Connecticut BHP
Supporting Health and Recovery

BHP Oversight Council
State Agency Report

October 12, 2011

Rate Meld Project

- The current HUSKY A program operates under a waiver which allows the Departments to pay different rates and fees for different coverage groups (HUSKY A vs. Fee For Service)
- The HUSKY A waiver ends on December 31, 2011
- On January 1, 2012 the state must have uniform rates and fees for the various coverage groups under the state plan

Rate Meld Project

- In order to have uniform rates and fees among all coverage groups, the Departments are required to develop and submit a rate methodology that is budget neutral to CMS for approval
- The new “melded” rates and fees must go into effect on January 1, 2012

Rate Meld Project

- The Departments used a variety of methodologies to maintain budget neutrality while minimizing the financial impact to providers
- Weighted Average Meld

$$\frac{\text{Total Expenditures (FFS, MLIA, HUSKY)}}{\text{Total Units}} = \text{Meld Rate}$$

- Use a percent of Medicare

Clinics

- Freestanding Mental Health Clinics:
  - Fixed fee meld by type of service:
    - Routine Outpatient (ECC)
    - Routine Outpatient (non-ECC)
    - Partial Hospitalization
    - Adult Day Treatment
    - Intensive Outpatient Program
- Other Free Standing Clinics
  - Fixed fee meld by type of service:
    - Medical Clinics (e.g. school based health centers)
    - Rehabilitation Clinics

Child Rehab Services and Child Targeted Case Management

- Fixed fee meld by type of service:
  - Home and community-based rehab (non-IICAPS)
  - Home and community-based rehab (IICAPS)
  - Targeted Case Management
  - Extended Day Treatment
  - EMPS (not currently covered under Medicaid FFS so no meld is required)

Chemical Maintenance Clinics

- Provider specific meld
- A number of providers have different rates across several service locations. The Departments are considering a provider specific cost neutral rate meld that would create one rate across all sites for the provider

Alcohol and Drug Centers

- Provider specific rate meld
  - Alcohol & Drug residential detox
- Fixed fee meld
  - Ambulatory detox
- Alcohol & Drug Rehab services (Note: Only covered for HUSKY A and B so no meld is required. Current coverage restrictions will remain in effect)

Home Health Services

- No meld required
- Proposed rates are the current FFS rates
- 98.5% of home health services are paid using the FFS rates

Independent Practitioner

- Fixed fee meld for psychiatrists. Other private practitioners are paid a % of the MD rate
  - MD
  - APRN
  - Psychologist
    - Coverage for adults will remain limited to family coverage populations (HUSKY A, B and Charter Oak)
  - Licensed Masters Level Clinician
    - Coverage for adults will remain limited to family coverage populations (HUSKY A, B and Charter Oak)

Psychiatric Residential Treatment Facilities

- Provider specific rate with adjustment for 24/7 nursing
- Interim rate will be replaced with final rate based on annual cost report filings
- No changes proposed for January 1, 2012

General Hospital

- Provider specific meld for inpatient services
  - Adult psychiatric inpatient
    - Medicaid FFS adult psychiatric volume and HUSKY adult psychiatric volume will be included in the development of a new inpatient hospital melded case rate for the Medicaid FFS and HUSKY medical program
    - The new case rate will apply to all medical inpatient admissions for individuals of any age and all psychiatric inpatient admissions for individuals age 19 and over
  - Propose to maintain the DMHAS certified acute intermediate duration unit

General Hospital *Cont.*

- Child psychiatric inpatient
  - Meld of HUSKY child volume and FFS child volume - FFS expenditure based on final cost settled case rate expenditures
  - Full per diem for all acute medically necessary days
  - Coverage for medically necessary discharge delays at 85% of per diem
  - Add the 15% reduction to the per diem rate

General Hospital Cont.

- Child psychiatric inpatient emergency stabilization (CARES)
  - Meld FFS volume and HUSKY volume
  - Coverage limited to 3 days, with exceptions
- Observation beds
  - Default to existing Fee For Service payment methodology based on cost to charges
  - 1 unit = 1 hour (23 hour maximum)

General Hospital Outpatient

- Fixed fee meld
  - Partial Hospital Program
  - Intensive Outpatient Program
- Routine Outpatient (non-ECC, child & adult)
  - Outpatient meld converts 513 to 900 series codes based on hospital reported allocation to 900 series subtypes
  - Price all outpatient 900 series codes to X% of Medicare 2011 MD Facility Based fees, except group therapy which will price at 100%

General Hospital Outpatient *Cont.*

- Routine Outpatient (ECC)
  - No meld, same as current BHP hospital ECC rate
  - Hospital ECC program will be restricted to the current four hospital outpatient ECC programs and the their current approved age span
  - ECCs that wish to retain their status will have to meet the requirements for all Medicaid coverage groups
  - Current recognized ECCs will have the option to relinquish their status and default to the non-ECC hospital rate
  - Projected costs associated with extended ECC payment to adult Medicaid FFS population will be offset by a reduction in the supplemental and performance pool of funding

Psychiatric Hospital Inpatient

- Provider specific meld
  - Adult psychiatric inpatient
    - Meld of FFS adult and HUSKY adult
    - Full per diem through 29th day, 85% thereafter
    - Coverage for medically necessary acute care
  - Child psychiatric inpatient
    - Meld of FFS child and HUSKY child
    - Full per diem for all acute medically necessary days. Coverage for medically necessary discharge delays at 85% of full per diem

Psychiatric Hospital Outpatient

- Provider specific meld
  - Partial Hospital Program
  - Intensive Outpatient Program
  - Routine outpatient (child and adult combined)

Federally Qualified Health Center

- No change required

Supplemental Payments

Starting January 1, 2012 Provider Performance Initiatives must be approved by CMS. The Department proposes to use calendar year 2011 performance initiative funds to provide one time supplemental payments to providers who were previously eligible to receive an incentive payment based on a percentage proportionate to expenditures for services rendered in 2011. This methodology must be approved by CMS.

Provider Performance Initiatives

The Department plans to submit a proposal to CMS for the implementation of incentives for calendar year 2012.

Next Steps

- The Departments will share rate and fee calculations with providers:
  - Clinics
  - Child Rehab Services
  - Chemical Maintenance Clinics
  - Alcohol and Drug Centers
  - Independent Practitioners
  - General Hospitals
  - Psychiatric Hospital

Next Steps *Cont.*

- The Department plans to submit the rate methodology to CMS by November 15, 2011.

Wellness Care Coordination Program

A coordination of physical & behavioral health care

Update

A joint venture between ValueOptions and McKesson

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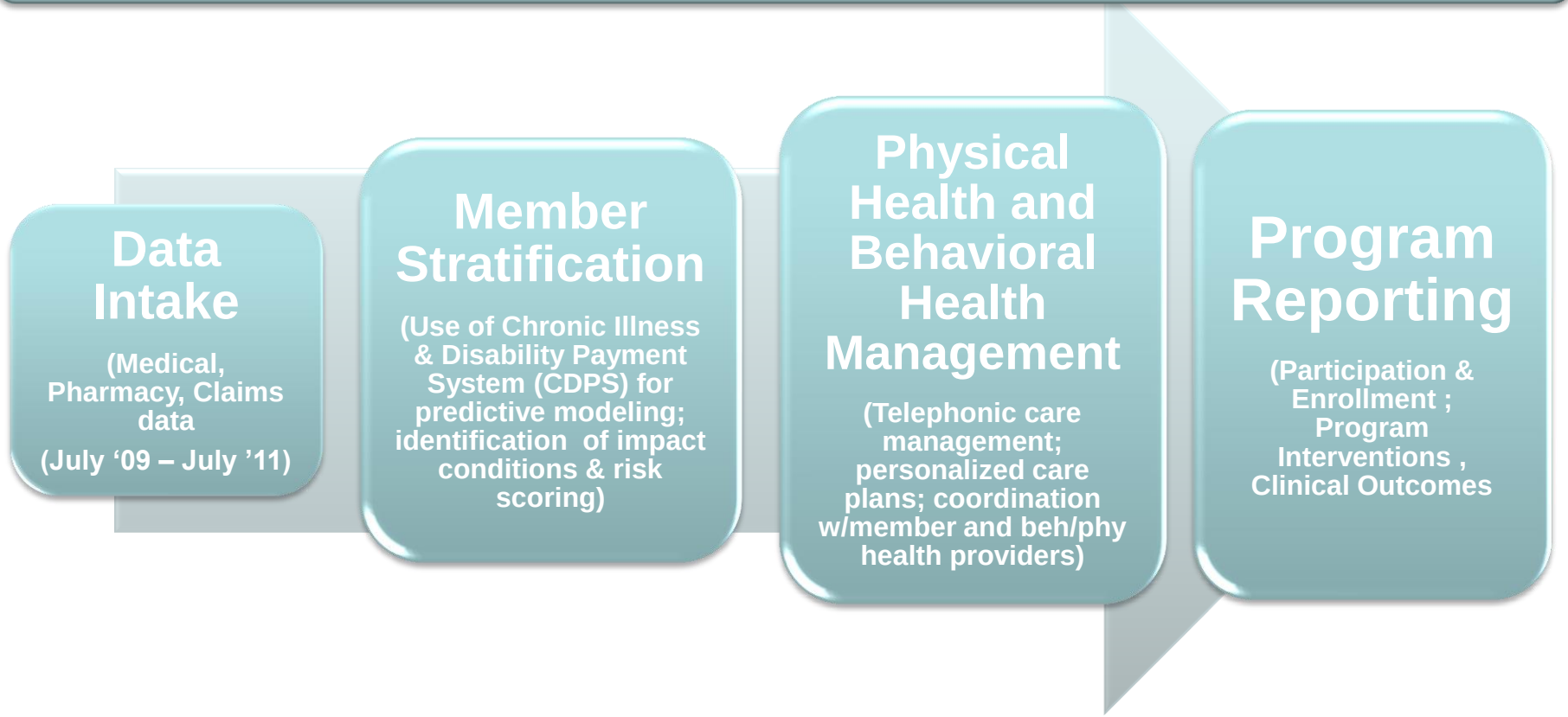
Wellness & Care Coordination Program (WCCP)

- The result of DSS, DCF, and DMHAS's vision to develop an integrated pilot program serving high risk co-morbid members
  - to improve overall health
  - increase preventative care
  - decrease hospitalizations and ED visits
- Included in ValueOptions contract with the State of Connecticut
  - Identify 300 members at high-risk for hospitalization and Intensive Care Management; in need of disease management; with significant gaps in care
  - Identify members using predictive modeling; source is integration of medical, pharmacy and behavioral health claims data

An Integrated Care Model

Meeting behavioral and physical health needs

Targeting child and adults members with high behavioral and physical risk



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Wellness & Care Coordination Program (WCCP)

- Program launched Sept 1, 2011
- Two (2) FTE nurses with medical and behavioral health expertise *(employed by McKesson; dotted line to VO)*
- Nurses on-site; integrated within CT BHP
- Additional support, coordination, and referrals with ICM and Peer services, as needed
- Dedicated link to WCCP from www.ctbhp.com website (information/brochures and resources; English & Spanish)

WCCP Program Details

Health Management

- Telephonic co-management of 300 high risk members identified primarily through claims (medical, pharmacy and behavioral health) data *(approximately 3 months' ramp up to achieve 300 members)*
- Shared referrals between ValueOptions ICMs, CCMs, Peers, and WCCP Nurses
- Shared case coordination/collaboration between ICMs, CCMs, Peers, RNMs and WCCP Nurses, as applicable
- Evidence-based clinical content
- Personalized wellness health care plan for each member
- Identifies/ensures medical home for each member
- Follow-up contacts with member to complete care plan goals
- Member and provider communications after assessment
- Clinical alerts to provider(s) as clinically appropriate

WCCP Program Details *Cont.*

From 9/1 to 9/6/11

- 108 enrollments attempted (contacts or outreach attempted)
  - 8 incomplete enrollments (spoke with the member but did not get the enrollment completed due to lack of interest, time etc.)
  - 11 completed enrollments
  - 3 completed full assessments (program intake assessment completed)
- 89 unable to contact (did not speak with member)

WCCP Program Details *Cont.*

- Sample summary of an outreach call to member by the preceptor for the WCCP RN monitoring a call:

  "The member was reluctant at first…the RN continued to support the member & use engagement techniques…member soon became very talkative…began disclosing a lot of health issues…thanked the RN and called the RN by her name which is an indication that the member was fully engaged…"

WCCP Summary

- Immediate Goal
  - Ramp up to 100% with 300 identified members to participate in program
- Intermediate Goal
  - Assess efficacy of program via measuring clinical outcomes
- Long Term Goal
  - Expand program beyond 300 members
  - Impact high risk members by increasing overall health and decreasing hospitalizations and ED visits

Questions?

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