CONNECTICUT

Behavioral Health Partnership

The Conversion of Intensive In-Home Child and Adolescent Psychiatric Services from Grants to Fee-for-Service

Report to the CT BHP Oversight Counsel

Connecticut Department of Social Services

--Caring for Connecticut--

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Introduction

Intensive In-Home Child and Adolescent Psychiatric Services (IICAPS) is a manualized treatment model designed to prevent children and adolescents from requiring hospital or residential care and to support discharge from hospital or residential care. The model was developed by the Yale Child Study Center, which provides credentialing and quality oversight for the IICAPS network under a contract with the Department of Children and Families.

IICAPS is an intensive, home-based service designed to address specific psychiatric disorders in the identified child, while promoting effective parenting practices and/or addressing other family challenges that effect the child and family's ability to function. Although children with psychiatric symptoms are the focus of IICAPS, the model also focuses on family, school, community resources and service systems. Providers seek to improve educational programming and to ameliorate environmental factors that may contribute to a child's psychosocial adversity. A two-person team provides the service. The team consists of a clinician and a bachelors level or experience equivalent mental health counselor.

Prior to the implementation of the Connecticut Behavioral Health Partnership (CT BHP), IICAPS was funded in part through DCF grant funds and in part through fee-for-service contracts with the HUSKY MCOs. DCF grants totaled approximately $4.417 million in SFY05 and HUSKY MCO payments totaled approximately $1 million.

Under the Connecticut Behavioral Health Partnership, the Departments converted this grant-subsidized service to one that is primarily fee-for-service. The rationale for the conversion was to improve providers' ability to add teams to accommodate unmet need. The Departments believe that timely access to this service is necessary to effectively prevent out-of-home placement and institutional care and to support children who have been discharged from institutional care.

The Departments would like to acknowledge the work of the Connecticut Behavioral Health Oversight Council's DCF Advisory Subcommittee on this conversion and the willingness of subcommittee members to invest time and energy on this challenging process.

Program Costs

There were between 30.5 and 32 teams active prior to the conversion. The average cost per team was estimated to be between $169,300 and $177,600. The Departments of Children and Families and Social Services ("Departments") established a per team cost of approximately $200,000 based on the estimated reasonable cost to operate a single team in SFY 2005 (see Table 1). This amount exceeded current per team cost by between $22,600 and $30,700 and was thought to be sufficient to bring teams up to fidelity with the model's requirements. The IICAPS programs include a psychiatrist and program director. The psychiatrist and the program coordinator provide overall clinical direction,

but do not provide the billable services that are the focus of this report. The clinician and counselor team provides all IICAPS billable services.

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%)	$	29,400
Total Salary and Fringe	$	127,400
Medical Director/Psychiatrist (b)	$	27,300
Other Expenses	$	45,114
Total	$	72,414
Grand Total	$	199,814

Notes:
(a) Current starting salary for MA clinicians in DCF funded PNP's
(b) Three and one-half hours of oversight per week at $150 per hour

Key Assumptions of the Rate Methodology

The IICAPS model calls for 5 hours of service per week for most clients, although some clients require more. The services can be a combination of therapeutic rehabilitation services and case management. Authorizations are predominantly for 5 hours per week, but some are for 8 hours. On average, the model assumes that a clinical team will provide 5.5 hours per client (e.g., seven 5 hour clients and one 8 hour client). The model also assumes that a team will carry eight or nine clients on its caseload at any point in time.

If one assumes eight clients for an average of 5.5 billable hours per week, a team would be expected to provide 44 hours of billable services per week. Each team member bills for services rendered, so each team member would need to bill for 22 hours in order for a team to achieve 44 billable hours in a week.

The 44 hours assumes that team members are both working on a given week and that they have eight active cases available to serve. The Departments have applied an adjustment factor of 83% to take into consideration times during the year when one or more team members would not be able to bill, allowing for sick, vacation and holiday time, as well

as any other lost productivity such as the time between when one client completes treatment and another starts treatment. This productivity factor was adjusted from 90% to 83% based on feedback from the DCF Subcommittee that the initial proposed rate of $24.20 was inadequate. The adjusted weekly productivity is 36.52 hours per team per week (83% times 44 hours). The 36.52 hours per week equates to an overall billing productivity (based on a 37.5-hour work week) of 48.7%.

The rate calculation based on the above assumptions is as follows:

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% inc.)	$27.39
SFY07 Rate (1% inc. estimated)	$27.66

Many of the IICAPS providers continue to question the reasonableness of the productivity assumptions described above and the adequacy of the rate that results from these assumptions. These issues lie at the center of the current debate regarding the reasonableness of the IICAPS rate methodology.

Residual Grant Funding

DCF retained residual grant funding in the amount of $599,442 or 10% of the projected annualized spending at the newly established pre-COLA rate of $26.41. Based on a review of December 2005 and January 2006 data, it was determined that 22 clients were being served that would have been ineligible for the Partnership. The grant funding was reserved for a total of 25 slots (the 22 above plus three to ensure a minimum of one slot for each provider). Grant funding for these 25 slots was set at approximately $24,000 per slot.

An additional $299,721 or 5% was reserved to assist those providers that had disproportionate travel times. To establish the travel portion of the grants, the $299,721 was prorated by team according to the average time between the program address and each client's address. Travel grants ranged from $0 to $140,732.

Transition to Fee-for-Service

The new rate and conversion to fee for service (FFS) went into effect on January 1, 2006. For the first 6 months, 100% grant funding was provided to ease the transition to a system under which the IICAPS programs would be almost entirely reliant on fee-for-service claims. Bridge funding arrangements of this type are typically used by states that convert from a prospective grant based system to retrospective fee-for-service. During this initial period, providers were permitted to bill the CT BHP for services rendered to CT BHP eligible clients and to retain any revenue generated in excess of their grants. The CT BHP paid IICAPS providers approximately $1.05 million for the first 6 months (total expenditures by date of payment). These payments were not included in the DCF cost reconciliation of the IICAPS grants.

In December 2005, the IICAPS programs were provided with updated draft billing guidelines to support proper coding and documentation of the rehabilitation and case management components of the service. The programs generated many questions for the Departments during the first 4 months. Accordingly, in June 2006 the Departments provided updated billing guidelines and a written response to frequently asked questions. In September 2006, IICAPS and other home-based service programs were subject to monthly prior authorization by the CT BHP ASO. Around this time, the Departments introduced the requirement for timely filing (120 days).

Before the prior authorization was introduced, few problems were reported with regard to claims processing. One significant problem was identified related to 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. The Departments began a modification of the MMIS in order to avoid rejection of these claims. This modification is expected to go into production with the first claims cycle in April 2007. In the interim, the Departments advised providers that they could accommodate this issue by combining the work of the clinician and mental health counselor on a single claim form.

With the 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). The ASO implemented system modifications to address this problem by November 2006 and authorizations for September and October were adjusted when requested by the provider.

Providers have reported other challenges related to authorization. Among these, they note that authorization requirements have eroded the time available to clinical team members to provide clinical services. In addition, some providers indicate that scheduling the reviews has been difficult, that it further compromises their time and may delay timely authorization. There have been some reports that the ASO has at times been unwilling to back date authorizations to accommodate scheduling related delays in conducting the reviews. The Departments have worked with the ASO to address these issues. Providers report that the situation is improved, if not entirely resolved.

Troubleshooting Revenue Shortfalls

By November of 2006, most providers reported that billing revenues were insufficient to support the cost of their programs. In addition to addressing the authorization and claims issues noted above, the Departments have conducted analyses to determine whether there are other factors that influence payment.

The first issue that the Departments examined was whether providers were receiving payment per unit at the established fee for the rehabilitative and case management service components. In order to receive full payment, the providers must bill a usual and customary charge for the rehab (H2019) and case management (T1017) service codes in excess of the fee schedule amount ($27.39). They must also bill the HK modifier in conjunction with the established service codes. Our analysis revealed that providers have been billing the HK modifier appropriately, but that two providers failed to bill a usual and customary charge at or above the established fee. Consequently, they were being paid $20 and $26.41 per unit, respectively. The Departments provided each of these providers with feedback so that they could make appropriate adjustments.

The second issue that the Departments examined was whether providers were billing for all CT BHP eligible clients. The Departments analyzed eligibility during the period 7/1/06 through 12/31/06 for each service recipient reported by providers to Yale. The analysis was based on recipients served each month or "recipient service months" in order to be able to examine the impact of recipients whose eligibility may have changed while receiving IICAPS services. The rate methodology described earlier assumes that 90% of the 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.

The results of this analysis are summarized in Table 3. The first two columns show the percentage of clients that were un-entitled or enrolled in Medicaid fee-for-service and thus ineligible for reimbursement under the CT BHP. The third column shows the percentage of children served who were DCF involved and thus eligible for the CT BHP under the Limited Benefit Program (LBP), but for whom the IICAPS provider did not facilitate enrollment.[1] The fourth column shows the percentage of clients that were eligible for the CT BHP (HUSKY A, HUSKY B, or LBP), but for whom the provider received no payment. This could be due to a billing problem, lack of authorization, or the need to bill a commercial carrier before billing the CT BHP. Finally, the last column shows the percentage of clients that were CT BHP eligible and for whom the provider received reimbursement.

[1]The Limited Benefit Program is a CT BHP coverage option available to children who are active clients of DCF and who are not otherwise eligible for HUSKY A or B. A child must be receiving DCF child protection services or be participating in the DCF Voluntary Services Program. In order to enroll a child in the Limited Benefit Program, the parent or guardian must complete a simple one-page application. The IICAPS provider must then submit this application to DCF.

Table 3. 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%

The chart shows several important things. Firstly, by adding the 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%). Furthermore, one can 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.

Finally, the Departments examined the percentage of CT BHP clients that have commercial coverage and for whom CT BHP coverage is secondary. For these clients, providers are required to bill the third party insurer before billing CT BHP. They must include evidence that the claim was denied by the commercial insurer (explanation of benefits document or EOB) in order for the claim to be paid by the CT BHP. If no EOB is forthcoming, after 6 months the provider may bill the CT BHP. Because of these billing requirements, many of the clients for whom providers have unpaid claims may pay sometime in the future. Table 4 provides a summary of this analysis.

The data in Table 4 show that about 11% of total recipient service months are for clients who have commercial insurance. These data suggest that sites B and L (among others) may be encountering significant delays in payment due to the third party billing requirements and that this delay may be contributing to the significant percentage of CT BHP recipient service months that remain unpaid. Although in the early stages of the

conversion, third party liability may present significant cash flow problems for some providers, cash flow should improve over time.

For some period of time in the latter part of calendar year 2006, claims submitted after billing a commercial insurer were inappropriately denied due to timely filing. DSS has since taken steps to ensure that the claims vendor bases the timely filing requirement on the date of the EOB from the commercial insurer rather than the date of service.

Table 4. Percentage of CT BHP Recipient Service Months From July 1, 2006 Through December 31, 2006 With Commercial Coverage

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

At the request of the DCF Advisory Subcommittee, the Yale Child Study Center undertook analyses to test the reasonableness of the assumption that providers will on average serve 8 clients per week with an average productivity of 4.565 hours per week (adjusted, 5.5 hours times 83%). Yale collected data from each provider on total clients served and billable activity per client. This data was reported weekly and summarized by Yale to provide average billable hours per week per client. According to Yale, the hours reported as billable were also submitted as claims to the CT BHP for reimbursement. The results are reported in Table 5.

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.

The Yale data suggest that, on average, IICAPS programs are providing 4.1 billable hours of service per client per week. This average is below the 4.565 hours assumed under the IICAPS rate methodology. Of the 14 network providers studied, only four averaged more than 4.565. The Departments are in discussion with Yale, which is reviewing its client level productivity expectations in light of these findings. The Departments recommend that any decision to revisit the productivity assumptions be deferred until team level productivity data can be compiled (see recommendation #1 at the end of this report).

There is considerable variability in the averages reported by providers. There could be a range of reasons for this. Specifically, providers may differ in terms of the efficiency of the clinical staff and of the overall service operation and they may differ with regard to what activities they believe are billable according to the guidelines established by the Departments.

Providers initially voiced concerns about the validity of this data. Yale has reviewed these concerns and the data have since been revised to address inaccuracies in the calculation of these averages.

Assessing Billing Efficiency

The Departments have conducted a related analysis to determine the hours of service paid per program per client per week. This analysis was conducted during the time period January 1st – November 10th, 2006 and then again from September 3rd through November 10th, 2006. Available data suggest that hours paid per client were not markedly different for the first 10 months of the year, compared to more recent months (September 3 – November 10).

The Departments also compared the hours of service paid per client per week based on CT BHP claims data to billable hours per client per week as reported by providers to Yale. These data are summarized in Table 6. The data indicate that only 3 of the 12 providers are receiving payment for less than 90% of the billable activity reported by providers. Several factors may influence these billing percentages. For example, the payment data include dates of service immediately after the implementation of new prior authorization and timely filing requirements. It typically takes providers some time to adjust to new requirements for payment. In addition, some claims may be outstanding because providers are required to bill commercial insurance before billing the CT BHP and the above noted problem with limits on authorizations in excess of 5 hours may also influence these percentages. Finally, underpayment may also result from inefficiencies in provider billing.

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.

Conclusion and Recommendations

The Departments believe that the conversion of the IICAPS grants to fee-for-service has required and continues to require the collective efforts of the providers, Yale, and the Behavioral Health Partnership Oversight Council's DCF Advisory Subcommittee. The Departments have not yet achieved their stated aim, which is to enable efficient providers to grow the IICAPS services to meet demand. To date, only one provider appears to be confident of the financial viability of the model as priced and, accordingly, this provider has added and continues to add IICAPS teams. In many areas of the state, there continue to be waiting lists.

The Departments believe that additional steps need to be taken to evaluate and support the IICAPS service as follows:

1. **Validate Productivity Assumptions**

Available productivity data have allowed the Departments to examine average billable hours per team per week. However, it is equally important that we validate the assumptions that a team can serve eight or nine billable clients per week and provide a total of 36.52 billable hours per week. The Departments recommend that the Yale Child Study Center revise its analysis of available data and collect information prospectively that will allow the Departments to assess the reasonableness of these key assumptions. Data will include the number of active teams per week per provider. This number would not be adjusted for vacations, holidays, and sick days. Yale should also capture the total active caseload per week per provider. This will allow Yale to calculate average caseload per team (which should be around eight) and total billable hours per team per week (which should be at or above 36.52). The Departments recognize that an acceptable caseload may be less than eight clients per week without compromising the 36.52 hours minimum if several of the clients require more than the usual 5 hours of service per week.

2. **Expansion of Teams**

The Departments believe that providers with one or two teams will not be viable over the long term. Providers with multiple teams are better able to support the program's fixed costs and arrange for cross-coverage. In addition, providers with multiple teams are less vulnerable to staff turnover because there is a larger revenue base available to cover fixed costs.

3. **Investment in IICAPS Staff**

The Departments have established rates based on a reasonable program cost that is somewhat above the cost of the service when it was grant funded. Moreover, these rates were increased by 3.67% in SFY06 and will be further increased by 1% in SFY07. Accordingly, the Departments recommend that providers review options for investing in staff (e.g., higher salaries), encouraging team

productivity, and promoting long-term staff commitment to the provision of this service.

4. Third Party Liability

The Departments will eliminate the requirement that providers bill private insurance before billing for IICAPS services under the CT BHP. If, in the future, commercial payers improve their coverage of IICAPS and other home-based services, the Departments will reintroduce this requirement.

5. Technical Assistance

The Departments recommend technical assistance for providers on various aspects of service documentation, coding and billing. The assistance should focus on ensuring that providers 1) distinguish activities that are billable, from those that are not billable, 2) distinguish rehabilitative services from case management services, and 3) identify and enroll all eligible clients. Such assistance may also help providers understand the 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.

6. Extension of Conversion Related Bridge Funding

The Departments are proposing to extend bridge funding beyond the initial 6 months that was already provided from January 1 to June 30, 2006. The purpose of the bridge funding extension would be 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 only be available to programs that have been unable to cover program costs through fee-for-service revenue. The initial allocation will be based on Interim Financial Reports to DCF due March 30th and any surplus payments will be subject to reconciliation.

7. Rate Adjustment

The Departments will review productivity information as complete and valid information becomes available. If the productivity data suggest that the assumptions are unreasonable, the Departments will consider modifying one or more of the key assumptions in the rate model to establish a temporary rate. If the Departments 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.

8. Differential Rates

In light of the waiting lists for service in many parts of the state, the 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.

The IICAPS program is one of two intensive home-based services specifically designed to serve children in Connecticut with serious psychiatric disorders. It is an important element in the system of care and should be one of the options available to families in need. The Departments remain committed to setting rates that are sufficient to cover the reasonable costs of economic and efficient programs and to support expansion to address unmet need.

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. As we bring the rate issues to resolution, it is necessary to turn our attention to reviewing the outcomes of children and families served under this program. Yale is in the process of gathering data that will help us to better understand for which children and families this service is most effective and how the service can be further improved. We look forward to continuing our examination of this program in partnership