FINAL REPORT

# FIELD TEST EVALUATION

## ILLINOIS DIVISION OF MENTAL HEALTH


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# Executive Summary

The State of Illinois plans to change from a grant based funding structure to fee for service reimbursement for its mental health system. As a part of implementing the funding changes, certain structures and documents were put into place to assist with planning for the system impacts of this significant financial shift for the mental health system, its consumers, providers and other stakeholders. Parker Dennison & Associates, Ltd. (Parker Dennison) was retained by the Division of Mental Health (DMH) to provide facilitation and technical assistance with the field test evaluation and System Restructuring Initiative (SRI) group. Based on information gathered from those processes, key conclusions and recommendations regarding the feasibility of moving the Illinois mental health system to full fee for service are summarized below.

## Key Conclusions and Recommendations

- **Fee for service reimbursement structures are feasible**—Fee for service reimbursement structures are feasible for the mental health system and can contribute to objectives such as increasing the funding available from federal match and increasing/improving the service information available to analyze system performance and funding.

- **There are lessons to be learned from other states**—Experience from other states that have converted from grant funding to fee for service for their mental health systems offer key insights into likely patterns and trends that may be experienced in Illinois, including the need for more financial supports than anticipated to support the conversion, with a short term drop in claiming followed by a significant, rapid increase in Medicaid costs that must then be addressed through some type of cost controls. These issues should be incorporated into the planning process in Illinois.

- **Additional financial resources will be needed for an effective transition**—Additional resources will be needed to transition to fee for service, and may be reallocated from other parts of the system or made available through new/increased funding. A range of issues have been identified throughout this report that will need financial support. Examples include funds for contingencies/emergency loans to assure consumer access where providers are unable to perform financially in the new environment, provider advances to deal with slow state payment, provider and state training/technical assistance and to relieve state bottlenecks in obtaining and analyzing information from existing data systems.

- **Separate and prioritize fee for service issues from other system improvement**—Specific activities necessary to implement fee for service, such as claims processing and cash flow management, must be separated from general system improvements to avoid paralyzing the system and jeopardizing fee for service implementation. System measurement and performance issues that have historically existed in the system cannot be corrected immediately as a part of fee for service transition, but rather should be identified with separate but coordinated initiatives and timelines established to address each area. Access to care and quality measures are examples of system improvement efforts that need attention in the Illinois mental health system, but since there are no historical provider or system performance standards in these areas, the emphasis needs to be on developing the measures, data systems and standards. These efforts should proceed concurrently with fee for service implementation, but completion of all system improvement efforts and corresponding measures should not be required prior to conversion to fee for service. (See Section 5, Recommendation #1)

- **System reform should be focused on and driven by consumer and community need**—As attention shifts from a narrow focus on fee for service issues, to true mental health system restructuring, the role and voice of consumers and community needs should be a priority and ultimately guide

decisions and policy. Efforts to achieve system changes need to be focused on desired outcomes of the intended beneficiaries of the public mental health system—consumers, families and other community stakeholders such as schools, law enforcement, courts, local funding boards, and the public at large. This appropriately places emphasis on desired results for those in need and broader community welfare and encourages recognition that each community has unique needs and resources. Thus far in the fee for service transition process, the providers as vendors in the mental health system have had the largest voice, though consumer involvement has grown substantially. The communities and other stakeholders such as schools, law enforcement, courts, and local funding boards have had virtually no voice in the process. Additionally, there is no community needs assessment information being used to inform priorities or decisions in the redesign of the mental health system. It will be important for all stakeholders to realize that mental health system reform cannot be achieved without significant changes in the delivery system including within service providers and state structures. (See Section 5, Recommendation #2, #19)

- **Renegotiate the MOU**—The current terms of the Memorandum of Understanding (MOU) do not facilitate fee for service implementation and should be renegotiated for FY06. Changes are needed to allow the system to focus on critical transition elements and to increase flexibility to proceed with implementation. Components of the MOU can be maintained as a part of extending the transition to fee for service, including a significant level of monthly provider advances. However, other financial terms need to be modified to begin to align billing performance with total provider contract amounts, and to address state cash flow issues associated with the timing of deposits to and provider advances from the Mental Health Trust Fund. (See Section 5, Recommendation #3)

- **Revise SRI and advisory structure(s)**—Although it has served as an important focus for gathering input and recommendations, especially from providers and consumers, the SRI group has struggled to find its role as either advisory or authorization/approval. As currently structured with provider associations and providers prominently among the members of SRI, there is an inherent conflict of interest if any action is recommended to be taken by the state that will result in financial or other perceived harm to any association members or provider peers. Therefore, it was recommended that the SRI structure be revised to clarify its role as advisory through integration with existing advisory groups, that the group become responsible for a wider range of mental health issues, and that its membership better reflect consumer and community voice. (See Section 5, Recommendation #4)

- **More time is needed to safely move to fee for service**—Additional time is needed to safely transition the system to fee for service, primarily to improve state and provider readiness as a means of maintaining consumer access to services in the state. While additional improvements and progress can be achieved during FY06, the earliest recommended date for conversion to full fee for service is July 1, 2006. Readiness issues include providers' ability to achieve fee for service targets and corresponding potential revenue reductions, available cash reserves in the provider system, and the state's ability to report and analyze claims and access data. (See Section 5, Recommendation #6)

- **Cash flow is critical**—The provider readiness process indicates that the provider network has very limited cash reserves, which is critical when moving from fixed monthly advances to claims payment after services have been delivered. This issue is compounded in Illinois with the extended timeframes that exist for payment of Medicaid claims during portions of the year and the structure of the Trust Fund. Therefore, in order to maintain consumer service stability, any transition to fee for service must include mechanisms that will assist providers with the inherent cash flow issues. (See Section 5, Recommendation #7)

- **Readiness of state operating structures must be addressed**—A comprehensive state readiness assessment could not be completed in the available time, although preliminary impressions indicate that state capacity issues do need to be addressed as a part of the implementation plan, particularly in

the areas of claims and data management, clarity for priority populations, and network management and standards. A structured state readiness process must be completed in the near term and critical issues must be addressed prior to full implementation of fee for service. (See Section 5, Recommendation #8)

- **Provider system is not ready for transition**—A structured assessment process indicates that the provider system is not yet "ready" to convert to fee for service, and a premature conversion may result in widespread disruption in services to consumers. The readiness process strongly supports the need for considerable provider development, training and technical assistance. Those activities need to be resourced and completed as a part of implementing fee for service. (See Section 5, Recommendation #12)

- **Expanded implementation of Recovery philosophy**—As the system moves to full fee for service, the effort to involve consumers in shaping the system must be expanded to the non-field test providers. Efficient and effective means of training, mentoring and supporting consumers in this process is essential. (See Section 5, Recommendation #16)

- **Taxonomy, Medicaid state plan, rule and related rate revision**—To minimize compliance risk to the mental health system, increase opportunity for medically necessary Medicaid claiming, and further evolve services consistent with a recovery philosophy, the Medicaid service taxonomy should be modified and according to Medicaid policy, rates re-based to the new service definitions. This will require a Medicaid State Plan Amendment and revision to state administrative Rule 132. This should be done as soon as possible with a target date for completion and implementation no later than July 1, 2006. (See Section 5, Recommendation #18)

## Report Structure

The report is structured into five sections plus appendices. The sections and the areas addressed in each are:

### Section 1: Scope of Work

This section summarizes the scope of work for which Parker Dennison was hired and defines the areas of work that informed conclusions and recommendations.

### Section 2: Structure for Transition

This section summarizes the conclusions regarding the effectiveness and adequacy of the structures supporting the fee for service transition.

### Section 3: Conversion Experience from Other States

This section highlights patterns and issues experienced in other states making large system transformations including fee for service implementations. This section effectively predicts and/or confirms the typicality of issues Illinois is experiencing in this transition.

### Section 4: System Readiness

Conclusions regarding consumer, provider, and state readiness to successfully and safely make the transition to fee for service are detailed in this section.

### Section 5: Recommendations

Recommendations are divided into three global areas in and include:

**Overall Recommendations:**

1. Separate fee for service elements from other system improvements.
2. Refocus on the needs of consumers.
3. Renegotiate the MOU.
4. Revise SRI and advisory structure(s)
5. Continued role of collaborative work groups

**Fee for Service Implementation Recommendations:**

6. Timeline for implementation
7. Cash flow
8. State readiness assessment
9. Claims data
10. Capacity grants are needed
11. Provider safety net
12. Provider training and technical assistance
13. Provider relations function
14. Incorporating non-field test providers
15. Short term strategies to increase federal match

**System Improvement Recommendations:**

16. Expanded implementation of Recovery philosophy
17. Target/priority population clarification and monitoring
18. Taxonomy, Medicaid state plan, rule and related rate revision
19. Community needs assessment
20. Access measures and monitoring
21. Consumer satisfaction and recovery perception
22. Consumer access contingency planning
23. Quality of services
24. Service definition fidelity
25. Medical necessity/prior authorization

## Appendices

This section provides additional and more detailed specific data and/or recommendations including:

Appendix A – Provider Readiness Data Summary

Appendix B – Provider Training and Technical Assistance Plan

Appendix C – State Readiness Areas

# Section 1: Scope of Work

Parker Dennison was engaged by DMH approximately five months after the execution of the MOU and Memorandum of Agreement (MOA) to assist with facilitation of the SRI group, and implementation and evaluation of the field test process. During the past 3 – 4 months, consulting resources were focused on the following primary work areas:

1. **Provider readiness assessments**—A self-assessment tool was tailored to Illinois and distributed to all field test agencies. Training sessions were conducted in three locations, and a video conference session was also held, all focusing on key competencies for provider performance in a fee for service environment along with specific instructions regarding how to complete the tool. Seven site visits were conducted for a range of providers to obtain "hands on" impressions and to validate self-report data. The assessment process was extended to non-field test agencies on a voluntary basis and more than 50% of total completed assessments were from non-field test agencies

2. **Structuring and facilitating field test workgroups**—Four workgroups, Financial, Services, Access & Eligibility, and Pilot Test, were structured to have input into how to evaluate MOU and MOA field test elements. An estimated 15 – 20 workgroup meetings were held to develop information to be used in the DMH report to the legislature and to make recommendations to the field test group and SRI. The workgroups included provider staff, consumer representatives, DMH and Department of Public Aid (DPA) staff, and consultants from EP&P, representing provider trade associations.

3. **Facilitating field test meetings**—Monthly meetings of the field test providers were required by the MOU to review field test processes and results, and these meetings were coordinated with workgroup meetings to ease provider travel costs and time requirements.

4. **Facilitating SRI meetings**—This area included assistance in developing agendas, participation in steering group telephone meetings, coaching for co-chairs and participation in the regular face to face meetings.

5. **Technical assistance to DMH**—As DMH has moved through issues related to conversion to fee for service, technical assistance has been provided for planning to meet various needs and to respond to a range of issues.

6. **Process for developing DMH/DHS legislative report**—A team was identified consisting of providers, consumers, consultants and DMH staff to provide input, writing and review resources for development of the report. The team developed a comprehensive outline for the content of the report, including key messages and recommendations that will be forwarded to SRI and the legislature.

Parker Dennison's involvement and data gathering processes in these areas serves as the foundation for the analysis and recommendations that follow.

# Section 2: Structure for Transition

At the time the MOU and MOA were created, the documents served as an important framework for moving the fee for service initiative forward in a thoughtful manner that minimized risk to the consumers being served by the public mental health system in Illinois. However, the documents did not focus solely on the critical issues that needed to be addressed to implement fee for service, but rather included pre-existing and/or greater mental health system policy issues that had minimal direct linkage to fee for service. Many of these issues related to unresolved or unclear policy positions, or to important but not pervasive or unusual concerns in a public mental health system. The early impressions of Parker Dennison were that the MOU and MOA had created an environment that did not include the flexibility necessary to achieve system changes, and those impressions were communicated to DMH and the SRI group at the time Parker Dennison was hired. The processes completed and information gathered during the past 3 – 4 months have reinforced the consultants' impressions regarding the difficulties of operating within the confines of the MOU and MOA.

In recognizing structural issues in the MOU and MOA and difficulties with implementing the requirements of these documents, it is also important to recognize that important accomplishments have been guided by the processes put into place to comply with their requirements. Examples include state government attention (legislature, governor's office and Department of Human Services--DHS) on the mental health system, continued development and implementation of revised Rule 132 related to service taxonomy including clarification of non-Medicaid services, elevation of the consumer voice in the mental health system, and developing meaningful stakeholder input structures. In the future, it will be important to develop structures that maintain these positive features, while creating sufficient flexibility to move the mental health system forward—both on fee for service implementation, as well as other system improvement areas.

Issues that need to be addressed:

- **Lack of identification and prioritization of fee for service implementation issues**—One of the most difficult aspects of the MOU and MOA as they are currently structured is that the list of items requiring attention is extensive and includes issues that are important, but sometimes peripherally related to fee for service implementation. Despite the length of the lists in the MOU and MOA, there were also items that were not specifically identified, such as claims processing timeliness and accuracy, and provider cash flow issues, that are paramount to successful fee for service implementation. In addition, all items were weighted equally without identifying which issues were critical to implementation. In some cases, baseline performance data was limited, in part due to existing grant based funding structures, making it impossible to assess any changes that might result from conversion to fee for service.

- **Maintaining all providers at FY04 levels**—The MOU requires that all providers be maintained at FY04 contracted funding levels through at least June 30, 2005. This element actually limits the amount of federal match that can be billed by capping the state match available for providers able to bill larger amounts of Medicaid. If amounts could be reallocated from lower Medicaid billing providers to higher billing providers, federal match could be increased. This could also be achieved if new money could be appropriated to DMH for this purpose. This structural component also prevents providers from adding services or capacity to serve additional Medicaid consumers or provide additional services to existing Medicaid consumers. The problem of "running out" of funds is in part a function of inefficiencies in a grant system where funding is distributed according to historical record instead of according to a system, such as fee for service, where money follows the consumer and is paid to the provider chosen by the consumer.

- **Structural problems with cash advances of federal match**—State FFP cash flow has not been a problem in previous fiscal years. Previously, providers who were able to bill Medicaid did not receive amounts equal to the federal portion of the total rate and Medicaid amounts billed until Medicaid services had been billed to and match amounts collected from the federal government (CMS). State funds equal to all non-Medicaid funding and 50% of Medicaid billings (the "state share"), were advanced to providers on a monthly basis. However, beginning in FY 05, the MOU required that 100% of Medicaid allocations (based on FY04) be included in monthly provider advances. This acceleration in cash flow to the providers equal to approximately 50% of FY04 Medicaid billings, combined with the time required to submit and process claims through DMH, DPA and onto the federal government to the point of cash collection by the state, has created a cash shortfall in the Mental Health Trust fund and thereby jeopardized cash advances to providers during the last quarter of FY05. Unless the structure related to cash advances is altered or modifications made to state financing of these costs, problems in making provider cash advances will occur consistently in the last part of each fiscal year.

- **SRI role**—The SRI group has struggled to find its role during Parker Dennison's tenure in the state. While it has served as an important focus for gathering input and making recommendations, some participants appear to understand its function to be approval of nearly any change in the mental health system, which has created dissension and some level of paralysis for the group and the system. Because of the inherent conflict of interest with provider trade associations and providers among its members, it will be difficult for the SRI group to come to consensus on any action by the state that will result in financial or other perceived harm to any association members or provider peers. Confusion about the role of the SRI group, approval or advisory, along with the difficult issues that need to be addressed by the mental health system at this time, contribute to limitations on the functioning and achievements of the SRI group.

- **Field test timeline**—A testing period for assumptions and operations for implementing fee for service is reasonable and will improve results from fee for service conversions and reduce related disruptions to the system. However, there were a number of elements included in the requirements for the field test process that cannot be accurately or adequately measured during a six month period. Examples include changes in access, utilization, and consumer satisfaction. Baseline data needs to be developed for these types of measures and longitudinal monitoring needs to occur over several years as fee for service is implemented and more fully absorbed by the system.

# Section 3: Conversion Experiences From Other States

## Conversion Variables

Conversion of mental health services to a fee for service reimbursement methodology is certainly not unique to Illinois. In fact, the majority of states now use fee for service methodology to reimburse at least some of their behavioral health services (inclusive of mental health, substance abuse, and developmental disability). Each state has factors that cause the conversion process to play out differently. These factors include differences in:

- **Target population** – who is the program designed to serve?
- **Number of providers** – how large is the network?
- **Type of providers** – is the network composed of large, comprehensive (full continuum of services) providers, niche or single service specialty providers (such as residential), or some combination?
- **Time line for implementation** – how quickly is the conversion to 'full' fee for service put in place?
- **Type of administrative support/resource** – is the state authority self fulfilling all functions or using a managed care organization, or an administrative services organization to manage data, claims, network development, and/or quality management?
- **Availability of non-Medicaid funds** – has the state historically had non-Medicaid dollars funding substantial portions of the mental health system and are those funding levels expected to change?

No single approach is 'right' for all situations but rather the best approach is one that adjusts to each state's circumstances in the key areas above.

## Implementation Patterns and Trends

While recognizing the unique circumstances of each state situation based on the variables above, there are certain patterns and trends in fee for service conversion that transcend state borders. Those patterns include:

- **Fee for service does change the mental health delivery system** – fee for service typically involves changes in allowable services, utilization patterns, access to care, and often new clinical modalities. The changes in financing methodologies require operational changes at the provider level and ultimately changes in the financial position of agencies. Networks nearly always change somewhat, with some providers discontinuing certain services and others adding new services. It takes some years (3-5 is not unusual) for these and related changes to run their course and return to a new level of equilibrium with predictable levels of utilization, services and consumer satisfaction after the conversion.

| State[1] | New Eligibility Criteria | New Services | New Prior Authorization | New Provider Certification Standards | New Rates | New Reporting Requirements |
|---|---|---|---|---|---|---|
| Georgia | X | X | X | X | X | X |
| Hawaii | X | X | X | X | X | |
| North Carolina | X | X | X | X | X | X |
| Louisiana | X | X | X | X | X | X |
| District of Columbia | X | X | X | X | X | X |

[1] *These five states were selected because each has either completed within the past 5 years, or is in the process of implementing fee for service and share some similarities with the Illinois circumstances.*

- **Transition requires more 'supports' than anticipated** – fee for service is not a panacea for budgetary ills. In virtually every state, considerable resources have been required to initially transition systems to fee for service, and there have been ongoing costs that were not anticipated. Examples of supports and costs include:

  - **Training and technical assistance to providers** – service training, billing training, conversion technical assistance, compliance training, information system supports, and many other areas have been required.

    - For example, North Carolina has spent $1.5 million thus far on training providers in the pre-implementation phase of fee for service. The District of Columbia spent over 10% of their then current Medicaid claiming amount on provider training and technical supports, not including staffing additions and financial supports to help providers purchase new information systems. Georgia spent nearly three quarters of a million dollars for provider training and technical assistance in their first year, again not including new state regional staff, information systems supports, or non-cash training costs already accounted for in their base budget. In addition, Georgia had hired an administrative services organization, which had as part of its contract extensive provider monitoring and technical assistance.

  - **Training and technical assistance to the state** – states rarely have all of the knowledge or skills in house to adapt their systems and processes to best facilitate a fee for service system. Several states have added resources permanently to fulfill the new expectations while others have established long term relationships with consultants. In some cases, the state budgetary issues are so restrictive that it is unrealistic for the states to self fulfill or a state determines that it is not their core competency to manage fee for service. Those states typically procure an administrative services organization (ASO) which has a strong track record of systems to manage fee for service. These arrangements are typically not 'risk-based' (where the ASO benefits by limiting utilization) but rather has the ASO bring technical capabilities such as data management and reporting, claims payment, utilization review, provider monitoring and quality review, and provider/state technical assistance.

- **State and Provider infrastructure costs** – to effectively manage and operate in a fee for service system, competent data management is essential. The overwhelming majority of states converting to fee for service have purchased new data systems, hired a vendor to manage data for them, or made large scale reprogramming of legacy systems. Providers also find that to manage their own operations and to effectively and efficiently interface with the state's data system, they too need to upgrade their information systems.

| State | State Data System Changes | Provider Data System Changes |
|---|---|---|
| Georgia | • Hired vendor to manage data as part of an Administrative Services Organization agreement | • 90% (+) providers purchased nationally licensed information systems<br>• State worked with national vendors (provided funds) to tailor linkages to their vendor |
| Hawaii | • Purchased new information system at the state level<br>• Included Provider Connect software | • Providers had to interface with Provider Connect software |
| North Carolina | • Purchased new information system(s) at the local authority level<br>• Required reporting to the state level | • Not yet implemented |
| Louisiana | • State legacy system substantially reprogrammed by outside vendor to meet new needs | • Providers strongly urged by state Medicaid authority to purchase own billing systems |
| District of Columbia | • Purchased new information system at the state level<br>• Included Provider Connect software | • 90% (+) providers purchased nationally licensed information systems<br>• DMH provided infrastructure grants to some providers to help them purchase and implement new information systems<br>• small agencies required to purchase at least billing software<br>• Providers had to interface with Provider Connect software |

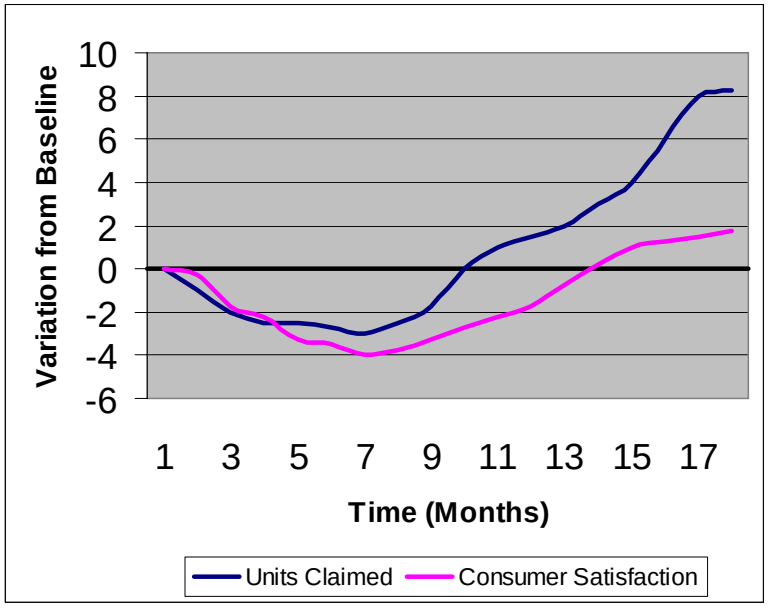
- **Unexpected costs due to conversion and/or compliance concerns** – since fee for service conversions impact services, billing, coding, and documentation several states have experienced unexpected costs.

  - *Prevalence of provider and state authority errors during early submission of claims* – Maryland for example, estimates they lost as much as $10 million due improper billing in year one.

  - *Data management errors/issues* – inadequate system edits to capture double billing, claims 'roll up' issues, service combination problems, eligibility data errors, etc. are typical during early conversion and result in unexpected reductions in Medicaid billing and increase in non-Medicaid expenses.

  - *Unrecouped advances* – to deal with provider cash flow issues during early months, states often must make substantial advances to providers with intent to reconcile in later months. Several states (including the District of Columbia, Georgia, Louisiana, and Maryland) have found that they have been limited in their abilities to force recoupement due to inadequate network coverage---recoupement could force out a provider and there is no ready alternative to ensure services.

- **Increases in federal match take time** – despite often ambitious and urgent need to increase federal match, most states find that it takes 12-18 months to begin to demonstrate meaningful increases in federal match. In fact, it is quite common that during the first calendar months of fee for service, federal match is depressed from prior year levels. Generally this is the result of early confusion, time spent doing training instead of providing services, billing system problems (provider and state), and other system realignment issues. Fortunately, 3rd and 4th quarters of the first year tend to take a marked upswing and by the time claims for the entire year flow through the system, most states can exceed prior year federal match levels, though they rarely reach the optimistic levels some states target.



- **States rapidly go from too little to too much Medicaid billing** – once provider and state systems get aligned for functioning in a fee for service reimbursement structure, Medicaid billing typically rises rapidly. It is notable that these rapid increases in Medicaid expenditures in the states noted below were in systems that required more restrictive eligibility than Illinois, pre-authorization of some or all services, and utilization review for extended care.

| State | Medicaid Claiming – Mental Health Rehabilitation ($ millions) | | | | |
|---|---|---|---|---|---|
| | FY 01 | FY 02 | FY 03 | FY04 | FY 05 (est) |
| New Jersey | | | $2.1 | $18.2 | $30.1 |
| Georgia | $64.75 | $88.6 | $105.3 | $101.2[1] | |
| DC | $6.3 | $5[2] | $19 | $33[3] | |

[1]*State implemented 10% across the board reductions in rates due to rapid cost increases in Medicaid*

[2]*Decrease was substantially the result of withdrawing of Medicaid billing due to compliance concerns*

[3]*District government has reduced provider contract levels by up to 40% to control rapid cost increases in Medicaid*

# Section 4: System Readiness

## Consumers

The primary issue for consumers in the transition to fee for service is to establish and maintain a voice in the process to ensure that the beneficiaries of the mental health system are not lost in the changes and that they have an opportunity to impact the system in which they are served. Structures and processes to gain consumer input into the development of the mental health system—both fee for service issues and overall system performance—have gained significant traction in the last 3 – 4 months. Provided the current efforts for consumer involvement and input are sustained and continue to grow, the consumer portion of the system is well-prepared to transition to fee for service.

Evidence of growing consumer involvement includes:

- Extensive and growing involvement of consumer representatives in the field test workgroups
- Identification of DMH funds to support consumer participation in various state level activities and development of criteria and a process for consumers to apply for the funding
- Multiple training efforts developed by and directed to consumers to provide information helpful to meaningful participation in system transformation efforts
- Leadership throughout the system from providers, consultants and DMH staff regarding consideration of a consumer perspective and inclusion of consumers in key processes

## Provider Readiness

### Operational Domains

Changing from a primarily grant-funded reimbursement structure to a fee for service methodology requires substantial operations changes in providers. Parker Dennison has assessed readiness of over 400 providers throughout the country and has found very common operational competencies that are essential to success in a fee for service reimbursement environment. These operational competences (or domains) include:

- **Governance and Leadership** – a governance structure that involves consumers and stakeholders, understands the organizational changes dictated by fee for service, and the operational leadership to lead an organization through a substantive change process in a structured manner
- **Access and Intake** – 'front door' operational systems that appropriately combine clinical and resource/funding triage including timely access to crisis, assessment and initial service planning, eligibility screening, and effective business practices (sliding scale, copay collection, etc)
- **Services** – clinical processes and services that are congruent with a recovery philosophy, consistently applied, increase the likelihood of compliance with Medicaid and local rules, and are productivity oriented

- **Billing and Financial Management** – business functions and financial position that support effective cash balances, timely billing and collections, cost of services consistent with reimbursement, and effective financial management tools

- **Compliance** – systems and processes that reasonably increase the likelihood of compliance with key federal, state and local rules and regulations, especially those directly related to Medicaid

- **Management Information** – computer hardware and software that supports the operational processes essential to success in a fee for service environment, including reporting and tracking functions

- **Outreach** – extent to which consumers and families are involved and supported in shaping the agency that serves them, and the extent to which the agency reaches out to the community it serves via education, information, and involvement

## Assessment Process

Parker Dennison has found that a site visit using a team comprised of a clinical and a business professional is the most definitive method to determine individual provider readiness for system transformation. However, given the large number of providers, short time line, and limited funds available to do individual provider readiness assessment in Illinois, a process using a combination of self assessment and sample site visits was developed. A stakeholder group within the Pilot Test Workgroup assisted in adapting the Parker Dennison tool to best fit Illinois terminology and circumstances. All field test providers were trained on the tool and the meaning and scoring of each element. As a result of the perceived value of the tool and process, the Pilot Test Group recommended an immediate expansion of the readiness self assessment to all providers. Seven field test providers were selected for site visits where a clinical and business team validated assessment scoring. The detailed summary of the readiness survey results is included in Appendix A. Final participation was:

- Total Participants – 64 providers
- Field Test Providers (self assessment) – 23 providers
- Field Test Providers (site visit) – 7 providers
- Non-field Test Providers – 34

This represents more than a third of the DMH mental health provider network that is targeted for fee for service conversion, suggesting that it is reasonable to extrapolate the results across the entire system. Though the data are not available to confirm it, based on experience with other provider systems, Parker Dennison believes it is likely that the majority of providers who elected not to participate in the self assessment process have lower scores and therefore somewhat greater training and technical assistance needs.

## Network Profile

To fully understand the impact of provider readiness issues, it is helpful to understand the context of the providers sampled. Key information about the sampled group representing over a third of the provider network include:

- **Overwhelmingly non-profit** – 88% of the sample is non-profit with the remainder being governmental. This is significant in that non-profit networks tend to reinvest more net proceeds into services and supports and have smaller cash reserves.

- **Bifurcated budget size** – 57% of the sample had total annual budgets of less than $6 million. Organizations of this size tend to be able to sustain and absorb some business changes and yet be small enough to more easily make operations changes. Those at the smaller budget size end of the range (less than $2 million) will find it more challenging because a larger percentage of their total budget will necessarily be fixed administrative costs and they will be affected by staffing issues more

immediately. The balance of the group had budgets of $6-15 million, 43%, and above $15 million, 27%.

- **Moderate to highly reliant on DMH contracts** – 56% of the sample rely on at least half of their annual revenue coming from DMH contracts. This number is considerably higher if all DHS contracts are included. This results in a network that is highly sensitive to changes in DMH funding levels and payment timeliness.

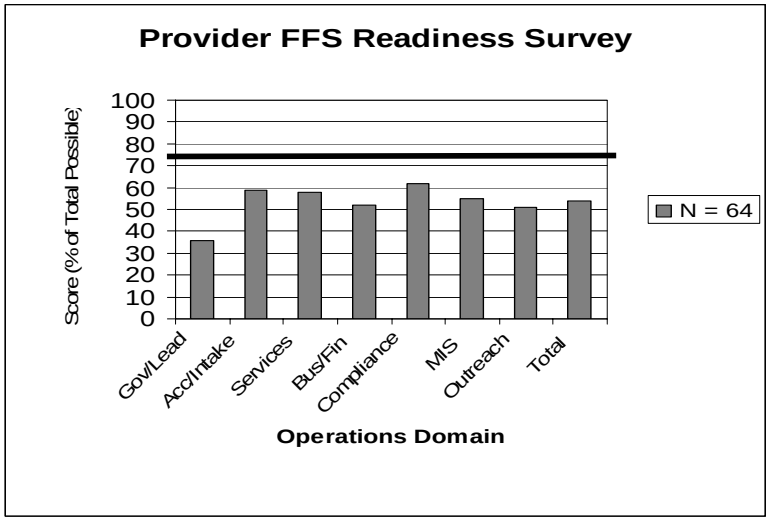
- **Serve high levels of Medicaid eligibles** – 68% of the sample reported that more than 50% of the clients they serve under DMH contracts are currently eligible for Medicaid. This level of Medicaid penetration is favorable to eventually achieving substantial levels of Medicaid billing. It should be noted that 11% of the sample reported a less than 25% Medicaid penetration rate in clients served, which may make it more difficult for them to achieve a high proportion of Medicaid billing.

- **Limited liquid assets/cash** – 25% of the sample have less than 30 days of cash reserves. 41% has less than 60 days. Parker Dennison typically recommends that providers have 60 days of cash going into systems transitions. In Illinois, however, as discussed in more detail in later sections, 60 days does not appear adequate unless mechanisms are developed to mitigate substantial delays in payment.

- **Limited information system resources** – 28% of the sample rely exclusively on ROCS, DMH's reporting software as their primary billing system. Another 31% have their own billing software but must manually enter data into both their own systems and ROCS. ROCS was not intended to provide management data for providers and was not created for a fee for service environment. Though it clearly is not the responsibility of the state to provide each provider with an information system, fee for service conversions increases the importance of strong provider (and state) information system capabilities and cash balances contribute to agencies being limited in their ability to immediately procure and/or support information system development.

## Provider Readiness Results

The provider readiness survey process strongly supports a need for considerable provider development, training and technical assistance to minimize service disruption resulting from conversion to fee for service. Additionally, the data do not appear to be skewed as a function of the self assessment. In fact, self assessment appears to result in only slightly overstated readiness. In some cases, providers are likely unable to fully self-evaluate the recommended level of functioning in a given domain due to lack of experience or information with regard to some readiness elements.



It should be noted that the purpose of the scoring and associated percentages was intended to offer 'order of magnitude' summary and to identify patterns and trends. To that end, the scoring may suggest a level of precision that is not fully validated.

These results suggest to Parker Dennison that the Illinois provider network is more advanced in their operational capabilities than what is typically found in a network at this stage of the implementation process. However, overall readiness is at a level that would indicate substantial risk to the mental health system and thus access to services, if fee for service implementation proceeded without additional provider technical assistance and training.

| Readiness Score Range | Percentage of Providers |
|---|---|
| **25% or below** | 4% of providers |
| **26-50%** | 28% of providers |
| **51-75%** | 65% of providers |
| **Greater than 75%** | 3% of providers |

These data suggest that fully a third of the provider network is substantially unprepared for successful operations in a fee for service market. These providers will likely require intensive training and in some cases ongoing mentoring to make the necessary operational changes. These providers as a group will likely require fairly intensive supports, strong commitment on their part to make changes, and require 9-12 months of additional time to have the opportunity to be successful in fee for service.

Conversely, nearly 70% of providers are within reasonable striking distance of operational readiness and with the availability of targeted training and technical assistance and focused effort on the part of the provider, have every opportunity to be successful in fee for service within 6-9 months. Of course, these findings assume timely cash flow from the state and are aggregate results. Individual provider circumstances may vary.

## Future Use of Provider Readiness Review

For providers who have participated in the provider readiness review process thus far, Parker Dennison does not recommend formal re-surveying using this tool. Providers who have participated thus far in the survey process can use the tool as an internal education aid, help set implementation and technical assistance priorities, and establish bench marks in key operational areas.

We would recommend that those providers who have not participated in the readiness review process be encouraged to do so. Should a provider request technical or financial assistance including advances, we would recommend that the tool be considered as one means to help assess likely areas in need of operational development.

## Areas of Need Identified from Provider Readiness Review

The results of the provider readiness review suggest that a substantial number of providers are in need of additional development, training, and technical assistance. Areas of need include:

- **Productivity management**

- Methods to increase productivity
- Clinical model shifts/identifying unmet clinical need
- Scheduling/management of case management activities
- Streamlining daily clinical operations
- Supervision and supports

- **Compliance**
  - Prioritizing/focusing compliance issues
  - Cost effective compliance methodology
  - High risk areas
  - Tools to minimize risk
  - Compliance by 'service' rather than 'program'
  - Integrating compliance into supervision

- **Recovery**
  - Operational definition and its importance to agencies
  - How recovery changes services and clinical approach
  - Role of consumers and families
  - Challenges and supports to expanding a recovery philosophy

- **Information systems**
  - Necessary core functions
  - Scalability/best fit for size/services of agency
  - Selection criteria
  - Options and alternatives
  - Reporting, data management, key indicators

- **Service documentation**
  - Assessment
  - Service planning
  - Service notes
  - Documentation strategies for specialty services
  - Supervision and monitoring of documentation quality and compliance

- **Functional assessment tools**
  - Options for functional assessment
  - Survey of frequently used functional assessment tools
  - Strategies for incorporation with minimal increase in costs

- **Expanding community based services**
  - Meeting consumer need with a recovery focus
  - Financial bottom line impact and cost effectiveness
  - Methods to shift clinical/service focus

- **Business office practices**
  - Billing best practices
  - Streamlining billing practices and improving timeliness
  - Role and interface with service staff in effective billing
  - Reconciliation of billing and claims
  - Tracking and resolution of billing errors (internal/state)

- **Financial analysis in a fee for service market**

- Financial modeling/impact analysis based on existing and targeted productivity
- Strategies to convert grant based revenues to fee for service
- Cost of service determination by type and staff
- Key financial indicators and benchmarks in a fee for service market

- **Provider operational competencies in a fee for service market (targeted for non-field test providers)**
  - Impact of fee for service on operations
  - Operational priorities in a fee for service market
  - Self assessment and prioritization of internal change efforts
  - Strategies to move an agency toward needed competencies

## State Readiness

Formal processes to evaluate the state's readiness to perform in a fee for service environment have not been completed, and recommendations for a structured state readiness assessment are provided in the next section. However, early impressions of some state readiness issues have been identified during the field test process.

- **Claims processing**—Claims processing data was not available for claims submitted after July 31, 2004 until January 2005 due to system changes required to implement the revised Rule 132 and to process non-Medicaid clients and services through the DPA system. There have also been delays in obtaining certain types of claims processing data that are important to managing the system and evaluating fee for service performance, such as claims by date of service (instead of date paid), and denials by type of consumer (Medicaid/non-Medicaid) and by type of service. Timely and accurate claims processing data that can be used to identify trends and problems is critical to monitoring system performance, and is particularly important for identifying potential system disruptions during the early stages of fee for service implementation. At this time, it is unclear whether claims data issues are caused by the DMH or DPA systems, inadequate system capabilities, inadequate assigned resources or other reasons.

- **Data management and analysis**—The field test process highlighted problems with obtaining stratified data about the types of consumers served—unduplicated counts, Medicaid, non-Medicaid, target population, or specialty populations. The system also has not been analyzing data using industry standard measures, such as penetration rates, to analyze performance across the system. Possible causes for these issues appear to include insufficient state resources, historical data structures, and absence of sufficient controls and requirements for mandatory elements for provider data. It is also interesting to note that the state's limited capacity for data management and analysis is reflected by overall insufficient development of management information system capabilities at the providers as evidenced by the site visits and provider readiness information. Implementation of fee for service requires effective data management and analysis capabilities throughout the system. This will in turn, create a structure and fiscal alignment to improve the amount, type and validity of data available to effectively manage the mental health system.

- **Network management and provider relations**—These functions are critical to measure individual and system-wide provider performance on a variety of dimensions, and to take action to make adjustments when the provider network is not performing at the expected level. The provider relations function is typically the front-line communication with providers for problem solving, training and technical assistance. Health insurers, managed care organization, and administrative service organizations all have network management and provider relations functions that are used to communicate with, train and shape the provider network. While portions of these functions exist in DMH/DHS in the form of audits conducted by the Bureau of Accreditation, Licensing and Certification (BALC) and efforts by contract and network staff, the activities are not performing at the level needed to

move the system forward, and are sometimes inconsistent across the state depending on resources, skills/experience, and leadership at each network location. These functions become critical at a time of system change to assist with issues such as identifying and solving implementation problems as they arise in the field, measuring and improving fidelity to service definitions, improving the consistency of performance across the state, offering training and technical assistance to providers, and developing and monitoring provider corrective action plans when problems are identified.

- **Identification/monitoring of DMH target or priority populations**—Although adults with serious mental illness (SMI) and youth with serious emotional disturbances (SED) are identified as the target or priority population in Illinois, DMH funds can be used for services for a very large range of persons with most types of mental health diagnoses. Though a target population is defined by policy for the priority use of non-Medicaid funds, there is no consistent audit or review function to insure that these funds are in fact used first for this priority population. This can lead to inconsistent and inequitable access to services depending on where a consumer lives. This is even more critical in an environment where the system is concerned that there may be inadequate levels of non-Medicaid funds available.

  While persons with Medicaid have access to a full range of available Medicaid compensable services, most states limit billing under rehabilitation services to those with certain types of diagnoses and levels of impairment as a means of directing state funds to those most at-risk populations. The extent to which the Illinois public mental health system has served those with SMI or SED, or persons with other types of mental illnesses appears to be inconsistent across the state due to host of issues, such as historical funding anomalies or regional differences, provider decisions regarding how to use DMH funds, and data management and analysis issues at the state and provider levels. Persons with SMI or SED are more likely to be eligible for Medicaid due to their disability however, eligibility is certainly not assured depending on the facts of each situation. As the system moves forward with fee for service, with funding more closely tied to individuals instead of providers or geographic areas, it will be important to more clearly define the priority and eligible populations.

- **Effective and efficient use of audits**—Parker Dennison has experienced that valid and consistent program and service audits can be one of the best tools to support needed provider system changes, and to minimize compliance risk for the entire mental health system. BALC is responsible for audits in the system currently and uses a standard audit tool that looks at both billing and regulatory requirements. While these functions are essential, the priority for audits in a transitional system should be more focused on high risk areas such as medical necessity, consistency with service definitions, effective agency compliance systems, verification of priority or target population, and documentation consistency with federal and state compliance standards. These types of audits require clinical training and for full credibility, clinical credentials. Though BALC currently does use a 'short form' audit for accredited agencies, to free up more resources to focus on critical transition issues, BALC may want to explore further reductions in the standard audit in light of 'deemed' status from national accreditation. Additionally, the state should explore whether DMH should continue its current audit processes, or if audits could be more effective if included as a part of existing Medicaid (DPA) audit structures.

- **Community-focused needs assessment**—all communities in a state as large and diverse as Illinois are not homogenous and are served best when, within guidelines, standards, and policy, mental health resources are distributed and targeted to local circumstances and need. This is especially pertinent in systems such as Illinois where a substantial amount of non-Medicaid mental health funds are distributed and there exists local mental health funding boards in some communities. While it appears that Illinois has done this on a limited basis at some point in the past, it has not been done recently, nor does it appear that systemically identified community need is driving current mental health funding allocation or priorities.

- **Consumer-focused network standards**—the ultimate purpose of the mental health system is to ensure appropriate services to those most in need. There appears to be a paucity of consumer-focused, clearly defined, and consistently measured provider network standards. This contributes to a substantial risk of inconsistent and inequitable service access by consumers and limited choice of providers. To fulfill their fiduciary requirements, state authorities typically have a clear picture of available services in each community, timely access standards (to assessment as well as ongoing services) that are measured and enforced, ensure that a full continuum of core services is available, and monitor that there is adequate capacity to meet the community needs.

The reasons for limited state performance in these areas are unclear, and may include a combination of inadequate staff resources and/or training, hardware or software capacity or functional limitations, historical data structures, insufficient staff resources with project management skills or other issues not yet identified. Also, some of the issues may, in part, be a result of the historical grant based funding structures that did not tie funding directly to consumers served or data submitted. The structured state readiness process described below should assist with the development of comprehensive information regarding state readiness and necessary changes for improvements to facilitate transition to fee for service and other system improvements.

# Section 5: Recommendations

Although the analyses above highlights many issues and risks associated with moving forward with fee for service, the change in the reimbursement structure will be beneficial to the system by making additional federal funding available and increasing/improving the service information available to analyze system performance and funding. Continued thoughtful planning and investments in the change process will be required over the next several years as a part of effectively implementing fee for service and other mental health system improvements.

Recommendations based on the information and analysis above are grouped into overall recommendations, those specifically pertaining to fee for service implementation, and finally, other system improvements that are important to the functioning and improvement of the mental health system in Illinois, but not critical to implementing fee for service.

## Overall

1. **Separate fee for service elements from other system improvements**—Critical issues that need to be addressed to implement fee for service should be identified and prioritized to achieve this objective as soon as feasible. A list of the fee for service critical issues is provided in the next subsection. The segregation of other system improvement issues, such as access standards or revisions to the service definitions to improve recovery elements and overall clarity, does not mean that these are less important or that some should not be on the same timelines as fee for service implementation. However, some areas, such as access measures and standards have not received extensive attention in the past, so it may require more time to determine the information needed, data collection methods and requirements, baseline performance and then to establish and move the system to the standards. Since most systems cannot take on fee for service conversion and the range of other improvements described in the MOU and MOA simultaneously, separation of the issues will help with focus and priorities for limited resources. It may also assist with moving forward with fee for service in a more timely manner.

2. **Refocus on needs of consumers**—The MOU and MOA appear to imply that fee for service implementation can be achieved with minimal changes to the provider network. Due to the magnitude of clinical, service, funding, and business system changes necessary to successfully function under a fee for service methodology, Parker Dennison has rarely, if ever observed system transformation that fully preserved the status quo in the provider network. In our opinion, requiring full provider status quo effectively immobilizes system transformation since it by definition does not allow the evolution of the mental health system. Some providers may not be able or choose not to make necessary changes or may opt to focus on different populations. The commitment of the mental health system then is not the preservation of a specific provider per se, but rather to ensure availability of adequate service levels regardless of who provides those services. Parker Dennison fully believes that there should be a priority to maintain the stability of the provider network and make every effort and reasonable accommodation to allow each provider to be successful. In the final analysis though, the accountability should be focused on consumers and contingency planning to ensure uninterrupted services.

3. **Renegotiate MOU**—The terms of the MOU should be renegotiated to focus specifically on critical issues for fee for service implementation. Those areas are listed in the next subsection. Changes in the MOU should also include allowing some percentage change in providers' allocation for FY06 for the purposes of capturing additional federal match, and to begin to align financial incentives with that

goal—rewarding providers able to bill more and reduce funding to providers billing very low Medicaid and non-Medicaid levels. The structural cash flow problems with the Mental Health trust fund must also be addressed by returning to the pre-FY05 practice of not advancing 50% of Medicaid billings, or developing loans or other accounting mechanisms at the state level that will allow for payments to providers prior to collection of federal matching funds. Given the somewhat precarious cash position of many providers, the latter option for a state solution is preferable.

4. **Revise SRI and advisory structure(s)**—The SRI structure should be revised to be better integrated with existing advisory groups, be inclusive of all mental health issues (including Screening Assessment and Support Services - SASS) which impact fee for service, modify its membership to better reflect consumer and community voice, and have its role expressly defined as advisory rather than oversight. It is clear that fee for service implementation and mental health system reform are long term processes that impact and are impacted by, other system initiatives. Parker Dennison did not have an opportunity to review other statewide mental health advisory bodies, but to the extent they exist, efforts should be made to eliminate areas of redundancy with SRI. Additionally, activities in the work groups have clearly demonstrated that other initiatives such as SASS can have significant impact on the fee for service conversion process and must be coordinated to have a complete picture of mental health system issues. If the scope of work is expected to truly be 'system reform' SRI should have a much more balanced representation including not only providers and consumers, but communities and local funding bodies. To this end, Parker Dennison recommends that membership on SRI (in whatever incarnation) be modified to focus more on consumer representation including youth and families, and community representatives including local funding Boards, schools, law enforcement, and community health. Again, this supports a refocus on consumers and communities and more appropriately reflects those who benefit from or are 'customers' of the mental health system. This is also important to minimize risk of cost shifting to local communities, maximize all mental health dollars, and ensure other social system structures involvement. Lastly, regardless of the form SRI might take, their charter should expressly note that their role is advisory rather than oversight and they may make recommendations but may not direct policy.

5. **Continued role of collaborative workgroups**—Collaborative workgroups have been effective thus far in the fee for service field test and should continue as a methodology on an ad hoc basis. Four work groups comprised of consumers, providers, consultants and state staff have been highly productive in analyzing issues, developing mutual understanding of impacts and constraints of key decisions, advancing of new ideas, and proposing modifications to enhance likelihood of success. Given the magnitude of system development needs, the continued use of a workgroup methodology is desirable and will likely result in not only good 'product' but continued growth in mutual understanding of issues. However, it must be noted that workgroups consume enormous amounts of provider, consumer, consulting and state staff resources, and accordingly they must constantly be focused on priority issues since there likely are not enough resources to continue to simultaneously support work groups on all issues. In the near term, Parker Dennison sees the most immediate priorities in the Finance and Services workgroups though the membership and specific areas of focus within these may need to evolve.

## Fee for Service Implementation

6. **Timeline for implementation**—Full fee for service should not be implemented until July 1, 2006, at the earliest. Progress must be made in each of the following areas prior to implementation, and critical "go/no go" elements are described within each recommendation.

    a. Some adjustments in FY06 provider funding allocations should be made to assist with capturing additional federal match and to begin to reward providers with strong billing and

reduce/reallocate funding for providers with very low Medicaid and non-Medicaid billing levels. Two possible options for funding reallocations are currently being explored by the Financial field test workgroup. The first is to have a small portion, up to 5% of FY05 Medicaid and non-Medicaid allocations, available for reallocation based on claims submitted for dates of service 7/1 – 12/31/04. The second option is to maintain current provider funding levels through 12/31/05, and to use claims for FY05 dates of service adjudicated 8/31/05 to reallocate 5 – 10% of a provider's funding. Any provider not attaining 75 – 80% of FY05 targets would have funds reallocated to those providers exceeding 100% of targets on a prorate basis.

7. **Cash flow**—The combination of the limited cash position of the providers (49% with under 60 days of cash) and the lengthy payment process at the state (30 - 83 days from claim receipt), creates the potential for significant service disruptions if fee for service implementation does not incorporate mechanisms to address cash flow. The cash flow issue must be addressed prior to fee for service implementation. Based on the state's payment history in other parts of the system, relying on possible improvements in state payment timeliness appears unwise. Therefore, the state should not implement full, retrospective fee for service (payment after claims submission) and should consider either on-going advance and reconciliation or a single large advance with retrospective fee for service to implement assuming a July 1, 2006 start. Both options are described below along with other cash flow issues.

    a. *Advance and reconciliation*—Amounts equal to FY06 contract allocations for Medicaid and non-Medicaid fee for service should be advanced to providers on a monthly basis beginning in July 2006. Beginning in November 2006, adjudicated claims for July dates of service would be compared to the 1/12 advance, and to the extent adjudicated claims are less than 75 - 90% of the advance, the November payment would be reduced by a corresponding amount. In December, the YTD calculation would be for adjudicated claims for July and August dates of service using the same 75-90% threshold. Any funding reductions would be available to allocate to providers exceeding 95 – 100% of their allocations on a prorata basis, assuming that the providers agree that funding increases are desired. A final reconciliation for FY07 would occur in January 2008 based on all FY07 dates of service adjudicated by 12/31/07, and providers could be subject to a payback of up to 10% of their FY07 allocations at that time. The threshold for funding reductions, 75 – 90%, should be set at a relatively high level to reduce the need for large paybacks at the final reconciliation. If providers are consistently advanced more funds than they are able to bill and those funds must be repaid, the repayment could generate a cash flow/viability problem with corresponding potential service disruptions. Limited exceptions could be made for providers experiencing temporary claims processing problems associated with implementation of new information systems. The state should determine the amount of resources, both staff and information system, needed to complete this reconciliation process in a timely and accurate manner and assure the availability of these resources by July 1, 2006.

    b. *Large advance and retrospective fee for service*—The state could make a 90 day advance to all providers equal to 25% of FY06 Medicaid and non-Medicaid fee for service allocations. Since capacity grants will continue to be advanced on a one month basis, the net advance to providers would be approximately 2 ½ months, which is in the range of advances made to providers as a part of the fee for service transition in other parts of the DHS system. Providers would then bill and collect on a retrospective basis beginning July 1, 2006. Contractual maximums for Medicaid and non-Medicaid billing would need to remain to prevent exceeding the total amount of state funding available. Mechanisms could be established for modifying the contractual maximums beginning in January 2007 based on billing performance for the first quarter of the fiscal year, and quarterly thereafter. Provisions would also need to be established to require provider to repay all or a portion of the advance if their contract with DMH is terminated or significantly reduced during FY07.

c. *Payment of capacity grants*--Capacity grants would continue to be paid through monthly advances.

d. *Other cash flow improvement strategies*--Other mechanisms to improve delays between date of service and claim submission, processing and payment have been developed by the Financial workgroup. Those strategies, including more rapid claims submission by providers, increasing the frequency of DMH processing, and 100% implementation of File Transfer Protocol (FTP), which is now fully operational, are the strategies that offer the greatest short term impact.

e. *Benchmarks for provider cash reserves*--Providers should work to build cash reserves of at least 60 days, and DMH should create a process to monitor providers' cash position on a quarterly basis, highlighting providers with less than 15 days of cash. Processes should be developed to monitor providers with less 15 days of cash on a monthly basis to assess cash reserves, changes in waiting lists, or other indications that a provider may be at risk of discontinuing or restricting services so that contingency plans can be developed for coverage in that geographic area.

f. *Future feasibility of contract maximums*--Based on increases in claiming levels experienced by other states following a fee for service conversion, reallocation of a fixed amount of funding will likely meet the system needs for 12- 18 months post conversion. At that point, other sources of funding and utilization controls will likely be needed to manage access to services and total system costs.

8. **State readiness assessment**—State readiness for operating in a fee for service environment should be assessed in a manner similar to that used for the providers. A readiness self assessment tool should be developed, and completed by the state, subject to site visit activities to verify readiness in key areas. An outline of the readiness tool is available in Appendix C. The final content and structure of the tool should be developed through representatives from one or more of the field test workgroups. State staff would then complete the tool, followed by a site visit by 2 – 3 consultants with specific content expertise to verify responses in key areas. The result should identify critical improvement areas—those required prior to implementing fee for service, and other improvement areas. The state readiness assessment should be completed by July 31, 2005 and any critical issues should be remedied prior to implementation of fee for service.

9. **Claims data**—Although claims processing will be captured as a part of the state readiness assessment, some improvements in the timeliness and reporting capabilities have already been identified, and planning in these areas should begin immediately. These elements must be present as soon as possible and must be present prior to implementation of fee for service.

   a. A set of standard monthly reports should be developed summarizing total network claiming levels for Medicaid and non-Medicaid. The reports should be by date of service include comparisons to FY04 Medicaid claiming levels and achievement of FY05 Medicaid and non-Medicaid targets in dollars and by number of providers. A denial report should also be developed showing the total dollar value of denials and the denial rate for Medicaid and non-Medicaid, along with a comparison to the FY04 Medicaid denial rate. The underlying provider by provider detail for these reports should also be available to target provider technical assistance as described in more detail below.

   b. FY05 denial rates are approximately three times FY04 levels largely due to the information system changes required at the state and provider levels. Claim denial rates must return to FY04 levels, 6 - 7%, for at least three months.

10. **Capacity grants needed**--The mental health system needs additional time to transition to a fee for service reimbursement structure, and the capacity grants offer a base funding level important to preserving access to services and sustaining providers from a fiscal perspective. Capacity grants should be maintained for FY06 under existing grant structures and at FY05 levels, with the exception of minor adjustments at the individual provider level required to correct FY05 errors. As funding structures are developed for FY07 and as a part of future changes in the service array, restructuring of capacity grants should include the following issues:

    a. Some level of capacity grants must be maintained as a part of the community safety net for mental health, and for services, such as crisis and outreach, that are difficult to fully support on a fee for service basis.

    b. Allocations of capacity funding should include an analysis by network and/or provider area of total population, population density, persons eligible for Medicaid, and at-risk populations that are defined by DMH as funding priorities. The analysis should increase the consistency of funding levels across the state and define priority individuals and services that may be funded with capacity grants.

    c. In the future, capacity grants can be tied more closely to serving priority populations, achieving access standards and other network performance measures that are developed as a part of system improvements.

11. **Provider safety net**—Prior to the implementation of fee for service, a plan must be developed and resources identified to address situations where providers are unable to make payroll (or must reduce staffing), and consumers' access to service is jeopardized as a result. The plan should include a baseline analysis of the number of consumers served and types/amounts of service available from each provider, regular monitoring of cash reserves as recommended above, criteria for inclusion on DHS emergency/hardship payment list (currently in place), and criteria for emergency loans. Loans should be subject to an onsite assessment of operations by DMH staff, and joint development and implementation of corrective actions plans by DMH and provider staff. The plan and criteria for emergency loans should also include provisions that indicate general cooperation with the fee for service conversion, such as some history of billing improvements from FY04 levels, and cooperation with assessment, technical assistance and development/implementation of corrective action plans. If general cooperation is not in evidence, DMH should be prepared to proceed with an emergency procurement to assure accessibility of service. Loans should be limited in amount based on the size of the DMH contract, and number of loans during the transition should also be limited. DMH should ensure that funds are available to make emergency loans, and processes are in place to replace services on an emergency basis.

12. **Provider training and technical assistance**—The readiness data and experience from other states indicate the importance of including provider training and technical assistance in stabilizing the provider network and minimizing disruptions in access to services. A plan for training and technical assistance to assist providers with the fee for service transition should be developed and implemented as soon as possible, but no later than July 1, 2005. The plan should be resourced, in part, by technical experts with experience in assisting providers with transitioning to fee for service. A draft plan is included in Appendix B, and covers large group training, customized technical assistance and criteria for which providers should receive technical assistance at various stages throughout the conversion. The plan assumes an approximate start date of June 1, 2005 and extends through one year after fee for service "go live". The plan also includes opportunities for transferring knowledge to existing state staff as a means of developing a provider relations functions as described below.

13. **Provider relations function**—Existing state network and contract management resources can serve as the foundation for development of a provider relations function in Illinois to assist the providers with the necessary operational changes. To develop provider relations competencies, the existing resources need to be organized under a senior manager at DMH with experience with provider operations and supervision of offsite staff, and sufficient time to devote to organizing these resources. Specific activities and measures need to be developed that will be applied consistently for all networks. For example, all networks should be monitoring provider cash balances, and should receive the provider monthly claiming reports for the providers in their network to determine "at risk" providers who may need increased attention or assistance. Network staff should serve as the front line response to all provider questions. Additional "frequently asked questions" should be developed in response to the inquiries to assure consistent communication across networks to all providers. Network staff should also participate in execution of the provider training and technical assistance plan as a training tool and to increase the consistency of provider message. Where possible, staff should be identified as "experts" in certain areas, such as documentation, claims, finance, or types of services, based on credentials and experience to serve as state-wide resources and trainers. The leadership and organizational activities in this area should be completed by December 31, 2005, and the development of capacity and competency in this area will be on-going.

14. **Incorporating non-field test providers**—Strategies must be developed to bring non-field test agencies along in the conversion process. While the readiness data does not indicate substantial differences in the readiness of field test and non-field test providers, it is important to begin to treat the network as an entire group from this point forward. As field test work groups proceed or are restructured after the close of the official field test, membership in these groups should be opened to other agencies, while maintaining some limitations on the overall size of the groups for maximum functioning. The recommended provider training and technical assistance is directed to all DMH providers. Also, methods for periodic meetings with all of the providers should be explored, similar to the monthly field test meetings that have been occurring. Feasibility and costs may require that the meetings are held less frequently or via videoconference. This is a general recommendation and no specific outcomes are indicated prior to fee for service implementation.

15. **Short term strategies to increase federal match**—Two possible strategies have been identified to increase federal match in the system in the short term which are described below. If these situations can be resolved prior to the beginning of FY06, the funds can be reallocated on some type of prorata basis to providers evidencing ability to exceed current Medicaid allocations, and an additional $1.5 - $2 million of additional federal match should be feasible. A third possible strategy is also outlined, but quantification of that approach is not available at this time.

    a. *Hospitals*—A number of DMH contracted providers that are part of a hospital system are able to bill for Medicaid rehabilitation services directly to DPA, bypassing DMH and depriving the mental health system of the federal match associated with services funded in part by DMH. Preliminary analysis indicates that there are approximately seven providers in this situation with Medicaid targets of approximately $2.5 - $3 million for FY05. Because these organizations are able to bypass billing through DMH, the mental health system will lose the potential for $1 – 1.5 million in federal match. Similar situations have existed in other states, and contractual provisions have been put into place to prohibit providers with direct contracts with the state Medicaid authority from billing any services defined as rehabilitative outside of the mental health system. Hospitals prefer to bill DPA directly because it results in total revenues equal to DPA billing plus DMH contractual allocations, which assists with subsidizing fully allocated hospital costs for rehabilitative mental health services. Non-hospital providers do not have this additional revenue source, direct billing to DPA, available to assist with funding of organization-wide costs. Informal inquiries about the issue have created some concerns about discontinuation of programs if the incremental DPA billing is not available.

Hospital providers in this situation should be given the option of billing DMH for all rehabilitative services beginning 7/1/05 or reducing their DMH funding for FY06 by Medicaid mental health rehabilitation services billed directly to DPA. Providers should notify DMH of their decision by 5/1/05 to allow time to replace services in the affected areas as needed.

b. *Providers not seeking Medicaid certification*—Approximately 5 – 10 providers have not sought Medicaid certification as requested by DMH and currently are allocated approximately $750,000 in Medicaid funds with no billing or capacity to bill due to the lack of Medicaid certification. While DMH has attempted to reduce funding or discontinue contracts with at least some of these providers in the past, political forces have reportedly caused it to be difficult to follow through with those changes. Under the current structure of the MOU, it is also impossible to reduce funding for these providers and make that state match available to other providers who might be in a position to generate additional federal match. By May 1, 2005, DMH should send a letter to each of these providers requesting a written response by May 15, 2005 explaining why Medicaid certification is not in place. Based on the information provided and the services provided by these organizations, DMH should take action to terminate contracts, reduce funding or provide technical assistance to assist with the completion of the Medicaid certification activities and initiation of billing by July 1, 2005. Technical assistance and additional time should only be made available to those providers indicating willingness to seek certification and striving to meet their Medicaid billing targets. If services will be impacted as a result of these actions, DMH should expand contracts with existing providers or re-procure the services, if time permits.

c. *Physician services*—Physician services are currently billed to and paid directly by DPA, and the rates are very low. It is likely that DMH state funding is subsidizing the cost of physician services for mental health consumers. If the rates were more reflective of actual costs to provide these services, the full cost would be shared equally by the state and federal governments, resulting in an increase in federal match generated by the mental health system. Since the amounts are currently billed to DPA, any increases in federal match would accrue outside the DHS budget and Mental Health Trust Fund. This approach would, however, allow DMH funds that are currently invested in psychiatric services to be used for other purposes, including increasing state match for providers able to increase Medicaid billing. Increasing physician rates has implications for physician services in other parts of the Medicaid system. However, other states have been able to improve only psychiatric Medicaid rates as a means of ensuring access to those services. At the time the cost analysis is completed later this year, the possibility of increasing physician rates should be considered as a means of increasing federal match.

## System Improvements

16. **Expanded implementation of Recovery philosophy**—As the system moves to full fee for service, the effort to involve consumers in shaping the system must be expanded to the non-field test providers. Efficient and effective means of training, mentoring and supporting consumers in this process is essential. Additional factors that should be considered to expand the role of consumers and their families more long term in shaping their service system include:

    a. Additional funding to support consumer development and participation

    b. Expansion of the consumer liaison role to all DMH providers

c. Phased in contractual requirement for consumer involvement in Boards, service development (type, curriculum), and satisfaction measures

d. Expansion of consumer peer supports as a funded service

17. **Target/priority population clarification and monitoring**—DMH should revisit its definition of priority population for non-Medicaid funds to ensure that it is reflective of policy. Considerations include whether pubic funds should be available to fund anyone without mental heath benefits, including those with jobs without insurance or without mental health coverage, or only those with more limited financial resources (100 – 200% of poverty) and/or acute levels of impairment (SMI or SED). Once DMH has confirmed the definition, a process should be implemented to monitor and ensure that non-Medicaid funds are being used first for that population and only being used for other purposes should a provider have excess funds not needed to serve the priority population. It is likely that there will need to be stakeholder discussion and perhaps legislative guidance regarding a revised priority population since this definition will directly relate to the amount of non-Medicaid funds that will need to be appropriated each year.

18. **Taxonomy, Medicaid state plan, rule and related rate revision**—To minimize compliance risk to the mental health system, increase opportunity for medically necessary Medicaid claiming, and further evolve services consistent with a recovery philosophy, the Medicaid service taxonomy should be modified. This will require a Medicaid State Plan Amendment and revision to state administrative Rule 132. The following services are consistent with the Services Workgroup analysis and recommendations.

    a. *Medicaid taxonomy changes (no additional costs)*—Create distinct State Plan definitions for the following taxonomy (includes existing services that should be reviewed/updated and some replacing existing services). With the exception of Case Management – Transition, Linkage and Aftercare, which should continue to be referenced in the State Plan under TCM, all of the services should be consolidated under the Rehab Option.

        i. Mental Health Assessment
        ii. Psychological Assessment
        iii. Treatment Plan Development, Review, and Modification
        iv. Crisis Intervention, inclusive of:
            1. Crisis Intervention Pre Hospital Screening
        v. Psychotropic Medication Administration, Monitoring, and Training
        vi. Behavioral Health Therapy & Counseling, inclusive of:
            1. Individual
            2. Family
            3. Group
        vii. Community Support, inclusive of:
            1. Individual
            2. Team
        viii. Assertive Community Treatment
        ix. Psychosocial Rehabilitation

x. Mental Health Intensive Outpatient

xi. Activity Therapy

xii. Intensive Family Based Services

xiii. Residential Supports, inclusive of:

1. Three intensities of service ranging from residential treatment to residential supports

xiv. Short Term Diagnostic and Mental Health Services

xv. Case Management – Transition, Linkage & Aftercare (TCM)

xvi. Peer Supports

b. *Timeline*--The targeted date for implementation of a revised taxonomy would be July 1, 2006. This would allow until March 1, 2006 to complete the State Plan Amendment and revise Rule 132. Four months would be allowed then for completing MIS changes, and provider training on new services. This time line is predicated on the assumption that the federal government (CMS) approves Illinois' State Plan Amendment in a timely manner.

c. *Workgroup approach*--Parker Dennison recommends that a workgroup approach be used to draft service definition recommendations for approval by DPA and DMH. The workgroups should be limited in size, be comprised of consumers, provider clinical staff, and state staff, and have considerable support from DMH staff and/or consultants to write drafts for review and discussion. Given the number services, it will likely be more effective to have several groups working simultaneously.

d. *Rate review*--Once modified service definitions are complete, rates will need to be reviewed to reflect cost implications of new standards and requirements.

e. *Limited non-Medicaid taxonomy expansion*--Though there are service gaps evident that are not compensable via Medicaid, Parker Dennison is not recommending aggressive expansion of the non-Medicaid taxonomy until there is adequate data to indicate the extent to which appropriated non-Medicaid funding levels are adequate to sustain the existing taxonomy.

19. **Community needs assessment**—To facilitate community responsiveness, DMH should conduct periodic (every 1-3 years) needs assessments. This can typically be effectively done at a regional level using a multifaceted approach inclusive of data analysis (population demographics, payer penetration rates, utilization history, etc), network analysis (locally available services/capacity), and stakeholder feedback (preferences, perceived needs, priorities from consumers, schools, law enforcement, social welfare, etc). The resulting product should be regional and aggregate state plans that identify priorities for mental health expenditures, strategies to maximize coordination and synergy of local expenditures across systems, and measures to evaluate impact.

20. **Access measures and monitoring**— DMH should have a clear picture of available services in each community, timely access standards (to assessment as well as ongoing services) that are measured and enforced, ensure that a full continuum is available, and monitor that there is adequate capacity to meet the community needs. It appears that various regions have done this to varying degrees and some practices could be used state wide. It is recommended that there be standard measures and reporting across the entire system to ensure comparability of monitoring.

21. **Consumer satisfaction and recovery perception**—If the state is adopting a Recovery philosophy, it should be accountable for measuring the degree to which consumers perceive the system change and their overall level of satisfaction with the results. DMH should maintain the work started through the

MOU/MOA processes of gathering of baseline data in both the ROSI and the MHSIP and monitor progress.

22. **Consumer access contingency plan**—DMH should have a written plan for each region indicating how they will go about ensuring uninterrupted services should a provider close new admissions, discontinue a service, or cease operations. The plan should be of considerable detail and be tailored to each region's community circumstances (available alternatives, needs, etc).

23. **Quality of services**—DMH should operationally define 'quality' for mental health services, develop key indicators, monitor those indicators and take corrective action when indicated. Again, some of this appears to exist in the regions but it was not evident that it is consistent statewide, reported, or used systemically for service improvement or corrective action. This process should include considerable input from consumers, other customers of the mental health system (schools, law enforcement, health care system) and providers to develop the areas of quality to be measured as well as to discuss findings and recommendations.

24. **Service definition fidelity**—The switch from 'programs' to 'services' under a fee for service model requires greater adherence to the definitions of each service in the taxonomy in order to minimize compliance risk and to ensure comparability of service state wide. As the service definitions are revised, an audit or review process should be instituted to periodically monitor adherence to the definitions. This can be done through the development of self assessment tools for each service which can be used by providers for their own development, and can be validated through incorporation into the routine BALC audits.

25. **Medical necessity/prior authorization**—Enhanced medical necessity standardization and guidance should be provided by the DMH to agency professionals (LPHAs) and plans should be developed for the likelihood of structured prior authorization of some services. As described above, other states that have converted to fee for service Medicaid have experienced rapid growth in Medicaid costs beginning in the second and third years after the transition. Increased short term attention to medical necessity criteria will better prepare the system to respond to this predictable future need.

# Appendices

# Appendix A—Provider Readiness Data

# RECOVERY FOCUSED FEE-FOR-SERVICE CONVERSION PROVIDER READINESS SELF-ASSESSMENT TOOL ILLINOIS VERSION - 2005

**Demographics and General Information**

1. ALL Respondents – N = 64
   Field Test (Self Score) – N = 23
   Field Test (Site Visit) – N = 7
   Non Field Test – N = 34

2. Ownership structure:

| ALL | Field Test | Site Visit | Non Field | Response |
|---|---|---|---|---|
| 0 | 0 | 0 | 0 | For Profit |
| 56/88% | 21/91% | 6/86% | 30/88% | Non Profit |
| 7/11% | 2/9% | 1/14% | 4/12% | Government |
| 0 | 0 | 0 | 0 | Other |

3. Total annual budget size of the total organization

| ALL | Field Test | Site Visit | Non Field | Response |
|---|---|---|---|---|
| 3/5% | 0 | 0 | 3/9% | Under $1,000,000 |
| 33/52% | 11/48% | 2/29% | 20/59% | $1,000,000 – 5,999,999 |
| 11/17% | 6/26% | 1/14% | 4/12% | $6,000,000 – 14,999,999 |
| 17/27% | 6/26% | 4/57% | 7/21% | Over $15,000,000 |

4. Percentage of annual budget from DMH contracts

| ALL | Field Test | Site Visit | Non Field | Response |
|---|---|---|---|---|
| 4/6% | 0 | 0 | 4/12% | More than 90% |
| 12/19% | 3/13% | 0 | 9/26% | 76 – 90% |
| 20/31% | 10/43% | 3/43% | 7/21% | 50 – 75% |
| 28/44% | 10/43% | 4/57% | 14/41% | Less than 50% |

*5.* Approximate number of consumers served under DMH contracts during FY04 *(Consumers served under DMH contracts is the number of Medicaid and non-Medicaid consumers funded in whole or in part)*

| ALL | Field Test | Site Visit | Non Field | Response |
|---|---|---|---|---|
| 7/11% | 1/4% | 0 | 6/18% | Less than 170 |
| 13/20% | 3/13% | 0 | 10/29% | 170 – 450 |
| 17/27% | 5/22% | 4/57% | 8/24% | 451 – 1300 |
| 27/42% | 14/61% | 3/43% | 10/29% | More than 1300 |

6. Percentage of clients served under DMH contracts enrolled in Medicaid (primary, secondary, or Medicaid managed care) during 7/1 – 12/31/04

| ALL | Field Test | Site Visit | Non Field | Response |
|---|---|---|---|---|
| 7/11% | 1/4% | 1/14% | 5/15% | Less than 25% |
| 14/22% | 6/26% | 1/14% | 7/21% | 25 – 49% |
| 33/52% | 14/61% | 3/43% | 16/47% | 50 – 74% |
| 10/16% | 2/9% | 2/29% | 6/18% | 75% or more |

7. Percentage of clients served under DMH contracts during 7/1 – 12/31/04 who were undocumented individuals?

| ALL | Field Test | Site Visit | Non Field | Response |
|---|---|---|---|---|
| 48/75% | 17/74% | 5/71% | 26/76% | Less than 1% |
| 7/11% | 1/4% | 1/14% | 5/15% | 2 – 4% |
| 6/9% | 4/17% | 0 | 2/6% | 5 - 9% |
| 3/5% | 1/4% | 1/14% | 1/3% | 10% or greater |

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8. Which description best describes the range of services covered under the DMH contract? (Mark one or the other description):

| ALL | Field Test | Site Visit | Non Field | Response |
|---|---|---|---|---|
| 59/92% | 23/100% | 7/100% | 29/85% | Comprehensive array of services including assessment, case management, crisis, medication services, and therapy/counseling |
| 5/8% | 0 | 0 | 5/15% | Specialty provider for a limited range of services, such as assertive community treatment, day treatment or vocational services |

9. What ages does your organization serve? (Check all that apply)

| ALL | Field Test | Site Visit | Non Field | Response |
|---|---|---|---|---|
| 39/61% | 19/83% | 5/71% | 15/44% | 0- 5 |
| 50/78% | 20/87% | 7/100% | 23/68% | 6 – 12 |
| 56/88% | 22/96% | 7/100% | 27/79% | 13 – 20 |
| 59/92% | 21/91% | 7/100% | 31/91% | 21 – 64 |
| 56/88% | 20/87% | 6/86% | 30/88% | 65 and older |

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10. Which best describes the information system used by your agency to bill for DMH services/consumers?

| ALL | Field Test | Site Visit | Non Field | Response |
|---|---|---|---|---|
| 18/28% | 5/22% | 3/43% | 10/29% | ROCS only (no other agency billing system is used) |
| 26/41% | 13/57% | 3/43% | 10/29% | Agency billing system with all client billing data, using electronic submission to ROCS |
| 20/31% | 5/22% | 1/14% | 14/41% | Agency billing system with required data manually entered into ROCS |
| 13/20% | 4/17% | 1/14% | 8/24% | Licensed system available nationally for billing only |
| 17/27% | 10/43% | 0 | 7/21% | Licensed system available nationally for billing and clinical record documentation |
| 10/16% | 4/17% | 1/14% | 5/15% | Locally developed billing system used by multiple DMH providers |
| 5/8% | 1/4% | 2/29% | 2/6% | Internally developed billing system |
| 1/2% | 0 | 0 | 1/3% | Other |

Information systems in use in sampled provider group:

1. PsychConsult
2. MedAssist
3. LYTECS
4. Unicare
5. CMHC Systems
6. PsychServ
7. Creative Socio Metrics
8. Echo
9. MediTech
10. CIS
11. HSIS
12. Theresa Pickering
13. MediSoft
14. Service Ticket Program
15. Quickbooks
16. Clinician's Desk Top
17. Shrink Rapt
18. Medical Manager
19. Med Ware
20. Anasazi
21. Tier
22. Software Solutions

11. Complete the following table indicating which services your agency currently provides in the first column and any plans to add or discontinue services upon full transition to fee-for-service.

| Current Service | | | | Services | Add/Delete | | | |
|---|---|---|---|---|---|---|---|---|
| ALL | Field Test | Site Visit | Non Field | | ALL | Field Test | Site Visit | Non Field |
| 12/19% | 5/22% | 1/14% | 6/18% | Activity therapy | 0/0 | 0/0 | 0/0 | 0/0 |
| 19/30% | 9/39% | 3/43% | 7/21% | Assertive community treatment | 1/0 | 1/0 | 0/0 | 0/0 |
| 62/97% | 23/100% | 7/100% | 32/94% | Case mgt—client ctd consultation | 1/0 | 0/0 | 0/0 | 1/0 |
| 62/97% | 23/100% | 7/100% | 32/94% | Case mgt—mental health | 0/0 | 0/0 | 0/0 | 0/0 |
| 57/89% | 21/91% | 6/86% | 30/88% | Case mgt—linkage/aftercare | 1/0 | 0/0 | 1/0 | 0/0 |
| 30/47% | 14/61% | 3/43% | 13/38% | Comprehensive MH services | 1/0 | 0/0 | 0/0 | 1/0 |
| 58/91% | 22/96% | 6/86% | 30/88% | Crisis intervention | 0/1 | 0/0 | 0/0 | 0/1 |
| 48/75% | 21/91% | 5/71% | 22/65% | Crisis intervention—pre-hospital scr | 0/1 | 0/0 | 0/0 | 0/1 |
| 15/23% | 8/35% | 3/43% | 4/12% | Intensive family-based services | 2/0 | 1/0 | 0/0 | 1/0 |
| 62/97% | 23/100% | 7/100% | 32/94% | Mental health assessment | 1/0 | 0/0 | 0/0 | 1/0 |
| 18/28% | 6/26% | 2/29% | 10/29% | Mental health day treatment | 0/1 | 0/0 | 0/0 | 0/1 |
| 11/17% | 5/22% | 2/29% | 4/12% | Mental health intensive outpatient | 1/0 | 0/0 | 0/0 | 1/0 |
| 37/58% | 15/65% | 7/100% | 15/44% | Psychological evaluation | 0/0 | 0/0 | 0/0 | 0/0 |
| 52/81% | 21/91% | 6/86% | 25/74% | Psych. medication administration | 0/0 | 0/0 | 0/0 | 0/0 |
| 59/92% | 22/96% | 7/100% | 30/88% | Psych. medication monitoring | 0/1 | 0/0 | 0/0 | 0/1 |
| 57/89% | 22/96% | 7/100% | 28/82% | Psych. medication training | 0/0 | 0/0 | 0/0 | 0/0 |
| 6/9% | 4/17% | 0 | 2/6% | ST diagnostic and MH services | 0/0 | 0/0 | 0/0 | 0/0 |
| 51/80% | 20/87% | 6/86% | 25/74% | Skills, trng and development | 2/0 | 0/0 | 1/0 | 1/0 |
| 49/77% | 20/87% | 7/100% | 22/65% | Therapeutic behavioral services | 1/0 | 0/0 | 0/0 | 1/0 |
| 61/95% | 22/96% | 7/100% | 32/94% | Therapy/counseling | 0/0 | 0/0 | 0/0 | 0/0 |
| 61/95% | 23/100% | 7/100% | 31/91% | Tx plan dev/review/modification | 1/0 | 0/0 | 0/0 | 1/0 |
| 23/36% | 9/39% | 0 | 14/41% | Adaptive/social rehab—vocational | 2/1 | 2/0 | 0/0 | 0/1 |
| 22/34% | 10/43% | 2/29% | 10/29% | Oral interpretation and sign language | 0/1 | 0/0 | 0/0 | 0/1 |
| 21/33% | 5/22% | 4/57% | 12/35% | Supported employment | 5/1 | 2/0 | 0/0 | 3/1 |
| 13/20% | 4/17% | 2/29% | 7/21% | Vocational, education testing/eval | 3/0 | 1/0 | 0/0 | 2/0 |
| | | | | | | | | |
| | | | | | | | | |

| | Dimension | ALL | Field Test | Site Visit | Non Field |
|---|---|---|---|---|---|
| **Governance and Leadership** | | | | | |
| 1. | Do current versions of organization's mission/vision/values include express commitment to recovery and a process for achieving recovery oriented services? | 14/22% | 4/17% | 1/14% | 9/26% |
| 2. | Is the board composition inclusive of a primary consumer and/or family member, and a business oriented professional (CPA, attorney, senior manager)? | 43/67% | 15/65% | 5/71% | 23/68% |
| 3. | Have all members of the board participated in education regarding both fiduciary responsibilities and establishing/monitoring organizational performance indicators? | 37/58% | 16/70% | 2/29% | 19/56% |
| 4. | Has the board received training regarding provider fee-for-service core competencies and the specific impact of transition to fee-for-service on governance and leadership? | 22/34% | 8/35% | 3/43% | 11/32% |
| 5. | Does the organization have a written plan (goals, tasks, resources, timelines) to transition to recovery oriented fee-for-service and report progress regularly (at least monthly) to senior management and the board? | 5/8% | 3/13% | 0 | 2/6% |
| 6. | Has the organization developed and communicated a change-management process (inclusive of what to expect in the process, plan for ongoing communication, changes in procedures/responsibilities) to staff and consumers? | 7/11% | 2/9% | 1/14% | 4/12% |
| 7. | Does organization have <u>all</u> of the following performance indicator information? *(Please check each area that is currently in place)* | 32/50% | 10/43% | 5/71% | 17/50% |
| | __Written indicators | 38/59% | 12/52% | 5/71% | 21/62% |
| | __Regular measurement against those indicators that is reported to leadership and board | 36/56% | 11/48% | 5/71% | 20/59% |
| | __Demonstrated impact on operations resulting from performance indicator measurement | 33/52% | 11/48% | 5/71% | 17/50% |

| | Dimension | ALL | Field Test | Site Visit | Non Field |
|---|---|---|---|---|---|
| | ***Max Score = 7 Average Total Score Governance and Leadership*** | 2.5/36% | 2.5/36% | 2.1/30% | 2.5/36% |
| **Access and Intake** | | | | | |
| 8. | Is the average time from first call to initiation of assessment less than or equal to ten calendar days? | 43/67% | 15/65% | 5/71% | 23/68% |
| 9. | Is eligibility for Medicaid, Medicare and other third party benefits checked and documented in the record at first appointment and once a month thereafter? | 24/38% | 9/39% | 4/57% | 11/32% |
| 10. | Do front desk (reception or clerical support) staff review financial resources, screen for possible Medicaid eligibility and apply a sliding fee scale to individuals who present without Medicaid or other third party benefits? | 41/64% | 14/61% | 6/86% | 21/62% |
| 11. | Are front desk staff able to determine the amount of any co-payment (from the record or the billing system) and expected to collect the co-payment at the time of service? | 37/58% | 13/57% | 4/57% | 20/59% |
| 12. | When indicated by client need (urgent/emergent), does the organization have the ability to provide same day face-to-face assessment appointments? | 60/94% | 21/91% | 7/100% | 32/94% |
| 13. | When indicated by client need (urgent/emergent), does the organization have the ability to provide same day face-to-face psychiatrist appointments? | 18/28% | 6/26% | 4/57% | 8/24% |
| 14. | Does the organization have a centralized scheduling process (manual or automated) where appointments are scheduled using a master schedule with ability to schedule urgent, next or missed appointments into any available slot? | 39/61% | 18/78% | 3/43% | 18/53% |
| | ***Max Score = 7 Average Total Score Access and Intake*** | 4.2/59% | 4.2/59% | 4.7/67% | 4.0/58% |
| **Services** | | | | | |
| 15. | Have direct service clinical staff been trained in <u>all</u> of the following areas? *(Please check each area where training has been provided)*<br>__ New service taxonomy | 19/30% | 9/39% | 2/29% | 8/24% |
| | __ Rule 132 requirements | 38/59% | 15/65% | 5/71% | 18/53% |
| | __ Recovery based approach to services | 46/72% | 16/70% | 5/71% | 25/74% |
| | __ Periodic training updates on changes/clarifications | 22/34% | 9/39% | 3/43% | 10/29% |
| | | 39/61% | 14/61% | 5/71% | 20/59% |
| 16. | Does the assessment process include <u>all</u> of the following? *(Please check each area included in the assessment)*<br>__ Consistent form (adult and youth forms may be different) | 44/69% | 13/57% | 5/71% | 26/76% |
| | __ Completed on a timely basis (within 45 days of admission) | 55/86% | 18/78% | 6/86% | 31/91% |
| | __ Standardized functional assessments (e.g., LOCUS, CALOCUS, CAFAS, Multnomah) | 54/84% | 18/78% | 6/86% | 30/88% |
| | __ Diagnostic components | 44/69% | 12/52% | 5/71% | 27/79% |
| | | 53/83% | 17/74% | 6/86% | 30/88% |
| 17. | At least 75% of the time, do consumers and parent/guardians (minors) participate in the treatment planning process as evidenced by participation in treatment planning conferences and their signature on the treatment plan? | 53/83% | 18/78% | 6/86% | 29/85% |
| 18. | Do at least 75% of treatment plans directly reflect diagnosis, assessed functional needs, consumer preferences, consumer strengths, and natural supports? | 38/59% | 15/65% | 2/29% | 21/62% |
| 19. | Are at least 75% of treatment plans reviewed and updated as needed or at least once every 180 days inclusive of consumer/family participation in the review process? | 49/77% | 18/78% | 6/86% | 25/74% |
| 20. | Are core services (assessment, medication monitoring/education, and case management, etc) available at times appropriate to consumer needs and preferences, including evenings and weekends? | 28/44% | 14/61% | 1/14% | 13/38% |
| 21. | Are the majority (>50%) of service units delivered in the community/natural setting (not office locations)? | 18/28% | 5/22% | 2/29% | 11/32% |
| 22. | Excluding psychiatric services, is the time from referral to first service < 30 days for Medicaid enrollees? | 46/72% | 16/70% | 3/43% | 27/79% |
| 23. | Excluding psychiatric services, is the time from referral to first service < 30 days for non-Medicaid consumers? | 47/73% | 16/70% | 3/43% | 28/82% |
| 24. | Do clinical supervisors receive staff productivity reports at least monthly, use those reports in direct supervision of staff, and demonstrate a change in practice as a result of these efforts? | 36/56% | 15/65% | 5/71% | 16/47% |

| | Dimension | ALL | Field Test | Site Visit | Non Field |
|---|---|---|---|---|---|
| 25. | Does the organization have a system to monitor and supervise line staff to ensure service delivery (type, frequency, duration), is consistent with the service definitions, and the treatment plan and can demonstrate a change in practice as a result of this system ? | 35/55% | 12/52% | 4/57% | 19/56% |
| | ***Max Score = 11 Average Total Score Services*** | 6.4/58% | 6.5/59% | 5.6/51% | 6.5/59% |
| **Billing and Financial Management** | | | | | |
| 26. | Does the organization require service staff to submit billing information within 1-2 business days from the delivery of service and does data indicate at least a 75% compliance rate with this policy? | 27/42% | 10/43% | 3/43% | 14/41% |
| 27. | Does the organization use a claims system capable of generating HIPAA compliant electronic claims (837I or 837P)? | 40/63% | 14/61% | 4/57% | 22/65% |
| 28. | Does the organization track average time from date of service to claims submission, and is the average time less than or equal to 14 calendar days? | 11/17% | 3/13% | 1/14% | 7/21% |
| 29. | Does the organization consistently bill Medicare (for Medicare eligible services) prior to Medicaid when a consumer is dually eligible? | 41/64% | 18/78% | 6/86% | 17/50% |
| 30. | Does the organization submit claims to any payor at least twice per month? | 26/41% | 13/57% | 2/29% | 11/32% |
| 31. | Does the organization submit claims to any payor at least once per week? | 10/16% | 5/22% | 1/14% | 4/12% |
| 32. | Does the organization have at least 30 days of cash reserves (Days of cash reserves = Cash + Investments/{Average monthly expenses/30 days})? | 49/77% | 17/74% | 3/43% | 29/85% |
| 33. | Does the organization have at least 60 days of cash reserves? | 39/61% | 13/57% | 3/43% | 23/68% |
| 34. | Is there a process to reconcile amounts billed to paid/accepted claims within ten business days of receipt of reports/remittance advice and resubmit claims as indicated? | 34/53% | 13/57% | 3/43% | 18/53% |
| 35. | Has the organization calculated costs per unit (including delineation of direct and indirect cost components) for each service provided under the DMH contract? | 30/47% | 7/30% | 2/29% | 21/62% |
| 36. | Have efforts been made during the past 12 months to reduce unit costs? | 31/48% | 12/52% | 2/29% | 17/50% |
| 37. | Does agency have productivity targets or standards for a majority (more than half) of clinical direct service staff? (Productivity = billed or reimbursable time under rule 132 / paid time) | 51/80% | 21/91% | 5/71% | 25/74% |
| 38. | Do average productivity rates for all clinical staff equal or exceed 50%? | 41/64% | 17/74% | 2/29% | 22/65% |
| 39. | Are <u>all</u> of the following financial elements available via report for management review and use? *(Please mark each element present in current system)*<br>__ Number of consumers by payment source served per month<br>__ Number of units of each type of service per month<br>__ Number of each type of staff and corresponding salary/benefit costs<br>__ Actual productivity rate for each direct service staff<br>__ Indirect costs for each program<br>__ General and administrative overhead rate | 28/44%<br>38/59%<br>47/73%<br>42/66%<br>40/63%<br>43/67%<br>45/70% | 13/57%<br>15/65%<br>17/74%<br>14/61%<br>15/65%<br>14/61%<br>15/65% | 4/57%<br>4/57%<br>5/71%<br>5/71%<br>4/57%<br>5/71%<br>5/71% | 11/32%<br>19/56%<br>25/74%<br>23/68%<br>21/62%<br>24/71%<br>25/74% |
| 40. | Has the organization prepared a financial impact analysis or projections for the transition to fee for service? | 23/36% | 9/39% | 4/57% | 10/29% |
| 41. | Do other revenue sources (non-DMH/non-Medicaid) comprise at least 15% of the organization's annual revenues? | 54/84% | 20/87% | 7/100% | 27/79% |
| | ***Max Score = 16 Average Total Score Billing & Financial Management*** | 8.3/52% | 8.9/56% | 7.4/46% | 8.1/51% |
| **Compliance** | | | | | |
| 42. | Does the organization have a compliance plan that has been approved by leadership and the board of directors, and a staff person assigned who is responsible for monitoring and updating the compliance plan? | 39/61% | 18/78% | 3/43% | 18/53% |
| 43. | Is there evidence that all current staff and new hires are trained on compliance requirements including confidentiality, fraud/abuse, and clinical record documentation requirements (for clinical staff)? | 52/81% | 19/83% | 4/57% | 29/85% |
| 44. | Does the organization have a consistent and reliable process to ensure all delivered services are included on a treatment plan that covers the date of service? | 38/59% | 17/74% | 4/57% | 17/50% |
| 45. | Does the organization have a consistent and reliable process to monitor the accuracy, completeness and timeliness of clinical record documentation for each billed service including matching to units billed? | 42/66% | 15/65% | 6/86% | 21/62% |
| 46. | Does the organization have a consistent and reliable process to monitor whether services delivered demonstrate fidelity to service definitions and programmatic requirements? | 31/48% | 11/48% | 3/43% | 17/50% |

| | Dimension | ALL | Field Test | Site Visit | Non Field |
|---|---|---|---|---|---|
| 47. | Does the organization have a written plan to monitor medical necessity & can demonstrate documented practice impact? | 18/28% | 8/35% | 3/43% | 7/21% |
| 48. | Does the organization have a consistent and reliable process to ensure that services are delivered by staff with credentials required by regulation and/or service definitions? | 58/91% | 22/96% | 7/100% | 29/85% |
| | ***Max Score = 7 Average Total Score Compliance*** | 4.3/62% | 4.8/69% | 4.3/61% | 4.1/58% |
| **Management Information** | | | | | |
| 49. | Does the organization have an information system that is capable of tracking client demographics and billing information? | 55/86% | 22/96% | 4/57% | 29/85% |
| 50. | Do at least 80% of employees have access to a work station and e-mail? | 42/66% | 16/70% | 2/29% | 24/71% |
| 51. | Does the information system track treatment plan expiration dates to ensure that services are not being delivered under an expired treatment plan? | 26/41% | 11/48% | 1/14% | 14/41% |
| 52. | Does the information system include eligibility/payer source for each consumer? | 51/80% | 22/96% | 4/57% | 25/74% |
| 53. | Is an automated scheduler available and used for at least assessments, therapy/counseling, and psychiatric services? | 30/47% | 14/61% | 3/43% | 13/38% |
| 54. | Are monthly productivity reports produced within 15 days of the preceding month for each direct service staff and program? | 35/55% | 15/65% | 3/43% | 17/50% |
| 55. | Are monthly no show rate reports produced within 15 days for the preceding month for each direct service staff and program? | 16/25% | 6/26% | 2/29% | 8/24% |
| 56. | Are information system functions resourced to ensure production of routine reports according to established deadlines, provide help desk functions within one business day, and produce 80% of *ad hoc* reporting within 14 business days of request? | 28/44% | 13/57% | 4/57% | 11/32% |
| | ***Max Score = 8 Average Total Score Management Information*** | 4.4/55% | 5.2/64% | 3.3/41% | 4.1/52% |
| **Outreach** | | | | | |
| 57. | Are consumers who have been asked to participate in governance or workgroup activities been offered assistance, training, and ongoing support to maximize their comfort and effectiveness consistent with the nature of their involvement? | 38/59% | 14/61% | 5/71% | 19/56% |
| 58. | Does the organization offer financial assistance (reimbursement for travel and/or time) for consumer participation in governance and work groups? | 30/47% | 11/48% | 5/71% | 14/41% |
| 59. | Is there a communication plan (goals, tasks, resources, timelines) targeting consumers and other key stakeholders describing the transition to recovery focused fee-for-service? | 6/9% | 3/13% | 2/29% | 1/3% |
| 60. | Does the organization have a plan (goals, tasks, resources, timelines) to participate in community activities designed to educate referral sources, consumers, and families regarding availability of services and supports? | 21/33% | 5/22% | 4/57% | 12/35% |
| 61. | Does the organization demonstrate cultural responsiveness through promotion of inclusion, prohibiting discrimination, staff race/ethnicity reflective of program participants, requiring competency training for all, and availability of translators? | 51/80% | 18/78% | 5/71% | 28/82% |
| 62. | Does the organization have a process to focus outreach efforts to encourage active engagement for consumers/families in need (both enrolled and new clients)? | 33/52% | 12/52% | 3/43% | 18/53% |
| 63. | Does the organization have a process to collect information regarding consumer/family satisfaction and can demonstrate the information has been used to change practice or processes? | 52/81% | 18/78% | 5/71% | 29/85% |
| | ***Max Score = 7 Average Total Score Outreach*** | 3.6/51% | 3.5/50% | 4.1/59% | 3.6/51% |
| | ***Max Score = 63 GRAND TOTAL ALL SECTIONS*** | 33.7/54% | 35.6/56% | 31.6/50% | 32.9/52% |

# Appendix B–Provider Training and Technical Assistance Plan

The plan described on the following pages combines group training with targeted technical assistance to improve provider readiness for operating in a fee for service environment. The plan assumes consulting resources for site visits and training to bring practical experience with fee for service implementation in other states. Implementation of the plan will include substantial participation by state network staff as a way to transfer knowledge to those with ongoing responsibilities to develop the provider network. The plan assumes an approximate start date of June 1, 2005, a "go live" date of July 1, 2006 for fee-for-service implementation, and extends approximately 12 months after that date. Additional training and technical assistance will be needed during the second year of implementation and should be identified based on performance results and issues during the first several months of fee for service implementation. It is important to note that a portion of the effectiveness of training and technical assistance is dependent on the investment and commitment of providers and their management teams.

# Provider Training and Technical Assistance Plan

**June 1 – August 31, 2005**

- **Technical assistance site visits to selected agencies**
    - Site visits for providers selected from two groups--those with the largest gaps between Medicaid and non-Medicaid actual billing and FY05 targets (amount and percentage), and providers who have not yet become Medicaid certified.
        - Criteria should be established to guide the providers selected for these site visits and should include quantitative elements, such as billing gap, ability to replace affected services, and submission of Medicaid application, as well as providers' indicated willingness to make changes and accept technical assistance.
        - DMH network staff should participate in the site visits as a training tool and to develop the capacity to follow-up on recommended actions.
        - Each site visit will result in a work plan identifying the top 4 – 6 priority areas that will result in the greatest short term improvement in appropriate billing and overall financial position. DMH network staff will be responsible for following implementation of the work plan.
- **Training for DMH network staff**
    - Brief training will be held for DMH staff who will be participating in site visits to describe the approach and activities at each site visit, and the role for these staff during the visit and for follow-up.
- **Training for non-field test agencies (available to all agencies)**
    - DMH staff and consultants should jointly conduct sessions describing the results from the field test process, recommended implementation plans for the next 1 – 2 fiscal years, and review of key operational areas for successful fee for service performance.
- **Publication of training schedule for the balance of the calendar year**
    - Using topics identified in the Provider Readiness section along with any newly identified training needs, a training schedule will be developed and published. Efforts will be made to coordinate DMH planned training with offerings by the provider trade associations to avoid duplication and maximize use of resources.
- **Development of financial models for fee for service performance and associated training**
    - Excel templates will be developed to assist agencies in optimizing financial performance under fee for service, along with how to begin to integrate this information into clinical operations
- **Assistance with selection of provider information systems**

  - Development of list of key functions for provider information systems and selection criteria along with training regarding how to use the information (training may be combined with financial models above).

- **Provider training**

  - Large group training based on the topics identified in the Provider Readiness section as time permits.

**September 1 – December 31, 2005**

- **Additional provider site visits**

  - Based on newly identified needs and associated selection criteria, these visits will generally be targeted to providers who have not received site visits in the past. However, situations may arise where follow-up site visits occur for a small number of providers based on the judgment of DMH and its consultants.

- **Provider training**

  - Based on the schedule and the topics identified in the Provider Readiness section. Large group training sessions will be held on each broad topical area by the end of the calendar year.

  - Specific sessions should be conducted for how to approach services using a recovery orientation, and how to develop meaningful roles for consumers in provider organizations.

- **Provider forums**

  - Periodic "all provider" meetings for an update on progress and plans for implementation of fee for service

- **Publication of materials for Board of Directors**

  - To assist with development of governance boards, which is consistent with the structure of nearly 90% of the DMH network, written materials will be developed to inform Board members, describing fee for service and offering ideas about their role in assisting with the transition--the right balance between advocating for their agency and effective governance and leadership through the change, key high level performance indicators, and expectations for a CEO in this environment. Use of the materials would be optional, but may be required if the provider requests technical assistance or bridge funding.

- **Implementation training**

  - If any changes will occur effective January 1, 2006 (for example, allocation changes or implementation of any new service requirements that are a part of Rule 132 and Medicaid state plan modifications), corresponding training will be provided.

**January 1 – June 30, 2006**

- **Provider training**

- Repeat of selected provider training from the previous period designed to reach additional staff and reinforce the messages.

- **Provider forums**

  - Continued from preceding section.

- **Implementation training** (assumes "go live" date of July 1, 2006)

  - Reimbursement--Training will be provided to describe planned changes in reimbursement, allocations and other financial terms of the FY07 contracts.

  - Services—If any changes will be made in service definitions and underlying requirements as a part of the recommended changes to the Medicaid state plan and rule 132, detailed implementation training will be held for each service or group of services.

**July 1, 2006 – June 30, 2007**

- **Post-implementation training**

  - Repeat implementation training, particularly for services, approximately 60 – 90 days post implementation once providers have had experience with delivering services under the new structures. These post-implementation sessions allows more in-depth discussion of operational aspects of the issues.

- **Written FAQs**

  - Implementation of new procedures and requirements always generate a series of questions that cannot be fully anticipated pre-implementation. Network staff should be responsible for identifying provider questions through the pre-implementation process and developing a "frequently asked questions" document. Processes should be identified for capturing questions, seeking guidance on accurate responses, and review by critical DMH staff. The initial version of the FAQs should be published near the implementation date and updated periodically thereafter. This document should focus on operational issues associate with billing and service changes.

- **Provider site visits**

  - Criteria should be developed to identify situations where provider site visits are needed to improve performance or preserve access to services. Criteria should include significant actual or potential revenue reductions (depending upon the payment mechanisms selected), waiting lists for services, extremely small cash balances, and request for emergency loans or bridge funding. Work plans should be produced describing the critical issues that need to be addressed to improve performance in the short term and network staff should be responsible for monitoring implementation of the plan.

- **Other training**

  - Based upon the activities described above, and performance monitoring, additional training needs will likely become apparent and will need to be addressed throughout the balance of the fiscal year.

# Appendix C—State Readiness Areas

The outline on the following pages identified broad areas and key issues that should be incorporated into the state readiness self-assessment tool and focus only on capabilities needed for successful performance in a recovery-focused fee for service environment. The final tool should be developed based on input from DMH and DPA staff, consultants and one or more of the field test work groups.

## State Fee for Service Readiness Outline

I. Leadership and experience

A. Amount of senior resources dedicated to fee for service implementation, including other responsibilities

1. Clinical
2. Financial
3. Consumer affairs
4. Network management
5. MIS

B. Level of experience—fee for service reimbursement, project management, Medicaid reimbursement requirements

1. Can be supplemented with contracted resources

C. Advisory/input structures—clear leadership, defined roles, regional input available

II. Staffing levels

A. Organization chart identifying staff with fee for service responsibilities and amount of time (in FTEs) available to this project

III. Claims processing

A. Staffing—amount and credentials/experience

B. Processing flow, edits, timelines and internal controls

C. Standard reports

D. Interface with DPA

E. Pends/denials

F. Testing routines and capacity

IV. Network management and provider relations

A. Staffing

1. Amount

2. Credentials/experience

3. Organizational structure/supervision

B. Performance measures and data

1. Provider monitoring

2. Process for identifying and addressing access/coverage issues

C. Defined provider responsibilities and interface

D. Documents and materials

1. Service definitions

2. Billing procedures

3. Frequently asked questions (FAQs)

4. Training schedule

5. Website

V. Information systems and data management

A. Hardware/software

1. New generation or legacy programs and impact on functioning levels

2. Feasibility of modifications—speed, risk to system stability, testing

3. Data warehouse capacity

4. Reliability--History of scheduled/unscheduled downtime

5. HIPAA transaction compliance

6. File transfer protocol (FTP)

B. Reporting capabilities

1. Inventory of regular reports in key areas—clients served (Medicaid, non-Medicaid, priority and specialty populations), services (not programs) delivered, encounters/claims, historical and current year.

2. Timeliness—average time to produce routine and ad hoc reports

3. Flexibility

VI. Quality management, compliance and audits

A. Provider performance standards

B. Tools

    1. Service fidelity

    2. Medical necessity

C. Audits

    1. Staffing—levels and credentials/experience

    2. Scope and purpose for audits

    3. Tools

    4. Interface with DPA