PARKER & DENNISON
Associates, Ltd.

Fee-for-Service State Readiness Review

Illinois Division of Mental Health (DMH)

~ F I N A L ~
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Executive Summary

As a part of the continued implementation of fee-for-service funding methodologies, Parker Dennison & Associates, Ltd. (*Parker Dennison*) was retained by the Division of Mental Health (DMH) to provide facilitation and technical assistance. DMH and *Parker Dennison* field test evaluation reports from last fiscal year were unanimous in their recommendations that an assessment of the state's readiness to proceed to fee-for-service was necessary and important.

To complete the assessment *Parker Dennison* assembled a team of national experts with specific experience in state government, fee-for-service conversions and system transformations in multiple states. Collectively, the team members have more than 50 years of experience with public sector mental health services and have worked in nearly every state. The team included clinical, financial, and information system resources, including two team members who have either previously or currently held positions in state mental health agencies. The team members are also familiar with the uniqueness of various federal funding streams and the complex federal laws and regulations that pertain to behavioral health services.

The assessment process included a combination of on and offsite review of materials and meetings with key staff from DMH, as well as DHS and HFS for information system reviews. The process also included teleconference meetings with more than 50 providers to gather first-hand information regarding their experiences with using the state's management information systems and the regional structures. The five-person assessment team was onsite for three days and met with nearly 40 representatives from DMH, DHS and HFS.

Based on information gathered from those processes, key conclusions and recommendations regarding the State of Illinois' readiness to move the mental health system to full fee-for-service are summarized in this report.

Summary Conclusion

It is not feasible for DMH to move the mental health system to full fee-for-service nor full advance and reconciliation reimbursement by July 1, 2006 due to a number of critical limitations and lack of capacity in key functional areas. *Parker Dennison* concluded that the most cost effective, timely, and most likely to succeed recommendation is for an Administrative Services Organization (ASO) to be procured to remediate the functional deficits. Assuming procurement timelines and implementation timeframes as specified in this report, the mental health system could move to full fee-for-service with the required competencies in place by July 1, 2007.

Key readiness issues include:

- **Information system limitations**—limited functionality, limited resources, poor data integrity and compliance
- **Limited claims processing capabilities**—complex process flows, no clear linkage to payment process, inadequate claims edits and related protections
- **Prohibitively slow payment cycles**—inadequate provider reserves to sustain viability with claims payment cycle currently ranging from 72-168 calendar days
- **Inadequate compliance monitoring**—unacceptable levels of financial and qualitative risk due to no monitoring of non-Medicaid services/consumers, limited scope of BALC audits, and over-reliance on provider self-monitoring

- **Paucity of effective cost controls**—ineffective eligibility and target population controls, extremely limited guidance and monitoring of medical necessity, questionable viability of contract limits, and no systems to require or manage prior authorization
- **Severe personnel under-resourcing for required operational functions**—shortage of approximately 70-75 DMH staff if self-fulfilling fee-for-service functions, restrictive and slow personnel system precludes rapid movement, competitive recruitment for needed skills/experience, and necessary re-deployment
- **Under-resourced DMH transitional supports**—nearly 35% of approved Central Office positions are vacant, only two staff are assigned to fee-for-service transition full time while a total of 10-15 FTEs contributing to fee-for-service and system redesigned efforts.

This report is structured with the following sections:

Section 1: State Competencies for Fee-for-Service—describes the capabilities that state authorities must either self fulfill or procure to successfully implement and manage a fee-for-service based mental health system.

Section 2: Feasibility/Risks of Fee-for-Service at July 1, 2006—describes the most significant findings of the evaluation of systems.

Section 3: Recommendations to Implement Fee-for-Service—provides information regarding the buy or build evaluation for remediating functional deficits, summarizes the recommendation for an ASO, and provides associated timelines.

Section 4: Recommended Structure for DMH Fee-for-Service Responsibilities—describes specific functions for fee-for-service, locus of those functions, and a functional organization chart incorporating management of an ASO.

Appendices—Includes detailed analysis and reports including:

A. Summary of the assessment process and *Parker Dennison* resources
B. DMH staffing analysis
C. DMH fee-for-service organizational structure and resources
D. MIS findings and recommendations
E. Claims payment cycle and timelines
F. Target and eligible population penetration for FY 04
G. Examples of ASO performance targets
H. Examples of ASO claims analysis reports
I. DMH readiness analysis detail

Section 1: State Competencies for Fee-for-Service

A change from grant funding to fee-for-service funding is not just a technicality regarding how services are billed. A shift to fee-for-service represents a fundamental change in the foundations of a mental health system to one that focuses ultimately on the consumer benefit. Specifically, states utilizing a primary fee-for-service system for purchasing services for consumers must build competencies and capabilities that consistently answer the following questions:

Consumer Benefit Questions

- ***Who do you pay for?—***The definition(s) of who is eligible to receive the defined state benefits.
- ***What do you pay for?—***The types, standards/requirements, and amounts of services that must be available and may be purchased (the benefit package).
- ***How do you pay for it?—***The fund source, unit of service, and payment method that will be used for each service purchased.
- ***How do you determine when to pay for it?—***The circumstances of necessity (medical or social), consumer choice, and duration of services.
- ***How are you sure that you've gotten what you paid for on behalf of consumers?—***The monitoring of compliance with service requirements, rules, standards, quality indicators, and outcomes for service purchased.

The answers to these questions and the ongoing development and monitoring of the corresponding accountabilities directly relate to the core competencies that states must evidence to effectively direct and manage a fee-for-service based service purchasing system (*Figure 1*).

Figure 1

Areas of State Competencies in Fee-for-Service

- **Mental Health Authority/Stewardship**—Establishes the vision, priorities, and policies for the mental health system. Includes:
  - Defining the role of Purchaser (rather than Funder)
  - Promoting and incorporating consumer involvement in system design and management
  - Defining the consumer benefit package(s)
  - Defining roles, responsibilities, and accountabilities both internally (Central Office, Regional, and any vendors), as well as within the delivery system
  - Aligning budget and payment with policy positions including assuring fund management, cash flow, and integration with state accounting mechanisms
  - Defining consumer outcomes and related measures
  - Defining system performance standards and indicators

- **Access/Eligibility**—Determines who is eligible for benefit package(s), the process of determining eligibility, and the service access standards for those defined as eligible. Includes:
  - Intake eligibility, including establishing the standards (financial and need) for target populations and the benefit packages
  - Enrollment, including ensuring that only eligible consumers are enrolled and that all data necessary for accountability is collected and maintained
  - Defining which services require prior authorization and the methods by which the authorization process may be executed in a clinically valid, reliable manner that does not cause unreasonable barriers to entry
  - Establishing provider system capacity standards including setting timelines, standards, geographic access requirements, special populations access standards and related functions

- **Consumer Relations**—Has the responsibility for ensuring that consumers are aware of system changes, their benefit options, rights and responsibilities, and have an objective forum for appeal of benefit and service decisions. Includes:
  - Ensuring information access, especially continual, uniform and accurate communication regarding system changes, benefit options, rights and responsibilities
  - Establishing and communicating the chain of authority for consumer grievance and appeals including the tracking/trending of grievances and serving as the terminal level of appeal and grievance for consumers

- **Manage Provider System**—Ensure the development, and ongoing effective performance of a provider system adequate to meet the obligations, priorities, and goals set by the authority. Includes:
  - Contract development, including contract templates, contractual expectations/performance targets and related incentives/sanctions, incorporated documents, and financial terms
  - Contract monitoring, including global oversight of contract management via regional offices
  - Ongoing provider service capacity development including a structured process to determine capacity requirements and the management of procurement/development efforts
  - Certification of providers to determine their eligibility to deliver services, as well as to confirm their capacity to deliver services consistent with definitions/program requirements
  - Provision of an adequately resourced function to support provider system performance via internal consultation, problem/issue research and resolution, and consistent interpretation of rules/regulations

- **Information System Capacity and Decision Support**—Purchase, develop, implement and maintain an information system capacity which meets the monitoring, reporting, and decision support needs for all mental health authority obligations. Includes:
    - Maintenance of timely and comprehensive enrollment process
    - Real-time linkage to eligibility verification
    - Incorporation of service prior authorization data including the capability of matching to claims payment during the adjudication process
    - Comprehensive array of provider/contract management capabilities including systemic methods of tracking contracted providers, services and rates by specific provider/vendor
    - Accessible and flexible reporting for management and decision support
    - Reporting of non-claim activities including block grant requirements, quality indicators, and other special initiatives
    - Gathering and reporting of outcome indicators
    - Data warehouse and decision support for all information system and claims activities

- **Claims Processing**—Sophisticated, timely, and accurate adjudication of claims. Includes:
    - Claims processing and adjudication that is consistent with a fee-for-service reimbursement system
    - Remittance advices which are compliant with federal law and which are usable for providers to reconcile payments on a consumer-specific basis
    - Sophisticated and flexible claims edits including setting prohibited service combinations, benefit limits/thresholds, authorizations, etc.
    - Establishment of clear, timely, and consistent standards of adjudication, issue resolution, notices, and payment
    - Monitoring of claims processing standards and effective corrective action when significant deviation occurs

- **Quality Management**—Responsibility for ensuring that the state is getting what it is intending to buy on behalf of consumers, including:
    - Monitoring of provider compliance with administrative rules, and state/federal laws
    - Program/service monitoring to ensure adherence to service definitions, program/provider manuals, and other service delivery guidance
    - Developing, maintaining and monitoring of quality improvement/management strategies and plans including establishing outcome, quality improvement, and quality assurance priorities (with consumer input)

The *Parker Dennison* review of state readiness for administration of a fee-for-service system was inclusive of all the competency domains above. Where gaps were identified in Illinois' current functional capabilities, consideration was given to whether the gap was a function that could be purchased or if it was a function that by its nature required it to be the exclusive province of the Division of Mental Health (DMH). Generally, *Parker Dennison* has found that functions embedded in the Mental Health Authority/Stewardship domain should not be delegated or purchased and therefore, should be the priority for internal competency development. Gaps in other domains, most typically may be procured or self fulfilled and the choice is driven by a straightforward buy/build analysis.

Section 2: Feasibility/Risks of Fee-for-Service at July 1, 2006

Summary Conclusion

It is not feasible for DMH to move the mental health system to full fee-for-service reimbursement, by July 1, 2006 due to a number of critical limitations in current resources, systems and functioning levels at DMH and its sister agencies. Many of these limitations carry significant financial risk to the state, and in other cases, there is not sufficient time or resources to complete the activities necessary to implement fee-for-service. It is also not possible for DMH to move to a full monthly advance and reconciliation process by July 1, 2006 due to the same limitations. It is possible to continue to transition the mental health system toward a fee-for-service model during FY07, and key transitional activities in FY07 fiscal year are highlighted in Section 3.

Key Readiness Issues

The readiness issues listed below represent critical areas that must be addressed prior to implementation of fee-for-service. DMH and the state must make informed choices about the identified issues and risks prior to proceeding to fee-for-service, and then develop an internal implementation plan and timeline consistent with those decisions. Many of these issues, or aspects of these issues, were identified as a part of the *Parker Dennison* Field Test Evaluation report dated March 24, 2005. The summary below is not an all inclusive list of every task that needs to be completed prior to fee-for-service implementation, nor does it include every area where changes are recommended to improve the overall functioning of the mental health authority in Illinois. A detailed analysis of the current status of DMH in each competency area, and recommended improvements is included in *Appendix I—DMH Readiness Analysis Detail*.

- **Information Systems**—There are very significant weaknesses and limitations in the current systems that if not remediated would make the transition to full fee-for-service reimbursement extremely problematic and would present a serious financial risk to the State of Illinois. The issues are varied and range from a lack of capacity to make changes to current systems due to lack of time and availability of resources, to serious deficiencies in the design of the systems that would need substantial modifications to meet even the lowest level of acceptable functionality to support fee-for-service reimbursement. Existing DMH/DHS information systems were designed for grant funding and the need to make extensive changes to support fee-for-service should be expected. Other states that have undergone fee for service transitions have experienced similar deficits in their legacy systems.
    - *IS resources limited*—The current systems design and the available resources to adapt these systems to fee-for-service billing are extremely limited. The systems, with the exception of the SIS On-Line, use older software development technologies that require a very high level of training and sophistication to modify. The number of DHS staff available to modify these systems is in extremely short supply, with many of those remaining approaching retirement. The software tools being used, especially for high-level transaction processing functions, such as claims adjudication, are all written in these older software languages that are very complex and require specialized training and knowledge. The current generation of programmers has little desire to learn these

older programming languages, so the ability to recruit and train staff in these areas is very difficult and often unsuccessful.

- *Data integrity and compliance is problematic*—In the majority of the non-claim information systems, data structures that exist (e.g. ROCS) have fields or elements that should be useful in the management of a fee-for-service system. However, data policies in provider contracts and in internal practice have not consistently required full utilization of the available fields, nor required regular updates (where updates are possible). Many fields desirable to manage a fee-for-service system are either not mandatory, or are allowed to be completed with 'unknown' or similar useless data. As found in the Fee-for-Service workgroups, these omissions are at times critical and result in inaccurate or unusable data. For example, during a recent targeted sample of approximately 100 consumer records from ROCS, nearly 100% were found by providers to not have the current psychiatric diagnosis nor to have all five axes as required by policy. For providers who rely exclusively on ROCS for claims submission, failure to update diagnosis (either in the system or manual override), may result in Medicaid claims being submitted without a valid/current diagnosis.

All of this is to paint a harsh, but realistic picture, that to fully implement a robust and state of the art fee-for-service claims management system that would meet the needs of a complex system such as DMH, will require a very different approach than trying to build internal capacity. A detailed analysis of the information system review is included in *Appendix D—MIS Findings and Recommendations*.

- **Claims Processing**—While claims processing is a subset of information systems and subject to all of the limitations described above, the issues in this area are significant enough to warrant specific detail. Some of these issues could be addressed by modifying existing processes or systems, however, those changes will require time and will be subject to the information system resource limitations described above.
  - *Claims flow*—The current claims flow includes a number of steps that would not normally be a part of a standard claims processing flow, which creates delays in claims adjudication and the availability of claims data. Currently, claims flow through ROCS, a DHS system, to the HFS Medicaid Management Information System (MMIS) for adjudication. Adjudicated claims then flow back through DHS and ROCS to produce a results summary, which is then used to create reports available to the providers through SIS Online, a separate DMH online reporting system.
  - *Payment link*—There is currently no link between claims data and a payment process, although this link existed prior to FY05 and is currently available for claims from the Division of Development Disabilities. A claims and payment link would need to be established and tested prior to implementation of fee-for-service or monthly advance and reconciliation.
  - *Claims edits*—Edits are an important cost control tool for assuring that providers are paid only for services that are contracted and delivered in accordance with those contracts and other regulatory requirements. The current claims flow includes an edit in ROCS that prevents payment in excess of total contract amounts as the primary cost control mechanism, and this edit is not currently available through HFS MMIS. Currently, there are no ROCS edits that prevent payment for Rule 132 services that are not included in a specific provider's contract, or to prevent payment for services that are not authorized as required by rule or DMH program manual. There are also no edits that would prevent payment for services that should not be delivered on the same day, which is industry standard and being included in planned revisions to the Illinois Medicaid state plan and Rule 132 to assure integrity of the services to the rates being paid. More information about cost control mechanisms is provided below.

- **Timely Payment**—Problems associated with lengthy timelines for claims to be paid was identified as a critical issue as a part of the *Parker Dennison* Field Test Evaluation report. An updated analysis of the claims timelines is included in *Appendix E*, and estimates of the time that would be required under current systems and processes are 72 – 168 calendar days from date of claim receipt by DMH to payment by the Illinois Comptroller's Office. The minimum industry standard for claims payment is 30 calendar days, and many states have the capacity to pay Medicaid claims within 1 – 2 weeks of submission. Most DMH providers do not have sufficient cash reserves to fund operations during a payment delay of more than 30-45 days from claims submission. Therefore, cash flow issues associated with implementation of retrospective fee-for-service could seriously jeopardize the mental health system and access to services unless strategies are developed to address this issue.

- **Compliance Monitoring**—Compliance monitoring has multiple dimensions, many of which are required activities on behalf of the Medicaid authority and all of which are advisable for appropriate execution of the state's stewardship of limited resources. Illinois compliance monitoring for mental health has severe deficits that expose the consumers, providers, and state to substantial financial (Medicaid and non-Medicaid) and qualitative risk. While most of the risks discussed here exist in the current funding system, the nature and structure of fee-for-service reimbursement highlights the deficits, especially in the context of Illinois' goal of Medicaid maximization within the Rehabilitation Option which is a current and well documented target of federal Office of Inspector General (OIG) audits.
    - *No compliance reviews for non-Medicaid clients or services*—Within the past two years with the marked decrease in DMH staffing due to the Early Retirement Initiative (ERI), virtually no review of non-Medicaid clients or services has occurred. Since non-Medicaid expenditures represent nearly 50% of total annual community mental health costs, this is significant. This is currently outside the scope of Bureau of Accreditation, Licensing and Certification (BALC) audits and though some aspects were historically monitored through DMH regional offices, this has not been comprehensive, systemic, consistent, or updated to reflect fee-for-service needs and requirements.
    - *BALC audits of Medicaid provide inadequate risk management*—BALC audits function adequately within their current scope and resources (limited staff and lack of clinical credentials). However, due to scope, frequency, adequacy of resources, and staff qualifications, BALC audits are of limited value for system risk management in a fee-for-service environment, especially one targeting increased Medicaid billing. Limitations include:
        - No review of Medicaid coordination of benefit requirements (including Medicare)
        - No review of medical necessity (an increasingly common target of federal OIG audits)
        - No review of eligible or target population requirements
        - Minimal qualitative review (nature of service beyond formal Rule—again, a very common and costly finding from federal OIG audits)
        - Minimal review of correlation between assessed issues/needs and treatment plan
        - Minimal review of correlation between number of units billed and amount/content of notes (except egregious)
        - BALC staff are not required to have clinical or service experience nor education in mental health and accordingly, most do not. This limits the scope of their reviews to areas where clinical knowledge is not necessary, and therefore does not support focus on areas critical in recent federal OIG audits
        - Reviews only occur every three years if minimal problems, approximately every 18 months for moderate issues. This is inadequate for risk management in a fee-for-service system, and does not afford even a modest level of system change feedback or support.

- *Over-reliance on provider self monitoring*—DMH has in part relied upon provider self monitoring of compliance. There has been substantial training to providers by the two largest provider trade organizations (CBHA and IARF). However, *Parker Dennison*'s field exposure and the results of the provider readiness review conducted in March of 2005 (as part of the fee-for-service pilot test) clearly indicates considerable vulnerability in providers' capacity for self monitoring:
  - 41% of agencies did not train their staff on the new service taxonomy
  - 28% of agencies did not train their staff on Rule 132 changes
  - 39% of agencies are not providing periodic training on updates or clarifications
  - 39% of agencies do not have an internal compliance plan
  - 52% of agencies do not have a system to monitor and supervise consistency with service definitions
  - 41% of agencies do not have a system to ensure a current treatment plan covers all billed services
  - 33% of agencies do not have a system to ensure a service note for each billed service
  - 72% of agencies do not have a system to internally monitor medical necessity

- **Cost Controls**—Medicaid is a federal entitlement that requires that persons determined eligible for Medicaid have access to medically necessary services. Each state must develop strategies to manage the cost of Medicaid services in order to have some level of control over the growth in Medicaid expenditures and the associated state budget impact of the required state match. Typically, states use a combination of cost control strategies including: standards for the persons who are eligible for Medicaid, varying benefit packages for different types of Medicaid eligibles, clinical criteria for determining medical necessity, authorization for some or all services, and medication formularies and other pharmacy management tools. States also use a variety of tools to assure that state standards in all of these areas are implemented effectively, including internally operated or contracted managed care and pharmacy benefit functions that provide eligibility determinations, proactive contract monitoring, service authorizations, and claims edits. DMH has historically used total contract maximums as ceilings to manage total mental health Medicaid costs and the associated state match. Contract maximums cannot be used to control Medicaid costs due to federal entitlement requirements, and implementation of fee-for-service and the planned growth in Medicaid funding will highlight problems associated with contract limitations as a cost control mechanism. Therefore, it will be very important that other cost control mechanisms be available to DMH to manage total Medicaid costs. As described elsewhere in this section, limited capacity exists in a number of areas (such as information system structures, claims edits and compliance monitoring) to effectively manage Medicaid costs using approaches that are allowable under federal Medicaid requirements.
  - *Eligibility and target population controls*—As noted above, nearly all states manage Medicaid costs in part through eligibility determination and medical necessity guidance. However, under the current system in Illinois, these options are not available to control costs and are in fact, nearly exclusively under the direct control of providers. Specifically, providers independently determine eligibility (need), as well as the determination of target population. Current DMH and HFS policy specifies both a definition of 'eligible' population and a definition for 'target' population and specifies via provider contracts that available funds must first be spent on the target population and only used for the less acute 'eligible' population as funds allow. Despite a target population definition that in *Parker Dennison's* experience in other states is comparatively broad, based on self report data from providers for FY 04, statewide only 56% of adults served met the definition of target population while only 32% of children/adolescents met the definition (see *Appendix F* for detail). Additionally, fully 11% of children/adolescents and nearly 6% of adults served did not even meet the extremely liberal 'eligible' population definition. Neither DMH nor BALC monitors compliance with target or eligible definition determination

guidelines nor enforce the policy of serving those most at risk (except as specific complaints of denied access arise). Though it is most common in other states to have state mental health expenditures targeted 75-100% toward the most at risk target population, it should be noted that Illinois' lenience in allowing a substantial share of dollars to go toward less acute populations may serve as a support for prevention and early intervention. If this is the intent, *Parker Dennison* would recommend that this effort be more targeted to those that have limited resources and evaluated for effectiveness. DMH should also ensure that in no case are target population consumers waiting or being denied services if eligible consumers (non-target) are being served.

- *Medical necessity guidance and monitoring*—Federal Medicaid rules require that all services paid via Medicaid must be deemed 'medically necessary', at least by a determination by a Licensed Practitioner of the Healing Arts (LPHA). In Illinois, this determination is exclusively the province of each provider's LPHAs and the state provides minimal written guidance or training and virtually no monitoring of this function for quality control or for adherence to even the most basic of guidelines. Though not statistically sampled, record reviews in nearly 20 providers suggests very liberal and highly divergent interpretations of medical necessity. This is particularly troublesome in the context of the results of the provider readiness study (from a statistically significant sample) that indicated that fully 72% of providers had NO system of internal monitoring of medical necessity which could demonstrate practice impact. Additionally, as noted above, medical necessity is not monitored by BALC or DMH.
- *Existing rationale for contract maximums not feasible*—DMH has historically taken the position that providers are not actually filing Medicaid claims, and that Medicaid claims are identified by DMH from all claims submitted by providers. DMH is then able to appropriately file those claims with the federal government through HFS. This rationale for contract maximums was likely subject to challenge historically, and becomes untenable under a fee-for-service system where provider contracts contain Medicaid allocations that providers should manage against. Also, federal and DMH contractual requirements that providers appropriately coordinate benefits with other payers to assure that Medicaid and state general revenue funds are used as the payers of last resort further undermine the historical rationale for the use of contract maximums to control Medicaid expenditures. Providers must be cognizant of the payer at the time of claims submission in order to fully execute their fiduciary requirements and therefore, assuming validity of the Medicaid claim, it must be paid by the state.
- *Funding and contract adjustments*—Historically, only a small number of providers have billed Medicaid in excess of total contract amounts and DMH had some flexibility to make funding adjustments to facilitate availability of sufficient state match so that all Medicaid claims could actually be paid. Beginning in FY05, DMH's flexibility to adjust funding or to hold back a portion of total service dollars to cover shortfalls, was severely limited by the expectation that no providers would lose funding as a part of the fee-for-service transition. Therefore, the risk that providers will bill Medicaid in excess of contract allocations is increasing and DMH will likely be in a situation where it must either violate federal Medicaid requirements by not paying the claims, or seeking budget increases to cover state Medicaid match.
- *Service authorizations*—DMH currently has service authorization requirements for a small number of services including Assertive Community Treatment, (ACT) and some residential services, and regional staff are responsible for authorizing these services. The effectiveness of these authorization processes is extremely limited due to variations across regions in authorization requirements, nearly automatic authorization of every service requested in some areas, and the complete absence of claim edits that assure that services that are not authorized are not paid.

- **DMH Staff Resources**—DMH has insufficient staff, even if existing vacancies were filled, to remediate all gaps identified in the readiness assessment. As detailed in the staffing analysis in *Appendix B*, an estimated 70 – 75 new positions would be needed to develop the critical functions needed to implement fee-for-service and effectively manage associated financial and compliance risks of the change in the reimbursement structure. If, however, an ASO is procured, these 70 – 75 positions would reside in the ASO, and DMH would need to fill existing vacancies and reorganize current resources to perform its authority functions and manage the ASO. An additional 70 – 75 positions represents an increase of nearly 120% over current DMH filled positions at central and regional offices that are dedicated to mental health authority and community service system functions. State-operated hospital functions are excluded from this analysis. In addition to new positions, DMH needs to be able to restructure and redeploy existing resources, approximately 120 filled and vacant positions, to fulfill mental health authority functions. Based on DMH estimates there are approximately 15-20 positions out of the recommended 120 positions on existing DMH organization charts that are not funded through existing appropriations. A recommended structure for existing DMH central and regional office staff is provided in *Appendix C*. DMH will also need incremental resources for the next 18 – 36 months to complete the activities associated with procuring and contracting with an ASO, and with continuing the system restructuring effort that will provide the foundation for the system to be implemented by the ASO. These resources are temporary and can take the form of contracted resources, temporary employees, and consultation assistance.

- **Policy Decisions**—As described in the preceding section, DMH must establish its role as a purchaser of services and make the underlying policy decisions regarding which consumers constitute the priority population and the service array that will be available to those consumers. Although DMH currently has a framework for defining target populations and an existing service structure, the transition activities associated with implementation of fee-for-service have highlighted the need to refine existing definitions and standards in several areas. Work is underway to gather stakeholder input and make the policy decisions that are needed in many of these areas. However, this work is progressing slowly in several areas due to limited DMH resources available to the fee-for-service implementation effort. There are only approximately 10 - 15 fulltime equivalents (FTEs) that are dedicated to fee-for-service, which includes both the implementation of fee-for-service, as well as the array of policy decisions and refinements of definitions and standards that are needed. Fifteen FTEs would be sufficient to implement fee-for-service, but are not adequate for the related and critical activities to re-design the system. Insufficient resources are likely due to a variety of factors including recent changes in leadership at DMH which resulted in loss of resources to the project, a vacancy rate at DMH of nearly 35% for non-hospital central and regional office positions, poor staff understanding of the range of issues that need to be addressed as a part of the fee-for-service and re-design efforts, and management/staff uncertainty regarding where fee-for-service and system re-design fit into the overall priorities of DMH and the state in general. Uncertainty related to the priority of the fee for service and system re-design issues is exacerbated by the limited sources available to the initiatives and historical willingness to invest resources in these projects.

Section 3: Recommendations to Implement Fee-for-Service

Summary Conclusion

Based on the recent state readiness assessment, *Parker Dennison* has grave concerns regarding DMH's ability to perform fee-for-service responsibilities without significant financial and compliance risks. Current structures and systems do not support critical functions, such as claims payment, service authorizations, linkage between service authorizations and claims payment, claims processing with appropriate edits, provider monitoring of compliance with service requirements, and data production and analysis capabilities required to assess and monitor the status of the entire community based system. The absence of or shortfalls in these and other key functions will cause it to be difficult, if not ill-advised for DMH to implement fee-for-service without significant restructuring and corresponding costs.

Therefore, an Administrative Service Organization (ASO) is the recommended approach for DMH to implement fee-for-service in Illinois. An ASO is defined as an outside firm with specific capabilities and experience to perform administrative functions under the direction of the mental health authority—DMH. The authority retains financial risk and responsibility for paying claims and does not pay the ASO contingent on the basis of any activities associated with limiting services. Estimated gross annual costs for an ASO based on the functions needed in Illinois are $5.5 – 6.0 million and an ASO could be procured and implemented by July 1, 2007. A significant portion of the state's costs for an ASO can be allocated to Medicaid and therefore subject to administrative claiming and federal match. DMH will need to work with HFS to determine the eligible Medicaid portion of the costs and the corresponding federal match.

Implementation of fee-for-service, even with the assistance of an ASO, will continue to require considerable time and resources to procure/manage the ASO and to make needed policy analysis and decisions. An ASO will give DMH access to a greater array of tools and expertise, but significant investments of other resources such as contract staff and consultants will be required through implementation of the ASO and up to 12 months thereafter.

The period from now until implementation of the ASO and fee-for-service should be used to accomplish several key tasks, including:

- Developing the detailed specifications for an ASO and completing the procurement and contracting process.
- Completing policy decisions in several areas, such as target population, network standards, and funding alignment, to facilitate implementation of these standards by the ASO.
- Completing the changes in service definitions and the corresponding Medicaid state plan amendment and rule changes that are currently underway. It may be feasible to implement all or portions of these changes prior to July 1, 2007 in anticipation of the implementation of the ASO.
- Continuing to adjust funding allocations and provider contract amounts based on analyses of consumer need, service capacity, and geographic accessibility to better align existing resources in preparation for the revised services and implementation of fee-for-service.

- Continuing provider training and technical assistance efforts to improve functioning in a fee-for-service environment and to be prepared to implement revised service definitions.

Further analysis of the recommendation for implementation of an ASO is provided in the following sections of this report.

Buy or Build

One option to remediate the operational gaps is for DMH to build the needed administrative functions by adding staff and developing the internal expertise in the identified areas. The comparison of current state staffing resources to those needed indicates that a build approach would require an additional DMH staff of approximately 70 – 75 staff at an estimated cost of $5.95 million based on average cost per position (as provided by DMH personnel office) of approximately $79,000 including salary, taxes and benefits. Significant time, 6 – 12 months, would also be required to recruit, hire and train staff prior to implementation. DMH could have difficulty attracting and retaining the types of staff needed for these functions within the constraints of the state personnel system, especially in the context of time constraints. A new information system would also be required, estimated at a cost of $2.5 million bringing the total cost of building internal capacity to approximately $8.45 million for year one, and at least $5.95 million annually thereafter for staffing and maintenance.

A second option is for DMH to outsource many of the administrative functions required for fee-for-service to an ASO. ASO costs are based on the specific types of functions and activities that an organization would be required to perform, along with the volume of activities measured by the number of services, claims and providers that are anticipated in the system. ASOs are expected to bring technologies and processes specific to mental health that have proven successful in other markets which can be adapted to the specific requirements in Illinois. Based on the functions needed for the Illinois mental health system, comparison to similar arrangements and costs in other states, and the estimated volumes in the Illinois mental health system, annual costs for an ASO are estimated to be approximately $5.5 – 6.0 million, which will include approximately 70 ASO staff located in Illinois and a fully functional management information system. Actual costs will obviously be based on a competitive procurement.

A significant portion of the cost of an ASO should be appropriate for administrative claiming under Medicaid and therefore eligible for federal match. A detailed analysis of functions and costs would need to be developed in conjunction with HFS in order to determine the portion eligible for allocation to Medicaid.

There may also be functions from other departments that could be performed under this ASO umbrella which would allow Illinois to gain economies of scale under a single contract. Additional discussions need to be completed within DHS divisions, HFS, and DCFS to determine the desired scope for an ASO and to explore the possibilities of shared responsibility and costs for an ASO.

The tables below summarize the pros and cons for building and buying ASO functions:

Build Option

Build	
Pros	**Cons**
• Allows direct control of the staff implementing the ASO functions by DMH • Avoids any appearance of handing stewardship/ responsibility over to a private entity	• Lack of necessary core competencies/experience • Leaves ultimate responsibility of implementation with DMH with limited experience and resources • Very difficult to define and classify all necessary positions for hiring • Very difficult to build an internal state-of-the art information system within the state parameters (systems may be obsolete before they are installed) • More difficult to reprimand/fire staff versus impose contractual sanctions • ASO functions are not necessarily core competencies of state authorities and therefore may distract DMH from the needed management of other key mental health authority issues

Buy Option

Buy	
Pros	**Cons**
• Specify needs as a package which allows efficiency in purchasing • Relatively quick implementation timeline • Allows DMH the ability to access national management practices and expertise • Provides a political separation related to management of providers • Reinforces DMH as purchaser, by allowing DMH to sever a relationship at will based on performance or change in needs • Prevents the challenge of state business practices negatively impacting implementation timelines • Immediate access to state of the art health management technologies • Creates an independent entity to improve provider performance • Shared accountability with a private entity for implementation • Provider monitoring and performance support comes from an external entity • Provides timely and accurate information for decision support • Easier to identify and document Medicaid administrative claiming	• Field may incorrectly perceive an ASO as a Managed Care Organization • Potential of being construed as another layer of bureaucracy • May be perceived as diverting services dollars into administration • DMH will need to be prepared to manage the political pressure related to implementation

Timelines

Major target dates for procuring an ASO and the relationship to implementing fee-for-service by July 1, 2007 are outlined below.

- DMH develops RFP and all requirements for ASO—5/1 – 6/30/06
- Release RFP for ASO—7/1/06
    - Proposals due—8/15/06
    - Evaluation complete—11/1/06 (to allow time for site visits/interviews of prospects, as needed)
    - Complete negotiations and execute contract 1/1/07
- Complete major DMH policy revisions—1/1/07 (service array/definitions, target population, network standards, etc)
- Complete Provider manual—5/1/07

- Provider training—5/1 – 6/15/07
    - Information system specification information/training--5/1/07 (priority to allow providers to make system modifications to correspond to ASO requirements)
- "Go Live" with ASO and full fee-for-service—7/1/07

Section 4: Recommended Structure for DMH Fee-for-Service Responsibilities

The table on the following pages lists the fee-for-service competencies and their components in the first column. The recommended responsibilities of central/regional offices and the ASO are then detailed in the subsequent columns. Two important issues should be considered in reviewing this table:

1. If an ASO is not feasible, tasks currently assigned to that area will need to be divided across other areas, resulting in increased risk to state and delays in fee-for-service implementation.

2. The recommended structure positions regional offices as an arm of central office, with limited operational autonomy. Regional offices and their constituents should provide input into the vision and policy decisions of DMH central office, but should fully and consistently reflect central office positions in the field. Central office will, in turn, need to assume additional responsibilities to assure strong communication and education for regional office staff to achieve the desired consistency of operations and message.

A suggested functional organization chart for DMH inclusive of the management of an ASO follows the table. Note that this organizational chart may not be inclusive of all non-fee-for-service areas.

Fee-for-Service Structure & Functions

Competency/Functions	Central Office	Regional Office	Administrative Services Organization	Provider
1. Mental Health Authority/Stewardship				
Role of Purchaser vs. Funder	Establish policies defining system. Communicates all policy decisions to system including to ASO, Regional Offices, providers, consumers.	Must function as an arm of Central Office and must reflect the vision of DMH as purchaser vs. funder		
Promote/ Incorporate consumer involvement in system design and management	Obtain consumer input in policy decision, promote/support involvement (including financial and development support), encourage meaningful involvement in all areas	Dedicated community recovery specialist attached to each region—involved in quality management, provider development and monitoring, grievance/appeals	Inclusive of recovery specialist management level position with role emphasis on training, audit, recovery plan support, development of peer resources	Consumer and family empowerment in recovery planning, support/develop consumer liaison in agency, incorporate into agency consumer appeal and grievance processes
Define consumer benefit package	Must clearly define the services and supports (including the role of evidence based practices) that will be purchased through fee-for-service. Design will include consumer and other stakeholder input.	Must reflect the policy of the Central Office. May advise Central Office on local service need.		

Competency/Functions	Central Office	Regional Office	Administrative Services Organization	Provider
Define roles, responsibilities, accountabilities	Define Central and Regional roles, responsibilities, and performance standards for Central/Regional staff, ASO and providers. Define parameters of provider manual, provider monitoring.			
Align budget with policy	Assuring that budget mechanisms support the benefit package and fee-for-service management --718 fund --cash flow/ dedicated fund --reallocation of match --connect claims to CARS, state accounting system			
Define Consumer Outcomes	Define Consumer Outcomes and include in provider contract templates (e.g. MHSIP)			
Define System Performance Standards	Define key measures to monitor system performance & include in provider contracts --penetration --service definition compliance --target population		Brings National benchmarking data and mental health experience	

Competency/Functions	Central Office	Regional Office	Administrative Services Organization	Provider
	penetration levels			
2. Access/Eligibility				
Intake Eligibility	Establish the eligibility standards (financial/need) for target population(s) and benefit package(s)		Receives provider information and validates eligibility	Point of contact and initial eligibility determination
Enrollment			Processes enrollment	
Service Authorization	Establishing criteria for authorization (ACT, Residential, Inpatient)		Approve authorization as required by policy	Submits request for authorization
Establishing Provider Network Capacity Standards	Must set standards for timeliness, geographic access, special population services access, etc.		Provide data/maps of network performance National benchmarking	Report capacity and access data as needed
3. Manage the Provider System				
Contract Development	Design the contract templates, contractual expectations/ incentives/sanctions, provider manual and financial terms	Communicate contract and provider manual terms to provider network	Draft and maintain provider manual subject to Central Office review and approval	
Contract Monitoring	Global oversight of contract management via Regional	Monitor contracts with provider agencies	Provide supporting information to Central	

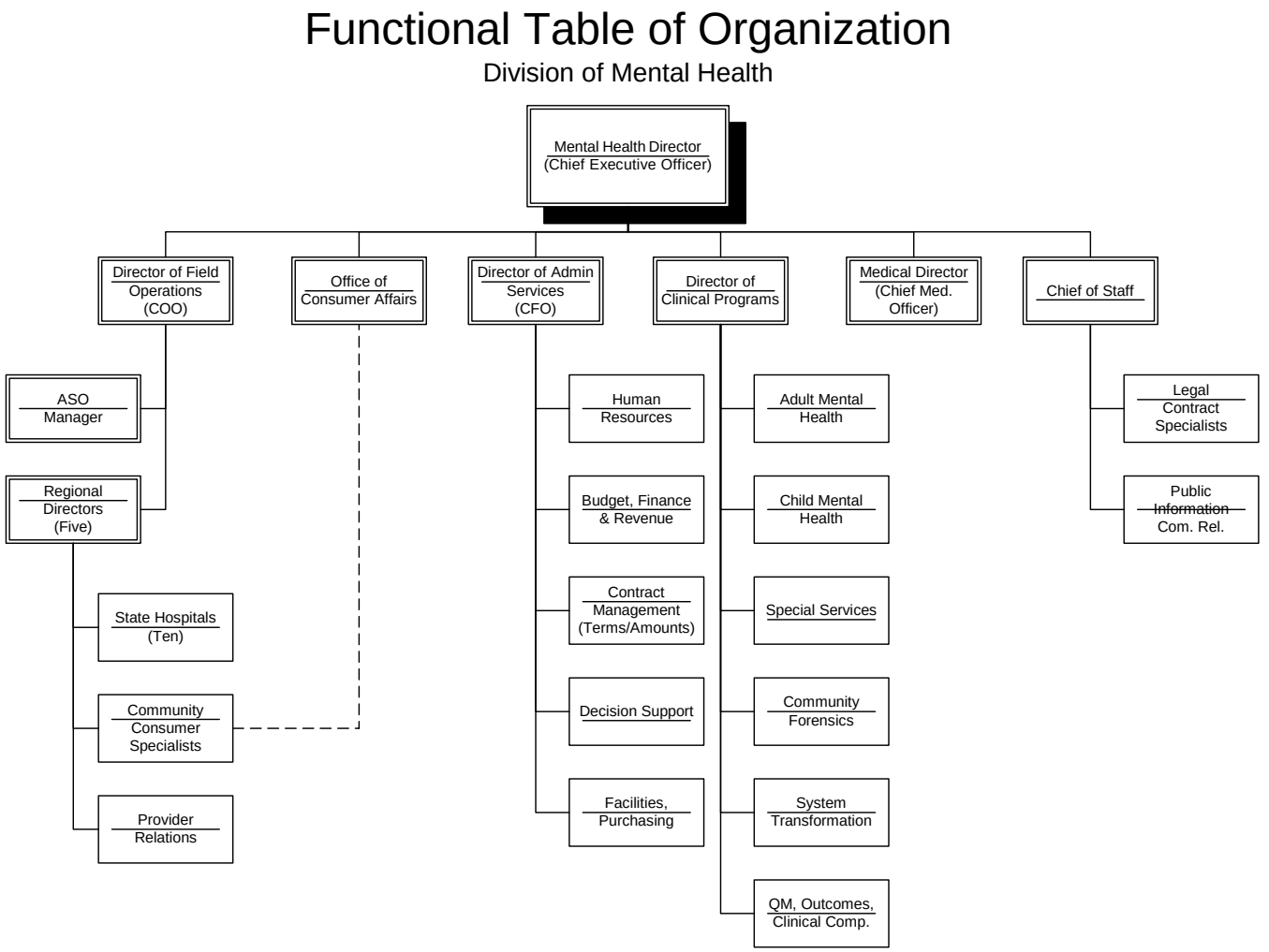
Competency/Functions	Central Office	Regional Office	Administrative Services Organization	Provider
	Offices	within their regional area	and Regional offices on contract performance	
Provider Development	Determine needs and manage procurement/ development efforts	Identify current provider capacity and service gaps Identify/support candidates for development efforts	Provides training/technical assistance on clinical policy implementation Provides data which supports the achievement of provider and consumer outcomes	Reports information according to contract/provider manual requirements
Provider Certification	Sets standards and criteria for providers		Completes certification review	Provides information and access necessary for certification review
Provider Relations	Policy clarification/ direction and rule interpretation for system	Establishes and maintains contractual oversight relationship with the provider Identification of training/TA needs	Identification and provision of training/TA needs	
4. Consumer Relations				

Competency/Functions	Central Office	Regional Office	Administrative Services Organization	Provider
Information Access	Central Office must establish communications plan related to fee-for-service change	Regional Office must participate in communication dissemination related to fee-for-service change		Provide benefit and appeal information upon intake
Grievances and Appeals	Central Office must have a policy which articulates the chain of authority for grievances and appeals Central Office serves as a last point of review for appeals/grievances	Regional Office serves as next level of appeal after provider appeal is exhausted.		Establish, implement, and document first level of grievance and appeal
5. Information System Capacity & Decision Support				
Enrollment	Authority, stewardship, and policy decisions define information system needs and processing requirements		Provides information system and administration, including experienced staff	
Eligibility verification				
Service authorizations (including match to claims adjudication)				
Provider/contract management (tracking contracted providers, services and rates by provider)				
Data reporting				

Competency/Functions	Central Office	Regional Office	Administrative Services Organization	Provider
Service reporting (non-claim activities)			Develops and manages system for non-claims reporting	
Outcome data			Assists with design/development of outcome data/reports	
Data warehouse and decision support for all IS and claims activities	Used by Central Office staff	Used by Regional Office for management reporting	Source of data to the data warehouse; development/management of warehouse	Receive reports and have online access to monitor status of claims and payments
6. Claims Processing				
Claims processing and adjudication	Authority, stewardship, and policy decisions define information system needs		Provides information system and administration	Submit claims
Remittance advices				Receive payment information
Fund management (cash management and accounting for fund source)				
Claims editing				
Timelines and procedures	Establish standards		Follows established guidelines and standards	
Monitoring Claims Payment Performance	Monitoring performance against standards and		Follows established guidelines and	

Competency/Functions	Central Office	Regional Office	Administrative Services Organization	Provider
	administering/approving payment process		standards	
7. Quality Management				
Compliance with administrative rule (132)	Establish/modify/maintain rule, associated guidance, interpretation	Communication to provider	Monitoring, development and monitoring of corrective action plans	
Program monitoring (adherence to service definitions, program/provider manual)	Establish parameters and approve program monitoring materials (drafted by ASO)	Communication to providers	Monitoring, development and monitoring of corrective action plans	
QM Strategies/Plan	Establish annual QM goals/priorities with consumer input	Regional input regarding QM goals/priorities	Supply data from data warehouse	

Functional Organization Chart for Fee-for-Service



PARKER & DENNISON Associates, Ltd.

Appendices

Appendix A–Assessment Process

Assessment Process

The DMH and *Parker Dennison* field test evaluation reports were unanimous in their recommendations that an assessment of the state's readiness to proceed to fee-for-service was necessary and important. The FY05 DMH field test process was to include a state readiness assessment, however, the task was delayed until the current fiscal year.

To complete the assessment *Parker Dennison* assembled a team of national experts with specific experience in state government, fee-for-service conversions and system transformations in multiple states. Collectively, the team members have more than 50 years of experience with public sector mental health services and have worked in nearly every state. The team included clinical, financial, and information system resources, including two team members who have either previously or currently held positions in state mental health agencies. The team members are also familiar with the uniqueness of various federal funding streams and the complex federal laws and regulations that pertain to behavioral health services. Detailed summaries of the experience and credentials of each team member are provided at the end of this Appendix.

The assessment process included a combination of on and offsite review of materials and meetings with key staff from DMH, as well as DHS and HFS for information system reviews. The process also included teleconference meetings with providers to gather first-hand information regarding their experiences with using the state's management information systems and the regional structures. The five-person assessment team was onsite for three days and met with nearly 40 representatives from DMH, DHS and HFS.

In addition to all of the telephone and onsite meetings, the following documents were reviewed as a part of the assessment process.

1. Staffing
    a. Functional organization chart for DMH (top 3 – 4 levels), including staff names and vacancies.
    b. Summary of all FTEs and vacancies
    c. Listing of staff dedicated/assisting with fee-for-service transition
2. Finance--DMH budgets for FY04, FY05 and FY06 summarizing funding for community services, all other services, and regional network structures
3. Eligible and target population definitions
4. Strategic Vision Report from June 2005
5. Bureau of Accreditation, Licensing and Certification (BALC)
    a. Certification Policies and procedures and related review tools
    b. Audit tools and two sample reports
6. Authorization standards/criteria for services currently requiring authorization at regional level
7. Management information systems
    a. ROCS User Manual
    b. HFS/MMIS Recipient Subsystem – Mental Health Services Authorization User Manual
    c. Mental Health Fee-for-Service Conversion Project – Phase II – Project Charter
    d. System flows

Team Experience and Credentials

Parker Dennison core staff have provided consultation services to more than 30 authorities (state/regional/local jurisdictions) and six national public sector managed care entities. Services have focused nearly exclusively on system transformation issues and have included readiness reviews for operational areas, technical training on key tasks (utilization management, crisis, central access, prior authorization, claims, service definitions, needs assessment, network development and management), and operational supports during start up. States in which *Parker Dennison* has provided services to local, regional, or state jurisdictions or public sector managed care entities include: Ohio, Virginia, Missouri, Iowa, Hawaii, Nebraska, Colorado, Arizona, Alaska, California, Massachusetts, Maryland, North Carolina, South Carolina, Texas, Tennessee, Illinois, New Mexico, Washington, District of Columbia, Oregon, Wyoming, Montana, Kansas, Georgia, and Florida.

Stephen L. Day is co-founder and Executive Director of TAC. Steve has provided consultation and technical assistance to 35 states, over 100 local jurisdictions, and numerous national policy and advocacy organizations. The results of these consultations include comprehensive analyses of public mental health or human services systems; multi-year strategic plans; service system improvement and financing strategies; outcome and performance measurement systems; and organizational and human resource development plans. Prior to co-founding TAC, Steve had extensive public sector and non-profit management experience, first in the field of aging and then in the field of mental health. Mr. Day was among the senior consultants providing technical input and support to the President's New Freedom Commission on Mental Health, authoring a technical monograph on Medicaid's role in public mental health services, and assisting to draft recommendations related to state-level mental health system master planning and on linking mainstream service resources to supportive housing for people with mental illness. Mr. Day has contributed to other major national policy initiatives related to state level system improvements, including publishing monographs on Olmstead and Supportive Housing: a Vision for the Future and Turning Knowledge into Practice: a Manual for Behavioral Health Administrators and Practitioners about Understanding and Implementing Evidence-Based Practices. Mr. Day specializes in the implementation and financing of best practice mental health and human services, organizational development and management, interagency service coordination and integration strategies, strategic planning, and consumer-based outcome and performance measurement. In addition to his experience in the fields of mental health, substance abuse, Medicaid, aging and related human services topics, Mr. Day was a Commissioner of a public housing authority, and participated in the development and management of HUD and state funded housing programs for elders, families with children, and people with disabilities.

Rusty Dennison is the President and cofounder of Parker Dennison & Associates, Ltd. Mr. Dennison has extensive experience with designing and implementing mental health rehabilitative services at the state and provider level. He has specific experience in developing clinical and operational requirements for community-based mental health services for children and adults with special focus on recovery and rehabilitation services. He has also assisted several states and jurisdictions with reforming their utilization management efforts for mental health rehabilitative services. Most recently, he is providing consultation to the Illinois Division of Mental Health and their providers to help them move from a grant funding structure to fee-for-service. Mr. Dennison provided assistance to the Louisiana Department of Health and Hospitals in the transition from case rates to fee-for-service including assisting in developing new service definitions, and providing extensive training to their provider network regarding community support, and operational requirements of a fee-for-service environment. He provided overall project management as well as consultation to the District of Columbia Department of Mental Health and its providers regarding the implementation of the Medicaid Rehabilitation Option. Technical assistance included: focus on provider readiness and development for successful operations, authorization process, utilization management, documentation, intake/triage; billing/claims process flow; and staff development activities. In Georgia, he provided technical assistance to the state's Administrative Service Organization (American Psychiatric Systems) and recommended changes on the clinical model, authorization process, utilization

management, documentation, intake/triage, and related data and tracking analysis and methodologies. Mr. Dennison has also served in several capacities with the National Council for Community Behavioral Healthcare including its Product Line Manager and Online Project Manager. He has provided training and consultation to more than 400 providers in over forty states, focusing on system change issues and operational adaptation. He has written over 20 training manuals on behavioral health operational issues including on managed care readiness, utilization management, centralized access, treatment protocol implementations, and board development. Rusty was the former administrative director for the Mount Airy Psychiatric Center in Denver, Colorado and Program Director for Addiction Research and Treatment Services, Adolescent Treatment Program at the University of Colorado, School of Medicine. He has an MBA from the University of Colorado and MA in Sociology in family therapy from Drake University in Iowa.

Susan Parker is the Executive Vice President and co-founder of Parker Dennison and Associates, Ltd. She has significant experience with the fiscal and operational aspects of publicly funded community behavioral health systems, having worked with providers, state and local funding authorities and managed care organizations in more than 40 states. Ms. Parker focuses on assisting with design and implementation of new and re-structured service, reimbursement, regulatory and managed care initiatives, bringing her extensive experience with provider operations for a practical approach. Specific activities have included assistance with development of rate setting methodologies for Medicaid and non-Medicaid behavioral health services in Connecticut, North Carolina, Hawaii, Louisiana, implementation of managed care behavioral health carve out systems in Massachusetts, Arizona, and Iowa, privatization of state-operated community mental health centers in Missouri and implementation of HIPAA privacy, security and claims requirements. Ms. Parker has most recently assisted with implementation of Medicaid rehabilitation and recovery-focused services within fee-for-service structures in Illinois, District of Columbia, Georgia, Connecticut and Louisiana. These efforts have included a range of rate setting methodologies, provider certification, provider training, claims processing and utilization management activities. Ms. Parker has extensive hands-on experience assisting providers in making the operational adjustments necessary for successful performance in fee-for-service Medicaid rehabilitation environment having worked with hundreds of providers in large group training and individual provider site visit settings. She is a certified public accountant and has a Master's from the University of Denver.

Wendy Tiegreen is currently the Project Director for the Georgia Division of MHDDAD Systems Design and Medicaid Coordination Section. She is responsible for the creation and interpretation of all policy with $100M System for Medicaid Mental Health and Substance Abuse Services Program. This includes the development of the first peer supports service to be reimbursed by the Center for Medicare and Medicaid Services. She is responsible for the design and oversight of the mental health system change initiatives and in partnership with division management, provides oversight, manages and tracks Medicaid financing of the Mental Health and Substance Abuse program. She also manages the External Review Organization contract to review utilization of services for the Medicaid mental health/substance abuse program. Wendy is a frequent presenter at state and national conferences and was a featured contributor for the PSR Connection, the quarterly publication of the International Association of Psychosocial Rehabilitation Services, Issue 2, April 2002. Among her most recent awards, she received the Partner in Recovery Award, 2003 awarded by the Georgia Consumer Peer Specialist Association and the Consumer Supporter of the Year award presented by the Georgia Mental Health Consumer Network.

Stephen A. Wood, FHIMSS, FHFMA of HealthCare Perspective LLC has thirty-three years experience in health care financial management and information systems and has been an Independent Consultant specializing in HealthCare Information Systems for 17 years. Steve was an Implementation Support Manager for Hewlett-Packard HCP Division for 6 years and served as CFO and Controller at two acute care hospitals for a decade. Steve's work has included being Project Director for the State of Ohio Department of Mental Health HIPAA project and MACSIS Project as well as several Revenue Maximization, IPPS, and Information System projects; Project Manager and Technical Advisor to the District of Columbia (DC) Department of Mental Health relating to HIPAA for Privacy, Security and EDI; Member of Receiver's Transition Team for DC Commission on Mental Health Services. Led to the

Formation of current DC DMH; Project Manager Ohio Department of Mental Health for design of MACSIS project, a statewide implementation of managed care for behavioral health services in 58 governmental entities; Consultant for State of Connecticut, Department of Correction, Health Services Department to develop state-wide Clinical Information system; managed acute care hospital as Director of MIS resulting in significant improvement in department performance. Developed and implemented long-range strategic plan; Consultant to State of Connecticut, Department of Mental Health. Defined, selected, and implemented an online, statewide Clinical Information System for nine DMH Hospitals; and managed major receivables recovery project-20 million-dollar recovery in nine months. Steve is a Fellow, Healthcare Financial Management Association, FHFMA (1982) and a Fellow, Healthcare Information Systems Society, FHIMSS (2000).

Appendix B—DMH Staffing Analysis

Staffing Analysis

An analysis of existing DMH central office and regional staff was completed, and the analysis excluded state-operated hospital resources, focusing on the authority, policy and community services resources. The analysis of existing DMH resources as of November 1, 2005 is summarized in the table below. The analysis show that approximately 35% of total DMH positions are vacant, and that net resources are split nearly evenly between regional and central office. DMH estimates that approximately 15 FTES are dedicated to implementation of fee-for-service. However, only two of those are full time resources, which means that most staff involved in the fee-for-service transition are not able to focus solely on those activities.

Current DMH Staffing Resources

	Central Office	Regional	Total
Total positions (FTEs)	85	65	150
Vacancies	39	11	50
Filled positions	46	54	100

A detailed analysis of the recommended staff to fulfill DMH's mental health authority functions and to manage community services, including the fee-for-service transition was also completed. The analysis also included filling the gaps in critical functions for fee-for-service operations that were identified as a part of the readiness assessment.

- DMH would need approximately 190 – 195 staff to fulfill its mental health authority and recommended ASO functions, which is an increase of nearly 120% over filled positions at DMH and an increase of approximately 45% over available positions, including vacancies.

- DMH has critical gaps in staff resources to perform registration/enrollment, claims processing/adjudication, utilization management, provider training/monitoring, quality management, and information systems/decision support functions. An estimated 70 – 75 staff would be needed to fill those functions, unless an ASO is procured.

- The remaining approximately 120 staff are needed to fulfill mental health authority functions, such as defining targeted consumers, the appropriate service array for those consumers, and how to pay for those services. These 120 positions are needed in addition to an ASO and its recommended functions. Authority functions also include defining standards in a number of areas, such as access to care, network capacity, certification and service requirements, and clinical necessity criteria. The mental health authority then needs to train providers on these standards and consistently monitor to assure compliance with the standard across the provider network. All of these functions are on-going activities that will need to constantly evolve and are not transitional related only to fee-for-service implementation.

As is typical in any state personnel system, the state position classification and hiring process in Illinois is lengthy and cumbersome, and it can be difficult to attract and retain staff with skills that are in high demand due to competition from the private sector. Even if funds were to be authorized to fill the functional/staffing gaps at DMH, it would be extremely difficult and time consuming to hire the number and types of positions needed. In some instances, it may be impossible to hire staff with the needed skills, and the positions could remain unfilled or compromises in job requirements would be necessary—either could extend the time required to fill gaps and impact the effectiveness of functionality in key areas.

Due to the magnitude of the gap between existing and needed resources and the need to implement fee-for-service as quickly as possible, the analysis of needed resources for DMH was split into functions that can be

contracted and those that must be fulfilled by state staff. The 120 staff needed for authority functions and management of the community-based service system need to be state staff, and the functions associated with the remaining 70 – 75 staff could be contracted to an outside organization, or ASO. This is the structure that is recommended for on-going management of the community service system and implementation of fee-for-service. *Appendix C* details the functions and associated staffing that is needed for DMH to fulfill its authority and community service management responsibilities.

Appendix C–DMH Fee-for-Service Organizational Structure and Resources

Organizational Structure and Resources

The table below represents recommended organizational structures, functions and staffing for DMH to perform all of its responsibilities for community services in a fee-for-service environment. The functional organization chart is based on information gathered during the state readiness assessment related to existing functions and resources, and experience regarding structures and staffing in other states for similar functions. In reviewing the information below, there are several key assumptions that were incorporated into the analysis:

- The chart assumes that DMH will fulfill a number of key functions through a contracted Administrative Services Organization (ASO). If an ASO is not available, significant modifications to this chart will be needed for additional DMH functions and staff resources.
- The chart does not include state hospital resources except where coordination or interface is required. Hospital resources would be in addition to those shown below.
- Several positions require very specialized skills, and the feasibility of this structure will depend on DMH's ability to attract and hire staff with those skills within existing state personnel requirements.
- The chart assumes that key functions that are the responsibility of other departments, such as DHS's existing capacity for data management and HFS's existing claims processing capabilities, will remain in place and available to DMH.

Functional Area	Staffing Requirements	Comments	Number FTEs (Total)
Office of the Director	MH Director (CEO) Admin. Asst.[a]	Authority/Stewardship leader; set vision and priorities; provide overall policy direction; interagency and Legislative liaison	1 1 (2)
Office of the Medical Director	Medical Director (Psychiatrist) (Chief Clinical Officer) Admin. Asst.	Clinical leadership and oversight; direct supervision of DMH psychiatrists; leadership for clinical best practices; participate in clinical P&P development; participate in QM/QI; input into development of medical necessity criteria; interface with ASO related to key clinical P&Ps/protocols	1 1 (2)
Office of the Chief of Staff	Chief of Staff Admin. Asst. Chief Attorney Contract Spec.	Principle staff assistant to Director; oversees Legal department, legislative analysis, contract specialists manage contracting process internally and externally, and assist to monitor contract compliance.	1 1 1 2

[a] Note: Administrative Assistants have been incorporated in several key places in the staffing plan. These are intended to be senior management support people, not clerical – they make it possible for the senior leadership to actually function as managers and leaders. DMH seems to be very short of both administrative assistant and clerical staff.

Functional Area	Staffing Requirements	Comments	Number FTEs (Total)
	Consumer rights legal specialist	Consumer rights specialists participate in critical incident investigations, grievances and appeal, and in review of policies and procedures.	1
	Community relations specialist	Liaisons between DMH and community on issues specific to an area, i.e. hospital closures	1
	Public information specialist	Coordinates response to general or media information requests	1
			(8)
Office of Consumer Affairs	Director	Oversees Consumer role in DMH	1
	Consumer Specialist Supervisor (Community and Hospital)	Recruits, trains and supervises Regional Consumer Specialists	2
	Grievance and Appeal staff	Process grievances and appeals at state level	2
			(5)
Director of Field Operations (Chief Operating Officer) (*Note: very senior and very important position within the MH authority*)	Director	Direct management and oversight of the five Regional Offices, including the state operated facilities; single line of communication and control between the Department director and the field, including both civil and forensic policy.	1
	Admin Asst		1
	ASO manager	Direct management, oversight and liaison with the contracted ASO	1
	ASO staff (One clinical and one finance/admin)		2
	Admin Asst		1
	Regional Operations staff	Liaison and communications with Regional Executives;	5
			(11)
Regional Offices (5)	Regional Executive	Direct management of state operated facilities; coordination and liaison with regional systems of care and provider organizations; primary mode of communication between DMH central office and contracted providers; monitoring of provider operations; working with providers to implement best practices.	5
	Admin. Asst.		5
	Provider relations staff		25[b]
	Regional consumer specialists – community	Represent consumer interests with regional office and providers; recruit and train consumer representatives and advocates; participate in provider monitoring and regional quality management and quality improvement activities.	5
	Regional consumer specialists – state operated facilities		10
			(50)

[b] Assumes an average ratio of staff to providers of approximately 1:7

Functional Area	Staffing Requirements	Comments	Number FTEs (Total)
Contracted ASO	NA	See other sections of chart – not DMH staff functions but would have to become staff functions if not specifically contracted to the ASO.	NA
Office of Clinical Program Operations	Director of Program Operations Admin. Assistant Manager of Adult Mental Health Staff Manager of Child and Adolescent Mental Health[c] Staff Manager of Specialty and Cross-Departmental Services Staff Manager of Community Forensics System Transformation Specialist Manager of QM/QI Admin. Asst. QM Staff Outcome staff Liaison to OIG for critical incidents	This operating division is the source of leadership and guidance for benefit design linked to priority consumer definitions; evidence based practice design and implementation; direct assistance in concert with Regional Office staff in the implementation of best practices; coordination with the Medical Director's office to incorporate the clinical overlay in best practices and quality assurance and quality improvement; develop annual quality improvement and program development plans, etc. Development of specialties in key areas such as housing, employment, co-occurring and long-term care, and their integration into DMH policy, services and operations May have additional staff or contracted functions—not address in state readiness assessment Responsible for coordinating system transformation issues with other agencies QM plan development and management; analyze and interpret data for quality improvement and decision support, including grievance and appeals summary data analysis	1 1 1 4 1 4 1 3 1 1 1 1 3 2 1 (23)
Office of Administrative Services (Chief Financial Officer)	Director of Administrative Services Admin. Asst. Director of Human Resource Development Admin. Asst. HR Staff Trng/Dev Staff	This functional area contains all business management/administrative operations functions in support of program operations. Substantially expanded HR functions designed to assure proper staffing classifications and salaries; appropriate staff performance standards and review criteria and processes; staff training and development activities, etc.	1 1 1 1 2 2

[c] For reasons of emphasis and attention as well as political importance, it might be necessary to have the Child/Adolescent mental health staff be in a separate, free-standing division.

Functional Area	Staffing Requirements	Comments	Number FTEs (Total)
	Director of Finance and Contracts	New financial analysis and forecasting capacity – analyze claims data and RA's to assure proper	1
	Analysts	financial accounting; 718 fund analysis; revenue generation; documentation of Medicaid match; inter-fund transfers; etc.	2
	Contract management	Develops financial terms and revenue targets for Community POS contracts; enters into accounting system(s); tracks and reconciles expenditures against budget categories, etc. (Existing staff with clarified and expanded functions)	2
	Other contracts/hospital interface	Existing functions	1
	Director of Decision Support	Oversight and management of ASO data related functions, including	1
	Analysts	performance monitoring of data	2
	Technical support	activities	2
	Administrative Operations	This includes office management; facility operations; purchasing, vehicles; etc.	NA – not included in review
			(19)
Total FTEs			**118**

Appendix D—MIS Findings and Recommendations

MIS Findings and Recommendations

This report is an independent analysis of the core capabilities of the DMH/DHS/HFS information system capacity to implement a Medicaid and Non-Medicaid fee-for-service system by July 1, 2006. The analysis looked at the following key competencies:

- Hardware and software technologies
  - Software tools
  - Data base structure
  - Web services
  - File Transfer Protocols (FTP)
- Feasibility of modifications
  - Flexibility of application software
  - Availability of staff to manage change
- Reliability of the systems
- HIPAA compliance
- Reporting Capabilities
- Support for Data Warehousing

A review of the following systems were conducted:

- DHS – ROCS
- FHS – MMIS
- DMH – SIS On-Line

General Findings

There are very significant weaknesses and limitations in the current systems that would make the transition to full fee-for-service reimbursement extremely dangerous and would present a serious financial risk to the State of Illinois. The issues are varied and range from a lack of capacity to make changes to current systems due to lack of time and availability of resources, to serious deficiencies in the design of the systems that would need substantial modifications to meet even the lowest level of acceptable functionality to support fee-for-service reimbursement. Existing DMH/DHS information systems were designed for grant funding and the need to make extensive changes to support fee-for-service should be expected. Other states that have undergone fee for service transitions have experienced similar deficits in their legacy systems. The details of these findings can be found in the expanded write up of each major application systems. These findings notwithstanding, there are potential strategies that would allow for the ROCS system to be modified allowing for a very low level of fee-for-service claims processing such as implementation limited only to Medicaid claims. Modifications to current claims processing within ROCS and a linkage with the payment process would be necessary obtain the minimal functionality and to minimize the financial risk.

The current systems design and the available resources to adapt these systems to fee-for-service billing are extremely limited. The systems, with the exception of the SIS On-Line, use older software development technologies that require a very high level of training and sophistication to modify. The number of DHS staff available to modify these systems is in extremely short supply, with many of those remaining approaching retirement. The software tools being used, especially for high-level transaction processing functions, such as claims adjudication, are all written in these older software languages that are very complex and require specialized training and knowledge. The current generation of programmers has little desire to learn these older programming languages, so the ability to recruit and train staff in these areas is very difficult and often unsuccessful in any part of the country. All of this is to paint a harsh, but realistic picture, that to fully implement a robust and state of the art fee-for-service claims management system that would meet the needs of a complex system such as the DMH, will require a very different approach than trying to build internal capacity.

Detailed Findings

DHS - ROCS

This is a critical system that has been used by DMH for many years to support historical grant funding systems. Modifications have been made over the years to address changes, such as HIPAA compliance, but at its core ROCS has been developed and still functions only as a grant reporting system, not a fee-for-service claims processing system. There is a complete separation of the claims (service) data in ROCS from the payment process in the state accounting system, CARS. ROCS has several components that support the grant reporting needs of DMH. In addition to the service data, ROCS is where registration information is collected on consumers being served in the system. Demographic data, diagnostic data and some basic assessment data are also captured in the system. Community providers transmit data to ROCS so that this data and the service data can be used to meet federal block grant reporting requirements. The resulting data is used to produce basic reports about the DMH community system. The data is not well maintained by the providers and DMH has not instituted sufficient data reporting standards, therefore the accuracy of the data is poor, but it represents the only data available to DMH on the functioning of the mental health system. There were several areas of concern regarding the use of this system to support fee-for-service billing.

1. The complete disassociation of the claims data and the payment process is obviously a serious concern. It is critically important that the claims adjudication process align directly and precisely with the payment process. Standard industry protocol is that the sum of all paid claims on the HIPAA 835 (remittance advice) equal the payment to the provider. This is clearly not the case with ROCS.
    a. A link between claims processing and payment existed prior to FY05 for DMH and is currently in place for the Division of Developmental Disabilities. However, precise alignment of the remittance advice payment information and actual payments needs additional attention prior to implementation of fee-for-service.
2. There are a number of front end edits performed by ROCS, but they are fairly basic and do not provide much support for controlling payment of fee-for-service claims. Essentially, the system was designed to receive and count data, not edit and pay fee-for-service claims. Thus, the system would pass through most claims for adjudication to the HFS MMIS system.
    a. The most significant edit is comparison of total YTD payments against contract limits, and that would need to be removed to allow for all Medicaid claims to be processed. Now once the contract limits are met, the claims are not allowed to pass through to the MMIS system. Current Federal law considers Medicaid payments to be a consumer entitlement and establishing maximum payment amounts is generally not allowable without provisions to assure consumer access to service. Eligibility and medical necessity criteria along with service authorizations are the more typical and allowable forms of Medicaid costs management. Therefore, the practice of a claims edit for Medicaid contract maximums would need to be discontinued or be modified under a fee-for-service model.
3. There is limited capacity in ROCS to add additional data elements that would be needed to support additional eligibility data for claims adjudication. For example, one technique to control costs in a fee-for-service system is to assign benefit levels to consumers based on eligibility that limit the amount and types of services that they can receive. ROCS has neither the data elements nor the functionality to perform these simple controls.
4. ROCS requires that each provider agency register a client in order to process claims for a consumer receiving services at that location. This restriction is more a requirement of grant reporting than it is of claims payment. Though not a serious issue, it can and does cause a fair number of claims to be rejected.
    a. Under a grant-funded system this is not a serious issue, however, under a fee-for-service system, these rejected claims become cash flow issues for the providers if not actively managed by both the provider and the managers of ROCS. The need for expanded demographic, assessment and outcomes data needs to be separated from the payment

process. The data being requested is important, but should not interfere with the payment process. The payment model needs to be based on standard HIPAA transactions. A gap analysis needs to be performed to separate the payment data from the other demographic, assessment and outcomes data that is desired.

   b. This requirement does increase providers' compliance with submission of demographic and clinical information contained in the registration portions of ROCS. If the link between claims and registrations is eliminated, alternative strategies will need to be developed to assure collection of necessary data about clients served beyond a claims data set.

5. Under the current grant funding data model, providers have been encouraged (perhaps required) to submit claims (service) data on clients that are not being paid for entirely by DMH. These would be services that are paid for by third party payers (insurance), self pay or even EAP (Employee Assistance Programs), where private payers pay for the services. Under a public health grant funding system it was common for "all" services to be reported for public health monitoring purposes. Providers also used this structure to fully account for all of the grant funding and to ensure that all funds could be retained under state grant recovery procedures. Under a fee-for-service model, only claims that are "paid for in part or in whole with public dollars" should be submitted to the system, which would include only those claims where DMH is a primary or secondary payer, and coordination of benefit rules apply. This is not a fatal issue, but one that needs to be addressed prior to fee-for-service implementation. It will require a significant effort to train providers to look at DMH as a payer and to send only data on patients where payments back are expected.
   a. For services that are not paid on a fee-for-service basis, alternative reporting structures, non-claims reporting, will be required to continue to appropriately account for any grant funds.
6. There is no capacity to support service authorizations in ROCS. Most fee-for-service systems have some level of authorizations and many allow only for payment for authorized services. This is the primary area of financial risk in the transition to fee-for-service since there is no capacity to control service utilization. The current system is wide open for the free flow of claims from the providers with no checks.
7. Contract management is another area of weakness. There is some functionality within ROCS, but it is limited to global contract limits that could be problematic. Most fee-for-service systems have the ability to limit claims payment based on specific contract services or service categories. Again, this capability is not necessary in a grant funding system, but becomes a very important capability for cost management under fee-for-service reimbursement.
8. Within the core design of the ROCS system there are "key indicators" that are used by the system to perform certain logic. The statement was made that these "key indicators" cannot be touched or changed without significant programming implications. This is very consistent with a third generation (3GL) programming environment. Though we did not get into specifics, this translates in layman's terms to – you must use the system as it has been designed. Changing any of these key indicators will require time and resources. If DMH is unable to contract with an ASO and ROCS will be used to support fee-for-service claims processing, an additional level of analysis will be needed to determine the exact nature of these key indicators and what restrictions there might be in making changes to the claims processing logic.

HFS - MMIS

The next system reviewed was the Medicaid Management Information System (MMIS) managed by the Department of Healthcare and Family Services (HFS). This is where all the claims that are approved through the ROCS system are sent for Medicaid and Non-Medicaid adjudication. Currently both Medicaid and Non-Medicaid claims are processed through the MMIS and reports are produced back to DHS indicating which claims were approved. This is an important point since most MMIS systems are not capable of adjudicating Non-Medicaid claims. The other important point that was discovered during this interview was that a special Child Mental Health program internally called SASS has already been

converted to fee-for-service and has been submitting both Medicaid and Non-Medicaid claims to HFS for over a year. Further, it was discovered that those services are being prior-authorized using the MMIS system.

One of the documents used as a part of the assessment was **HFS/MMIS Recipient Subsystem – Mental Health Services Authorization User Manual**. This manual is an instruction manual that describes how users can interact with the MMIS system to determine eligibility and to enter authorizations. The MMIS system does accept standard HIPAA transactions, but produces a proprietary 835-remittance advice (not HIPAA compliant) for all claims that are adjudicated for DHS and the ROCS system. A HIPAA compliant 835 is under development. In addition the MMIS has several web enabled on-line functions that allow for real time access to claims status, eligibility status and for submitting claim files for processing.

If claims will be submitted directly from providers to MMIS in the future, further research is needed to confirm that claims will process correctly if a single claim is submitted with both Medicaid and Non-Medicaid services on the same claim. Combined Medicaid and non-Medicaid claim lines on the same claim has been a conversion issue in other states, and the information from the MMIS interview and follow-up discussions was inconclusive on this issue. Therefore, further research and testing should be conducted if any conversion plan includes moving to provider claim submission directly to MMIS in the future. Under the current billing flow from providers to ROCS to MMIS, each service record or claim line is submitted separately. Therefore, under current processes, claims are not submitted or rejected due to the mix of Medicaid and non-Medicaid services.

Another important document reviewed as a part of the assessment is **Mental Health Fee-for-Service Conversion Project – Phase II – Project Charter.** Although this document describes in some detail a planned approach to using the MMIS to adjudicate DMH claims, this project is currently not active pending review and approval from DMH. Even if approved, staffing and resources to complete the project will be an issue that must be resolved. That was further reinforced during the interview when staffing and resource issues were discussed. The bottom line of those discussions was that there were not enough resources available between November 2005 and July 2006 to implement changes in the MMIS. Even more important, there would need to be several more months of planning and design before any programming changes could be made. Bottom line is that there could be no significant changes made to the MMIS prior to July 2006.

Summary--The following are a list of issues, observations or concerns that were identified during this review process:

1. The MMIS system accepts claims submitted from providers daily.
2. The MMIS online system is known as MEDI and it allows for online access to claims and eligibility data.
3. Testing should be performed to ensure that if a single claim is submitted from providers directly to MMIS with both Medicaid and Non-Medicaid services on that claim, the claim processes both the Medicaid and non-Medicaid components correctly.
4. The SASS system that handles some Child Mental Health claims currently uses an outside vendor to process prior authorizations and to maintain client eligibility status. This is a small subset compared to the entire DMH system, however, there are many parallels. Here are some of the lessons learned that were shared by the HFS staff regarding the SASS implementation.
    a. It is important that program policy be aligned with system capabilities. This was not done well with SASS initially.
    b. Need several months (4-6) of intensive planning around policy decisions prior to making system design decisions.
    c. Need to allow several months (4) for intensive testing prior to implementation.
    d. Provider training and technical assistance is critical to the success of the program. Providers need lots of help.

e. Access to funds to pay claims; making funds available so that claims can be paid needs to be well thought out to avoid payment delays.

5. HFS is going through a major staffing and resource change after December 31, 2005 that will adversely affect its ability to take on any new projects.

DMH – SIS On-line

The SIS On-Line system (SIS) stands for Service Inquiry System and has been developed within DMH to address the need for access to data and reports by the providers. This system has been developed with very limited resources and is not being supported as a key strategic system at this point. The system is meeting a need by providers for access to data and reports from ROCS, which are used by DMH. The data reported is around service utilization and attempts to match grant funding to the actual service data being submitted. However there are internal issues related to the source of data for reports that impact the accuracy of the data, and corresponding providers issues associated with the consistency and accuracy of the SIS reports. This system needs to be determined to be a strategically important system for DMH and supported as such, or abandoned.

From an information systems perspective, the use of a data warehouse or decision support system that recaps important operational data and makes it accessible to management and to the provider network is a very common solution and can be a strategically powerful tool. Data warehouse functions were clearly a part of the development of SIS. However, if the system is strategically important, then it must be supported as such and developed in a way that assures integrity and accuracy. This would include security protections and disaster recovery. How this relates to the transition to fee-for-service is very important. Once providers are dependant on accurate and timely processing of claims data for cash flow or reconciliation data, the data contained in a system like SIS must be timely and accurate or the providers will be confused and upset, and rightly so.

Since this system currently does not provide any operational support, and does not fulfill data warehouse functions, it really is not a major factor in the implementation of fee-for-service from a process perspective. However, this functionality must be created to make timely claims payment data available to providers and DMH management during the transition. Once the fee-for-service operational strategy is established, the method for long term implementation needs to be part of the total information system strategy for DMH. If DMH contracts with an ASO, data warehouse and decision support systems should be incorporated into the required ASO activities. If an ASO is not available, additional analysis and planning will need to be completed to assure sufficient provider and DMH reporting during and following the fee-for-service conversion.

Conclusions and Recommendations

After reviewing these systems in some detail and looking at the various components identified in the scope there are some obvious conclusions and a couple of recommendations on what can be realistically accomplished by July 2006.

1. There is neither adequate time nor sufficient human resources to make any substantive changes to the MMIS system prior to July 2006. There is time for July 2007, but work will need to begin early in calendar year 2006 in order to allow for adequate program design and then system development and testing to ensure a smooth transition.
2. The ROCS system may be able to be modified, but again there is little time or human resource capacity to make any significant changes. Changes would need to be done to reduce some of the current functions, such as batch balancing, rather then adding functions. Some other possible changes would include:
    a. Remove the requirement that each agency “register” the patient as a pre-requisite for payment. This does not mean that the data is not captured, but that claims not be “rejected” if a registration for that agency is not on file. If there is a correct RIN (Recipient Identification Number) on file and that provider has a contract with DMH, then the claims

should be processed. Implications for the continued submission of registration information would need to be assessed.

b. There should be no "D" (do not bill) claims allowed into ROCS. Providers will need to be instructed to send only claims for billable activities that "are paid for in part or in whole with public (DMH or Medicaid) dollars."
c. The batch balancing process that ties inbound claims and processed claims from the MMIS together should be abandoned. Instead, the providers should be given copies of the remittance advices pertaining to their services that return from MMIS. Providers would then be responsible for tracking their receivables. Claims that are rejected by ROCS should be reported immediately back to the providers. Claims accepted by ROCS should be processed through the MMIS and allow providers to track the status of their claims through online access to the MMIS via MEDI.
d. The MMIS remittance advice information (835) should be used to either pay for services under a true fee-for-service model or be used to reconcile against advances. In either case, the remittance advice must be fully accounted for in the payment and reconciliation process. Further, this process must be crystal clear to the providers so that they can have accurate accounting of the services they have submitted for payment.

The SIS On-Line system should be given proper resources and an adequate redesign completed so that it can be used as a reliable decision support tool for DMH and for the provider community. Initially, its functions should be centered on the payment and reconciliation process so that there is a common source of "truth" about what has been processed and accounted for under the fee-for-service system. This will take additional resources, both technical and human, and a strong commitment from DMH to accomplish this recommendation.

Looking longer term to July 2007, the recommendation is to replace ROCS with an ASO. There are two options to consider from an information technology perspective.

1. Option 1 would be to outsource all of the fee-for-service function to an external entity, an ASO, to provide the information system infrastructure as well as the human resources necessary to manage a fee-for-service information system. This system would need to perform the following major functions:
    a. Enrollment and eligibility of all clients receiving services. This would include eligibility checking for Medicaid and making eligibility determinations for Non-Medicaid clients. It would also manage benefit limits based on the level of care needed for clients.
    b. Gather assessment data and make level of care determinations.
    c. Authorizations for services for both Medicaid and Non-Medicaid clients.
    d. Provider contract management. Manage services allowed, limits and rates for providers within the network.
    e. Claims processing. Complete the claims adjudication process including determination of which claims are Medicaid eligible services. Submitting those claims to Medicaid and reconciliation of those claims to maximize appropriate FFP recovery for DMH.
    f. Produce remittance advices and payments back to providers. This can be modified to create the warrants for payment that are then processed through the state general accounting system.
    g. Capture outcomes data from providers.
    h. Produce utilization management reports and reports that monitor the claims payment process.
    i. Provide web access to the information system to submit claims, check eligibility status, check claims status, receive remittance advice information and submit or enter outcomes and assessment data.
    j. Administrative FFP recovery. This process would have the Medicaid eligible services extracted and sent to Medicaid to cover administrative FFP.

    These are just a few high level examples of the functions that would need to be performed by an ASO service and there are several minor variations that can be considered to the above.

2. Option 2 is a variation of Option 1 that utilizes the capabilities of the HFS MMIS system to perform the claims adjudication function rather than the ASO. An ASO with information system capacity would do several of the other key functions – enrollment, eligibility, authorizations, outcomes and assessments, claims editing and contract management, but then would send claims through to MMIS for adjudication. The resulting remittance advice data would be brought back into the information system and reconciled. The payment process would be made from the MMIS remittance advice process.
    a. The advantage of this approach is that it takes advantage of an already existing system resource (MMIS) that is very good at claims adjudication and making payments within the state system and mirrors the current ROCS system approach with a much more robust enrollment, eligibility, authorization management, claims editing and contract management capabilities.

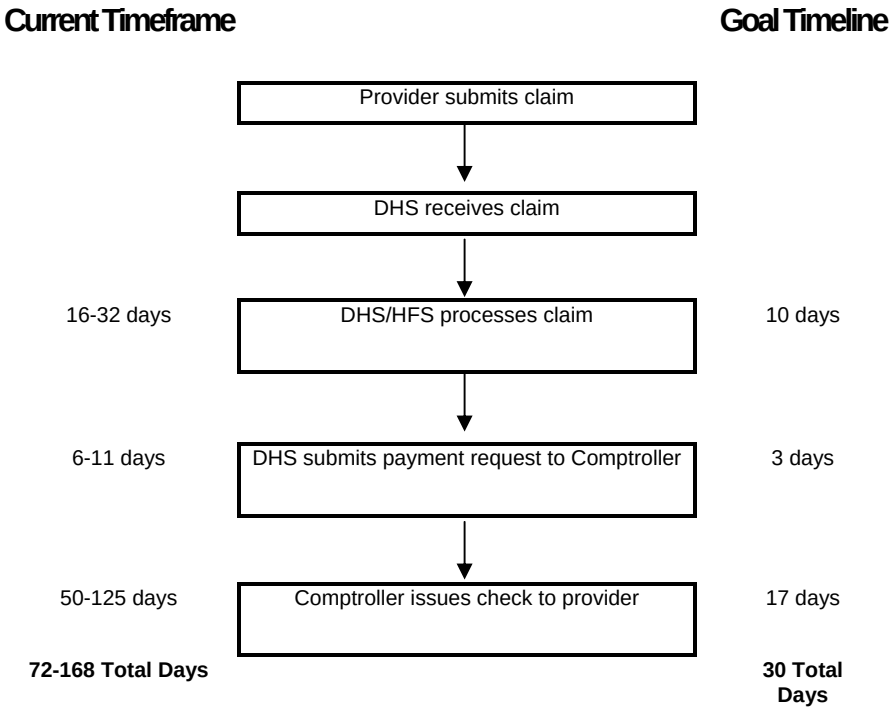
Appendix E—Claims Timelines

Payment Cycle Needed for Mental Health Fee-for-Service

Although all community mental health service providers are currently receiving advance payments in the form of grants to support their delivery of services, it is important to forecast the provider cash flow implications of moving to fee-for-service. Since community mental health service providers are mission-driven non-profit organizations they generally have little or no cash reserves to sustain their organization's ongoing operations, making prompt payment for services already delivered imperative for their ongoing operation.

When the system converts to true fee-for-service—that is, where payment is not issued until after the provider has provided the service and submitted a bill--DHS/DMH expert consultants experienced with similar organizations in other state have recommended a payment cycle of thirty (30) days or less from the time a bill or claim is received by the state until the time the state issues payment to the provider.

The following table shows an estimate of the current bill processing cycle and the payment cycle that will be needed when the system converts to true fee-for-service.



Note: days shown are calendar days

Appendix F—Target & Eligible Population Penetration

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Office of Mental Health
Client Registration Information

Statewide by Network - Adults (Age >= 18) Eligible and Target
(07/01/2004 - 06/30/2005)

NETWORK	TOTAL ADULTS SERVED DURING PERIOD	ADULTS ELIGIBLE	% ADULTS ELIGIBLE	ADULTS TARGET WITHIN ELIGIBLE	% ADULTS TARGET	ADULTS NON-ELIGIBLE	% ADULTS NON-ELIGIBLE	ADULTS WITH VALID DMHDDID	% ADULTS WITH VALID DMHDDID
	(A)	(B)	(B/A)	(C)	(C/A)	(D)	(D/A)	(E)	(E/A)
Central	15,745	14,574	92.56%	7,134	45.31%	1,171	7.44%	1,162	7.38%
Metro-C&A	624	613	98.24%	87	13.94%	11	1.76%	28	4.49%
Metro-East	6,348	5,894	92.85%	4,047	63.75%	454	7.15%	337	5.31%
Metro-North	17,792	17,059	95.88%	9,153	51.44%	733	4.12%	2,072	11.65%
Metro-South	10,763	9,190	85.39%	7,015	65.18%	1,573	14.61%	1,290	11.99%
Metro-Suburban	14,361	13,682	95.27%	9,898	68.92%	679	4.73%	949	6.61%
Metro-West	8,522	7,605	89.24%	4,965	58.26%	917	10.76%	517	6.07%
North Central	20,085	19,169	95.44%	8,705	43.34%	916	4.56%	710	3.53%
Northwest	7,663	7,048	91.97%	4,432	57.84%	615	8.03%	444	5.79%
Southern	9,617	9,095	94.57%	3,732	38.81%	522	5.43%	548	5.70%
Adapt of Illinois, Inc *	308	306	99.35%	300	97.40%	2	0.65%	0	0.00%
Asian Human Serv.Of Chgo.,Inc. *	426	421	98.83%	252	59.15%	5	1.17%	9	2.11%
Chicago Board of Health *	9,063	8,809	97.20%	6,169	68.07%	254	2.80%	1	0.01%
Community Mental Health Coun. *	5,581	5,465	97.92%	3,738	66.98%	116	2.08%	0	0.00%
Fam.Serv.& M.H.C. McHenry Co. *	2,187	1,520	69.50%	890	40.70%	667	30.50%	6	0.27%
Grow, Inc. *	18	17	94.44%	17	94.44%	1	5.56%	6	33.33%
Heartland Health Outreach Inc. *	790	783	99.11%	422	53.42%	7	0.89%	17	2.15%
Jewish Vocational Services *	455	444	97.58%	396	87.03%	11	2.42%	23	5.05%
McHenry County On Illinois *	102	102	100.00%	96	94.12%	0	0.00%	0	0.00%
Mt. Sinai Hospital Medical Center *	3,392	3,257	96.02%	2,087	61.53%	135	3.98%	51	1.50%
Proviso Family Services, Inc. *	2,007	1,885	93.92%	1,253	62.43%	122	6.08%	50	2.49%
Thresholds *	4,993	4,751	95.15%	4,030	80.71%	242	4.85%	989	19.81%
TOTAL FOR STATEWIDE	140,842	131,689	93.50%	78,818	55.96%	9,153	6.50%	9,209	6.54%

Note:
1. Col A = Col B + Col D
2. Clients are unduplicated within an agency. (e.g. if a client is served by an agency in two or more programs, or served more than once, the client will be counted only once for the agency.)
3. Definitions of Indicators for Adults (Age>=18) Eligible and Target Report
4. Metro C&A data are from agencies funded by Metro C&A only.
5. (*) These agencies belong to multiple networks. Their data are the sum of all the services provided by that agency.

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Office of Mental Health
Client Registration Information

Statewide by Network - Children and Adolescents (Age 3-17) Eligible and Target
(07/01/2004 - 06/30/2005)

NETWORK	TOTAL C&A SERVED DURING PERIOD (A)	C&A ELIGIBLE (B)	% C&A ELIGIBLE (B/A)	C&A TARGET WITHIN ELIGIBLE (C)	% C&A TARGET (C/A)	C&A NON-ELIGIBLE (D)	% C&A NON-ELIGIBLE (D/A)	C&A WITH VALID DMHDDID (E)	% C&A WITH VALID DMHDDID (E/A)
Central	5,088	4,715	92.67%	1,420	27.91%	373	7.33%	65	1.28%
Metro-C&A	1,934	1,833	94.78%	605	31.28%	101	5.22%	76	3.93%
Metro-East	1,232	1,109	90.02%	447	36.28%	123	9.98%	7	0.57%
Metro-North	4,221	3,968	94.01%	1,275	30.21%	253	5.99%	187	4.43%
Metro-South	2,292	1,887	82.33%	1,114	48.60%	405	17.67%	7	0.31%
Metro-Suburban	2,070	1,766	85.31%	1,149	55.51%	304	14.69%	108	5.22%
Metro-West	1,970	1,261	64.01%	244	12.39%	709	35.99%	8	0.41%
North Central	6,318	5,925	93.78%	1,873	29.65%	393	6.22%	69	1.09%
Northwest	2,995	2,718	90.75%	1,232	41.14%	277	9.25%	10	0.33%
Southern	2,655	2,459	92.62%	508	19.13%	196	7.38%	21	0.79%
Asian Human Serv.Of Chgo.,Inc. *	30	29	96.67%	5	16.67%	1	3.33%	0	0.00%
Chicago Board of Health *	352	316	89.77%	121	34.38%	36	10.23%	0	0.00%
Children's Home & Aid Society *	99	99	100.00%	14	14.14%	0	0.00%	0	0.00%
Community Mental Health Coun. *	914	894	97.81%	384	42.01%	20	2.19%	0	0.00%
Fam.Serv.& M.H.C. McHenry Co. *	811	520	64.12%	195	24.04%	291	35.88%	1	0.12%
Mt. Sinai Hospital Medical Center *	837	646	77.18%	213	25.45%	191	22.82%	8	0.96%
Proviso Family Services, Inc. *	435	370	85.06%	113	25.98%	65	14.94%	3	0.69%
Thresholds *	11	0	0.00%	0	0.00%	11	100.00%	0	0.00%
TOTAL FOR STATEWIDE	34,264	30,515	89.06%	10,912	31.85%	3,749	10.94%	570	1.66%

Note:
1. Col A = Col B + Col D
2. Clients are unduplicated within an agency. (e.g. If a client is served by an agency in two or more programs, or served more than once, the client will be counted only once for the agency.)
3. Definitions of Indicators for Children and Adolescents (Age 3-17) Report
4. Metro C&A data are from agencies funded by Metro C&A only.
5. (*) These agencies belong to multiple networks. Their data are the sum of all the services provided by that agency.

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Appendix G--Examples of ASO Performance Standards

Potential ASO Standards/Deliverables

ASO standards should be primarily driven by the vendor's response to the request for proposal which contains all requirements established by the state. DMH procurement managers should read each proposal and note any and all areas of concern and ambiguity in the proposals. Proposals are often lengthy and are written by multiple partners in a corporation, so attention should be paid to conflicting information in different parts of the proposal. In addition, at least one non-voting DMH manager should also witness the procurement review and capture any concerns of the reviewers. The selection process should also include other state staff from HFS and DHS with experience with Medicaid and behavioral healthcare.

All of this information should be utilized in obtaining best and final offers from the vendors to DMH. When contracts are negotiated, the proposal, any best and final offer information, and any additional expectations of the state should a part of the contract document itself. If the vendor has not provided specific information, the following should be considered as minimum expectations of the selected vendor:

Standard/Deliverable	Notes/Comments/Options
The ASO shall have an average authorization disposition time of not more than 24 hours.	DMH may want to have this 24 hour disposition related only to certain high intensity services and have a routine authorization disposition time of 48 hours.
The ASO shall resolve all authorization issues within 2 weeks.	This standard allows some time for the ASO to request additional information from a provider and respond to it. This standard should be paired with the first suggested outcome in order assure timeliness on the majority of all transactions with some allowance for special circumstances (with outside parameters).
A qualified management team will be selected by the ASO. DMH will hold the right of refusal for the hiring of an executive director for the Illinois project.	Depending on the amount of authority DMH wants to exert, this may also be extended to other key leaders in the ASO management structure.
An upper management position for DMH project shall be held by a self-identified consumer in recovery with a mental illness.	This demonstrates DMH commitment to consumer recovery, the commitment to the mental health advocacy locally, and the commitment of DMH to valued employment roles for those with a mental illness.
All ASO policies and procedures must be developed and approved by DMH management within 90 days of the contract implementation. Negotiation of policy will occur during and between contract management meetings.	While many policies may not require DMH's review, it is best to provide for this opportunity in order to exert the MH authority role and to assure that the ASO operates as a seamless extension of the MH authority goals and objectives.
X% of all Trainer/Auditors and Care Managers must have any exclusive IL licenses/certifications, etc. within one year of contract implementation.	DMH must judge whether there are any specific licensure/certification requirements which will be part of the procurement mandates. Then other preferred certifications which will provide the selected vendor with experience essential to the Illinois DMH culture can be negotiated through such a sample deliverable.
X% of all annual Trainer/Auditor and Care Manager continuing education must be specific to [*Selected EBT*].	Given that certain staff will be required to be licensed and that the ASO will typically supply their staff with this training directly or indirectly, this is an opportunity to shape the knowledge base of the primary reviewers to reflect principles of DMH. For example, with co-occurring mental health and addictive disease treatment being a federal priority, 50% of all continuing education for ASO professionals could be required to train on the Treatment Improvement Protocol [TIP42] for co-occurring behavioral health issues.

Standard/Deliverable	Notes/Comments/Options
Provider orientation training specifications	Specific requirements should be established regarding the topics to be included, educational formats (website, written materials didactic training, etc.) and minimum number of training sites should be established for the first year of the contract
All training provided to providers must be approved by DMH through its contract management process.	While the ASO should be in a position to use its Quality Improvement information to drive training curriculum, DMH should be the ultimate authority on training events.
Direct telephonic technical assistance to providers must be made available within 72 hours. If the technical assistance request exceeds normal expectations, DMH manager must be notified of the request and recommend ASO course of action.	This outcome assures that the call centers, computer techs, trainer auditors, etc. are responsive to direct provider needs.
The vendor shall participate in weekly contract management meetings with DMH throughout Year One of the contract. DMH will decide on whether this frequency can be reduced to every other week at the beginning of Year Two.	Weekly meetings are essential. They will build the team approach to the MH authority's management of the ASO and are absolutely necessary with the scope of work proposed.

Appendix H—Examples of ASO Claims Analysis Reports

Print Date : 1/21/2005 2:15:42PM

Annual Statewide Claims by Provider

For Service Dates between 07/01/2003 and 06/30/2004

Start Date: 07/01/2003
End Date: 06/30/2004
Data Date : 01/01/2005

S1

Data Source : ACS Paid/Denied Claims

Agency	# of Consumers	Amount Billed	Amount Paid
Adv[redacted]	3,834	$ 3,893,093	$ 3,157,549
Alb[redacted]	2,000	$ 3,952,923	$ 3,240,941
ALL[redacted]	3	$ 15,287	$ 15,284
Am[redacted]	445	$ 2,594,664	$ 1,545,018
Bac[redacted]	39	$ 229,880	$ 195,349
Beh[redacted]	3,121	$ 4,694,061	$ 1,553,584
BH[redacted]	2,721	$ 4,164,042	$ 3,456,255
Car[redacted]	32	$ 238,243	$ 190,180
Cer[redacted]	32	$ 216,204	$ 114,269
ChA[redacted]	193	$ 167,815	$ 99,999
Chr[redacted]	1	$ 5,369	$ 1,166
Cla[redacted]	1,560	$ 2,593,221	$ 2,280,187
Clin[redacted]	65	$ 218,825	$ 173,247
Cob[redacted]	3,494	$ 27,743,085	$ 5,122,232
Cor[redacted]	17	$ 115,020	$ 90,543
Cor[redacted]	21	$ 132,495	$ 102,513
CSI[redacted]	3,739	$ 7,782,205	$ 3,764,742
CSI[redacted]	2,301	$ 4,837,485	$ 2,907,725
Dec[redacted]	1	$ 204	$ 0
DeK[redacted]	4,679	$ 6,798,657	$ 4,673,827
Far[redacted]	65	$ 285,662	$ 231,908
FAI[redacted]	3	$ 3,885	$ 0
FAI[redacted]	110	$ 261,665	$ 175,740
Firs[redacted]	3	$ 8,800	$ 0
Ful[redacted]	2,225	$ 1,992,922	$ 1,466,867
Ful[redacted]	1	$ 89	$ 0
Gat[redacted]	5,228	$ 9,600,454	$ 5,902,231
GE[redacted]	27	$ 82,531	$ 60,463
Gec[redacted]	42	$ 251,193	$ 166,488
Gec[redacted]	3,342	$ 4,349,865	$ 3,550,286
Gec[redacted]	3,351	$ 5,171,544	$ 4,065,561
Gec[redacted]	160	$ 342,735	$ 252,934
Gec[redacted]	118	$ 340,779	$ 295,693
Gra[redacted]	732	$ 1,878,777	$ 620,854
GR[redacted]	3,158	$ 5,872,454	$ 4,266,788
Har[redacted]	423	$ 586,789	$ 426,297
Her[redacted]	13	$ 28,453	$ 14,895
Hig[redacted]	7,047	$ 7,577,702	$ 5,213,163
Inte[redacted]	21	$ 84,032	$ 41,559
Loc[redacted]	2,003	$ 3,019,377	$ 1,950,402
Mcl[redacted]	2,155	$ 3,636,385	$ 2,702,659
Met[redacted]	118	$ 468,076	$ 346,636
Mid[redacted]	1,797	$ 3,811,722	$ 3,130,525
Nev[redacted]	3,477	$ 11,715,311	$ 7,423,828
Nev[redacted]	32	$ 116,487	$ 87,582
Nev[redacted]	64	$ 552,261	$ 373,161
Nor[redacted]	14	$ 206,094	$ 43,981
Occ[redacted]	1,351	$ 4,274,824	$ 2,553,244
Oge[redacted]	1,404	$ 2,869,788	$ 2,402,284
Pat[redacted]	2,842	$ 7,892,568	$ 5,025,269
PA[redacted]	33	$ 84,724	$ 66,162
Phc[redacted]	31	$ 352,632	$ 283,448

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Print Date : 1/21/2005 3:50:52PM

Annual Statewide Claims by Service

For Service Dates between 07/01/2004 and 12/31/2004

Start Date: 07/01/2004
End Date: 12/31/2004
Data Date : 01/11/2005

S2

Data Source : ACS Paid/Denied Claims

Service	# of Consumers	Amount Billed	Amount Paid	$ per Consumer
7/2004				
Psychosocial Rehabilitation	1,655	$1,474,583	$1,139,796	$688.70
Community Support - Individual	7,636	$1,272,589	$1,033,894	$135.40
Intensive Family Intervention	519	$879,295	$717,120	$1,381.73
Physician Assessment/Care	11,255	$982,540	$695,048	$61.75
C&A Day Supports	902	$689,931	$551,728	$611.67
Diagnostic Assessment	5,414	$717,383	$526,795	$97.30
SA Adolescent Day Treatment	284	$631,213	$485,786	$1,710.52
Adult Peer Supports	1,171	$529,210	$389,637	$332.74
Residential Rehab Supports 2	444	$608,949	$368,946	$830.96
Group Training/Counseling	1,592	$494,253	$362,053	$227.42
C&A Day Treatment	334	$433,960	$336,356	$1,007.05
Nursing Assessment/Services	7,017	$429,350	$312,311	$44.51
Individual Counseling	2,947	$400,666	$284,459	$96.52
Substance Abuse Day Services	510	$385,254	$264,823	$519.26
Community Support - Team	762	$320,873	$247,051	$324.21
Activity Therapy	133	$200,872	$152,706	$1,148.16
Assertive Community Treatment	183	$153,877	$113,738	$621.52
Medication Administration	1,723	$305,699	$97,921	$56.83
Family Counseling	968	$128,380	$95,176	$98.32
Residential Rehab Supports 1	103	$127,586	$80,544	$781.98
Crisis Residential Services	97	$115,851	$76,749	$791.23
Intensive Day Treatment (PH)	59	$53,288	$43,524	$737.69
Out-of-Clinic Crisis	78	$10,356	$7,506	$96.23
In-Clinic Crisis	52	$7,277	$4,950	$95.19
Invalid YCode	664	$108,924	$3,281	$4.94
Ambulatory Detoxification	1	$1,809	$904	$904.28
8/2004				
Psychosocial Rehabilitation	1,657	$1,496,146	$1,193,528	$720.29
Community Support - Individual	7,991	$1,368,356	$1,114,813	$139.51
Physician Assessment/Care	12,344	$1,070,962	$784,640	$63.56
Intensive Family Intervention	547	$968,585	$738,103	$1,349.37
Diagnostic Assessment	5,741	$743,464	$566,683	$98.71
C&A Day Supports	932	$546,339	$449,807	$482.63
SA Adolescent Day Treatment	268	$592,314	$433,144	$1,616.21
Adult Peer Supports	1,176	$547,573	$411,682	$350.07
Residential Rehab Supports 2	433	$549,722	$372,258	$859.72
Nursing Assessment/Services	7,451	$449,569	$343,890	$46.15
Group Training/Counseling	1,690	$447,480	$325,684	$192.71
Substance Abuse Day Services	537	$393,012	$294,665	$548.72
Individual Counseling	3,032	$385,991	$294,023	$96.97
Community Support - Team	763	$339,537	$268,267	$351.60
C&A Day Treatment	353	$315,093	$264,486	$749.25
Assertive Community Treatment	180	$157,770	$125,861	$699.23
Family Counseling	925	$118,631	$96,086	$103.88
Medication Administration	1,664	$224,032	$95,802	$57.57
Residential Rehab Supports 1	111	$140,411	$90,947	$819.35
Crisis Residential Services	107	$130,384	$87,838	$820.91
Activity Therapy	96	$98,151	$84,258	$877.68
Intensive Day Treatment (PH)	54	$52,643	$36,730	$680.18
Out-of-Clinic Crisis	96	$13,761	$8,829	$91.97
In-Clinic Crisis	81	$12,389	$7,731	$95.44

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Report Run Date: 1/24/2005

Statewide Monthly Comparison of Service Activity

Start Date: 07/01/2003
End Date: 06/30/2004
Data Date : 01/11/2005

S5

Data Source: ACS Paid/Denied Claims

(Based on Service Delivery Date)

		Jul	Aug	Sep	Oct	Nov	Dec	Jan
Activity Therapy	# Unique Csrs	234	226	216	224	211	215	232
	Total Billed	$587,404	$362,371	$411,733	$414,718	$312,858	$388,467	$391,218
	Total Paid	$263,558	$220,338	$237,101	$227,704	$189,296	$223,498	$246,591
	% Paid	45	61	58	54	60	56	61
Adult Day Supports	# Unique Csrs	0	0	0	1	0	1	2
	Total Billed	$0	$133	$0	$450	$0	$68	$168
	Total Paid	$0	$0	$0	$0	$0	$0	$0
	% Paid	0	0	0	0	0	0	0
Adult Day Treatment	# Unique Csrs	0	0	1	0	0	0	0
	Total Billed	$0	$0	$124	$0	$0	$0	$0
	Total Paid	$0	$0	$0	$0	$0	$0	$0
	% Paid	0	0	0	0	0	0	0
Adult Peer Supports	# Unique Csrs	1,214	1,215	1,245	1,251	1,219	1,213	1,189
	Total Billed	$939,003	$742,633	$703,423	$783,283	$580,909	$627,602	$599,964
	Total Paid	$391,986	$365,173	$403,329	$426,732	$345,989	$397,602	$386,020
	% Paid	40	48	55	53	59	62	64
Ambulatory Detoxification	# Unique Csrs	0	1	2	0	1	1	1
	Total Billed	$0	$98	$318	$0	$3,715	$391	$782
	Total Paid	$0	$73	$98	$0	$0	$49	$782
	% Paid	0	67	33	0	0	40	100
Assertive Community Treatment	# Unique Csrs	265	248	248	234	225	217	210
	Total Billed	$275,857	$205,462	$206,335	$207,710	$170,106	$156,612	$151,644
	Total Paid	$168,884	$160,929	$157,844	$158,702	$130,170	$133,179	$129,828
	% Paid	63	81	78	74	79	83	85
C&A Day Supports	# Unique Csrs	924	945	930	960	957	979	978
	Total Billed	$1,399,627	$865,393	$739,624	$810,560	$588,500	$657,169	$664,703
	Total Paid	$574,947	$427,005	$416,244	$446,969	$360,080	$418,740	$412,485
	% Paid	38	46	53	52	57	60	60
C&A Day Treatment	# Unique Csrs	335	320	325	310	301	298	317
	Total Billed	$1,034,040	$546,144	$468,220	$458,064	$279,859	$308,230	$306,103
	Total Paid	$341,061	$231,920	$243,978	$257,240	$192,814	$227,517	$224,792
	% Paid	33	43	52	54	67	72	73
CHSS Specialized Medical Supplies	# Unique Csrs	1	1	1	4	3	3	3
	Total Billed	$104	$155	$111	$601	$290	$290	$366
	Total Paid	$0	$0	$0	$0	$0	$0	$0
	% Paid	0	0	0	0	0	0	0
Community Habilitation and Support Services	# Unique Csrs	2	3	2	3	3	3	1
	Total Billed	$10,193	$9,249	$8,305	$9,815	$9,948	$17,931	$6,418
	Total Paid	$0	$0	$0	$0	$0	$0	$0
	% Paid	0	0	0	0	0	0	0

		Feb	Mar	Apr	May	Jun	**Total**
Activity Therapy	# Unique Csrs	208	224	196	181	165	786
	Total Billed	$319,062	$387,488	$281,030	$245,045	$343,867	$4,445,261
	Total Paid	$231,776	$257,374	$214,410	$190,698	$206,427	$2,708,772
	% Paid	70	65	76	77	60	60%
Adult Day Supports	# Unique Csrs	0	0	1	0	0	5
	Total Billed	$0	$0	$33	$0	$0	$852
	Total Paid	$0	$0	$0	$0	$0	$0
	% Paid	0	0	0	0	0	0%
Adult Day Treatment	# Unique Csrs	0	0	0	0	0	1
	Total Billed	$0	$0	$0	$0	$0	$124
	Total Paid	$0	$0	$0	$0	$0	$0
	% Paid	0	0	0	0	0	0%
Adult Peer Supports	# Unique Csrs	1,206	1,232	1,198	1,153	1,174	1,941
	Total Billed	$586,896	$727,725	$674,911	$591,053	$622,197	$8,179,599
	Total Paid	$386,081	$465,788	$415,788	$395,142	$427,931	$4,807,561
	% Paid	66	63	60	64	68	57%
Ambulatory Detoxification	# Unique Csrs	1	2	1	0	2	9
	Total Billed	$98	$562	$293	$0	$2,395	$8,652
	Total Paid	$0	$540	$293	$0	$49	$1,884
	% Paid	0	87	100	0	5	29%
Assertive Community Treatment	# Unique Csrs	201	214	195	195	190	394
	Total Billed	$148,579	$159,400	$138,529	$143,208	$140,676	$2,104,119
	Total Paid	$119,159	$144,489	$119,676	$123,101	$113,640	$1,659,602
	% Paid	79	90	86	86	80	79%
C&A Day Supports	# Unique Csrs	953	974	958	960	905	2,521
	Total Billed	$675,327	$749,256	$669,764	$554,091	$808,055	$9,182,069
	Total Paid	$406,383	$469,715	$434,612	$423,718	$560,253	$5,351,151
	% Paid	59	58	59	74	68	55%
C&A Day Treatment	# Unique Csrs	314	330	357	363	345	990
	Total Billed	$320,287	$406,257	$507,081	$406,435	$574,195	$5,614,915
	Total Paid	$227,131	$280,792	$276,474	$275,892	$372,627	$3,152,238
	% Paid	72	66	53	65	64	56%
CHSS Specialized Medical Supplies	# Unique Csrs	2	0	0	0	0	4
	Total Billed	$162	$0	$0	$0	$0	$2,078
	Total Paid	$0	$0	$0	$0	$0	$0
	% Paid	0	0	0	0	0	0%
Community Habilitation and Support Services	# Unique Csrs	1	2	0	0	0	8
	Total Billed	$6,418	$2,847	$0	$0	$0	$81,122
	Total Paid	$0	$0	$0	$0	$0	$0
	% Paid	0	0	0	0	0	0%

Print Date : 1/25/2005 9:18:51AM

Annual Service Specific Analysis by All Providers

Start Date : 07/01/2004
End Date: 12/31/2004
Data Update :01/11/05

S7

Data Source:ACS Paid/Denied Claims

Psychosocial Rehabilitation

	Unique Consumers	Paid Units	Billed Amount	Paid Amount	% Paid	$ Per Consumer
Adva[redacted]	20	4,022.8	$ 50,864	$ 49,762	98%	$2,488
Alba	98	23,440.3	$ 331,863	$ 289,957	87%	$2,959
Ame	48	13,760.1	$ 221,508	$ 170,213	77%	$3,546
BHS	15	3,436.2	$ 42,505	$ 42,505	100%	$2,834
Clay	46	8,189.6	$ 112,135	$ 101,305	90%	$2,202
Cobl	121	18,850.9	$ 336,020	$ 233,185	69%	$1,927
Com	12	1,732.0	$ 44,175	$ 21,425	49%	$1,785
CSB	101	14,815.4	$ 201,286	$ 183,267	91%	$1,815
CSB	60	11,446.7	$ 145,669	$ 141,596	97%	$2,360
DeKa	157	40,282.5	$ 557,851	$ 498,294	89%	$3,174
Fulto	58	13,825.7	$ 230,424	$ 171,024	74%	$2,949
Gate	130	25,195.8	$ 632,476	$ 311,672	49%	$2,397
Geor	107	16,510.5	$ 226,351	$ 204,236	90%	$1,909
Geor	61	15,092.3	$ 199,559	$ 186,692	94%	$3,061
Geor	5	380.0	$ 6,075	$ 4,701	77%	$940
Geor	16	1,749.1	$ 22,772	$ 21,637	95%	$1,352
Grad	33	11,939.0	$ 189,166	$ 147,686	78%	$4,475
GRN	88	24,470.7	$ 414,359	$ 302,703	73%	$3,440
Hara	9	919.6	$ 11,686	$ 11,375	97%	$1,264
High	91	16,131.8	$ 222,667	$ 199,550	90%	$2,193
Look	14	1,639.2	$ 26,832	$ 20,276	76%	$1,448
McIn	18	3,693.5	$ 46,668	$ 45,689	98%	$2,538
Midd	49	15,907.2	$ 208,487	$ 196,772	94%	$4,016
New	134	26,980.1	$ 414,203	$ 333,744	81%	$2,491
New	22	5,104.3	$ 68,077	$ 63,140	93%	$2,870
Ocor	74	15,493.8	$ 319,153	$ 191,659	60%	$2,590
Ogee	68	13,981.3	$ 198,170	$ 172,949	87%	$2,543
Path	77	17,561.5	$ 260,653	$ 217,235	83%	$2,821
Phoe	31	5,241.1	$ 77,374	$ 64,832	84%	$2,091
Pine	98	11,130.9	$ 172,904	$ 137,689	80%	$1,405
Rive	146	36,101.9	$ 490,284	$ 446,580	91%	$3,059
Satil	43	5,598.6	$ 83,742	$ 69,254	83%	$1,611
SAV	73	15,827.6	$ 229,124	$ 195,787	85%	$2,682
Tyju	21	3,469.4	$ 59,712	$ 42,917	72%	$2,044

Note:
The amounts above reflect claims paid for service delivery during September 2,004.00.

Denotes a difference that is greater than 30% above the State Average Paid per Consumer for the % Difference field.
Denotes a difference that is greater than 30% below the State Average Paid per Consumer for the % Difference field.

Print Date : 1/25/2005 5:31:14PM

Annual Statewide Diagnostic Analysis

Start Date : 7/1/2004
End Date : 12/31/2004
Data Date : 01/11/2005

S10

Data Source: ACS Paid/Denied Claims

DX1	Diagnosis Description	Billed	Paid	Avg % Paid
314.01	Attention-Deficit/Hyperactivity Disorder, Predominantly	$8,158,924	$6,629,993	83%
295.30	Schizophrenia, Paranoid Type	$5,203,483	$4,147,917	80%
295.70	Schizoaffective Disorder	$5,094,352	$4,048,825	80%
295.90	Schizophrenia, Undifferentiated Type	$4,766,474	$3,875,841	81%
313.81	Oppositional Defiant Disorder	$3,684,055	$3,005,674	82%
304.80	Polysubstance Dependence	$1,920,087	$1,505,789	80%
304.30	Cannabis Dependence	$1,457,545	$1,217,279	84%
296.34	Major Depressive Disorder, Recurrent, Severe With Ps	$1,393,085	$1,128,745	81%
305.20	Cannabis Abuse	$1,350,622	$1,029,479	77%
296.32	Major Depressive Disorder, Recurrent, Moderate	$1,078,438	$864,454	82%
309.81	Posttraumatic Stress Disorder	$845,781	$667,498	80%
304.20	Cocaine Dependence	$786,572	$597,376	80%
309.4	Adjustment Disorder With Mixed Disturbance of Emotic	$627,319	$489,666	77%
296.33	Major Depressive Disorder, Recurrent, Severe Without	$644,961	$483,071	73%
296.80	Bipolar Disorder NOS	$643,050	$482,296	75%
303.90	Alcohol Dependence	$584,927	$428,069	78%
312.8	conduct Disorder	$492,492	$424,882	86%
296.30	Major Depressive Disorder, Recurrent, Unspecified	$564,766	$419,795	76%
300.4	Dysthymic Disorder	$519,316	$409,958	81%
298.9	Psychotic Disorder NOS	$533,766	$403,414	76%
Others		$11,716,732	$8,376,355	72%
Total		**$52,066,749**	**$40,636,377**	

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Appendix I–DMH Readiness Analysis Detail

Competency/ Functions	Strengths	Challenges
1. Mental Health Authority/Stewardship		
Role of Purchaser vs. Funder	• New leadership and senior management appear willing to adopt authority and purchaser roles and functions. • An explicit determination to inculcate evidence based practices in the new service definitions and in provider practices can assist in the conversion from funder mode to purchaser mode. • DMH is saying it intends to purchase best practices for defined priority consumers with the intent of paying for improved outcomes.	• Funding has historically been tied to providers and programs. While DMH must ensure equitable access to services, DMH should shift its focus to develop competency at skillful purchasing of high quality services with the money following consumers. • Based on past grant funding methodologies and planning processes, DMH has filtered significant communication through regions and other disparate means. Especially during system transition, DMH should strengthen its clarity of message with Central Office directly communicating key messages to providers, consumers, and other stakeholders. • Management and program development staff will need to develop the skills and attitudes necessary to convert from a funder to a purchaser mode of operations • Strengthened and clarified contract specifications, contract compliance monitoring processes and performance measurement are all necessary components of DMH's enhanced role as purchaser. • Strong behavioral health purchasers manage and direct the system through data used for decision support. The ASO is an essential component of this, but It will also be necessary to develop in house capacity for data analysis and interpretation for decision support. DMH managers will also have to learn to use data for management, which will be a substantial change from the current environment.
Promote/ Incorporate consumer involvement in system design and management	• DMH commitment to consumer input across senior management • Introduced funding to support consumer involvement for the first time in FY05 • Developed/expanded role/staff of	• Development of meaningful consumer involvement requires consistent funding and sustained effort, including consumer and provider training, as well as travel support. • Existing Office of Consumer Affairs is not fully integrated into operational aspects including grievance/appeals, quality

Competency/ Functions	Strengths	Challenges
	recovery services development functions • Office of Consumer Affairs is established and has good leadership. • Substantial progress was made during the last year on development of community provider Consumer Liaisons and their role. • CFAC has the potential to increase the involvement of consumers and families in DMH planning and evaluation activities.	management, and network planning. • Regional Directors do not now appear to have a common understanding of or commitment to the important roles of community consumer specialists located in the Regional Offices. • Assure recovery service development including dedicated community resource at each region; expand role to include QM and grievance and appeals at both the regional and Central Office • Expand consumer role throughout provider network including minimum participation requirements in such key areas as quality management, program development and governance/oversight. • It will be a challenge for DMH to find adequate resources to commit to the CFAC to assist it to become more effective.
Define consumer benefit package	• Currently has definitions of target and eligible populations • Numbers of target and eligible populations served can be measured through ROCS • New service definitions are intended to be aligned with specific target populations meeting functional criteria for service access.	• Existing target and eligible population definitions are broad, not uniformly applied, not audited or reviewed, and there is extremely low penetration in target population. DMH should reexamine target populations definitions, establish minimum target population penetration in provider contracts, and monitor for compliance with definition and penetration rates. • Extensive development is needed to define benefits that each type of target/eligible population is eligible to receive. • Development and implementation of evidence based practices is not clearly defined in DMH vision nor integrated into the realignment in funding methods. DMH must define which evidence based practices it wishes to implement, and fully integrate DMH clinical staff implementation efforts with the fee-for-service implementation methods and process. • A thoughtful schedule of implementation of evidence based practices should consider the extent of other changes in the system, cost to DMH and the providers in training and development, and the overall priorities in the fee-for-service realignment

Competency/ Functions	Strengths	Challenges
Define roles, responsibilities, accountabilities	• There is a structure in place for communicating with Regional Offices and providing leadership and guidance to Regional Directors.	• Roles and functions for Central Office and Regional Offices have not been realigned for the changing functional requirements of a fee-for-service environment. Staff responsibilities and deployment should be specifically redefined (see Section 3) • Job descriptions, performance appraisals and related personnel operations should be aligned to support new fee-for-service functions. • In the absence of revised personnel documents, DMH should develop internal performance plans for key roles/functions as guidance tools. • DMH should establish performance targets for Central Office, Regional functions, providers, and other administrative contractors it may use, and measure and report on adherence to those targets • DMH Program Book and Mental Health Medicaid Manual are substantially out of date and inaccurate for current rules and funding requirements. These documents, or an integrated Provider Manual, should be defined, updated, provider adherence required by contract and performance against requirements consistently monitored.
Align budget with policy	• The mechanisms currently used to allocate contract dollars to contracts, load payment schedules into the payment system, and balance the appropriation accounts appears functional, albeit not adaptable in its current form to a fee-for-service environment. • Budget staff have good historical knowledge of provider budgets, contract allocations and cost reports.	• Data indicates considerable variation and inequity in service provision and availability by county and region. • Budget data is not currently used systematically for decision support, and the financial data currently available is limited, not timely, and of uncertain accuracy (SIS-OnLine seems to be the best current financial tracking data) • Funding needs to be aligned with consumers and their needs, requiring analysis of geographic distribution of target/eligible populations • Current provider contract structure and historical grant funding makes re-aligning resources across providers and regions more

Competency/ Functions	Strengths	Challenges
		disruptive. • Structure of the 718 fund continues to result in shortfalls and payment delays at the end of the fiscal year. • In order to implement either fee-for-service payments or an advance and reconciliation process based on actual services adjudicated, a work flow process that takes the MMIS remittance advice and uses that to process payments to the providers must be established. It would be ideal if the MMIS remittance advices could be used as the source documents for fee-for-service payment and be given to the providers along with their payments. • The payment cycle needs to be shortened as much as possible prior to implementation of any fee-for-service payment system. It appears from our review that having funds in the appropriate fund accounts is one critical issue that must be addressed. The flow of claims from ROCS to MMIS must be shortened as much as possible. Ideally, the time from receiving the claims data in ROCS to being processed in MMIS needs to be no more than five days. The process once the MMIS remittance advices are available until checks are produced needs to be no more than 10 days. The overall process should take no more than 30 days from the time a clean claim is submitted to ROCS and the provider receives either payment or a notification of rejection of the claim.
Define System Performance Standards	• Have information in some system performance areas in ROCS that can be used to establish baselines in key performance areas • SIS Online facilitates direct access to reporting on many ROCS elements by providers and DMH. • ROCS is a very typical application for	• While ROCS is robust in the breadth of data fields available, many fields are not mandatory and there is no provider contractual obligation to update or ensure its integrity. DMH must re-establish minimum data elements and update requirements in order to have the data necessary to effectively meet its stewardship and monitoring requirements in fee-for-service. • DMH should define key measures to monitor system

Competency/ Functions	Strengths	Challenges
	state mental health authorities in grant funded environments, with limited capabilities for fee-for-service application.	performance & include in provider contracts o Penetration o Service definition compliance o target population penetration levels • Need to shift provider network culture to understand and respond to performance standards/monitoring • Need to create mechanisms and develop resources to monitor performance against standards regularly along with training/ technical assistance • Though MHSIP data has been collected in IL for a number of years, there appears to be no consistent measures of consumer outcomes incorporated into planning, resource deployment or provider contracts. o DMH should establish measurable consumer outcome measures and systemically incorporate them into network management. A phased approach that starts with a few, simple process measures and advances in complexity over time is advisable
2. Access/Eligibility		
Intake Eligibility		• As noted above, DMH has broad definitions for eligible and target populations and does not monitor adherence, compliance or penetration. Ensuring consistent application of eligibility and target population is a key stewardship role of the authority in a fee-for-service market to ensure equitable access to service.
Enrollment	• ROCS has an enrollment function that captures a large array of enrollment and eligibility data, including block grant requirements	• While a large array of data fields is available, the utility of the data is limited by lack of required fields and update requirements. Enrollment data is central to administration of a fee-for-service funding environment and data related to assurance of access to care should be considered mandatory data submission by providers

Competency/ Functions	Strengths	Challenges
Service Authorization	• Limited historical experience with authorization of ACT and residential services.	• Service authorization is no longer required by rule for any service though it is still required by networks for ACT, and in some networks, for residential. • Where still applied, the process is largely administrative, does not have a valid clinical review/appeal process, and cannot be tied to claims payment for enforcement. Management of the clinical resources that are most limited, expensive, and most important to reduction in Olmstedt compliance (inpatient, residential, and ACT) is critical to DMH's clinical and budget efficacy under fee-for-service • DMH should develop and integrate into claims payment, a clear, consistent, and clinically sound authorization process, including availability of peer review for appeals • Utilization review resources (primarily nurses) exist in most regions and are used for community hospital reviews. DMH should explore a short term solution of maximizing these resources by developing ACT and Residential authorization processes that leverage existing skills and staff.
Establishing Provider Network Capacity Standards		• During the fee-for-service transition process, focus has been on maintaining funding for providers. DMH has not had the data to consistently manage service availability and access. The DMH Vision Report identified considerable variance in service access by county and region. Under fee-for-service the authority must ensure adequacy of core services across the state, including for special populations to ensure that 'good' billers do not monopolize available funds while underserved consumers/ areas have deteriorating access. • Timely access to crisis services, assessment and core services should be monitored by fund source (Medicaid/non-Medicaid) to ensure equitable access, should be incorporated into the provider contracts, and monitored for compliance.

Competency/ Functions	Strengths	Challenges
3. Manage the Provider System		
Contract Development	• Current DMH contracts are specific to mental health through Attachment B and performance standards were introduced in prior fiscal years	• DMH contract templates do not incorporate the full breadth of recommended elements as noted throughout this table. • A detailed review of the attachment B for fee-for-service related changes including new provider manual/program book updates, access standards, performance measures, etc. must be completed. This should be undertaken prior to entering into FY07 contracts.
Contract Monitoring	• DMH has a history of doing some contract monitoring utilizing region resources.	• Monitoring of contract requirements has been inconsistent in recent years. This has been due to competing priorities, as well as to out of date tools such as the program book and mental health Medicaid manual. • As part of the transition from DMH as funder to purchaser of quality services, greater emphasis must be placed on monitoring and developing compliance with the provider contract and associated contractually required tools.
Provider Development	• DMH has a long history of supporting and fostering development of local services in response to provider requests for project funding.	• DMH currently has no systematic means to identify service capacity or service gaps throughout the state. Based on identified consumer need and capacity gaps, DMH should procure additional necessary services to ensure equitable access. • While focus of funding should be on consumer need, DMH should be prepared to manage procurements and support provider development to remediate identified service gaps.
Provider Certification	• BALC currently conducts provider certification and has a highly structured and generally consistent certification process.	• Current certification processes are focused on agencies and sites. Under fee-for-service, to ensure consistency in service requirements and to minimize compliance concerns, certification should focus on agencies and services. Specifically, a certification of an agency confers eligibility to apply for provision

Competency/ Functions	Strengths	Challenges
		of each service. Service certification confers that the provider has the staffing, resources, and program capabilities consistent with the service definition as required by state plan, rule, and provider manual. • DMH should revise its certification process to align with fee-for-service including requiring certification of services rather than sites. Site certification should only be required when the site/facility is integrally related to the nature of the service (e.g. residential). • Based on a review of BALC audit processes, it appears that additional audited components could be 'deemed' if the provider is accredited. Specifically, facility review could be substantially reduced thereby increase available BALC resources for fee-for-service related audit functions.
Provider Relations	• Regional contract managers have a history in functioning in part as provider relations.	• With the complexities of fee-for-service and the necessary centralization of decision making for compliance with the MOU/SRI, Regions have been less able to offer assistance to providers. As part of defining roles and responsibilities for the Region, the provider relations activities and boundaries should be developed. • To facilitate the ongoing implementation of fee-for-service, provider relations in the region should be the single point of entry for problem solving regarding claims, policy clarifications, and technical assistance requests. Region staff should not be expected to have the answers directly but should be expected to 'case manage' issues through documented resolution. • In order to be effective in this role, region staff will need structured and ongoing training, assistance and performance feedback to fully understand the complexities of fee-for-service and the necessary policy modifications.

Competency/ Functions	Strengths	Challenges
4. Consumer Relations		
Information Access	• DMH has made significant efforts to disseminate information regarding fee-for-service through encouraging consumer participation in activities and through supporting the development of consumer liaisons. • DMH regional staff have made efforts to communicate to consumers via planning council activities and their recovery specialists (where present).	• Consistent with a realignment of resources around consumer need, DMH should ensure that all consumers are aware of the available benefit package and their rights for choice at intake. • DMH has relied extensively on providers to communicate to consumers regarding fee-for-service changes, and their rights and choices. DMH should develop and implement a communication plan to consumers that directly explains these issues and provides a method for questions and issues. Coordinating this through the Office of Consumer Affairs using consumer staff as trainers could be a recovery supportive methodology.
Grievances and Appeals	• Consumers are encouraged to resolve issues and grievances directly with their providers and each provider is required to have a procedure to operationalize.	• Medicaid requires some linkage of certain types of grievance and appeals to the state authority. In any case, to further support consumer's rights to choice and to offset any unintended pressures on consumers from the switch to fee-for-service, DMH should redefine the required grievance and appeal process to include the following: • At least three levels of appeal/grievance—1) using the providers defined internal appeal policy; 2) to the Regional office; and 3) to the Director of DMH or her designee in Central Office. • Require tracking and annual reporting by providers of all grievances and appeals and the outcomes within their agency • Expanded role of regional office recovery specialist and Office of Consumer Affairs as omsbuds for consumer issues • It is anticipated that the majority of issues would continue to be resolved at the provider level.

Competency/ Functions	Strengths	Challenges
5. Information System Capacity & Decision Support		
Enrollment	• The ROCS system current collects registration information on every client served in the system. • File transfer process used is efficient. • RIN (Recipient ID Number) is assigned through the Medicaid system whether the client has Medicaid or not. This establishes the patient record in the Medicaid system for later adjudication.	• Currently a registration must be recorded in ROCS for a specific provider before claims can be processed for that provider. This creates a large number of claims that are rejected due to lack of registration information. This could be a barrier to fee-for-service (fee-for-service) since providers will be dependant on the speed of payment of claims. An alternative requirement would be for the client to be enrolled in ROCS and that the provider use a valid RIN (Recipient ID Number) for submitting claims. Then the edit would be against a valid contract and rate for that service rather then a complete registration. DMH could still require registration data, but the processing of claims would be disconnected from the registration data. If the link between claims and registration is eliminated, alternative strategies will need to be developed to assure collection of necessary data about clients served beyond that which is available in a claims data set.
Eligibility verification	• The RIN process is done directly with Medicaid and therefore part of the process of assigning a RIN requires the providers to make a Medicaid eligibility determination.	• There is no criteria that determines which Non-Medicaid clients are eligible to receive services. Under a grant funded system this is adequate, but once under a fee-for-service system, criteria are needed to establish both financial and clinical eligibility.
Service authorizations (including match to claims adjudication)	• The MMIS system does have some capacity in this area and it was used to implement SASS (Child Mental Health).	• The ROCS system does not have this capacity. • This is a major weakness that cannot be addressed by the ROCS system. • The only control is the contract limit which is appropriate for grant funding, but not for fee-for-service.

Competency/ Functions	Strengths	Challenges
Provider/contract management (tracking contracted providers, services and rates by provider)	• Current provider contract information is designed for grant funded service system.	• The ROCS provider contracting system has limited applicability in a fee-for-service billing environment other then basic contract limits.
Data reporting	• ROCS does have the data fields to capture a fair amount of demographic and assessment data and the file structures are well established and implemented.	• ROCS system has limited ability to expand to capture any new data requirements. The system is very stable and static at this point in time. • Data integrity is poor due to lack of system update structures in ROCS, minimal requirements to update or maintain data, and incomplete data collection (significant use of 'unknown')
Service reporting	• ROCS currently supports several basic service reporting methodologies including monthly services.	• Service reporting in ROCS is done using non-HIPAA compliant codes and non-HIPAA compliant claims processing. Any new information system will need to use HIPAA compliant codes and transactions in order to comply with federal law.
Outcome data	• Some limited outcomes data is currently available in ROCS.	• The ROCS system has limited ability to capture new data and therefore until there is a new information system available, outcomes data will be limited to what is currently collected.
Data warehouse and decision support for all IS and claims activities	• The SIS On-Line system is an attempt to fill a void in data reporting and providing information back to the providers. • The concept of a data warehouse and decision support information system is valid and is viewed as supported by DMH.	• The SIS On-Line system is poorly supported in terms of technical and human resources and as a result data integrity and quality is limited. • Resources should be made available to support the current system until a replacement solution can be developed. • A more complete system design is needed to address both short term and long term data reporting needs of DMH.
6. Claims Processing		
Claims processing	• The ROCS system has been designed	• In the short term, the existing process can work with some minor

Competency/ Functions	Strengths	Challenges
and adjudication	to receive service information (not HIPAA compliant claims) and therefore there is an existing method to receive service level information. • There is some level of adjudication, but again the system was designed for grant reporting, not true claims adjudication.	modifications. However, this approach will simply allow DMH to process claims data with little or no utilization controls or other cost control measures. • Long term, this is a major capability that needs to be added and the probability is that the sophisticated changes needed cannot be developed in ROCS. In other words, ROCS needs to be replaced with a more robust claims management information system capable of providing DMH the software tools needed to manage a fee-for-service system of care.
Remittance advices	• The MMIS system produces a HIPAA compliant 835 remittance advice for all claims submitted from ROCS.	• The current process does not use the HIPAA compliant 835, but rather converts the data into a Results Summary format that is then used by ROCS to reconcile with the claims submit. This is an unnecessary step and process and does not reflect current best practice in the health care industry. • A new process that uses the HIPAA 835 source data needs to be developed so that the 835 data can be sorted and given to the providers. This same data will be used to either pay the providers true fee-for-service or be used as part of a periodic advance and reconciliation process. The important point is that the 835 become the source of "TRUTH" for what services are counted towards the fee-for-service contracts. • A companion file, with data similar to the 835, should be produced to make it easier for providers to read the information on service/claims data that has been adjudicated by the MMIS. • All financial reporting, including SIS On-Line must use the 835 as the source data for adjudicated claims. • The ROCS batch reconciliation process should be abandoned and replaced with a comprehensive training and technical assistance program that would teach providers how to maintain an accurate accounts receivable on their books. This is an important compliance issue that needs to be addressed.

Competency/ Functions	Strengths	Challenges
Fund management (cash management and accounting for fund source)	• Currently this is done as a separate process from the grant reporting system.	• The remittance advice process and the payment process must be developed to compliment each other. In a commercial setting using a fee-for-service payment model, the remittance advice would equal the payment made to the provider, without exception. However, in a government fund management environment, the payment process is separate from the payment process and therefore controls need to be developed to ensure that the funds are available to pay for the services that are adjudicated and ready for payment. • If advance and reconciliation is used as the interim payment process, the data from the remittance advice must be used as the source data for reconciliation and clearly communicated to the providers when the reconciliation process is completed. • Having sufficient funds available to pay for services was noted as a problem in the SASS fee-for-service implementation so special attention needs to be given to ensure that funds are available and in the correct accounts so payments can be made in full and on time.
Claims editing	• Some capacity in ROCS and MMIS though most of the edits within the MMIS are not used.	• This is a critical area of functionality that compliments the claims adjudication process. The more advanced edits involved benefit and service limits at the client level based on an eligibility status and at the provider level based on contract limits and special conditions.
Timelines and procedures		• Time from claims receipt to claims payment under current systems and processes is estimated to be 72 – 168 days, including HFS and Comptroller's activities. • DMH must develop a strategy to assure claims payment within 30 days of claims receipt.
Monitoring Claims Payment Performance		• DMH currently has control over only a portion of the claims flow, with HFS and the Comptroller's office managing significant parts of the flow and time line.

Competency/ Functions	Strengths	Challenges
7. Quality Management		
Compliance with administrative rule (132)	8. A DHS function, BALC, is responsible for monitoring compliance with Rule 132 and post payment reviews. Within their defined scope, BALC appears to have sound methodology and reasonably consistent application of review criteria/procedures.	9. BALC is limited in their ability to fully monitor Rule 132 due to the credentials of their staff with the majority of their staff having limited or no direct experience or credentials in mental health. This precludes review of target population, medical necessity, consistency of diagnosis, adequacy of assessment, and treatment planning. These issues are central to Medicaid rehabilitation compliance. 10. Provider processes and documented efforts at coordination of benefits should be reviewed as part of Rule 132 compliance reviews. 11. Unannounced audits were recently instituted, reportedly at the request of the DD authority. These unannounced visits appear to inadvertently lead to cancelled consumer appointments, inefficient use of BALC staff, and disruption of provider productivity. Alternatives to unannounced visits should be explored. 12. BALC only reviews on a three year cycle unless they are following up on problematic reviews. This frequency is inadequate during implementation of new rules and major transitions in funding mechanisms. 13. BALC deems compliance with some aspects if a provider is accredited by a recognized body. However, it appears that additional opportunities to increase deemed aspects and thereby refocus BALC resources on fee-for-service related priorities is possible.
Program monitoring (adherence to service definitions, program/provider manual)		• As noted above, review against provider contracts, provider manual/program books, or the mental health Medicaid manual is not defined in the current scope of BALC. Consistent with the intended structure, these documents contain the bulk of the program detail and are central to effective fee-for-service

Competency/ Functions	Strengths	Challenges
		implementation and compliance risk management. • No review of non-Medicaid services or non-Medicaid clients is currently occurring. • Review of service and program integrity will be central to successful implementation of new Medicaid services, as well as to increase compliance with existing program standards.
QM Strategies/Plan		• DMH will need to identify several annual priorities for quality improvement (e.g., increase the effectiveness of supportive employment strategies, improve consumer-directed rehabilitation goal setting and service planning, etc.) and devise strategies for accomplishing and measuring the results of these strategies. • The annual QM/QI plan needs to become one of the primary ways in which consumer outcome and system performance data are translated into administrative and service development action. All levels of the system, including consumers, regional office staff and providers need to be involved in both selecting and implementing annual QM/QI strategies.