Recovery Focused Fee-For-Service Conversion
Provider Readiness Self-Assessment Tool With Instructions

This document is an accompaniment to the Provider Readiness Self-Assessment Tool and includes clarification for use in completing the form. Please record all answers on the actual form, not on this instruction sheet.

Demographics and General Information

1. Organization name: a. Contact person for questions: b. Phone: c. E-mail: d. FEIN:	*List a person who can be contacted with any questions about how this form was completed.*
2. Ownership structure: ___For Profit ___Non Profit ___Govt ___Other (describe)______________	*If the field test agency is part of a larger agency, report the ownership structure of the parent company.*
3. Total annual budget size of the total organization ___Under $1,000,000 ___$1,000,000 – 5,999,999 ___$6,000,000 – 14,999,999 ___Over $15,000,000	*If the field test agency is part of a larger agency/system, report the total budget of the larger agency or system.*
4. Percentage of annual budget from DMH contracts ___More than 90% ___76 – 90% ___50 – 75% ___Less than 50%	*For "DMH Contracts," include Medicaid and non-Medicaid DMH sources; do not include any local or federal grants, private insurance, or self-pay. Divide that amount by total revenue to obtain the percentage.*
5. Approximate number of consumers served under DMH contracts during FY_____ ___Less than 170 ___170 – 450 ___451 – 1300 ___More than 1300	*Consumers served under DMH contracts is the number of Medicaid and non-Medicaid consumers funded in whole or in part.*

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6. Percentage of clients served under DMH contracts enrolled in Medicaid (primary, secondary, or in Medicaid managed care) during ______________________ ___Less than 25% ___25 – 49% ___50 – 74% ___More than 75%	*Divide the total number of clients enrolled in Medicaid as the primary or secondary (i.e. Medicare/Medicaid dual eligibles) or in a Medicaid managed care plan and served under DMH contracts by the total number of consumers reported in question 5.*
7. Percentage of clients served under DMH contracts during _________________ who were undocumented individuals? ___Less than 1% ___2 - 4% ___5 - 9% ___10% or greater	*Using data (not just estimates), indicate the percentage of the total clients served under DMH contracts, who are not legal US residents.*
8. Which description best describes the range of services covered under the DMH contract? ___Comprehensive array of services including assessment, case management, crisis, medication services, and therapy/counseling ___Specialty provider for a limited range of services, such as assertive community treatment, day treatment or vocational services	*Mark ONLY one.*
9. What ages does your organization serve? ___0-5 ___6-12 ___12-20 ___21-65 ___65 and older	*Check all that apply.*

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10. Which best describes the information system used by your agency to bill for DMH services/consumers?	*Choose only one option of the three options, and indicate the type of system used in addition to ROCS, if any.*
___ ROCS only (no other agency billing system is used) ___ Agency billing system with all client billing data, using an electronic submission to ROCS ___ Agency billing system with required data manually entered into ROCS If you are using a billing system in addition to ROCS, indicate the type of system below: ___ Licensed system available nationally for billing. Name: ________________________________ ___ Licensed national system for billing and clinical record documentation. Name_________________ ___ Locally developed billing system used by multiple Illinois DMH providers. Name________________ ___ Internally developed billing system ___ Other: describe	

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

X = Current Service	Services	A = added/D = Delete
	Activity therapy	
	Assertive community treatment	
	Case mgt—client ctd consultation	
	Case mgt—mental health	
	Case mgt—linkage/aftercare	
	Comprehensive MH services	
	Crisis intervention	
	Crisis intervention—pre-hospital scr	
	Intensive family-based services	
	Mental health assessment	
	Mental health day treatment	
	Mental health intensive outpatient	
	Psychological evaluation	
	Psych. medication administration	
	Psych. medication monitoring	
	Psych. medication training	
	ST diagnostic and MH services	
	Skills, trng and development	
	Therapeutic behavioral services	
	Therapy/counseling	
	Tx plan dev/review/modification	
	Adaptive/social rehab--vocational	
	Oral interpretation and sign language	
	Supported employment	
	Vocational, education testing/eval	

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Please check yes or no for each of the following questions. If the question has more than one part, each part must be yes for the entire answer to be a yes. To fully inform future technical assistance needs, some multi-part questions (i.e. #7) must be answered in two ways—first, indicate the answer to the entire question in the Yes/No column, and then indicate the answer to each part of the question in the check boxes below. At the end of each dimension/section, please total the number of 'yes' and 'no' answers for that section. At the end of the table, please add a grand total of all 'yes' and 'no' responses. ***Additional instructions are listed in bold.***

#	Dimension	Yes	No
Governance and Leadership			
1.	Do current versions of organization's mission/vision/values include express commitment to recovery and a process for achieving recovery oriented services? ***This should be expressly stated, not just implied.***		
2.	Is the board composition inclusive of a primary consumer and/or family member, and a business oriented professional (CPA, attorney, senior manager)? ***Must have both to answer yes.***		
3.	Have all members of the board participated in education regarding both fiduciary responsibilities and establishing/monitoring organizational performance indicators? ***To answer yes, the training must have been offered, and all Board members must have participated.***		
4.	Has the board received training regarding provider fee-for-service core competencies and the specific impact of transition to fee-for-service on governance and leadership? ***To answer yes, the training must have been provided.***		
5.	Does the organization have a written plan (goals, tasks, resources, timelines) to transition to recovery oriented fee-for-service and report progress regularly (at least monthly) to senior management and the board?		
6.	Has the organization developed and communicated a change-management process (inclusive of what to expect in the process, plan for ongoing communication, changes in procedures/responsibilities) to staff and consumers? ***There should be written evidence of this process and the communication.***		

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#	Dimension	Yes	No
7.	Does organization have all of the following performance indicator information? *(Please check each area that is currently in place)* __Written indicators __Regular measurement against those indicators that is reported to leadership and board __Demonstrated impact on operations resulting from performance indicator measurement		
	Total Governance and Leadership		
Access and Intake			
8.	Is the average time from first call to initiation of assessment less than or equal to ten calendar days? ***This should include all categories of clients - urgent, emergent and routine, in all levels of care.***		
9.	Is eligibility for Medicaid, Medicare and other third party benefits checked and documented in the record at first appointment and once a month thereafter? ***Both parts must be present for a "yes" answer.***		
10.	Do front desk (reception or clerical support) staff review financial resources, screen for possible Medicaid eligibility and apply a sliding fee scale to individuals who present without Medicaid or other third party benefits? ? ***All parts must be present for a "yes" answer.***		
11.	Are front desk staff able to determine the amount of any co-payment (from the record or the billing system) and expected to collect the co-payment at the time of service? ***Both parts must be present for a "yes" answer.***		
12.	When indicated by client need (urgent/emergent), does the organization have the ability to provide same day face-to-face assessment appointments?		
13.	When indicated by client need (urgent/emergent), does the organization have the ability to provide same day face-to-face psychiatrist appointments?		
14.	Does the organization have a centralized scheduling process (manual or automated) where appointments are scheduled using a master schedule with ability to schedule urgent, next or missed appointments into any available slot?		
	Total Access and Intake		
Services			

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#	Dimension	Yes	No
15.	Have direct service clinical staff been trained in ***all*** of the following areas? *(Please check each area where training has been provided)* ***There should be written evidence of the training.*** __ New service taxonomy __ Rule 132 requirements __ Recovery based approach to services __ Periodic training updates on changes/clarifications		
16.	Does the assessment process include ***all*** of the following? *(Please check each area included in the assessment)* __ Consistent form (adult and youth forms may be different) __ Completed on a timely basis (within 45 days of admission) __ Standardized functional assessments (e.g., LOCUS, CALOCUS, CAFAS, Multnomah) __ Diagnostic components		
17.	At least 75% of the time, do consumers and parent/guardians (minors) participate in the treatment planning process as evidenced by participation in treatment planning conferences and their signature on the treatment plan? ***Both parts must be present for a "yes" answer.***		
18.	Do at least 75% of treatment plans directly reflect diagnosis, assessed functional needs, consumer preferences, consumer strengths, and natural supports? ***All parts must be reflected for a "yes" answer.***		
19.	Are at least 75% of treatment plans reviewed and updated as needed or at least once every 180 days inclusive of consumer/family participation in the review process? ***Both parts must be present for a "yes" answer.***		
20.	Are core services (assessment, medication monitoring/education, and case management, etc) available at times appropriate to consumer needs and preferences, including evenings and weekends?		
21.	Are the majority (>50%) of service units delivered in the community/natural setting (not office locations)? ***This includes all service units, not just case management.***		
22.	Excluding psychiatric services, is the time from referral to first service less than 30 days for Medicaid enrollees?		
23.	Excluding psychiatric services, is the time from referral to first service less than 30 days for non-Medicaid consumers?		

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#	Dimension	Yes	No
24.	Do clinical supervisors receive staff productivity reports at least monthly, use those reports in direct supervision of staff, and demonstrate a change in practice as a result of these efforts? ***All parts must be reflected for a "yes" answer.***		
25.	Does the organization have a system to monitor and supervise line staff to ensure service delivery (type, frequency, duration), is consistent with the service definitions, and the treatment plan and can demonstrate a change in practice as a result of this system?		
	Total Services		

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Billing and Financial Management			
26.	Does the organization require service staff to submit billing information within 1-2 business days from the delivery of service and does data indicate at least a 75% compliance rate with this policy? **"Billing information" includes any chart documentation**. ***Both parts must be present for a "yes" answer.***		
27.	Does the organization use a claims system capable of generating HIPAA compliant electronic claims (837I or 837P)?		
28.	Does the organization track average time from date of service to claims submission, and is the average time less than or equal to 14 calendar days? ***Both parts must be present for a "yes" answer.***		
29.	Does the organization consistently bill Medicare (for Medicare eligible services) prior to Medicaid when a consumer is dually eligible?		
30.	Does the organization submit claims to any payor at least twice per month?		
31.	Does the organization submit claims to any payor at least once per week?		
32.	Does the organization have at least 30 days of cash reserves ***(Days of cash reserves = Cash + Investments/{Average monthly expenses/30 days})?***		
33.	Does the organization have at least 60 days of cash reserves? reserves ***(Days of cash reserves = Cash + Investments/{Average monthly expenses/60 days})***		
34.	Is there a process to reconcile amounts billed to paid/accepted claims within ten business days of receipt of reports/remittance advice and resubmit claims as indicated?		
35.	Has the organization calculated costs per unit (including delineation of direct and indirect cost components) for each service provided under the DMH contract? ***This is based on unit of service, not total cost of program.***		
36.	Have efforts been made during the past 12 months to reduce unit costs? ***If costs per unit have not been calculated, answer NO. If costs per unit are below Medicaid reimbursement rates, no cost reductions are indicated, answer YES.***		
37.	Does agency have productivity targets or standards for a majority (more than half) of clinical direct service staff? ***(Productivity = billed or reimbursable time under rule 132 / paid time) These should be available in written form/policy for a "yes" answer.***		
38.	Do average productivity rates for all clinical staff equal or exceed 50%?		

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39.	Are **_all_** of the following financial elements available via report for management review and use? *(Please mark each element present in current system)* __ Number of consumers by payment source served per month __ Number of units of each type of service per month __ Number of each type of staff and corresponding salary/benefit costs __ Actual productivity rate for each direct service staff __ Indirect costs for each program __ General and administrative overhead rate		
40.	Has the organization prepared a financial impact analysis or projections for the transition to fee for service? ***These should be written to count as a "yes" answer.***		
41.	Do other revenue sources (non-DMH/non-Medicaid) comprise at least 15% of the organization's annual revenues?		
	Total Billing and Financial Management		
Compliance			
42.	Does the organization have a compliance plan that has been approved by leadership and the board of directors, and a staff person assigned who is responsible for monitoring and updating the compliance plan? ***Both parts must be present for a "yes" answer. The compliance plan must be written.***		
43.	Is there evidence that all current staff and new hires are trained on compliance requirements including confidentiality, fraud/abuse, and clinical record documentation requirements (for clinical staff)?		
44.	Does the organization have a consistent and reliable process to ensure all delivered services are included on a treatment plan that covers the date of service? ***There should be evidence of this process for a "yes" answer.***		
45.	Does the organization have a consistent and reliable process to monitor the accuracy, completeness and timeliness of clinical record documentation for each billed service including matching to units billed? ***There should be evidence of this process for a "yes" answer.***		
46.	Does the organization have a consistent and reliable process to monitor whether services delivered demonstrate fidelity to service definitions and programmatic requirements? ***There should be evidence of this process for a "yes" answer.***		
47.	Does the organization have a written plan to monitor medical necessity & can demonstrate documented practice impact? ***Both parts must be present for a "yes" answer.***		

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48.	Does the organization have a consistent and reliable process to ensure that services are delivered by staff with credentials required by regulation and/or service definitions? ***There should be evidence of this process for a "yes" answer.***		
	Total Compliance		
Management Information			
49.	Does the organization have an information system that is capable of tracking client demographics and billing information?		
50.	Do at least 80% of employees have access to a work station and e-mail? ***Both parts must be present for a "yes" answer.***		
51.	Does the information system track treatment plan expiration dates to ensure that services are not being delivered under an expired treatment plan? *To answer "yes", it should be possible to produce a report summarizing treatment plan expiration dates for all consumers.*		
52.	Does the information system include eligibility/payer source for each consumer?		
53.	Is an automated scheduler available and used for at least assessments, therapy/counseling, and psychiatric services? ***All parts must be present for a "yes" answer.***		
54.	Are monthly productivity reports produced within 15 days of the preceding month for each direct service staff and program?		
55.	Are monthly no show rate reports produced within 15 days for the preceding month for each direct service staff and program?		
56.	Are information system functions resourced to ensure production of routine reports according to established deadlines, provide help desk functions within one business day, and produce 80% of *ad hoc* reporting within 14 business days of request? ***All parts must be present for a "yes" answer.***		
	Total Management Information		

Outreach			
57.	Are consumers who have been asked to participate in governance or workgroup activities been offered assistance, training, and ongoing support to maximize their comfort and effectiveness consistent with the nature of their involvement? ***To answer yes, consumers must have been asked to participate, AND they must be able to report that they received assistance, training and/on ongoing support.***		

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58.	Does the organization offer financial assistance (reimbursement for travel and/or time) for consumer participation in governance and work groups?		
59.	Is there a communication plan (goals, tasks, resources, timelines) targeting consumers and other key stakeholders describing the transition to recovery focused fee-for-service? ***To answer yes, there should be written evidence of this plan.***		
60.	Does the organization have a plan (goals, tasks, resources, timelines) to participate in community activities designed to educate referral sources, consumers, and families regarding availability of services and supports? ***To answer yes, there should be written evidence of this plan.***		
61.	Does the organization demonstrate cultural responsiveness through promotion of inclusion, prohibiting discrimination, staff race/ethnicity reflective of program participants, requiring competency training for all, and availability of translators? ***All parts must be present for a "yes" answer.***		
62.	Does the organization have a process to focus outreach efforts to encourage active engagement for consumers/families in need (both enrolled and new clients)? ***Process must be in action to be counted as a "Yes."***		
63.	Does the organization have a process to collect information regarding consumer/family satisfaction and can demonstrate the information has been used to change practice or processes? ***Both parts must be present for a "yes" answer.***		
	Total Outreach		
	Grand Total		

Thanks to representatives from the Pilot Test workgroup for their input to tailor this tool to the provider environment in Illinois.

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