# Smoky Mountain Center (SMC)
# Operations at a Glance – January 2013

SMC is committed to being a transparent organization and keeping stakeholders informed. To support these efforts, SMC will create a brief, monthly summary of operations by functional area.

## Individuals Eligible for Medicaid Services through SMC

SMC is responsible for the oversight of behavioral health and intellectual/developmental disability Medicaid services in our 15-county area. For January:

- Individuals on the NC Innovations waiver: **638**
- Other individuals who receive Medicaid: **75,677**

Explanation: Each month the North Carolina Division of Medical Assistance (DMA) pays SMC a capitated amount per Medicaid recipient (numbers above). From those funds, we must manage services for any individual in SMC's 15 counties who needs a Medicaid service for mental health, intellectual/developmental disabilities, or substance abuse.

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## Customer Services (Medicaid and State-funded)

- SMC customer service representatives answered: **2,826 calls during January** and **2,826 YTD***
- Average time to answer a call: **11 seconds during January** and **11 seconds YTD**

Explanation: Customer service representatives take calls related to accessing services, answering questions, and providing support. SMC is required to answer calls within 30 seconds.

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## Care Management/Utilization Management (Medicaid Only)

- SMC care managers processed **2,419** requests for the authorization of services **during January** and **2,419 YTD**
  - Average time for review and authorization of requests: **7.4 days during January** and **7.4 YTD**
  - Mental health or substance abuse service requests: **2,008 during January** and **2,008 YTD**
  - Intellectual/developmental disability service requests: **411 during January** and **411 YTD**
  - Requests not authorized: **851 during January** and **851 YTD**
    - Incomplete or inappropriate requests: **517 during January** and **517 YTD**
    - Requests without supporting evidence for "medical necessity": **334 during January** and **334 YTD**
- Reconsideration requests: **44 during January** and **44 YTD**
- Reconsideration decisions appealed**: 1 during January** and **1 YTD**

Explanation: Many Medicaid services require prior authorization. In this process, a care manager reviews a request for services along with supporting documentation for "medical necessity." Services that meet "medical necessity" criteria are necessary and appropriate for prevention, diagnosis or treatment, and reasonably related to the diagnosis for which prescribed. SMC expects care managers to complete service request reviews within 14 calendar days of receipt. Days reported above are business days. Weekends and holidays are not calculated in the total. Incomplete requests do not contain all of the information necessary to properly identify the provider, the consumer or the service being requested. Inappropriate requests are those for services that do not require authorization from SMC. These two types of requests are returned to the provider as unable to process. When SMC denies a request for service due to lack of medical necessity ("adverse decision"), the consumer has the right to appeal the decision. There are three (3) steps in the appeal process. Those steps are local reconsideration, mediation and the State fair hearing.

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***YTD** - Year to date. For the purpose of this report, it is everything that has occurred since January 1, 2013.

## Care Coordination (Medicaid and State-funded)

- SMC I/DD-Innovations care coordinators worked with **660** individuals/families during January.
- At the end of January, SMC has **408** individuals on the waiting list for a NC Innovations waiver slot.
- SMC mental health or substance abuse care coordinators worked with **891** individuals/families identified with special healthcare needs or who are at high risk during January.

Explanation: The Medicaid 1915 (b)/(c) Waiver clearly defines criteria for people considered to have special health care needs. The LME-MCO must ensure that care coordination occurs for those individuals. Individuals who have high-risk conditions or those who use an amount of services considered high-cost (the top 20% of service dollars) also receive care coordination. The goal is to ensure that all individuals receiving care coordination have access to the right amount of clinically appropriate care.

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## Quality Management (Medicaid only)

- SMC staff handled **13** grievances **during January** and **13 YTD**
  - Grievances about SMC: **Four (4) during January** and **Four (4) YTD**
  - Grievances about providers: **Nine (9) during January** and **Nine (9) YTD**
- Of the 13 grievances received in January, **one (1)** is fully resolved.
- Average time to resolve a grievance: **eight (8) days during January** and **eight (8) YTD**

Explanation: SMC is required to track all grievances. The definition of grievance is "an expression of dissatisfaction by or on behalf of an Enrollee." A grievance is about any matter other than a service request that does not get prior authorization. SMC is required to resolve grievances within 30 days of their receipt.

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## Finance/Claims (Medicaid only)

- SMC Claims Specialists processed **85,965 claims during January** and **85,965 YTD.**
  - Claims approved and paid: **72,462 during January** and **72,462 YTD**
  - Average time to process a "clean claim": **0.2 days during January** and **0.2 days YTD**
  - Payments: **$6,724,695 paid to 232 providers in January** and **$6,724,695 paid to 232 providers YTD**

Explanation: SMC now processes Medicaid claims. SMC is required to process a claim within 18 days of receipt, and is required to pay 90% of clean claims within 30 days. A "clean claim" is one that can be processed without obtaining additional information from the provider. SMC pays providers on a weekly basis. This means that once a claim is processed and approved, the provider rarely has to wait longer than eight (8) days to receive payment.

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## Provider Network (Medicaid and State-funded)

- There are **286** providers in SMC's network as of the end of January.
- As of the end of January, SMC has agreements with **six (6)** providers outside our network who provide services to individuals with Medicaid eligibility in one of SMC's 15 counties.

Explanation: Before "going live" on the Waiver, there were 162 providers in the SMC network. During Waiver implementation, SMC offered contracts to 263 providers. SMC now operates a closed provider network. That means SMC must determine a need or gap to introduce a new service to the network. When that happens, SMC may contract with a new provider, or request that a current network provider add the service to its array.