Connecticut BHP
Supporting Health and Recovery

# BHP Oversight Council
# State Agency Report

# December 14, 2011

# Definitions

- Fee or Fixed fee:  a uniform price that is paid to a all providers for a specific service regardless of coverage group
- Provider Specific Rate:  a price that is paid to a provider for a specific service that is negotiated between the provider and payer
- Coverage Group:  HUSKY A, HUSKY B, HUSKY C (ABD), HUSKY D (MLIA)
- CMS: Centers for Medicare and Medicaid Services
- FFS: fee-for-service coverage group: Title XIX, Aged, Blind, Disabled, Low Income Adults

# Background

- Currently the HUSKY A Program operates under a waiver which allows DSS to pay providers different rates for the same service, but for different coverage groups
- The waiver under which the HUSKY A Program operates expires on December 31, 2011
- Starting January 1, 2012, DSS cannot pay providers different rates based on eligibility coverage groups
- The rate meld process must be budget neutral

# Example

- Procedure code 90801: Psychiatric Diagnostic Evaluation:
  - HUSKY A fee: $107.00
  - Fee-for-service fee: $100.00
- If the State did nothing, all providers would be paid at the current fee-for-service fee for services provided to all coverage groups with dates of service January 1, 2012 and forward

# Deadlines

- Federal law requires DSS to publish its intention to amend the state plan prior to the effective date of the change
- In order to publish in the Ct. Law Journal on December 27, 2011, DSS is required to submit our intentions to the CLJ by December 15, 2011
- State plan language will be available to the public by December 27, 2011
- DSS must submit the state plan amendment to CMS within the quarter that the changes take effect (March 31, 2012)

# Implementation

- The new rates and fees will not be implemented on January 1, 2012, but will be effective for dates of service January 1, 2012 and forward
- A retroactive rate adjustment will be required after the rates are loaded in the DSS payment system
- The rate adjustment must occur within the first quarter of calendar year 2012 in order for the state to submit a claim to CMS and receive a federal match on the expenditures for services provided in the first quarter of calendar year 2012

# General Hospital Psychiatric Inpatient

- Adult: comprehensive case rate/discharge rate that includes medical and adult psychiatric services
- Child: Provider specific rate meld between FFS and HUSKY utilization. Full per diem for acute medically necessary days, 85% of per diem for discharge delays
- CARES Program: default to HUSKY rates
- Observation beds: default to FFS methodology based on cost to charges; 1 unit = 1 hour

# General Hospital Outpatient

- Fixed fee meld for Intermediate Levels of care: PHP & IOP
- Enhanced Care Clinic (ECC): default to HUSKY rates. Three hospitals elected to expand their access to FFS population- this expansion is projected to increase expenditures by $185,000
- The Departments recommend using some of the performance pool to cover the increase in expenditures

# General Hospital Outpatient Cont.

- Non-ECC hospitals: Departments converted 513 revenue center codes to 900 series codes based on data provided by hospitals.
- All 900 series codes were priced at 75% of Medicare, except group therapy which was priced at 100% of Medicare

# Psychiatric Hospital

- Provider Specific Rates
- Adult Inpatient:  meld between FFS and HUSKY utilization.  Full per diem through 29th day, 85% thereafter
- Child Inpatient: meld between FFS and HUSKY utilization.  Full per diem for acute medically necessary days; 85% for discharge delay days
- Outpatient: meld of FFS and HUSKY utilization

# Mental Health Clinics

- Meld of FFS and HUSKY child utilization
- Meld of FFS and HUSKY adult utilization
- Fixed fees for all service codes with adult fees paid at 95% of child fees
- Fixed fees for PHP and IOP

# Other Provider Types/Services

- Child Rehabilitative Services: fixed fee
- Alcohol and Drug Centers: Provider Specific Rates, except amb. detox
- Chemical Maintenance Clinics: Provider Specific Rates

# Other Provider Types Continued

- Home Health: default to FFS fees
- Medical Clinics (School Based Health Centers): fixed fee
- Rehabilitative Clinics: fixed fee
- FQHC: no change required

# Independent Practitioners

- Meld of FFS and HUSKY utilization and expenditures
- Based on utilization, the Departments determined there was no rationale to have a child and adult fee differential
- Fixed fees without a child/adult fee differential

# Supplemental Payment

- Departments plan to use calendar year 2011 performance incentive funds to provide one time supplemental payments to providers who were previously eligible to receive an incentive payment.
- Payments will be made during the period of April – June 2012.
- Subject to CMS approval

# Provider Performance Initiatives

•The Department plans to submit a proposal to CMS for the implementation of provider incentives for calendar year 2012. CMS needs to approve all performance initiatives going forward.

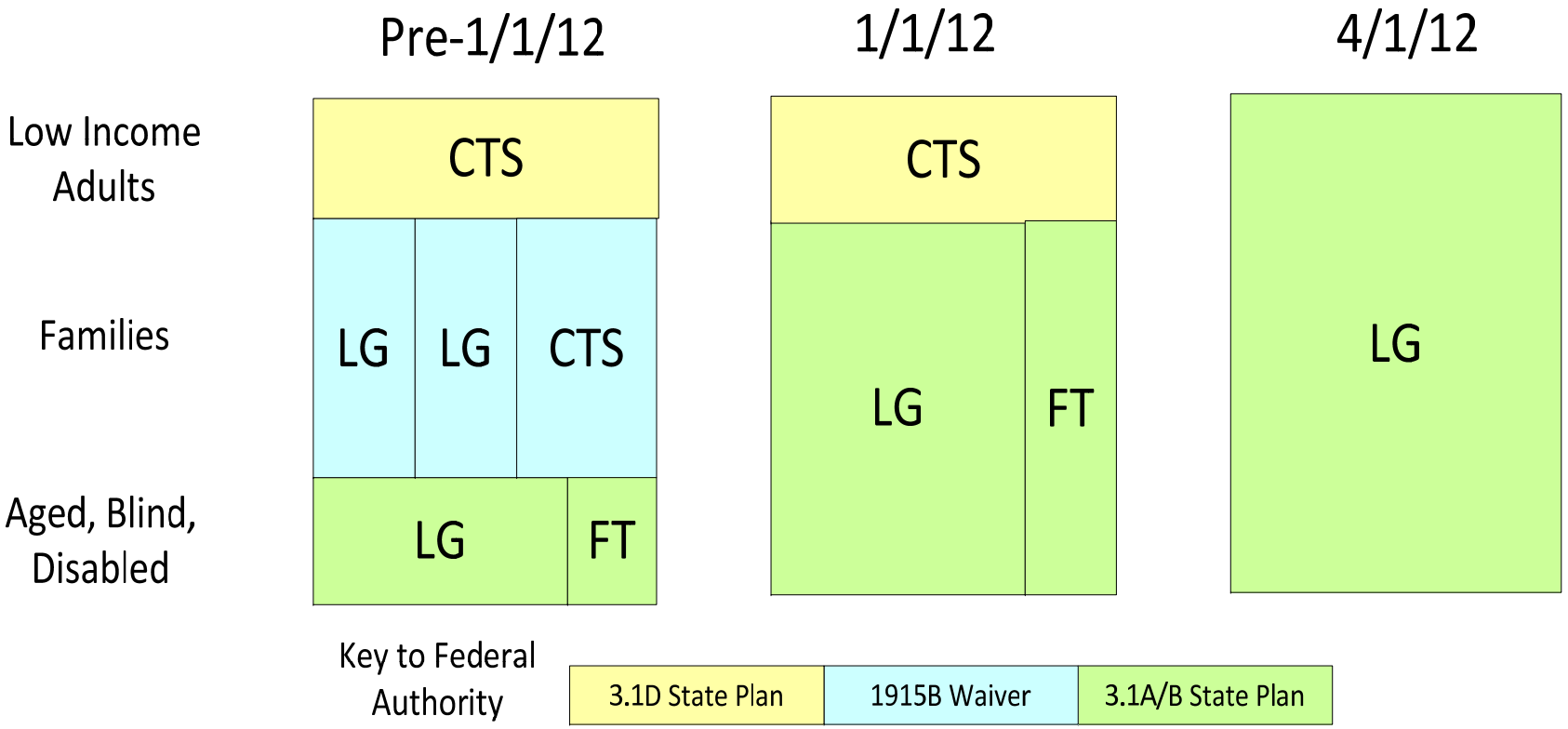
• Subject to CMS approval

Connecticut BHP
Supporting Health and Recovery

# ASO Implementation Update

- ASO Implementation is on track for January 1, 2012
- For dates of services on or after January 1, 2012, claims should be submitted to HP
- Providers who currently receive payment from HP do not need to enroll
- Providers who have been paid exclusively by the managed care companies need to enroll in the Departments Medical Assistance Program
- www.ctdssmap.com
- www.huskyhealth.com

# Non-Emergency Medical Transportation Update



# Questions?

# DCF Certification Process for Children's Rehabilitation Services

December 2011

# Background

- CT BHP Statute gives DCF the authority to certify providers of children's rehabilitation services for the purposes of Medicaid coverage
- DCF Certification Regulation published on December 5, 2011 and outlines provider criteria and service model endorsement process

# 2 Step Process

- Rehabilitative services being delivered must be endorsed and included in the CT Medicaid State Plan Amendment for reimbursement under Medicaid
- Agencies must be certified to deliver model-specific rehabilitation services

# Model Review/Approval

- Children's Behavioral Health Program Review Board designated to review and approve model driven programs for inclusion in the State Plan Amendment
- Board has met weekly since October and has approved the following:
  - MST (also MST –FIT, MST-PSB)
  - MDFT
  - FFT
  - IICAPS

# EMPS and EDT

- EMPS and EDT are services that do not require review by the Certification Board
- No Model endorsement or separate provider certification process needed
- DCF EDT License and/or DCF EMPS Contract are only requirements

# Next Steps

- Model Developers notified of endorsement and asked to provide letters of attestation for every provider within their CT network
- Letters due 12/12/11
- Providers and DCF to receive copies of letters to support provider certification process

# Provider Certification Process

- Each provider wishing to continue to bill Medicaid for any one of the approved home-based models must:
- Provide copies of DCF OPCC License, or DPH Outpatient substance abuse license or proof of accreditation from CARF, JCAHO or COA

*and*

# Provider Certification (cont.)

- Copies of the Letters of Attestation from the Model Developers for whom they are a documented provider in good standing
- Documentation must be submitted to DCF (Karen Andersson) electronically by 12/31/11

# Status of Process

- All impacted  in- home providers notified via email of  certification requirements on 11/28/11.  Hard copy letter sent on 12/2/11
- CCPA  included mention of DCF outreach and  certification process in e-mail to members on 11/30
- All Model Developers informed of need to prepare letters of attestation during week of 11/22

# Status of Process (cont.)

- Formal Rehab Review Board Model approval letters sent to developers from 11/22/11 – 12/8/11
- DCF electronic tracking and review system set up to receive documentation on 11/30/11

# Activity to Date

- Model Developers have sent letters out to providers with Master lists submitted to DCF
- Providers are submitting copies of licenses and letters of attestation on a daily basis
- Any providers with documentation still missing by 12/27 will receive outreach call from DCF to assist/trouble shoot

# Questions?

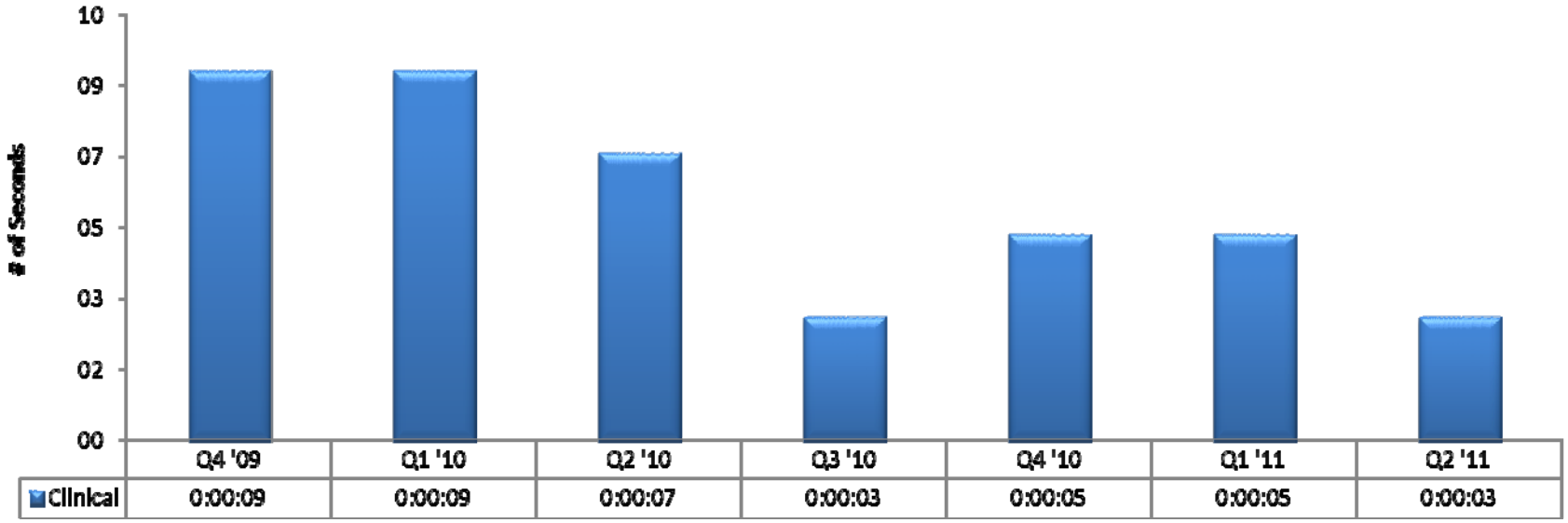
# Performance Standards
# Q2 ‘11

# Performance Standards

- 15 Standards designed to ensure consistency in ASO operations, customer service and programmatic processes
- Shape and focus ASO resources
- Penalties for non-compliance/poor performance
- Penalties totaling approximately $219,000 per year
- $5,000 in penalties since contract initiation 1.1.2006
  - File transfer issue in 2007

# Average Speed of Answer – Clinical (Provider) Calls

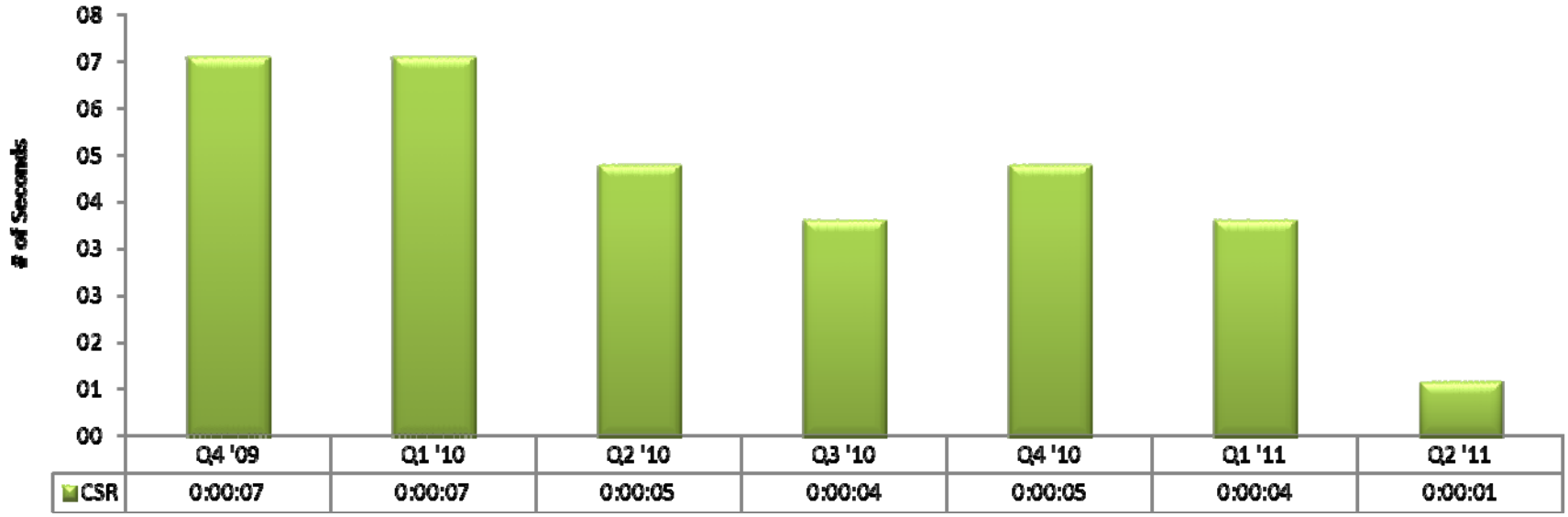
## Performance Standard = ≤ 30 seconds




- In Q2 ’11 the average speed of answer for all Clinical Calls decreased by 2 seconds from the previous quarter

# Average Speed of Answer – Customer Service (Member) Calls

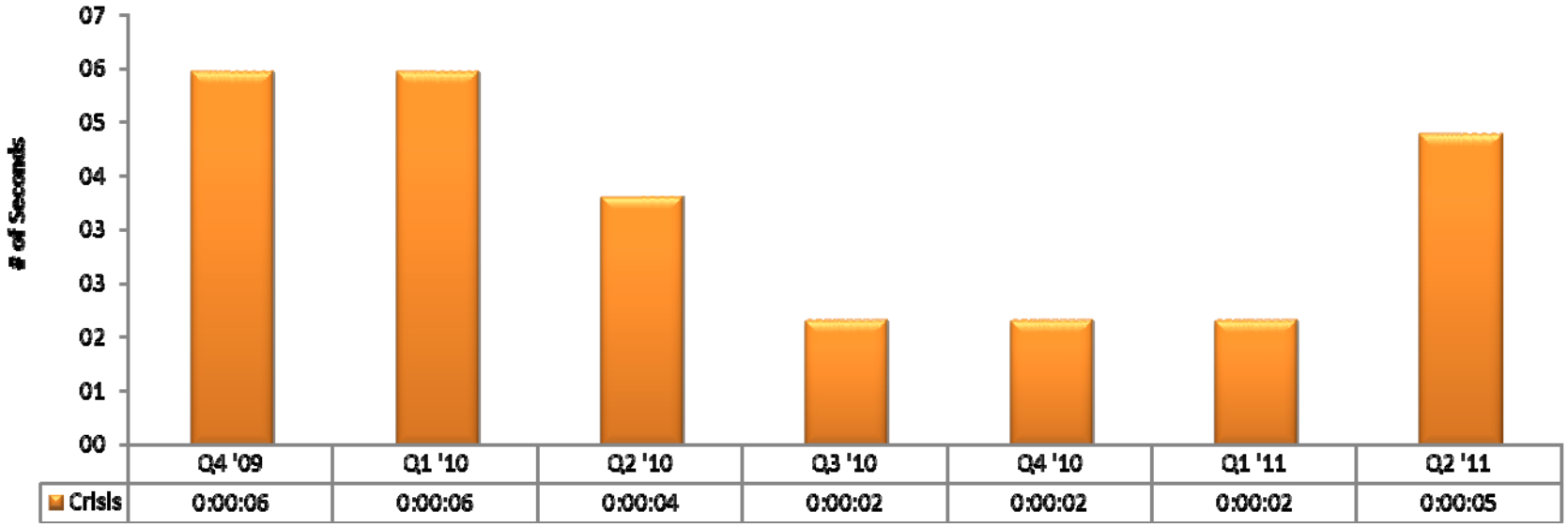
## Performance Standard = ≤ 30 seconds




- Average speed of answer for all Member calls decreased by 3 seconds in Q2 '11

# Average Speed of Answer – Crisis Calls

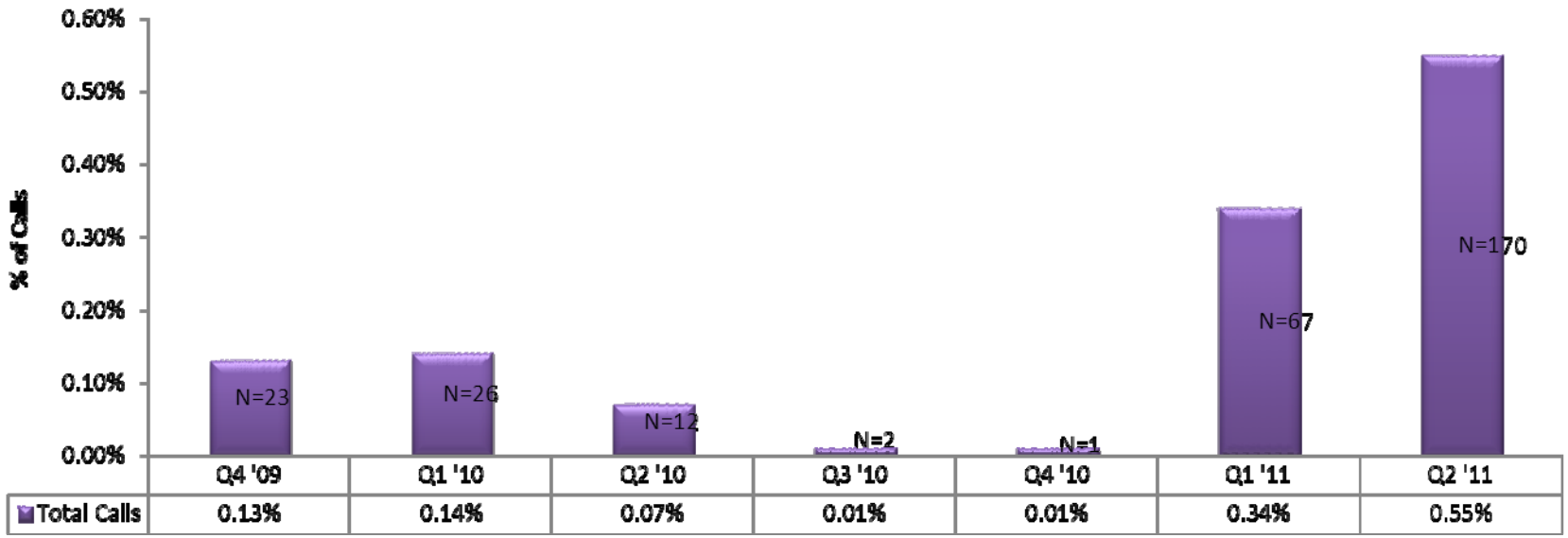
## Performance Standard = ≤ 15 seconds




- The average speed of answer for crisis calls increased by 3 seconds from Q1 ’11 to Q2 ’11

# Call Abandonment Rate

## Performance Standard = ≤ 5%

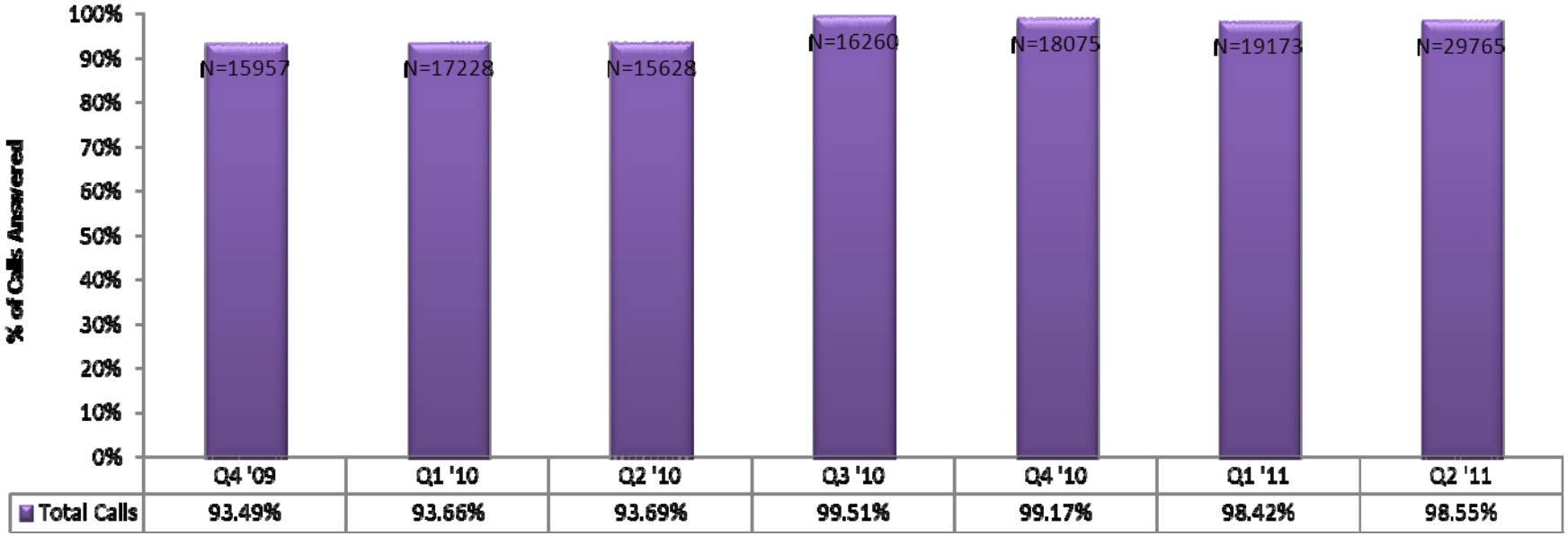



- The percentage of Abandoned Calls increased by 0.21% from Q1 '11 to Q2 '11

# Calls Answered within Service Level

(30 Seconds)

## Performance Standard = ≥ 90%

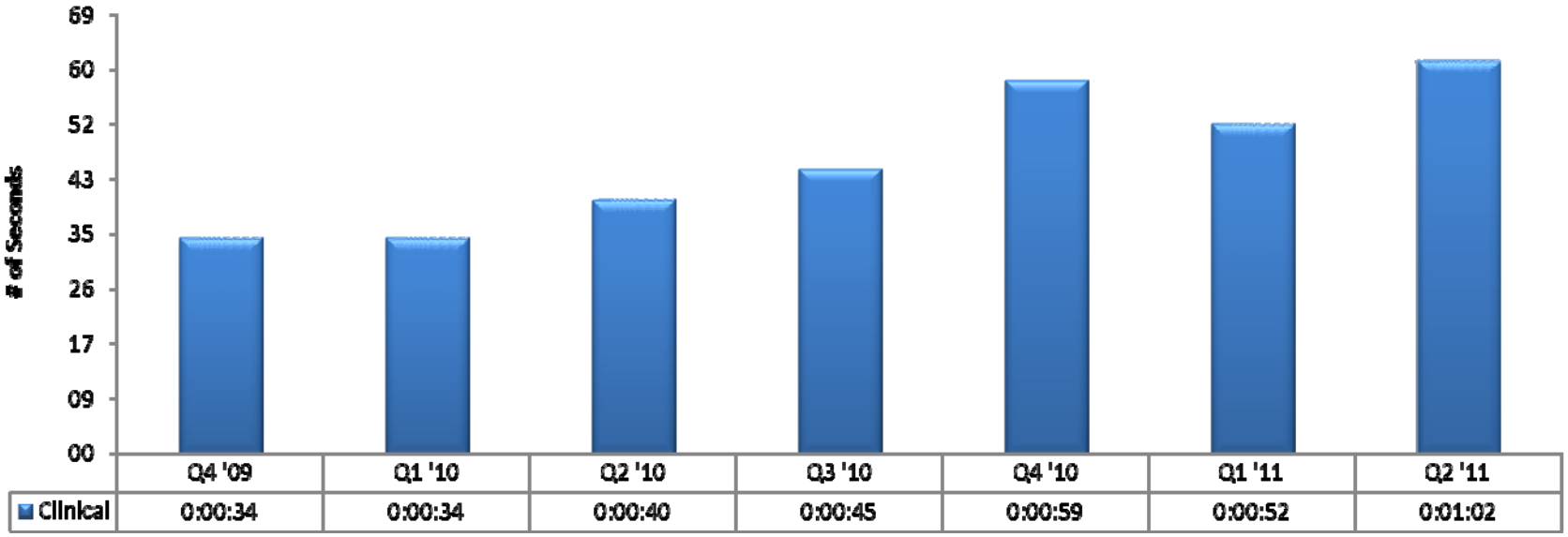



| | Q4 '09 | Q1 '10 | Q2 '10 | Q3 '10 | Q4 '10 | Q1 '11 | Q2 '11 |
|---|---|---|---|---|---|---|---|
| Total Calls | 93.49% | 93.66% | 93.69% | 99.51% | 99.17% | 98.42% | 98.55% |

- Percent of calls answered within 30 seconds continues to remain stable

# Average length of time on hold – Clinical Services (Provider Calls)

Performance Standard = ≤ 5 minutes

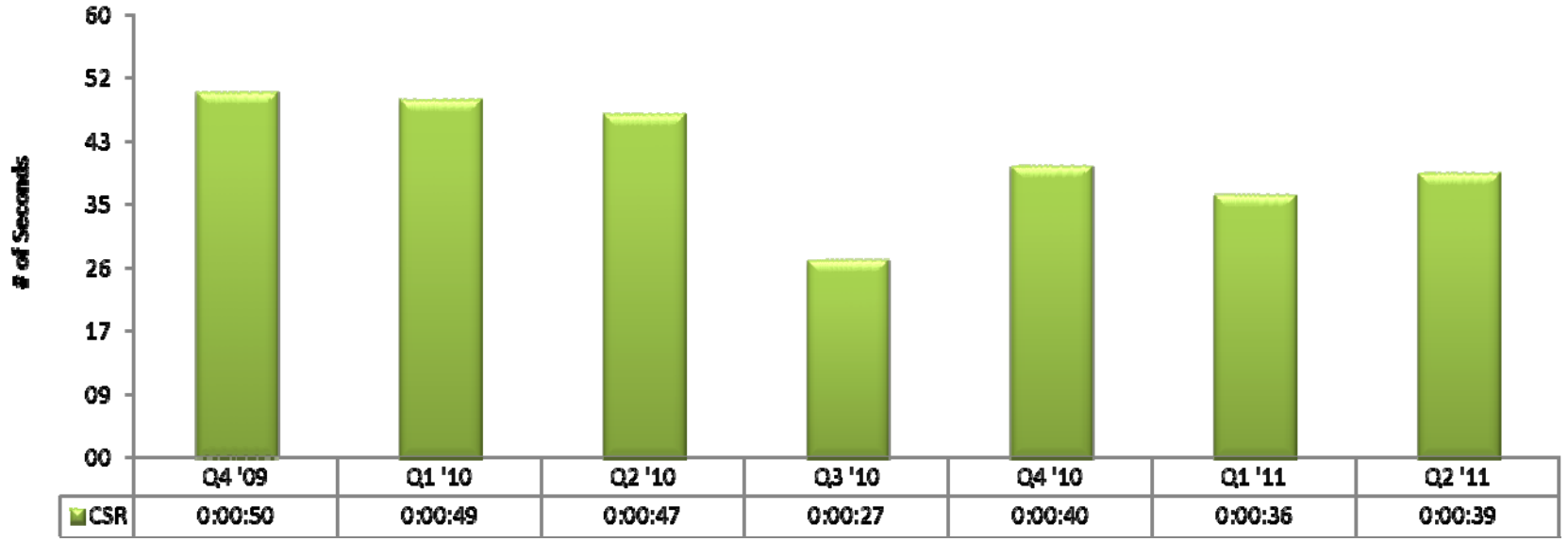



| | Q4 '09 | Q1 '10 | Q2 '10 | Q3 '10 | Q4 '10 | Q1 '11 | Q2 '11 |
|---|---|---|---|---|---|---|---|
| Clinical | 0:00:34 | 0:00:34 | 0:00:40 | 0:00:45 | 0:00:59 | 0:00:52 | 0:01:02 |

- There was a 19.2% increase in the average length of time on hold from Q1 '11 to Q2 '11

# Average length of time on hold – Customer Services (Member)

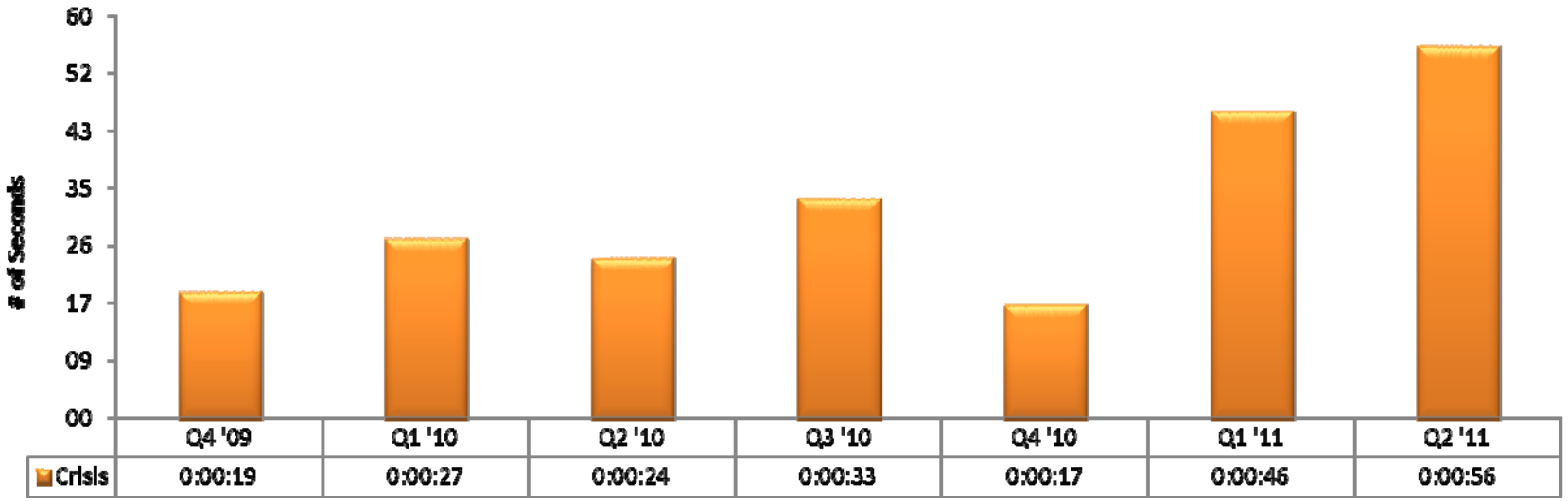
## Performance Standard = ≤ 3 minutes




- Average length of time on hold increased 3 seconds from Q1'11 to Q2'11

# Average length of time on hold – Crisis Calls

## Performance Standard = ≤ 1 minute




- The average hold time for Crisis calls increased by 10 seconds from Q1 ’11 to Q2 ’11

# Higher Levels of Care Timeliness Summary for *Initial Auths* – with and without Peer Review

Quarter 2 2011

Performance Standard = 95% of decisions communicated within designated timeframe

- UM Decisions communicated timely (number and %):

  1820 of 1822 or 99.89%

- Not requiring a Peer Review (60 minutes):

  1806 of 1808 or 99.89%

- With Peer Review, in-patient (120 minutes):

  14 of 14 or 100%

# Higher Levels of Care Timeliness Summary for *Concurrent Auths* – with and without Peer Review

Quarter 2, 2011

## Performance Standard = 95% of decisions communicated within designated timeframe

- UM Decisions communicated timely (in number and %):

  2690 of 2692 or 99.93%

- Not requiring Peer Review (60 minutes ~ inpatient/PRTF/OBS):

  2688 of 2690 or 99.93%

- Not requiring Peer Review (2 days, non acute LOC):

  47 of 47 or 100%

- With Peer Review (1 Business day, intermediate LOC):

  2 of 2 or 100%

- With Peer Review (2 Business days, outpatient LOC):

  2 of 2 or 100%

# Lower Levels of Care Timeliness Summary for *Initial Auths* – with and without Peer Review

Quarter 2, 2011

Performance Standard = 95% of decisions communicated within designated timeframe

- UM Decisions communicated timely (number and %):

  1123 of 1123 or 100%

- Not requiring Peer Review (1 Business Day):

  1122 of 1122 or 100%

- With Peer Review: (1 business day):

  1 of 1 or 100%

# Lower Levels of Care Timeliness Summary for *Concurrent Auths* – with and without Peer Review

Quarter 2, 2011

Performance Standard = 95% of decisions communicated within designated timeframe

- UM Decisions communicated timely (number and %):

  2902 of 2915 or 99.15%

- Not requiring Peer Review (2 Business Days):

  2902 of 2915 or 99.15%

- With Peer Review (2 Business Days):

  13 of 13 or 100%

# NOAs and Denials Letters Timeliness-issued within 3 Business days

Quarter 2, 2011

Performance Standard = 100% within 3 business days

- In Q2 '11 498 out of the 499 letters were sent out within 3 business days or 99.8% (one letter)
- Increase in denials given growth of contract, required refinements in existing processes

# Percentage of appeals resolved timely
Quarter 2, 2011

Performance Standard = ≥90%

- Medical Necessity Appeals
  - Provider Level 1

    1 Business Day – 10 out of 10 - 100%
  - Provider Level 2

    5 Business Days – 3 out of 3 - 100%
  - Member Level 1

    1 out 1 – 100%
- Administrative Appeals

  185 out of 185 – 100%