Second Annual Evaluation Calendar Year 2007

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Second Annual Evaluation
Calendar Year 2007

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www.ctbhp.com (click on publications)

Department of Children and Families
www.ct.gov/dcf (click on publications)

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EXECUTIVE SUMMARY

INTRODUCTION

The primary role of the Connecticut Behavioral Health Partnership (CT BHP) is to manage the funding and delivery of behavioral health services to children covered under Husky A and B and selected DCF behavioral health funding through an administrative services organization (ASO). Their primary goals include reducing hospital emergency department overcrowding, unnecessary inpatient admissions, and lengths of stay in hospitals and residential treatment settings, and promoting alternative treatments such as community-based and outpatient services.

The state legislature requires submission of an annual report summarizing the performance of CT BHP during each calendar year. The current report summarizes findings from calendar year 2007. The report includes the following sections:

- Introduction
- Summary of Past Accomplishments
- CT BHP Enrollment and Performance
- Targeted Areas of Performance
- Results of Comprehensive Member Survey
- CT BHP Key Accomplishments
- Special Projects
- Financial Information
- Strengthening the Local Delivery System
- Lessons Learned
- Significant Issues for 2008 and Beyond
- Conclusions

FINDINGS

<u>CT BHP Enrollment and Performance</u>

Each year, CT BHP tracks their enrollment and reports on a number of key performance indicators that represent important functions related to managing service delivery. These performance indicators include: telephone call management, utilization management, denials of services requests and appeals, complaints, and service utilization. CT BHP's performance on these key performance indicators suggests that they continue to do a very good job completing the administrative tasks that are vital to managing the publicly funded behavioral health system.

- In December 2007 there were 328,579 members enrolled in CT BHP, an increase of 3.9% from CY 2006.
- There were a total of 87,988 calls received at the Call Center in 2007 compared to a total of 52,119 calls in CY 2006, an increase of 69%. The Call Center met or exceeded all contractual obligations for telephone call management in CY 2007.
- Higher and lower levels of care have established standards related to turnaround times for authorizations of care. For each of the timeframes related to higher and lower levels of care, the contracted standards were met or exceeded in all four quarters.
- The total number of denials was 451, an overall denial rate of 3.5%. All Level I provider appeals were resolved within the standard timeframe and 6 of 7 (86%) Level II appeals were resolved within the timeframe.
- A total of 47 complaints were received, compared to 75 complaints in CY 2006, a reduction of 37%. All complaints were reviewed and closed within the standard 30 days.

- There was evidence to suggest that inpatient and residential service utilization declined in 2007, although data collection became more reliable toward the end of the year. As a result, subsequent data on inpatient and residential utilization will allow for stronger conclusions about quarterly and yearly trends.
- Utilization of ambulatory (outpatient) services clearly increased in 2007 in terms of unduplicated clients served and units of service delivered. Significant growth in utilization was observed for home-based services such as Multi-Systemic Therapy (MST) and Intensive In-Home Child and Adolescent Psychiatric Services (IICAPS), as well as clinic-based intensive outpatient programs.

Targeted Areas of Performance Linked to Payment Withholds

ValueOptions' contract with the Departments identified eight performance targets that would serve as an incentive for ValueOptions to continually improve performance. The eight areas included: data management; provider satisfaction; member satisfaction; quality of care for DCF-involved youth that experienced placement disruption; rates of 30-day follow-up care; discharge delays from inpatient care; intensive care management; and clinical documentation. ValueOptions' performance in each of these targeted areas indicates that they continue to do a very good job managing the administrative functions of CT BHP. Their performance in each of the eight areas is summarized below.

- With the exception of accuracy on the provider file, which resulted in a partial return of the withhold for that element, CT BHP met or exceeded all other CY 2007 contracted standards for data management.
- The overall provider satisfaction rating was 89.8%, slightly below the 90% standard for full return of the withhold. Thus, ValueOptions received 75% of the associated withhold.
- The overall member satisfaction rate was 91.5%, which exceeded the contracted standard of 90% and exceeded CY 2006 performance (83.7%).
- The findings of a study on placement disruptions suggested that children who had been authorized for behavioral health services in the past six months were significantly more likely to experience a disruption in their foster care placement than children without a service authorization. Based on their completion of all tasks within specified timeframes, ValueOptions received 100% of the associated withhold.
- With regard to improving rates of follow-up care for members discharged from inpatient settings, there were continued concerns regarding the state's ability to provide accurate and timely data to assess this performance target. Therefore, ValueOptions received a full return of the associated withhold.
- ValueOptions was asked to work on reducing discharge delays for children receiving inpatient treatment. Throughout 2007, ValueOptions worked to improve data accuracy, improve access to community-based services, and develop a treatment improvement education series for discharge planning. A slight reduction in discharge delays was observed from the 3rd to the 4th Quarter of 2007. ValueOptions completed this work in the specified timeframes and recovered 100% of the associated withhold.
- The Intensive Care Management program served 1,426 members including 364 adults, which exceeded the standard and resulted in a 100% return of the associated withhold.

- ValueOptions improved on each of the three areas of clinical documentation compared to the baseline measurement (medical necessity, quality management, active care management). However, only their performance on medical necessity met the established thresholds. Therefore, ValueOptions received 40% of the associated withhold.

Comprehensive Member Survey

In CY 2007, Fact Finders conducted a survey to assess members' experiences with, attitudes toward, and suggestions for improvement of treatment services received through the CT BHP provider network. Among the most encouraging findings were:

- Approximately 60% of members were aware that CT BHP was providing their mental health services, compared to 53% in CY 2006.
- Sixty one percent of members rated their counseling services as "excellent" or "very good" compared to 58% in 2006.
- The results demonstrated many areas of improvement in member satisfaction compared to 2006, although percentage changes in positive or negative directions on individual items generally were small.

CT BHP Key Accomplishments in CY 2007

Each year, CT BHP provides a brief overview of their accomplishments. A selection of their accomplishments in 2007 include the following:

- Developed a Quality of Care Committee and quality improvement planning
- Transformed the Systems Management Department to Network Management
- Reviewed and updated all policies and procedures
- Initiated programs to decrease discharge delays in inpatient settings and continued to facilitate decrease in emergency department discharge delays
- Implemented use of the Child and Adolescent Needs and Strengths (CANS), and refined the residential referral and triage system for children presenting for residential care
- Began on-site reviews at high volume hospital programs
- Co-managed, with managed care organizations, high-risk cases with co-occurring physical and behavioral health care needs

Special Projects

Each year, CT BHP identifies and carries out special projects related to key issues and challenges in the service system. Three such projects in 2007 were the following:

- Monitor the ongoing concern with children experiencing discharge delays in inpatient and emergency departments. CT BHP worked closely with the Connecticut Children's Medical Center to reduce discharge delays in their emergency department.
- Ongoing expansion and implementation of Enhanced Care Clinics, with attention to coordination with primary care physicians.
- Ongoing development and refinement of the functions of Residential Care Teams.

Financial Information

A significant innovation and strength of CT BHP is its braided funding structure, which allows the Departments to maximize resources for funding behavioral health services. As a result, members have access to funding from both agencies to support their service plans and needs.

- In 2007, the total state expenditure for CT BHP was $129,182,953 for HUSKY A and $4,086,155 for HUSKY B. Comparable figures in CY 2006 were $101,878,843 for HUSKY A and 2,480,581 for HUSKY B.
- The total DCF expenditure for CT BHP was $160,162,327, as compared to 151,243,872 in CY 2006. An additional $21,291,625 was spent in 2007 on services not managed by the ASO, but critical to the overall service system.

Strengthening the Local Delivery System

Implementing a system of care approach statewide relies on a well-developed local behavioral health delivery system. In 2007, CT BHP continued to work with 26 existing community collaboratives throughout the state to help build this system. Improved policies and procedures were implemented to support this process.

- The concept of 'Systems Management' was replaced with the concept of 'Network Management,' which has a more explicit focus on working with the provider network on issues of capacity, quality, and access and is guided by analysis of data within a pre-determined set of network improvement initiatives.
- Regional Network Managers remain assigned to specific DCF Area Offices, Community Collaboratives, and programs/facilities.

Lessons Learned in 2007

The second full year of CT BHP implementation resulted in important lessons that will guide future work to develop and refine the service system.

- Effective, transparent working relationships among CT BHP partners are essential.
- Staff selection, training, and retention at ValueOptions were important factors in accomplishing the goals set forth for 2007.
- The success of important initiatives can be determined by "staging" such initiatives prior to implementation and involving community members early in the process.
- Collecting and using data to evaluate the success of initiatives is helpful to guide stakeholders and ensure that there are objective ways to assess outcomes.
- Building relationships with hospitals was a critical element of the success of many initiatives in 2007.
- Financial incentives, clear contract language, and effective network management are key strategies for promoting improved quality of care.

- Future contracts between state agencies and the ASO must balance the importance of clearly defined expectations and responsibilities, with flexibility to modify the contract and respond to identified needs.
- CT BHP should continue to consider appropriate ways in which to make full use of the data in order to inform the growth and improvement of the service system.
- There should be ongoing outreach to all stakeholders in a complex system such as CT BHP, including children, families, providers, state agencies, and legislators.

Significant Issues for 2008 and Beyond

In a service system as complex as that managed by CT BHP, challenges must be identified proactively and confronted. In 2007, three specific issues were identified as ongoing challenges within the behavioral health service system, each of which will require a commitment of time and resources. These three areas were: residential services, discharge delays, and expansion of services to meet the need.

- Despite significant accomplishments in 2007, challenges remain with the management of residential services, including vacancies in facilities, difficulty finding placements for specific populations of children, and high costs.
- There remains a need for focused attention on the problem of discharge delay in higher levels of care, including inpatient treatment, emergency departments, and psychiatric residential treatment facilities.
- CT BHP must continue to work together to expand the availability of services for youth with behavioral health needs. Despite an influx of new money to support community-based services, data on discharge delays suggest that expansion has not yet met the need.

Conclusions

Data from the second full year of implementation indicate that the CT BHP continues to successfully manage and administer the Husky A and B program for behavioral health services in the state. Enrollment has increased, yet CT BHP continues to meet or exceed the majority of its performance targets. ValueOptions has performed well as the ASO for CT BHP, resulting in return of withholds related to key performance targets. Data collection related to utilization of higher levels of care (e.g., inpatient hospitalization, residential treatment) became increasingly reliable in the 3rd and 4th Quarter, and it was during this time that some evidence of decreased utilization began to emerge. Community-based outpatient service utilization generally increased in 2007 compared to 2006. Members and providers generally are satisfied with CT BHP. Special projects have been managed successfully, which has contributed to the knowledge base and has allowed stakeholders to monitor trends, plan targeted interventions, and prepare for challenges.

Based on meeting the requirements of the BHP contract and the associated standards and performance targets, the second year of CT BHP was a success. It is important to note that given the still early stage of development of CT BHP, its successes are significant. Ultimately, it is the ongoing partnership between CT BHP stakeholders that will allow for the continued development of a community-based mental health system that will effectively and efficiently meet the behavioral health needs of children and families in Connecticut.

CONNECTICUT BEHAVIORAL HEALTH PARTNERSHIP
ANNUAL EVALUATION
CALENDAR YEAR 2007

I. INTRODUCTION

In January 2006, the Connecticut Department of Social Services (DSS) and the Department of Children and Families (DCF) partnered to establish the Connecticut Behavioral Health Partnership (CT BHP). The CT BHP manages the funding and delivery of behavioral health services that are provided to Connecticut children and families covered under HUSKY A (Medicaid) and B (SCHIP) plans, as well as DCF-involved children with behavioral health needs. Since its inception, CT BHP has been organized around the values and principles of a system of care approach.[1] In short, these values and principles call for behavioral health services that are child-centered and family-focused, are provided in the community, keep children in their homes and communities, and prevent unnecessary utilization of highly restrictive and costly services. CT BHP emphasizes increased access to community-based programs and services and better management of state and federal resources.

The establishment of CT BHP represented the beginning of a new administrative structure to support this conceptualization of behavioral health service delivery for children and adolescents. This structure was designed to address major problems in the system as articulated in a February 2000 report entitled *Delivering and Financing Behavioral Health Services for Children in Connecticut,* [2] and the Governor's Blue Ribbon Commission on Mental Health.[3] One major finding in the 2000 report captured the fundamental problem.

> *Seventy percent* of annual state spending on behavioral health services was for costly and restrictive out-of-home services provided to only *19%* of the children served. In contrast, only *30%* of spending was devoted to community-based services delivered to the remaining *81%* of children served.

These findings and others became the basis for restructuring the children's mental health service system in a plan initially called *Connecticut Community KidCare*. The plan called for a full carve-out of the HUSKY child behavioral health benefit to be managed by an administrative services organization (ASO). The Connecticut General Assembly authorized this new approach in 2005 and named the newly established entity the *Connecticut Behavioral Health Partnership*. Through a competitive bidding process, ValueOptions was selected and continues to serve as the ASO. The legislation articulated the purpose and oversight mechanisms of the CT BHP. The law specified that the purpose was to increase access to quality behavioral health services through:

- Expansion of individualized, family-centered, community-based services
- Maximization of federal revenue to fund behavioral health services
- Reduction in unnecessary use of institutional and residential services for children
- Capture and investment of enhanced federal revenue and savings derived from reduced residential services and increased community-based services
- Improved administrative oversight and efficiencies
- Monitoring individual outcomes and provider performance

Primary goals included reducing hospital emergency department overcrowding, unnecessary inpatient admissions, and lengths of stay in hospitals and residential treatment settings. As an alternative, the legislation called for increased availability and use of community-based and outpatient services.[4]

Furthermore, the legislation called for submission of an annual report summarizing the performance of the CT BHP during each Calendar Year (CY) to provide a review of issues related to ASO implementation, collaboration between DSS and DCF, the number of children served in CT BHP programs, and outcomes and spending for covered children and adults.

This is the second annual report summarizing key accomplishments of the CT BHP for Calendar Year 2007 (CY 2007). It draws from several sources including:

- ValueOptions reports to DSS and DCF
- Minutes and presentations at meetings of the Behavioral Health Partnership Oversight Council and its subcommittees
- Reports of member satisfaction surveys conducted by Mercer Government Human Services Consulting (Mercer) and Fact Finders.
- Reports summarizing the results of key CT BHP initiatives for CY 2007
- Interviews with key staff at DSS, DCF and ValueOptions

II. SUMMARY OF PAST PERFORMANCE AND ACCOMPLISHMENTS

This report will summarize the second full calendar year of CT BHP implementation (January 1 to December 31, 2007). However, key findings from the pre-implementation phase of 2005, and from the first full calendar year of operation in 2006, as presented in the 2006 Annual Report[5], are relevant to the ongoing operations of CT BHP. These findings are briefly summarized below.

Calendar Year 2005

The state department's activities in CY 2005 were focused on supporting the initial implementation of CT BHP in preparation for a January 1, 2006 start-up. Through a competitive bidding process, ValueOptions was selected as the ASO. The first contract with ValueOptions was issued in May 2005, covering the period of August 17, 2005 through December 31, 2008.

During CY 2005, ValueOptions developed the infrastructure, policies, and procedures to perform major roles and functions of the partnership including: utilization management, intensive care management, customer service, enhanced web systems, peer support, quality management, systems management, and local service and provider network development. DSS and DCF contracted with Mercer Government Human Services Consulting (Mercer) to conduct a pre-implementation readiness review, the results of which did not support a full implementation on January 1, 2006. Consequently, the Departments decided in December 2005 to proceed with the carve-out of behavioral health services from the HUSKY Managed Care Organizations (MCOs) but chose to postpone the initiation of clinical management. A series of steps took place in 2006 to ensure that the information technology systems would be able to link authorization to claims for all sectors of the behavioral health system. A follow-up report by Mercer identified additional

steps required to support full implementation, and ValueOptions developed plans to address each concern.

Calendar Year 2006

As noted above, CT BHP officially began operations in January 2006. The first six months of 2006 were devoted to addressing the readiness concerns raised by the Mercer report. By December 2006 there were 316,168 enrolled members. Of these, over two-thirds (71%) were children under 18 years of age.

The 2006 contract with ValueOptions specified six key performance areas that would be tracked and reported on a quarterly basis. The six areas included:

- Telephone call management
- Utilization management
- Denials of service authorization
- Access to providers
- Utilization of services
- Provider and member complaints

In general, quarterly reports revealed that CT BHP was meeting or exceeding expectations for managing the funding and delivery of behavioral health services. The contract between state departments and ValueOptions also allowed the state to withhold a portion of payments to ValueOptions that could be recovered based on their performance in six additional targeted areas, including:

- Data management
- Provider satisfaction
- Member satisfaction
- Hospital inpatient re-admissions
- Follow-up care
- Emergency department utilization

ValueOptions met all contract requirements for four of the six areas, and partially met a fifth objective. The targeted area related to emergency department utilization was waived for 2006.

Emergent Themes from CT BHP's Initial Operations

A consistent theme from the operations of CT BHP in CY 2006 was the utilization of higher-end treatment settings, in particular by children involved with DCF. These children comprised only 5% of the member population but they utilized a relatively high proportion of high-end and out-of-home services. For example, children involved with DCF comprised 49% of the population of acute psychiatric inpatient admissions in the 4th Quarter of 2006, and 75% of enrolled HUSKY adults and children in inpatient care in 2006 had a history of DCF involvement. Furthermore, children involved with DCF had close to three times longer lengths of stay in inpatient settings than children with no DCF involvement. In addition, many children admitted to inpatient units were found to be in "discharge delay" status, defined as remaining in inpatient

hospitalization beyond medical necessity. This was usually due to difficulties arranging for appropriate post-discharge living arrangements and/or clinical services.

A second and related theme from the first full year of implementation was the development of new initiatives to increase the investment in a community-based system of care. For example, in CY 2006 CT BHP funded the first cohort of Enhanced Care Clinics. Clinics designated as an Enhanced Care Clinic (ECC) received an enhanced reimbursement rate (approximately 25% increase) in return for meeting specific service delivery requirements. The first phase of requirements was launched in CY 2006, and focused on increasing access to outpatient services depending on the level of need (i.e., emergent, urgent, routine). Under this initiative, priority access was to be given to youth with DCF involvement. A related initiative in 2006 focused on converting the Intensive In-Home Child and Adolescent Psychiatric Services (IICAPS) program from a DCF grant-funded structure to a full fee-for-service model. The IICAPS program, a treatment model developed by the Yale Child Study Center, is designed to divert children from inpatient admissions and residential care, and facilitate discharge from these facilities, by providing alternative home-based services developed specifically for youth with severe psychiatric challenges.

A number of significant challenges were identified in 2006, providing the basis for CY 2007 initiatives. Among the challenges noted were:

- Staff turnover at the CT BHP service center
- High rates of discharge delays (particularly for children in inpatient treatment and with DCF involvement)
- Insufficient capacity of community-based services to meet the demand
- Coordination of physical and behavioral health care between CT BHP and managed care organizations

In general, the first full year of implementation of CT BHP was considered a success, despite the presence of some challenges consistent with the initial implementation of any new and complex system of management and administration.

III. CT BHP ENROLLMENT AND PERFORMANCE IN 2007

A. CT BHP Enrollment

In December 2007 there were 328,579 members enrolled in CT BHP, an increase of 3.9% from December 2006. Approximately 70.2% of members were under 18 years of age (compared to 71.4% of members in December 2006). Table 1 summarizes enrollment information for CY 2006 and CY 2007.[6, 7]

Table 1. CT BHP Enrollees in CY 2006 and CY 2007

Membership	2006 Enrolled Members	2007 Enrolled Members
Children (0-18)	**225,719**	**230,504**
Adults (19+)	**90,449**	**98,075**
Total	**316,168**	**328,579**

B. CT BHP Performance

CT BHP produces quarterly reports on key performance indicators related to their functioning. This allows stakeholders to track performance on these indicators, monitor emerging problems, and plan necessary corrective actions. These six contracted indicators are listed in Exhibit E of the contract between the Departments and ValueOptions and include:

1. Telephone Call Management
2. Utilization Management – Authorizations for Care
3. Denials of Service Requests and Appeals
4. Complaints
5. Service Utilization

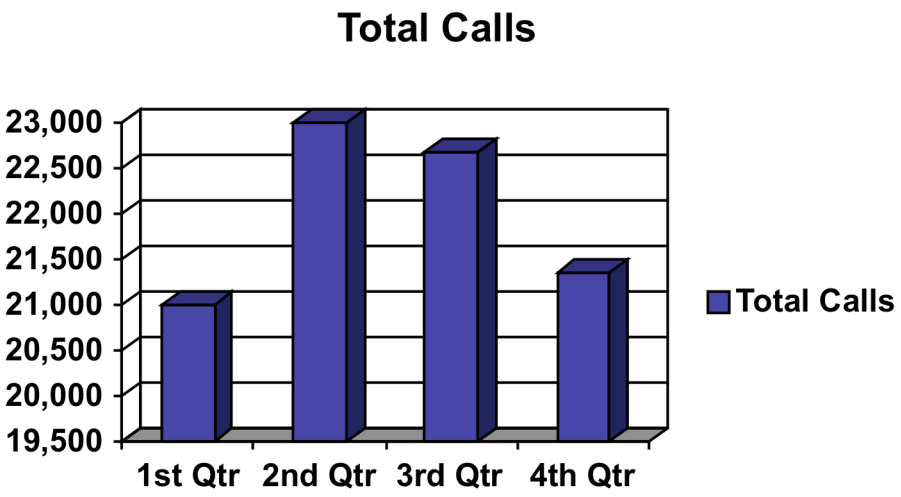
Performance in each area is summarized below for CY 2007, with comparisons to data from CY 2006 when appropriate.

1. Telephone Call Management

CT BHP is expected to track incoming calls and to maintain the capacity to answer 6,000 calls per month. This capacity is increasingly important as enrollment grows and as providers and members become more familiar with CT BHP authorization processes and procedures. With increasing numbers of enrolled members comes the potential for incoming calls to overwhelm the Call Center. To prevent this, the CT BHP service center is expected to track incoming calls and their performance in managing these calls.

Performance. There were a total of 87,988 calls received at the Call Center in 2007 compared to a total of 52,119 calls in CY 2006, an increase of 69%.[8] Of the 87,988 calls received in 2007, 64,892 (73.7%) were from providers and 23,096 (26.3%) were from members. The Call Center received 6,000 or more calls in 10 of 12 months in CY 2007. (See Figure 1 for calls by quarter.) The standards require that 90% of calls be answered within 30 seconds. In CY 2007, 93% of calls met the standard, compared to 99% in CY 2006.[9] The average speed of answer was 4 seconds for routine and crisis calls, exceeding the standard requiring that routine calls be answered within 30 seconds and crisis calls be answered within 15 seconds. In CY 2007, 36% of all calls received for clinical services were placed on hold, and remained there for an average of 16 seconds.[10] These results were better than results from CY 2006 (26 seconds). Based on this performance, the Call Center met or exceeded all contractual obligations for telephone call management in CY 2007.

Figure 1. 2007 Call Volume by Quarter



2. Utilization Management – Authorizations for Care

The CT BHP service center is required to manage thousands of calls for authorization of services each year. Authorization decisions are based on a review of demographic and clinical information to ensure that children meet eligibility and level of care requirements for the particular service being sought. The authorization process is intended to manage the distribution of clinical services to youth with demonstrated need for the service. A danger of the authorization process is that decisions might not be made in a timely manner, thereby limiting members' access to needed services. For this reason, CT BHP tracks and reports performance in responding to requests for authorization to ensure an efficient authorization process.

Care managers are expected to respond to providers with an authorization decision within certain timeframes, referred to as turnaround times. Expectations for turnaround times vary depending on the level of care for which authorization is sought, and whether clinical review by a psychiatrist is required. For example, contract expectations call for a turnaround time of one hour for authorization of higher level of care services for which no peer review is required. These services include admission to psychiatric hospital inpatient, general hospital inpatient, inpatient detoxification, psychiatric residential treatment facilities, partial hospitalization, and intensive outpatient services. If peer review by a psychiatrist is required for the higher level of care services, standards call for turnaround times within the following timeframes: 2 hours for psychiatric hospital inpatient and general hospital inpatient, 3 hours for inpatient detoxification, and 1 business day for partial hospitalization, intensive outpatient, psychiatric residential treatment, and crisis stabilization services.

Lower levels of care, including extended day treatment, group home, residential treatment, residential rehabilitation, and home-based services, require an authorization decision to be communicated to the provider within one business day. The contract also calls for written

notification of authorization decisions to be mailed to providers within three business days. For each response category, it is expected that CT BHP will meet the standard at least 95% of the time.

As authorizations were phased in throughout 2006, there are only data for the last two quarters of that year. During that time there were 4,573 authorization requests for the higher levels of care and 1,931 for the lower levels of care.

Performance. For services in the higher levels of care in 2007, a total of 9,791 cases were presented for initial authorization (with and without peer review). In total, 9,671 of these requests for authorization were responded to within the designated timeframe, resulting in a compliance rate of 98.77%. For each of the timeframes related to higher and lower levels of care, the contracted standards were met or exceeded in all four quarters.

There were 3,115 initial authorization requests for the lower levels of care in CY 2007. Of those, 3,103 met the contracted standard, resulting in a compliance rate of 99.62%. ValueOptions met the required 95% standard in 2006 as well, but contract sanctions were enacted when ValueOptions failed to provide written authorization in a timely manner to approximately 8,000 requests. Results from CY 2007 indicate that this issue was resolved and written notifications were provided within the designated timeframe for 99% of cases.[11, 12]

3. Denials of Service Requests and Appeals

The authorization process is intended to ensure that services paid for under the CT BHP are medically necessary and appropriate. CT BHP tracks all denials[a] of authorization and reports these on a quarterly basis. There are two types of provider denials: 1) administrative, and 2) medical necessity. Administrative denials typically occur when a provider fails to contact the CT BHP in the required timeframe or otherwise fails to follow administrative requirements. Medical necessity denials occur when it cannot be shown that a requested service is medically necessary and appropriate. CT BHP tracks each type of denial.

When there is a denial of a request for care, members and providers are offered the opportunity to appeal. Appeals requested by members are reviewed by ValueOptions internally and a decision is made to uphold or overturn the denial. If the member is not satisfied with the determination, they can proceed to a second level of appeal. In the case of HUSKY A members, the second level appeal is an administrative hearing conducted by DSS. In the case of HUSKY B members, a second level appeal would be conducted by the Department of Insurance. The standards for resolving HUSKY A member appeals are 30 calendar days for routine appeals, 3 days for expedited appeals, and 5 days for expedited appeals that include a member meeting.

Appeals requested by providers also are reviewed by ValueOptions internally. Initial appeals are referred to as Level I appeals. If the member or provider is still dissatisfied with the outcome of the Level I appeal, a second appeal (Level II) is offered. For provider appeals, the standard for resolving appeals is one business day. The contractual expectation is that CT BHP will resolve

[a] A denial is referred to as a Notice of Action when the action pertains to a HUSKY A member.

90% or more of member and provider appeals within the appropriate standard. In CY 2006, there were no member or provider appeals.

Performance. Table 2 displays information on denials of service authorization for CY 2007. Of the 12,906 calls for authorization in CY 2007, the total number of denials was 451, an overall denial rate of 3.5%. The majority of denials (89%) were administrative, all of which were due to providers failing to contact the BHP within the required timeframe. Only 48 denials (11%) were for medical necessity (32 related to children and 16 related to adults). Because of the phase-in of authorizations in 2006, there are only data for the last two quarters of the year. These data indicated that a total of 126 denials were issued (a rate of 1.9%), 92% of which were administrative (compared to 89% in CY 2007).

Table 2. Denials of Authorization for Services in CY 2007: Children and Adults

Quarter	Administrative	Medical Necessity	Total
Quarter 1	127	11	138
Quarter 2	103	14	117
Quarter 3	110	18	128
Quarter 4	63	5	68
TOTAL	**403 (89%)**	**48 (11%)**	**451**

Among children, the highest numbers of administrative denials were for Intensive Outpatient (67), Extended Day Treatment (58), and IICAPS (43). The highest numbers of administrative denials among adults were for Intensive Outpatient (64), Inpatient (26), and Inpatient Detoxification (11). For children and adults, the highest number of medical necessity denials was for inpatient treatment.

There were a total of 2 member appeals in CY 2007. Both were Level I appeals and were resolved within the standard timeframe (100% performance). In both instances, the denial was upheld. There were no expedited member appeals in CY 2007. With regard to provider appeals, there were 14 Level I appeals, including 12 pertaining to children and 2 pertaining to adults. All Level I provider appeals were resolved within the standard timeframe (100% performance).[13, 14]

4. Complaints

ValueOptions tracks all complaints received from the provider and member community and makes every effort to ensure that they are attended to in a timely manner. The standard for CT BHP is to review and close all complaints and grievances within 30 days. In addition, ValueOptions tracks trends in complaints received over time as one indicator of overall satisfaction with CT BHP.

Performance. In CY 2007, a total of 47 complaints were received, compared to 75 complaints in CY 2006, a reduction of 37%. Sixteen of these 47 complaints (34%) were received from providers and 31 complaints (66%) were received from members. Seven complaints were in reference to adult members and 24 were in reference to child members. In CY 2007, 100% of

complaints were reviewed and closed within 30 days, with an average time to resolution of 13.0 days. Most member complaints were in reference to the quality of care of services received. [16]

The drop in overall complaints in 2007 can be attributed to a number of factors. In 2007 CT BHP continued staff and provider trainings on the proper procedures for recording complaints. An appeals process was instituted for providers relating to administrative denials involving failure to meet accepted timeframes. Furthermore, in CY 2007 providers who called with problems entering registration for outpatient services in the web-based system were treated as appeals, whereas in CY 2006 these were handled as complaints. Finally, feedback from members or providers who had concerns about the care they received was tracked internally as quality of care feedback if the member or provider declined to submit a formal complaint. Informal complaints are not reported here. It is possible that the changes described above had some effect on the reduced number of complaints received in CY 2007. Changes in procedures for tracking complaints aside, the overall number of complaints in both years was low.

5. Service Utilization

Since its inception, a primary goal of CT BHP has been to prevent unnecessary utilization of costly and restrictive out-of-home placements and increase the use of home- and community-based services in an effort to maintain children in their homes whenever possible. Data from Quarters 3 and 4 of CY 2006 demonstrated that children with DCF involvement had higher rates of admission to inpatient settings and longer lengths of stay than other children. These data suggested that children with DCF involvement are likely to have a greater need for behavioral health treatment, possibly as a result of exposure to maltreatment and other complex individual and family-level risk factors.

Performance. Utilization data from CY 2007 are summarized below for inpatient, residential, and ambulatory service settings.[17, 18] When appropriate, comparisons are made to CY 2006 data. However, it should be noted that CY 2006 data generally were incomplete until the 3rd or 4th Quarter, so comparisons to CY 2006 should be made with caution.

Inpatient Hospital Utilization

Table 3 displays data on inpatient service utilization for children and adults in 2006 and 2007. Inpatient services include hospital inpatient and residential rehabilitation and detoxification services, and for children only, psychiatric residential treatment facilities. In 2007, there were 1,676 children (0-18 years old) and 1,392 adults (19 years and older) admitted to psychiatric inpatient services (unduplicated counts).

Comparisons between CY 2006 and CY 2007 reveal interesting trends. Fewer children were admitted to inpatient settings in CY 2007 (1,676) than in CY 2006 (1,784), yet the number of units of inpatient services delivered to children increased from 78,374 units in 2006 to 80,020 units in 2007. A similar pattern was observed for adults. A total of 1,488 adults were admitted to inpatient settings in 2006 compared to 1,392 in 2007, but more units of services were delivered in 2007. It is possible that higher average lengths of stay in inpatient settings in 2007 could have contributed to these observed trends.

Table 3. Psychiatric Inpatient Utilization in 2006 and 2007 [17]

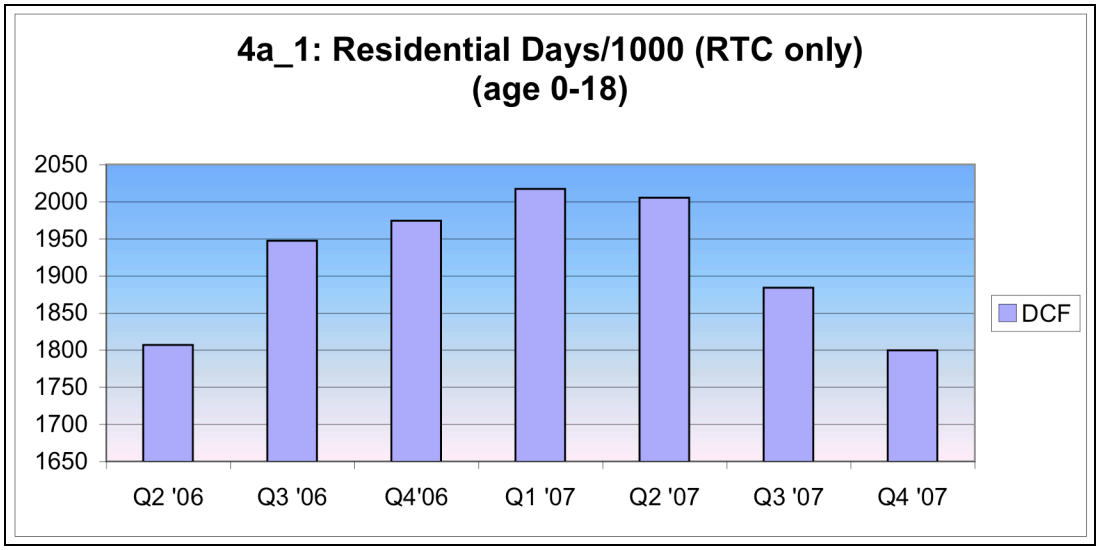
Inpatient Utilization	CY 2006	CY 2007
Children - Number of Admissions	1,784	1,676
Children - Units of Service	78,374	80,020
Adults - Number of Admissions	1,488	1,392
Adults - Units of Service	11,931	12,802

Note. Data for 2006 have been updated from what was reported in the report, *First Annual Evaluation: Calendar Year 2006*. The data presented here incorporate more claims data than was used to calculate the 2006 statistics.

Residential Treatment Utilization

Days in residential treatment for children with DCF involvement decreased in 2007 compared to the final three quarters of CY 2006. As displayed in Figure 2, from Quarter 2 of CY 2006 until Quarter 1 of CY 2007, there was a steady increase in the number of days spent in residential treatment per 1,000 members. Starting in Quarter 2 of CY 2007 there were steady decreases during each quarter. In Quarter 1 of CY 2007, 2,017 days per 1,000 members were spent in residential care. By Quarter 4, this number had decreased to 1,799 days per 1,000 members, a reduction of approximately 10%. With regard to average length of stay in residential settings, children appeared to experience slightly longer lengths of stay in 2007 than in 2006 (27.6 days compared to 26.6 days). Data on length of stay are authorization-based and the residential authorization process was in development in 2006. As a result, 2006 residential admissions often received authorization in the midst of a stay, which results in a somewhat lower calculated length of stay than if calculated using the admission date as the starting point, as was done in 2007. Comparisons between 2006 and 2007 residential lengths of stay should be made with caution.

Figure 2. Residential Days per 1,000 Members, CY 2006 and 2007 [17]



Ambulatory Service Utilization

As described above, a primary goal of the CT BHP is to increase the use of services that are less restrictive and maintain children in their homes and communities. To that end, CT BHP reports on the utilization of ambulatory, or outpatient, services provided by hospitals, clinics, and independent practitioners. This can include routine and intensive outpatient services, intermediate-level services such as Extended Day Treatment and Partial Hospitalization, as well as home-based services and emergency mobile psychiatric services. In CY 2007, there were a total of 20,523 children and 11,931 adults (unduplicated counts) that received ambulatory services, representing change from CY 2006 of 5.5% more children and 2.4% more adults.

Among services provided to children, home-based services experienced the highest rate of growth in unduplicated clients served from 2006 to 2007. The combined home-based service category of Multisystemic Therapy (MST), Multidimensional Family Therapy (MDFT), and Functional Family Therapy (FFT) experienced the highest rate of growth (35% increase) followed by IICAPS (30% increase) and clinic-based intensive outpatient (22% increase). Clinic-based partial hospitalization (39% decrease) and routine hospital-based outpatient services (19% decrease) experienced the largest declines in the number of unduplicated children served from 2006 to 2007.

Among services provided to adults, the highest growth in unduplicated members served from 2006 to 2007 was observed for clinic-based intensive outpatient services (11% increase) and routine outpatient services provided by independent practitioners (10% increase). The largest decrease in unduplicated clients served was observed for clinic-based day treatment/partial hospitalization programs (25% decrease).

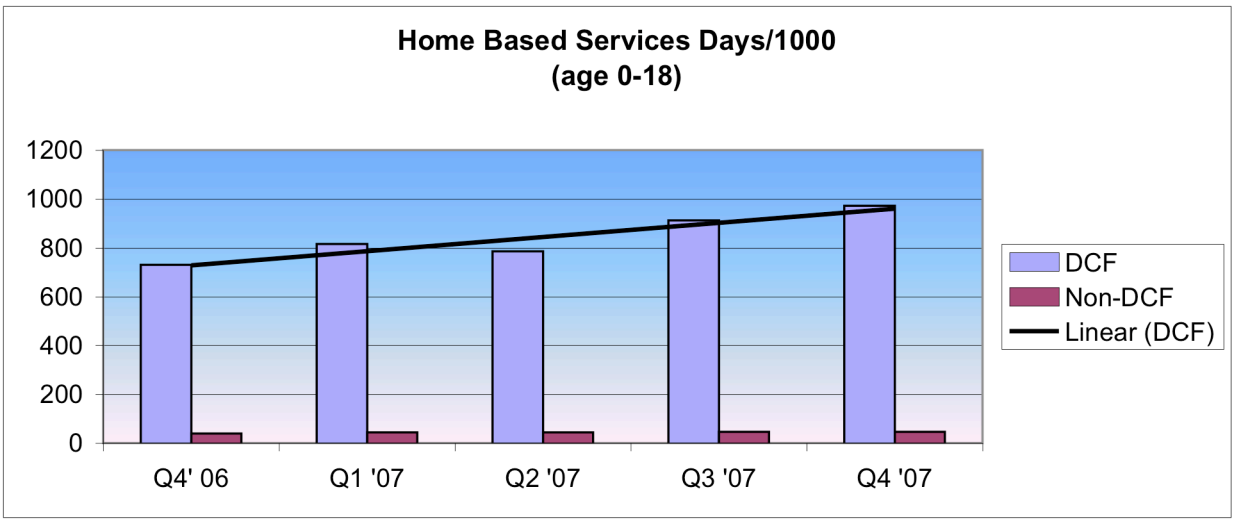
Table 4 summarizes the number of unduplicated recipients and units of service received for each type of ambulatory service, reported separately for children and adults. Comparisons are made between CY 2006 and CY 2007.

Table 4. Outpatient Service Utilization: Children and Adults, CY 2006 and CY 2007 [19]

Under 19	CY 2006		CY 2007	
Type of Service	**Recipients by Service (Unduplicated)**	**Units of Service**	**Recipients by Service (Unduplicated)**	**Units of Service**
Routine Hospital Outpatient	1,862	10,718	1,503	6,954
Routine Clinic Outpatient	13,692	152,022	14,309	159,444
Routine Independent Practitioners – Outpatient	4,453	43,488	4,672	45,079
Hospital Extended Day Treatment	182	7,865	201	8,306
Hospital Intensive Outpatient	1,155	20,538	1,101	21,223
Hospital Partial Hospitalization Program	596	10,107	610	9,871
Clinic Extended Day Treatment	601	34,539	564	31,539
Clinic Intensive Outpatient	512	12,161	626	18,961
Clinic Partial Hospitalization	149	1,835	91	1,529
Intensive In-home Child and Adolescent Psychiatric Services (IICAPS)	656	138,741	850	226,568
MST/FFT/MDFT	758	95,391	1,023	154,106
Emergency Mobile Psychiatric Services (EMPS)	1,204	3,090	1,319	3,199
Total – Duplicated recipients	25,820	530,495	26,869	686,779
Total – Unduplicated recipients	19,462		20,523	
19 and Over	**CY 2006**		**CY 2007**	
Type of Service	**Recipients by Service (Unduplicated)**	**Units of Service**	**Recipients by Service (Unduplicated)**	**Units of Service**
Routine Hospital Outpatient	2,551	15,714	2,361	15,290
Routine Clinic Outpatient	6,102	45,276	6,095	45,418
Routine Independent Practitioners – Outpatient	3,562	31,975	3,910	34,319
Hospital Extended Day Treatment	0	0	0	0
Hospital Intensive Outpatient	621	7,564	568	7,076
Hospital Partial Hospitalization Program	245	2,900	230	2,485
Clinic Extended Day Treatment	0	0	0	0
Clinic Intensive Outpatient	624	6,639	691	7,712
Clinic Day Treatment/Partial Hospitalization	331	3,769	249	3,110
IICAPS	0	0	0	0
Home-based	0	0	1	46
EMPS	10	13	3	6
Total – Duplicated recipients	14,046	113,850	14,108	115,462
Total – Unduplicated recipients	11,650		11,931	

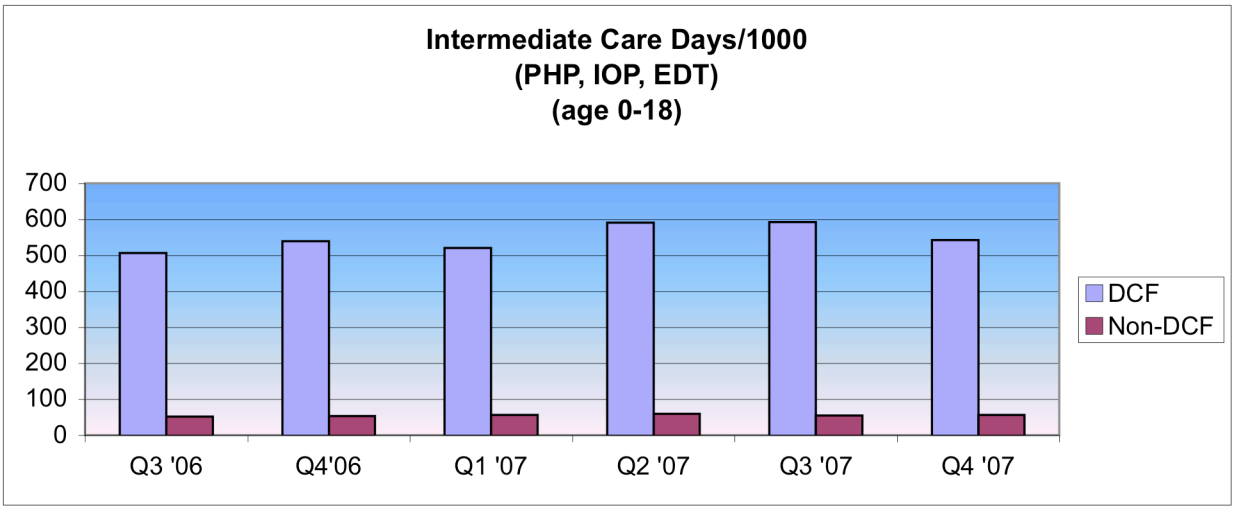
A closer examination of the data on home-based services demonstrates further the increased utilization of these services in CY 2007 (not including IICAPS). Figure 3 displays information for the total number of days per 1,000 members spent in home-based treatment in CY 2007, which includes Multisystemic Therapy, Multidimensional Family Therapy, and Functional Family Therapy. In this figure, days per 1,000 members refers to the number of days covered by the authorizations for home-based services, even though home-based services are billed in 15-minute increments. As shown in the figure, from Quarter 1 to Quarter 4 of 2007, the number of days per 1,000 members increased 19.3% for DCF-involved youth and increased 8.7% for Non-DCF-involved youth. These data suggest that DCF-involved youth have experienced a comparatively greater increase in home-based service utilization. The trend line depicted in Figure 3 represents growth in home-based service utilization for DCF-involved youth only.

Figure 3: Days in Home-Based Levels of Care per 1,000 Members, CY 2006 and CY 2007



Additional evidence exists to support increased utilization in CY 2007 of intermediate levels of care (Extended Day Treatment, Partial Hospitalization Programs, Intensive Outpatient Programs). Figure 4 summarizes days in care per 1,000 members in the last two quarters of CY 2006 and all of CY 2007. In Quarter 1 of CY 2007, DCF-involved members spent 521 days per 1000 members in intermediate levels of care, and children without DCF involvement spent 56.8 days per 1,000 members. In Quarter 4, these figures increased to 542 days per 1,000 members for children with DCF involvement and decreased to 56.2 days per 1,000 members for children without DCF involvement. Additionally, the rates of intermediate care for children with DCF involvement were even higher in the 2nd and 3rd Quarters than in the 4th Quarter of CY 2007. Again, these data suggest that children with DCF involvement experienced a significantly higher rate of growth in utilization of intermediate-level services than children without DCF involvement.

Figure 4: Days in Intermediate Levels of Care per 1,000 Members, CY 2006 and CY 2007



Conclusions on Utilization

Utilization data on inpatient, residential, and ambulatory services reflects the overall success of CT BHP in gradually increasing the utilization of home- and community-based programs and services. There was some data to suggest a gradual decrease in inpatient and residential utilization, particularly toward the end of the year. Inpatient admissions for children decreased from 1,784 children in 2006 to 1,676 children in 2007. Despite the decreased admissions, the number of units of inpatient services increased from 78,374 in 2006 to 80,020 units in 2007 suggesting that average lengths of stay in inpatient settings might have increased. Similar patterns were observed for adults when comparing inpatient utilization in 2006 to 2007.

With regard to residential treatment, there were more children admitted to residential treatment in 2007 compared to 2006. Average lengths of stay increased slightly compared to 2006, yet the days per 1,000 members spent in residential treatment declined in each quarter of 2007. Key stakeholders within CT BHP reported that it was unknown whether children were diverted or discharged from residential settings and treated in alternative community-based settings, or if these children were more likely to be treated in similar levels of care such as group homes. An encouraging trend in 2007 was the increased use of ambulatory services, particularly home-based services such as MST, MDFT, FFT, and IICAPS. These services saw significant increases in the number of unduplicated clients served in CY 2007. An intriguing area for further inquiry would be to examine how children move between services and programs; for example, by tracking a large group of children over time to determine patterns in movement from higher to lower levels of care.[b]

It is possible that increases in outpatient forms of treatment are linked to the observed decreases in inpatient and residential utilization. CT BHP has instituted several policy and program changes to support these changes. For example, Enhanced Care Clinics--which were instituted during 2007--were intended to increase children's access to a range of community-based

[b] An RFP for such a study was released in 2008 and a grantee selected, but funds were cut before a contract could be completed.

supports and services. There also was a significant investment in the expansion of intensive in-home services. Initiatives such as these appear to be having their intended impact on the broader behavioral health service system for children. Consistent with system of care principles, CT BHP appears to be helping children remain in the least restrictive treatment settings.

IV. TARGETED AREAS OF PERFORMANCE LINKED TO PAYMENT WITHHOLDS

In CY 2007, ValueOptions' contract with the Departments identified eight performance targets that would serve as an incentive for ValueOptions to continually improve performance in key areas. There was a withhold of 7.5% of the monthly administrative capitation payment tied to performance in these key areas (located in Exhibit A of the contract). A portion of the total withhold was associated with each performance target, outlined in Table 5. Detailed performance results for each target area are summarized below.

Table 5. Performance Targets, Withholds, and Results in CY 2007

Performance Area	Description of Target	Withhold	Target Met
1. Conduct timely and accurate data management related to authorization and payment in five domains			
a. Eligibility File – build and update	Upload 98% of all monthly full files within two business days; and all daily update files within one business day; error rate of 2% or less.	.3%	Yes
b. Provider File – build and maintain	Update 98% of weekly adds or changes within three business days, and monthly updates within five business days of receipt of clean data; error rate 2% or less.	.3%	Achieved 97.2%; received ½ of associated withhold.
c. Authorization File timeliness – provide and update daily	98% shall occur prior to the start of business the day following production of authorization file.	.3%	Yes
d. Authorization File accuracy	Error rate less than 2%.	.3%	Yes
e. Authorization File - error correction	98% of errors corrected within two business days.	.3%	Yes

2. Achieve a high level of provider satisfaction	Favorable average rating from 90% of providers in order to receive 100% of withhold.	0.75%	Achieved 89.8%; received 75% of withhold
3. Achieve a high level of member satisfaction	Favorable average rating from 90% of members surveyed in order to receive 100% of withhold.	0.75%	Yes (91.5% satisfied)
4. Improve quality of care outcomes for DCF-involved youth who disrupt out of a first or second foster home placement	Collaborate with DCF to identify whether behavioral health service utilization predicts placement disruptions; help develop preventive interventions.	1%	Yes
5. Improve the rate of connecting members to follow-up services within 30 days after inpatient hospitalization	Improve on rates of follow-up mental health and substance abuse care, compared to CY 2006.	1%	Yes; data not available; withhold returned
6. Reduce discharge delays for children and adolescents receiving inpatient behavioral health treatment	Reduce percentage of overall inpatient days that are 'discharge delay' days. Deliverable based on preparatory steps toward hospital delay day reduction.	1%	Yes
7. Maintain a minimum annual caseload in the Intensive Care Management program	Serve 1,400 unduplicated ICM members, no less than 250 of whom are adults.	0.5%	Yes
8. Improve clinical documentation of CT BHP cases by care managers, intensive care managers, and physician advisors	Improve clinical documentation in the areas of medical necessity, quality management, and active care management.	1%	Met threshold for medical necessity only; received 40% of withhold

Performance Target 1: Conduct timely and accurate data management related to authorization and payment in five domains

Essential functions of CT BHP are linked to their ability to track and maintain accurate data and assure that these data are effectively communicated across the Partnership. CT BHP generates, shares, and maintains data to ensure member eligibility, update provider information, authorize services, and pay claims. Each of these functions must take place in a timely manner with few errors. In CY 2006, 2.5% of the total withhold was linked to this performance target. In CY 2007 this was reduced to 1.5% of the total withhold. The data files used to determine performance toward these goals are the eligibility, provider, and authorization files.

Standards for the eligibility file were related to turnaround times for monthly and daily updates and maximum error rates. ValueOptions was to upload 98% of all monthly data files within two business days and all daily update files within one business day, with an error rate of 2% or less. Regarding the provider file, ValueOptions was expected to upload weekly additions or changes within two business days and upload monthly updates within five business days, with no more than 2% errors (based on random quarterly audits). Finally, related to the authorization file, ValueOptions was to provide a daily Prior Authorization Transaction batch file consisting of 98% of all authorizations from the previous day, prior to the beginning of the next business day. This file was to have no more than 2% errors and 98% of errors were to be corrected within two business days.

Performance: Regarding the eligibility file, a total of 508 files with over 3.8 million records, were uploaded into ValueOptions' system in CY 2007. In total, 501 of 508 (98.6%) files were uploaded within the designated turnaround time (TAT), which exceeded the performance standard of 98%. Of the 3.8 million records, there were 439 errors, all of which were identified as state-initiated. The error rate of .012% resulted in exceeding the performance expectation (less than 2% errors).

Regarding the provider file data exchange, ValueOptions met or exceeded the 98% accuracy standard in three of four quarters. During Quarter 3, ValueOptions achieved 90.85% accuracy. Aggregating across all four quarters, ValueOptions' accuracy was 97.2%, slightly below the performance target of 98%. ValueOptions did meet the second threshold, which called for at least 93.1% accuracy. Thus, they received half of the associated withhold for the provider file portion of the performance target. ValueOptions cited short staffing in their Provider Relations Department as the key contributor to Quarter 3 performance. However, in Quarter 4 of 2007, a corrective action plan resulted in 100% accuracy in the provider file.

Related to the authorization file, a total of 250 authorization files were created, 248 of which were delivered within TAT standards (99.2% in compliance), exceeding the 98% standard. In Quarter 1, 56 of 58 (96.5%) authorization files were delivered within the designated turnaround times, and all remaining authorization files in CY 2007 were delivered on time. In total 78,044 authorizations were processed and 598 (0.77%) were errors. This performance exceeded the standard (fewer than 2% errors). Of these 598 errors, 594 (99.3%) were corrected within two business days, above the standard (98% corrected in two business days). Based on this performance, ValueOptions received a full return of the associated withhold.

In sum, with the exception of accuracy on the provider file, which resulted in a partial return of the withhold for that element, CT BHP met or exceeded CY 2007 contracted standards for the data management performance target.

Performance Target 2: Achieve a high level of provider satisfaction

CT BHP contracted with Fact Finders to conduct an independent provider satisfaction survey.[20] The survey assessed ValueOptions' performance in the following areas:

- Provider relations/call management – courteous, professional, knowledgeable, helpful
- Clinical management processes – easy to use and understand; simple/efficient, web interface easy to use, convenient
- Authorization information – easy, accurate, reliable
- Denials/appeals – fair, timely, efficient, user-friendly
- Complaints – satisfaction with resolution process

Recovery of 100% of the associated withhold was contingent on 90% of providers giving a favorable average rating. A favorable rating was attained if the provider scored greater than 2.5 on a 4-point Likert Scale or greater than 3 on a 5-point Likert scale. A provider's average rating was calculated by computing each provider's average score including all valid responses. A favorable average rating from 85% of providers was to result in a 75% recovery of the withheld amount. A favorable average rating from 80% of providers was to result in a 50% recovery of the withheld amount.

Performance: In CY 2007, the overall satisfaction rating on this survey was 89.8%, thus falling only slightly below the 90% required for full return of the associated withhold. Consequently, performance on this target resulted in the ASO receiving 75% of the associated withhold. The ASO noted in letters to DSS their belief that lower than anticipated provider satisfaction was related to providers' dissatisfaction with issues that are not related to ValueOptions' role within CT BHP, but bias their perception of the entire system. Such issues include pre-established authorization timeframes (the main factor related to administrative denials) and problems that providers experience with paying claims (even though ValueOptions does not pay claims).

Performance Target 3: Achieve a high level of member satisfaction

In CY 2007, the CT BHP contracted with Mercer to conduct an independent survey intended to assess member satisfaction with the ASO.[21] The survey sample comprised 750 randomly chosen members who had contacted CT BHP by telephone in August, September, and October of 2007. Telephone surveys were attempted for each member, and when these were not possible, equivalent paper versions of the survey were mailed. Parallel versions of the survey were developed in English and Spanish. Surveys were completed between December 2007 and February 2008.

The Mercer survey assessed performance in the following areas:

- Member services – courteous, professional, knowledgeable, helpful, timely
- Member materials – clearly written and helpful
- Peer Specialists – courteous, professional, knowledgeable, helpful, timely
- Complaints – satisfaction with resolution process

The ten item survey achieved a final sample size of 283 members. Seventy percent of surveyed members were female, 87% were Caucasian, and 19% were of Hispanic ethnicity. Sixty percent of surveyed members were the member themselves and 37% were the parent or guardian of a member. The survey methodology for CY 2007 included more sampled members than CY 2006 (750 compared to 650) and performance was based on responses to all ten items, whereas CY

2006 used only nine of ten items. In CY 2006, the item on satisfaction with the member handbook was excluded because it had not been widely distributed at the time of the survey. In order to recover 100% of the associated withhold, a favorable average rating was to be obtained from at least 90% of the members surveyed.

Performance: Responses were averaged on all completed items. Members were considered satisfied with services if their average response was greater than the 2.5 midpoint on a 4-point scale, or 3.5 on a 5-point scale. Using this methodology, 91.5% of members were satisfied with CT BHP in CY 2007. This performance exceeded the contracted standard of 90% and exceeded CY 2006 performance (83.7%). In CY 2007, the items with the highest satisfaction were related to positive interactions with peer specialists and with courteous and professional interactions with CT BHP staff members. The item with the lowest satisfaction was related to members' perceptions of receiving the help they sought the first time they called. Significant improvements from 2006 to 2007 were observed for several items, including the accuracy and usefulness of information provided, how the referral request was handled over the telephone, and overall satisfaction with the call. Based on their overall performance in CY 2007, the ASO recovered 100% of the withhold associated with this target.

Performance Target 4: Improve quality of care outcomes for DCF-involved youth who disrupt out of a first or second foster home placement

ValueOptions was asked to collaborate with DCF to examine whether disruptions from a first or second foster care placement were associated with child behavioral health service utilization.[22] This performance target was developed due to perceived concerns that foster caregivers who brought their foster child to a hospital emergency department for behavioral problems often believed that they could no longer care for the child, which resulted in many disruptions of foster care placements.

CT BHP designed a study to examine behavioral health service utilization received in the six months prior to a placement disruption for youth in DCF custody, and compared this to behavioral health service utilization for a matched comparison group of children that had not disrupted from their placement. If an association was found that linked behavioral health service utilization to placement disruption, ValueOptions then would collaborate with DCF to develop a targeted intervention. If no association was found, they were to collaborate with DCF to develop an alternative plan to address the concern. In addition to this quantitative analysis, ValueOptions also conducted qualitative interviews and focus groups with foster families to assess causes for placement disruption. A report was submitted that summarized the results of this study.

Performance: ValueOptions' findings suggested that there was a relationship between behavioral health service utilization and placement disruption. Children who had been authorized for behavioral health services in the previous six months were significantly more likely to experience a disruption in their foster care placement than children without a service authorization. Disruption rates were highest for youth in traditional foster care in comparison to relative care, and most disruptions occurred within the first seven days following removal from the home. Older youth (10 to 18 years old) were more likely to disrupt from a first or second placement than younger children (birth to 10 years old). Gender was not related to disruption.

Hispanic youth entering foster care and African-American youth entering relative care were more likely to disrupt than children in other racial/ethnic groups.

Focus groups with foster families suggested several possible interventions, based on their identified needs. Foster families requested more coaching services to cope with 'acting-out' situations, access to respite programs including structured after school and summer programs, behavioral health assessments and home-based care, and improved communication regarding available local services. The findings of this study were used to plan targeted interventions for this high-risk group of children and families.

Based on their completion of all tasks within associated timeframes, ValueOptions received 100% of the associated withhold.

Performance Target 5: Improve the rate of connecting members to follow-up services within 30 days after inpatient hospitalization

In order to prevent multiple relapses, it is important to ensure that members receive appropriate follow-up mental health and substance abuse care after being discharged from an inpatient hospitalization. The expectation is that members will be connected to follow-up psychiatric and substance abuse services within 30 days of discharge from inpatient hospitalization. In CY 2006, an initial performance benchmark was established based on the average performance of the four managed care contractors in Fiscal Year 2004. Baseline data for the four managed care contractors indicated that follow-up psychiatric services were provided within 30 days to 61.4% of members, and follow-up substance abuse services were provided within 30 days to 39.7% of members.

The Departments' preliminary calculations in 2006 were based on 6 months of data and suggested that ValueOptions had exceeded these benchmarks. The rate of 30-day follow-up for psychiatric care was 64.6%, and the rate of 30-day follow-up for substance abuse treatment was 63.3%. As a result, the Departments returned 100% of the associated withhold, but they noted that they retained the right to recover all or part of the return if follow-up analyses of 9 months of claims data suggested that ValueOptions did not meet the established standards. The Departments were not able to manually re-calculate these rates due to resource constraints, and ValueOptions kept the returned withhold.

Performance: In 2007, there were continued concerns regarding the ability to provide accurate and timely data to assess this performance target. In a letter from the Departments to ValueOptions dated June 16, 2008, the Departments noted that a reliable assessment of the performance target would require a manual calculation, and they did not have the resources available for such a task. Therefore, ValueOptions was invited to submit an invoice for a 100% return of the associated withhold.

Performance Target 6: Reduce discharge delays for children and adolescents receiving inpatient behavioral health treatment

Connecticut has experienced what has been called "system gridlock" in which children remain in higher levels of care (e.g., inpatient hospitalization, emergency departments, residential treatment) longer than medically necessary, often because appropriate community-based alternatives are not available. Children in inpatient treatment who experience this phenomenon are said to be in "discharge delay" status. In 2007, ValueOptions was asked to collaborate with the Departments to reduce discharge delays for children receiving inpatient behavioral health treatment. Preliminary data suggest that children are most likely to enter discharge delay status because they do not have an appropriate place to live following discharge from inpatient levels of care.

In CY 2007 ValueOptions was required to: 1) improve the accuracy of the discharge delay data; 2) improve access to community-based services for youth in discharge delay status (particularly utilization of enhanced care clinics and therapeutic support services); and 3) develop a treatment improvement education series related to best practices for discharge planning. ValueOptions submitted a year-end report summarizing their activities related to this performance target, with associated target dates.[23] Findings from that report are summarized below.

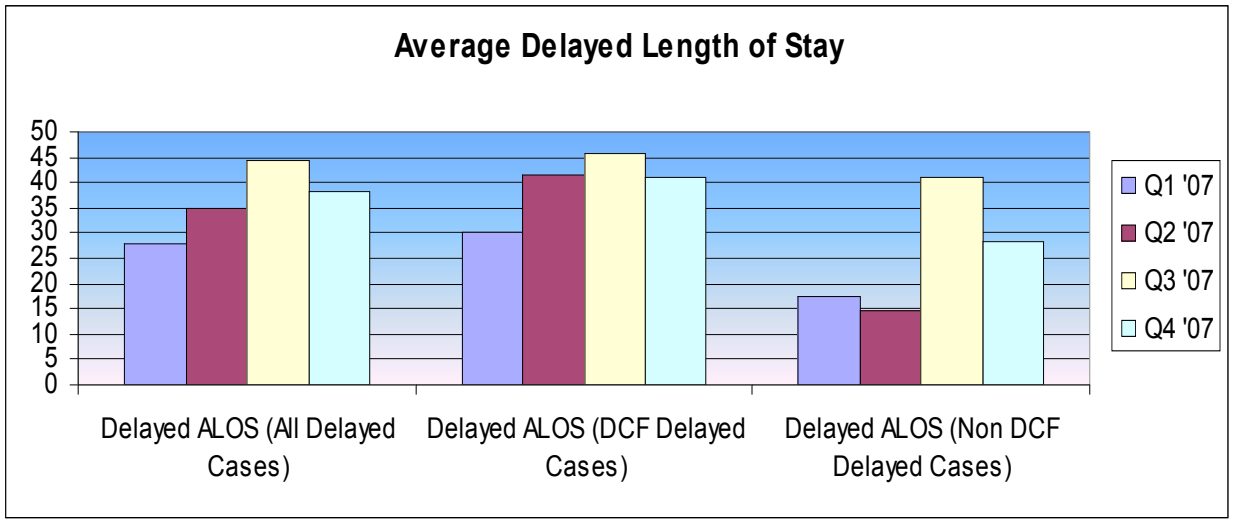
Performance: Related to the first aspect of this performance target, ValueOptions worked internally and externally to ensure consistent adherence to Level of Care criteria for inpatient treatment, develop consistent definitions of discharge delays, and track discharge delays more accurately. ValueOptions made significant improvements by developing a revised audit tool for making Level of Care determinations, enhancing clinical documentation that justifies an extended inpatient stay, and enhancing the clinical rounds process. Stakeholders in CT BHP reported that it wasn't until the 3rd Quarter of 2007 that data were collected with improved reliability. Although 16.6% of children in inpatient treatment were found to be in discharge delay status in Quarter 1, the data from Quarter 3, which can be considered more accurate than earlier in the year, demonstrated that 21.3% were in discharge delay status.

Related to the second aspect of this performance target (improved access to community-based placements), DCF anticipated that three programs or services would be fully implemented in 2007 to support timely access to lower levels of care including Enhanced Care Clinics, a therapeutic support staff model, and behavioral consultation. Only Enhanced Care Clinics were fully implemented in CY 2007. ValueOptions noted their commitment to work with DCF to identify and enhance access to community-based supports and services.

Related to the third aspect of this target (training in best practices related to discharge planning), ValueOptions developed a Treatment Improvement Initiative titled "Improved Planning for Youths being Discharged from Inpatient Care." The content of these trainings was based on the results of focus groups with key stakeholders and a comprehensive literature review. An article summarizing the Training Improvement Initiative titled, "Improved Planning for Youths being Discharged from Inpatient Care," was posted on the CT BHP website. Additionally, it was mailed to all child and inpatient hospital units that are enrolled in the Connecticut Medical Assistance Program network.

Figure 5 displays information on the average length of stay among children in inpatient settings who were in discharge delay status (excluding Riverview Hospital). At first glance, the figure appears to demonstrate that average lengths of stay among delayed cases increased during the first three quarters, peaked in the 3rd Quarter, and began to trend downward in the 4th Quarter. However, as noted above, during the first two quarters of 2007, there were focused efforts to increase the reliability of data collected on discharge delays. Thus, the 3rd Quarter is considered to be the first in which data were collected with reliability. Given that, there was a slight reduction from Quarter 3 to 4 in delayed lengths of stay for children with and without DCF involvement. It will be important to examine quarterly trend data in CY 2008 in order to control for fluctuations that are specific to each quarter. For example, if the interventions put into place in CY 2007 are having their intended effects, then the average length of stay among children in inpatient hospitals should be significantly lower in Quarter 4 of 2008 than in Quarter 4 of CY 2007.

Figure 5. Average Delayed Length of Stay in Inpatient Treatment Settings in CY 2007



Note. Data from Quarters 1 and 2 predated reliable measurement of discharge delays, and as such, undercount actual discharge delay days.

Additional recommendations from the year-end report included the following:

- Work with child and adolescent inpatient units to implement best practices in discharge planning, including early discharge planning for all children upon admission to an inpatient unit and standardized communication and coordination of care between family members and providers.
- Work with child and adolescent inpatient units to implement best practices in medication reconciliation, which refers to the process of comparing a member's medication orders to all of the medications that the member has been taking. Medication reconciliation has been shown to reduce the likelihood of re-admission.

- Implement the Provider Analysis Reporting Initiative; a provider-specific quality improvement plan that can be used to facilitate cross-provider comparisons and the development of pay for performance initiatives.
- Provide training to CT BHP staff members and community partners on all community-based levels of care to ensure that inpatient facilities can navigate the referral process and facilitate discharge to these programs and services.

Based on the performance summarized above, the ASO met all requirements and recovered 100% of the associated withhold.

Performance Target 7: Maintain a minimum annual caseload in the Intensive Care Management program

The Intensive Care Management (ICM) program provides case management services to children with complex behavioral health needs and adults with severe and persistent mental illness. Acceptance of referrals into ICM is based on rigorous application of criteria that are distributed to common referral sources across the state (e.g., MCOs, primary care physicians, DCF, DSS, community agencies). In CY 2007, this program was required to provide intensive care management services to 1,400 unduplicated members with at least 250 of those members being adults.

Performance: Regarding the performance targets for number of members served, all 2007 standards were met. The ICM program served 1,426 members including 364 adults (25.5%). This level of performance was achieved despite fluctuations in staffing levels throughout the year. As a result of their performance, the ASO recovered 100% of the associated withhold. Key stakeholders noted the need to develop a reliable means to assess not only the number of cases served, but also the quality of intensive care management services.

ICM program staff engaged in additional activities throughout 2007. ICM staff members were integral members of a CT BHP team deployed to the Connecticut Children's Medical Center Emergency Department for a targeted intervention to reduce discharge delays (described in Section VII below). As part of the same initiative, ICM staff members also worked closely with the Child and Adolescent Rapid Emergency Service (CARES) unit at Hartford Hospital to reduce emergency department utilization and inpatient admissions at Connecticut Children's Medical Center. In addition, ICM staff members worked with local managed care organizations (MCOs) to "co-manage" cases in which mental health and physical health problems were co-occurring, and negatively affected overall health. Such cases often involved issues related to pregnancy, asthma, obesity, diabetes, or chronic pain.

Performance Target 8: Improve clinical documentation of CT BHP cases by Care Managers, Intensive Care Managers, and Physician Advisors

In CY 2006, the Departments noted that there was a need to assure that Care Managers, Intensive Care Managers, and Physician Advisors complete appropriate clinical documentation for CT BHP cases. Specifically, enhanced clinical documentation was needed to provide a clinical rationale for admission to higher levels of care, and for any child entering discharge delay status.

This documentation ensures that rigorous clinical review of each case has occurred, that it aids in planning targeted interventions, and that it can be used to track clinical issues related to key performance areas monitored by the CT BHP.

The standard in 2007 was that the documentation of cases that have been initially or concurrently reviewed with the treating provider by CT BHP Care Managers or Intensive Care Managers will reflect both responsible utilization management and the consistent application of Connecticut Level of Care Guidelines. Clinical documentation was to include sufficient detail to determine medical necessity of the treatment being authorized, and assure quality of care received. CT BHP was expected to improve its performance on an on-line follow-up audit conducted by Mercer in order to earn the return of the withhold.

For this performance target, the ASO was required to improve clinical documentation in the areas of medical necessity, quality management, and active care management. For each of the three areas, baseline performance and performance thresholds were established, and associated returns of the withhold were linked to various performance thresholds.

Performance. In CY 2007, ValueOptions improved on each of the three areas of clinical documentation compared to the baseline measurement. The presence of clinical documentation justifying medical necessity of services improved from 44.1% to 83.7% which exceeded the top threshold associated with the metric, and resulted in a return of 40% of the total withhold for the target. Quality management documentation in 2007 improved from 21.2% to 37.3% and documentation of active care management improved from 11.7% to 34.4%. Performance on quality management and active care management did not meet the minimum threshold levels so the associated withholds were not returned for either metric. Overall performance across the three metrics resulted in ValueOptions receiving 40% of the total withhold for this performance target. Key informant interviews indicated that although performance improved on all three metrics, significant staff turnover in the Intensive Care Management Department negatively affected overall performance on the quality management and active care management metrics.

Summary of 2007 Performance Targets

ValueOptions' performance in each of these targeted areas strongly indicates that they continue to do a very good job managing the administrative functions of CT BHP. ValueOptions has maintained and shared eligibility, provider, and authorization data files in a timely manner with few errors. Members are satisfied with ValueOptions' services to a greater degree than in 2006, and performance on provider satisfaction in 2007 was only slightly below the target of 90% satisfaction. ValueOptions demonstrated the ability to respond flexibly to the identified needs of the Departments by conducting a comprehensive study of placement disruptions and behavioral health service utilization among youth in DCF-sponsored foster care. Finally, ValueOptions demonstrated the ability to improve clinical documentation procedures and to accurately track and report on youth in discharge delay status. In 2008, ValueOptions must continue to attend to issues of provider satisfaction, particularly with respect to authorization timeframes. CT BHP partners should closely examine the performance target related to measuring whether follow-up psychiatric and substance abuse care is provided within 30 days following discharge from inpatient settings. In 2006, and again in 2007, data were not available to properly assess this

target. CT BHP should work to improve data collection and reporting mechanisms in order to ensure the appropriateness of this performance target for future contracts.

V. RESULTS OF COMPREHENSIVE MEMBER SURVEY

In CY 2007, Fact Finders conducted a survey to assess members' experiences with, attitudes toward, and suggestions for improvement of services received through the CT BHP.[24] In contrast to the member survey conducted by Mercer (described in Section IV, Performance Target 3), the Fact Finders survey was not tied to a payment withhold, was more comprehensive in scope, and was designed to measure satisfaction within the entire CT BHP system, not just the activities of the ASO. The sections of the survey included:

- Awareness of CT BHP
- Satisfaction with CT BHP
- Counselor Ratings
- Access to Treatment
- Change of Provider
- Case Management/Care Coordination
- Day Programs
- Home-Based Services
- Inpatient Care
- Hospital Emergency Departments
- Crisis Services
- Outcomes of Services
- Toll-Free Number Service
- Member Characteristics
- Additional Suggestions

Fact Finders identified a stratified random probability sample of 200 members who had received services through CT BHP in 2007. The 200 member sample included 50 members from four levels of care, including outpatient, inpatient, home-based, and day treatment. Fact Finders interviewers conducted telephone interviews between December 2007 and February 2008. On average, surveyed members were 19 years old (median age=14 years). Less than half (46%) of members identified themselves as Caucasian, 28% as Hispanic, 14% as African-American, and 12% as another race/ethnicity. The 2007 Fact Finders report, similar to the 2006 report, noted that the barriers to completing the survey were the fluid nature of service delivery, accuracy of contact information, and ensuring that the survey methodology met all HIPAA requirements.

The results demonstrated many areas of improvement in member satisfaction compared to 2006. For example, 37% of members surveyed had heard of CT BHP, compared to 29% the year before. Approximately 60% of members were aware that CT BHP was providing their mental health services, compared to 53% in CY 2006. Sixty one percent of members rated their counseling services as "excellent" or "very good" compared to 58% in 2006. Satisfaction decreased on a few items in CY 2007, though the differences often were very small. Approximately 74% of members said that they received the care they desired, compared to 80% in CY 2006; and 92% were involved in care decisions compared to 94% in CY 2006. Table 6 displays results on a number of key items.

Table 6. Review of Key Items from Comprehensive Members Survey, CY 2006 and CY 2007

Item	CY 2006	CY 2007	Percent Change
Inpatient care helped child a great deal	42%	57%	+15%
Day program helped child a great deal	38%	50%	+12%
Problems getting to appointments	14%	24%	+10%
Aware that CT BHP is providing services	29%	37%	+8%
Home-based services helped child a great deal	44%	52%	+8%
Better school performance	48%	55%	+7%
Hospital emergency department helped child a great deal	37%	43%	+6%
Getting along better with friends	45%	51%	+6%
Convenient appointment times available	91%	94%	+3%
Overall quality of counselor was "excellent" or "very good"	58%	61%	+3%
Family involved in treatment services	76%	78%	+2%
Called toll-free number in last six months	6%	8%	+2%
Felt welcomed and respected	94%	95%	+1%
Child feeling better than a year ago	67%	68%	+1%
"Completely satisfied" or "very satisfied" with mental health services	58%	58%	0%
Able to cope with problems	72%	72%	0%
Crisis services – had a crisis plan	57%	56%	-1%
Someone there for child to talk to	84%	83%	-1%
Someone there for child no matter what	80%	78%	-2%
Involved in care decisions	94%	92%	-2%
Case manager/care coordinator assigned	38%	36%	-2%
Better school attendance	41%	38%	-3%
Received the help I desired	80%	74%	-6%
Getting along better with family	65%	59%	-6%
Child avoiding trouble	85%	71%	-14%

The limitations of the survey methodology notwithstanding, performance on these member satisfaction indicators suggests that, in many areas, members perceive that CT BHP is meeting their needs and that they are satisfied with services received in CY 2007. Given the limitations of the survey methodology, it is difficult to draw solid conclusions about overall satisfaction with CT BHP services. Statistical significance testing should be considered in order to compare results from year to year.

VI. CT BHP KEY ACCOMPLISHMENTS IN 2007

Based on the preceding summary of performance and interviews with key stakeholders, below is a list of the key accomplishments achieved by the CT BHP in 2007.

- Met all contract Program Standards
- Developed and instituted a Quality of Care Committee to review and track all quality of care concerns related to network provider performance
- Initiated quality improvement planning, monitored identified providers' patterns of quality of care complaints
- Transformed the System Management Department to Network Management under the direction of the Quality Department to support quality improvement activities across the BHP provider network ~ hired a Director of Provider Analysis and Reporting
- Reviewed and updated all policies and procedures
- Achieved a provider satisfaction rate of 89.8%
- Achieved a member satisfaction rate of 91.5%
- Initiated program to decrease discharge delay in inpatient settings
- Continued to facilitate a decrease in emergency department discharge delays
- Utilization Management (UM) program resulted in decrease in hospital admissions per 1,000 members in 2007 for children with DCF involvement
- UM program resulted in an upward trend in days per 1,000 members in home-based services
- UM program resulted in a decrease in days per 1,000 members in residential care
- Coordination of care: co-managed 490 MCO referred members; managed 1,462 ICM cases and provided consultation to 1,526 individuals in the Peer/Family Specialist Department
- In conjunction with DCF, refined the residential referral and triage system for children presenting for residential care
- Began on-site reviews at high volume hospital programs
- Initiated monthly rounds with MCOs to facilitate co-management of high risk cases
- Initiated daily on-site rounds with the Child and Adolescent Rapid Emergency Service (CARES) unit at Hartford Hospital

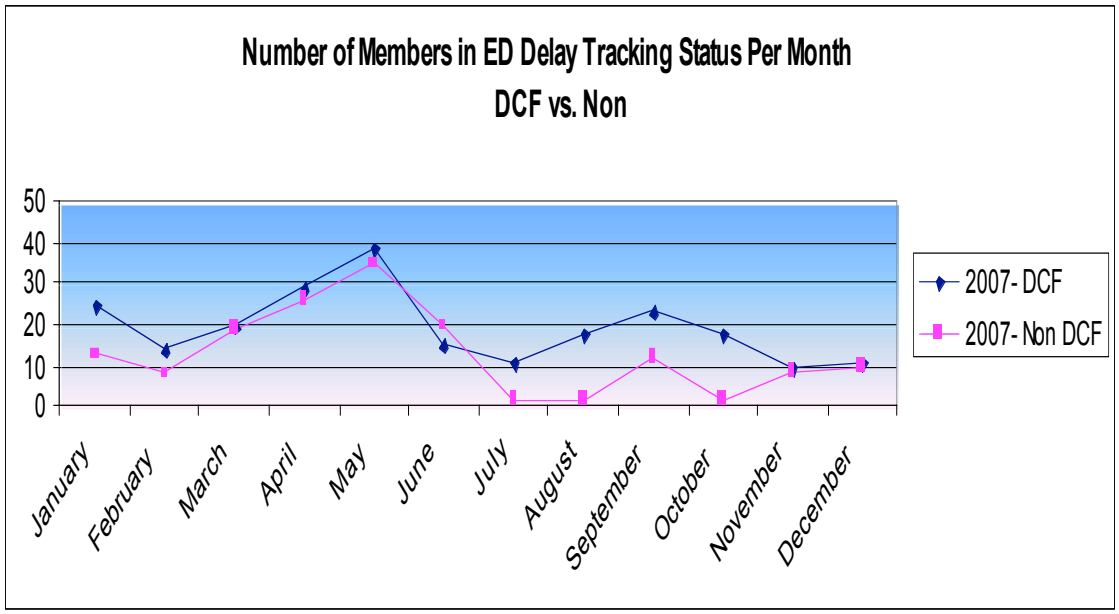
VII. SPECIAL PROJECTS

There were three special projects of significance to the ongoing development of CT BHP and the provider community in 2007. The first was a project to monitor the ongoing concern with children experiencing discharge delays in inpatient and emergency departments. To demonstrate how this could be accomplished, CT BHP worked closely with the Connecticut Children's Medical Center to reduce discharge delays in their emergency department. The second project was the ongoing expansion and implementation of Enhanced Care Clinics. The third special project was the ongoing development and refinement of the functions of Residential Care Teams. Each project is described in more detail as follows.

A. ED Discharge Delays: The Connecticut Children's Medical Center Emergency Department Intervention

In 2007, 407 members were in discharge delay status in hospital EDs, with 956 total days in discharge delay status. Youth involved with DCF tended to be overrepresented in the pool of members in discharge delay status. Figure 7 displays the number of members in discharge delay for each month of CY 2007, with comparisons to the same months in CY 2006 for those months where data was available. The overall number of members in discharge delay status was higher for each month of CY 2007 when compared to the same month in 2006, except for December.

Figure 6: Number of Members in Discharge Delay Status in CY 2007



Connecticut Children's Medical Center Emergency Department Targeted Intervention

Leading up to 2007, Connecticut Children's Medical Center (CCMC) was observed to have the largest number of children in discharge delay status. In 2007, CT BHP implemented a special project to intervene within their ED. The goals of these corrective actions were to divert children from ED admissions when possible, procure immediate access to community-based services, support families while in the ED, and when necessary, assist in locating available inpatient beds throughout the state. The active phase of the CCMC intervention took place during April, May, and June of 2007. Data were tracked after June in order to monitor the ongoing impact of the targeted intervention.

CT BHP engaged in a number of supportive actions with CCMC that included the following:

- An Intensive Care Manager (ICM) assigned to the CCMC ED conducted site visits five days a week and was available for consultation during the week and on an on-call basis on the weekends and after-hours.

- A Peer Specialist was available on an on-call basis to support families in the ED.
- A Systems Manager co-chaired a weekly community-based service resource meeting at the CCMC ED to facilitate identification of resources and to support diversion to these services when possible.
- In April 2007, the Wheeler Clinic EMPS team signed a Memorandum of Understanding (MOU) with CCMC and Hartford Hospital in an effort to better integrate the Wheeler Clinic EMPS team into the hospital ED environment, link families with EMPS and a community-based treatment setting, and prevent inappropriate admissions from the ED to an open inpatient bed.
- Hartford Hospital submitted a Certificate of Need Application to implement a CARES program, which provides short-term stabilization, diverts children from ED admissions, and provides post-ED follow-up services.

Between April and June 2007, there were 100 children (5 to 17 years old) at CCMC identified as being in discharge delay status. Just over one half (51%) were DCF-involved. The final report noted that the amount of time a youth was "stuck" in the Emergency Department decreased from 2.48 days in April 2007 to 1.87 days in June 2007. During each month of the intervention, the percentage of youth admitted from the CCMC ED to inpatient units decreased from 60% in April to 38% in June. After direct face-to-face time of the intervention was reduced, follow-up data indicated that the number of inpatient admissions trended upward to near pre-intervention levels.

It is possible that the reduction in direct face-to-face involvement between the CT BHP team members and the CCMC ED staff resulted in a partial return to prior practices. However, the active phase of the CCMC intervention strongly indicates that such a targeted intervention can be effective in reducing the number of children that are stuck in Connecticut Emergency Departments.

B. Enhanced Care Clinics: Continued Implementation

The Enhanced Care Clinic (ECC) initiative was designed by the Departments to increase access to outpatient and crisis intervention services and to improve service quality. ECCs are specially designated Connecticut-based mental health and substance abuse clinics that serve adults and/or children that receive a 25% increase in their reimbursement rate in exchange for meeting certain criteria. New criteria are phased in over time. Clinics designated as ECCs in 2007 are listed in Appendix B.

ECCs were required to adhere to access requirements by providing CT BHP members with timely access to services. This involved seeing clients with emergent needs within two hours, clients with urgent needs within two days, and clients with routine needs within two weeks, and providing extended coverage outside normal business hours. In CY 2007, a second set of ECC requirements for the first cohort of clinics was developed, related to coordination of outpatient mental health care with primary care. Guidelines developed for the requirement included: mechanisms for the implementation of referral protocols, shared treatment plans, communication tools, and access for primary care providers to consultation from child psychiatrists. ECCs were required to develop memoranda of understanding with one or more primary care practices by

September 2008. The Behavioral Health Partnership Oversight Council approved the criteria for ECC partnerships with Primary Care.

In September 2007, a Request for Applications was released to solicit applications for a second cohort of ECCs. In response, the Departments received 27 letters of intent; 11 applications were submitted by the deadline. As of the end of CY 2007 the applications were under review.

Upcoming aspects of the ECC initiative include:

- Member Welcoming and Engagement
- Co-occurring capability (psychiatric and substance abuse)
- Evidence-based practice
- Cultural Competence

C. Focus on Residential Treatment

During 2006, staff members from the ASO and from the DCF Central Placement Team combined efforts to form the CT BHP Residential Care Team (RCT). This team is responsible for reviewing all DCF and Court Support Services Division (CSSD) requests for residential and group home care to ensure appropriateness of the request and to identify the most suitable facility for each referred child/adolescent. As the first year of operation ensued, protocols became perfected and best practices solidified.

A standardized referral instrument, the Child and Adolescent Needs and Strengths (CANS) was introduced to DCF Area office staff and juvenile parole and probation staff, who were trained on its use. The introduction of the CANS allowed for greater consistency of referral information and set the stage for the collection and analysis of clinical and psychosocial information on CT BHP members referred to these very restrictive levels of care. Clinical rounds, convened twice weekly by the DCF Bureau Chief of Behavioral Health, also were implemented to provide final review and approval of all placement decisions. DCF state facility superintendents, CSSD staff members, the RTC team, and DCF group home liaisons were to be in attendance. In addition to formalizing child/facility matches, clinical rounds provided the opportunity for dialogue on the status of various programs, reviews on children for whom no suitable program could be found, and procedural reviews and revisions.

During 2007, additional modifications to the RCT operations evolved. RCT staff members were assigned to cover specific aspects of RCT operations (e.g., referrals on children in inpatient units, court ordered referrals, out of state referrals). This effort to specialize job functions was designed to enhance communications between the RCT, providers, and other system participants, and to promote timely problem-solving strategies regarding challenging cases. In addition, plans were formalized to develop and use an electronic version of the CANS. This decision was based on the need to avoid faxing paper documents, and to streamline data entry from the CANS. Although implementation was not achieved in 2007, plans to move this initiative forward were finalized with a 2008 “go live” date finalized.

Another project involved developing a work plan with providers to link residential authorizations to facility payment within the 2007 contract year. The work plan laid the foundation for phasing

in the linking of authorizations to facility payments, which is anticipated to take place in 2008. Finally, 2007 saw an expansion of monthly and quarterly data reporting that allowed trends within residential and group home utilization to be identified, tracked, and monitored.

VIII. FINANCIAL INFORMATION

As mentioned previously in this report, CT BHP's braided funding structure allows DCF and DSS to maximize their resources for funding behavioral health services. As a result, members have access to funding streams from both agencies to support their service plans and needs.

In 2007, the total state expenditure for CT BHP was $129,182,953 for HUSKY A and $4,086,155 for HUSKY B. Comparable figures in CY 2006 were $101,878,843 for HUSKY A and $2,480,581 for HUSKY B. The total DCF expenditure for CT BHP in CY 2007 was $160,162,327, as compared to $151,243,872 in CY 2006 (see Tables 7 and 8 for more detailed information).

Table 7. DSS Expenditures for CT BHP in CY 2007

TYPES of EXPENDITURES	HUSKY A/ Medicaid	HUSKY B/ SCHIP
DSS Program Expenditures	100,537,763	3,497,255
DSS Administrative Expenditures	9,216,105	0
Total DSS Expenditures	**109,753,868**	**3,497,255**
Other State Agency Expenditures	19,429,085	588,900
Grand Total	**$129,182,953**	**$4,086,155**

Table 8. DCF Expenditures for CT BHP in CY 2007

SERVICES	DCF Expenditures
ASO Managed Services	
Residential Treatment, In-State	54,151,571
Residential Treatment, Out-of-State	26,363,891
Total Residential	**80,515,462**
Community Services	
PASS Group Homes	9,456,483
Therapeutic Group Homes	39,481,166
IICAPS DSS Transfer	1,836,969
IICAPS Fee For Service	562,108
Total Community	**51,336,726**
Grant Based and In-Home Services	
Extended Day Treatment	7,243,303
Intensive Home-Based Services: Functional Family Therapy	1,744,641
IICAPS	1,280,098
Multidimensional Family Therapy	1,500,999
Multi-systemic Therapy	3,892,609
Total Grant Based and In-Home Services	**15,661,650**
Grant Based Emergency Mobile Psychiatric Services (EMPS)	
Care Coordination (Local System of Care)	680,747
EMPS	1,655,061
EMPS/Care Coordination	8,493,728
Enhanced Care Coordination	1,818,953
Total EMPS/Care Coordination	**12,648,489**
Grand Total	**$160,162,327**
Additional Services [a]	
Total Crisis Stabilization	1,887,463
Total Family Support Teams	6,918,425
Total Child Guidance Clinics	11,245,099
Total Outpatient Adolescent Substance Abuse	1,240,638
Total Additional Services	**$21,291,625**

[a] Additional services comprise integral parts of the CT BHP service system, but are not managed by the ASO. These services were not included in the 2006 report. At the request of the CT BHP Oversight Council, these additional service types have been reported out at several 2007 Council meetings, and are included in this report to provide a more comprehensive view of DCF behavioral health expenditures.

IX. STRENGTHENING THE LOCAL DELIVERY SYSTEM

Implementing a system of care approach statewide relies on a well-developed local behavioral health delivery system. To that end, CT BHP continued to work with 26 existing community collaboratives throughout the state to help build this system. The community collaboratives were established with the legislation that adopted the System of Care Model.[4]

In 2007, there were significant changes in practice at the ASO, designed to better support and develop the local delivery system. This was the result of challenges experienced throughout 2006 and 2007 with the Systems Management Department and the defined scope of work from the original contract language, namely to create and implement Local Area Development Plans (LADPs) with each of the community collaboratives. Although a significant amount of work was done to develop LADPs in conjunction with the community collaboratives, stakeholders expressed their concern that a systematic plan to collect data and assess the impact of this process was not implemented. This made it difficult to integrate the development and implementation of LADP into the larger managed system in order to track progress. The successful implementation of LADPs was also believed to be largely dependent on the training and previous work experience of Systems Managers and their ability to develop effective working relationships with members of the provider community and DCF Area Offices. It was found that the work experience of System Managers varied, as did their ability to carry out such a complex task. This, in combination with the lack of sufficient data to evaluate the success of the LADP development left many members of local community collaboratives questioning the ultimate usefulness of LADPs, and many plans were never fully utilized by the Area Offices or other stakeholder groups.

In 2007 and into 2008, ValueOptions implemented an organizational change by transforming the Systems Management Department to the Network Management Department. This change also involved a shift in the conceptualization of the services provided. Network management involved a more explicit focus on working with the provider network on issues of capacity, quality, and access and was guided by data analysis within a pre-determined set of network improvement initiatives. Regional Network Managers remain assigned to specific DCF Area Offices, Community Collaboratives, and programs/facilities. This regional assignment assures that the analysis of available information is contextualized within the experience of the local community, particularly as it relates to available resources. Although the problems encountered with the LADPs limited their perceived usefulness in 2006 and into 2007, the overall goals were continued within the context of the improved organizational and procedural strategies described above.

X. LESSONS LEARNED FROM 2007 EXPERIENCE

Based on interviews with key informants at DSS, DCF, and ValueOptions, the following captures observations about the lessons learned from the second year of the implementation of CT BHP.

1. Effective and transparent working relationships among CT BHP partners are critically important. It was noted by several key stakeholders that ignoring issues and problems in the

system tends to make these problems worse, but acknowledging problems and issues and taking a problem solving approach to resolving these issues is far more effective. Working relationships have been enhanced by decisions such as the co-location of DSS and DCF staff offices with ValueOptions staff offices, to create a single CT BHP office suite.

2. Staff selection, training, and retention at ValueOptions were important factors in accomplishing the goals set forth for 2007. The example of Intensive Care Management provided important learning opportunities regarding the importance and difficulty of selecting staff members that have the training and expertise to carry out complex tasks. It is particularly important to recruit and retain staff members that understand how managed care works.
3. Properly "staging" important initiatives prior to implementation and involving community partners early in the planning and implementation process are critical elements related to enhancing buy-in and increasing the likelihood of success. One key stakeholder noted in relation to the Local Area Development Plans that when community partners distrust the process and the people involved, they tend to distrust the product as well. Such lessons can be applied to new initiatives for 2008 and beyond.
4. Collecting and using data to evaluate the success of initiatives is helpful to guide stakeholders and ensure that there are objective ways to assess outcomes. The examples of the targeted interventions at CCMC and the transition to a more data-informed Regional Network Management department at ValueOptions provide examples of how data can be used to track progress and assess outcomes. Setting clear goals up front and a plan to evaluate progress toward those goals has proved to be an effective strategy.
5. Building relationships with hospitals was a critical element of the success of many initiatives in 2007. For example, working closely with hospital staff at CCMC and other state emergency departments will continue to be critically important for reducing discharge delays and preventing unnecessary inpatient admissions. To the extent that future initiatives involve hospital emergency departments and inpatient units, building and maintaining positive working relationships with hospital staff will be critical.
6. Initiatives focused on improving quality of care will be increasingly important to the ongoing development of CT BHP and the provider network. Establishing financial incentives and clear contract language and engaging in effective network management are key strategies for promoting improved quality of care.
7. A well-constructed contract between the state agencies and the ASO continued to be an important ingredient of success in 2007, providing clarity about expectations and responsibilities. That said, flexibility to modify the contract as the members of the CT BHP learn from their experience, is important. For example, in future contract years, there might be limited utility in rigorous monitoring and reporting of performance areas that have historically been areas of consistently high success.
8. The information systems designed to meet the requirements of the contract continues to result in an extensive amount of data. Despite occasional concerns related to managing the volume of data, however, it is a tremendous resource that will provide information on the status of all children receiving services. With an additional year of development and refinement of data collection procedures, CT BHP should consider appropriate ways in

which to make full use of the data in order to inform the growth and improvement of the service system. This would be particularly relevant as CT BHP confronts matters related to quality assurance, outcome assessment, and clinical decision-making.

9. There should be considerable ongoing outreach to the myriad stakeholders in a complex system such as CT BHP, including children, families, providers, state agencies, and legislators. As CT BHP continues to expand its role in the state, it will be important to find ways to educate others about the roles, functions, responsibilities, and outcomes of CT BHP and its initiatives.

XI. SIGNIFICANT ISSUES FOR 2008 AND BEYOND

Three critical issues were identified in 2007 as being likely to impact the CT BHP in 2008. These three issues are related to the utilization and high costs associated with residential services, discharge delays from higher levels of care, and expansion of community-based services to meet the need in the mental health system. These three issues are discussed in more detail below.

A. Residential Services

In CY 2006, several changes were made in the way that Residential Treatment Centers (RTC) are operated, with several functions coming under the purview of CT BHP. For example, a Residential Care Team: composed of staff from DCF, ValueOptions, and the Court Support Services Division of the Judicial Branch, began overseeing all referrals and placements to residential services. A bed tracking system was implemented in order to anticipate vacancies at residential treatment facilities, and a more rigorous clinical rounds process was implemented.

The major development in CY 2007 was the implementation of the Child and Adolescent Needs and Strengths (CANS) measure as the primary instrument for assessing all potential referrals to residential care. To facilitate this change in practice, CT BHP worked closely with staff members from DCF Area Offices and select DCF-operated facilities across the state. Throughout the year, results from CANS were reviewed by the CT BHP Residential Care Team to approve or deny this level of care. In addition, the Residential Care Teams collaborated with DCF Area Offices to determine appropriate matches to residential facilities for youth that had been authorized for residential treatment.

Even with these changes in place for CY 2007, challenges remained with the management of residential services. At any given time, there were a number of vacancies in residential facilities, yet many children who had been authorized for residential treatment had not been placed. Placements were found to be particularly problematic for children with mental retardation or developmental disabilities, problem sexual behavior, severe aggression, a history of fire setting, or cognitive/neurological impairment. In addition, controlling the costs associated with residential treatment was an ongoing challenge. In CY 2007, over 80 million dollars ($80,514,462) were spent on residential treatment to serve 810 children, a cost of nearly $100,000 per child. Furthermore, CT BHP pays for out-of-state residential treatment for children that need the service but cannot be placed in an appropriate setting in Connecticut. Of the total amount spent on residential treatment, $26,363,891, or nearly one-third of the total costs, was to pay for out-of-state placements.

Having an appropriate screening and assessment process for all potential residential placements will be beneficial for an efficient authorization process. However, in the future, CT BHP must find a way to manage the high costs of residential treatment, particularly for children with special needs and for children that are likely to be placed out-of-state. The children that are referred for residential treatment inevitably have complex and serious mental and behavioral health needs. For such children, appropriate residential treatment options must be made more accessible in Connecticut. When appropriate, access to home- and community-based treatment should be greatly expanded for youth that can be maintained in less intensive levels of care.

B. Discharge Delays

Despite the attention given to discharge delays in CY 2007, there remains a need for focused attention on the problem in higher levels of care, including inpatient, emergency departments, and psychiatric residential treatment facilities. In CY 2007, too many children remained in intensive levels of care for reasons other than treatment need. This was particularly problematic for DCF-involved children. For example, 31.8% of DCF-involved youth in inpatient settings were in discharge delay status at some point during the year. Comparable figures for psychiatric residential treatment facilities and residential treatment centers was 38.6% and 17.5%, respectively.

In CY 2007 (as was the case in CY 2006), the primary reason for discharge delays was that children were awaiting placement. In fact, the percentage of youth for whom this was the reported reason for delay increased in each quarter of CY 2007. The lack of availability of services or placements required to leave the hospital is an ongoing concern in the children's behavioral health system. The continued goal moving forward will be to reduce the percentage of inpatient days that are due to discharge delays.

C. Expansion of Services to Meet the Need

Related to the above, CT BHP must continue to work together to expand the availability of services for youth with behavioral health needs. There has been a tremendous influx of new money to community-based services, with the total commitment increasing from $14 million in 2001 to nearly $100 million in 2007. Service utilization data clearly demonstrate that utilization of higher levels of care such as inpatient and residential treatment have declined in CY 2007, whereas utilization of community-based services such as home-based services and clinic-based outpatient services has increased. Data on discharge delays from inpatient, emergency departments, and residential facilities, however, continue to suggest that this expansion has not yet met the need. In fact, the primary reason for discharge delays is that children are awaiting an appropriate placement.

CT BHP now has demonstrated the ability to accurately track and report data to monitor this problem. Future initiatives must be developed to address needs and gaps in services so that resources can best be distributed appropriately. Simultaneously, efforts should attend to the quality of treatment received at all levels of care.

XII. CONCLUSIONS

Data from the second full year of implementation indicate that in general, the CT BHP continues to successfully manage and administer behavioral health services for Husky A and B members (the Medicaid program for behavioral health services in the state). Enrollment has increased, yet CT BHP continues to meet or exceed the majority of its performance targets. ValueOptions has performed well as the ASO for CT BHP, resulting in return of most monetary withholds related to key performance targets. Indicators reflecting utilization of higher levels of care generally have decreased, whereas indicators of utilization of community-based outpatient forms of care generally have increased. Members and providers generally are satisfied with CT BHP. Special projects have been managed successfully, which has contributed to the knowledge base and allowed stakeholders to monitor trends, plan targeted interventions, and prepare for future challenges.

The experience of the second year of implementation of CT BHP set the stage for 2008 and the major initiatives being undertaken. These include:

- Managing discharge delays in inpatient settings and emergency departments by improving discharge planning and expanding community-based treatment options
- Improving the quality of service delivery through data sharing and "pay for performance" initiatives
- Continuing to attend to the needs of children with DCF-involvement who continue to be the highest utilizers of services

Overall, based on meeting the requirements of the BHP contract and the associated standards and performance targets, the second year of CT BHP was a success. CY 2007 was not without its mistakes and problems along the way. It is important to note, however, that given the still early stage of development of CT BHP, its successes are significant. Perhaps to an even greater degree than 2006, the nature of the relationships among the partners allowed for difficulties that were encountered to be openly addressed and corrected. Ultimately, it is this ongoing partnership between stakeholders that will allow for the continued development of a community-based mental health system that will effectively and efficiently meet the needs of children and families served by the public mental health system in Connecticut.

Appendix A: GLOSSARY OF ACRONYMS

ASO – Administrative Services Organization

BHP – Behavioral Health Partnership

CANS – Child and Adolescent Needs and Strengths

CARES - Child and Adolescent Rapid Emergency Service

CM – Care Management

CT - Connecticut

CT BHP – Connecticut Behavioral Health Partnership

CY – Calendar Year

DCF – Department of Children and Families

DSS – Department of Social Services

ECC – Enhanced Care Clinic

ED – Emergency Department

EDS – Electronic Data Systems

EMPS – Emergency Mobile Psychiatric Services

IICAPS - Intensive In-Home Child and Adolescent Psychiatric Services

LADP – Local Area Development Plan

LOC – Levels of Care

MCO – Managed Care Organization

SCHIP – State Child Health Insurance Program

Appendix B: ENHANCED CARE CLINICS IN 2007

Name	Address
ALSO-Cornerstone	871 State Street, New Haven, CT 06511
Bridges…A Community Support System	949 Bridgeport Ave., Milford, CT 06460
The Counseling Center of Bristol Hospital	440C North Main Street, Bristol, CT 06010
Charlotte Hungerford Hospital-Center for Youth and Families	1061 East Main Street, Torrington, CT 06790
Charlotte Hungerford Hospital-Behavioral Health Center	540 Litchfield Street, Torrington, CT 06790
Child Guidance Clinic for Central Connecticut, Inc.	257 West Main Street, Meriden, CT 06451
Child Guidance Center of Greater Bridgeport, Inc.	180 Fairfield Avenue, Bridgeport, CT 06604
Community Child Guidance Clinic, Inc.	317 North Main Street, Manchester, CT 06042
Child Guidance Center of Southern Connecticut, Inc.	103 West Broad Street, Stamford, CT 06902
Wellpath	70 Pine Street, Waterbury, CT 06710
Clifford W. Beers Child Guidance Clinic	93 Edwards Street, New Haven, CT 06511
Community Mental Health Affiliates, Inc.	29 Russell Street, New Britain, CT 06052
Community Health Resources	995 Day Hill Road, Windsor, CT 06095
Harbor Health Services, Inc.	14 Sycamore Way, Branford, CT 06405
Catholic Charities, Inc. Archdiocese of Hartford Institute for the Hispanic Family	80 Jefferson Street, Hartford, CT 06106
InterCommunity Mental Health Group, Inc.	281 Main Street, East Hartford, CT 06118
Klingberg Family Centers	370 Linwood Avenue, New Britain, CT 06052
McCall Foundation, Inc.	58 High Street, Torrington, CT 06790
Middlesex Hospital	28 Crescent Street, Middletown, CT 06457
Rushford Center, Inc.	1250 Silver Street, Middletown, CT 06457
United Services, Inc.	PO Box 839 1007 North Main Street, Dayville, CT 06241
Valley Mental Health Center, Inc.	PO Box 658 435 East Main Street, Ansonia, CT 06401
The Village for Families and Children, Inc.	1680 Albany Avenue, Hartford, CT 06105
Wheeler Clinic, Inc.	91 Northwest Drive, Plainville, CT 06062
Yale Child Study Center	230 South Frontage Road, New Haven, CT 06520

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