CONNECTICUT

Behavioral Health Partnership

First Annual Evaluation Calendar Year 2006

A Report Submitted to the Connecticut General Assembly Committees of Public Health, Human Services, and Appropriations, pursuant to Section 17a-22m of the General Statutes of Connecticut

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First Annual Evaluation
Calendar Year 2006

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Copies of the report can be obtained from the following websites:

Behavioral Health Partnership
www.ctbhp.com (click on publications)

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

Department of Social Services
www.ct.gov/dss (click on publications)

Child Health and Development Institute of Connecticut
www.chdi.org (click on resources)

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CONNECTICUT BEHAVIORAL HEALTH PARTNERSHIP
FIRST ANNUAL EVALUATION
CALENDAR YEAR 2006

I. INTRODUCTION

The Connecticut Department of Social Services (DSS) and the Department of Children and Families (DCF) formed the Connecticut Behavioral Health Partnership (CT BHP) to plan and implement an integrated public behavioral health services system for children and families enrolled in the state's Medicaid program (HUSKY A), S-CHIP program (HUSKY B), and for other children with complex behavioral health needs and DCF involvement. The primary goal of the CT BHP is to provide enhanced access to and coordination of a more complete and effective system of community-based behavioral health services and supports leading to better outcomes for the children and families. Other goals include better management of state resources and increased federal financial participation in the funding of behavioral health services.

The CT BHP began operations on January 1, 2006. This was a significant step in a sweeping reform of Connecticut's public behavioral health service system for children and families that was initiated over seven years ago. In February 2000, DSS submitted a report to the Connecticut General Assembly on children's behavioral health services – *Delivering and Financing Behavioral Health Services for Children in Connecticut*.[1] The report summarized an analysis of existing behavioral health services and financing for children enrolled in HUSKY A. One key finding was that 70% of the $207 million the state spent annually on behavioral health services was to pay for out-of-home care (psychiatric inpatient services funded primarily through Medicaid and residential treatment services funded primarily through DCF), serving only 19% of those children receiving services in the course of a year. The remaining 30% of funds was for community-based services for the other 81% of children enrolled.

That report identified significant problems in the existing services system that could be addressed through better coordination of care, enhanced community-based services, family involvement in policy and service planning, a redistribution of resources from expensive out-of-home care to community-based care, and a restructuring of financing including better management of services and financing, and integration of funding streams. The recommendations included in the report became the basis for a restructuring of the children's mental health service system that was initially called *Connecticut Community KidCare*.

Additional recommendations related to how services were to be organized and financed so that they could be administered more effectively. The report recommended a partial carve-out of funding for behavioral health services from the capitation rate for the existing managed care plans, blending funding streams from DSS and DCF, contracting with an Administrative Services Organization (ASO) to centralize certain administrative functions, and designation of up to 10 regional Lead Service Agencies to contract with providers and provide services and administrative support for a community-based delivery system.

The proposed reforms were enacted into legislation in 2000. The legislation endorsed a restructuring of children's behavioral health service delivery and financing based on a system of care model[2] and called for DSS and DCF to work together to develop an implementation plan.[3] In 2001, DCF and DSS submitted a second report to the General Assembly outlining the details of the plan for *Connecticut Community KidCare*.[4] Some key elements of that initial plan were never adopted (most notably the use of Lead Service Agencies), but the plan proposed procurement and contracting with an ASO to administer a full carve-out of the HUSKY child behavioral health benefit to begin July 1, 2002. The statewide ASO would be responsible for managing integrated funding streams and basic administrative services such as claims processing, provider network development, credentialing and contracting, member services, data management and reporting on quality, cost, and utilization.

It was another three years before the General Assembly authorized this plan to go into effect. The legislation, passed in 2005, calls for the development and implementation of "an integrated behavioral health service system for HUSKY Part A and HUSKY Part B members, [and] children enrolled in the voluntary services program operated by the Department of Children and Families ….which shall be known as the Behavioral Health Partnership." [5]

The legislation further articulates the purpose of the Behavioral Health Partnership (BHP) and its mechanisms for operations, and establishes a Behavioral Health Partnership Oversight Council to advise on the planning and implementation of the Partnership.[6] According to the law, the BHP is 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 the 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; and
- monitoring of individual outcomes and provider performance.

The Behavioral Health Partnership, with DCF and DSS working with an ASO, was specifically directed to develop a community-based system of care that would alleviate hospital emergency department overcrowding, reduce unnecessary admissions and lengths of stay in hospitals and residential treatment settings, and increase availability of outpatient services.[7]

This 2005 legislation required the Commissioners of DCF and DSS to submit an annual report to the General Assembly that addresses the following:

> …the provisions of behavioral health services under the Behavioral Health Partnership, including information on the status of the administrative services organization implementation, the status of the collaboration among the Departments of Children and Families and Social Services, the services provided, the number of persons served, program outcomes and spending by child and adult populations.[8]

This is the first annual report and is a summary of accomplishments leading up to and during the first full year of CT BHP's operations (Calendar Year 2006). It draws from several sources including:

- ValueOptions reports to DSS and DCF
- Minutes of the Behavioral Health Partnership Oversight Council and its subcommittees
- Reports of pre- and post-implementation readiness reviews and a member satisfaction survey conducted by Mercer Government Human Services Consulting (Mercer)
- Member and provider satisfaction studies conducted by Fact Finders, Inc.
- Interviews with key staff at DSS, DCF and ValueOptions

II. PRE-IMPLEMENTATION PHASE (2005)

Through a public procurement process finalized in 2005, DCF and DSS selected ValueOptions, a national managed behavioral health care company, to serve as the Administrative Services Organization (ASO) for CT BHP. A contract was issued in May 2005 covering the period of August 17, 2005 through December 31, 2008, with the possibility of two one-year extensions. Karen Andersson, Ph.D. at DCF and Mark Schaefer, Ph.D. at DSS were designated as the lead staff for each agency to oversee and manage this contract. Lori Szczygiel was hired by ValueOptions as Chief Executive Officer of the ASO for CT BHP. In December 2005, the Centers for Medicare and Medicaid granted waiver authority to Connecticut for the proposed change in the behavioral health delivery system.

From September through December, ValueOptions began to develop the infrastructure, policies, and procedures to perform the following major roles and functions in preparation for a January 2006 start-up:

- **Utilization Management** – Prospective, concurrent, and retrospective utilization management services that assess the necessity and appropriateness of the allocation of health care resources and services given, or proposed to be given, for eligible children and adults, according to an agreed upon set of guidelines.

- **Intensive Care Management** – Specialized care management techniques (evaluation, planning, linkage, support, and advocacy to assist individuals in gaining access to needed medical, social, educational, or other services) for members who meet certain criteria, especially if at risk for out-of-home placement or who are encountering barriers to effective care.

- **Customer Service** – Member and provider access through development of a toll-free telephone line at a call center so that all calls (routine, crisis, and after hours) are handled in a timely manner according to industry standards.

- **Enhanced Web Systems –** Web-enabled services such as registration of services that do not require clinical review, online look-up, provider and member referral and case management planning.

- **Peer Support –** Peer specialists who are parents of children with behavioral health needs or adults with personal experience of the behavioral health delivery system, to provide support for members through education, help to engage in treatment, assistance in navigating the service system and identifying natural supports.

- **Quality Management –** A comprehensive program of quality improvement and quality assurance activities to ensure that all members have access to and receive appropriate, effective, medically necessary, and cost-efficient treatment. This includes analysis of utilization data, satisfaction surveys, complaints, and other sources of quality information, and entails the development of information systems and reporting requirements and processes.

- **Systems Management and Local Service and Provider Network Development –** Strengthening local behavioral health service delivery systems with an emphasis on coordination and expansion of community-based services and supports to better meet the needs of children and families within local communities.

For a brief summary of the ASO and its functions, see Attachment 1.

The state agencies contracted with Mercer Government Human Services Consulting (Mercer) to conduct a pre-implementation readiness review of both clinical and information technology operations, to assess whether CT BHP would be ready for a January 1, 2006 start-up. In December 2005, the Departments determined that ValueOptions was not ready to undertake the information technology portion of the readiness review, which required the completion of end-to-end testing of the interface between the authorization of services and the payment of claims. As a result, the Departments decided to proceed with the carve-out of behavioral health services from the HUSKY Managed Care Organizations (MCOs) effective January 1, 2006, but to postpone the initiation of clinical management.

The information technology pre-implementation review took place in January 2006. Based on this review, Mercer recommended additional systems testing with an emphasis on end-to-end testing before proceeding with clinical management and the linkage of authorization to claims. The one exception was the management of residential services, which commenced on February 1, 2006. Residential service claims are paid through the DCF LINK system, and the initial plan for residential management did not include linkage of authorization to claims.

In March, the preliminary results of end-to-end testing indicated that the claims payment system, operated by Electronic Data Systems (EDS), would be unable to process inpatient hospital authorizations. Consequently, the Departments decided to proceed with the management of hospital services effective April 1, but to defer linkage of authorization to claims until modification of the claims payment system could be undertaken and tested. The phase-in of

management of other intensive services began April 1, including linkage of authorization to claims.

Throughout the implementation, the Departments emphasized the need to ensure a smooth transition from the HUSKY program to CT BHP. The Departments phased in those functions necessary to ensure continuity of patient care and customer service, while deferring clinical management until information system readiness could be established.

A. Pre-Implementation Reviews

A summary of the Mercer Readiness Reviews follows.

1. Clinical Readiness Review

Mercer conducted an on-site clinical readiness review in January 2006 to verify that ValueOptions had the essential administrative and clinical staffing, processes, and infrastructure in place to effectively administer CT BHP programs and services.[9] They conducted both a desk review of policies, procedures, and key documents, and an on-site review of how policies and procedures were implemented in day-to-day operations. Their report summarized both strengths and opportunities for improvement, as follows:

Strengths:

- All staff members who were interviewed were professional, committed, and brought a diversity of experience that was well matched to the positions for which they were hired.
- The Call Management reporting and data systems were fully functional.
- The online recipient and care management record system was highly customized to meet the CT BHP contract requirements regarding data capture.
- The utilization management, care management, and intensive care management staff were familiar with the relevant admission and discharge criteria as well as roles and responsibilities of the intensive care manager.
- There was a thoughtful approach to supporting and integrating the peer specialist role into day-to-day operations.
- Staff members were well versed in the policies governing denials and grievances.
- Top management was well versed in recovery/resiliency approaches and followed a strengths-based approach that was inclusive of community and natural supports.
- The provider network staff was very experienced and well versed in contract expectations.
- A comprehensive member brochure in both English and Spanish was produced.
- The appropriate security and privacy protocols were in place.

Opportunities for Improvement:

- Filling vacant positions (28 of 80 were open as of January 25, 2006, with close to half of the openings in the clinical area of care management);
- Staff training too reliant on self-study of policies, procedures, plan documents, and level of care guidelines;

- Inadequate methods of supervision, monitoring inter-rater reliability, and coaching;
- Insufficient experience of some staff with the Connecticut delivery system;
- No policy regarding emergency diversion and staff unfamiliar with this as a requirement;
- No co-location plan for intensive care managers;
- Staff unfamiliar with the status of the development of transition protocols for members in treatment with non-network providers;
- Complexity of online registration and care management record system;
- Spanish language option not yet implemented.

Recommendations:

- Provide a formal plan for covering open positions until new hires are approved and trained.
- Implement formal training and monitoring systems to bring clinical operation capabilities to a higher level of readiness and build familiarity with the service array and providers in the Connecticut system.
- Implement a Spanish language telephone line and customize policy on handling non-English speaking consumers to match the most prevalent populations in CT BHP.
- Provide the emergency diversion plan and communicate the plan to staff.
- Formalize the co-location plan.
- Increase coordination with DCF and DSS around protocols for transition of members in active treatment with providers who are not in the CT BHP network.

ValueOptions submitted plans for addressing each of these recommendations. The plans were approved by DSS and DCF and implemented during the first few months of 2006. In a letter dated March 21, 2006, from the lead CT BHP staff at DCF (Karen Andersson) and DSS (Mark Schaefer), the Departments commended ValueOptions for their response to the Clinical Readiness Review.

> In all instances, Mercer's requests were responded to promptly and courteously. In addition, staff members were consistently well prepared, enthusiastic, and clearly committed to the goals of the Connecticut Behavioral Health Partnership. These same qualities remained evident in VO's immediate initiation of plans to remedy those challenges within existing operations that were mutually acknowledged. The Departments wish to thank you and your team for your demonstrated commitment to excellence.

2. <u>Information Technology Readiness Review</u>

As stated above, Mercer conducted a similar review of the ValueOptions information systems in late January-early February of 2006 to verify that the essential information technology structure was in place to effectively administer CT BHP. They specifically examined eligibility data load and maintenance, provider file load and maintenance, and authorization management.

In a March 2006 report, they recommended 23 improvements across these three areas that they believed needed to be undertaken prior to the "go live" date for Phase I for a smooth implementation of the ASO's operations. In addition, they recommended six further actions to

be completed over the next three months before full implementation of the authorization process for all provider types.

Key recommendations called for the following:

- Complete all necessary policies and procedures.
- Fill the vacant computer programmer position.
- Conduct additional end-user testing for all three database systems.
- Establish quality assurance policies and procedures.
- Review, confirm, or revise contract requirements for eligibility information, providers, and authorizations.
- Develop, test, and/or confirm performance target reports.

The full set of their specific recommendations can be found in their printed report.[10]

III. CT BHP PERFORMANCE AND ACCOMPLISHMENTS IN 2006

CT BHP began operations in January 2006, but many of the functions were phased in over the first six months of the year as plans were developed and implemented to address the concerns raised in the Mercer readiness reviews.

By December 2006, there were 316,168 members enrolled in CT BHP; over two-thirds (71%) were under 18 years of age (see Table 1). This number includes approximately 52 children enrolled in the CT BHP Limited Benefit Program for children who are not HUSKY-eligible, but who are DCF-involved and who require access to home-based services.

Table 1. CT BHP Enrollees for CY 2006 (as of December 2006)[11]

Membership	Number Enrolled
Children 0-17	225,719
Adult 18+	90,449
Statewide Total	316,168

The state's contract with ValueOptions establishes performance criteria in a range of key areas and requires them to report quarterly on their operations. These reports (listed in Exhibit E of the contract) serve as a source of information on how ValueOptions performed in 2006 and are summarized in this section. The areas of operation include the following (with more detailed information about performance below).

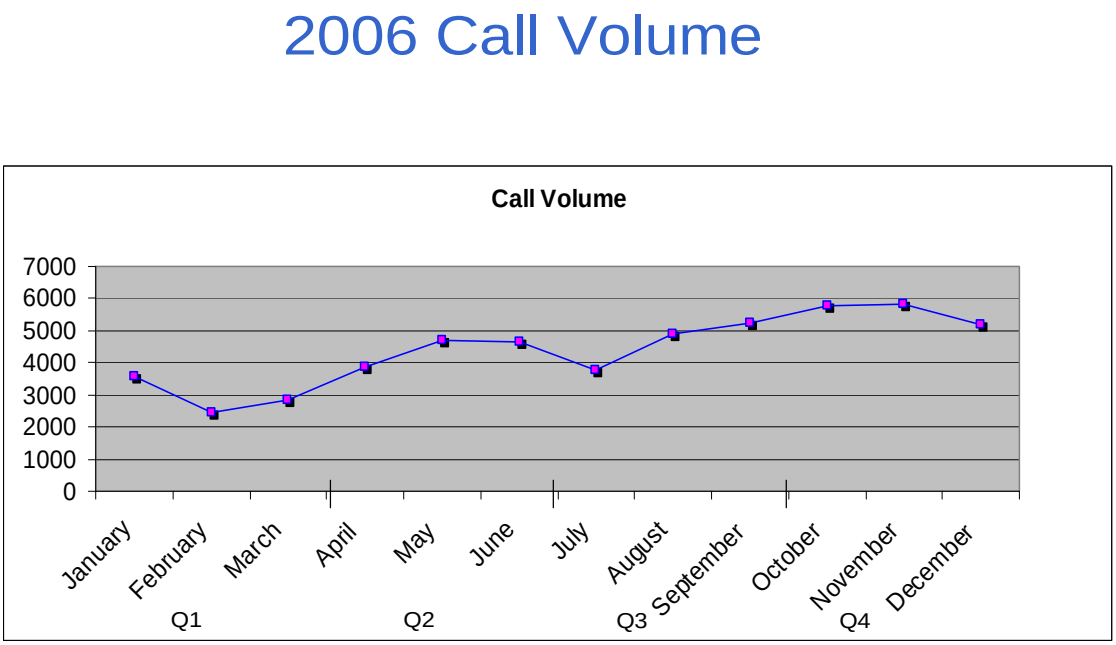
A. Telephone call management
B. Utilization management – Authorizations for care
C. Denials of service requests
D. Service accessibility

E. Service utilization
F. Complaints

A. Telephone Call Management

The CT BHP Call Center successfully managed the start-up and implementation of CT BHP. There were approximately 52,000 calls into the Call Center in 2006, beginning with 8,684 calls during the first quarter of Calendar Year 2006 as the implementation phase began, and building to 16,200 in the fourth quarter (See Figure 1).[12] Calls were answered in a timely manner, with over 99% answered within 30 seconds, and most in less than five seconds during business hours.[13]

Figure 1.



B. Utilization Management – Authorizations for Care

The authorization process is the basis both for ensuring that members receive the appropriate levels of care to meet their individual needs and for tracking and monitoring the care provided. ValueOptions gradually phased in the process for authorization of services throughout 2006. The authorization process began with residential treatment services during the first quarter; however, there was no link between authorization and claims payment. Authorization for inpatient, partial hospitalization, and intensive outpatient services began during the second quarter followed by outpatient and home-based services in the third quarter. By the fourth quarter, over 90% of services required authorization.

Care managers were expected to respond to providers within one hour for requests for authorization of services for higher levels of care where no peer review was required. These services include admission to psychiatric hospital inpatient, general hospital inpatient, inpatient detoxification, partial hospitalization, and intensive outpatient services. If peer review is required, all higher levels of care require a response within the following: two hours for psychiatric hospital inpatient and general hospital inpatient, three hours for inpatient detoxification, and one business day for partial hospitalization, intensive outpatient, and crisis stabilization services. There were a total of 2,273 cases presented for authorization (with and without peer review) at the higher levels of care in the third quarter of 2006 and 2,300 in the fourth quarter.[14]

Lower levels of care require a response to the provider within one business day. Lower levels of care include 23-hour observation, extended day treatment, group home, residential treatment, and home-based services. There were 1,100 initial authorizations in the third quarter of 2006 and 831 in the fourth quarter.[15]

The contract standard required that 95% of decisions be communicated to the provider within the designated timeframe. ValueOptions maintained this required level of performance. However, written notification of decisions was to occur within three days. Due to a technical problem approximately 8,000 authorization letters were not sent out until the first quarter of Calendar Year 2007. This resulted in the imposition of a contract sanction ($3,000 penalty)[16]. ValueOptions proposed a corrective action plan, which the Departments accepted.

C. Denials

One concern with transition to a new administrative entity is that service referrals and requests will result in a high number of denials. This was not the case during the first year of operations. As the authorization process was phased in, there were no denials issued until the third quarter. From August through December, there were 126 denials in all, two-thirds (84) for requests for treatment for children and one-third (42) related to adults. The vast majority (92%) were administrative denials largely due to providers failing to contact the BHP for prior authorization within the required timeframe. Only 10 were clinical denials for lack of medical necessity (five related to children and five related to adults). Seven of those were for inpatient treatment (four related to children and three to adults). The highest numbers of denials (101) were for the three highest levels of care: intensive outpatient services (41), extended day treatment (35), and acute inpatient (25).[17] There were no provider or member clinical appeals in 2006.[18]

D. Access to Providers

Table 2 depicts the number of independent or group practitioners active in the CT BHP network during 2006. The data include practitioners who submitted outpatient claims for services to CT BHP members anytime during 2006.

Table 2. Number of Providers by Provider Type in CT BHP Network in 2006[19]

Degree Type	Total
Psychiatrists	116
Psychiatric APRNs	51
Psychologists	143
Social Workers	324
Marriage/Family Therapists	147
License Professional Counselors	92
Alcohol/Drug Counselors	12

ValueOptions also collected and reported on members' access to at least one provider within a certain mileage radius of their home, based on enrollment data provided by EDS. The standards set according to the contract required that members in urban and suburban areas must have access to a participating provider within 20 miles of their home and members living in rural areas must have access within 25 miles.

Because there were problems in determining the number of providers practicing in group practices who were not credentialed as independent practitioners, the data reported were not fully representative. ValueOptions has since established a more reliable method for tracking this information in Network Connect, having collected the rosters of the group practices during 2006.

The validity of this measure as an indicator of accessibility, however, is still a concern. Variables that may impede the ability of families to actually receive and benefit from the services they seek, and therefore need to be taken into account, include:

- provider waiting lists
- number of HUSKY enrollees accepted into a practice
- the expertise of the practitioner as a match for a client's needs
- awareness on the part of members about which providers are in the CT BHP network
- lack of transportation for members, gender or cultural match between provider and client

E. Utilization

The sources of utilization data are service authorizations and registration (for services not requiring authorization) and claims data. The data for the first two quarters were not as accurate as they will be going forward because the requirements for authorizations were phased in over the course of the year, with claims payments tied to authorizations beginning July 1, 2006. There was continued improvement in data collection as greater numbers of providers became informed about the need for involvement in the authorization process. Given these circumstances, the data for utilization for the various levels of service for 2006 are incomplete, particularly for the earlier quarters.

Based on the best available data, inpatient and ambulatory service utilization information is summarized below.

1. Acute Inpatient Service Utilization

Phase-in of authorizations for the inpatient levels of care was completed by the end of the second quarter. This category includes inpatient psychiatric services in a general or psychiatric hospital (including Riverview Hospital), inpatient psychiatric boarding on a medical unit, observation, and psychiatric residential treatment facility services.

In 2006, 1,166 adults (18 and older) and 1,633 children received hospital psychiatric inpatient services (see Table 3).[20] The data indicate that children are driving the utilization numbers at a far greater rate than the adult population. Children stay four times as long in inpatient psychiatric units as adults. The average length of stay for children was 26.6 days over the last three quarters of 2006, compared to 6.7 days for adults.[21]

There was a concern that a significant proportion of the children in psychiatric hospitals were on discharge delay status. That is, they were in the hospital for longer stays not because of their clinical status but because there were no step-down placements to appropriately serve their needs. ValueOptions developed methods for tracking the number of and reasons for discharge delays in the summer of 2006. However, the data were not captured reliably until 2007 and cannot be reported here.

Table 3. Utilization of Inpatient Services, CY 2006, Adults and Children

18 and Over	**CY06**	
Type of Service	**Number of Recipients**	**Units of Service**
Hospital Inpatient	1,166	9,113
Residential Detox/Rehab	554	4,342
Total Duplicated Count of Recipients	1,720	13,455
Total Unduplicated Count of Recipients	1,493	
Under 18	**CY06**	
Type of Service	**Number of Recipients**	**Units of Service**
Hospital Inpatient	1,633	52,495
Residential Detox/Rehab	53	757
Psychiatric Residential Treatment Facilities	134	21,910
Total Duplicated Count	1,820	75,162
Total Unduplicated Count	1,538	

2. Ambulatory Service Utilization

CT BHP reported utilization for a range of outpatient services (including routine, intensive, extended day, partial hospitalization, home-based, and emergency mobile services). In Calendar Year 2006, 14,245 adults (unduplicated count) and 20,603 children (unduplicated count) received outpatient services.

Table 4 provides the number of recipients for each type of outpatient service for both adults and children.[22]

Table 4. Utilization of Outpatient Services, CY 2006, Adults and Children

18 and Over	CY06	
Type of Service	**Recipients by Service (Unduplicated)**	**Units of Service**
Routine Hospital Outpatient	2,790	17,039
Routine Clinic Outpatient	8,497	65,312
Routine Independent Practitioners – Outpatient	3,772	35,215
Hospital Extended Day Treatment	1	19
Hospital Intensive Outpatient	689	8,138
Hospital Partial Hospitalization Program	275	3,169
Clinic Extended Day Treatment	2	8
Clinic Intensive Outpatient	791	8,732
Clinic Day Treatment/Partial Hospitalization	349	4,048
Intensive In-home Child and Adolescent Psychiatric Services (IICAPS)	5	480
Home-based	12	1,639
Emergency Mobile Psychiatric Services (EMPS)	27	54
Total – Duplicated count of recipients across all services	17,210	143,853
Total – Unduplicated count of recipients across all services	14,245	
Under 18	**CY06**	
Type of Service	**Recipients by Service (Unduplicated**	**Units of Service**
Routine Hospital Outpatient	1,786	11,240
Routine Clinic Outpatient	15,470	175,860
Routine Independent Practitioners – Outpatient	4,263	41,596
Hospital Extended Day Treatment	178	7,690
Hospital Intensive Outpatient	1,105	20,495
Hospital Partial Hospitalization Program	570	9,946
Clinic Extended Day Treatment	594	35,256
Clinic Intensive Outpatient	466	12,538
Clinic Day Treatment/Partial Hospitalization	123	1,526
IICAPS	642	140,775
Home-based	751	85,998
EMPS	1,213	3,102
Total – Duplicated count of recipients across all services	27,161	546,022
Total – Unduplicated count of recipients across all services	20,603	

3. Utilization by Children in DCF Custody

Of the 250,866 children (ages birth-21) enrolled in CT BHP in the fourth quarter of 2006, approximately 12,846 (5%) were involved with DCF, yet they represented 21% of those members authorized for services.[23] DCF-involved children are especially high users of intensive behavioral health services. This is consistent with the data reported in the 2000 study of the children's behavioral health system, where DCF-involved children accounted for 5% of the HUSKY population and 60% of behavioral health expenditures.[24]

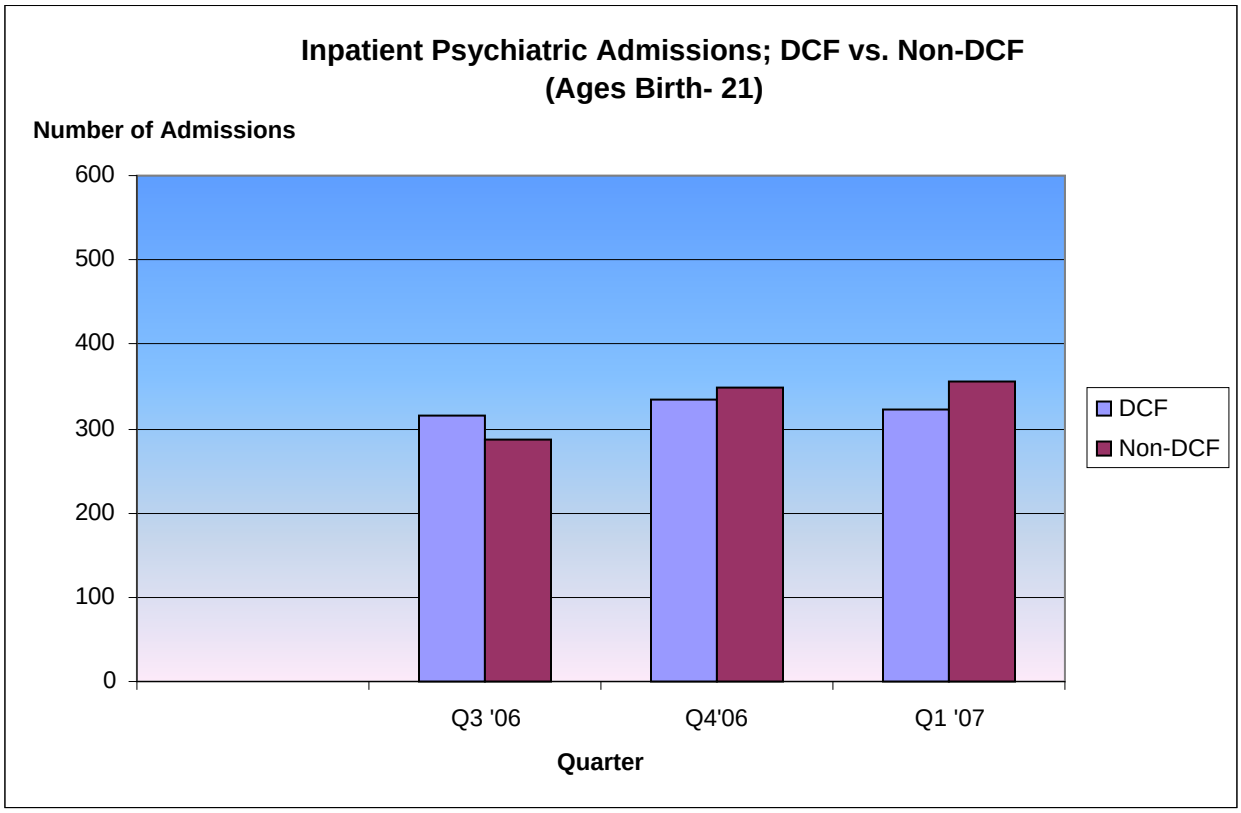
As exhibited in Table 5, children involved with DCF had significantly more admissions to inpatient psychiatric services relative to their population than did other children, and the average length of stay for inpatient services was more than double that of other children (42.3 days vs. 14.3 days in the fourth quarter of 2006).

Table 5. Utilization of Inpatient Psychiatric Services by Children, Fourth Quarter of 2006

	DCF-Involved	Non-DCF-Involved
Numbers enrolled	12,846	238,020
Inpatient Admissions	335	348
Admissions per 1,000 enrolled	9.0	0.5
Average Length of Stay	42.3	14.3
Days per 1,000 enrolled	453.8	8.7

Presented another way, the rate of admissions to inpatient psychiatric hospitals for children involved with DCF in the fourth quarter of 2006 was 9.0 per 1,000 enrollees with 453.8 days of care per 1,000 enrollees. In contrast, for children not involved with DCF, the rate of admissions was 0.5 per 1,000 enrollees with 8.7 days of care per 1,000.[25] Figure 2 portrays the proportion of inpatient psychiatric hospital admissions for DCF-involved and non-DCF involved children for the third and fourth quarter of 2006 and the first quarter of 2007 (again, noting that those involved with DCF comprised only 5% of the enrolled population).[26]

Figure 2.



F. Complaints

During 2006, only a small number of complaints (75) were registered. A little over half (53%) were received from providers, and the remainder were from members. Of the member complaints, 69% concerned treatment of services received by adults and 31% concerned treatment or services received by children. Members complained about the quality of the service (14) or the quality of care (6) they received. The low number of complaints may partly be a reflection of the newness of the system; perhaps members did not know how to make a complaint or were not comfortable in doing so. In 2007 CT BHP continued staff trainings on the proper procedure in recording complaints. Staff feedback provided more detail regarding perceived barriers to tracking complaints. An alternate process was instituted, which included collecting information while on a call in which the caller is expressing areas of concern, yet is not comfortable with filing a formal complaint. These inquiries can then be tracked separately for internal use to identify trends and patterns. This will provide a more accurate reflection of the level of problems being experienced.

Provider complaints were received almost exclusively in the fourth quarter with the implementation of Web Registration. The complaints centered on the authorization process or problems with claims payment. All complaints were resolved within 30 days. Provider workshops and individual provider site visits were held throughout the year to educate providers on both the Web Registration and the appeals process.[27]

IV. POST-IMPLEMENTATION REVIEWS

Complementary to the pre-implementation readiness reviews conducted by Mercer in early 2006, Mercer conducted a post-implementation review one year later to verify that the clinical operations and information systems were consistent with contract terms and industry best practices. The results of these reviews are summarized in this section.

A. Clinical Review

The focus of this review was on utilization management and care management (CM). Mercer conducted a review of the written clinical policies, procedures, and plan documents; conducted on-site interviews with key staff; observed staff in action; and performed clinical record reviews on a sample of 50 cases.

In their April 2007 report, Mercer concluded that significant progress was made on most of the issues raised in the pre-implementation readiness review, particularly in hiring and training clinical staff, and that ValueOptions was:

> ….well-positioned to take the necessary steps to shape the delivery of care within a framework of recovery and CT systems principles. This will require that clinical staff learn to more consistently apply LOC [level of care] criteria and to take (and document) a more active role in the CM process. In order to do this, there will need to be a shift of focus toward the CM process, moving from primarily relying on system-wide provider training and collaboration initiatives to achieve system change to introducing more rigor into the CM process. [28]

Mercer provided the following recommendations: [29]

1) Assess and address the reasons for staff turnover in the service center.
2) Address language issues and other barriers to family engagement in the network development and emergency diversion plans.
3) Revise and simplify the care management documentation templates to focus on essential elements of a review in order to improve the percent of cases in which documentation fully supported the authorization decision. The document template should be limited to no more than 2-3 sections and the number of individual items should be able to be completed in a 15-20 minute review with a provider.
4) Focus staff development efforts on enhancing the performance of clinical care managers conducting initial and concurrent reviews and intensive care manager staff handling complex cases.
5) Consider formalizing a requirement for physician leadership at two or more of the weekly clinical rounds to enhance quality management of complex cases and improve case formulation skills while maintaining a focus on recovery and system principles.
6) Implement an incremental approach to improving the rigor of reviews by targeting one level of care at a time and identifying a minimum number of cases per manager that will be targeted for improvement as a prototype.

7) Develop and implement a more formal, data-driven system for identifying over- and under-utilization at the provider level.
8) Continue to monitor intensive care manager caseloads as additional cases are identified.
9) Review and update the denial and appeal policies to avoid conflict of interest in conducting denial and appeal reviews.

Mercer's summary statement with regard to case record reviews of care management captures the overall sense of the challenges faced by CT BHP in its first year:

> Hiring and on-boarding of staff includes a steep learning curve for a number of issues, particularly in an environment as clinically complex as that of the CT BHP, which requires in-depth knowledge of both behavioral health and child welfare systems of care. It is …worth noting that the CT BHP is a unique program, so many initiatives are being implemented for the first time with no comparable program models upon which to build.[30]

B. Information Systems (IS) Review

Mercer consultants conducted a review of written documentation and an onsite review in January 2007 to examine the information systems and management reports required in Contract Exhibit E. They looked at the performance of the web-based registration system and the grievance and appeals systems, the call center availability from implementation to date, and performance with regard to the eligibility, authorization, and provider files. The post-implementation review indicated that extensive progress had been made in the first year and that ValueOptions was "substantially compliant with the majority of requirements of the CT BHP ASO contract pertaining to IS."[31]

V. FINANCIAL INFORMATION

One of the significant innovations of CT BHP was to create a structure that would braid the funding for behavioral health services from DSS and DCF. Although the funds themselves are not actually pooled, they are braided so that enrollees have access to funding streams from both agencies to support their service plans and needs.

In 2006, the total state Medicaid expenditure for CT BHP was $101,878,843 for HUSKY A and $2,480,581 for HUSKY B. The total DCF expenditure for CT BHP was $151,243,872. (See Tables 6 and 7 for more detailed information.)

A summary of monthly Medicaid expenditures for CT BHP in 2006 is included as Attachment 2. The chart summarizes expenditures by category of service for HUSKY A, other state agency expenditures, and HUSKY B.

Table 6. DSS Expenditures for CT BHP – Calendar Year 2006[32]

TYPES of EXPENDITURES	HUSKY A/ Medicaid	Husky B/ SCHIP
DSS Program Expenditures	76,874,668	2,411,356
DSS Administrative Expenditures	10,998,348	0
Total DSS Expenditures	**87,873,016**	**2,411,356**
Other State Agency Expenditures[1]	14,003,561	69,225
Grand Total	**$101,878,843**	**$2,480,581**

Table 7. DCF Expenditures for CT BHP – Calendar Year 2006[33]

SERVICES	DCF EXPENDITURES
ASO Managed Services	
Residential Treatment, In-State	52,157,811
Residential Treatment, Out-of-State	27,330,798
Total Residential	**79,488,609**
Community Services	
Traditional & PASS Group Homes	10,749,707
Therapeutic Group Homes	29,509,350
IICAPS DSS Transfer	1,820,256
IICAPS Fee For Service	141,164
Total Community	**42,220,477**
Grant Based In-Home Services	
Extended Day Treatment	6,471,336
Intensive Home Based Services: Functional Family Therapy	1,233,386
IICAPS	3,057,109
Multidimensional Family Therapy	1,766,365
Multi-systemic Therapy	3,719,817
Total Grant Based In-Home Services	**16,248,013**
Grant Based Emergency Mobile Psychiatric (EMPS) Services	
Care Coordination (Local System of Care)	673,100
EMPS	1,648,544
EMPS/Care Coordination	9,045,129
Enhanced Care Coordination	1,920,000
EMPS Total	**13,286,773**
Grand Total	**$151,243,872**

[1] The Psychiatric Reinsurance program ended 12/31/05, and the program's funds are now reflected in the expenditures for State Mental Health Hospital and Hospital Inpatient categories of service.

Summary of Key Accomplishments of CT BHP in 2006

Key Accomplishments

- Developed all necessary Connecticut-specific policies and procedures
- Established level of care guidelines and rates for the majority of services
- Initiated authorizations of various levels of care in a progressive roll-out through September 2006
- Implemented Web Registration for outpatient levels of care
- Designed and rolled-out Member and Provider Satisfaction Surveys
- Implemented complaint and grievance processes
- Performance reports (Exhibit E) prioritized and specifications developed
- Formulated Local Area Development Plans
- Completed Mercer Post-Implementation Audit
- Implemented limited management of residential and group home levels of care and enhanced the admission process
- Facilitated a decrease in ED delayed discharges
- Initiated coordination of care activity with the four MCOs
- Received grant to study mental health services for children in foster care placement, with a focus on multi-disciplinary evaluations

VI. TARGET AREAS OF PERFORMANCE LINKED TO PAYMENT WITHHOLDS

ValueOptions was responsible for meeting a set of six performance targets during 2006 that are outlined in their contract with the state (Exhibit A of the contract). There was a withhold of 7.5% of the monthly administrative capitation payment to be paid only upon ValueOptions' ability to meet these targets. Each Performance Target has a separate value associated with it.

These target areas and their associated withholds for 2006 are outlined in Table 8.

Table 8. Performance Targets, Withholds, and Results

Performance Area	Target	Withhold	Target met
1. Data management related to authorization and payment in five domains: a. Eligibility File – build and update	Upload 98% of weekly or monthly data files within 2 business days; daily update files within 1 business day; error rate of 2% or less.	.5%	Yes
b. Provider File – build and maintain	Update 98% of weekly adds or changes within 3 business days and five business days for monthly updates; error rate 2% or less.	.5%	Yes
c. Authorization File timeliness – provide and update daily	98% shall occur timely	.5%	Yes
d. Auth. File accuracy	Error rate less than 2%	.5%	Yes
e. Auth. File - error correction	98% of errors corrected within two business days	.5%	Yes
2. Provider satisfaction	Favorable average rating from 90% of providers surveyed	1%	Yes
3. Member satisfaction	Favorable average rating from 90% of members surveyed	1%	Achieved 84.1%; received 75% of withhold
4. Hospital inpatient readmissions for child and adult mental health (MH) and substance abuse (SA)	Child MH: less than 16% Child SA: less than 15.8% Adult MH: less than 9.6% Adult SA: less than 11.4%	1%	Yes at 6 months; will recalculate at 9 months
5. Follow-up care	Rates greater than 61.4% for mental health and 39.7% for substance abuse	1%	Yes at 6 months; will recalculate at 9 months
6. Emergency department utilization	Less than 1.7 ED visits per thousand member months	1%	Waived

Performance in each of these major areas is summarized in this section.

A. Data Management

The quality and timeliness of data transmission is key to the effective operation of CT BHP, since the data are the basis for many of the administrative, quality monitoring, and oversight functions of the ASO. The expectation is that data regarding the eligibility of members, participating providers, authorization of services, and payment of claims should be communicated among the three organizations involved (DSS, ValueOptions, and EDS) in a timely manner with few errors. There were five domains within this target related to the eligibility files, provider files, and authorization files. One fifth of the applicable 2.5% withhold for this target was assigned for each domain.

Regarding the eligibility file, 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. The target for a comprehensive provider file was that ValueOptions would receive and upload an initial provider file within 48 hours of receipt of a clean file and then update 98% of the provider file weekly adds or changes within three business days and monthly updates within five business days. There was to be a 98% accuracy rate based on random quarterly quality audits. There were three separate domains assigned to authorizations. They addressed timeliness, accuracy, and error correction. ValueOptions was to provide a daily Prior Authorization Transaction batch file of all authorized services and updates with 98% occurring prior to the start of the business day following production of the file, with less than 2% error rate. 98% of errors were to be corrected within two business days.

Performance. The eligibility file transmissions were initiated prior to the January 1, 2006 go-live date. Monthly enrollment files were submitted and uploaded into ValueOptions' system at the end of December 2005. There were some challenges with the provider file which were ironed out during the first quarter of 2006, leading to a high rate of accuracy for the remainder of 2006. Passing of authorizations to EDS commenced during the second quarter of 2006. Since that time the targets for timeliness, accuracy and error correction were met.

B. Provider Satisfaction

A provider satisfaction survey was conducted by Fact Finders to assess Value Options' performance in the following areas:

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

Fact Finders conducted a telephone survey between July and September 2006. They developed a stratified random probability sample of all enrolled CT BHP providers that included 106 individuals (providers treating CT BHP members outside the confines of a facility), and 104 organizations (providers treating CT BHP members within a facility's program or agency). ValueOptions was expected to achieve a favorable average rating from 90% of providers surveyed. 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.

Performance. Based on responses to a question about overall satisfaction, using a three-point scale (very satisfied, somewhat satisfied, not satisfied), the majority of providers interviewed were somewhat satisfied or very satisfied with CT BHP. Fourteen percent were not satisfied. Three-quarters of organizations and 60% of individuals surveyed reported that their experience with CT BHP has been the same or better than with other managed behavioral health care organizations. However, two-thirds of individuals interviewed and one-third of organizations reported that CT BHP fees are lower than other plans with fewer than 5% saying that the fees were higher. The majority of responses to the questions related to authorization of care, provider relations, clinical management, and website use were positive.[34]

ValueOptions achieved a favorable rating from at least 90% of the providers surveyed, thus qualifying for a full return of the withhold associated with this target.

C. Member Satisfaction

Two member satisfaction surveys were initiated during 2006, one by Mercer and one by Fact Finders. The purpose of the Mercer survey was to assess the performance of ValueOptions relative to their performance target.[35] The Fact Finders survey was broader, intended to assess the performance of the CT BHP network,[36] and is summarized on Page 23 of this report.

1. Mercer Member Satisfaction Survey

Mercer's survey was brief (10 items) and focused entirely on performance of ValueOptions relative to their target. The sample was drawn from the population of clients or parents that contacted the ASO for customer service.

The Mercer survey assessed performance in the following areas:

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

Two samples of 300 members each were randomly chosen from those who contacted CT BHP by telephone from October to December 2006. Of those sampled, 229 (38%) completed surveys. Mercer advised that this was high enough to determine whether the required level of performance was met. The return of the full 1% withhold required that 90% of those surveyed

were, on average, satisfied. An average of 85% would result in a return of 75% of the 1% withhold.

Performance. Satisfaction was determined by averaging responses to the completed items on each survey, excluding a question on member materials that the Departments agreed was premature as the member handbook had not been widely disseminated. If the average was greater than the 2.5 midpoint on the 4-point scale (very dissatisfied, dissatisfied, satisfied, very satisfied), the member was deemed to be satisfied. Of the 227 members surveyed, 190 (84.1%) reported a favorable average rating. DSS and DCF agreed to return 75% of the withhold allocated in recognition of "a solid performance in the area of member services during the first year of operation and through the course of an especially complex and extended implementation."[37]

D. Hospital Readmission

One measure of performance with regard to the effectiveness of clinical services was the rate for inpatient hospital readmission within 30 days of discharge for both children and adults. Rates were to be lower than the average of the rates over the State Fiscal Years 2002-04.

Target rates were as follows:

- Child mental health readmissions – less than 16%
- Child substance abuse readmissions – less than 15.8%
- Adult mental health readmissions – less than 9.6%
- Adult substance abuse readmissions – less than 11.4%

The data available to measure performance on this target were limited, due to the phase-in of authorizations. The target was determined to have been met based on a preliminary calculation examining six months of claims data restricted to the third and fourth quarters of CY 2006. The contract requires that the withhold be awarded based on six-month performance and that payment be adjusted as necessary based on a recalculation at nine months. A further analysis is to be performed when nine months of data become available.

E. Follow-up Care

Members are expected to be connected to follow-up services with a mental health professional within 30 days after discharge from inpatient hospitalization. The expectation was that this would occur at greater than the average performance of the four HUSKY managed care contractors in State Fiscal Year 2004, which was set at 61.4% for mental health care and 39.7% for substance abuse treatment. A clinical study to examine performance specifically with regard to children was designed but not completed in 2006. It will continue in 2007.

ValueOptions requested that this target be waived due to concerns regarding the methodology and data utilized to set baseline performance. Their request was not granted. The Departments' preliminary calculation, based on a six-month run out, concluded that the target was met for both substance abuse and psychiatric follow-up care. The withhold was to be paid with the understanding that it may be readjusted pending recalculation of the target at nine months. The

margin for psychiatric follow-up was thin, and in a letter dated May 31, 2007 from the Departments to ValueOptions, it was noted that the results may change when calculated based on nine months of data.

In the interim, ValueOptions initiated several interventions to assure that every member with an inpatient admission obtained follow-up care. Members discharged from the hospital were contacted to assure that they had an appointment for a follow-up visit and encouraged to attend. Barriers such as transportation problems were assessed during the call, and actions were taken to circumvent those barriers.

F. Emergency Department (ED) Utilization

Concerns about the increase in ED visits among children with mental health diagnoses led the Departments to establish a target related to reduced ED visits. The target required a rate of ED utilization that was less than the 2001-04 rate trended to CY 2006, based on visits per 1,000 member months. The rate had been declining gradually from 2.03 in 2001 to 1.8 in 2004. The target rate set for 100% return of the withhold was 1.7 visits per 1,000 member months.[38] However, when 2005 HUSKY utilization data became available, it appeared that there had been an increase in the rate, returning to near the 2001 baseline. In light of the 2005 utilization data, the Departments determined that the trend-based 2006 target was no longer valid and that the ED performance target should be waived.

An additional concern in 2006 was that children were being detained in hospital EDs due to lack of follow-up services and supports. Of those on delay status, 75% were children involved with DCF in Q3 and 71% in Q4. The average number of days that children were held in EDs (days delayed) was between 2 and 2.5 during this time. Connecticut Children's Medical Center had the largest number of children in delayed status, followed by Yale-New Haven Hospital. This concern was being considered as the basis for a performance target in 2007.

VII. COMPREHENSIVE MEMBER SURVEY

Fact Finders Survey

In addition to the Mercer survey summarized above, CT BHP contracted with Fact Finders to conduct a more comprehensive survey of CT BHP operations that was not tied to a specific performance target. The Fact Finders survey explored a broader range of items, including satisfaction with clinical services and outcomes.

A stratified random probability sample of 223 members who had received services through CT BHP in 2006 was interviewed between August 2006 and January 2007. The original sample design included 50 interviews for each of five levels of care segments: residential, home-based, outpatient, inpatient, and day treatment. However, there were significant challenges involved in collecting the data due to such factors as the fluid nature of service delivery, the accuracy of the contact information, and HIPAA requirements. The final sample included fewer members

assigned to inpatient level of care (41) and home-based care (32), with 50 in each of the other categories. Fact Finders reported that they were "confident that the research findings were highly representative and reliable indices of sentiments" of the CT BHP members.[39]

Some of their findings of interest include the following:[40]

- In its first year, only one-third of respondents were aware that CT BHP was providing their mental health benefits; over half (53%) had not heard of the name Connecticut Behavioral Health Partnership.
- Over half of the members interviewed were completely or very satisfied with the mental health services received in the last year. Larger proportions of those receiving home-based or outpatient services were satisfied than those receiving residential, day treatment or inpatient services.
- Just over two-thirds of inpatients, and at least eight in ten members in all other level of care segments, received all the help they desired from CT BHP.
- Two-thirds of respondents said they/the member (the child) were feeling better, compared to a year ago. This was more likely the case with those members receiving outpatient treatment.
- While about half of the members reported doing better in school compared to a year ago, one in ten reported doing worse.
- Three-quarters of respondents thought that they/the child were better able to cope when things went wrong, compared to a year ago; least likely to feel so were those in inpatient or day treatment segments (compared to a year ago).
- Over eight in ten respondents thought the services of CT BHP helped the child stay out of trouble.
- Eight in ten respondents thought the service they/the child received helped a great deal or somewhat.

As with the other member and provider satisfaction studies, the challenges of the methodology, the limited number of respondents, and the fact that the survey was conducted early in the life of CT BHP, suggest that the results are not a sound basis for an evaluation of CT BHP performance. However, they do spell out the types of measures that could be the basis for future evaluations, with a more refined method of quantitative and qualitative data collection.

VIII. STRENGTHENING THE LOCAL DELIVERY SYSTEM

One of the major goals of the reform of the children's mental health system over the past six years has been to enhance the local delivery system in keeping with a system of care approach. The intent has been to build a family-centered, community-based system of services and supports so that children could remain in their own homes, schools, and communities, and the state would be less reliant on expensive and often less effective out-of-home care.

To that end, CT BHP has been working with 26 existing community collaboratives throughout the state to help build this system. The community collaboratives were established 10 years ago with legislation that adopted the System of Care Model for Connecticut.[41] CT BHP hired eight

Systems Managers who were assigned to DCF's local area offices to work with providers, consumers, school systems, local law enforcement agencies and others in the community collaboratives to create 15 Local Area Development Plans (LADP) in the fall of 2006.

These plans were structured around six goals:[42]

1) Improved service capacity
2) Improved care linkages and collaborative planning
3) Identification of preferred practices that will lead to quality outcomes
4) Identification of individuals who are experiencing barriers to recovery
5) Identification of children receiving care coordination through the local community collaborative
6) Improved behavioral health care for children and families served by the DCF Bureau of Child Welfare

Within each goal, area-specific objectives were identified and customized action steps developed to reflect the needs of the communities. Area-specific goals, objectives and action plans were reviewed with a large stakeholder community and approved by DCF Area Office and Central Office staff prior to implementation. The first set of plans was approved in the fall of 2006 and will be reviewed and revised in 2007.

Among the most prevalent activities within all LADPs was the creation of an inventory of local services and supports to distribute to schools, parents, hospitals, and others. Systems Managers assisted in collecting, organizing, and analyzing the information to further support system development and coordination. The Systems Managers presented recommendations around service needs that evolved out of the activities within the LADP to DSS and DCF to support budget options and service expansion. Reportedly, the process of developing the LADPs helped local community collaboratives and DCF area offices to identify local needs, recruit new providers, hold informational forums on a variety of behavioral health related topics, and educate communities about the role of CT BHP.

There were no established performance targets tied to the six goals or data collected to assess how well the goals will be met, however, making it difficult to integrate the development and implementation of the LADP plans into the larger managed system in order to track progress. It is important to note that while ValueOptions has responsibility for assisting with the assessment and development of the provider network, it is not responsible for contracting and credentialing, and it does not have the ability to use contracting to enhance, refine, or develop the network as a result of recommendations pursuant to the LADP process.

IX. SPECIAL PROJECTS

Over the past year, there were several major initiatives undertaken by CT BHP to improve the performance of the mental health service system. These included:

A. Enhanced Care Clinics
B. Residential Care Team
C. Children in Foster Care
D. Intensive In-home Child and Adolescent Psychiatric Services (IICAPS)
E. Performance Measurement Project – CT BHP Report Card

Progress in each of these initiatives is summarized in this section.

A. Enhanced Care Clinics

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 will receive higher reimbursement rates (25% increase) if they meet certain criteria.

All hospital outpatient and freestanding mental health and substance abuse clinics that provide routine outpatient services such as individual therapy, group therapy, family therapy, medication management and other special services for CT BHP members are eligible to receive this designation if they meet special requirements. The first requirement is the ability to see clients in a timely fashion depending on their level of urgency. This includes the capacity to:

- see clients with emergent needs within two hours
- see clients with urgent needs within two days
- see clients with routine needs within two weeks
- provide extended coverage outside of normal business hours

In the future, ECCs will meet other special requirements related to:

- coordination of care with primary care physicians
- member services and support
- quality of care
- cultural competence

The ECC Request for Qualifications was issued in 2006 with selection and start-up scheduled to occur in 2007.

B. Residential Care Team

Although residential treatment services were the first level of service to be phased in under the utilization management process, the process was experienced by the Departments as less than

satisfactory. Prior to December 2006, referrals for residential and group homes were entered into the ASO tracking system only after the Central Placement Team (CPT) at DCF had reviewed the clinical material and made a match to a facility. In addition, the use of Level of Care Guidelines was not part of the previous CPT process, as it was for all other services administered through the ASO. Provider participation in the concurrent review process was minimal, and, as such, there was little difference between the new CT BHP process and the old internal DCF process.

The process was changed beginning in December 2006, when CT BHP inaugurated a new Residential Care Team composed of staff members from ValueOptions, DCF, and the Judicial Branch's Court Support Services Division. All referrals for residential or group home care are now managed by this team, extending the role of CT BHP to this additional level of service.

The Child and Adolescent Needs and Services Instrument (CANS), a nationally known and standardized tool, was introduced as the means by which area office, parole, and probation staff made referrals. Information from the CANS is now used to determine the need for residential or group home care and the specialized type of care needed. Information on each child is entered into a larger data system that allows CT BHP to track children through the system. In addition, providers were trained to use a new bed tracking system that alerts CT BHP to immediate or anticipated vacancies at a residential treatment or group home setting.

All of this information is used to support a much more clinically rigorous process that includes twice weekly clinical rounds wherein each child presented for a match to a residential or group home placement is more fully reviewed and discussed to ensure that the match is both viable (i.e., a vacancy exists) and appropriate (i.e., the facility is designed to meet the child's clinical needs). The entire system redesign will provide much better information about residential care and provide for better triage both for admission and discharge.

C. Children in Foster Care

An analysis of inpatient admissions for 2006 indicated that more than 75% of HUSKY children and HUSKY adults in inpatient care had a history of DCF involvement. To address the vulnerability of children in state custody, CT BHP applied and was awarded a technical assistance grant from the Center for Health Care Strategies to assess the adequacy of the behavioral health needs assessment component of the comprehensive multi-disciplinary exam (MDE) that children entering custody of DCF for the first time are required to have within 30 days. The project will measure the frequency with which newly placed foster children are referred for behavioral health treatment and then the frequency with which the connection is made. The goal of the initiative is to create the capacity to track the extent to which children actually receive the services recommended through the MDE. This project will be piloted in Waterbury and in Bridgeport beginning in 2007. This issue is a proposed new 2007 Performance Target.

A second project to be initiated in 2007 will assess the relationship between the use of behavioral health services by children either before being placed in foster care or after placement and subsequent placement disruptions.

D. IICAPS

Intensive In-Home Child and Adolescent Psychiatric Services (IICAPS), developed by the Yale Child Study Center, is an intensive home-based model designed to prevent children and adolescents from requiring hospital or residential care or to support discharge from these settings. The intervention focuses on the child with psychiatric problems as well as the child's family, school, and community. A two-person team consisting of a clinician and a bachelor's-level mental health counselor provides the service.

IICAPS was the first clinical service that had been subsidized through grants funded by DCF to be converted to a full fee-for-service model under CT BHP. The issues of determining a fair and reasonable rate and managing the transition process for this service were complex, requiring extensive data gathering, analysis, and negotiation. Much of this work was accomplished in 2006 with the assistance of the Behavioral Health Partnership Oversight Council's DCF Advisory Subcommittee. [See the CT BHP report to the BHP Oversight Council (March 2007) for a detailed review of the process.[43]] Much was learned from the process and methodology, which will serve as a model for future DCF grant to fee-for-service conversions. In the report referenced above, the Departments conclude with the following statement:

> The Departments recognize that this first year of operation under the CT BHP has presented special challenges for the IICAPS program. The Departments appreciate the good faith efforts that providers have made to work with the state to resolve these challenges and to continue to support these programs even in the face of significant revenue shortfalls.[44]

At the end of 2006, they indicated their commitment to continuing to work with IICAPS providers in 2007 to set rates that are sufficient to cover reasonable costs and to support expansion to address unmet needs.

E. CT BHP Report Card

With a grant from the Center for Health Care Strategies, DSS contracted with the Human Services Research Institute (HSRI) to develop a set of performance indicators that would provide another mechanism for measuring the effectiveness of CT BHP. During 2006, HSRI worked with the Quality Management and Access Subcommittee of the Behavioral Health Partnership Oversight Committee to develop a set of performance indicators related to:

- Access
- Connection to care
- Discharge delays from hospitals, residential treatment, and other congregate care settings, EDs, or delays in accessing outpatient treatment
- Coordination of behavioral health and medical care
- Client stability and effective community management
- Complaints
- High utilizers
- Member and provider satisfaction
- Use of natural supports

- School attendance
- Connection with Juvenile Justice System
- Treatment of co-occurring disorders (substance abuse and mental health)
- Successful transition to adult services

Implementation of these measures will greatly enhance future evaluations of the impact of CT BHP.

X. SIGNIFICANT ISSUES FOR 2007 AND BEYOND

A. Staff Turnover in the CT BHP Service Center

Recruiting and retaining staff was one of the key challenges for ValueOptions in its first year. There was a 46% turnover in care managers in 2006. CT BHP managers attribute some of the challenge to Connecticut's employment market. ValueOptions was competing with the state agencies that provide better salary and benefits. In addition, they noted that Connecticut did not have a long history of public sector managed behavioral health care and thus there was not a pool of candidates with the requisite experience from which to draw. Only three of the first 28 people hired had public sector experience. As a result, more time than anticipated was needed to recruit, train, and develop staff on how to be care managers and then managed care managers. This was especially challenging with regard to the Intensive Care Manager positions. Other stresses for staff related to the demands for high productivity during a start-up phase when all the administrative supports were not fully developed and operating smoothly.

B. Discharge Delays

Delays for discharges at all levels of care, but particularly from inpatient psychiatric hospitals, are an ongoing and significant concern. In the 2000 study on the children's behavioral health system, it was reported that 55% of the children in DCF custody who were in private acute care psychiatric hospitals were ready for discharge to a less intensive and less expensive environment, but there was nowhere for them to go. Almost half of these children had been hospitalized for longer than 90 days.[45] Although the BHP delay data for 2006 are not entirely reliable, gross estimates revealed that about 200 children experienced a discharge delay in the fourth quarter of 2006, with an average delay of 111 days. Children in DCF custody represented 68% of those in delay status. The length of stay for children involved with DCF tends to be extended, with almost twice as many discharge delay days than for other children (42.8 vs. 17.9 in the fourth quarter of 2006).

Lack of availability of the services or placements they need in order to leave the hospital was identified as the primary problem. The largest percentage of discharge delays is represented by children awaiting placement in an alternative level of care or foster care (62%). The most frequently awaited services were residential treatment and Level 2 Group Homes.[46]

CT BHP will be working to improve the reliability and validity of the discharge delay data in 2007. This will help the Departments better understand the nature of the problem, and develop

alternative step down services, with the goal of reducing the percentage of inpatient days that are due to discharge delays rather than treatment needs.

C. Expansion of Services to Meet the Need

With the advent of Connecticut Community KidCare in 2001, there was an increased investment in some of the services necessary to allow children to remain in their own homes, schools, and communities. New services were added and there was an expansion of existing services, including care coordination, emergency mobile psychiatric services, and intensive in-home services. The expansion, however, has not been sufficient to meet the need, thus contributing to the ongoing problem of gridlock in hospitals and residential treatment settings.

With the improvement of data collection and management of care, CT BHP is positioned to address the needs and the gaps in services and how resources can best be allocated to meet those needs. This has been a challenge for Connecticut for a long time, but new information will be helpful in guiding the decisions and overcoming some of the barriers that have precluded the ability to improve the quality of care and invest in the most effective services to meet the mental health needs of children and families.

D. Coordination of Physical and Behavioral Health Care

With the carve-out of behavioral health benefits from the four managed care organizations (MCOs) with whom DSS contracts for medical services for HUSKY enrollees, the issue of coordinating care across these two systems is a challenge. The major concerns are coordination or co-management of care including medications, pharmacy and transportation services (which remain under the purview of the MCOs).

CT BHP staff met monthly with the MCOs, and a primary care provider advisory group has been organized and meets regularly to address issues as they arise. Protocols for referrals and co-managing cases were developed and practice guidelines are in development. The requirement for ECCs to develop mechanisms of coordination with at least two primary care sites will also enhance and inform this work.

The Care Coordination Subcommittee of the Behavioral Health Partnership Oversight Council is addressing these issues and there are several initiatives and studies under way to identify, track, and address problems in these areas.

XI. LESSONS LEARNED FROM 2006 EXPERIENCE

Based on interviews with key informants at DSS, DCF, and ValueOptions, the following captures observations about the lessons learned from the first full year of this major undertaking of implementing CT BHP.

1. A well-constructed contract between the state agencies and the ASO has been an important ingredient of success during the first year, as it provided clarity about expectations and

responsibilities. That said, flexibility to modify the contract as the members of the BHP learn from their experience will be important.

2. Phasing in the start-up for the authorization of services was helpful. This process reduced provider confusion, disruption in services, and difficulties with claims payments. Problems with one sector could be identified and resolved before taking on the next.
3. The challenge of accuracy and timeliness of data management was related to the number of parties involved in the process [state agencies, ValueOptions, EDS, providers, members]. As stated by the Service Center CEO, Lori Szczygiel, "The more parties in the circle, the more complicated it gets. Everyone speaks a different language, but everyone needs to be on the same page for it to work." In a start-up, as this was, it was hard to anticipate where the problems would arise. More testing of the system, using various scenarios, would have been helpful. The goal is to identify issues as soon as possible and bring them to the attention of senior staff and the state government for problem solving and actions for resolution.
4. The information systems designed to meet the requirements of the contract, with a large number of reports, is resulting 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. The data will inform the growth and improvement of the service system, if used appropriately for quality assurance, outcome evaluation and clinical decision-making.
5. ValueOptions underestimated the number of staff required to fulfill the requirements of the contract. Eight Care Managers for over 300,000 enrollees is not sufficient. Though some restructuring of job demands helped with this towards the latter part of the year, the concern is that the volume of work and the expectations to meet the Performance Targets has the potential to lead to staff burnout and continuing challenges with staff turnover.
6. The braided funding across state agencies has been an important element of the reform, creating more flexibility in the design of treatment plans.
7. Effective working relationships are important. The three key staff from DCF, DSS, and ValueOptions (Karen Andersson, Mark Schaefer, Lori Szczygiel) commented about the effective working relationship, among and between them. This reduced the possibility of confusion and contention. Everyone operated as a team, working to address problems and design and implement solutions in a timely and effective manner.
8. In keeping with Governor Rell's strong policy of transparency and accountability in contracting, transparency in all aspects of the work has been helpful to minimize tensions among partner agencies, the ASO, members, providers, and other key stakeholders. The contract specifications regarding the responsibilities of ValueOptions and the role of the state agencies were clear, and mechanisms of accountability are public. The Behavioral Health Oversight Council, a collaborative body established by the General Assembly in 2005 to advise the Departments of Social Services (DSS) and Children and Families (DCF) on the development and implementation of the CT BHP, played a significant role in this regard. The Council consists of legislators, consumers, advocates, health care providers, representatives of managed care plans, and state agencies. The Council met monthly throughout 2006 and reviewed and made recommendations on key aspects of the implementation of the CT BHP.[47]

9. Ongoing, consistent training at all levels and for all involved (including CT BHP staff, providers, members, and communities) about the existence of CT BHP, its role, functions, and how it operates is an essential ongoing task.
10. Major systems change such as the initiation of CT BHP is a complex enterprise that affects and therefore involves numerous people (children, families, providers, state agencies, legislators) and requires considerable targeted outreach, education, technical assistance and staff support. It is easy to underestimate the time and resources needed to be effective.

CONCLUSION

The experience of the first year of implementation of CT BHP set the stage for 2007 and the major initiatives being undertaken. These include:

- The need to address the ongoing problem of gridlock in inpatient settings and emergency departments so that children do not remain on discharge delay because of inadequate discharge planning and lack of community-based treatment options
- Improvements in the quality of service delivery through collecting and sharing information about the performance of individual providers and facilities
- Improving the local area development plans so that there are clear expectations for performance and accountability for results in building comprehensive community-based systems of care
- Fully meeting the assessment and treatment needs of children in the custody of DCF, as they clearly are the highest utilizers of care

Overall, based on meeting the requirements of the BHP contract and the associated standards and performance targets, the first year of CT BHP was a success. There were clearly mistakes made along the way, but the nature of the relationships among the partners allowed for the difficulties to be openly addressed and corrected. A solid foundation was put in place upon which to build 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.

GLOSSARY OF ACRONYMS

ASO – Administrative Services Organization

BHP – Behavioral Health Partnership

CANS – Child and Adolescent Needs and Services Instrument

CM – Care Management

CPT – Central Placement Team

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

HSRI - Human Services Research Institute

IICAPS - Intensive In-Home Child and Adolescent Psychiatric Services

IS – Information Systems

LADP – Local Area Development Plan

LOC – Levels of Care

MCO – Managed Care Organization

MDE – Multi-disciplinary Exam

S-CHIP – State Child Health Insurance Program

VO – Value Options

Attachment 1

Quick Reference Guide to the Connecticut Behavioral Health Partnership

CT BHP Administrative Services Organization (ASO)

The Connecticut Behavioral Health Partnership
500 Enterprise Drive, Suite 4D
Rocky Hill, CT 06067

CT BHP Toll Free: (877) 552-8247 **Fax:** (866) 434-7681 **TTY:** (866) 218-0525

CT BHP Web site: www.ctbhp.com

Member and Provider Services Lines are open from 9:00 a.m. to 7:00 p.m. EST on regular business days. Care Managers (for crisis and pre-certifications for inpatient services) are available 24 hours a day, 365 days a year for members and providers.

For your convenience, we have one central toll-free number with a menu from which callers select the appropriate option.

Provider Relations
- Provider training/education
- Newsletter, updates and alerts
- Service/network development

Member Services
- Eligibility verification
- Provider listings & referral
- General information
- File complaint/grievance

Peer Specialists/Family Peer Specialists
- Provide family/member Support
- Member calls & referrals
- Educational mentoring
- Outreach & training services
- Promote recovery & resiliency

- **Care/Intensive Care Management**
- Prior authorizations
- Concurrent reviews
- Intensive Care Management
- DCF residential authorization and census tracking

Quality Management
- Critical incidents/significant events
- Provider profiling
- QM committees
- QM studies
- QM and improvement initiatives

System Management
- Local area development plans
- Regional planning meetings
- New service development/expansion
- Outreach, education & training

Service Center Executive Leadership
- Chief Executive Officer
- Medical Director
- Finance
- Information Technology/Reporting

Department of Social Services - March 2007
CY 2006 Behavioral Health Partnership Expenditures
By Category of Service and Medical Coverage Plan

Medicaid - CY 2006 Behavioral Health Partnership Program and Administration Expenditures [1] [2]

DSS	Jan-2006	Feb-2006	Mar-2006	Apr-2006	May-2006	Jun-2006	Jul-2006	Aug-2006	Sep-2006	Oct-2006	Nov-2006	Dec-2006	Total ($)
Hospital Inpatient [4]	8,316.48	1,385,030.34	1,602,416.63	1,727,736.77	2,817,012.61	3,400,342.64	2,222,819.74	3,254,713.22	2,918,873.62	2,181,515.75	2,394,619.49	3,034,690.70	26,948,087.99
Hospital Outpatient	45,387.77	615,834.87	823,985.72	837,183.15	822,206.02	726,987.95	976,981.57	647,454.32	880,114.68	532,145.75	345,860.19	683,859.62	7,938,001.61
Physician	5,320.48	42,236.66	76,994.45	118,333.19	68,460.31	68,494.28	70,707.43	63,269.97	52,682.58	42,411.38	49,946.71	57,762.23	716,619.67
Clinic	331,463.75	2,097,695.79	2,502,008.83	2,489,695.54	2,891,023.09	3,096,885.16	2,785,990.74	2,547,518.18	2,469,005.25	2,247,109.12	2,954,911.95	3,647,652.40	30,060,959.80
Home Health	3,557.58	16,859.06	20,285.08	31,926.76	78,155.98	75,756.13	91,556.35	73,663.32	97,427.01	105,384.00	98,890.88	107,379.67	800,841.62
Alcohol and Drug	16,116.26	96,363.02	80,411.83	114,166.53	121,742.28	83,253.82	91,131.13	124,849.71	110,623.31	131,872.57	196,824.66	221,901.85	1,369,256.97
Other Practitioner	7,043.52	31,010.33	465,786.83	691,277.36	901,297.82	674,838.70	1,039,371.46	1,024,234.91	1,047,421.50	865,504.16	1,349,948.65	923,165.12	9,020,900.36
Total DSS Program Expenditures [5]	**$417,206**	**$4,285,030**	**$5,571,889**	**$6,010,319**	**$7,699,898**	**$8,126,559**	**$7,278,558**	**$7,735,704**	**$7,576,148**	**$6,105,943**	**$7,391,002**	**$8,676,412**	**$76,874,668**
Administration Expenditures	602,315.00	0.00	602,315.00	2,146,465.00	602,315.00	2,146,465.00	0.00	602,315.00	0.00	602,315.00	1,697,149.00	1,996,694.00	10,998,348.00
Total DSS Expenditures	**$1,019,521**	**$4,285,030**	**$6,174,204**	**$8,156,784**	**$8,302,213**	**$10,273,024**	**$7,278,558**	**$8,338,019**	**$7,576,148**	**$6,708,258**	**$9,088,151**	**$10,673,106**	**$87,873,016**

Other State Agency	Jan-2006	Feb-2006	Mar-2006	Apr-2006	May-2006	Jun-2006	Jul-2006	Aug-2006	Sep-2006	Oct-2006	Nov-2006	Dec-2006	Total ($)
State Mental Health Hospital [4]	0.00	0.00	0.00	2,492,599.16	1,489,945.90	2,899,710.11	3,103.56	1,247,329.03	36,980.11	96,670.74	2,840,705.25	2,872,362.12	13,979,405.98
State Mental Health Clinic	0.00	0.00	0.00	0.00	0.00	0.00	0.00	8,498.52	2,861.33	9,209.65	1,961.13	1,624.74	24,155.37
Total Other Agency Expenditures	**$0**	**$0**	**$0**	**$2,492,599**	**$1,489,946**	**$2,899,710**	**$3,104**	**$1,255,828**	**$39,841**	**$105,880**	**$2,842,666**	**$2,873,987**	**$14,003,561**
Program Total / Medicaid	**$1,019,521**	**$4,285,030**	**$6,174,204**	**$10,649,383**	**$9,792,159**	**$13,172,734**	**$7,281,662**	**$9,593,846**	**$7,615,989**	**$6,814,138**	**$11,930,818**	**$13,547,092**	**$101,878,843**
											+Nov SAGA In-Patient (claim error)	$2,266	
												$11,933,084	

HUSKY B / SCHIP - CY 2006 Behavioral Health Partnership Program Expenditures [1] [3]

DSS	Jan-2006	Feb-2006	Mar-2006	Apr-2006	May-2006	Jun-2006	Jul-2006	Aug-2006	Sep-2006	Oct-2006	Nov-2006	Dec-2006	Total ($)
Hospital Inpatient [4]	0.00	0.00	60,054.10	21,820.20	5,480.28	201,528.56	88,451.58	92,787.39	78,084.02	83,773.69	76,479.29	60,572.12	769,031.23
Hospital Outpatient	0.00	0.00	23,098.88	3,523.05	13,489.21	69,467.09	47,028.27	30,800.64	39,164.41	22,697.83	31,162.62	37,591.91	318,023.91
Physician	0.00	0.00	1,394.82	1,161.21	1,881.59	2,108.08	4,006.86	1,573.87	1,863.74	1,123.32	1,509.83	1,604.87	18,228.19
Clinic	0.00	0.00	23,646.37	31,696.52	37,988.56	167,381.33	114,511.57	80,705.64	71,040.72	65,433.02	104,075.06	119,326.57	815,805.36
Home Health	0.00	0.00	0.00	0.00	0.00	0.00	576.80	268.40	2,476.20	407.80	0.00	84.50	3,833.70
Alcohol and Drug	0.00	0.00	0.00	0.00	0.00	8,093.54	0.00	1,613.92	2,400.00	0.00	2,230.65	16,095.14	30,433.25
Other Practitioner	0.00	0.00	873.76	4,250.92	17,634.08	27,027.24	40,342.17	40,625.30	135,160.90	13,854.80	93,253.87	82,977.46	456,000.50
Total DSS Program Expenditures [5]	**$0**	**$0**	**$109,068**	**$62,452**	**$76,474**	**$475,606**	**$294,917**	**$248,395**	**$330,190**	**$187,290**	**$308,711**	**$318,253**	**$2,411,356**
Administration Expenditures	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Total DSS Expenditures	**$0**	**$0**	**$109,068**	**$62,452**	**$76,474**	**$475,606**	**$294,917**	**$248,395**	**$330,190**	**$187,290**	**$308,711**	**$318,253**	**$2,411,356**

Other State Agency	Jan-2006	Feb-2006	Mar-2006	Apr-2006	May-2006	Jun-2006	Jul-2006	Aug-2006	Sep-2006	Oct-2006	Nov-2006	Dec-2006	Total ($)
State Mental Health Hospital [4]	0.00	0.00	0.00	0.00	0.00	0.00	0.00	7,800.00	0.00	0.00	31,200.00	30,225.00	69,225.00
State Mental Health Clinic	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Total Other Agency Expenditures	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$7,800**	**$0**	**$0**	**$31,200**	**$30,225**	**$69,225**
Program Total / HUSKY B SCHIP	**$0**	**$0**	**$109,068**	**$62,452**	**$76,474**	**$475,606**	**$294,917**	**$256,195**	**$330,190**	**$187,290**	**$339,911**	**$348,478**	**$2,480,581**

Grand Total DSS & Other Agency Medicaid and HUSKY B / SCHIP ($)	**$1,019,521**	**$4,285,030**	**$6,283,272**	**$10,711,835**	**$9,868,633**	**$13,648,340**	**$7,576,579**	**$9,850,041**	**$7,946,179**	**$7,001,429**	**$12,270,729**	**$13,895,570**	**$104,357,159**

FOOTNOTES:

[1] Expenditures are listed by date of payment.
[2] The Medicaid report is a subset of the Department's Medical Expenditure Report.
The above BHP Medicaid data is from the BHP Tansfer Table (all Transfer Table columns excluding the HUSKY Enhanced and HUSKY Band 3 columns). The Transfer Table is in turn populated from the HMDRBHST report for the current month.
[3] The HUSKY B report includes BHP expenditures for Band 3 Clients.
The above HUSKY B data is from the BHP Tansfer Table (the Transfer Table HUSKY Enhanced and HUSKY Band 3 columns.)
[4] The Psychiatric Reinsurance program ended 12/31/05, and the program's funds are now reflected in the expenditures for State Mental Health Hospital and Hospital Inpatient categories of service.
[5] JulyTotal DSS Expenditures include a positive $1,233,563 adjustment for the SFY 2006 BHP retro rate increase of 3.763% afforded to BHP providers.

10/4/2007

Attachment 2

ENDNOTES

[1] Child Health and Development Institute of Connecticut. (2000). *Delivering and Financing Children's Behavioral Health Services in Connecticut*.
[2] Stroul, B. & Friedman, R. (1986). *A system of care for children and youth with severe emotional disturbances (rev.ed)*. Washington, DC: Georgetown University, Child Development Center.
[3] Section 17a-22a, Section 17a-22b, Section 17a-1, and Section 17a-127 of the General Statutes of Connecticut. Public Act 00-2, Section 5 of June Special Session, 2000. *An Act Concerning Programs And Modifications Necessary To Implement The Budget Relative To The Department Of Social Services.*
[4]Connecticut Department of Children and Families and Department of Social Services. (2001*). Connecticut Community KidCare: A plan to reform the delivery and financing of children's behavioral health services.*
[5] Section 17a-22h of the General Statutes of Connecticut.
[6] Sections 17a-22i to 17a-22p, inclusive, of the General Statutes of Connecticut.
[7] Section 17a-22i of the General Statutes of Connecticut.
[8] Section 17a-22m of the General Statutes of Connecticut.
[9] Mercer Government Human Services Consulting. Clinical Readiness Review Report. Connecticut Behavioral Health Partnership. March 8, 2006.
[10] Mercer Government Human Services Consulting. Connecticut Behavioral Health Partnership – Information Technology Readiness Review. Final Report. March 10, 2006.
[11] CT BHP. Exhibit E Reporting Matrix. 4A-2. Utilization Statistics. Calendar Year 2006.
[12] From BHP presentation to BHPOC Operations Subcommittee, March 9, 2007.
[13] CT BHP. Exhibit E Reporting Matrix . 1.D: Call Management – percentage of total calls answered within 30 seconds. Calendar Year 2006.
[14] CT BHP. Exhibit E Reporting Matrix. 2A: Higher Levels of Care Timeliness Summary for Initial Authorizations. 3rd quarter report – 10/3/2006; 4th quarter - 1/3/2007.
[15] CT BHP. Exhibit E Reporting Matrix. 2B: Lower Levels of Care Timeliness Summary for Initial Authorizations. 3rd quarter report – 10/3/2006; 4th quarter - 1/3/2007.
[16] CT BHP. Exhibit E Reporting Matrix. 3. Timeliness of UM Decision Written Notification, p. 4.
[17] CT BHP. Exhibit E Reporting Matrix: 16A: NOA and Denial Tracking Report. Calendar Year 2006.
CT BHP. Exhibit E Reporting Matrix: 17: Denial Letter Turnaround Time. Calendar Year 2006.
[18] CT BHP. Exhibit E Reporting Matrix: 23 A and B: Provider and Member Appeals. Calendar Year 2006.
[19] CT BHP. Ad hoc claims report provided by DSS, November 2007.
[20] DSS Claims Data
[21] CT BHP. Exhibit E Reporting Matrix: 4A-2. Calendar Year 2006
[22] DSS Claims Data
[23] CT BHP. Exhibit E Reporting Matrix 4A-1. CY 2006. Ages Birth-21. As of 12/31/06.
[24] Child Health and Development Institute of Connecticut (2000). *Delivering and Financing Children's Behavioral Health Services in Connecticut*. p. ES-3.
[25] CT BHP. Exhibit E Reporting Matrix: 4A-1. Calendar Year 2006. As of 5/1/07.
[26] CT BHP. Utilization Statistics. 4A-1.
[27] CT BHP. Exhibit E Reporting Matrix: 20E: Complaint Reason Codes.-Revised 5/07. Calendar Year 2006.
[28] Mercer Government Human Services Consulting. Post-Implementation Review of ValueOptions, Inc. Connecticut Behavioral Health Partnership. April 11, 2007. p. 16.
[29] Mercer Government Human Services Consulting. Post-Implementation Review of ValueOptions, Inc. Connecticut Behavioral Health Partnership. April 11, 2007.
[30] Mercer Post-Implementation Report p. 11.
[31]Mercer Government Human Services Consulting. Connecticut Behavioral Health Partnership Information Systems Post Implementation Review. Final Report. February 20, 2007.
[32] Provided by DSS
[33] Provided by DCF
[34] Fact Finders, Inc. 2006 Provider Survey: Final Report. September 28, 2006.
[35] Mercer Government Human Services Consulting. Member Satisfaction Report. June 19, 2007.
[36] Fact Finders. 2006 Member Survey: Final Report. February 2, 2007.
[37] Correspondence (Letter of 6/5/07 to Lori S. from Mark and Karen)

[38]Departments of Social Services and Children and Families. Exhibit A. Year One ASO Performance Targets. p. 14.
[39] Fact Finders. 2006 Member Survey: Final Report. February 2, 2007, p. 4.
[40] Fact Finders. 2006 Member Survey: Final Report. February 2, 2007.
[41] Public Act 97-272.
[42] CT BHP. July 2007. Local Area Development Plans Year-To-Date: Update Summary.
[43] CT BHP. The Conversion of Intensive In-Home Child and Adolescent Psychiatric Services from Grants to Fee-for-Service. Report to the CT BHP Oversight Council. March 2007.
[44] CT BHP. The Conversion of Intensive In-Home Child and Adolescent Psychiatric Services from Grants to Fee-for-Service. Report to the CT BHP Oversight Council. March 2007. p. 14.
[45] Child Health and Development Institute of Connecticut (2000). Delivering and Financing Children's Behavioral Health Services in Connecticut. p. 9.
[46] CT BHP. 2006 Quality Management Program Evaluation and Project Plan Report. pp. 36-37.
[47]See Report of the Connecticut Behavioral Health Partnership Oversight Council, March 2007 for more information about the work of the Council. Available at: www.cga.ct.gov/ph/BHPOC