CONNECTICUT ASSOCIATION FOR HEALTHCARE AT HOME℠

Final edits Association 5-21-18

LEAN Process Improvement
Applied to CT Medicaid Home Health and Community-Based Care Delivery

CT Association for Healthcare at Home Provider Input for Kate McEvoy, refined and expanded by DSS 5-15-18, final edits by Association 5-21-18

1. Sub-group on Engagement with OPM and DPH Regarding Modernization of CT Home Health Regulations

Purpose: To resurface recommendations made by Association that were substantially accepted by DPH but have not yet been implemented. Moreover, consider aligning state regulations with Medicare Conditions of Participation to eliminate duplication, waste, added costs and burdens on DPH to oversee and on provider agencies to implement and sustain while maintaining quality of care and compliance.

This sub-group met on April 3, 2018.

Background: As all CT licensed Home Health and Hospice providers must be Medicare certified and follow the Medicare Conditions of Participation (CoPs), to the extent feasible, it makes sense that the new CT regulations mirror the federal Medicare CoPs.

- Medicare Home Health CoPs were just updated January, 2018.
- CT DPH Home Health Regulations date back to 1979.
- Hospice CoPs were updated in 2008.
- At least four states, including Massachusetts, use the federal Medicare CoPs as their state standards.

Goal: Create state regulations that mirror the CoPs to the extent feasible, with the goals of avoiding duplicative work for both DPH and providers and ensuring that compliance requirements are in line with state and federal payment reform and innovations that promote quality of care for the individuals served.

Proposed Solutions: DPH will review requests for waivers received from home health and hospice providers. DPH, HHAs and hospice agencies will form a small work group to develop a process for waiver review and to propose a list of potentially waivable regulations (e.g. 15 FTEs per Supervisor of Clinical Services; Clinical Supervisor and Administrator Credentials; hospice orders every 60 days). Once the process is developed and finalized, it will be communicated to all licensed HHAs.

Timeframe:

- DPH will add a dedicated staff person in May, 2018 to address the Home Health regulations and will begin revising the regulations immediately.
- DPH will seek input on new draft regulations from a workgroup comprised of Association and provider representatives, DSS and OPM in the time period between May and July, 2018.

- DPH will prioritize moving the draft regulations through the required review and approval process (2018).

2. Sub-group on LTSS Eligibility Processes

Purpose: Create efficiencies through process flow improvement and technology enhancements to streamline new Medicaid client applications, medically needy spend-down and redeterminations.

This sub-group met on February 27, 2018 and discussed redeterminations only. New applications and spend-downs were not addressed.

Proposed Solutions:

- DSS will broadcast to the Association the established process through which individual providers may become Authorized Representatives, and reciprocally, can be removed, for Medicaid home health consumers. This involves completion of W298 forms and submission of the forms to the DSS Scan Center.

- DSS is developing a data collection tool to be used by providers to report claim issues that relate to eligibility problems.

- The provider request that DSS share members' eligibility re-determination dates directly with HHAs. Access Agencies already have access to this information.

- DSS and the Association will continue to discuss matters related to initial eligibility and spend-down.

Timeframe: As soon as is feasible.

3. Sub-group on Billing/Authorization/Claims

This sub-group met on March 8, 2018 to inventory and propose means of addressing claiming challenges including required documentation, means of making adjustments, format of denied claims, inability to adjust individual (v. batched) claims, confusion over G-codes, duplicate authorizations for behavioral health/waiver cases, delays in viewability of authorizations in EVV system

Proposed Solutions:

- DSS has agreed to work with the Association to create a checklist for providers to send bill out and get it returned and paid accurately. The checklist will prompt providers to include items not already addresses by the EVV aggregator:
    - Correct authorization, which can and does frequently change from initial to final (e.g. over, under, require additional authorization for changes in condition, PRN visits, etc.)
    - Signed physician orders
    - ABN supported and documented annual date renewal
    - PCAR (Paid claim adjustment request)

- DSS has implemented the EVV aggregator.
- DSS issued clarification regarding the use of the G-Codes and T1001 on 4/9/18 via an Important Message.
- DSS is evaluating possible solutions to the duplicate authorizations required for behavioral health. DSS agrees to review and adapt for home health care its current process for handling these situations as addressed in hospital inpatient settings.
- DSS will also be evaluating means of centralized communication and tracking through its CT METS (Medicaid Management Information System modularity) project.
- While real time updates are not an option presently, DSS sends authorization files to Sandata daily.

4. Sub-Group on Electronic Visit Verification (EVV)

The group agreed to re-direct items 19, 20 and 21 to the standing EVV workgroup, which has been convened separately by the Department, and to invite the Access Agencies to participate in future discussion.

DSS rolled out the EVV Alternate Claims Solution to all providers on 4/11/18.

Ongoing engagement: DSS and the Association have agreed that DSS, Access Agencies and other collaborative partners will continue to meet ongoing, potentially on a quarterly basis, to promote and monitor continual process improvement.

5. Support for Access Agency Referral Process

We have discussed, but do not yet have a solution to, development of an automated database that could be used by the Access Agencies for the following purposes:

- to check agency capacity to take members/census;
- to check on any limits on which insurances agencies will accept, in context of TPL
- to check agency capacity for specialized services such as pediatric IV, specialty wound, cardiac