Community Report

STRATEGIES TO OBTAIN MEDICAID AND OTHER THIRD PARTY MENTAL HEALTH SERVICES REIMBURSEMENT

June 7, 2017

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Glossary of Abbreviations

A-CRA—Adolescent Community Reinforcement Therapy
AAP—American Academy of Physicians
ACA—Affordable Care Act
ACH—accountable communities for health
ACO—accountable care organization
ANSA—Adult Needs and Strengths Assessment
ANSI—American National Standards Institute
AOITR—administrative operations and information technology recommendation
AP—accounts payable
APM—alternative payment method
BH—behavioral Health
BHO—behavioral health organization
CANS—Child and Adolescent Needs and Strengths
CBO—community-based organization
CCD—Clinical Care Document
CCHIT—Certification Commission for Health Information Technology
CHIP—Children's Health Insurance Plan
CLASS—Community Living Assistance and Support
CM—Care Management
CMBHS—Clinical Management for Behavioral Health Services
CMS—Centers for Medicare and Medicaid Services
COR—clinical operations recommendation
CPP—Community Partner Program
CPR—community partner recommendation
CPT—Current Procedural Terminology
CRM—Customer Relationship Manager (Microsoft software)
CSS—Cascading Style Sheet
CVO—credentialing verification organization
DADS—Department of Aging and Disability Services
DBMD—Deaf Blind and with Disabilities
DFPS—Department of Family and Protective Services
DRG—Diagnosis-Related Group
DSM—Diagnostic and Statistical Manual of Mental Health Disorders
EAP—employee assistance program
EBP—evidence-based practice
EDI—electronic data interchange
EHR—electronic health record
EMR—electronic medical record

EOB—explanation of benefits
EPSDT—Early and Periodic Screening, Diagnosis and Treatment
FFCC—Former Foster Care Children
FFS—fee-for-service
FMAP—Federal Match Assistance Percentage
FQHC—federally qualified health center
GAAP—generally accepted accounting principles
GAF—Global Assessment of Functioning
HCBS—Home and Community-Base Services
HEDIS—Healthcare Effectiveness Data and Information Set
HHSC—Health and Human Services Commission
HIE—health information exchange
HIPAA—Health Insurance Portability and Accountability Act
HR—human resources
HRSA—Health Resources and Services Administration
ICD—International Classification of Diseases
ICF—intermediate care facility
IDD—intellectual and developmental disability
IPA—independent practice association
IPC—individual plan of care
ISP—Individual Service Plan
IT—information technology
LCSW—licensed certified social worker
LMFT—licensed marriage and family therapist
LMHA—local mental health authority
LOC—level of care
LPC—licensed professional counselor
LT—long term
MBR—Medicaid billing recommendation
MCO—managed care organization
MDCP—Medically Dependent Children Program
MMARS—Medical Management and Rehabilitative Services
MMHPI—Meadows Mental Health Policy Institute
MSDP—Multicast Source Discovery Protocol
MST—Multisystemic Therapy
MT—mid term
MOU—memorandum of understanding
MUE—Medically Unlikely Edits
NASHP—National Academy for State Health Policy
NPMR—national partnership models recommendations

ONC—Office of the National Coordinator (for Health Information Technology)
ONC-ATBC—Office of the National Coordinator—Authorized Testing and Certification Body
OCR—organizational culture recommendation
PACS—picture archive and communication system
PAM—Provider Allocation Management
PBHCI—Primary Care and Behavioral Health Care Integration
PCHH—Person-Centered Healthcare Home
PCIT—Parent-Child Interaction Therapy
PCP—person-centered planning
PH—physical health
PHS Act—Public Health Services Act
PIBR—private insurer billing recommendation
PIP—performance improvement project
PM—project management
PNO—provider network organization
PPS—prospective payment system
QM—quality management
RFR—right of first refusal
RRUMG—Resilience and Recovery Utilization Management Guidelines
RS—Resolution Services
SAMHSA—Substance Abuse and Mental Health Services Administration
SB—Senate Bill
SDA—service delivery area
SED—serious emotional disturbance
SMA—State Medicaid Agency
SMI—serious mental illness
SPA—security and privacy agreement
SPMI—severe and persistent mental illness
SSI—Supplemental Security Income
SPS—Share Psychiatric Services
ST—short term
TAHP—Texas Association of Health Plans
TANF—Temporary Assistance for Needy Families
TCM—Targeted Case Management
TLP—third-party liability
TMHP—Texas Medicaid Healthcare Partnership
TMPPM—Texas Medicaid Provider Procedures Manual
TX—Texas
TXHmL—Texas Home Living
UCI—Unique Client Identifier

VBP—value-based purchasing
YAC—Youth and Young Adult Counseling
YES—Youth Empowerment Services

Purpose

Medicaid reimbursement provides a pathway for eligible individuals and families to obtain behavioral health services. When supplemented with state and philanthropic funds, Medicaid offers resources that contribute to the sustainability of non-profit community-based organizations (CBOs) whose mission is to serve people with low incomes. This report summarizes the "lessons learned" about the Texas Medicaid program and the strategies for obtaining Medicaid reimbursement for Medicaid enrollees as well as sustaining the delivery of behavioral health services.

LifeWorks and the Meadows Mental Health Policy Institute (MMHPI) would like to extend our gratitude to Impact Austin, which was the catalyst for this initiative and provided the initial grant for the project, St. David's Foundation, which allowed MMHPI to use additional grant funds, and The Meadows Foundation, which has provided the Institute's base funding that allowed us to expand the scope of the project. MMHPI would also like to thank LifeWorks and its team for their insights and hard work over and above their day-to-day efforts to serve Central Texas youth in identifying the issues that challenge CBOs to bill Medicaid and other insurers. We hope the information contained in this report is useful in addressing opportunities for expanding and sustaining critical programs by braiding together multiple sources of funding.

Organization of the Report

The early sections of the report describe the benefits and billing information of the Texas Medicaid program and strategies for working with and billing Medicaid managed care organizations (MCOs) and other insurers. We also discuss value-based purchasing approaches, which award providers for achieving targeted outcomes for specialized services that are usually not supported by basic Medicaid or other insurance rates. In addition, we describe national partnership models that offer shared resources for information technology, billing systems, and quality improvement as a means to achieve financial sustainability and maximize the use of resources among multiple CBOs. We also discuss integrated care partnerships between behavioral health and primary care providers since these models provide increasing access to both primary care and behavioral health services and usually have the administrative capacity to bill Medicaid and other insurance.

In the latter section of the report, we offer specific recommendations for CBOs and in the final section, we include a Roadmap that offers steps for implementing the recommendations. Attachments to the report provide resource information, such as Medicaid billing and coding information, productivity standards, and linkages to other reference materials.

Texas Medicaid and Managed Care

The Texas Medicaid program primarily covers children from families with low incomes, children with disabilities, pregnant women with low incomes, SSI recipients, adults age 65 and older with low incomes, adults with disabilities, and current and former foster care youth. The eligible Medicaid population includes many individuals with significant mental health needs and current and former foster care children and youth, all of whom are priority populations for many CBOs. The rationale for billing Medicaid (and other insurance) is to appropriately make use of all available resources. Then, the CBO's philanthropic and state funding can be braided to cover other services that Medicaid and other medical insurance will not pay for, such as housing.

Medicaid State Plan

The basis for the Texas Medicaid program is the Medicaid State Plan, a contract between the state and the Centers for Medicare and Medicaid Services (CMS) that outlines Medicaid eligibility, benefits, provider qualifications, and reimbursements that are allowed by the state. The federal government matches state funding through its Federal Match Assistance Percentages, known as FMAP. In Texas, this means that the federal government pays $56.18 on every state dollar used for Medicaid. Under the federal plan, there are mandatory and optional Medicaid State Plan services. States must cover mandatory benefits such as inpatient and outpatient medical services, and may cover alternative benefits such as rehabilitation and pharmacy services. Texas covers all the optional services listed in the following table.

Medicaid State Plan Services

Federal Medicaid State Plan Services/Texas State Plan Services	
Mandatory	**Optional**
Inpatient Hospital Services	TX Rehabilitation Services
Outpatient Hospital Services	TX Pharmacy
Physician Services	TX Clinic Services
Federally Qualified Health Center (FQHC) Services	TX Other Medical and Remedial Care Authorized by a Licensed Practitioner
Rural Health Clinic Services	TX Institutions for Mental Disease for Children under the Age of 21 or Adults over the Age of 65
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	TX Case Management and Targeted Case Management Services
Nursing Facility	

CMS allows states to amend their state plan rules to modify provider qualifications and to provide target populations with services not allowed under the state plan. For example, the "1115 demonstration" waiver in Texas actually modifies the state plan by adding populations

and services not otherwise permitted under Medicaid. There are also waivers to implement Medicaid managed care.

Texas still has some Medicaid programs that are not under managed care. For those programs, providers bill the state's Medicaid program directly and are reimbursed under a fee-for-service (FFS) payment model. However, most Medicaid services in Texas have moved to a managed care model that integrates the management of physical health (PH) and behavioral health (BH) services through the MCOs. For services under managed care, the provider must bill the MCO directly for services provided to the MCO's enrollees. Under managed care and the state's provider contract with MCOs, value-based payments are allowed as an alternative to traditional FFS payments.

MCOs under Texas Medicaid Managed Care

Managed care organizations (MCOs) have the responsibility to oversee the service delivery of physical health and behavioral health care. MCOs may directly manage behavioral health care or may contract with behavioral health managed care organizations (BHOs) to oversee the utilization and quality of services. Also, MCOs and their respective BHOs (if any) may contract for different Medicaid programs that cover different populations and different health and mental health benefits for children, youth, and adults. These programs are described briefly below.

- **STAR** is a Medicaid managed care program for women and children with low incomes who receive Temporary Assistance for Needy Families (TANF) and/or for pregnant women and newborns with limited income. The program also covers young adults from ages 21 to 26 years who are eligible for Medicaid for Former Foster Care Children (FFCC).
- **STAR+PLUS** is a Medicaid managed care program for adults with Supplemental Security Income (SSI) or disabilities, or are age 65 or older, and for adults who are eligible for STAR+PLUS Home and Community-Based Services (HCBS) Waiver services.
- **STAR Health** is a Medicaid managed care program for children under the age of 18 years who are in Texas Department of Family and Protective Services (DFPS) conservatorship, young adults in DFPS extended foster care, and young adults who were previously under DFPS conservatorship and have returned to foster care through voluntary foster care agreements (ages 18 to 20). Superior Health Plan is the only MCO to offer STAR Health and covers children and youth in foster care statewide.
- **STAR Kids** is a Medicaid managed care program for youth under the age of 21 who have SSI or disabilities, or who are eligible for Medically Dependent Children Program (MDCP) Home and Community-Based Services (HCBS) Waiver services or Youth Empowerment Services (YES) Waiver services; live in a community-based intermediate care facility (ICF) or a nursing facility for individuals with an intellectual or developmental disability (IDD) or related condition; receive services through a Medicaid buy-in program; or receive

services through Department of Aging and Disability Services (DADS) intellectual and developmental disability (IDD) waiver programs, such as Community Living Assistance and Support Services (CLASS), Deaf Blind with Disabilities (DBMD), Home and Community-Based Services (HCBS), and Texas Home Living (TXHmL).

In the Austin-Travis County area, the following Medicaid MCOs provide health and behavioral health services in the Travis Medicaid managed care service delivery area (SDA).

- The STAR program includes Blue Cross Blue Shield, Sendero, Seton, and Superior.
- The STAR+Plus program includes Amerigroup and United.
- The STAR Health program includes Superior, the only MCO statewide for all children and youth in the conservatorship of the state.
- The STAR Kids program includes Superior and Blue Cross Blue Shield.

Expanded Access to Additional Medicaid Mental Health Services

Before 2013, community-based organizations (CBOs) could only bill Medicaid for Mental Health Rehabilitative Services and Targeted Case Management (TCM) through local mental health authorities (LMHAs). In 2013, Senate Bill (SB) 58, 83rd Legislature, Regular Session, integrated Mental Health Rehabilitative Services and TCM into the state's Medicaid managed care program—reimbursed through capitated (or fixed, predetermined) rates—and enabled provider entities, other than LMHAs, to become credentialed and obtain reimbursement for the provision of these services. This was an important first step in expanding the capacity to provide these services statewide. Only LMHAs and provider entities that are organizations—not individual practitioners—can bill for TCM and Mental Health Rehabilitative Services.

Today, all Mental Health Rehabilitative Services and TCM provider entities (not independent practitioners) enrolled in Medicaid must utilize the Texas Health and Human Services Commission's (HHSC) Texas Resilience and Recovery Utilization Management Guidelines (RRUMG), which were originally designed for LMHA use. Information on how to become a Mental Health Rehabilitative Services and TCM provider, and how to access the current HHSC Medicaid managed care contracts and manual, is included in the recommendations section of this report.

During the 85TH Legislature, Regular Session, additional efforts were made to help increase the state's capacity to help children in poverty and involved in foster care who have acute mental health needs gain access to Mental Health Rehabilitative Services and TCM. Senate Bill 74, which streamlines the Medicaid managed care credentialing process, increasing the state's capacity to connect children and adolescents to the intensive treatment they require, overwhelmingly passed both houses of the legislature and now awaits Governor Abbot's signature. Key provisions of the bill include clarifying that non-LMHA providers can contract with a managed care organization to provide Mental Health Rehabilitative Services and TCM to

children, adolescents, and their families. The bill also clarifies that non-LMHA providers are not required to provide crisis services, such as crisis hotlines or mobile crisis teams. It also requires HHSC to update Medicaid managed care contracts and related manuals and guidelines.

In addition, SB 74 is associated with a budget rider that makes $2 million available to establish a grant program to increase access to Mental Health Rehabilitative Services and TCM to children and youth in the child welfare system. This one-time grant program will provide funds to LMHAs and other nonprofit entities that are making investments to either become providers of Targeted Case Management and Mental Health Rehabilitative Services for children in foster care at the Intense Service Level, or to expand their existing capacity to provide these services. In order to receive grant funds, an entity must provide local matching funds in an amount defined by HHSC, based on the entity's geographical location. Funds may only be used to pay for costs directly related to developing, implementing, and training teams to provide Targeted Case Management and Mental Health Rehabilitative Services to children in foster care at the Intense Service Level. The Health and Human Services Commission, in collaboration with the Department of Family and Protective Services (DFPS), must establish the initiative no later than November 1, 2017.

Private Insurance

The Texas Association of Health Plans (TAHP) lists 30 different health plan member organizations in Texas.[1] While some of these plans do not cover the Austin-Travis County service area, many offer coverage through employers, the individual market, and the Affordable Care Act. In 2016, a survey related to depression in the workplace conducted by MMHPI and the Texas Business Group on Health (an association for employer benefits specialists) found that almost 90% of the 133 mid-to-large size employers surveyed had mental health coverage and an Employee Assistance Program (EAP) as part of their employee benefits.[2] Furthermore, 90% of the responders believed their executive teams were interested in improving access to and the quality of treatment for depression. These findings suggest that it is typical for mid-to-large size employers to cover behavioral health benefits. Smaller employers often also provide coverage. With employees frequently accessing care through private insurers or EAPs, CBOs can also pursue commercial insurance to obtain reimbursements for covered individuals. Under the Affordable Care Act (ACA), there are up to 204 health plan choices in the Austin area.[3] This does

[1] The Texas Association of Health Plans. (n.d.). *TAHP members*. Accessed March 24, 2017 at http://tahp.org/becoming-a-member/members/.

[2] Meadows Mental Health Policy Institute and the Texas Business Group on Health. (2016). *Depression in the workplace*. Author. Executive Summary of TBGH's Survey of Texas Employers. Retrieved from http://tbgh.org/documents/TBGH_Depression in the Workplace.pdf.

[3] MMHPI used the official U.S. Affordable Health Care website (https://www.healthcare.gov/) on March 25, 2017 to determine the number of plans in the Austin area. Using several zip codes to test out the number of plans, we found 204 in the Austin areas.

not necessarily mean there are that many insurers (some offer multiple plans), but it does appear that there is a healthy commercial insurance market in the area. The recommendations section of this report discusses specific strategies for pursuing private insurance and EAP reimbursements.

Partnership Models

In this section of the report, we discuss emerging national partnership models that improve the quality and efficiency of health care. These models focus on the integration of behavioral health (BH) and physical health (PH) care, an emerging best practice in provider delivery systems. We recognize that community-based organizations (CBOs) have extensive experience with forming partnerships with other providers and in merging operations, which is invaluable when assessing other opportunities for partnerships.

Federally Qualified Health Centers

When considering partnership models, it is important to understand how federally qualified health centers (FQHCs) are funded. FQHCs can access enhanced funding through Medicare and Medicaid as well as receive grants from the Health Resources and Services Administration (HRSA). A comprehensive report on FQHC payment mechanisms developed by Truven Health Analytics describes the financing as complex and variable by payer and state.[4] The key financing mechanisms described in the Truven report are listed below.

- **"Federal 330 Grants:** Grants authorized under Section 330 of the PHS Act cover growth and operating costs and offset some of the cost of uncompensated care and enabling services (e.g., transportation, translation, and education). FQHCs may receive other federal and non-federal grants to cover services and costs as specified in the grants.
- **Insurance:** Insured patients in FQHCs are covered by the following types of insurance:
  - Medicaid: State Medicaid Agencies (SMAs) pay FQHCs using a prospective payment system (PPS) or an alternative payment method greater or equal to the PPS rate. Behavioral health services rendered by physicians, physician assistants, licensed clinical psychologists, and licensed clinical social workers practicing within their scope of services are covered. Some states may allow other providers to bill. (The federal Prospective Payment System (PPS), is a methodology based on the average of each FQHC's reasonable costs.)
  - Medicaid Managed Care: Medicaid managed care plans pay FQHCs on either a capitated or fee-for-service basis. Their covered services and billable providers vary by plan. If the rate paid by the managed care company is less than the PPS rate, the

[4]Brolin, M., Quinn, A., Sirkin, J.T., Horgan, C.M., Parks, J., Easterday, J. & Levi, K. (2012, July 23). *Financing of behavioral health services within FQHCs*. Washington, DC: Truven Health Analytics, pp.1-4. http://www.integration.samhsa.gov/Financing_BH_Services_at_FQHCs_Final_7_23-12.pdf.

SMA pays the FQHC the difference. These supplemental payments are called "wrap-around" payments.

- Children's Health Insurance Plan (CHIP): CHIP payment policies are similar to Medicaid. However, CHIP policies vary depending upon whether the program is a Medicaid expansion, stand-alone, or combination program. For services delivered to patients enrolled in managed care plans, FQHCs receive wrap-around payments similar to Medicaid.
- Traditional Medicare: The ACA requires Medicare to implement a PPS similar to Medicaid. Under Traditional Medicare (Part B), FQHCs currently receive an all-inclusive payment for each covered visit, regardless of the specific services provided, that includes a range of primary care services and services accompanying or occurring as a result of primary care services, including clinical psychologist and clinical social worker services.
- Medicare Managed Care: Medicare managed care plans under Medicare Advantage (Part C) pay FQHCs on either a capitated or fee-for-service basis. Their covered services and billable providers vary by plan. They also receive wrap-around payments from traditional Medicare similar to Medicaid and CHIP wrap-around payments.
- Private Insurance: Arrangements vary by private health plan. Many plans contract out behavioral health services to managed behavioral health care organizations. FQHCs are not always included in the provider networks established by the carve-out entities; therefore, behavioral health services provided to enrollees may not be reimbursable.

- **Patient Self-Payments:** Health centers determine patient charges on the basis of patients' ability to pay using a sliding-fee scale."(Brolin et al., pp.3-4).

The Truven report describes different mechanisms through which FQHCs can collaborate with behavioral health providers, including referrals, co-location of services, and establishing new FQHC sites with partnering providers. However, FQHCs must have their projected scope of services approved annually, and the delivery of behavioral health services must be included in their projected scope in order for a FQHC to provide behavioral health services or subcontract with a provider for these services. FQHCs may deliver behavioral health services directly or contract for these services, either on site or off site at other provider locations. However, an important goal of providing behavioral health services at FQHCs is to promote improved integration of physical and behavioral health care. The Truven study noted that, based on data before 2012, most FQHCs that provided on-site mental health services used staff employed by the FQHC. However, this approach to practice appears to be changing with the emphasis on integrated care and the bi-directional delivery of behavioral health and physical health services at either the physical health or behavioral health provider, based on the acuity and severity of the individual's physical and behavioral health conditions. For example, under bi-directional

approaches, community mental health centers may establish a primary health care model in their settings either on their own or with a health partner such as an FQHC.

In Texas, the payment models used when partnering or aligning with an FQHC for referrals may include a subcontract with the FQHC to provide the service, *or* an agreement to bill the Medicaid MCO for the services for shared clients. A behavioral health provider cannot bill the FQHC for the service and also bill Medicaid managed care. In the past, there have been challenges with the FQHC and a behavioral health provider billing Medicaid for the same client on the same day as a result of billing code gaps. However, behavioral health providers have reported that the billing system is working more smoothly now and they can bill Medicaid for behavioral health services provided to clients enrolled in FQHCs who also receive primary care services from the FQHC on the same day (when the FQHC is not directly paying the behavioral health provider for the behavioral health services). It is important to work with Medicaid MCOs to clearly explain subcontract arrangements with FQHCs to avoid any confusion about the funding source for the behavioral health service. The rule of thumb is that it is either a subcontracted FQHC payment or a Medicaid MCO payment, but not both.

Other Partnership Models

CBOs could consider various partnership models that provide examples for maximizing resources to achieve financial sustainability and for providing state-of-the-art behavioral health care. These models include formal partnerships, where CBOs would become a part of a larger organization, and contractual arrangements to purchase or exchange services. Brief descriptions of the organizational models are provided below.

- Accountable care organizations (ACOs)—Typically, ACOs are large hospital and physician practices that form integrated care networks and assume responsibility for the health of their patients, the quality of care, and costs. ACOs first emerged during the discussions about the Affordable Care Act in 2011 and have been supported through CMS's Medicare program.[5] Providers may "buy in" to the ACO or participate as subcontractors, often sharing financial risk for outcomes. While ACOs originally focused on Medicare, in April 2016, there were 838 active ACOs across the country in all states covering Medicare, Medicaid, and commercial health plan members. [6,7] Seton Health Alliance,

[5] Department of Health and Human Services, Centers for Medicare & Medicaid Services. (2011, November 2). *Medicare shared savings program: Accountable care organizations; final rule 76*. Fed. Reg. 212.

[6] Merlis, M. (2010, July 27). *Health policy brief: Accountable care organizations.* Health Affairs. Retrieved March 25, 2017 from http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_23.pdf.

[7] Muhlestein, D., & McClellan, M. (2016, April 21). *Accountable care organizations in 2016. Private and public sector growth and dispersion*. Health Affairs Blog. Retrieved March 25, 2017 from http://healthaffairs.org/blog/2016/04/21/accountable-care-organizations-in-2016-private-and-public-sector-growth-and-dispersion/.

Inc., was a pioneer Medicare ACO in Austin. A list of Medicare ACOs in the Austin area is included as Attachment A.

- Independent practice associations (IPAs)/provider network organizations (PNOs)—Physician practices formed IPAs to provide a range of administrative and care coordination services, including quality improvement and sharing financial risk for outcomes. IPAs and PNOs have expanded to include behavioral health providers or have been established by behavioral health providers.
- Accountable communities for health (ACH)—CMS is administering this initiative, which funds selected communities to test the impact of identifying health-related social needs and connecting Medicaid beneficiaries to services that address those needs, as well as being responsible for overall health care.[8]

These partnership models vary widely from formalizing a corporation or other legal entity, to membership and financial contribution requirements or subcontracting arrangements. For example, ACOs can include membership of IPAs and other providers. Attachment B describes these models, their characteristics, and the participation determinants. Attachment C is a pictorial view of the progression from medical homes to health care neighborhoods and their overarching administrative organizations. These materials provide background for assessing future ways that CBOs can participate in the various evolving health care transformations.

Entering into a Partnership

Moving into a formal partnership arrangement such as an IPA can improve administrative capacity, but it also has the potential, when executed well, to improve the delivery of services and care coordination—key requirements for participation in provider networks of ACOs and MCOs. Interviews with four IPAs representing community health and behavioral health organizations reported the following strengths of entering into a partnership:[9]

- Negotiation of complex contracts with payers;
- Opportunities to improve clinical practice and obtain financial incentives;
- When at financial risk, managing risk sharing is easier when a single organization is in charge of billing and distributing risk sharing benefits (and losses).

The IPAs also reported the following start-up issues that must be considered when forming partnerships.

- Definition of the legal entity, including non-profit status;
- Funding to form an entity or requirements to “buy in”;
- Voting members’ equality (based on participants or revenue or other factors);

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[8] See: Centers for Medicare and Medicaid initiative on Accountable Communities for Health. Accessed, January 2, 2017 at https://innovation.cms.gov/initiatives/AHCM.

[9] TriWest Group, LLC. (2014). Unpublished report on interviews with four community-based IPAs.

- The length of time it took for provider members to develop trust (12 – 18 months);
- Assumption of financial risk;
- Need for legal counsel to address state and federal laws related to anti-trust, federal managed care requirements, and state laws related to FQHC payments;
- Understanding of IPA accounting (it is different from FQHC/health center accounting if partners include FQHCs);
- Focus and range of subcontracted administrative functions;
- How to share payor incentives and use incentives to improve quality, not to fund "business as usual."

We highlight these findings primarily because they illustrate key areas when considering any type of formal partnership. This background information should help guide CBOs in their future decisions about making or buying various administrative functions.

Purchasing Administrative Services

Other strategies include subcontract arrangements with providers or management services organizations.

- Purchase of administrative services from an administrative/management services organization or a larger provider, e.g., LMHA/community mental health center or MCOs.
- Arrangements with FQHCs that cover management services and/or direct service delivery to the FQHC patients. It is essential to understand the financing models of FQHCs and the difference in their funding compared to Medicaid FFS and managed care programs. As described above, FQHCs are designated to receive Medicare and Medicaid payments through the federal Prospective Payment System (PPS), a methodology based on the average of each FQHC's reasonable costs. There are other financing mechanisms that support FQHCs, including Public Health Services 330 grants, managed care programs, and other insurance, but most payment mechanisms (except grants) center around the method of payment of a minimum all-inclusive rate for any services provided to an individual during a day.

Each approach has unique administrative requirements and legal arrangements, range of services offered, and reimbursement models. The following table provides an array of administrative and clinical services that are available through these various arrangements, depending on the scope of services the entity wants to offer its providers.

Array of Available Clinical and Administrative Services	
Accounting and financial management	Information technology/health information network
Billing, reimbursement, and collections	Pharmacy management
Call answering coverage	Population-based planning, global budgeting
Care management/utilization management/case management	Purchasing program (clinical supplies, office supplies, health care, liability insurance)
Compliance (training, monitoring, compliance officer, other)	Provider contracting, risk contracting, and provider relations
Decision support (types of reports)	Quality improvement
Human resource (HR) functions, such as recruitment, employee benefits management, malpractice and/or other professional or business liability insurance	Risk management
Marketing	

The decision to "make or buy" any of these functions depends on the capabilities, needs, and resources of the participants. For example, purchase of administrative services for billing Medicaid or other insurers through a billing firm may be very efficient and useful without adding the administrative burden of forming or entering into a new legal entity or partnership. If forming the partnership requires financial contributions or administrative capacity to shape the direction of the new combined entity, it may be easier to purchase the service through a subcontractor.

Yet, the capacity to grow may depend on the subcontractors' capabilities to perform required functions. Reliance on subcontractors to perform various functions may inhibit development of needed skills and information capacity to be competitive in the future environment, unless the subcontractor offers a wide range of services. If the subcontractor has depth in areas that promote greater expertise with managing insurance, such as capacity to train staff on clinical and administrative documentation requirements of insurers, then the subcontract may be the most efficient strategy.

Value-Based Contracting via Alternative Payments Methodologies

There has been an increase in the use of value-based contracting via alternative payment methods (APMs) that reward providers for meeting agreed upon performance targets and outcomes based on quality and efficiency. The rationale for creating accountable care

organizations (ACOs) and accountable communities for health (ACHs) focuses on achieving the triple aim of improving the experience of care, improving the health of populations, and reducing per capita costs of health care.[10] Alternatives to traditional unit cost fee-for-services payment methodologies typically involve some type of financial risk. Capitation—providing a "per member per month" payment—is one example where the provider must offer all needed services for the individual within the capitated rate. There are various APMs ranging from extra payments for care coordination to higher rates for the delivery of evidenced-based practices or achieving accreditation. These APMs are outlined in Attachment D. The recommendations section of this report provides guidance on possible actions that CBOs can take to benefit from APMs.

Medicaid Billing Recommendations (MBR)

MBR-1: Learn about the various Medicaid programs and covered benefits, which have specific service definitions and staff qualifications for the delivery of services. CBOs must enroll with the state Medicaid program to provide services under a traditional fee-for-service model or contract with Medicaid MCOs for the delivery of services. In either situation, CBOs will need to demonstrate knowledge of the Medicaid service definitions and the qualifications of staff that can provide particular services, and align qualified staff with the covered Medicaid services for each of the "STAR" programs, including:

- STAR,
- STAR+Plus,
- STAR Kids, and
- STAR Health.

MBR-2: CBOs should bill Medicaid and other insurance for the covered behavioral health services they provide to individuals who are eligible for Medicaid and other insurances. Rather than relying solely or primarily on grant funds or other philanthropic activities (e.g., fundraising), CBOs should bill Medicaid and other insurers for all covered services and reserve other funding sources for services not covered by Medicaid or other insurance. While it is often less administratively burdensome to bill grant funds or philanthropic dollars for behavioral health services, "braiding" funds to stretch resources is essential as foundations and other grantors raise expectations about billing Medicaid and other insurance.

MBR-3: Contract as an entity/organization with all Medicaid MCOs in the CBO's service area. By contracting with all MCOs, the CBO will have the option of billing Medicaid when serving a new MCO client at the "in network" rate. CBOs can usually bill MCOs if they are an "out of

[10] Berwick, D.W., Nolan, T.W., & Whittington. J. (2008). The triple aim: Care, health, and cost. *Health Affairs, 27*, 3, 759-769 doi: 10.1377/hlthaff.27.3.759.

network" provider, but the MCO often pays a lower rate. The CBO should also negotiate contracts and become credentialed as an entity/organization, rather than credentialing individual clinicians. Becoming a credentialed entity with MCOs and all of the available Medicaid programs will ensure that the CBO can bill Medicaid every time a Medicaid eligible individual receives a Medicaid billable service from a staff person qualified to offer the service. This approach does not relieve the CBO from ensuring that appropriately credentialed staff provide Medicaid covered services and does not affect the payment rate for these services.

MBR-4: Establish an internal credentialing committee to review the credentials of all staff that will bill Medicaid (or other insurers). By establishing a credentialing committee, the CBO will broaden its knowledge of the provider requirements and qualifications for the delivery of specific Medicaid services (and those of other commercial insurers). The purpose of the credentialing committee is to review the credentials of licensed behavioral health professionals or subcontractors under consideration for hire or engagement to make sure the applicants are in good standing and have the qualifications required by funders to deliver and bill for services. The committee should include representatives of the licensed behavioral health clinical positions that deliver services funded by Medicaid or other insurances, such as licensed professional counselors, licensed social workers, licensed marriage and family counselors, and licensed psychologists. Ideally, the credentialing committee is led by a physician, when there are staff physicians available. Quality improvement staff also participate in the credentialing committee to address any issues the come up once the staff person is credentialed, such as loss of license or other factors that may jeopardize the person's ability to deliver care (e.g., substance use). The credentialing committee also addresses any issues related to federal compliance with fraud and abuse requirements that pertain to credentialed staff. Credentialing committees schedule meetings according to the frequency of new hires, and at least quarterly.

In many provider agencies, human resources (HR) staff often have the responsibility for checking references and obtaining verification of licenses. That function can continue; however, the credentialing committee should review new hires' clinical qualifications to deliver various services as well as oversee that the credentials have been verified by HR. Depending on the size of the CBO and its volume of services, it could subcontract with a credentialing verification organization (CVO) to conduct verification of all credentials.

MBR-5: Decide if your CBO wants to provide Medicaid Mental Health Targeted Case Management (TCM) and Mental Health Rehabilitative Services. A provider entity can be credentialed to provide TCM and Mental Health Rehabilitative Services to children or adults or both, as long as the services delivered conform to the level of care (LOC) criteria established by the state. Prior to 2013, these services were only allowed to be offered by local mental health authorities (LMHAs), and an increasing number of CBOs are becoming credentialed to provide them. The criteria for becoming credentialed for TCM and Mental Health Rehabilitative Services

differ from the criteria for providing outpatient counseling, as well as services provided by a psychiatrist or other licensed clinicians.

In order to be credentialed for either TCM or Mental Health Rehabilitative Services, the provider must be willing to offer both TCM and Rehabilitative Services and must complete very specific training, which can be costly. Based on our experience and meetings held with providers who have developed this credentialing, the costs are about $5,000 per child capacity slot created. One organization we contacted estimates that 300 training hours are required for each staff member directly providing these services. Providers also incur additional costs for updating their billing system when they add a new service. However, many CBOs are already providing very similar services today, such as case management, yet they must rely solely on foundations and grants to fund these services.

To determine the cost/benefit of billing for TCM and Rehabilitative Services, CBOs will need to do a functional assessment of their case management staff across all programs to identify the number of hours current case managers and other staff spend on care coordination as distinct from rehabilitative services and apply the hours to current Medicaid billing rates for TCM and Mental Health Rehabilitative Services. If the CBO provided TCM and Mental Health Rehabilitative Services, it could bill Medicaid for eligible youth and prioritize foundation and grant funding for those individual clients who do not have Medicaid or are uninsured, and for costs that are not funded by Medicaid. Attachment E provides billing codes and Attachment F provides guidelines on levels of care and access to other instructions for Medicaid providers, inclusive of training requirements.

MBR-6: Propose value-based contracting to the MCOs to support the delivery of evidence-based practices (EBPs), the costs of which may not be covered by standard Medicaid rates. CBOs can request an alternative payment method (APM) for services such as Parent Child Interaction Therapy (PCIT),[11] or Adolescent Community Reinforcement Therapy (A-CRA),[12] as long as these services have good outcomes. Developing an APM involves defining the services and identifying the qualifications of staff, the program resources that can be covered by Medicaid, and those services that must be covered by another funding source (e.g., room and board are not typically paid by Medicaid except for inpatient care), training costs

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[11] California Evidence-Based Clearinghouse for Child Welfare. (n.d.). *Parent-Child Interaction Therapy (PCIT)*. Retrieved May 22, 2017 at http://www.cebc4cw.org/program/parent-child-interaction-therapy/detailed. PCIT is an evidence-based practice for Children ages 2.0 – 7.0 years old with behavior and parent-child relationship problems; it may be conducted with parents, foster parents, or other caretakers.

[12] Center for Children. (2013). *Adolescent Community Reinforcement Approach (A-CRA).* Retrieved May 22, 2017 at http://center-for-children.org/programs/adolescent-community-reinforcement-approach-a-cra/. A-CRA is an evidenced-based practice that uses behavioral techniques and skills training to teach adolescents about managing their substance use.

(encompassing training for TCM and Mental Health Rehabilitative Services), and administrative costs. Development of an APM would allow CBOs to recover more of the costs of services than currently reimbursed by the Medicaid MCOs. Attachment D to this report provides information on the different types of value-based contracts via APMs and Attachment G provides a template for assembling the information necessary to develop an alternative payment for evidence-based practices (EBPs). The type of alternative payments MMHPI recommends at this time are payments for delivery of EBPs that meet performance goals determined in advance with the MCO, such as a reduction in emergency department or inpatient utilization, or a higher payment for services that meet similar performance goals. Other examples of EBPs include trauma-informed therapies, Supported Education, and supportive independent living. This type of APM involves a case rate, where the risk to the provider is more limited and similar to a fee-for-service payment. However, if the provider doesn't meet the outcomes specified in the APM agreement, the MCO may levy a penalty. Keep in mind that developing an APM will require substantial effort, persistence, a partnering stance with the MCO, and, potentially, expert consultation. Most APMs require multiple iterations and substantial negotiation, and the provider also needs to understand the financial risks involved in committing to deliver care outside of a case rate payment or a unit cost fee-for-service arrangement.

MBR-7: Consider becoming a designated HHSC Community Partner, or affiliate with a Community Partner, which would then allow enrollment of eligible individuals in Medicaid at the CBO's sites. This is especially useful for youth aging out of foster care who were eligible for Medicaid at the time of their completion of foster care and often miss out on accessing Medicaid benefits through young adulthood**.** Information on becoming a Community Partner is included in Attachment H.

Clinical Operations Recommendations (COR)

COR-1: When negotiating rates with MCOs and other insurers, emphasize the outcomes your organization has achieved. CBOs offering a range of support services that address the social determinants of health may be able to negotiate higher rates from MCOs for behavioral health services when the CBO can track related outcomes. This is particularly true for outcomes that directly affect the MCO (e.g., reduced out-of-home care), but increasingly MCOs are interested in value-adding clinical outcomes that go beyond controlling utilization (e.g., parent participation, reduction in school disciplinary issues, maintenance of a job or housing, fewer interactions with police, or less school disciplinary action). The types of supports that are increasingly being recognized as important to achieving good outcomes include enhancing the nature of social interactions and relationships and making supports available for youth and families in their homes, neighborhoods, schools, and communities.[13] The Centers for Medicare

[13] Office of Disease Prevention and Health Promotion. (2017, March 30). *Healthy People 2020.* Retrieved March 31, 2017 from https://www.healthypeople.gov/2020/about/How-To-Use-HealthyPeople.gov.

and Medicaid Services' Innovations Center has moved toward testing how health can be improved by addressing social and environmental needs.[14] This important approach provides value for Medicaid MCOs.

COR-2: To promote sustainability, establish productivity targets for each service.

The development of productivity targets must be closely tied to a number of factors:

- Reimbursement model (fee-for-service—global contract);
- Wages, staff benefits, and training and certification requirements;
- Program costs;
- Administrative expenses;
- The location of the services, if not based in an office; and
- Travel time to the location of the services, if delivered outside a typical counseling office.

A widely used productivity model develop by Scott Lloyd is available through the National Council.[15] Lloyd, a vice president with M.T.M. Services, LLC, and a consultant affiliated with the National Council (a provider membership and advocacy organization), identified the following productivity targets:[16]

- Productivity targets for CBOs are often set at 60%, according to Lloyd.[17] This target is based on 100 direct service hours per month per staff, or 1,200 hours per year, which is 7.2 clinic business months of the year, leaving 4.8 clinic business months, or 104 business days, per year for a direct care staff to perform non-direct care duties. He further describes productivity standards as being useful in addressing costs as well as quality factors such as helping an organization reduce waiting lists and considering or reducing requirements for documentation, other meetings, and clerical duties.
- As a guideline, productivity targets for typical Medicaid outpatient office-based therapies range from 70% to 90%, depending on the profession of the clinician, the acuity of their clients' needs, and other assigned duties.[18]

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[14] Wahowiak, L. (2016, September). Medicaid, Medicare making the move toward social determinants *The Nation's Health, 46:*7, 18. Retrieved March 18, 2017 from http://thenationshealth.aphapublications.org/content/46/7/18.full/reply#nathealth_el_52199.

[15] Lloyd, S.C. (2017). *Using data to drive your service delivery strategy. A toolkit for healthcare organizations*. https://www.thenationalcouncil.org/store/products/using-data-to-drive-your-service-delivery-strategies/.

[16] Lloyd, S.C. (2007, January 1). *The value of productivity standards.* Behavioral Healthcare Executive. Retrieved from https://www.behavioral.net/article/value-productivity-standards.

[17] Ibid.

[18] B. J. Jackson (personal communication, May 4, 2017). Ms. Jackson provided information on productivity standards for behavioral health services used by actuaries to develop Medicaid rates.

- Psychiatrists and other prescribers often have productivity targets in the range of 80% to 90% of their working hours, unless they have other assigned clinical and administrative duties (e.g., utilization review or quality management oversight).
- Licensed outpatient clinicians typically have productivity standards that range between 70% and 80%.
- Non-licensed staff providing outpatient supports have a lower productivity target than licensed staff because of supervision requirements and other assigned duties.

- Productivity targets for home- and school-based evidence-based practices (EBPs)—where the service occurs in the family home, on site at different community locations, or in schools—vary significantly, based on the practice. For example, the productivity target for Multisystemic Therapy, an intensive but time limited family-based intervention for youth, is 3.5 direct care hours per day. When a specific evidence-based practice is utilized, fidelity standards for the model may include criteria for the average length of stay during which time the treatment is expected to help the individual achieve his or her desired goals. If the therapist has to travel to a different site to provide the services, the travel time may also be factored into productivity goals, as are training and certification time and costs necessary to deliver the service. Attachment J provides examples of productivity targets for state Medicaid-funded EBPs that serve youth and families.

COR-3: Develop strategies to address "no-shows" for appointments. A brief review of the literature on "no-shows" in behavioral health care found that no-show rates ranged between 10% and 50% for community mental health centers and other outpatient mental health and substance use disorder treatment settings.[19] The reasons for no-shows are highly variable, from clients forgetting appointments to limited public transportation, long wait times for appointments (and long wait times upon arrival to the counseling center), lack of awareness on the part of clients and staff about no-shows, or not returning for a second appointment because of a lack of engagement.[20, 21] Previously cited peer-reviewed research articles and blogs or electronic articles all pointed to very practical strategies for engaging clients and reducing no-shows rates.[22, 23] These strategies include:

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[19] PhoneTree. (n.d.). *A guide to reducing no shows*. Accessed May 6, 2017 at https://www.phonetree.com/guides/guide-to-reduce-no-shows/.

[20] Ibid.

[21] Gajwani, P. (2014, September). Can what we learned about reducing no-shows in our clinic work for you? *Current Psychiatry*, *13*(9), 13-15, 22-14. Accessed on May 5, 2017 at http://www.mdedge.com/currentpsychiatry/article/86564/practice-management/can-what-we-learned-about-reducing-no-shows-our/page/0/1.

[22] Medical Group Management Association (MGMA). (2010, July 9). *30 ways to reduce patient no-shows*. MGMA *In Practice* Blog. Accessed May 5, 2017 at http://www.mgma.com/blog/30-ways-to-reduce-patient-no-shows.

[23] Van Dieren, Q., Rijckmans, M.J.N., Mathisjssen, J.J.P., Lobbestael, J. & Arntz, A.R. (2013, September). Reducing no-show behavior at a community mental health center. *Journal of Community Psychology, 41*(7), 844-850. Accessed

- Calling clients to confirm their appointments the day prior to the appointment and/or sending an automated message by text or email;
- Calling clients to reschedule appointments once missed or cancelled;
- Having an after-hours message center for clients to leave messages to reschedule;
- Developing a list of clients who are able to come in for short-notice appointments;
- Educating clients about the need for regular participation in treatment in order to reach their goals;
- Emphasizing behavioral engagement strategies such as motivational interviewing or contingency management;
- Reducing wait times for initial appointments and missed appointments, typically by establishing some same day, open access appointments each day to accommodate individuals who call for an appointment or can attend an appointment on short notice;
- Streamlining admissions;
- Creating a welcoming environment through decoration changes; and
- Adding capacity so as to reduce wait times upon arrival at the counseling center or clinic.

Some clinics also found that no-shows decreased after they created, implemented, and publicized clear no-show policies, such as discharging clients if they missed several appointments in a row. However, outreach and follow up with clients, especially youth and young adults, are more positive approaches to engagement and increasing attendance in treatment. Another article suggested collaborating with referral sources to ask them to offer an incentive for attendance (or a penalty, in the case of the justice system). For youth and young adults, focusing on incentives may be more productive than emphasizing penalties.

Double booking is also a strategy that was recommended. However, as noted by Gajwani in his study at the University of Texas—Houston, "double booking fails to address non-adherence or the poor care that usually results when a patient misses regular outpatient appointments."[24] Although his study focused on individuals with serious mental illness and adherence related to medication, double-booking may also have an adverse impact on clients who likely struggle with many of the social determinants of health that cause stress in their daily lives.

May 6, 2017 at https://www.researchgate.net/publication/264684508_Reducing_no-show_behavior_at_a_community_mental_health_center.

[24] Gajwani, P. (2014, September). Can what we learned about reducing no-shows in our clinic work for you? *Current Psychiatry*, *13* (9), 13-15, page 15. Accessed on May 5, 2017 at http://www.mdedge.com/currentpsychiatry/article/86564/practice-management/can-what-we-learned-about-reducing-no-shows-our/page/0/1.

COR-4: If the CBO decides to provide Medicaid TCM, clarify the difference between allowable TCM care coordination functions and direct services. Medicaid funded TCM is a care coordination function, not a direct service. Medicaid will only pay for one TCM position that provides care coordination across a range of services. If the CBO decides to provide TCM, it will need to distinguish between TCM care coordination functions and other direct support functions that maybe provided by staff that are called case managers. Conduct a functional assessment of any current case management services to determine if the services focus on care coordination or more direct care functions such as skill building. Distinguish between the services that can be billed as TCM and those that should be billed as Mental Health Rehabilitative Services based on the Medicaid rules outlined in the Texas Medicaid Provider Procedures Manual. See Attachment E for a link to this manual.

COR-5: If the CBO provides TCM, reserve the title of case manager for those staff who provide TCM for Medicaid clients who meet the level of care requirements for TCM services. Alternatively, the CBO could add the title of "TCM Case Manager" for those staff providing Medicaid TCM.

COR-6: When billing Medicaid or other insurance, have licensed clinicians and other qualified providers focus their time on the delivery of direct services in order to maximize revenues. Rather than using clinicians to coordinate other administrative, non-clinical tasks that are not billable, use non-licensed staff to perform administrative tasks, including managing the approval process with MCOs, unless there is a need for a clinician to speak with the MCO.

COR-7: Have non-licensed staff perform all prior approval and reauthorization activities with MCOs, unless a clinician needs to speak to the MCO, or contract out that function.

Administrative Operations and Information Technology Recommendations (AOITR)

AOITR-1: Conduct an assessment of the current information technology (IT) capacity to track authorizations for services and ensure that submitted claims are compliant with HIPAA requirements. If the CBO has less than 2,000 claims per month for Medicaid and other insurance, subcontracting to a claims management vendor may be the best option. Once the claim volume exceeds 2,000 claims per month, the CBO may want to determine if purchasing an internally-managed billing system may be more cost effective.

AOITR-2: If the CBO does not have an electronic health record (EHR) for documenting behavioral health services, consider purchasing an EHR. An electronic health record that integrates service authorizations, billing, and documentation is very useful but could be expensive, although costs are decreasing.

AOITR-3: Alternatively, explore the IT systems of other partners/affiliates to identify the potential and opportunities for exchanging health information through their EHR and billing systems. CBOs may want to determine if their partners/potential partners have IT systems that the CBO could use if it has a larger volume of claims from Medicaid or other insurances, or if there is a need to move to a new billing system. Similarly, it will be critical for CBOs to assess their partners' EHR data elements to determine if they can capture, or have the capacity to capture, reporting information for insurers and grant funders.

AOITR-4: If the CBO does not have an EHR, begin the process of identifying and maintaining key elements necessary for an EHR. This process should address all the services offered by the CBO and determine the elements necessary to collect for all funders**.** Begin by identifying key data elements in current medical records and reports for funders that need to be incorporated into an EHR. Attachment I lists common data classifications for an EHR that will need to be tailored to the CBO's services.

AOITR-5: Plan for the administrative staffing needed to support billing and IT system changes. It may be necessary to hire additional administrative staff as the CBO decides whether to "make or buy" administrative services through various community partnerships or the development of a national partnership model**.** Specific staffing requirements can then be assessed based on the CBO's needs to manage a subcontractor or to actually implement new systems. The volume of claims (at least 2,000 per month) should drive the cost-benefit analysis of purchasing a new billing system or contracting for claims management.

Private Insurer Billing Recommendations (PIBR)

PIBR-1: Once the CBO achieves entity network contracting status with a Medicaid MCO, work with the MCO network manager to gain access to the MCO's commercial behavioral health provider network. The commercial plans may be willing to include the CBO in their networks, especially if the CBO's Medicaid services demonstrate effective outcomes. The CBO may also be able to negotiate contracts using APMs after gaining experience with Medicaid APMs and obtain higher rates for evidence-based practices.

Recommendations Related to National Partnership Models (NPMR)

NPMR-1: While participation in accountable care organizations (ACOs), independent practice associations (IPAs), and accountable communities for health (ACHs) [not yet established in Texas] has potential benefits for the CBO, the volume of behavioral health claims for Medicaid and other insurers may not yet be worth the cost of participating as a partner. If the CBO expands its behavioral health services, it may be worth considering affiliating with an ACO or establishing an IPA with similar organizations to realize the benefits of having an administrative organization provide electronic tools, billing services, and assistance with quality improvement.

Organizational Culture Issues Emerging from Billing Medicaid and Other Insurers

As CBOs offer Medicaid and other insurance-funded services, rather than simply relying on foundation and state grants, their staff will need to learn a different set of rules and regulations that are very exacting. Learning and complying with the rules can place a strain on individual clinicians who have operated more freely and focused primarily on serving their clients and providing best practice clinical services. Insurance rules are also different from the requirements of government grants, tending to focus on discrete services rather than global budgets. While the provider must account for the grant funds through reports, the information required from the organization is typically not as exacting as Medicaid requirements. Moving to different payment models is challenging for administrators and clinicians.

Medicaid payments are typically based on the delivery of a unit of service to an individual (or group of individuals) and, after the service is rendered, providers are paid a fee based on a unit of time basis (e.g., 15 or 30 minute units), unless the provider negotiates a value-based contract via alternative payment methodologies (APMs). Even under managed care, most MCOs make a payment for a service rendered to an individual on a unit of time basis. The payment is based on a claim submitted to the MCO or Medicaid intermediary. While some CBOs have experience with this model through state contracts where they are reimbursed for direct encounters, most state funds and grants have global budgets.

Medicaid includes intricate federal laws and regulations that must be followed or funds paid to a provider can be recouped by the state and federal governments. Texas has a State Medicaid Plan as well as waivers to the state plan approved by the Centers for Medicare and Medicaid Services (CMS) that spell out the Medicaid covered services, provider qualifications, and other rules such as documentation requirements, the frequency of treatment plan meetings, and quality requirements. Providers must understand these rules as put forth in Texas Medicaid manuals and other documents, including documentation requirements. Fraud and abuse requirements are extensive. Ignorance of the rules does not alleviate a provider from the consequences of inadvertently making an error when fraud and/or abuse is suspected.

Recommendations Related to Organizational Culture Issues Emerging from Billing Medicaid and Other Insurers (OCR)

OCR-1: Develop a communications plan for all staff and consumers about any organizational changes the CBO implements to facilitate Medicaid billing. For example, if the CBO institutes new policies related to consumers' inquiries about their insurance status, it may raise concerns from consumers and staff about the potential termination of services. To promote an understanding of changes that will be implemented by expanding billing of Medicaid and other insurance, develop a step-wise communications plan that informs all staff and consumers about

these changes. It is important to implement the plan by providing essential information at the right time to minimize fears about change as well as conveying the confidence of top management that these changes are manageable.

OCR-2: Effectively manage organizational change by developing a leadership structure that includes a leadership team, project managers, and project teams to implement the changes. It may be necessary to a hire project manager(s) to assist with the changes because most CBOs have very streamlined administrative operations. The CBO may need to hire a certified project manager (there are training programs for project management certification) or a highly organized individual with effective communication skills, generally someone with a bachelor level degree, to help implement changes to meet billing and documentation requirements. It is not necessary to hire a licensed clinician for this role. However, licensed staff may need to be part of a project team, depending on the project tasks. The project manager should report to a position high up in the chain of command to demonstrate the importance of the role and the tasks to be undertaken.

A project manager is typically responsible for scheduling meetings, maintaining notes and all project documents, setting up project plans and tracking action and time frames, and communicating progress/challenges to the project team and the executive team. The CBO may need more than one project manager and project team, depending on the tasks it undertakes based on the recommendations in this report. The project teams may change composition during different phases of implementation. Organizations may hire temporary project managers to help them through the design and implementation phases. Often, however, the project manager becomes so knowledgeable about the operations of the organization that executive leadership decides to hire this person for long-term employment.

OCR-3: As necessary changes in the organizational chart and staff functions emerge from planning, update the communications plan. Whenever possible, assure staff of the intention to expand rather than eliminate staff.

OCR-4: Develop training modules on Medicaid covered services, provider qualifications, and billing and documentation requirements. Provide this training to all clinical, supervisory, administrative, and IT staff who will have a part in delivering or reporting on these services. Identify a trainer who can offer this information in technically correct ways, but with a sense of humor and focus that emphasizes effective client care. While the Medicaid rules are intricate, many of these rules stem from the rationale of delivering best practices and care to individuals and families. The CBO may want to consider providing periodic staff training through a consulting arrangement with an employee from another provider organization or billing organization that has successfully billed Medicaid services.

Summary of Recommendations

Medicaid Billing Recommendations (MBR)
MBR-1: Learn about the various Medicaid programs and covered benefits, which have specific service definitions and staff qualifications for the delivery of services.
MBR-2: The CBO should bill Medicaid and other insurance for the covered behavioral health services it provides to individuals who are eligible for Medicaid and other insurances.
MBR-3: CBOs should develop contracts as an entity/organization with all Medicaid MCOs in the CBO's service delivery area (SDA).
MBR-4: Establish an internal credentialing committee to review the credentials of all staff that will bill Medicaid (or other insurers).
MBR-5: Decide if your CBO wants to provide Medicaid Targeted Case Management and Mental Health Rehabilitative Services for individuals who have significant mental health needs and are assessed and determined to meet a certain level of care (LOC). Refer to Attachments E and F.
MBR-6: The CBO should propose value-based contracting to the MCOs, requesting alternative payment methodologies to address the inadequacy of the current Medicaid rates for the delivery of evidence-based practices, which do not cover the CBO's costs. Refer to Attachments D and G.
MBR-7: The CBO should consider becoming a designated HHSC Community Partner, or affiliate with a Community Partner, which would then allow enrollment of eligible individuals in Medicaid at the CBO's sites, especially for youth aging out of foster care who were eligible for Medicaid at the time of their completion of foster care and often miss out on accessing Medicaid benefits through young adulthood. Refer to Attachment H.

Clinical Operations Recommendations (COR)
COR-1: When negotiating rates with MCOs and other insures, emphasize the outcomes your organization has obtained. CBOs offering a range of support services that address the social determinants of health may be able to negotiate higher rates from MCOs for behavioral health services when the CBO can track related outcomes (e.g., parent participation in school disciplinary issues, maintenance of a job or housing, fewer interactions with police, or less school disciplinary action).
COR-2: To promote sustainability, establish productivity targets for each service. See Attachment J for sample productivity targets and a methodology for developing targets.
COR-3: Develop strategies to address "no-shows" for appointments. See page 17.
COR-4: If the CBO decides to provide Medicaid TCM, clarify the difference between allowable TCM care coordination functions and direct services. Medicaid funded TCM is a care coordination function, not a direct service.
COR-5: If the CBO decides to provide Medicaid TCM, reserve the title of case manager for those staff who provide TCM for Medicaid clients who meet LOC requirements for TCM services. Alternatively, the CBO could add the title of "TCM Case Manager" for those staff providing Medicaid TCM.

Clinical Operations Recommendations (COR)
COR-6: When billing Medicaid or other insurance, have licensed clinicians and other qualified providers focus their time on the delivery of direct services in order to maximize revenues, rather than using clinical time to perform administrative, non-clinical tasks that are not billable.
COR-7: Consider having non-licensed staff perform all prior approval and reauthorization activities with the MCOs, or contract out that function to a subcontractor or billing vendor.

Administrative Operations and Information Technology Recommendations (AOITR)
AOITR-1: The CBO should conduct an assessment of its current IT capacity to track authorizations for services and ensure submitted claims are compliant with HIPAA requirements.
AOITR-2: If the CBO does not have an electronic health record (EHR) for documenting behavioral health services, it may want to consider purchasing an EHR.
AOITR-3: Alternatively, the CBO could explore the IT systems of other partners/affiliates to identify the potential and opportunities for exchanging health information through their EHR and billing systems.
AOITR-4: If the CBO does not have an EHR, begin the process of identifying and maintaining key elements necessary for an EHR for all services offered by the CBO and determine the elements necessary to collect for all funders. See Attachment I.
AOITR-5: Plan for administrative staffing needed to support billing and IT system changes. It may be necessary to hire additional administrative staff as the CBO decides whether to "make or buy" administrative services through various community partnerships or the development of a national partnership model.

Private Insurer Billing Recommendations (PIBR)
PIBR-1: Once the CBO achieves entity network contracting status with a Medicaid MCO, work with the MCO network manager to gain access to the MCO's commercial behavioral health provider network.

National Partnership Model Recommendation (NPMR)
NPMR-1: While participation in accountable care organizations (ACOs), independent practice associations (IPAs), and accountable communities for health (ACHs) [not yet established in Texas] has potential benefits for the CBO, the volume of behavioral health claims for Medicaid and other insurers may not yet be worth the cost of participating as a partner.

Organizational Culture Recommendations (OCR)
OCR-1: Develop a communications plan for all staff and consumers about any organizational changes the CBO implements to facilitate Medicaid billing. For example, if the CBO institutes new policies related to consumers' inquiries about their insurance status, it may raise concerns from consumers

Organizational Culture Recommendations (OCR)
and staff about the potential termination of services. It is important to implement the plan by providing essential information at the right time to minimize fears about change as well as conveying the confidence of top management that these changes are manageable.
OCR-2: Effectively manage organizational change by developing a leadership structure that includes a leadership team, project managers, and project teams to implement the changes.
OCR-3: As necessary changes in the organizational chart and staff functions emerge from planning, update the communications plan.
OCR-4: Develop training modules on Medicaid covered services, provider qualifications, and billing and documentation requirements.

Roadmap

The Roadmap lists all recommendations; categorizes the associated tasks as short-term (three to six months), medium-term (seven to 14 months), or long term (15 to 30 months) activities; and provides a format for documenting the assigned lead staff or team and the date of assignment.[25] (The Roadmap will be provided in a separate Word document that the CBO can use to create additional columns or transfer to project management plans and tracking sheets.) Each of these Roadmap recommendation areas (e.g., Medicaid Billing, Clinical Operations) will require more detailed project plans.

Operational Roadmap

Medicaid Billing Recommendations (MBR)	Short, Mid-Term or Long Term (ST, MT, LT)	Assigned to/Date: (for use by the CBO
MBR-1: Learn about the various Medicaid programs and covered benefits, which have specific service definitions and staff qualifications for the delivery of services.	ST	
MBR-2: The CBO should bill Medicaid and other insurance for the covered behavioral health services it provides to individuals who are eligible for Medicaid and other insurances.	ST	
MBR-2a: Identify all Medicaid eligibles.	ST	

[25] The CBO can amend these time periods to adjust to its resources. MMHPI selected medium term as seven to 14 months to accommodate the complexities of searching for IT systems and becoming knowledgeable about various Medicaid requirements.

Medicaid Billing Recommendations (MBR)	Short, Mid-Term or Long Term (ST, MT, LT)	Assigned to/Date: (for use by the CBO
MBR-2b: Determine if services provided are covered by Medicaid and if staff providing the services meet Medicaid qualifications	ST	
MBR-2c: Identify current funding for providing services to Medicaid eligible individuals; identify the impact of transitioning to Medicaid. For example, will the grant allow use of funds for other services or individuals?	ST	
MBR-2d: Institute accounting methods to allocate costs for behavioral health services to appropriate funding source, in compliance with generally accepted accounting principles (GAAP) and Medicaid requirements. For example, Medicaid does not typically pay for start-up funds or room and board outside of an inpatient psychiatric hospital or residential treatment facility. Follow the rules noted in the Texas Medicaid manuals.	MT	
MBR-3: The CBO should develop contracts as an entity/organization with all Medicaid MCOs in the CBO's SDA and set up an internal credentialing process and credentialing committee. Rationale: These steps are necessary if the CBO wants to have continuous Medicaid billing when staff leave and if the decision is made to provide TCM and Mental Health Rehabilitative Services.	ST	
MBR-3a. Identify a project manager and project team to implement entity contracting.	ST	
MBR3b: Review credentialing requirements for entities and prepare relevant materials. Refer to Attachment F.	ST	
MBR-3c: Contact each MCO in the CBO SDA and initiate the network contracting adjustments.	ST	

Medicaid Billing Recommendations (MBR)	Short, Mid-Term or Long Term (ST, MT, LT)	Assigned to/Date: (for use by the CBO
MBR-4: Establish an internal credentialing committee to review the credentials of all staff that will bill Medicaid (or other insurers). (If The CBO chooses to deliver TCM and Mental Health Rehabilitative Services, there should be a process to verify credentials of licensed and non-licensed staff.) Guidelines for credentialing committees and processes should be available from accrediting organizations or the MCOs.	MT	
MBR-5: Decide if the CBO wants to provide and bill Medicaid Mental Health Targeted Case Management and Mental Health Rehabilitative Services for individuals who have significant mental health needs and are assessed and determined to meet a certain level of care (LOC). Refer to Attachments E and F.	MT	
MBR-5a: The CBO should use its leadership team to determine pros and cons of delivering/billing for TCM and Mental Health Rehabilitative Services and the cost/benefit of training staff. If the decision is to pursue delivery of these services, appoint a project manager and team to implement them.	ST	
MBR-5b: If the decision is to pursue TCM and Mental Health Rehabilitative Services, identify clients who are eligible for Medicaid and the staff who will be providing the services; determine if staff meet Medicaid qualifications.	ST	
MBR-5C: If there are staff who meet qualifications, orient eligible clinical and administrative staff to the Medicaid billing process.	MT	
MBR-5d: Assign only one TCM to each client for the purposes of service coordination and consistency with Medicaid rules.	ST	
MBR-6: The CBO should propose value-based contracting to the MCOs, requesting APMs to address the inadequacy of the current Medicaid rates for the delivery of evidence-based practices, which do not cover the CBO's costs. Refer to Attachments D and G.	ST	

Medicaid Billing Recommendations (MBR)	Short, Mid-Term or Long Term (ST, MT, LT)	Assigned to/Date: (for use by the CBO
MBR-6a: Designate a project manager from the fiscal area and recruit clinical staff familiar with the services to be involved in the APM project team. Crosswalk current clinical protocols, services, and program costs with Medicaid service definitions, staffing requirements, and billing requirements/rates. Use the templates provided in Attachment G to identify proposal contents.	ST	
MBR-6b: The APM template should be completed and include all program costs that are covered Medicaid costs, including staff training, supervision time, and related costs as described in the template.	ST	
MBR-6c: When completing the APM template, it is important to understand Medicaid cost requirements to determine what costs to include in the APM proposed rate. For example, program costs are allowable. It may be useful to work with a community partner that has extensive Medicaid billing experience and understands Medicaid rules, or assess if current staff or a billing subcontractor can provide this expertise.	ST	
MBR-7: The CBO should consider becoming a designated HHSC Community Partner, or affiliate with a Community Partner, which would then allow enrollment of eligible individuals in Medicaid at the CBO's sites. This is especially useful for youth aging out of foster care who were eligible for Medicaid at the time of their completion of foster care and often miss out on accessing Medicaid benefits through young adulthood. Refer to Attachment H.	MT	

Medicaid Billing Recommendations (MBR)	Short, Mid-Term or Long Term (ST, MT, LT)	Assigned to/Date: (for use by the CBO
MBR-7a: The CBO will need to assess the tasks described in Attachment H as well as the operational costs of becoming a site that can enroll eligible individuals in Medicaid. Considerations include the volume of likely eligible individuals that the CBO serves and the time involved for staff and other resources to enroll them. A project manager and project team should be assigned to study the issue and determine the cost/benefit of this program.	MT	
MBR-7b: Determination of the cost/benefit to the CBO should be based on the additional revenue that may be generated by assisting clients to enroll.	MT	
MBR-7c: If the cost/benefit is negative, the CBO should consider affiliating with an existing community partner to help enroll clients.	MT	

Clinical Operations Recommendations (COR)	Short, Mid-Term or Long Term (ST, MT, LT)	Assigned to/Date: (for use by the CBO)
COR-1: When negotiating rates with MCOs and other insurers, emphasize the outcomes your organization has achieved. CBOs offering a range of support services that address the social determinants of health may be able to negotiate higher rates from MCOs for behavioral health services when the CBO can track related outcomes (e.g., parent participation in school disciplinary issues, maintenance of a job or housing, fewer interactions with police, or less school disciplinary action).	ST	
COR-2: To promote sustainability, establish productivity targets for each service. See Attachment J for sample productivity targets and a methodology for developing targets.	MT	
COR-3: Develop strategies to address "no-shows" for appointments. (See page 17)	MT	

Clinical Operations Recommendations (COR)	Short, Mid-Term or Long Term (ST, MT, LT)	Assigned to/Date: (for use by the CBO)
COR-4: If the CBO decides to offer TCM, clarify the difference between allowable TCM care coordination functions and direct services. Medicaid funded TCM is a care coordination function, not a direct service.	MT	
COR 4a: Complete a functional assessment of current case management services provided in each program. Determine if the functions focus on care coordination or more direct care functions such as support and skill building, and distinguish which services can be billed as TCM for individuals eligible for Medicaid and which services should be billed as Mental Health Rehabilitative Services.	MT	
COR-4b: Assign a project manager and team; identify key job functions by assessing if the focus is on direct service, such as skill building support services, or care coordination/service coordination, recognizing that every position has some element of care coordination (usually communicating with other providers or caregivers on behalf of the individual). Medicaid TCM does not include the provision of direct services.	MT	
COR-4c: If possible, determine positions that primarily provide direct care and those that primarily provide service coordination.	MT	
COR 4d: Consider separating out positions that are primarily care coordination from those that provide direct care. Aligning positions by those that provide care coordination and those that provide direct care increases the opportunity to bill TCM for care coordination and to bill Mental Health Rehabilitative Services for positions that provide direct services.	MT	

Clinical Operations Recommendations (COR)	Short, Mid-Term or Long Term (ST, MT, LT)	Assigned to/Date: (for use by the CBO)
COR-5: If the CBO decides to provide TCM, we suggest reserving the title of case manager for those staff who provide TCM for Medicaid clients with SMI or SED who meet LOC requirements, utilize behavioral health services, and are in need of coordination of care among the different programs. Alternatively, the CBO could add the title of "TCM Case Manager" for those staff providing Medicaid TCM.	MT	
COR-5a: Based on the exercise to differentiate care coordination from direct care functions, develop a position title for a TCM Case Manager for Medicaid clients, recognizing that Medicaid will not pay for duplicative services provided by case managers.	MT	
COR-6: When billing Medicaid or other insurance, have licensed clinicians and other qualified providers focus their time on the delivery of direct services in order to maximize revenues, rather than using clinical time to perform other administrative, non-clinical tasks that are not billable.	MT	
COR-6a: Care coordination and service planning across programs is an essential component of TCM and required by Medicaid when billing for TCM services. Appoint a project manager and team to assess confidentiality agreements and add the provision to inform clients that information relevant to assisting them with their care may be shared among clinicians, including at treatment team meetings to which the client will be invited.	MT	
COR-6b: It is a best practice to coordinate clinical care and support services. Request the client's permission to share information that will assist them in meeting their goals.	MT	
COR-7: Consider having non-licensed staff to perform all the prior approval and reauthorization activities with the MCOs, or contract out that function to a subcontractor or billing vendor.	ST	

Clinical Operations Recommendations (COR)	Short, Mid-Term or Long Term (ST, MT, LT)	Assigned to/Date: (for use by the CBO)
COR-7a: To promote efficiency, assign non-clinical staff the function of obtaining prior approval. Many MCOs now have automated processes for obtaining prior approval. If the process involves person-to-person calling, use non-licensed staff to obtain ongoing approvals and licensed staff to address MCO denials of care or if the MCO has questions for a licensed clinician.	ST	
COR-7b: Alternatively, consider if a subcontractor can perform the prior approval and reauthorization function.	ST	

Administrative Operations and Information Technology Recommendations (AOITR)	Short, Mid-Term or Long Term (ST, MT, LT)	Assigned to/Date: (for use by the CBO)
AOITR-1: The CBO should conduct an assessment of its current information technology (IT) capacity to track authorizations for services and ensure that submitted claims are compliant with HIPAA requirements.	ST	
AOITR-1a: If the CBO has less than 2,000 claims per month for Medicaid and other insurance, subcontracting to a claims management vendor may be the best option.	ST	
AOITR-1b: Once the claim volume exceeds 2,000 claims per month, the CBO may want to determine if purchasing an internally-managed billing system may be more cost effective.	MT	
AOITR-2: If the CBO does not have an electronic health record (EHR) for documenting behavioral health services, it may want to consider purchasing an EHR.	MT	
AOITR-3: Alternatively, the CBO could explore the IT systems of other partners/affiliates to identify the potential and opportunities for exchanging health information through their EHR and billing systems.	LT	

Administrative Operations and Information Technology Recommendations (AOITR)	Short, Mid-Term or Long Term (ST, MT, LT)	Assigned to/Date: (for use by the CBO)
AOITR-3a: Assess potential partners' EHR data elements to determine if they can capture, or have the capacity to capture, reporting information for insurers and grant funders.	MT	
AOITR-4: If the CBO does not have an EHR, begin the process of identifying and maintaining key elements necessary for an EHR for all services offered by the CBO and determine the elements necessary to collect for all funders.	MT	
AOITR-4a: The ideal approach would be to have one EHR for all mental health services and relevant social services. Identify a team and project manager that can begin to assess the potential for a unified EHR.	MT	
AOITR-5: Plan for administrative staffing to support the billing and IT system changes as the CBO decides whether to "make or buy" administrative services through various community partnerships or the development of a national partnership model.	MT	

Private Insurer Billing Recommendation (PIBR)	Short, Mid-Term or Long Term (ST, MT, LT)	Assigned to/Date: (for use by the CBO)
PIBR-1: Once the CBO achieves entity network contracting status with a Medicaid MCO, work with the MCO network manager to gain access to the MCO's commercial behavioral health provider network.	MT	

National Partnership Models Recommendation (NPMR)	Short, Mid-Term or Long Term (ST, MT, LT)	Assigned to/Date: (for use by the CBO)
NPMR-1: While participation in accountable care organizations (ACOs), independent practice associations (IPAs), and accountable communities for health (ACHs) [not yet established in Texas] has potential benefits for the CBO, the volume of behavioral health claims for Medicaid and other insurers may not yet be worth the cost of participating as a partner.	MT	
NPMR-1a: If the CBO decides to expand its behavioral health services and billing for Medicaid and other insurers, track the potential to affiliate with other providers either as part of an ACO or establishing an IPA that can provide a range of administrative services as well as assist with quality improvement.	LT	

Organizational Culture Recommendations (OCR)	Short, Mid-Term or Long Term (ST, MT, LT)	Assigned to/Date: (for use by the CBO)
OCR-1: Develop a communications plan for all staff and consumers about any organizational changes the CBO implements to facilitate Medicaid billing.	ST	
OCR-1a: Appoint a project manager and consider subcontracting with an external communications expert to develop a communications plan, with input from senior staff and, as needed, from the board of directors.	ST	
OCR-1b: Periodically update the communications plan to address key decisions and implementation activities.	Ongoing	
OCR-2: Effectively manage organizational change by developing a leadership structure that includes a leadership team, project managers, and project teams to implement the changes.	ST	
OCR-2a: Involve staff from various organization levels in the project teams.	ST	

Organizational Culture Recommendations (OCR)	Short, Mid-Term or Long Term (ST, MT, LT)	Assigned to/Date: (for use by the CBO)
OCR-2b: Provide guidance on the project management (PM) role and responsibilities (e.g., convene and schedule meetings; maintain meeting notes for action items; maintain all project files; develop and track project plans; and communicate successes, challenges, and delays to senior leadership). Offer orientation for PMs and communicate the PM role to all staff. Use simple software to develop standard project plans and tracking codes (such as green for on-target, yellow for some obstacles to target, and red for significant challenges or delays to target) to assist multiple PM staff with managing their projects.	ST	
OCR-2c: Senior leadership should convene all PMs monthly to provide updates and discuss cross-functional activities and issues that have an impact on the organization as a whole.	Ongoing	
OCR-3: As necessary changes in the organizational chart and staff functions emerge from planning, update the communications plan.	ST	
OCR-3a: Use regular communications to update staff about potential changes in roles and responsibilities at the macro level.	Ongoing	
OCR-3b: Senior leadership will need to inform supervisors of potential changes to enlist their help in managing staff anxiety.	Ongoing	
OCR-4: Develop training modules on Medicaid covered services, provider qualifications, and billing and documentation requirements.	ST	
OCR-4a: The PM and project teams involved with implementing TCM and Mental Health Rehabilitative Services should participate in developing the training modules.	ST	
OCR-4b: Subcontractors involved in billing or quality improvement should be included in the development of project training modules.	ST	

Attachment A: Accountable Care Organizations in Austin

Medicare:
Essential Care Partners, LLC
5900 Southwest Parkway, Building 3
Austin, Texas, 78735
http://www.essentialcarepartners.com
Jeffrey Spight
Jeffrey Spight@Universal American.com
Tel: (480)-250-1984

Integrated ACO LLC
3267 Bee Caves Road, Suite 107-511
Austin, Texas, 78746
http://www.integrated-aco.com
Omen Safavi
omen.safavi@integrated-aco.com
Tel: (512) 782-2987 ext. 154

Seton Health Alliance, Inc.
1345 Philomena Street, Suite 402
Austin, Texas, 78723
https://www.seton.net/medical-services-and-programs/seton-accountable-care-organization/
Amy Miller
Tel: 512-324-9999, Ext. 17362

Originally Medicare, but not listed on CMS Website for 2016:
SW Provider Partners, LLC
5625 Eiger Road, Suite 200;
Austin, TX 78735
http://www.swproviderpartners.com
Dr. Kevin Spencer, President
kspencer@swproviderpartners.com
512-814-1800

Attachment B: Provider Partnership Models

Health Home
Description Health Homes are provider organizations that are responsible for delivering person-centered care for the" whole person," often for individuals with chronic health conditions. The Person Centered Healthcare Home (PCHH) model described by Barbara Maier in 2010 provided guidance for providers wanting to integrate primary care and behavioral health (BH) for people with serious mental illness, including children with serious BH conditions. Known as the 4-Quadrant Model, which articulates the different needs of population subsets, this approach identified the potential for BH providers to actively participate in the health care delivery system through integrated care models. Health homes have expanded to address a broader set of community-based services, moving toward incorporation of a full range of research-based practices and community supports.
Characteristics While Congress defined the term "health home" in section 2703 of the Affordable Care Act, the medical home model provides instructive history on the evolution of the health home model. In 1967, the American Academy of Physicians (AAP) *Standards of Child Health Care* envisioned the medical home as "one central source of a child's pediatric records to resolve duplication and gaps in services that occur as a result of lack of communication and coordination." In 1992, the AAP applied the medical home term to medical care that is accessible, continuous, comprehensive, family-centered, coordinated, and compassionate; and in 2002, AAP further characterized care in a medical home as accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective. "In 2009, SAMHSA launched its Primary Care and Behavioral Health Care Integration (PBHCI) program. This program seeks to improve the physical health status of people with serious mental illnesses (SMI) by supporting community-based efforts to coordinate and integrate primary health care with mental health services in community-based BH care settings… …Many State Medicaid programs have developed medical home models and States receive Medicaid reimbursement for medical homes through a variety of authorities. Under the authority of section 1932(a) of the Act, States have implemented delivery systems beyond traditional primary care case management programs, many focusing on high-cost, high-user beneficiaries (not limited to specific diagnoses)." (Excerpts from Centers for Medicare and Medicaid, November 16, 2010, SMDL 10-24; ACA# 12)

Health Home
Participation Determinants • Must provide a service that the health home values and meets the needs of the targeted populations. • Must meet credentialing standards of payors that contract with the health home. • Can participate as a linked provider to a primary care health home as a consultant or a direct provider of care as part of a health home network or direct health home. • Usually must have some capacity to manage risk for the services offered. • Capacity to share patient information via EHR and participation in a health information exchange (HIE), if available.

Organizational Model: Accountable Care Organization
Description Initiated by Medicare, ACOs are typically health delivery systems that accept responsibility for the cost and quality of care delivered to a defined group of patients cared for by ACO clinicians. Considered integrated delivery systems with capacity to manage financial risk, ACOs are often large hospital systems or large physician practices that engage other provider participation. Their purpose is to create integrated networks of providers that coordinate care across a range of health needs (Heider, Kniffin and Rosenthal, May 2016; NASHP). Some states have initiated ACO models through various Medicaid waiver programs.
Characteristics (Torrieri, 2012) • Providers are jointly held accountable for the health of their patients. • There is shared risk. • Reimbursement is tied to performance on quality metrics. • Good information technology is necessary to share patient information and collaborate on care. • There is an emphasis on reducing unnecessary care and saving money while meeting performance requirements. • ACOs include various types of memberships, such as voting members or participating members; roles can vary depending on financial contributions, assumption of risk, and other factors determined by the participants. • The ACO can perform various functions for the member. • ACOs have expanded beyond Medicare, but to qualify as a Medicare-approved ACO, the entity must serve at least 5,000 patients, have sufficient primary care capacity (including inpatient capacity), and be able to report on cost, quality and patient experience. • It is important to note that Texas health care environment emphasizes the development of ACOs as "strong business entities able to negotiate optimal risk-sharing contracts, drive up quality, and manage appropriate utilization."
Participation Determinants (Kroch, 2012) • Legal entity? Profit or non-profit? • Is the ACO an existing collaboration with other health systems or part of a larger corporate entity?

Organizational Model: Accountable Care Organization
• Is the ACO owned fully or partially by a health plan? • Does it have existing risk-based contracts with payors? • What would be your responsibilities as a member of the ACO? • Do you need to "buy-in" to the ACO—pay membership fees? • Does the ACO have a sophisticated EHR and HIE across the continuum of care? • Is there clinical integration across the continuum of care and care coordination? • Does the ACO have experience with your target patient population? • Is there a patient-centered health home approach? • How is the patient-centered health home staffing accomplished? With employees of the ACO or community providers? • How would your organization fit with this model?

Accountable Communities for Health (aligned with a health care "neighborhood" that addresses the social determinants of health)
Description Similar to ACOs, but expanded to address community partners that address the social factors influencing health, such as housing, food, work, and community life, ACHs are a promising strategy that align state health care delivery system transformation with community-based social services to create communities that promote health and well-being (NASHP, May 2016). California, Minnesota, Washington, and Vermont have initiated ACHs. Other states are implementing integrated care models under System Innovation Models.

Accountable Communities for Health (aligned with a health care "neighborhood" that addresses the social determinants of health)

Characteristics

- ACH projects are locally planned and led.
- Communities identify a target population—people in geographic area, a patient population, or a segment of a community—with substantial health and social needs.
- ACHs bring together community partners that contribute to a person's health, such as local public health boards, behavioral health care providers, social services agencies, long-term care providers, primary care providers, and schools. ACH teams use formal business agreements to integrate services through enhanced referrals, transitions management, and implementation of new practice guidelines.
- In order to address population-specific needs, each ACH project features a unique mix of partner organizations and a focus on prevailing health and social conditions.
- A common hypothesis in starting ACHs is that payment reforms, including value-based contracting via APMs and shared funds (such as wellness funds), are essential to sustainability.

Participation Determinants

The criteria is similar to ACOs for BH providers plus the following common state criteria for ACHs.

- Is there a shared vision and goals among partners?
- Does the ACH have multi-sector partnerships?
- Is there an established governance structure or leadership?
- Are there population-based prevention activities?
- Is the ACH a backbone or integrator organization?
- Has the ACH identified community engagement activities/interventions?
- Does the ACH have the ability to perform basic financial and administrative functions?
- Has there been any sustainability planning?

"At this time, California, Minnesota, Vermont, and Washington State are all in the process of developing and implementing statewide ACH models as part of their larger health care delivery system transformation strategies. At the federal level, the Center for Medicare & Medicaid Innovation (CMMI) is administering an Accountable Health Community initiative, which funds selected communities to test the impact of identifying health-related social needs and connecting Medicaid beneficiaries to those services." In some situations, the ACH may have an ACO performing various functions (NASHP, May 2016).

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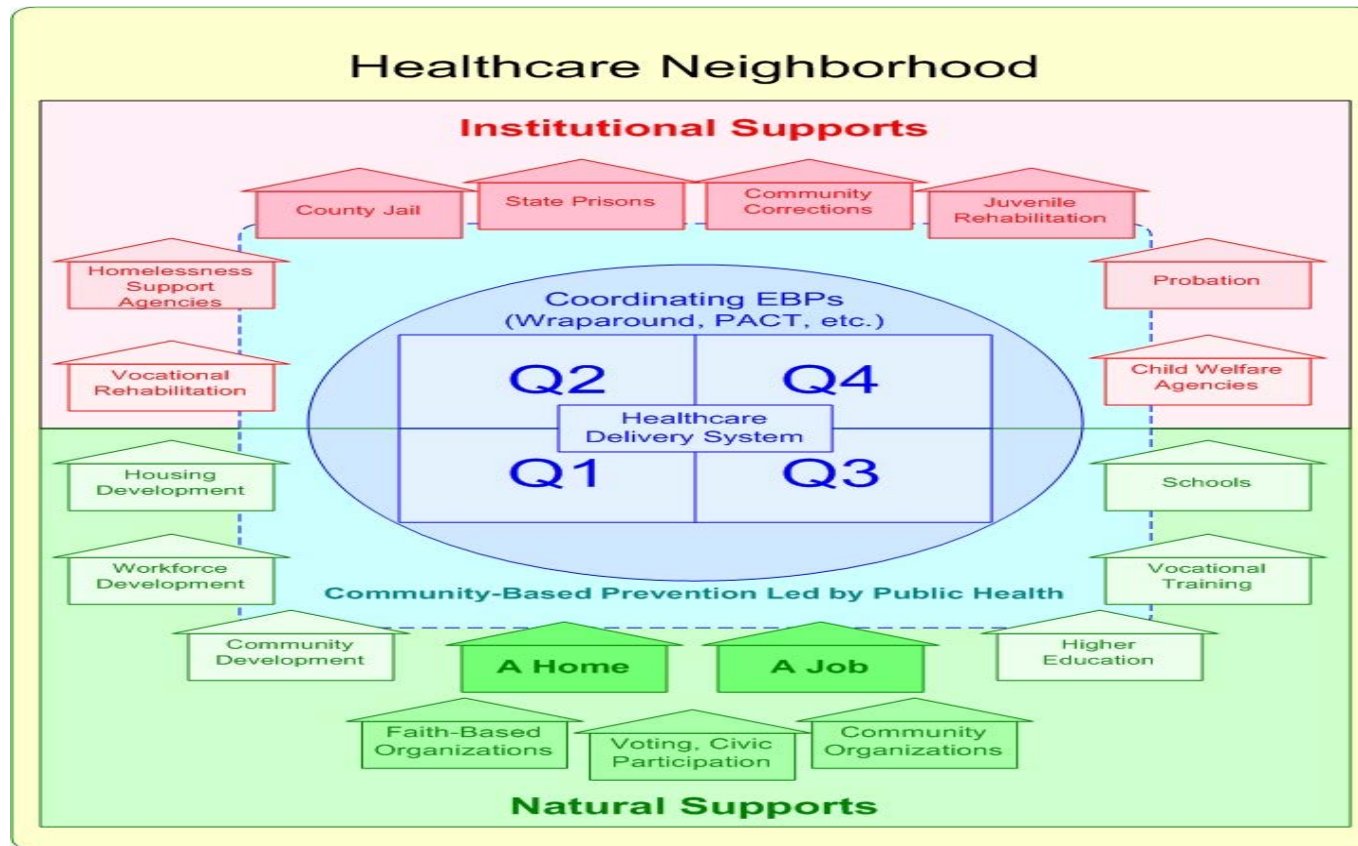
Attachment C: Progression from Primary Care Health Home to Health Neighborhood via ACO and ACH



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Attachment D: Value-Based Contracting Strategies Via Alternative Payment Methodologies

It is important to acknowledge that different providers have different operational capabilities, membership volume, and contracted services. All of these factors play an important role in the type of value-based contracting (VBC) via alternative payment methodologies (APMs) that will work for the provider. Therefore, each provider will need to identify strategies that meet their capabilities and goals. Providers should have a multi-year strategy to increase the percentage of contracts that are driven by value-based contracting. The strategies outlined in the table below discuss value-based contracting via APMs.

VBC Strategy	Brief Description	Considerations
Capitation	An actuarially sound, single per member per month payment for all services within the provider's contract.	• Provider must be able to take financial risk. • Risk corridors that reduce the provider's risk by partially offsetting high losses and sharing in large profits should be considered. • Assess negative consequences such as avoiding members with higher risk or complex conditions. • Outcome measures must be included with decision on whether performance bonuses are made out of the capitation. • Must have volume to spread risk.
Evidence-Based Practice (EBP) Certification and/or High Fidelity	A provider group is eligible to receive additional payments for delivery of EBP services that meet certification and/or fidelity.	• Provider must have required certifications for EBP, such as Multisystemic Therapy (MST) certification, and/or provider must demonstrate fidelity through external review (could be by external certification/fidelity review body or the provider after demonstrating good outcomes).
Behavioral Health (BH) Accreditation	Accreditation can be for a BH home or a BH organization.	• Requires a provider to meet national standards for quality of care. • May consider additional requirements, such as use of practice guidelines. • Can be a one-time bonus or ongoing payment enhancement.

VBC Strategy	Brief Description	Considerations
Payment for Coordination	Payments made to providers furnishing care coordination that integrates care between providers and between care systems.	• Payments may include a base for the function and a bonus for outcomes. • Evaluation criteria for effectiveness of coordination must be identified, baseline data gathered, and targets for change determined in advance. • To enhance the ability to integrate systems, the provider must have and communicate information on inpatient admissions, prescribers, and other utilization data to the coordinating provider.
Pay for Performance	Providers receive differential payments for meeting or missing performance benchmarks.	• Specified outcome measures are identified, baseline data is gathered, and performance targets are all determined in advance. • Providers receive bonus payments for meeting or exceeding targets. • Providers may face financial penalties for performance below targets. • Providers must be able to track progress in real time in order for adjustments in clinical practice to change outcomes.
Shared Savings	Providers receive a portion of savings identified from outcomes on specific performance improvement plans.	• Similar to pay for performance; however, the focus is on sharing the financial savings from a particular strategy. • Focuses on a performance improvement project (PIP) that has been identified at the regional level, with performance targets for quality and cost. • The provider must clearly understand the design and implementation for both financial and clinical outcomes. • Factors beyond the control of the provider may have an impact on the level of savings.

Attachment E: Medicaid Recipient Eligibility and Billing Codes and Modifiers for all Mental Health, Rehabilitative and Targeted Case Management Services

This document describes the Medicaid eligibility requirements for Targeted Case Management (TCM) and Mental Health Rehabilitative Services. It includes mental health billing codes for all Medicaid covered behavioral health services and payment rates per unit of time, starting with Mental Health Rehabilitative and TCM service codes.

Medicaid Recipients Eligibility Requirements

For an individual to be eligible for Texas Medicaid mental health Targeted Case Management services and Mental Health Rehabilitative Services, the individual must:

- Be a resident of the state of Texas, be an adult (age 18 and above) with a severe and persistent mental illness (SPMI); or a
- Child or youth with a serious emotional disturbance (SED) (age three to 17) who may have a diagnosis as defined in the latest edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Health Disorders (DSM);
- Not have a single diagnosis of an intellectual or developmental disability or a substance use disorder; and
- Qualify for a level of care (LOC) as determined by following the HHSC's Resilience and Recovery Utilization Management Guidelines (RRUMG) and the Adult Needs and Strengths Assessment (ANSA) or the Child and Adolescent Needs and Strengths (CANS) tools for assessing individuals' needs for services.

Mental Health Rehabilitative Services

Mental Health Rehabilitative Services are designed to reduce an individual's mental health condition and to restore an individual to their best functioning level in the community. The following Mental Health Rehabilitative Services may be provided to individuals who require rehabilitative services as determined by either the ANSA or the CANS:

- Adult Day Program
- Medication Training and Support
- Crisis Intervention
- Skills Training and Development
- Psychosocial Rehabilitative Services

Mental Health Rehabilitative Services, as well as any limitations to these services, are described in the most current Texas Medicaid Provider Procedures Manual (TMPPM) Behavioral Health, Rehabilitative, and Case Management Services Handbook. Mental health TCM must be billed using appropriate procedure codes and modifiers as listed in the TMPPM. The following charts

outline the current procedure codes and modifiers and fee-for-services (FFS) rates for Mental Health Rehabilitative Services.

Mental Health Rehabilitative Modifiers

Modifier	Description
ET	Emergency Treatment
HA	Child/Youth Program
HQ	Group Setting
TD	RN

Mental Health Rehabilitative Service Codes

Medication Training Support

Service	Procedure Code	Modifier 1	Modifier 2	Rate	Unit
Individual Services for Adults	H0034			$13.53	15 min
Group Services for Adults	H0034	HQ		$2.71	15 min
Individual Services for the Child and Youth Ages 20 and Under	H0034	HA		$13.53	15 min
Group Services for the Child and Youth Ages 20 and Under	H0034	HA	HQ	$3.38	15 min

Day Program

Service	Procedure Code	Modifier 1	Modifier 2	Rate	Unit
Adult Day Program for Acute Needs	H2012			$24.32	15 min

Crisis Intervention

Service	Procedure Code	Modifier 1	Modifier 2	Rate	Unit
Adult Services	H2011			$36.89	15 min

Service	Procedure Code	Modifier 1	Modifier 2	Rate	Unit
Child and Youth Services	H2011			$36.89	15 min

Psychosocial Rehabilitative Services Adults Only

Service	Procedure Code	Modifier 1	Modifier 2	Rate	Unit
Individual Services	H2017			$26.93	15 min
Individual Services Rendered by an RN	H2017	TD		$26.93	15 min
Group Services	H2017	HQ		$5.39	15 min
Group Services Rendered by an RN	H2017	HQ	TD	$5.39	15 min
Individual Crisis Services	H2017	ET		$26.93	15 min

Skills Training and Development

Service	Procedure Code	Modifier 1	Modifier 2	Rate	Unit
Individual Services for Adults	H2014			$25.02	15 min
Group Services for Adults	H2014	HQ		$5.00	15 min
Individual Services for Child and Youth (with or without family)	H2014	HA		$25.02	15 min
Group Services for Child and Youth	H2014	HA	HQ	$6.26	15 min

Mental Health Targeted Case Management Services

Mental health Targeted Case Management services are designed to help individual adults or children/youth and their caregivers gain and coordinate access to necessary care and services appropriate to the individual's needs. There are two types of mental health Targeted Case Management services that can be provided to individuals who qualify for a LOC: Routine Case Management and Intensive Case Management. *Routine Case Management* can be provided to both adults and children/youth as determined by the RRUMG. *Intensive Case Manage*ment can

only be provided to children/youth who qualify for LOC 4 or the YES Waiver, where wraparound planning is used to develop an individual plan of care (IPC); it must also be determined by the RRUMG.

Mental health Targeted Case Management services, as well as any limitations to these services, are described in the most current Texas Medicaid Provider Procedures Manual (TMPPM), including the Behavioral Health, Rehabilitative, and Case Management Services Handbook. Mental health Targeted Case Management must be billed using appropriate procedure codes and modifiers as listed in the TMPPM, with the following exception: The MCO is not responsible for providing criminal justice agency-funded procedure codes with modifier HZ because these services are excluded from the capitation. The following charts outline the current procedure codes and modifiers and fee-for-services (FFS) rates for mental health Targeted Case Management services.

Targeted Case Management Codes

Service	Procedure Code	Modifier 1	Limitations	Rate	Unit
Routine Mental Health Targeted Case Management (adult)	T1017	TF	32 units (8 hours) per calendar day for clients who are 18 years of age and older	$19.83	15 min
Routine Targeted Case Management (child and youth age 20 and under)	T1017	TF, HA	32 units (8 hours) per calendar day for clients who are 17 years of age or younger	$24.07	15 min
Intensive Targeted Case Management (child and youth age 20 and under) Using Wraparound Planning	T1017	TG, HA	32 units (8 hours) per calendar day for clients who are 17 years of age or younger	$31.69	15 min

All Other Medicaid Mental Health Services

Some CBOs may be currently billing for the Mental Health Medicaid covered services listed in the following tables. These tables outline the types of services and the current billing codes and fee-for-service rates.

Non-Facility Psychotherapy/Counseling Conducted by LCSWs, LMFTs or LPCs

Service	Procedure Code	Modifier	Limitations	Rate
Diagnostic Evaluation Ages 0-20	90791	**U8	*	$119.82
Diagnostic Evaluation Ages 21-Up	90791	**U8	*	$113.91
Individual Psychotherapy/Counseling Ages 0-20	90832	**U8	*	$49.39
Individual Psychotherapy/Counseling Ages 21-Up	90832	**U8	*	$44.66
Psychotherapy/Counseling Ages 0-20	90834	**U8	*	$68.49
Psychotherapy/Counseling Ages 21-Up	90834	**U8	*	$65.08
Psychotherapy/Counseling Ages 0-20	90837	**U8	*	$100.78
Psychotherapy/Counseling Ages 21-Up	90837	**U8	*	$95.93
Family Psychotherapy/Counseling Ages 0-20	90847	**U8	*	$72.97
Family Psychotherapy/Counseling Ages 21-Up	90847	**U8	*	$69.50
Group Psychotherapy/Counseling Ages 0-20	90853	**U8	*	$24.70
Group Psychotherapy/Counseling Ages 21-Up	90853	**U8	*	$23.52

* Rates for LCSWs, LMFTs, and LPCs equal 70 percent of the rate paid to a psychiatrist or psychologist for a similar service.
** LMFTs must use U8 modifier.

Non-Facility Psychotherapy/Counseling Conducted by Physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist

Service	Procedure Code	Modifier	Limitations	Rate
Diagnostic Evaluation Ages 0-20	90791		*	$110.23
Diagnostic Evaluation Ages 21-Up	90791		*	$104.80
Individual Psychotherapy/Counseling Ages 0-20	90832		*	$45.44
Individual Psychotherapy/Counseling Ages 21-Up	90832		*	$41.99
Psychotherapy/Counseling Ages 0-20	90834		*	$63.01
Psychotherapy/Counseling Ages 21-Up	90834		*	$59.87
Psychotherapy/Counseling Ages 0-20	90837		*	$92.72
Psychotherapy/Counseling Ages 21-Up	90837		*	$88.26
Family Psychotherapy/Counseling Ages 0-20	90847		*	$67.13
Family Psychotherapy/Counseling Ages 21-Up	90847		*	$63.94
Group Psychotherapy/Counseling Ages 0-20	90853		*	$22.72
Group Psychotherapy/Counseling Ages 21-Up	90853		*	$21.64

* Rates for physician assistants, nurse practitioners, or clinical nurse specialists equal 70 percent of the rate paid to a psychiatrist or psychologist for a similar service.

Non-Facility Psychotherapy Conducted by Physician Clinic Group Practice, Physician D.O, Physician M.D, or Physician Group D.O.

Service	Procedure Code	Modifier	Limitations	Rate
Diagnostic Evaluation Ages 0-20	90791			$119.82
Diagnostic Evaluation Ages 21-Up	90791			$113.91
Psychiatric Evaluation MD Ages 0-20	90792			$119.82
Psychiatric Evaluation MD Ages 21-Up	90792			$113.91
Individual Psychotherapy Ages 0-20	90832			$49.39
Individual Psychotherapy Ages 21-Up	90832			$44.66
Psychotherapy MD Ages 0-20	90833			$18.68
Psychotherapy MD Ages 21-Up	90833			$19.29
Psychotherapy Ages 0-20	90834			$68.49
Psychotherapy Ages 21-Up	90834			$65.08
Psychotherapy Ages 0-20	90837			$100.78
Psychotherapy Ages 21-Up	90837			$95.93
Family Psychotherapy Ages 0-20	90847			$72.97
Family Psychotherapy Ages 21-Up	90847			$69.50
Group Psychotherapy Ages 0-20	90853			$24.70
Group Psychotherapy Ages 21-Up	90853			$23.52
Office Visit	99212			$24.54

Service	Procedure Code	Modifier	Limitations	Rate
Med Check 15 Minute	99213			$36.89
Med Check 25 minute	99214			$51.80
Med Check 40 minute	99215			$79.75

Non-Facility Psychotherapy Conducted by Psychologist or Psychologist Group

Service	Procedure Code	Modifier	Limitations	Rate
Diagnostic Evaluation Ages 0-20	90791			$119.82
Diagnostic Evaluation Ages 21-Up	90791			$113.91
Individual Psychotherapy Ages 0-20	90832			$49.39
Individual Psychotherapy Ages 21-Up	90832			$44.66
Psychotherapy Ages 0-20	90834			$68.49
Psychotherapy Ages 21-Up	90834			$65.08
Psychotherapy Ages 0-20	90837			$100.78
Psychotherapy Ages 21-Up	90837			$95.93
Family Psychotherapy Ages 0-20	90847			$72.97
Family Psychotherapy Ages 21-Up	90847			$69.50
Group Psychotherapy Ages 0-20	90853			$24.70
Group Psychotherapy Ages 21-Up	90853			$23.52

Procedure Codes Not Currently Billed by the CBO for SPS Program Only

Service	Procedure Code	Modifier	Limitations	Rate
Add-on code for individual psychotherapy when performed with an evaluation and management service—45 minutes Ages 0-20	90836			$41.77
Add-on code for individual psychotherapy when performed with an evaluation and management service—45 minutes Ages 21-Up	90836			$40.01
Add-on code for individual psychotherapy when performed with an evaluation and management service—60 minutes Ages 0-20	90838			$72.43
Add-on code for individual psychotherapy when performed with an evaluation and management service—60 minutes Ages 21-Up	90838			$70.27

Attachment F: Enrolling as a Medicaid Provider and Becoming a Credentialed MCO Provider for the Delivery of Rehabilitative and TCM Services

This attachment provides information on how provider organizations enroll with Medicaid and become credentialed MCO providers for the delivery of rehabilitative and TCM services. It also includes the state's provider requirements for provider entities that deliver these services.

Once The CBO has decided it intends to provide rehabilitative and TCM services, it will need to contact the MCOs that cover the Austin-Travis SDA to become credentialed as a **provider entity** and negotiate a contract and rates. Contact information for the MCOs can be found at the following links:

- **STAR** is a Medicaid managed care program for low income women and children who receive Temporary Assistance for Needy Families (TANF) and/or for pregnant women and newborns with limited income. The program also covers young adults from ages 21 to 26 years who are eligible for Medicaid for Former Foster Care Children (FFCC). https://hhs.texas.gov/sites/hhs/files//documents/services/health/medicaid-chip/programs/star/providerinformation.pdf
- **STAR+PLUS** is a Medicaid managed care program for adults with Supplemental Security Income (SSI) or disabilities, or are 65 or older, and for adults who are eligible for STAR+PLUS Home and Community Based Services (HCBS) Waiver services. https://hhs.texas.gov/services/health/provider-information/expansion-managed-care/starplus-expansion
- **STAR Health** is a Medicaid managed care program for children under the age of 18 years who are in Texas Department of Family and Protective Services (DFPS) conservatorship, young adults in DFPS extended foster care, and young adults who were previously under DFPS conservatorship and have returned to foster care through voluntary foster care agreements (ages 18 to 20). Superior Health Plan is the only MCO to offer STAR Health and covers children and youth in foster care statewide. http://www.dfps.state.tx.us/Child_Protection/Medical_Services/guide-star.asp#what
- **STAR Kids** is a Medicaid managed care program for youth under the age of 21 who have SSI or disabilities, or who are eligible for Medically Dependent Children Program (MDCP) Home and Community-Based Services (HCBS) Waiver services or Youth Empowerment Services (YES) Waiver services; live in a community-based intermediate care facility (ICF) or a nursing facility for individuals with an intellectual or developmental disability (IDD) or related condition; receive services through a Medicaid buy-in program; or receive services through Department of Aging and Disability Services (DADS) intellectual and developmental disability (IDD) waiver programs, such as Community Living Assistance

and Support Services (CLASS), Deaf Blind with Disabilities (DBMD), Home and Community-Based Services (HCBS), and Texas Home Living (TXHmL). https://hhs.texas.gov/services/health/star-kids/star-kids-managed-care-organizations-mcos-provider-relations-contacts

Enrolling as a Texas Medicaid Provider in Texas

The first step in becoming a Texas Medicaid Managed Care provider of Mental Health Rehabilitative Services and TCM is enrolling as a Medicaid provider in Texas. HHSC contracts with the Texas Medicaid Healthcare Partnership (TMHP) to enroll providers in the Texas Medicaid program. TMHP has representatives throughout Texas to assist providers with education and training on the TMHP Texas Medicaid provider enrollment requirements and application process. Providers must contact TMHP to first complete enrollment. To access information about the TMHP Texas Medicaid provider enrollment process, contact the TMHP Contact Center at 1-800-925-9126. The Texas Medicaid Provider Enrollment Application, which includes additional instructions and information, can be found at the following link: http://www.tmhp.com/provider_forms/provider%20enrollment/texas%20medicaid%20provider%20enrollment%20application.pdf

Additional information about the medical policy, including billing codes for Mental Health Rehabilitative and Targeted Case Management services, can be found in the TMHP Provider Manual for Behavioral Health at the following link: http://www.tmhp.com/TMPPM/TMPPM_Living_Manual_Current/2_Behavioral_Health.pdf

Provider Requirements

Provider entities (exclusive of independent licensed practitioners) that offer TCM and Mental Health Rehabilitative Services are required to use the HHSC Recovery and Resiliency Utilization Management Guidelines (RRUMG) available at https://hhs.texas.gov/sites/hhs/files/documents/laws-regulations/handbooks/umcm/15-1.pdf

and must be trained and certified to administer either the Adult Needs and Strengths Assessment (ANSA) or the Child and Adolescent Needs and Strengths (CANS) assessment tools, or both, depending on whether the provider wants to serve adults or children and youth, or both populations. After completing an assessment, the provider must recommend a level of care (LOC) to the MCO by using the DSHS Clinical Management for Behavioral Health Services (CMBHS) web-based system. Please note that use of the CMBHS system is required. Providers must also complete a user agreement to access the HHSC CMBHS system by contacting HHSC at cmbhs@dshs.state.tx.us.

The HHSC Medicaid Managed Care Manual has specific chapters on TCM and Mental Health Rehabilitative Services. The manual also provides information on the RRUMG for adult mental

health services and child and youth mental health services. These utilization guidelines are linked to LOC determined by the assessments completed for each individual using either the ANSA or the CANS, depending on the individual's age. The manual chapters below provide information on the required provider qualifications and training.

- HHSC UNIFORM MANAGED CARE MANUAL 15.1 3 OF 7 CHAPTER TITLE EFFECTIVE DATE Mental Health Targeted Case Management and Mental Health Rehabilitative Services https://hhs.texas.gov/sites/hhs/files/documents/laws-regulations/handbooks/umcm/15-1.pdf
- Mental Health Targeted Case Management and Mental Health Rehabilitative Services Training Requirements https://hhs.texas.gov/sites/hhs/files/documents/laws-regulations/handbooks/umcm/15-3.pdf
- Mental Health Targeted Case Management and Mental Health Rehabilitative Services Request Instructions https://hhs.texas.gov/sites/hhs/files/documents/laws-regulations/handbooks/umcm/15-4.pdf
- Targeted Case Management and Rehabilitative Services Request Form https://hhs.texas.gov/sites/hhs/files/documents/laws-regulations/handbooks/umcm/15-2.doc

Attachment G: Alternative Payment Methodologies—Blank Sample

Authorities: 42 CFR 438.6(e) and State Managed Care Organization (MCO) Value-Based Contracting (VBC) Requirements

1. Service Name and Description

Describe service. Include any definitions from the literature, for example, evidence-based practice (EBP) definitions, such as Parent-Child Interaction Therapy (PCIT), Supported Employment, Supportive Housing, Wraparound Planning and citations.

2. Key Components

Describe characteristics and components of the service, e.g., use of two therapists, team approach, intensity of services, location of services (home-based, community, office-based). Reference any research about requirements of the service components.

References: (Add references for evidence-based standards and requirements.)

3. Information About Population to be Served

Population	Age Ranges	Projected Numbers	Characteristics
List population such as children with serious emotional disturbance, homeless youth with substance use conditions, youth who have dropped out of school and require support to engage in education or work; include diagnostic categories if possible			Characteristics of the individuals the service is intended to service.

4. Expected Outcomes

Describe outcomes such as increase in school days, harm reduction activities, family reunification, or achievement of educational goals, etc.

Goals (see samples below):

- Provide services and supports that lessen or eliminate the symptoms of mental illness and support:

- Daily school attendance
- Successfully living with family

- Promote recovery principles, dignity, hope, and well-being
- Teach community living skills and help youth to reach a variety of personal goals, such as employment, educational attainment, and having fulfilling social relationships
- Help youth to establish economic self-sufficiency and housing stability

Research Demonstrating the Success of the Service

Summarize research on effectiveness, including any SAMHSA EBP Toolkit research information, or other information on EBPs, and discuss and list the references that address the efficacy of the services.

References: (Add references for evidence-based standards and requirements.)

5. Staffing Qualifications, Credentialing Process, and Levels of Supervision (Administrative and Clinical) Required:

Include the standards (especially those cited in the literature) for staff-to-client ratios, qualifications, credentialing, and levels of supervision. For example, utilize typical staffing requirements for the practice as described in the literature (e.g., PCIT, Supported Education, and Supportive Housing). Cite and list references, including any state requirements.

Staff	Qualifications

References: (Add references for evidence-based standards and requirements.)

6. Unit of Service and Procedure Code

Identify the unit of service and the current procedure code for the service.

7. Anticipated Units of Service per Person

Describe the average units of service per person per week/month and provide a reference if the practice has standards for utilization.

References: (Add references for evidence-based standards and requirements.)

8. Targeted Length of Service

Indicate the targeted length of the service. For example, Multisystemic Therapy (MST) has a targeted length of service that is discussed in the literature. Include a brief discussion of the literature and list references. If there is no literature on the targeted length of service, or there are not specific limits, discuss your organization's experience. If transition from the service takes time depending on the youth (e.g., those with co-occurring mental health and substance use conditions), briefly describe the differences in transition time for different populations.

References: (Add references for evidence-based standards and requirements.)

9. Describe why this service is needed and is different than any state plan or alternative service already defined. If implemented in other states, describe successful outcomes.

Briefly summarize how the research supports the service and list references.

Description of comparable state plan Service Payment Arrangements ("Cost of Service" examples given below should be updated based on available data form Texas and demonstrate that the EBP or proposed services are cost effective compared to more restrictive services):

Service	Procedure Code	Unit Definition	Units of Service	Cost of Service[1]	Cost per person per stay
Residential Placement	H2013	Per diem	90 days assumed	$350.23 per diem $410.50 per diem	$31,520.70 $36,945
State Hospital[2]		Per diem	256 days	$945 per diem	$241,920
Acute Care Hospital[3]		Per diem	9.4 days	$1000 per day	$9400

Service	Procedure Code	Unit Definition	Units of Service	Cost of Service[1]	Cost per person per stay
PRTFs—Psychiatric Residential Treatment Facilities [4]		Per diem	127 days	$500 (50 days or >) – $570 (49 days or less)	$63,500
Day Treatment[5]		Per diem	109.9 days	Day Treatment – $290 (50 or more days), $351 (49 days or less)	$31,871

[1]Texas Medicaid Fee for Service rate.
[2]United States Department of Justice. (2014, January 2). *Integration of community mental health and compliance with Title II of the Americans with Disabilities Act*. Interim Report to the State of State.
[3]Program Analysis and Evaluation Team. (2008, November). *Children's mental health utilization report, April 1, 2007 through March 31, 2008*. State Department of Human Services, Addictions and Mental Health Division, p. 17.
[4]Program Analysis and Evaluation Team. (2008, November). *Children's mental health utilization report, April 1, 2007 through March 31, 2008*. State Department of Human Services, Addictions and Mental Health Division, p. 15.
[5]Program Analysis and Evaluation Team. (2008, November). *Children's mental health utilization report, April 1*.

Description of Alternative Service Payment Arrangements (include type, amount, frequency, etc.):

Service	Procedure Code	Unit Definition	Units of Service	Cost Per Unit	Cost per person
Name	Texas codes	15 minutes, hour, day, month, etc.	# of units	Cost per unit	Cost of service by length of treatment (based on standard length of treatment)

The cost of the services must be calculated by the provider and should include all allowable program and administrative costs.

Description of Process for Reporting Encounter Data (include record type, codes to be used, etc.):
Sample: Each provider will encounter a monthly alternative case rate for this service on a CMS 1500. (Actual process must address Texas Medicaid and Managed Care Organization requirements.)

Description of Monitoring Activities:
Describe how you will monitor fidelity to the program standards. If there are national or standard fidelity guideline for the practice, identify the guidelines that will be used, discuss the frequency of the fidelity review, and provide the reference.

References: (Add references for evidence-based standards and requirements.)

Appendix
The appendix can include any additional information that would clarify issues in the main part of the rationale.

Attachment H: Texas Health and Human Services Commission (HHSC) Community Partners Program for Managing Access to Texas Benefits.

As of January 1, 2014, young adults are eligible to receive Medicaid through age 25 if they were receiving Medicaid when they aged out of foster care.[26] A critical component of sustaining current programs and services is to ensure that eligible The CBO clients who aged out foster care are enrolled in Medicaid. The CBO can help individuals apply for and maintain Medicaid benefits by becoming a Community Partner or setting up a formal referral system with an existing Community Partner.

The Texas Health and Human Services Commission (HHSC) partners with a statewide network of community-based organizations through the Community Partner Program. Organizations that become Community Partners help individuals apply for and manage their HHSC benefits through YourTexasBenefits.com. There is no fee to become a Community Partner; however, organizations may incur operational costs. Organizations who wish to become Community Partners must have a computer with internet access and the most recent version of Adobe Flash installed.

Organizations must also:

- Be based and operate in Texas,
- Have a mission/purpose that is consistent with that of the Community Partner Program,
- Not be included in a series of regulatory lists (maintained by the Office of the Inspector General, HHSC, etc.),
- Demonstrate an established community presence by being listed as a resource on 2-1-1 Texas ***or*** provide HHSC two letters of support upon request, and
- Be in good standing in their community.

Enrolling as a Community Partner

Community Partners provide individuals access to a computer so that they can apply and manage their HHSC benefits at YourTexasBenefits.com. Furthermore, certified Community Partner staff or volunteers can offer support in using the website and provide information about HHSC programs available in Texas.

To enroll as a Community Partner, organizations must complete the following primary steps:

1. Submit an online Interest Form using this website.
2. Select their level of participation (Self Service Site or Assistance Site).

[26] Texas Department of Family and Protective Services. (n.d.). *Medicaid for former foster youth and STAR and STAR health services*. Retrieved from https://www.dfps.state.tx.us/Child_Protection/Youth_and_Young_Adults/Transitional_Living/medical_benefits.asp.

3. Sign a non-financial Memorandum of Understanding (MOU) with HHSC.
4. Make sure staff and volunteers take the HHSC web-based training and get certified to help the people they serve learn how to use YourTexasBenefits.com.

Step 1: Submitting an Interest Form

Organizations interested in becoming a Community Partner must first submit an Interest Form online. This form provides key information to HHSC and helps identify which Community Partner level is best suited for that organization through a series of questions. The Interest Form can be found at the following link: https://www.texascommunitypartnerprogram.com/TX.CPP/UI/cppInterestForm.aspx. The list of questions included in the Interest Form can also be found in Appendix A.

If organizations have a question regarding the Interest Form or the application process, organizations can send an e-mail to the Community Partner Support Team at OCA_Community_Partners@hhsc.state.tx.us. The support team helps potential, new, and existing Community Partners:

- Fill out an Interest Form to become a Community Partner;
- Complete the enrollment process;
- Select a partnership level;
- Choose a site manager;
- Certify staff and volunteers;
- Use YourTexasBenefits.com, State Portal, or TexasCommunityPartnerProgram.com;
- Understand CPP policies and procedures;
- Receive other types of technical assistance and support.

Step 2: Selecting Level of Participation

Organizations may participate in the Community Partner Program on two levels: as a Self-Service Site or Assistance Site (or both). Self-Service Sites and Assistance Sites must provide a computer with internet connection for clients to access YourTexasBenefits.com and receive and display information about HHSC benefit programs and YourTexasBenefits.com. Assistance Sites must also have staff or volunteers take the HHSC web-based training and have at least one staff become certified to help people apply for benefits and manage their cases online.

Step 3: Signing a Non-financial MOU

HHSC will e-mail a copy of an enrollment pack to each organization accepted as a participant in the Community Partner Program. The enrollment packet will include a non-financial Memorandum of Understanding (MOU) with HHSC to participate in the Community Partner Program that must be signed by a representative of the organization. HHSC's Community

Partner Program provides the following sample MOU on their website as a reference:
https://www.texascommunitypartnerprogram.com/TX.CPP/Pdf/CPP%20MOU%20Sample.pdf.

The enrollment packet will include:

- MOU-The person that will sign the MOU for the organization must read, print, and sign the MOU.
- Community Partner Information and Contact Form — the organization must complete this form to provide information to HHSC about their web-listing preferences.
- Vendor Information Form — the organization must complete this form to allow HHSC to process their MOU.
- Security and Privacy Agreement (SPA) — the site manager of the organization must complete the SPA to request the initial YourTexasBenefits.com login accounts for their organization. See the section of this guide titled "Manage Login Access to YourTexasBenefits.com" for more information on these login accounts.

All documents must be returned to HHSC as one packet within 10 business days of receipt.

Step 4: Training and Certification
After an organization is approved to be a Community Partner, HHSC provides online training and certification to staff and volunteers who will be providing one-on-one assistance with YourTexasBenefits.com.

HHSC provides the following training and resources to all Community Partners:

- Online training in using YourTexasBenefits.com,
- Program and technical support,
- Statistical reports on the Community Partner services they provide clients, and
- Free materials promoting state benefits and features of YourTexasBenefits.com.

The Community Partner Training lessons can be viewed by anyone who wants to learn more about how to help individuals use YourTexasBenefits.com. The lessons can be found at the bottom of the Community Partner Program "Links" tab:
https://www.texascommunitypartnerprogram.com/TX.CPP/UI/RelatedLinks.aspx.

Community Partners participating as Assistance Sites must certify at least one staff member in order to maintain their status as an Assistance Site. All staff and volunteers at Community Partner Assistance Sites do not need to be certified. However, those staff or volunteers at a Community Partner Program site who are not certified cannot represent themselves as certified Community Partner Program staff or volunteers to their clients or to the general public.

Staff and volunteers may be certified as a Your Texas Benefits Navigator or Community Partner Site Manager. A Your Texas Benefits Navigator is certified by HHSC to assist with application enrollment and management of benefits. A Community Partner Site Manager supervises certified Your Texas Benefits Navigators. To become certified as either, staff and volunteers must submit a criminal background check and provide self-attestation that they are a U.S. citizen or otherwise legally employable in the United States. HHSC pays for and performs a criminal background check through the Texas Department of Public Safety. Staff and employees who wish to be certified must also complete the following steps:

- Create a Your Texas Benefits Navigator login account on this website.
- Complete a series of online training modules (approximately 3.5 hours).
- Submit a registration request to their Community Partner site(s).
- Have their request(s) approved by the site manager(s) of those site(s).

***Please Note:** If a site manager is also serving as a Navigator at their Community Partner site, the individual will use the site manager account created by the Community Partner Program to complete these steps. Site managers also serving as Navigators will approve their own registration request.

Partnering with an Existing Community Partner

Organizations can also refer clients to existing Community Partners for assistance in enrolling for and managing their benefits. Individuals can search for existing Community Partners by zip code, city, and/or county on the Texas Community Partner Program website: https://www.texascommunitypartnerprogram.com/TX.CPP/UI/SearchCP/SearchCP.aspx?city=&county=227&zip. To ensure that an organization's clients are adequately served by an existing Community Partner, MMHPI recommends establishing a formal partnership with a Community Partner to establish a referral system.

Self-Service at YourTexasBenefits.com

Although Community Partners provide a computer for applicants or clients who may not have access to one, anyone can create an account, apply for HHSC benefits, and manage their case using YourTexasBenefits.com. To apply for benefits, an individual should visit YourTexasBenefits.com, click on the "Apply for benefits" box, set up an account, fill out the form, and send the form to HHSC by clicking a button at the end of the form. Individuals applying should be ready to answer questions such as:[27]

- Social Security number and birth date,
- Citizenship or immigration status,

[27] Texas Health and Human Services Commission. (n.d.). *Learn how your Texas benefits can help you*. Retrieved from https://www.yourtexasbenefits.com/Learn/Home.

- Money from jobs and other sources,
- The value of cars and other property, and
- Costs of bills they pay.

Individuals may also download the Your Texas Benefits app to manage their application. Through the Your Texas Benefits mobile app, individuals can use their cell phones to send paycheck stubs and other documents to HHSC when applying for benefits. The mobile app instructs clients on how to take pictures of documents needed for the application, such as paycheck stubs and Social Security cards, and then upload them securely.

Attachment I: Electronic Health Records

The CBO does not currently support an electronic health record (EHR), but has begun the analysis for collecting the data necessary to support one. This report includes additional information that can be helpful as The CBO begins the discovery process. While standards for health care transactions are part of the Health Information Portability and Accountability Act (HIPAA), requirements for EHRs have not yet been provided. The Centers for Medicare & Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC) have established standards and other criteria for structured data that EHRs must meet in order to qualify for use in the Medicare and Medicaid EHR Incentive Programs. It is recommended that The CBO implement a solution that meets the CMS standards (see CMS website—https://www.healthit.gov/—for additional information).

A fully functioning EHR includes clinical, operational and financial information accessible across all venues in real time, creating a more efficient care delivery process. EHRs typically include functionality for items such as the clinician's homepage, doctor homepage, and the assessment and treatment planning components. A list of potential functional areas and associated requirement examples are provided in the attached document (*insert Excel requirements document reference*).

Following is a list of potential BH EHR vendors:

Example list of some BH/MH EHR Vendors

Name	Link	Short Description (from vendor or website)
Netsmart myAvatar Suite	http://www.ntst.com/Communities-We-Serve/behavioral_health.aspx	myAvatar Suite from Netsmart can be used in both outpatient and inpatient settings, including substance abuse, psychiatric hospitals, community mental health centers, methadone clinics, state mental health systems, and others.
Centricity	http://www3.gehealthcare.com/en/Products/Categories/Healthcare_IT/Electronic_Medical_Records/Centricity_EMR	GE Centricity is an integrated EHR and practice management system ideal for larger mental health providers. The system is also ONC-ATBC and CCHIT certified.
NextGen	https://www.nextgen.com/Specialties/Behavioral-Health-EHR	Behavioral healthcare is in flux. With new reform regulations, behavioral health (BH) providers are under immense pressure. Our simple, smart, scalable, and integrated technology can help ease those pressures as well as day-to-day challenges. Our robust EHR, BH knowledge base, intuitive content, and workflow tools can help streamline data access, ease reporting, and improve care.
Qualifacts CareLogic Enterprise	http://www.qualifacts.com/	CareLogic Enterprise by Qualifacts Systems is specifically for behavioral healthcare organizations. It's a web-based system with electronic health records, billing, and scheduling in a single, integrated suite. ONC-ATCB certified.
ADP AdvancedMD EHR and Practice Management Software	http://www.advancedmd.com/ehr-software	AdvancedMD is an ONC-ATCB and CCHIT certified medical practice management system. It can be used in psychology and therapy offices. It is a feature-rich system with e-Prescribing, tablet support, voice recognition, and more.
Epitomax EHR/PM by PsyTech Solutions	http://www.psytechsolutions.net/	Launched in 2001, an ONC-ATCB certified platform for EMR, scheduling, billing, eMAR, and patient portal. A wide range of behavioral health services common to inpatient & outpatient environments is supported. ICD-10 Ready.

Name	Link	Short Description (from vendor or website)
SmartCare by Streamline	http://www.streamlinehealthcare.com/about-streamline-healthcare/	SmartCare by Streamline Healthcare Solutions is a browser-based, comprehensive EHR and practice management solution created specifically for behavioral healthcare organizations and substance abuse agencies.
Vālant Behavioral Heath EHR	http://www.valant.com/	Vālant is an EMR, billing, and scheduling system for psychiatrists. It can also be used by psychologists, therapists, and other mental health professionals. Web-based and priced at an affordable monthly rate. ONC-ATCB certified.
eClinicalWorks	http://www.eclinicalworks.com/products-overview.htm	eClinicalWorks is a fully unified solution for practices and enterprise groups of all sizes and most specialties, linking all features via a single database. All products were developed by one company and will function as one powerful system. Our company will work with you to take advantage of the various quality initiatives available including Meaningful Use, Patient-Centered Medical Homes, and Accountable Care Organization (ACO).

Electronic health record characteristics include:

- Secure Login
- Client Search
- Clinician Signature
- Scheduling - by client including program, service type, location, scheduled time, duration, date
- Scheduling a resource (room, clinician, staff)
- Scheduling a service - billable
- Scheduling a service - non-billable
- Completing a service (start and end times, diagnosis, follow up instructions)
- Deleting a scheduled service
- Modifying a service
- Mobile capabilities (in the field) to allow viewing schedule, completing service in the field,
- Progress Notes (editing, viewing, modifying)
- Incomplete Services (no-shows) reporting and follow up
- Instant Messaging (between staff, providers)
- iPAD (or similar) capabilities
- Outcome tracking

The following are several additional considerations:

- Customized quality reports
- Implementation and future support (communication efficiency and experience with product and company
- Existing data migration strategy
- Sufficient infrastructure and architecture to accommodate growth and high availability performance.
- Ability to integrate with other products (e.g., practice management software, billing systems, PACS, Lab, and public health interfaces
- Privacy and security capabilities and back-up planning
- Appropriate access controls
- Audit logs generated and maintained
- Conduct a workflow analysis to determine how a particular system will impact how tasks will change
- Data sharing with partners

Sample Subject Areas for Requirements
Case Management Functions (Management of Contract Services, etc.)
A1 Eligibility Determination
Intake Process - Pre-screening/Initial Contact Process
Expanded Demographic Data
Clinical Data
Agency Eligibility Application Process
Waiver Eligibility and Determination Process
Communication/Letters
A2 Clinical Assessment, Needs Determination and Level of Care
Clinical Assessment
A3 Case Managers/Eligibility Teams User Interface
Clinical Dashboard - configurable
A4 Enrollment
Prioritization of services
Enrollment in program/services (Benefit Package)
Case Status
Management of transfer - site to site, area to area, region to region, facility to facility
Length of Stay calculation
A5 Wait List Management/Prioritization Process
A6 Prior Authorization/Pre-Certification/Referrals
A7 Service Capture/Targeted Case
A8 Disenrollment Process From Agency Services
Management
Tracking
A9 Records Management
Document Management and Scanning
Transmittal and Archiving (see Technical)
A10 Utilization and Capacity Management
A11 Provider Network Management
Provider Network Management

Sample Subject Areas for Requirements
Provider Certification/Licensure
A12 Provider Agency Web Portal
A13 Provider Application Process for Functional/Programmatic Qualifications
A14 Contract and Fiscal Management
A15 Claims Processing and TPA Functions
A16 Performance Management/Quality Management
A17 Customer Service
Care Management (Direct Provider Care – Inpatient, Outpatient, etc.)
B1 Pre-admission/Pre-Screening
B2 Master Patient Index (MPI)
B3 Admission (Registration) Discharge and Transfer Process
B4 Demographics
B5 Financial Information, Insurance and Eligibility
B6 Intake/Initial Assessment
Intake/Initial Assessment
Diagnosis
Staffing
B7 Medical and Psychiatric History
B8 Census Management
B9 Electronic Status Board
B10 Discharge Planning Management Process
B11 Referral Out Tracking
B12 Episode of Care/Episode Management
B13 Order-Entry (Results Reporting) and Service Recording
Order Management
Order Sets
Authorized Prescriber Order Entry
Clinical Decision Support
Laboratory (see B14 below for more detail)
Pharmacy

Sample Subject Areas for Requirements
Support Services - External Consultation, Radiology, other Therapies, Privileges, etc.
Facility Services - Housekeeping, Dietary, Engineering, etc.
Nutrition Services
B14 Laboratory
General
Specimen Routing and Handling
Result Entry and Reporting
Interfaces
Microbiology
Blood Bank
Anatomic Pathology
Quality Control
Management Reports
External Reports
Charge Management
Outreach Lab
B15 Medication Management
B16 Clinical Records Documentation (all disciplines)
Assessments and Level of Care Determination
Allergy Information
Treatment Planning
Service Reporting
Notes - Progress, Group, Nursing, Memo to Chart, Other Notes
Clinical Results Reporting
Behavioral Risk Assessments, Requirements and Results
Clinical Flow Sheets
Graphical Interface
Transcription/Voice Recognition
Printing for Clients/Patients
Interfaces (see Technical)

Sample Subject Areas for Requirements
B17 Clinical User Interface
B18 Scheduling – Inpatient, Outpatient
Scheduling
Appointment Viewing/Lists, Confirmation
Schedule and Appointment Tracking
Group Schedules
Appointment Management
B19 Workflow Support
B20 Service Authorizations
B21 Utilization Review/Case Management
B22 Performance Improvement/Quality Management/Compliance
B23 Risk Management
B24 Staff Profile
B25 Health Information Management
Releases, Consents, and Disclosures
Chart Completion
Records Access, Compliance and Auditing
Coding/ICD 10 and Abstraction
Document Management
Transmittal and Archiving
Imaging
HIM Reporting
B26 Call Center/Call Logging/Referrals
Other Business Functionality
C1 Client/Patient Portal
C2 Incident Management
C3 Appeals/Grievance/Reconsideration Tracking Process
C4 Guardianship/Legal/Forensic
Commitment - Tracking of Legal Status
Forensics - Tracking of Forensic Status (Inpatient and Community)

Sample Subject Areas for Requirements
Guardianship
Conservatorship
Other Guardianship/Legal/Forensic Considerations
General Accounting and Business Operations (Billing and Accounts Receivable)
D1 Billing - General Requirements (Agency Perspective)
D2 Service Entry/Charge Capture
D3 Charge Generation and Review
D4 Bill Submission/HIPAA Transactions
External Payers
Self-Pay
Client/Patient Statements
Grant Billing
D5 Payment/Adjustment/Denial
D6 AR and Collections
D7 Reporting
D8 Materials Management/Inventory Control
D9 Consumer/Individual Funds and Resident Trust Management
D10 Budgeting, Analysis, Modeling and Forecasting
Technical Requirements
E1 Access
Presentation Channels
Publication Channels
E2 Application
Application Composition
Design and Development
Platform and Infrastructure
E3 Business Enabling Services
Platform
Domain
E4 Business Intelligence, Analytics and Reporting

Sample Subject Areas for Requirements
Reports
Dashboards
Analytics
Predictive Modeling
E5 Decision Support
E6 Domain Management
E7 Industry Standards
State
Federal
E8 Information
Data Formats
Data Interoperability
Data Management
E9 Integration
Enterprise Service Bus
Registry Services
Transport
E10 Security
Application Management
Identity Management
Technical Interfaces
F1 Technical Interfaces and Processes

Business Requirements

A1			Service Authorization Determination
			Intake Process - Pre-screening/Initial Contact Process
A1.1			The system assigns a Unique Client Identifier (UCI) for all new clients. This is critical to allow for tracking service delivery and claims payment for all clients. Describe how the system maintains a single identifier for all clients across all settings.
A1.2			The system allows for alternative methods of searching, identifying, and locating an existing client record in the system including the following, such as:
	a		Partial Name
	b		First or Last Name
	c		Soundex
	d		Aliases
	e		Date of Birth
	f		Sex
	g		Race
	h		Ethnicity
	i		Social Security Number
	j		Unique Client Identifier (UCI)
	k		Medicaid Recipient ID Number
A1.3			The system allows the end user to select the order of display of the search results.
A1.4			The system resolves duplicate UCI numbers and does a real time check during the intake process prior to a new UCI being created. Describe in detail how the system addresses this critical requirement.
A1.5			The system can support AKA (aliases) as a method of identifying a client record.
A1.6			The system accepts multiple approaches to identification, including aliases. If a match is found, the system will return items, such as:
	a		ID Number
	b		Specified client data
	c		Prior episodes
A1.7			The system does not require reentry of data already entered. Once a client is appropriately ID'd, the most recent demographic information captured from previous encounters is displayed for review and update.
A1.8			The system can retrieve and display previous client encounters based on the security clearance of the end user.

A1			Service Authorization Determination
A1.9			The system captures financial information to determine who is responsible to pay for some or all of the services provided.
A1.10			The system allows for an insurance eligibility transaction to be sent to each payer identified to confirm the financial information. This can be a real time 270/271 with a response that can be viewed and then accepted by the user. Describe the level of integration of standard HIPAA eligibility transactions in the system.
A1.11			The system allows for multiple fund sources to be identified per client. For example, Medicare, Medicaid, Waiver, Grants, Insurance, Self-pay, etc.
A1.12			The system has fields to designate individuals as being in special categories and that these have user defined table values, such as:
	a		Legal status
	b		Target populations – as defined by Agency
	c		State hospital patients
	d		Children involved with juvenile justice and/or child welfare
	e		Developmentally disabled clients
A1.13			The system has the ability to track special category start and end dates.
A1.14			The system allows for staff to upload "attachments" to the client record when needed to provide additional documentation, such as:
	a		Proof of residency
	b		Proof of income
A1.15			The system has the ability to store and retrieve client information on referral and screening for clients not admitted for services.
A1.16			The system incorporates the results of the Medicaid eligibility checking in each client's eligibility record.
A1.17			The system is capable of automated Medicaid eligibility updates and can capture and manage updates.
A1.18			The system records information on clients that have breaks in their eligibility periods. Describe your system's approach to the example below.
	a		For example, a client might be Medicaid eligible from January to June, off Medicaid from July to October and then Medicaid eligible from November to December; or a client might be in a spend down status at the beginning of the month and then become eligible for Medicaid part way through the month. System maintains permanent record of all eligibility checks that could be from 834 enrollment records or 270/271 transactions to verify eligibility.
A1.19			The system's service authorization determination information includes at a minimum:
	a		Fund source or payer

A1			Service Authorization Determination
	b		Aid category or plan information
	c		Eligibility start date
	d		Eligibility end date (if ended)
	e		Subscriber name if different than client
	f		Reason for ending eligibility
A1.20			The system provides mechanism to report changes in Medicaid eligibility on the same frequency that the eligibility file is received.
A1.21			The system has the ability to communicate Agency service authorization determination updates to the State.
A1.22			The system supports all HIPAA Transaction standards related to enrollment and eligibility (834, 270, and 271).
A1.23			The system can capture and report on the dates critical for federal and state reporting, such as:
	a		Date of service request
	b		Date of screening
	c		Date of first service
	d		Length of Stay
A1.24			The system handles historical data elements such that the user has control over determining what records can be selected for options, such as:
	a		Historical or longitudinal storage
	b		What changes trigger the generation of historical data
	c		What flexibility is available in defining and changing triggers
A1.25			The system allows for additional data elements and screens to be added to the service authorization determination process.
A1.26			The system can permit or prevent multiple current episodes based upon department or program defined criteria.
A1.27			The system can permit a client be entered retroactively in the system, due to the need to address a crisis situation or immediate need for treatment.
A1.28			The system allows State HHS Agencies and provider access according to security granted, to check the system for a client’s service authorization determination status and then allow for client data to be submitted.
A1.29			The system has the ability to pull in the valid Medicaid number and other key data from the Medicaid system to avoid data entry errors. Describe where in the system this data is stored.
A1.30			The system has the ability to assign a lead organization such as:

A1			Service Authorization Determination
	a		Area
	b		Site
	c		Region
A1.31			The system has the ability to track start and end dates for changes in lead organization over time.
A1.32			The system has the ability to assign a client to an individual staff person from the lead organization, such as a CSS or CM.
A1.33			The system has the ability to assign a client to multiple Agency staff people and/or teams.
A1.34			The system can generate reports that include:
	a		The client's status relative to clinical, financial, and contractual eligibility criteria.
	b		The client's current Medicaid eligibility status.
	c		The client's status at the end of the initial screening process, as, screening only, screening and referral to a specified agency, declined further services, etc.
	d		The ability for agency to determine how many people presented for services and were screened and their disposition after screening.
A1.35			The system records that the appropriate consent forms are signed and on file, including date signed and the expiration dates a "Consent for Disclosure" form is signed and filed. Examples of consents:
	a		Consent for Disclosure
	b		Consent for Treatment
A1.36			The system generates client identification cards.
			Expanded Demographic Data
A1.37			The system is capable of supporting expanded address data.
A1.38			The system captures address including county of residence, with effective start and end dates to allow tracking of residency changes over time.
A1.39			The system can support multiple addresses per client and those address types are user defined. For example – home, work, parents' address, etc.
A1.40			The system captures benefits data for clients who are minor children, such as:
	a		Entitlements
	b		Food subsidies
A1.41			The system captures linguistic, mobility impairment, and ADA requirements such as:
	a		Languages
	b		Hearing impairment

A1			Service Authorization Determination
	c		Disabilities – user defined table
	d		Need for Interpreter for client
	e		Need for Interpreter for parents of client
A1.42			The system has the ability to capture additional data elements specific to each Agency, such as:
	a		Race
	b		Ethnicity
	c		Target population
	d		DOB
	e		Calculate age dynamically from DOB
	f		Living arrangement
A1.43			The system has the ability to capture and track the history of Guardian(s) (multiples) information, such as:
	a		Name
	b		Type of guardianship
	c		Contact information
	d		Effective dates of guardianship
A.44			The system has the ability to capture and track the history of information related to other significant people for each individual. This includes the ability to:
	a		Identify the type of relationship, such as:
		1	Parent
		2	Guardian
		3	Doctor
	b		Identify effective date of the information added
	c		Identify contact information, such as:
		1	Multiple phone numbers
		2	Type of phone number (home, cell, work)
		3	Multiple Addresses
		4	Type of address (mailing, residence, business)
	d		Include a checkbox to indicate if this person may/can receive communication about this individual such as:
		1	Identify type of communication that can be sent

A1			Service Authorization Determination
		2	Ability to edit this over time as needed
A1.45			The system has the ability to add additional data elements and define the table values for those items. This would include special circumstances, such as:
	a		Special classes
	b		Litigation holds
A1.46			The system has the ability to enter effective dates and track history for key data elements.
A1.47			The system has the ability to add effective dates for specific key elements so that this information can be maintained historically.
			Clinical Data
A1.48			The system has the ability to add clinical data as part of the intake process to determine clinical eligibility prior to a full assessment. Describe your approach to adding additional data, such as a clinical screening tool, to the system.
A1.49			The system can incorporate the implementation and use of standardized and/or other customer defined screening and assessment instruments reflective of service eligibility criteria, such as:
	a		Global Assessment of Functioning (GAF)
	b		Milestones of Recovery
	c		CANS Assessment Tool (C/A)
			Agency Service Authorization Determination Application Process
A1.50			The system has the ability to capture and report on data, such as:
	a		Application start date
	b		Application submitted date
	c		Application due date
	d		Application completed date
	e		Application status
A1.51			The system has the ability to track the history of previous contacts/requests for services such as:
	a		The intake history
	b		The eligibility history
			Waiver Eligibility and Determination Process
A1.52			The system has the ability to track the application process for service authorization determination for a waiver such as:
	a		Dates of application

A1			Service Authorization Determination
	b		Type of waiver
	c		Services requested/needed
	d		Dates of documentation requested/received/validated
	e		Date service authorization determination determined
A1.53			The system has the ability to track/pend the determination process. Describe how the system will handle this requirement.
A1.54			The system has the ability to maintain a history of the waiver determination process.
A1.55			The system has the ability to track and be able to report on processes, such as:
	a		Waiver application timelines
	b		Waiver capacity
	c		Waiver assurances
	d		Waiver target groups
	e		Waiver enrollments
	f		Waiver letters
A1.56			The system has the ability to support the waiver eligibility redetermination process including the ability to:
	a		Send an alert to the appropriate staff at a pre-determined time prior to due date of waiver redetermination.
	b		Track documentation for redetermination.
	c		Track date effective.
			Communication/Letters
A1.57			The system allows for set up of letter templates with configurable content.
A1.58			The system will allow users to define standard letters and notices using data from the system to populate key fields.
A1.59			The system has the ability to manage the various logos and letter heads via tables.
A1.60			The system allows for free text to be included in standard letters.
A1.61			The system has the ability to add State logo to letters for each Agency.
A1.62			The system has the ability to add agency/area/site/region letterhead to letters. Describe specifically how the system can handle the switching of letterhead to the correct agency/area/site/region letterhead.
A1.63			The system maintains dates of correspondence to allow for tracking of communication.

A1			Service Authorization Determination
A1.64			The system has the ability to maintain a record of all communications with the ability to recreate the correspondence including content.
A1.65			The system has the ability to date and timestamp letters.
A1.66			The system will create and store a pdf of each letter.
A1.67			The system supports sending communications to:
	a		Clients
	b		Guardians
	c		Contract providers
	d		Internal staff
	e		Other Agencies

A2			Clinical Assessment, Needs Determination and Level of Care
			Clinical Assessment
A2.1			The system collects and allows for scanning of diagnostic and needs related information for a client, allowing analysis of this data, and advice on initial diagnosis, eligibility determination and treatment service recommendations on an ongoing basis.
A2.2			The system captures a clinical determination of level of care that can assist in identifying and/or assigning appropriate initial level of services.
A2.3			The system captures the result of the eligibility assessment in the client's record along with the treatment service recommendation as appropriate.
A2.4			The system has the capability to have the assessment data entered through a secure web portal and available for use by staff (Agency or provider) that are performing assessments.
A2.5			The system has the capacity to have the output from this assessment information be formatted into a report that can be available to service providers through the secure web portal.
A2.6			The system records the client's status or disposition (treatment service recommendation) at the end of placement assessment.
A2.7			The system allows reports to be run to show items, such as:
	a		How many people received assessments and their disposition?
	b		How many received assessments then received services?
A2.8			The system collects all data needed to generate reports that include for example:
	a		The clinical diagnosis
	b		Clinical service authorization summary such as:

A2			Clinical Assessment, Needs Determination and Level of Care
		1	Narrative summary
		2	Outcome
		3	Decisions
A2.9			The system creates reports that aggregate clinical information into reports according to needs of different constituents.
A2.10			The system allows for a referral to be submitted from the assessing entity to the admitting agency.
A2.11			The system maintains a historical record of all Clinical Eligibility Determination Summaries.
A2.12			The system includes functionality for Agencies to capture more extensive client information including structured clinical data and/or historical information for clients requiring specific levels of care or specific special categories, such as:
	a		Global Assessment of Functioning (GAF)
	b		Milestones of Recovery
	c		CANS Assessment Tool (C/A)
A2.13			The system has the capability to have additional structured clinical/historical data entered through the secure provider web portal and available for use by staff (or providers) that are providing care, making decisions regarding service authorization determination, redetermination and managing utilization. Describe the various approaches used to allow clinical data to be entered via the provider web portal.
A2.14			The system has the capability to have attachments (.pdf or other scanned files) uploaded through the secure provider web portal and available for use by staff that are providing care, making decisions regarding service authorization determination, redetermination and managing utilization.
A2.15			The system has forms tool for building assessments, including some with scoring systems, such as:
	a		PASRR
	b		Ability to link multiple assessments to a Standard of Care and add assessments to individual's record via identifying that Standard of Care.
	c		MSDP forms – See Appendix XX of all Standardized Documentation Project forms.
A2.16			The system allows integration with external assessments with built-in scoring systems. Describe how the system handles third party data that is passed back to the system and where and how it will be displayed.
A2.17			The system supports Individual Service Plans (ISPs) such as:
	a		Ability to Develop/Maintain/Update.
	b		Ability to Maintain History.
	c		Ability for the system to have needs determined feed goals in Planning (ISP, Tx Plan).

A2			Clinical Assessment, Needs Determination and Level of Care
A2.18			The system has alerts tied to due dates for documentation/review, redetermination, etc.
A2.19			The system has the ability to have configurable notes. Describe the approach taken by the system to address the need for multiple note formats.
A2.20			The system has the ability to have spell check for notes. Describe the method used to provide spell check in notes.
A2.21			The system has the ability to note when a note may be entered into the wrong record such as:
	a		Indicate the note is inactive
	b		Reason note is inactive
	c		Date note was made inactive
A2.22			The system has the ability to establish Individual budgets for clients/patients. Describe how this feature works in your software.
A2.23	-		The system allows integration with Provider Allocation Management (PAM).

A3			Case Managers/Eligibility Teams User Interface
			Clinical Dashboard – configurable
A3.1			The system has a Clinical Dashboard feature or function that is designed to be configurable based on the needs of the specific user. The user can select from the following items to display on their personalized Dashboard, such as:
	a		Caseload
	b		Schedule
	c		Due dates for documents
	d		Announcements
	e		Clinical triggers/decision points based on defined parameters
	f		Client/individual/patient face sheet
	g		Clinical/behavior alerts
	h		Email

A4			Enrollment
			Prioritization of services
			Service offering/benefit package
A4.1			The system has the ability to capture the results of the service offering, such as:
	a		Record and maintain a history of the service offerings provided to the client.
	b		Dates of offer
	c		Accepted offer (y/n)?
	d		Dates of acceptance
			Enrollment in program/services (Benefit Package)
A4.2			The system has the ability to capture where the individual is enrolled (program, site).
A4.3			The system has the ability to capture the effective start and end dates of enrollments.
A4.4			The system captures who is the responsible Service Coordinator/Case Manager/Area Director including information such as:
	a		Contact information
	b		Effective date of case assignment
			Case Status
A4.5			The system will track Case Status, such as:
	a		Active
	b		Inactive
A4.6			The system will track effective dates of Case Status.
			Management of transfer – site to site, area to area, region to region, facility to facility
A4.7			The system manages referral documentation.
A4.8			The system will record the referral information and allow for follow-up documentation to document the status and disposition of the referral.
A4.9			The system has the ability to capture the following for Transfers:
	a		The program/site/area/region/facility an individual is transferred to/from
	b		The effective date of transfer
	c		The reason for transfer
	d		The reason for discharge from a program (but staying open in another one)
			Length of Stay calculation
A4.10			The system has the ability to determine program length of stay calculations.

A4			Enrollment
A4.11			The system can track multiple lengths of stay based on the programs that the client is registered or admitted into.
A4.12			The system can track length of stay of an entire Episode of Care that can span entry and transfer from one program or level of care to another.
A4.13			The system has the ability to have a single longitudinal record for an individual over time. Describe the systems design approach to the maintenance of a longitudinal record.

A5			Wait List Management/Prioritization Process
			Wait List/Prioritization Process
A5.1			The system identifies and tracks all treatment slots available within the system on a real-time basis.
A5.2			The system maintains a real-time prioritization/waiting list by Agency or program.
A5.3			The system supports multiple prioritization/waiting lists for specific programs.
A5.4			The system has the ability to have one prioritization/waiting list for adults and one for children/adolescents.
A5.5			The system has the ability for the prioritization/waiting list to be sorted by user-defined criteria such as:
	a		Region
	b		Area
	c		Site
	d		Application/referral date
	e		Length of Stay on List
	f		Waiver Type
	g		Disability
	h		Service Need
	i		Age
	j		Sex
A5.6			The system can identify clients with priority needs that can prompt the staff by moving them up in the wait list queue.
A5.7			The system can identify candidates from the prioritization/waiting list based on funding availability.
A5.8			The system can determine the number of individuals awaiting treatment at any point in time and the specific services for which they are waiting, and also identify trends over time.

A5			Wait List Management/Prioritization Process
A5.9			The system provides the ability to see wait time per client/patient.
A5.10			The system allows agency and providers to have access to the prioritization/waiting list according to security.
A5.11			The system can provide for automatic updates to the prioritization/waiting list when clients are enrolled in a service.
A5.12			The system can compute the average wait time per service category and user defined demographic and diagnostic categories.
A5.13			The system can compute by provider and by service category the system's service utilization rates, i.e., occupancy/actual enrollment against capacity.
A5.14			The system can compute the average wait time between completion of a placement assessment and intake into a service modality.
A5.15			The system allows Agency and providers according to security to determine the current program assignment(s) of any client at any point in time.
A5.16			The system generates a variety of user-defined reports that can be used by the Agencies and providers to monitor utilization.
A5.17			The system allows for an automated letter process to notify both client and provider when an assignment is made.

A6			Prior Authorization/Pre-Certification/Referrals
			Prior Authorization/Pre-Certification/Referrals
A6.1			The referral or authorization system includes at least the following data elements:
	a		Client name
	b		Start Date
	c		End Date
	d		Dollar $ Limit
	e		Unit # Limit by Service
	f		Date of birth
	g		Sex
	h		Date referral was made
	i		Type of services to be provided
	j		Level of care authorized
	k		Appointment date or admission date
	l		Total # of visits, days, or dollar limit
	m		Reason for referral or admission (diagnosis - ICD-9/10)

A6			Prior Authorization/Pre-Certification/Referrals
	n		Authorization effective date
	o		Authorization end date
A6.2			The system allows for Authorization and Referral information to be sent/received via the Provider Web Portal.
A6.3			The system tracks actual utilization against authorizations.
A6.4			The system allows for correspondence to be created at the time of authorization that can be sent to the provider and to the client.
A6.5			The system supports an integrated faxing/email system so that authorizations and assessments can be faxed/emailed to the providers if desired.
A6.6			The system supports an online link for providers so that they can request, obtain, and determine the status of authorizations, such as:
	a		Ability to capture provider acknowledgement of authorization
	b		Ability to tie acknowledgement to claims approval process
A6.7			The system supports a single authorization that can cover multiple service categories and multiple providers.
A6.8			The system allows for online review of previous or open authorizations while new requests are being processed.
A6.9			The system checks against other open authorizations for duplications or conflicts.
A6.10			The system verifies that the services authorized are covered under that client's benefit plan that could include Medicaid certified services, Non-Medicaid Services, and special benefit packages.
A6.11			The system can be interfaced or integrated with a third party criteria based authorization system such as InterQual. Describe your solution and include in the cost proposal if not part of the standard software package.
A6.12			The system supports data elements being tracked as part of the authorization follow-up process, such as:
	a		Actual dates of visits/admission and discharge dates
	b		Actual number of visits/days (length of stay)
	c		Procedure code (s) - CPT4
	d		Clinician or Provider providing service
	e		Location where service was provided
	f		Diagnosis code (s) - ICD-9/10
	g		Claim status against authorization
	h		Claim history
	i		Status of any required documentation

A6			Prior Authorization/Pre-Certification/Referrals
	j		Comments specific to authorization
A6.13			The system retains authorization information for a user-defined period of time.
A6.14			The system supports a single authorization to be used for multiple referrals and subsequent claims against that authorization.
A6.15			The system has the ability to automatically produce a referral slip or hospital admission form that includes the following:
	a		Client name
	b		Provider name
	c		Referral authorization number
	d		Referral source (referred by)
	e		Location of service (referred to)
	f		Number of visits authorized
A6.16			The system has the ability to track referral process, such as:
	a		Receive referral acceptance from provider
	b		Receive enrollment date of client to provider
A6.17			The system has the ability to list referrals and/or authorization numbers outstanding for Incurred But Not Reported (IBNR) liability (no claims data).
A6.18			The system can directly generate form letters from the referral process to:
	a		Providers
	b		Clients
	c		Other State Agencies
A6.19			The referral or authorization system is integrated with the claims payment system to verify authorization and expedite claims payment.
A6.20			The system allows for additional discharge information (such as client disposition, outcome, and final diagnosis) to be added to a specific authorization after the authorization has been closed.
A6.21			The system identifies services as ineligible for payment based on criteria, such as date or number of units of service.
A6.22			The system allows for additional information to be tracked on Inpatient accounts such as:
	a		Admission date
	b		Type of admission
	c		Admitting diagnosis (ICD-9)
	d		Procedure codes (CPT4)

A6			Prior Authorization/Pre-Certification/Referrals
	e		Estimated length of Stay
	f		Actual length of stay
	g		Hospital name
	h		Discharge Date
	i		Discharge diagnosis (ICD-9/10)
	j		Discharge disposition
	k		Outcome indicators
A6.23			The system flags specific types of cases for future review and reference.

A7			Service Capture/Targeted Case
			Service Capture/Targeted Case
A7.1			The system has the ability to capture the date of the event that first occurred during the month rather than force the date to be the last day of the month. (This would allow agencies to bill for certain services that can't be billed at one charge per month and should be captured even if the individual had multiple TCM events). Describe how the system addresses this requirement.

A8			Disenrollment Process From Agency Services
			Management
A8.1			The system will allow for the disenrollment of a client from the system indicating that this client is no longer the responsibility of the Agency.
A8.2			The system has the ability to periodically check Medicaid eligibility status of Waiver clients to ensure that they are still enrolled per Mass Health and if no longer eligible will send notification that the person needs to be disenrolled from the waiver. Describe in some detail how the system will address this requirement.
			Tracking
A8.3			The system has the ability to maintain a historical record of all enrollments and disenrollments.
A8.4			The system has the ability to track reason for disenrollment, such as:
	a		Death
	b		Loss of eligibility
	c		Choice
	d		Moved from State
	e		Change in need

A8			Disenrollment Process From Agency Services
	f		Jail
	g		No longer meet level of care (LOC)
A8.5			The system has the ability to track effective dates of disenrollment.
A8.6			The system supports the generation of real time communications necessary at time of disenrollment and would allow for notification to client and providers who have been working with client.

A9			Records Management
			Document Management and Scanning
A9.1			The system supports the scanning of documents and attaching them to the client record.
A9.2			The system supports a scanning process that allows user to index the scanned document for organization and easier retrieval.
A9.3			The system supports the use of checklists to facilitate and organize the scanning process.
			Transmittal and Archiving (see technical as well)
A9.4			The system supports the recording of documentation that is transmitted to other organizations.
A9.5			The system has the ability to maintain a historical record of all records transmitted.

A10			Utilization and Capacity Management
			Utilization and Capacity Management
A10.1			The system supports data elements being tracked and easily available online for utilization management staff to manage all clients. These data elements include:
	a		Treatment admission date
	b		Current funding/eligibility
	c		Actual dates of service for each service received
	d		Actual number of visits/encounters
	e		Service modality discharge date
	f		Discharge from treatment/service
	g		Discharge reason
	h		Outcome
	i		LOS

A10			Utilization and Capacity Management
	j		Episode history showing level of care, start date and LOS
	k		History showing care cost by service modality
	l		Anticipated discharge date
A10.2			The system supports utilization "triggers" for outliers.
A10.3			The system allows the prioritization/waiting list to be sorted by user-defined criteria, including priority of need, days on list, etc.
A10.4			The system generates a variety of user-defined reports that can be used by the agencies and providers to monitor utilization, such as:
	a		Wait time between issuing referral and acceptance of referral
	b		Program referral and start date
	c		How many clients receive service in x amount of time

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	e		Service modality discharge date
	f		Discharge from treatment/service
	g		Discharge reason
	h		Outcome
	i		LOS
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	b		Program referral and start date
	c		How many clients receive service in x amount of time

A12			Provider Agency Web Portal
			Provider Agency Web Portal
A12.1			The system supports Direct Data Entry Claims Submission including CMS-1500 and UB-04 and complies with all HIPAA transaction standards.
A12.2			The system supports Service Authorization Request and Status Tracking.
A12.3			The system will capture Enrollment and Referral Requests from providers. Format of Referral Request will be tailored to the specific department.
A12.4			The system will allow for documents to be sent electronically and associated with a specific client, such as:
	a		Crisis Plan Submission
	b		Treatment Plan (ISP/PCP)
	c		Client assessments
	d		Client level outcome data
A12.5			The system provides for secure transfer of data files from and to providers such as:
	a		837 Claim Files
	b		835 Electronic Remittance Advice files back to providers
	c		270 Eligibility Request Files
	d		271 Eligibility Response Files back to providers
A12.6			The system provides for secure transfer of reports to and from providers.

A13			Provider Application Process for Functional/Programmatic Qualifications
			Provider Application Process for Functional/Programmatic Qualifications
A13.1			The system has the ability to track the status of the Provider Application RFR Process by allowing for a checklist and workflow that tracks each step in the process. The process should include items, such as:
	a		Name of the process step
	b		Date stamp of the start and stop dates of each process

A13			Provider Application Process for Functional/Programmatic Qualifications
	c		The responsible party for each process
	d		Due dates for each process
	e		Alerts and reports when a process step is delinquent
A13.2			The system will support providers sending documentation via the provider portal so that required documents can be submitted electronically.
A13.3			The system will support individual and agency providers submitting their application via the portal.
A13.4			The system will support providers updating and maintaining their directory information with the ability for them to authorize the publishing of their directory information.
A13.5			The system would support an interface with the State bidding system (COMM-PASS).
A13.6			The system provides an interface with a virtual gateway, mass.gov, etc. for provider applications.

A14			Contract and Fiscal Management
			Contract and Fiscal Management
A14.1			The system supports integrated contract management. Integrated in this context implies that the data can be updated online, and that modifications impacting service descriptions, staff qualifications, and the **billing rates** entered are instantly available and edits and cross references are accomplished online and in real time.
A14.2			The system supports complex contract and payment arrangements between Agencies and providers, such as:
	a		Fee for service
	b		Procedure code based fee schedules
	c		Capitated method
	d		Bundled service packages
	e		Per diem
	f		Cost reimbursement
	g		Individual consumer budget (voucher system)
	h		Fixed Contract/Block Grant with 1/12 draw down
	i		Performance Based Incentive Contract (withhold and allowances)
	j		Tiered rate structure based on LOS (for example, one rate for first five days, lower rate for remaining days)
	k		Other payment methods as required.
A14.3			The system supports the creation of new provider agency contracts at any time.

A14			Contract and Fiscal Management
A14.4			The system can support payment methodologies that are service-date sensitive and support differing timely filing limits by Agency and line of business combinations as well as different filing limits for TPL (Third Party Liability) and non-TPL situations.
A14.5			The system can support multiple Agencies having multiple contracts with a single provider, with varying effective dates, services, rates, and payment arrangements. Describe specifically how the system will support this requirement.
A14.6			The system allows each contract to have a unique system identifier that is used for claims adjudication.
A14.7			The system allows each contract to have a status and status effective start and stop dates.
A14.8			The system allows each contract to have an Agency assigned financial system identifier that is used for finance processing (MMARS Contract ID Number in State AP system).
A14.9			The system allows each contract to have an Agency assigned fiscal year end processing date, which is used in the modified accrual method to manage when claims from the previous fiscal year are received after the fiscal year end.
A14.10			The system supports multiple lines of business funded under one contract.
A14.11			The system allows a contract to include volume detail of what is being purchased, including unit of service volume and number of clients served, which can be used for analysis and reporting against actual adjudicated claims.
A14.12			The system allows specific services in a contract be designated to be paid from specific designated fund sources.
A14.13			The system has options to set specific services in a contract to require or not require an individual clinician to be reported as the rendering provider and whether the individual clinician requires an active license # in order for the service to adjudicate as payable. Describe specifically how the system will support this requirement.
A14.14			The system allows the fund source code to be based on Agency specific values assigned by a combination (or "Waterfall") of fields such as provider, contract, fund source, service authorization determination, benefit plan, client type, episode type, program, and priority.
A14.15			The system can establish specific service categories, such as co-occurring vs. substance abuse, adults vs. children, outpatient, residential, prevention, etc. to be used as groups of services that can be included/excluded from both a client benefit package and a provider contract. Describe specifically how the system will support this requirement.
A14.16			The system can be configured to set quantitative benefit and benefit group limitations.
A14.17			The system can be configured to exclude providers from being reimbursed for specific services.
A14.18			The system can determine, at any time, what contract is in effect for a specified service.
A14.19			The system supports contracts that have rates or pricing methods that are date sensitive.

A14			Contract and Fiscal Management
A14.20			The system has the ability to set and monitor upper level contract limits by provider. For example, a provider contract may have a "not to exceed" limitation. No claims would be paid above that amount. Describe specifically how the system will support this requirement.
A14.21			The system will allow, with proper security, to override not to exceed limits.
A14.22			The system supports an annual not to exceed amount contract by service code.
A14.23			The system will create a configurable alert when contract limits are approached or hit, i.e., amount equals 80% of limit.
A14.24			The system has the capacity to record, compare, and report by provider by contract and by service activity type, such as:
	a		Total contract award by service
	b		Billed amount
	c		Paid amount
	d		Unbilled balance
	e		Forecasted end of contract balance
A14.25			The system has the ability to generate reports showing information such as:
	a		Operating volume (e.g., client days, procedures, visits)
	b		Revenue and expenses for the previous year, current year projected, and budgeted year for each provider, including budget versus actual
A14.26			The system has templates to pre-populate and/or update support files such as providers, services, contracts, etc.
A14.27			The system is capable of updating the claims database and provider billing and balancing reports to reflect reconciliation, gross settlements and cost recoveries between the Agencies and the providers. Describe specifically how the system will support this requirement.
A14.28			The system provides the following edits such as:
	a		Validate member fund source eligibility at point of claim adjudication
	b		Check against any plan limitations defined in benefit plans
	c		Validate services against authorization number
	d		Identification of duplicate claims
	e		Check for dollar limitations and unit of service limitations
A14.29			The system can support receiving claims data via the ANSI ASC X12 - 837 standard.
A14.30			The system supports providers entering claim data directly into the system according to security.

A14			Contract and Fiscal Management
A14.31			The system can support claims being processed without having prior authorization. This requirement assumes that the user would choose certain levels of services that do not require authorization.
A14.32			The system supports the ANSI ASC X12 - 835 electronic remittance advice standard.
A14.33			The system will time and date stamp claims as they are received, and generates an acknowledgement to the submitting entity.
A14.34			The system will time and date stamp claims as they are sent back to the submitting entity for correction and adjustment.
A14.35			The system supports online adjudication. Describe specifically how the system will support this requirement.
A14.36			The system suppresses payments for services provided under capitated contracts and yet still provides detailed remittance advice to those providers that report service utilization under capitated agreements.
A14.37			The system provides for additional lines of business to be added, at any time, to the system. Line of business means the ability to add a new product line or even a separate fiscal entity with several lines of business to the system.
A14.38			The system is capable of producing Explanation of Benefit reports (EOB) for providers and recipients or their representatives that lists services and benefits received.
A14.39			The system will allow for a retroactive authorization to be added (based on security) to facilitate payment.

A15			Claims Processing and TPA Functions
			Claims Processing and TPA Functions
A15.1			The system enables claims processing to be fully integrated with all other system data such that once data is entered, it is instantly available and the edits and cross references are online and real time.
A15.2			The system supports HIPAA 5010 EDI standards for receiving electronic claims and sending remittance advices in HIPAA compliant formats.
A15.3			The system allows contract agency provider staff according to security, to sign on to the system via a secure web portal and determine items, such as:
	a		Client Agency and Medicaid eligibility status
	b		Client enrollment status
	c		Claims status
A15.4			The system allows claims to be directly entered by provider agency staff according to security via a secure portal.

A15			Claims Processing and TPA Functions
A15.5			The secure portal direct entry method of claim submission has controls to facilitate entry of valid data (valid dates, service codes, diagnosis codes, etc.). Describe the features in the system that facilitate the submission of clean claims via the provider portal.
A15.6			The system supports adjudication of claims upon successful submission, regardless of submission method (manual direct entry via portal and 837 files).
A15.7			The system supports online correction and resubmission of denied claims via the secure portal regardless of form of original claim submission (manual direct entry via portal and 837 files).
A15.8			The system allows the same adjudication rules to be used for all claims regardless of form of submission (manual direct entry via portal and 837 files).
A15.9			The system allows the same adjudication reports to be used for all claims regardless of form of submission (manual direct entry via portal and 837 files).
A15.10			The system can automatically generate acknowledgement of receipt of claims files from providers via a 999.
A15.11			The system has a clear and easy to understand report showing the reason a file or claim could not be processed if claims are not accepted for processing (does not require the provider staff have 999 expertise in order to use).
A15.12			The system can provide Online Explanation of Benefits (EOB) reports that are available via the secure portal that providers can use to reconcile claim submission, remittance, and payment processes - can be printed or data downloaded to Excel for sorting, grouping, such as:
	a		Claims by date of service date range
	b		Claims by submit date range
	c		Claims by remittance date range
	d		Claims by batch name (provider submitted batch name or filename)
	e		Claims by check number (county AP assigned check number)
	f		Claims by remittance number
15.13			The system processes claims by date range (for claims that are reprocessed automatically due to Medicaid retroactive eligibility processing, Medicaid spend-down processing, retroactive rate increases, etc.)
A15.14			The system adjudicates claims, calculates the reimbursement amount, and creates a detailed and summary report or voucher by provider that can be forwarded electronically to the State MMARS system to process the checks for the services. Describe bidder's experience providing this data is similar situations.
A15.15			The system allows the detailed claim record to be electronically updated with the actual check number once a check number has been assigned.

A15			Claims Processing and TPA Functions
A15.16			The system allows for user-defined service authorization determination information to be viewed online, (such as program eligibility, priority, etc.) during the claim entry and adjudication process.
A15.17			The system supports claims received from more than one line of business (for example, Medicaid or Non-Medicaid) or provider per enrolled client. Describe your experience with this requirement and how you handle multiple funds source adjudication.
A15.18			The system can cross check provider certification numbers against claims to assure that this provider is certified for the service.
A15.19			The system has options to define whether a valid authorization number is required on a claim based on parameters such as Agency/Provider contract, benefit plan, and/or service.
A15.20			The system provides the following edits such as:
	a		Validate client enrollment at point of claim adjudication
	b		Check for enrollment restrictions
	c		Check against limitations and restrictions defined in contract billing manual
	d		Identify duplicate claims
	e		Check for dollar limitations and unit of service limitations
A15.21			The system creates a pend queue to allow for review and approval of payments prior to release to financial system for payment processing.
A15.22			The system provides a mechanism to establish critical thresholds based on units of service or dollar limits that will allow for quick identification of high utilization.
A15.23			The system supports the following coding conventions as part of the standard product, such as:
	a		CPT, HCPCS, etc.
	b		ICD-9 and ICD-10 and other successor codes
	c		DSM IV and DSM V and other successor codes
	d		Agency specific local service codes
A15.24			The system stores a claim payment fund code for each claim service as a part of the adjudication processing. The code may be based on Agency specific values assigned by a combination of fields such as provider, contract, payer, eligibility, benefit plan, client type, episode type, program, and priority.
A15.25			The system stores the specific Agency/provider contract code for each adjudicated claim service. This is used for balancing paid claims against contract balances as well as tracing adjudication rules used during claims processing.

A15			Claims Processing and TPA Functions
A15.26			The system allows Agency specific edits to be implemented (for example, different diagnosis codes may be allowed for court-ordered clients, different locations, modifiers, etc.).
A15.27			The system allows custom adjudication logic to be configured to include data elements not contained within the claim, such as holding/pending a claim if the client is on the provider's prioritization/waiting list.
A15.28			The claims payment system automatically maintains provider billing and contract balances and can create reports that reflect these balances.
A15.29			The system can receive claims from providers at gross charges and recalculate the payment amount automatically based on the provider's contract and then give a detailed recap of the calculation in a format suitable for communicating back to the provider.
A15.30			The system suppresses payments for services provided under special contracts (such as capitated, fixed price/block grant and cost reimbursement) yet still provides detailed remittance advice to those providers that report service utilization under these agreements.
A15.31			The system allows for additional providers and lines of business to be added to the system at any time.
A15.32			The system allows for select categories of claims to require manual intervention prior to final adjudication. For example, all contract provider agency Inpatient claims or any claim over a dollar limit must be manually released prior to final processing.
A15.33			The system has the ability to reverse and resubmit claims for previously paid services to client and provider accounts when it is determined that an overpayment or underpayment has occurred based on items, such as:
	a		Increased provider contract limits
	b		Corrected or revised third party reimbursement
	c		Corrected or revised service authorization or limits, and/or
	d		Service rate information.
A15.34			The system can pay and track claims activity for a new system enrollee until Medicaid eligibility is determined and then provide an easy method for reclassifying expense and billing data as Medicaid eligibility data is determined to be different than originally billed and paid. This is particularly important for clients who will apply for Medicaid at time of service and become retroactively eligible or those that reach Medicaid Spend-down during the month. Describe specifically what features the system has to address this requirement.
A15.35			The system has automated processes to support re-processing previously adjudicated claims and automatically reversing and resubmitting claims if the adjudication results are different than the initial adjudication. The selection parameters include options for provider, service date range, service code, denial reason, fund source, etc.

A15			Claims Processing and TPA Functions
A15.36			The system maintains a full history of paid claims, but has mechanisms to manage system performance so the claim processing functions do not slow down over time due to increasing file size.
A15.37			The system has flexible options for selecting claims for viewing/editing including combinations of fields including client UCI, client name, provider, dates of service, service codes, dates received, etc.
A15.38			The system can send payment (Warrant) information to MMARS in correct file format.
A15.39			The system will generate claims random audit sampling.
A15.40			The system will support receiving claims from a certified claims clearing house.
A15.41			The system has ability to add Medically Unlikely Edits (MUE) to screen out potential fraudulent claims. Describe specific system capabilities that address this requirement.
A15.42			The claims system supports DRG grouper processing for the pricing of Inpatient claims.
A15.43			The claims system support APG grouper processing for the pricing of ambulatory claims.
A15.44			The system can create, submit, receive, process the following EDI functions:
	a		Batch Authorization Requests and Response**
	b		837P/I incoming and outgoing
	c		835 incoming and outgoing
	d		999
	e		CCR/ Clinical Care Document (CCD) for data exchange with capable providers and State HIE using State mandated format. The system should leverage the current “Rhapsody” product, an HL7 Interface engine that provides the framework for the exchange, integration, sharing and retrieval of electronic health information.

A16			Performance Management/Quality Management
			Performance Management/Quality Management
A16.1			The system will capture demographics, clinical assessments, service utilization, and utilize this client level data to report aggregate level data for performance management and quality management reporting such as:
	a		Length of Stay
	b		Community Tenure
	c		Employment
	d		Health and Wellness
	e		Admission and Discharge Information
	f		Housing

A16			Performance Management/Quality Management
	g		Service Utilization
	h		Enrollment History
	i		Measures of Recovery
	j		Census Management
	k		Prioritization/waiting list Information
	l		Psychopharmacology Information
	m		Financial Information
	n		Insurance Eligibility Information
	o		Consumer Satisfaction Surveys
	p		National Core Indicators
	q		Others as needed
	r		Other Federal and Agency reports as required
A16.2			The system allows all performance monitoring and quality data to be stored in the system's data warehouse and is available for reporting and analysis at both client detail and summary levels. Describe the systems approach to data warehouse and how this is addressed in this proposal.
A16.3			The system supports standard reports that can be run on demand for key reporting data.
A16.4			The system will support ad hoc reports that are parameter driven to allow end users to easily create custom reports based on the parameters in the report design.
A16.5			The system will support the development of data cubes that will allow end users to easily create a host of custom views of the data.
A16.6			The system provides the ability for Dashboard reports to be created by user or group of users so that the system will produce and update reports that monitor key elements from the data warehouse.
A16.7			The system supports the ability to extract data views for export into other applications for presentation and analysis.
A16.8			The system provides the ability to report historical trends for outcome reporting.
A16.9			The system provides the capability for providers to submit outcomes data files and other agency required data by client or by various aggregate categories, including by program, provider, service, geographic area and others online through the secure provider web portal.
A16.10			The system allows for all data submitted through the Web portal to be reviewed and accepted by the Agency.
A16.11			The system needs to specify/track the data source.
A16.12			The system allows submitted changes to be governed by business rules – not the system.

A16			Performance Management/Quality Management
A16.13			The system provides the ability for performance data to be available for each Agency to use to determine whether providers have met user defined/configurable contractual performance standards.
A16.14			The system can incorporate real-time online data entry of consumer outcomes instruments for an individual through the web portal.
A16.15			The system supports real-time outcome reports that:
	a		Are easily accessible for Agency staff
	b		Can display a synopsis of the outcome findings
	c		Can incorporate computed scales
A16.16			The system supports real-time reports, easily accessible for Agency staff to view change over time - with options to compare either the current to previous data or changes over a specified period of time (three months, six months, etc.).
A16.17			The system has standard reports by Agency service authorization determination criteria such as:
	a		IQ scores
	b		Ineligible determination – scores
	c		CANS
A16.18			The System will provide the ability to restrict access to data for privacy by job title, function or other.
A16.19			The System will allow Agencies to see aggregate changes over time from intake, at intervals and at discharge by client or a group of clients.
A16.20			The System will provide the ability to report trend data.
A16.21			The System will provide auditing capability for provider services and processes.
A16.22			The system supports reporting of standard HEDIS Measures. Describe systems ability to meet this requirement.
A16.23			The system supports reporting of Medicaid QM Measures. Describe systems ability to meet this requirement.

A17			Customer Service
			Customer Service
A17.1			The system provides a customer service function such as a detailed and flexible call log to support recording complaints and inquiries from clients, family members, and providers, the general public and collaborating agencies. The system includes a process that will log and track inquiries, response to inquiries, and maintenance of ongoing history of correspondence. Describe systems ability to meet this requirement.

Attachment J: Sample Productivity Targets of Child/Youth State Medicaid Services Developed as Part of an Actuarial Rate Setting Process

Productivity Target—Hours per Day	Medicaid Service (State Plan or Waiver Service)
5.5 hours	Family Partner Peer Support—community-based (family, school, other non-clinic settings) with fidelity to evidence-based practice (EBP)
6.5 hours	Family Partner Peer Support—program site-based
3.75 hours	Functional Family Therapy—community- and program site-based with fidelity (http://fftllc.com/about-ffttraining/implementing-fft.html)
3.5 hours	Multisystemic Family Therapy—community-based (family, school, other non-clinic settings) with fidelity
3.5 to 4 hours	Other evidence-based practices with collaterals—community-based with fidelity
4.5 to 5.5 hours	Other evidence-based practices with collaterals—program site-based with fidelity
6.5 to 7 hours	Outpatient therapies by licensed professional
6.5	Outpatient counseling by a non-licensed counselor
4.75 hours	Psychiatric rehabilitative services—community-based (family, school, other non-clinic settings)
6.5 hours	Psychiatric rehabilitative services—program site-based
7 hours	Physician services/prescriber services