.

The DSS has released the BH Administrative Service Organization (ASO) RFP on 10/7 and held a bidders conference on 10/17. Letters of intent from prospective bidders was due 10/28, DSS will provide written responses to RFP questions early in November and bidder's proposals are due to DSS by 3 PM 12/20/02. The successful bidder will be announced 1/31/03, contract negotiations will begin 1/31/03, concluding in April. The new BH carve-out will begin 10/1/03.

The BHP goals of administrative integration and expanded rehab options will be achieved through SFY 04-05 initiatives of service system redesign, financial management and revenue maximization.

- Administrative integration, achieved through a Memorandum of Understanding (MOU) among the three agencies (DSS, DCF, DMHAS), would reduce barriers to community-based (CBS) care by reducing administrative fragmentation, provide for coordinated policies across the three agencies, and provide better utilization data. Improved data would allow identification of spending/utilization trends, and evaluation of service effectiveness. Clinical management of services would lead to appropriate changes in clinical practices and CBS availability/utilization.
- The broader exercise of the rehab option for children and adults would expand the array of services and ease access to these services while maximizing the federal revenue match for some services currently not receiving federal matching funds. The rehab option is consistent with a national mental health goal of allowing funding resources to 'follow the client' rather than remain categorically funded to service entities. Child and adult rehab services would be converted to Fee-For-Service with a phase-in timeline for services to be covered by Medicaid.
 - An actuarial analysis is being prepared that summarizes the current BH costs and

provides cost projections for SFY04-05 within the BHP. The three agencies are preparing an integrated budget option, informed by the analysis of current costs, projected administrative costs and offsets under the BHP, cost-neutral increases in CBS funding, revenue projections and one-time costs/offsets. The analysis, performed by Mercer, takes into account the current Medicaid fee schedule as the base for rate restructuring; the agencies are looking at modifications of this rate structure.

Highlights of Council questions and comments:

- How has the Mercer actuarial study estimated the portion of BH spending that would be carved out of the HUSKY program and from the MCO capitated payments? Dr. Schaefer stated that the HUSKY BH encounter data was incomplete so the most up-to-date HUSKY BH financial spending for administrative, inpatient and outpatient spending was used, comparing this to the statutory subcontractor reports. Two plans currently have risk-based BH contracts (FirstChoice/Preferred One and Health Net) and CHNCT and Anthem have non-risk based BH subcontractors contracts. Since the BH carve-out implementation date falls within the new HUSKY contract period, there won't be a 'reduction' in MCO capitation rates, rather a submission of rates by MCOs within the new HUSKY procurement process for July 1, 2003.
- What is the actuarial approach to expanding CBS, as some non-traditional services are not currently within the HUSKY program? Dr. Schaefer stated that the analysis seeks to maintain cost neutrality. Current HUSKY BH expenditure data and other data such as chart reviews of clients remaining in higher cost settings identified the need to expand CBS, including housing and non-traditional services, to reduce higher cost inpatient care. The DCF is building up CBS through KidCare. Existing information supports the need to significantly expand access to CBS, including improving access to a wider variety of outpatient services and providers. As the array of CBSs increase and clinical management is implemented through the ASO, some dollars will be able to shift from inpatient care to effective lower cost community-based care.
- How will the state change a fragmented system with existing service gaps in geographic areas without creating instability in the system during the transition? Will grants continue to fund areas with service gaps and/or new administrative burdens for service entities during the transition? The DSS commented that the issues are different for adult and child services. For the child population, grant funding will continue to be needed for uninsured and/or underinsured populations. The BHP is cognizant of the dangers of destabilization of the overall system during and after the transition. The ASO will assess geographic community service need and capacity problems, targeting the development of new resources within those geographic areas. The BHP is carefully looking at the impact of the carve-out rate changes; grants may be maintained, depending on the needs assessment. Karen Andersson (DCF) stated that DCF is working with the child guidance clinics in developing a three-year plan for the conversion of some grants to Medicaid Fee-For-Service (FFS).
- Will there be opportunity for public discussion as the transition paradigm for rates and grants? Dr. Schaefer stated the Partnership would discuss with OPM the use of the MH Strategy Board as an advisory group.
- What does 'cost neutrality' refer to- the state or the federal match funding? Mark Schaefer

stated that the actuarial analysis takes the gross BH budget and anticipated increase in the federal match funds, reorganizing spending within the trend lines.

KidCare Update: Dr. Karen Andersson (DCF)

Dr. Andersson provided a brief overview of CT Community KidCare, an initiative that represents a shift in treatment philosophy toward a collaborative effort that is family and community-focused. The approach includes emphasis on strength-based treatment planning for community-based services that are culturally sensitive and support evidenced-based practices. The collaborative approach moves away from a behavioral health ‘expert’ model of care to one that meets the service needs expressed by the community. (Please see the DCF website: www.state.ct.us/dcf for KidCare updates, a Resource Directory, and linkage to the CT BHP DSS website).

A four-day training program has been developed to promote the understanding of the program and the shift in philosophy among participants including families, DCF child welfare staff, providers, educators, probation officers, etc. To date 25 ‘trainers’ have been part of training approximately 1000 people involved in children’s behavioral health in Connecticut.

Children eligible for KidCare include all children enrolled in HUSKY A & B, Medicaid FFS, and in the DCF Voluntary Services Program. All children in the care and custody of DCF and most children in the DCF child welfare and juvenile justice systems are eligible for Medicaid and KidCare. As the KidCare design evolves, attention will be focused on mechanisms to allow cost sharing with parents of children in the Voluntary Services program and commercially insured parents of children with serious emotional disturbance in order to allow access to community-based services currently outside existing eligibility rules.

There are currently 25 Community Collaboratives (local systems of care) that cover over 150 towns throughout the State. These collaboratives, comprised of parents, behavioral health providers, community leaders and KidCare Care Coordinators, form the service network from which the Care Coordinators help families to develop a child’s Individualized Service Plan. A statewide family advocacy organization (FAVOR) has been funded to work with families, educating them about the new service delivery system and available resources. Eight specially trained family advocates are supported by FAVOR to assist specific families involved with their local community collaboratives.

Over \$21 million, allocated to DCF by the legislature, have been committed to contracted new or enhanced statewide KidCare services that include Emergency Mobile Psychiatric Services (EMPS), Care Coordination, enhancement of Extended Day Treatment, crisis stabilization beds (awards pending), therapeutic mentoring (RFP pending), and short-term residential treatment (RFA pending). Dr. Andersson and Ann Adams, program director for MH in DCF and responsible for EMPS oversight, described beginning data trends for KidCare Care Coordination and the EMPS program:

Care Coordination

- There are now **60 coordinators** throughout the state, with the addition of 44 new coordinators. The role of the Coordinator is to work with the Community Collaboratives to identify families in need of help in securing services, develop a treatment plan with the

family and broker services based on this plan.

- Data derived from 2001, that had 16 coordinators to 246 child/youth, showed that **the average age of the client is 12 years, males comprise 70% of the coordinator caseload and 88% of clients involved with Care Coordination had 2 or more risk factors.** These factors include residential care, gang activity, BH hospitalization, suicide attempts, run aways and families with mental health disorders. These youth identified with serious problems would have been re-hospitalized or admitted to long-term residential care if coordinated CBS were unavailable.
- DCF is using the data to look at CBS gaps by geographic area as well as steps to enhance the care coordinator services as **all the care coordinator slots are filled.**

EMPS Services

While the mobile crisis teams began as early as January 2002 in certain regions, the statewide data, collected between 7/1-9/30/02 describes the calls and youth served by this system over this time period:

- There were **1,185 calls in 3 months**: 30% required no on-site services, 19% were from the child's residence, 23% from a clinic-office, 16% from the Emergency Room. Approximately 13% involved schools, shelter/group homes and other.
- The average **client age was 12 years, 58% had no previous or current DCF involvement; 44% presented with depression/suicide ideation.**
- Care coordination associated with the EMPS program averages a 6-week involvement, although 40% of the EMPS callers were seen longer than a month. Discharge residence frequencies showed that most children remained with **their family (441 (88%) of 500 intake family residence-based calls**, with 5% admitted to residential care). Of the calls originating from foster care (35), 25 (71%) remained in foster care and 2 were placed in residential care. Of calls originating from shelters (23), 20 (87%) of the children remained in the shelter and 2 were placed in residential care. Of the total 593 calls, 76% were discharged to the family, 4.9% to foster placement, 3.7% to shelters, 7.4% to residential care and 7.65 to other residences.
- Only 20% of families allowed services in the home: DCF will stress the goal of having the child remain in the home and reduce concerns about 'losing' the child to DCF custody.
- Family risk factors of domestic violence, substance abuse and mental health issues correlate with the frequency of 4-6 year old children with severe problems requiring EMPS care coordination. This speaks to the need for preventive services to reduce the onset of crises in these families.

Council questions/comments included:

- Will the KidCare care coordination, currently grant funded, continue as a grant? Karen Andersson (DCF) stated the plan is to continue grant funding over the next several years. Mark Schaefer (DSS) noted that the BH ASO would not directly contract for any provider services. It is important to keep the grants and look to a federal match.
- Is there a statewide effort to identify potential providers, especially from the minority community? Recruitment is a global issue, as the CBS expand the need for professional and paraprofessional providers in the community will increase. Dr. Andersson stated that CT, like other states, has a dearth of minority-trained providers. Using proven curriculums from other states, DCF will be developing training programs over the next 6 months for non-traditional providers such as therapeutic mentors that will engage community minority

participants.

- Do we have data on changes over the past 10 years in the demand for state-funded BH services? The Department will provide information on this.
- Do we have information on the root causes of risk factors that lead to serious BH disorders in children, which would allow the state to target dollars appropriately to prevention initiatives? Karen Andersson noted that data such as that reported earlier allows DCF to identify common risks, and then target preventive interventions. There needs to be more national focus on this and identifying outcomes from prevention programs. Mark Schaefer (DSS) stated there are evidenced based interventions available for serious emotional disorders (SED) such as oppositional defiant disorder that, with accurate diagnosis, can be successfully applied by BS/MA level practitioners. The CTBHP is working with the CT Child Health & Development Institute to encourage BH providers to apply evidenced based, time-limited treated for accurately diagnosed SED and other less severe diagnoses.
- Is there a pent up demand for family-focused CBS? Mark Schaefer responded that this remains to be seen. KidCare may not be able to quickly reduce the stress on inpatient care because the need for additional CB services outweighs what is currently available.

Senator Harp thanked both Drs. Schaefer and Andersson for their presentations and hard work in improving the public mental health programs, noting, “we are all depending on your success”. David Parrella, Director of Medical Administration (DSS) stated that the leadership of Mark Schaefer and Karen Andersson have been crucial to the development and implementation of KidCare and the BHP.

Department of Social Services

MCO quarterly data: Hilary Silver, DSS

- EPSDT screening and participation ratios were presented (% ratios approximated from the 1Q02 graph):

Individual MCO ratios were not available for 1Q02. The patterns continue with an increase in screens in the 3rd Q, associated with the timing of school physicals. The age group screens remain close to or at times above 80% for children under one to 2 years of age. Three-five year old ratios drop below this, followed by a precipitous drop in screens for youth aged 6 to 19 years.

- The DSS, in response to a Council question, acknowledged that DSS has the responsibility to improve EPSDT rates and has worked with the health plans, however rates remain well below the CMS 80% guidelines. (*Past Council recommendations requested DSS & MCOs develop action plans for incremental, sustained increases in EPSDT screens across age groups*).
- It was recommended that encounter data be used to identify other patterns of health care utilization among HUSKY children that do/do not have EPSDT screens, focusing on the use of more costly ED services.
- Dental care access for ‘any dental service’ decreased slightly in 1Q02 compared to 1Q01, decreasing from 19% to 17% total percent receiving dental services for HUSKY A children aged 3-20 years.

- Inpatient days per 1000 member months (MM) average 41% in the 1Q02, compared to 38% in 1994 FFS. The following table shows the total average inpatient MM, length of stay (LOS) and ED rates per 100MM over the 1998-2002 1st quarters. (The ALOS ranges from 3.3 to 3.8, with FFS rates at 3.5).

The first quarter comparisons based on data presented to the Council by DSS shows a gradual increase in inpatient days/1000MM and ED visits per 1000MM; however these utilization patterns remain at or under the 1994 rates.

- Quarterly behavioral health utilization for total MH & substance abuse varies by quarter and plan. The following shows 1st quarter BH utilization for MH & SA since 1997:

	1Q97	1Q98	1Q99	1Q00	1Q01	1Q02	FFS 94
Total MH & SA Use	4.17	5.23	4.17	5.84	5.11	6.20	4.75

While the % of members receiving MH & SA services generally remain above the FFS rates of 1994, DSS noted that an identified reasonable range is not known.

Sen. Harp requested the following:

- DSS present prenatal care data, (*the last report to the Council was for the 4Q00*) as it is important to track any impact from funding changes, begun in January 2002, to the Healthy Start programs.
- DSS partner with the CT Chapter of the American Academy of Pediatrics, other Primary Care pediatric provider associations, as well as the Dept. of Education to identify steps that can be taken to improve use of EPSDT services. Sen. Harp would bring this meeting together.

Dental Carve-out Update

David Parrella stated that the Medicaid dental management ASO RFP will go out to interested bidders on 11/13/02 and will be placed on the DSS web site. Subsequent to the State Employee Union agreement to the linked dental procurement on October 25, the RFP will include specifics related to this. The Department is close to hiring a lead dental procurement expert, whose role will be similar to Dr. Schaefer's role in managing the HUSKY BH carve-out. The DSS has received approval from OPM to hire 4 new HUSKY staff; the department has lost 6 experienced staff over the past 1.5 years.

HUSKY Enrollment

William Diamond, Regional Director of ACS, the HUSKY enrollment broker, presented current HUSKY enrollment numbers as of November 1, 2002:

- Total HUSKY A & B enrollment increased by 2602 members, to 298,972 members.
- Total HUSKY A increased by 2246 members to 285,044.
 - Adult enrollment increased by 1106 for a total of 84,394 enrolled as of 11/1/02

(adults represent about 30% of the Total A membership).

- <19 years HUSKY A enrollment increased by 1080 members, for a total of 200,650 members.
- HUSKY B enrollment increased by 356 members, with 13,928 children enrolled in the CT SCHIP program.

Other Council Questions to DSS

- Rep. Nardello requested DSS present an update on the HUSKY outreach dollars/initiatives that remain after the budget changes at the December Council meeting. It was noted that enrollment continues to climb without additional media outreach, which may reflect downturns in the State economy.
- Sen. Harp asked the department to comment on the status of the Medicaid optional service budget changes that will impact Medicaid adults (including adults in HUSKY A). David Parrella stated that the implementation of the changes has been delayed to January at the earliest. A thirty-day advanced notice will be sent to Medicaid members and health providers.
- Sen. Harp requested information about the drug formulary issues discussed in October. The DSS noted that 3 of the 4 plans (FirstChoice/P-1 excluded) have drug formularies in place. These formularies are intended to address the spiraling HUSKY prescription costs. The current DSS/MCO contract contains provisions related to members' access to brand name drugs deemed urgent by the prescribing provider. The confusion involves MCO notices to members informing them of formulary changes and whether this constitutes the required Notice of Action be sent to the member. The DSS has discussed this with one MCO and is dealing with this on a case-by-case basis.
- The Department was requested to provide the Council staff with the new rates for the HUSKY cell categories.
- Mark Schaefer (DSS) reported that the collection of data for the BH Outcomes study is complete and data analysis and report will be completed, based on the revised contract submitted by Dr. Kazdin, Principle Investigator at YCS. Sen. Harp requested Barbara Park Wolf (OPM) assist in moving the release of the funds in the non-lapsing account forward so that the report will be available for review and input into the ongoing redesign of BH services within the HUSKY programs.

The Medicaid Council will meet on Friday December 13 at 9:30 AM.