DSS and DCF report to the

Behavioral Health Partnership Oversight Council

March 14, 2007

Intensive In-home Child and Adolescent Psychiatric Services (IICAPS)

Introduction

- Intensive home and community based service
- Focus on children with serious psychiatric disorders
- Formerly, grant funded (about $4.4 million) with some billing to HUSKY MCOs (about $1 million)
- Converted to fee for service - January 1, 2006
  - Rationale for conversion was to improve providers' ability to add teams to accommodate unmet need

Program Costs

- 30 to 32 teams active prior to conversion
- Average cost per team - $169,300 and $177,600.
- Departments established per team cost of approximately $200,000 based on estimated reasonable cost to operate a single team in SFY 2005 (see Table 1)
- This amount exceeded per team cost by between $22,600 and $30,700 and was intended to be sufficient to bring teams up to fidelity with the model’s requirements

Program Costs

Table 1: Reasonable Program Cost

Administrative & Clerical Services	$11,000
Clinical (Master's Level) (a)	$42,000
Mental Health Counselor	$31,000
Program Coordinator	$14,000
Total Salary	$98,000
Fringe Benefits (@30% of Salary)	$29,400
Medical Director/Psychiatrist (b)	$27,300
Other Expenses	$45,114
Grand Total	**$199,814**

Notes:

(a) Current starting salary for MA clinicians in DCF funded PNP's

(b) Three and one-half hours per week at $150 per hour

Key Assumptions of the Rate Methodology

- 5.5 hours of service per client per week; 8 or 9 clients per team
- Assume 8 clients with an average of 5.5 billable hours per week, each team would be expected to bill 44 hours of service per week
- Adjustment factor of 83% to take into consideration times during the year when one or more team members would not be able to bill
  - E.g., sick, vacation and holiday time, time between when one client completes treatment and another starts treatment
- Adjusted weekly productivity is:
  - 4.565 hours per client per week (83% times 5.5 hours)
  - 36.52 hours per team per week (83% times 44 hours)
- Equates to an overall billing productivity of 48.7%

Key Assumptions of the Rate Methodology

Table 2: Rate Calculation

Reasonable Cost Per Team	$199,814
Clients per team	8
Average hours per client	5.5
Billable hours per week	44
Adjustment factor	83%
Adjusted billable hours	36.52
Billable hours per year	1,899
Billable units per year	7,596
Initial Rate	$26.41
SFY06 Rate (3.763% increase)	$27.39
SFY07 Rate (1% increase estimated)	$27.66

Residual Grant Funding

- Residual grant funding - $599,442
  - Reserved 25 slots at approximately $24,000 per slot
- Additional $299,721 reserved to assist those providers that had disproportionate travel times
  - Travel funds prorated by team based on average time between program address and each client's address
  - Travel grants ranged from $0 to $140,732.

Transition to Fee-for-Service

- New rate and conversion to fee for service effective January 1, 2006
- For first 6 months bridge funding was provided to ease the transition to fee for service
- Providers permitted to bill for services rendered to CT BHP eligible clients and retain billing revenue
- CT BHP payments approximately $1.05 million for first 6 months (total expenditures by date of payment)

Transition to Fee-for-Service

- December 2005 - IICAPS programs provided with billing guidelines to support proper coding and documentation
- June 2006 - programs provided with updated billing guidelines and a written response to frequently asked questions
- September 2006 –
  - Prior authorization
  - Timely filing (120 days)

Transition to Fee-for-Service

- Before prior authorization - problem with claims denials when providers billed the services of a clinician and a mental health counselor on separate claim forms for the same client and same dates of service. MMIS modification expected to go into production in Spring 2007
- With introduction of prior authorization, an additional problem surfaced related to the ability of the ASO to accommodate requests for authorization in excess of the typical 5.5 hours per week (or 22 hours per month). ASO implemented system modifications to address this problem by November 2006 and authorizations for September and October were adjusted when requested by the provider.

Troubleshooting Revenue Shortfalls - Billing

- Examined whether providers were billing a usual and customary charge in excess of the fee schedule amount ($27.39)
  - Two providers failed to bill a usual and customary charge at or above the established fee
- Examined whether provider were billing with the HK modifier in conjunction with the established service codes.
  - All providers were using HK appropriately

Troubleshooting Revenue Shortfalls - Eligibility

- Rate methodology assumes that 90% of service recipients would be eligible for reimbursement under the CT BHP and that approximately 10% (i.e., the 25 grant funded slots) would be unentitled
- Examined whether providers were billing for all CT BHP eligible clients
- Analyzed eligibility during the period 7/1/06 through 12/31/06 for each service recipient reported by providers to Yale based on recipients served each month or “recipient service months”

Troubleshooting Revenue Shortfalls – Eligibility

- Table 3 shows several important things:
  - By adding final three columns, one can see that all of the providers except Sites B and Site K served a sufficient proportion of potentially billable clients (i.e., 90%)
  - One can also see that several of the sites did not enroll children who could have been reimbursed under the Limited Benefit Program
  - Finally, it is evident that Sites B, G and L have a substantial number of eligible clients for whom they have not yet received payment

Troubleshooting Revenue Shortfalls – Eligibility

Analysis of Recipient Service Months for IICAPS Cases Served From July 1, 2006 Through December 31, 2006

	Unpaid				Paid
Site	% Unentitled	% FFS	% Potential LBP	% CT BHP	% CT BHP
Site A	1.82%	0.91%	2.73%	13.64%	80.91%
Site B	26.00%	2.00%	0.00%	48.00%	24.00%
Site C	4.49%	0.00%	2.25%	4.49%	88.76%
Site E	0.00%	0.00%	0.00%	2.82%	97.18%
Site F	0.76%	0.00%	6.06%	6.82%	86.36%
Site G	0.00%	0.00%	2.60%	13.96%	83.44%
Site H	2.34%	0.78%	3.91%	5.47%	87.50%
Site I	6.54%	0.00%	7.48%	8.41%	77.57%
Site J	0.00%	1.88%	5.63%	8.13%	84.38%
Site K	6.63%	4.97%	3.87%	6.63%	77.90%
Site L	2.56%	0.00%	0.00%	24.36%	73.08%
Site N	0.79%	0.00%	11.11%	9.52%	78.57%
	2.92%	0.97%	4.16%	10.97%	80.97%

Troubleshooting Revenue Shortfalls – Third Party Liability

- Examined percentage of CT BHP clients with commercial coverage
- Providers required to bill the third party insurer before billing CT BHP
- Table 4 provides a summary of this analysis.
  - 11% of total recipient service months have commercial insurance
  - Sites B and L (among others) may be encountering payment delays due to third party billing requirement
  - Payment delay may be contributing to the significant percentage of CT BHP recipient service months that remain unpaid

Troubleshooting Revenue Shortfalls – Third Party Liability

Site	% CT BHP Recipient Service Months with Third Party Liability
Site A	**10.58%**
Site B	**41.67%**
Site C	**18.07%**
Site E	**0.00%**
Site F	**19.51%**
Site G	**7.33%**
Site H	**10.92%**
Site I	**10.87%**
Site J	**7.43%**
Site K	**3.92%**
Site L	**23.68%**
Site N	**14.41%**
	11.37%

Assessing the Reasonableness of the Key Assumptions

- Yale Child Study Center tested reasonableness of assumption that providers will on average serve 8 clients per week with an average productivity of 4.565 hours per week (5.5 hours times 83%)
- Analysis based on provider reported data on billable service hours for each client. Results reported in Table 5
- On average, IICAPS programs are providing 4.1 billable hours of service per client per week—less than the 4.565 hours assumed under the IICAPS rate methodology.
- Of the 13 network providers studied, only four reported an average above 4.565

Assessing the Reasonableness of the Key Assumptions

Table 5. Active IICAPS Cases from October 2, 2006 to November 30, 2006: Average Time Billed per Week per Case at each IICAPS Network Site

Site	Average face-to-face time per case per week (in hours)	Average indirect time per case per week (in hours)	Average Time Billed per Case per week (in hours)
Site A	3.11	0.31	**3.4***
Site B	2.17	0.41	**2.6***
Site C	5.04	0.63	5.7
Site D	3.14	0.44	**3.6***
Site E	3.93	1.36	5.3
Site F	3.04	0.84	**3.9***
Site G	3.26	0.75	**4.0***
Site H	3.02	0.80	**3.8***
Site I	3.27	1.04	**4.3***
Site J	2.64	1.00	**3.6***
Site K	3.52	1.04	4.6
Site L	3.02	1.74	4.8
Site N	2.31	1.19	**3.5***
	3.17	0.94	4.1

* Denotes providers whose average billable time per client per week falls below the 4.565 minimum threshold.

Assessing Billing Efficiency

- The Departments examined hours paid per client for each site
- These data were compared to billable hours reported to Yale for the same time period
- Results are presented in Table 6
- Substantial majority of programs are receiving reimbursement for more than 90% of their billable activity

Assessing Billing Efficiency

Table 6: Hours Paid Compared to Hours Reported as Billable

	Average paid hours per client per week (CT BHP claims)	Average billed hours per client per week (Yale)	Percent paid of reported billed
Site A	3.08	3.4	90.59%
Site B	2.39	2.6	91.92%
Site C	5.60	5.7	98.25%
Site E	4.27	5.3	80.57%
Site F	3.16	3.9	81.03%
Site G	3.80	4.0	95.00%
Site H	3.59	3.8	94.47%
Site I	4.28	4.3	99.53%
Site J	3.85	3.6	106.94%
Site K	5.07	4.6	110.22%
Site L	3.36	4.8	70.00%
Site N	3.38	3.5	96.57%

Notes: Payment data were available for 13 of the 14 network providers.
Two provider locations have been combined into one.

Assessing Billing Efficiency

- There are a variety of reasons that payments may be slightly less than billable service hours provided:
  - Some services may be in excess of authorization or beyond timely filing
  - Providers may not yet have billed for some services
  - Some claims remain outstanding because providers await commercial insurance denials before billing the CT BHP
  - Billing efficiency issues, e.g., providers may not be billing for some billable activity

Conclusion and Recommendations

- Conversion of IICAPS grants to fee-for-service has required and continues to require collective efforts of providers, Yale, and CT BHP Oversight Council's DCF Advisory Subcommittee
- Have not yet achieved stated aim, which is to enable economic and efficient providers to grow the IICAPS services to meet demand
- Additional steps need to be taken to evaluate and support the IICAPS service

Recommendations

Expand productivity analysis

- Departments recommend that Yale Child Study Center revise its analysis of available data and collect information prospectively that will allow the Departments to assess the reasonableness of the assumptions that a team can serve eight billable clients per week and provide a total of 36.52 billable hours per week

Recommendations
Expand teams per site

- Providers should expand number of teams that they are operating:
  - Providers with multiple teams can better support fixed costs and thus can more efficiently cover costs through billed revenues
  - Providers with multiple teams are less vulnerable to staff turnover because a single staff member contributes less to overall program revenue
  - Providers with multiple teams have a greater number of staff from which to draw upon to provide cross-coverage

Recommendations
Invest in Staff Quality and Retention

- The Departments have established rates based on the reasonable cost for the service that is somewhat above the cost of the service when it was grant funded
- Rates have since increased an additional 4.67%
- The Departments recommend that providers use available revenues to:
  - Invest in staff
  - Encourage team productivity
  - Promote long-term staff commitment to the provision of this service.

Recommendations
Technical Assistance

- Technical assistance for providers that focuses on ensuring that providers:
  - distinguish activities that are billable from non-billable
  - distinguish rehabilitative services from case management
  - identify and enroll all eligible clients
- Help providers understand reason that claims submitted are not fully paid, thus allowing them to make adjustments to internal operations to address issues within their control
- To the extent that problems are identified related to the authorization or claims adjudication systems, the Departments will work with Value Options and EDS to bring about a resolution

Recommendations
Extended Bridge Funding

- The Departments are proposing to extend bridge funding beyond the initial 6 months already provided from January 1 to June 30, 2006
- Purpose of bridge funding extension is to offset deficits that providers have incurred related to the conversion to fee-for-service
- The Departments propose to use unspent CT BHP SFY07 rate increase dollars (up to $515,000) to fund this extension
- Bridge funding extension dollars would be allocated based on deficits shown in Interim Financial Reports to DCF due March 30 and subject to end of year reconciliation

Recommendations
Rate Adjustment

- Departments will review productivity information as complete and valid information becomes available
- If productivity data suggest that assumptions are unreasonable, the Departments will consider modifying one or more of the key assumptions in the rate model to establish a temporary rate
- A final rate may not be established until the program has at least one year of operation after the resolution of issues related to billing efficiency, definition of billable services, documentation and coding

Recommendations
Differential Rates

- In response to waiting lists for service in many parts of the state, Departments are considering establishing a differential rate schedule, which would be higher for IICAPS providers that guarantee timely access and/or an expansion in service capacity

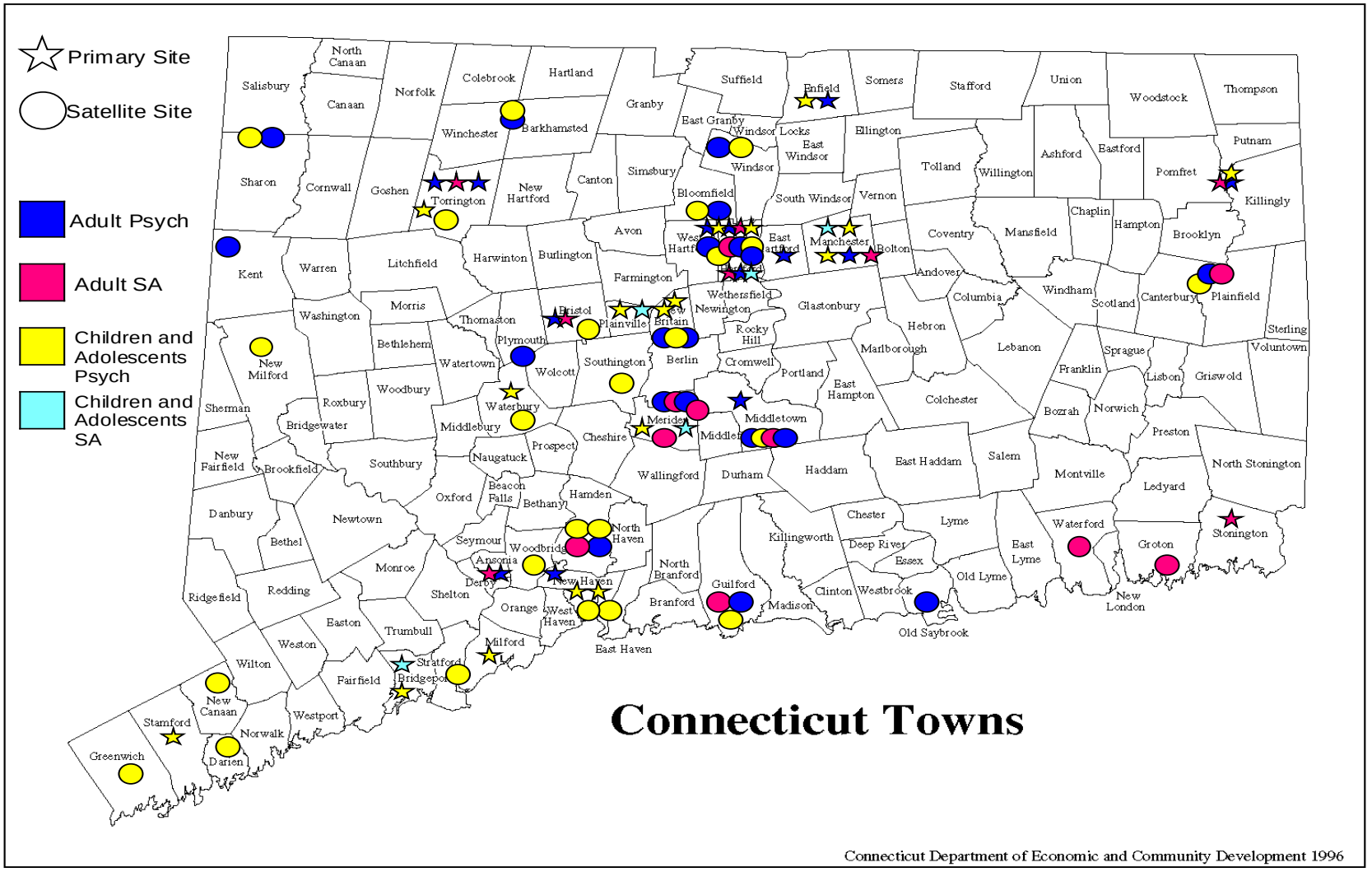
Conclusion

- Departments remain committed to setting rates sufficient to cover the reasonable costs of economic and efficient providers and to support expansion to address unmet need
- The Departments recognize special challenges of first year and appreciate the good faith efforts that providers have made to work with the state to resolve these challenges
- Future plans include outcome evaluations developed by the Departments with Yale and the IICAPS providers

Enhanced Care Clinics (ECC)

- RFA process has been concluded
- 31 ECCs designated
- All will be required to meet access requirements as of 9/1/07
- Target date for primary care/behavioral health requirements – 1/1/08

ECC Geo-Access Chart



ECC Child Psychiatric Clinics

Catholic Charities/Institute for the Hispanic Family
Charlotte Hungerford Hospital-Center for Youth and Families
Child Guidance Clinic for Central Connecticut
Child Guidance Clinic of Greater Waterbury
Child Guidance Clinic of Southern CT
Child Guidance of Greater Bridgeport
Clifford Beers Clinic
Community Child Guidance Clinic
Community Health Resources - Genesis Site
Community Health Resources - Windsor/Enfield
Community Mental Health Affiliates
Klingberg Family Centers
Northwest Center for Family Service and Mental Health
United Services
Village for Families and Children
Wheeler Clinic
Yale Child Study Center
Bridges….A Community Support System

ECC Adult Mental Health Clinics

ALSO Cornerstone
Bristol Hospital
Catholic Charities/Institute for the Hispanic Family
Charlotte Hungerford Hospital
Community Health Resources - Genesis Site
Community Health Resources - Windsor/Enfield
Family Services of Central Connecticut
Harbor Health Services
Intercommunity Mental Health Group
Middlesex Hospital
Northwest Center for Family Service and Mental Health
Rushford Center/Adult
The McCall Foundation
United Services
Valley Mental Health/Birmingham Group
Village for Families and Children

ECC Substance Abuse Clinics

Bristol Hospital
Catholic Charities/Institute for the Hispanic Family
Child Guidance Clinic for Central Connecticut
Child Guidance of Greater Bridgeport
Community Child Guidance Clinic
Community Health Resources - Genesis Site
Community Mental Health Affiliates
Family Services of Central Connecticut
Harbor Health Services
Rushford Center/Adult
Rushford Center/Child
Stonington Behavioral Health
The McCall Foundation
United Services
Valley Mental Health/Birmingham Group

SFY07- Strategic Rate Investment Update

Package #4

Strategic Investment Fund	$	3,831,075
ECC Clinic	$	1,897,821
ECC Hospital	$	179,996
Across the board (1%)	$	1,011,388
IOP/PHP Clinic ($120/$140 floor)	$	170,260
IOP/PHP Hospital ($120/$200 floor)	$	120,867
Case Management ($15.00/unit)	$	85,757
Independent Practitioner	$	78,694
Extended Day Treatment (EDT)	$	285,871
Balance Available	$	421

Package Notes

Note 1: All figures are annualized

Note 2: Across the board increase is 1%

Note 3: IOP/PHP Clinic assumes $120 floor for IOP and $140 floor for PHP; increases minimum IOP duration to 3 hours

Note 4: IOP/PHP Hospital assumes $120 floor for IOP and $200 floor for PHP; increases minimum IOP duration to 3 hours

Note 5: Case management increase from $9.08/unit to $15.00/unit

Package Notes

Note 6: Independent practitioner increase includes:

- **increase in codes related to psychiatric prescribing and psychiatric consultation**
- **increase in APRN/PHD fees from 80% of MD to 90% of MD (consistent with Medicaid FFS)**
- **increase in Licensed Masters Level Clinician fees from 70% of MD to 75% of MD (consistent with Medicaid FFS)**

Note 7: The ECC clinic and hospital expenditures have been revised to include the 31 providers that have been designated (provisional or final)

Note 8: Final rates and percentages will be adjusted to avoid over or under expenditures with respect to the $3.67 million allocation

Package Notes

Note 9: Extended Day Treatment (EDT) increase for hospitals and clinics will raise floor from $51.88 to $62.50

Note 10: Total strategic investment fund has been adjusted to reflect 3.88% of base including both HUSKY A and HUSKY B

CT BHP Claims Update

Acronyms

- See handout

Questions?