

Questions and Answers (Q&A) from the “I Spy – 2011 TennCare Reporting Changes” Webinar

1. **Q:** Will all of the MCOs use the same BH Initial Appointment Timeliness Report format?

A: That is correct. The templates reviewed today were developed by the Bureau of TennCare.

2. **Q:** Will providers receive a copy of the completed PDSR?

A: The PDSR is an aggregate report, but VO will revisit the current CMHC report card format and attempt to provide as much relevant PDSR information as possible to each agency so they are aware of their performance and how it compares to the average performance during any specific reporting period.

3. **Q:** Will No Shows for post hospitalizations reflect negatively on the report?

A: No-shows will dilute performance, but the standards have been normalized based on similar national Medicaid benchmarks. [Note: “first cut” test reporting utilizing authorization and encounter data (for 3rd Quarter 2010) does reflect the percentages to be in line with expectations.]

4. **Q:** If a client's private psychiatrist refuses to give the hospital a timely appointment, does this count against the hospital?

A: Again, this is a system generated report, so it pulls information based on first appointment delivered post-discharge. However, if a facility is experiencing difficulty securing a timely appointment during the discharge planning process, that facility is encouraged to communicate this to BlueCare/TennCare Select so that we can assist in securing a timely appointment.

5. **Q:** Who do we contact if a private provider is not giving a timely appointment?

A: You may contact BlueCare/TennCare Select via the appropriate Medical Management number listed on the Quick Reference Guide included in the PowerPoint presentation.

6. **Q:** So, if a client fails their initial post hospital medication appointment and chooses to reschedule 2 weeks later we will be considered out of compliance?

A: A member’s failure to incur an eligible encounter within the standard will negatively impact the percentage of compliance, but the percentage that is

submitted to the Bureau each quarter is an aggregate report. [Note: should VO identify providers who are outliers and who are negatively impacting overall compliance, we will want to engage in discussions around that outlier performance with the objective of achieving compliance.]

7. **Q:** What if we aren't notified of the discharge by the facility and what if the person does not show up for appointment. Do we get credit for that...how is that counted?

A: The system generated report does not identify a targeted receiving provider, only the provider that renders the first appointment received post-discharge, the date of that appointment, and the number of days post-discharge.

8. **Q:** Does the new crisis hotline replace the 800 number that served as the statewide crisis line for adults?

A: Yes [note: the old hotline number will remain active for an unspecified transition period]

9. **Q:** The Mental Health Case Management Report (post discharge) that was generated by the Agency is no longer required from us?

A: You will need to submit one more MHCM report for the 4th quarter 2010, due on April 15th, 2011. After that, CMHCs will only be responsible for BHIATRs and MCRT reports (if your agency provides MCRT services).

10. **Q:** The BHIAT report is not due until July 15, 2011 with reporting data from January – March 2011 only?

A: You will submit one more BHIATR using the old format, due April 15th, 2011, for 4th Quarter 2010. Beginning July 15th, 2011, you will submit the BHIATR using the new format. The first report using this format will be for 1st Quarter 2011.

11. **Q:** Is it acceptable to continue to submit the BHIATR report based on a representative sample of members seen during the reporting period?

A: Please continue to submit information based on the universe of applicable initial appointments until otherwise notified.

The below FAQs were recently distributed by the Bureau of TennCare regarding the PDSR Report.

12. Q. The CRA lists both urgent and non-urgent services. Is there a plan to capture data and report services by urgent/non-urgent categories?

A: The intent here is to state that both urgent and non-urgent services are to be included in the count, but there is no plan to report services by an urgent and non-urgent category, for now, or by any breakdown to a category of service.

13. Q. Are discharges from a psychiatric hospital, only, to be included? What about a rural hospital that bills a MH DRG?

A: Right now we would include all discharges from a hospital where the hospitalization took place. However this merits a further discussion for the sake of consistency, and can be included in the operational meeting we plan to have in late May, early June.

14. Q. Will discharges from Residential Treatment Facilities also be included?

A: A preliminary answer is a qualified “no” as the intent here is to have this parallel the HEDIS measure for follow-up to hospitalization, which tracks services after discharge from an inpatient facility. Confounding this is the way residential stays for care may be extended due to appeals. This will warrant further discussion and study.

15. Q. Substance abuse (IOP): Should this be counted as an urgent or non-urgent appointment? Detoxification also would not normally be done as part of an aftercare program but in conjunction with hospitalization; should it be included as a follow-up service?

A: Again we will not be counting urgent and non-urgent services (see above). We agree that detox would probably be done while hospitalized; in the rare event that it is a follow-up to hospitalization, then it can be counted as a post-discharge service.