Mental Health Field Test Evaluation

Illinois Department of Human Services
Division of Mental Health (DMH)

April 29, 2005

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Executive Summary

This Report was produced in fulfillment of item # 19 of the Memorandum of Understanding (MOU) executed July 2, 2004 by relevant House and Senate Legislative Committee Leadership, the Governor's Office of Management and Budget, and the Department of Human Services.

Although the Report is the responsibility of the Department of Human Service's Division of Mental Health (DHS/DMH), a team of stakeholders that included community mental health service providers, consumers, expert consultants and staff from the DHS/DMH collaborated in the drafting of the Report.

Included as part of the Report are the findings and observation by Parker Dennison & Associates, expert consultants retained by the DHS/DMH. A summary of their findings and observations is provided as part of this Report, with a copy of their full report available in Appendix I. It should be noted that this summary as well as the full report by Parker Dennison & Associates reflects their professional opinions, and not necessarily those of the Field Test Agencies, report writing team or the DHS/DMH.

As prescribed by the above referenced MOU, the Field Test was one of the initial steps of converting the Illinois community mental health system to a fee-for-service (FFS) funding approach. It involved thirty (30) volunteer agencies, with the design and execution of the Field Test under the direction of a stakeholder group. In addition to the meetings and participants of this stakeholder group, the Field Test evaluation process included over twenty-five meetings of the thirty agencies and workgroups involving almost 210 participants representing consumers, advocacy organizations, service provider agencies, trade organizations, and the DHS/DMH staff.

During the course of the Field Test evaluation considerable knowledge and experience was gained. Expert consultants contributed to this knowledge base, framed the knowledge and experience within the context of a multi-state perspective, and guided the process away from the pitfalls and barriers encountered in other states. The availability and involvement of expert consultation was one of the most significant factors contributing to the success and progress achieved thus far in the Field Test and the overall effort to convert to FFS.

The considerable accomplishments and progress made during the course of the Field Test is also reflective of the commitment of the provider agencies, consumer advocates and trades in achieving a successful conversion to FFS. However, of equal importance is concern that adverse consequences to the conversion, both anticipated as well as unintended, are minimized so that critical access to services and care is not compromised. These concerns parallel many of those reflected in the MOU by the Governor's Office, legislators, and the DHS/DMH. These interests and concerns led the Field Test to listing not only several of the potential benefits of converting the system to FFS, but also several warnings and recommendations concerning when and how the conversion process should proceed as well as what should be monitored during the process. To place these concerns within a constructive context, the values that should be the underpinning of the evaluation and the conversion process were described, including:

- Moving the mental health system to become more aligned with building consumer resiliency and facilitating consumer recovery;
- Enhancing access to mental health services, including for non-Medicaid eligible consumers;
- Assuring effective and efficient mental health services; and
- Maximizing funding available for mental health services.

The Field Test evaluation and process produced some key findings regarding the conversion to FFS, which in turn led to some specific conclusions and recommendations for the next steps in the conversion process.

Findings from the Field Test evaluation included the following:

1. Conversion of the Illinois community mental health system to FFS is viable. During the course of the evaluation the state and the providers grew increasingly effective in submitting and processing bills for services. However, it was also reaffirmed that some services and conditions important to an effective system are not suited for a FFS funding approach, and that some services essential to an effective recovery-oriented system are not presently covered under the Federal guidelines for Medicaid services.

2. FFS provides opportunities for increasing the amount of federal dollars returned to the state (federal financial participation or FFP) through the Medicaid program. System design that includes proper incentives for providers, such as re-investment of increased funding from FFP into the service system, will further boost these increases. There are short and long term strategies for accomplishing this. For the short-term these included identifying system performance issues for the state and the providers, such as sources or reasons for high rates of denials of billings or low rates of timely billing submissions or processing of bills. Longer-term strategies include the need for flexibility in funding provider contracts, such a reallocation of funds across providers, and examination of alternative approaches for state and federal support of services essential for an effective mental health system. Also recommended as a longer-term strategy is refinement of the Medicaid State Plan, state rules and service definitions relative to mental health services to align them with a recovery-oriented system while maximizing the FFP revenue potential for the state. This should be addressed with attention to facilitating provider and state compliance with federal and state regulations.

3. The terms of the MOU provided an effective safety net for consumers by sustaining the provider network during the course of the Field Test. However, it was also clear that as the conversion process evolves additional risks would arise and need to be planned for. One risk in the immediate future is the cash flow problem for the state that has the potential to limit timely advance payment to providers. This problem is due to the interaction of the structure of the Mental Health Trust Fund (718 Fund) with the interim process (on the path to post-service delivery FFS) of advance payments to providers. Parallel cash flow risks exist for providers, especially since the provider pool consists almost entirely of service-oriented non-profit and governmental entities that generally have not had a focus on accumulating the cash reserves and assets necessary for sustainability under a post-service delivery FFS system.

4. Continuous improvements in FFS billing as well as FFP capture has occurred during the course of the year. By the second (of three) billing cycles in March (which could include billings for services through February 28th, the end of the Field Test period) billings were $2.15 million above the levels achieved at about the same time in FY04. However, the desired targeted level of FFP set by the DHS/DMH for the system was not achieved by the end of the Field Test period, being $37.3 million or 30% below the prorated FFP target of $125 million for the end of March. By this same time, 21 providers of the 162 exceeded their prorated Medicaid billing target, while an additional 31 providers were within 80% of achieving their prorated target and, thus, within range of achieving their target by years end. That is, almost a third of the 162 providers were within 80% of their Medicaid target, but two-thirds were below 80% of achieving their target and, therefore, unlikely to do so by the end of the fiscal year. Although a decline in Medicaid billings was not anticipated in initial projections of billings, expert consultants have confirmed that a decline followed by accelerated billing is typical in conversions to FFS.

5. Issues remain regarding the overall readiness of the system for conversion to FFS, including readiness issues for consumers, providers and the state. Although some of these issues can be addressed through planning and effort, many require additional resources in order to achieve readiness levels required for a smooth transition to FFS. Some of the more significant needs include support for:

    - Ongoing consumer involvement and education;
    - Training and technical assistance for providers and the state, including maintenance of outside expert consultation to reduce replication of the problems encountered by other states;
    - Effective information systems for providers and the state;
    - State readiness assessment with action on critical issues that may be identified; and

- Conversion costs for the provider and the state in order to avoid deterioration in the access and quality of services and operations.

6. Although early in the conversion process and with only the six-month time limited period of the Field Test, there is not yet evidence of any significant changes in the quality or access to mental health services funded by the state. However, additional baseline data needs to be obtained and monitored throughout the conversion to FFS.

The above findings led to the following conclusions and recommendations:

1. Post-service FFS for suitable services should not be implemented earlier than FY 2007 (July 1st 2006), although limited changes to provider contracts as recommended by Field Test workgroups should occur for FY 2006 as a step toward this implementation and to prepare the system for this conversion.

2. Full post-service FFS should not be implemented until specific benchmarks are achieved, such as:

   - Assurance of timely payments (within 30 days) by the state of provider billings;

   - Completion of an assessment of the readiness of the state systems for the conversion; and

   - Achievement of a manageable gap between current levels of state funding to the provider network and provider funding levels likely to be achieved under FFS.

3. Monitoring of key factors should continue during and after the conversion process to minimize adverse consequences and to identify opportunities for improvements as the service system evolves.

Much has been achieved through the Field Test process. Under the guidance and direction of the signatories of the MOU, the next step should be expanding these achievements beyond the thirty Field Test agencies to impact all providers within the DHS/DMH funded community mental health system, and the implementation of improvements that will assure consumer, provider and state readiness.

Acknowledgment

Although this Report of the Mental Health Field Test Evaluation is the responsibility of the Department of Human Service's Division of Mental Health (DHS/DMH), the drafting of this report is the result of the combined efforts of a team of state staff, consumers, providers, and expert consultants.

The Report Team included the leaders and some participants of the Field Test groups:

Lora Thomas, Co-Chair of the System Restructuring Task Group and Executive Director of NAMI Illinois, a mental health advocacy organization;

Kathy Roberts, Chair of the Field Test Pilot Workgroup and Executive Director of Coles County Mental Health Center;

Cheryl Lietz, Chair of the Field Test Services Workgroup and Executive Director of DeWitt County Mental Health Center;

Evelyn Willis, Chair or the Field Test Financial Workgroup and Chief Financial Officer for Human Resources Development Institute;

Frederica Garnett, Member of the Field Test Financial Workgroup and Executive Director of Delta Center;

Dan Kill, Chair of the Field Test Access and Eligibility Workgroup and Executive Director of Family Services of Oak Park;

Tony Kopera, Member of the Field Test Access and Eligibility Workgroup and Executive Director of Community Counseling Center of Chicago.

Also included on the Report Team were "at large" providers and consumers:

Greg Coughlin, DuPage Mental Health Center;

Virginia Lake, Thresholds;

Orville Mercer, Chestnut Health Systems;

Hayward Suggs, Community Mental Health Council.

The Report Team had the benefit of expert consultants funded by the DHS/DMH as well as by the Illinois Association of Rehabilitation Facilities (IARF) and the Community Behavioral Healthcare Association (CBHA):

Parker Dennison & Associates (**Susan Parker** and **Rusty Dennison**);

EP&P Consulting (**Gretchen Engquist** and **Leena Hiillivirta**).

As a result of this team effort, some important points are repeated in the report not only for emphasis, but also to retain some of the unique perspectives and wording provided by individual team members that foster a deeper understanding and appreciation of the issues and concerns.

The report benefited greatly from the effort and contributions of the above individuals.

Overview

This report on the Mental Health Field Test Evaluation is a product of an agreement and process (described below) that called for an evaluation of the initial steps of the conversion of the Illinois community mental health system from grant-based funding to fee-for-service (FFS). The report describes what has been learned and proposes future actions based on the impact of the initial conversion activities, especially as reflected by a "field test" of thirty agencies representing a subgroup of all 162 agencies currently funded to provide community mental health services.

This report begins by providing an overview and history of the conversion effort, followed by a description of the values underpinning the evaluation activities, a summary of the findings by expert consultants Parker Dennison & Associates, key findings from the Field Test, and Conclusions. It is important to note that the one section of the report by Parker Dennison & Associates represents their findings and professional opinions only, and not necessarily those of the DHS/DMH or the Report Team. Detailed tables and data regarding the Field Test and the conversion effort are found in the Appendices, along with the complete report by Parker Dennison & Associates.

The following acronyms and abbreviations are use in this report:

FFS: Fee-for service

FFP: Federal Financial Participation

DHS/DMH: Department of Human Services' Division of Mental Health

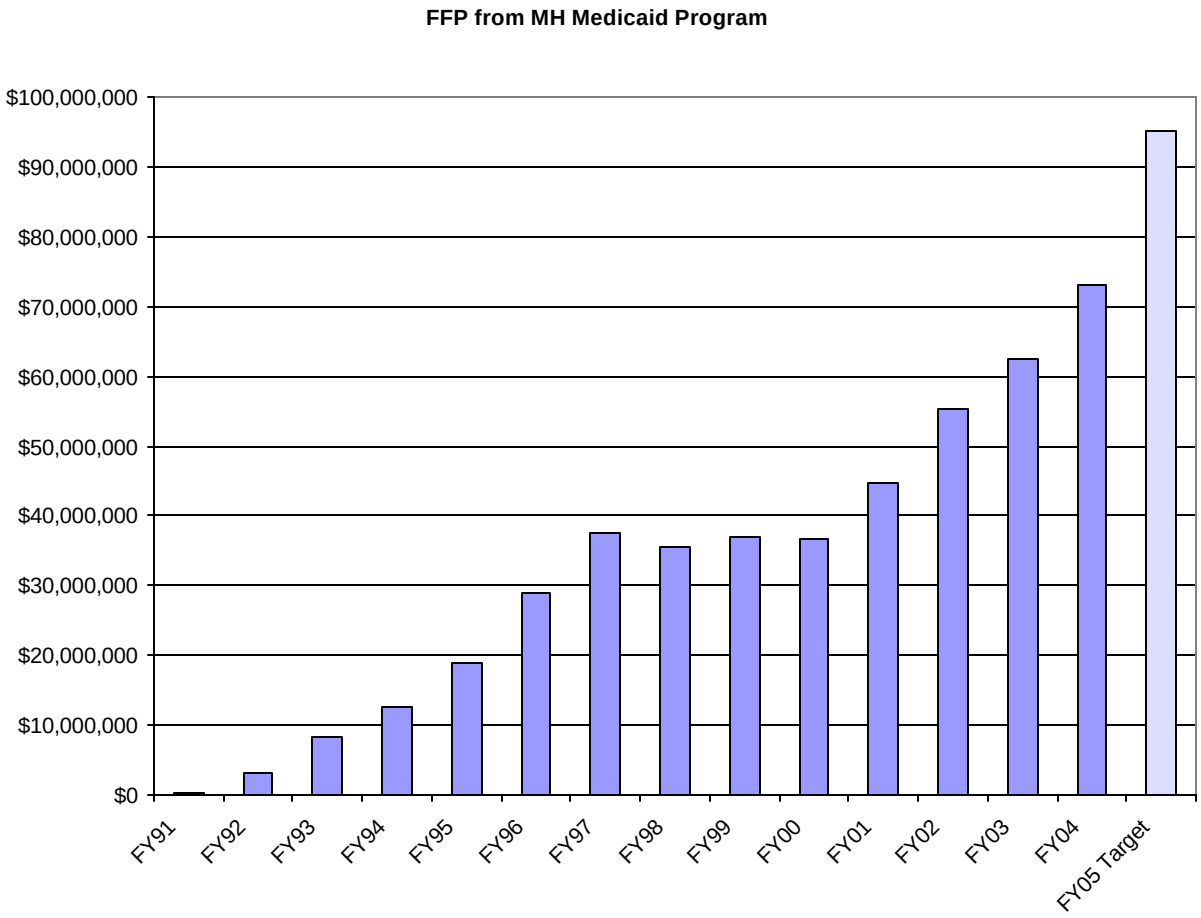
SRI: System Restructuring Initiative

Initiation of change efforts frequently precipitates interests in additional changes. The planned conversion to FFS is no exception. Although the focus of the report is on the conversion to FFS, the complex and interrelated nature of the many components of a public mental health system leads to additional suggested changes and actions not solely required by FFS conversion. Similarly, as the conversion process evolved not all ideas and recommendations were fully vetted with interested groups, but nonetheless seemed worthy of inclusion in this report as a means of offering further thoughts and suggestions on the future of the conversion effort.

History

Illinois' system of community mental health services has historically been funded primarily by a grant-based system. This payment mechanism has utilized grants to community mental health service providers, now numbering over 160, to support defined mental health service programs. While this grants-based system supports an array of services, most other states have evolved beyond grant-based funding as the primary means of supporting their public mental health system.

Since the inception of the mental health Medicaid program in Illinois almost fifteen years ago, the community mental health system in Illinois has exhibited a steady increase in Medicaid billing levels, growing an average of 18.8% over the past four years. Even with this growth, though, Illinois has not yet achieved the levels attained by other states. Of the 47 states where the state mental health authority administers Medicaid services, Illinois is ranked 21st in the proportion of community mental health services funded by Medicaid dollars in FY 2002 (National Association of State Mental Health Program Directors' National Research Institute's Revenues and Expenditure Study, Table 27). Illinois has not been garnering available Federal Financial Participation (FFP) monies through its mental health Medicaid program at anticipated levels.



Severe pressures on the State budget and a renewed focus on accountability became the impetus for proposed changes in the funding mechanisms for community mental health services in Illinois. Given the severity of the state's fiscal situation, possible reductions in state funding support for community mental health services could be minimized or avoided if supplanted by additional FFP obtained through significant increases in provider Medicaid billings.

Thus, in February 2003 the Department of Human Services announced its intention to convert to a payment methodology for community mental health services that would reimburse on a fee-for-service (FFS) basis, with specific expectations for increased Medicaid billings by providers resulting in an increase of $25 million in FFP, a 36% increase from FY04 levels. FFS was defined as the payment by the state to contractual providers for specific services delivered and billed to the state after they have been provided. Implementation of the new payment approach was scheduled to become effective July 1, 2004.

A House Special Committee on Fee-for-Service Initiatives was convened in the Illinois General Assembly to review the planned transition and to gather input on the impact of the proposed changes. Following a series of hearings with input from consumers, families, advocacy groups, providers of mental health services and representatives of DHS and DMH, an agreement was reached on a process for field testing and development of a phased-in conversion to a FFS payment methodology.

The terms of this agreement were spelled out in a Memorandum of Understanding (MOU) executed July 2, 2004 between the Illinois Department of Human Services' Division of Mental Health, The Governor's Office of Management and Budget, Mattie Hunter, Vice-Chairperson of the Senate Health & Human Services

Committee, Dale Righter, Republican Spokesperson for the Senate Health & Human Services Committee, Rosemary Mulligan, the Republican Spokesperson for the House Special Committee on Fee-for-Service Initiatives and Barbara Flynn Currie, Chairperson of the House Special Committee on Fee-for-Service Initiatives.

The MOU (available at: http://www.dhs.state.il.us/ffs/dhs_ffs_memomh.asp) outlines a framework for the conversion to FFS which includes:

> 1. The Department and related Mental Health care providers will develop reinvestment and enhancement strategies to expand resources and increase efficiency;
>
> 2. The fee-for-service reinvestment and efficiency strategy will promote consumer access and choice, as well as provider sustainability, based upon equitable reimbursement for quality services provided in response to demonstrated need;
>
> 3. Strategies should include long-term solutions and include a review and assessment process. Planning must occur to develop an appropriate infrastructure for the fee for service initiative reinvestment and efficiency strategy. Client choice, financial and programmatic accountability, access and continuity of care will guide planning decisions;
>
> 4. The Mental Health care providers will assist the State in ensuring the availability of affordable, accessible, accountable, and quality community services by working to increase federal funds capture, as appropriate, while ensuring a system that facilitates serving consumers with easy access to services and supports, utilizing fee-for-services, grants, and any other necessary financing vehicles along with the necessary technology and business services. Each provider's rights and obligations with respect to the Department are set forth in its annual award agreement with the Department, and nothing in this Memorandum shall impose any contractual obligations upon the providers or grant to the providers any rights as a third party beneficiary or any related rights with regard to the fee-for-service conversion. The necessary technology and business services will include, but not be limited to:
>
> a. processes sufficient to maintain/track/improve access to services;
>
> b. enable appropriate retroactive claiming;
>
> c. increase appropriate Medicaid claiming;
>
> d. implement appropriate administrative support and claiming; and participate in system planning, implementation, and monitoring according to the plans developed by the Steering Committee in consultation with the expert consultant.

The MOU continues by prescribing 27 additional requirements. Of special relevance to this report, MOU item #18 prescribes a field test of "trial advance and reconciliation" for a group of thirty volunteer provider agencies, and item #19 further details the focus of the Field Test evaluation as well as stakeholder involvement in the evaluation:

> 19. The evaluation of the Mental Health Conversion Field Test should be designed to focus on consumers' ability to receive services, quality of the services funded, the fiscal sustainability of the involved provider agency, the impact on the conversion initiatives primary objectives, the benefits and viability of moving to Fee-For-Service, and an assessment of conversion impact on each individual provider. The design of this evaluation will be the focus of the Mental Health Stakeholders Workgroup and the outside consultant and the results of the analysis are to be submitted in writing to all the members of the Senate Health & Human Services Committee, the House Special Committee on Fee-For-Service Initiatives (or its successor in the 94th General Assembly, if any) and the Governor by April 30, 2005

The System Restructuring Initiative Task Group (SRI Task Group) was formed and served as the Stakeholders Workgroup to work with DHS and expert consultants toward a smooth transition to a FFS methodology.

At the same time in July 2004 a related Memorandum of Agreement (MOA) was entered into between the Department of Human Services' Division of Mental Health and the members of the SRI Task Group to establish a framework for:

> "…identifying, testing, adjusting and implementing a series of changes, including expanding Fee-for-Service reimbursement to ensure the availability of affordable, accessible, accountable, high quality community services that respect and are responsive to individuals form all cultures and ethnic groups."

The MOA (available at: http://www.dhs.state.il.us/ffs/dhs_ffs_mh-ma.asp) parallels the MOU in prescribing a Field Test process and particular elements to be the focus of the evaluation (see Sections Q, R and S of the MOA).

Thus, the terms of the MOU and MOA provided the framework for development of the Field Test process, evaluation of the initial steps in converting to FFS, and the reporting of results.

Potential Benefits and Opportunities with Fee for Service

Each payment structure that may be used to fund a public mental health system brings with it particular strengths and weaknesses. Much of this report discusses possible problems that may arise under a FFS system, but the potential opportunities merit attention as well. Effective leadership and management can determine the extent of problems or benefits that arise under any payment structure.

Increase Federal Match (FFP)

As noted above, the principle stimulus for initiating a conversion to FFS was to take advantage of the incentive this payment mechanism has for providers to maximize their billings and, thus maximize Medicaid billings as well, thereby increasing FFP available to the state.

However, stakeholders recognize additional potential benefits to converting from a grants-based payment mechanism to FFS. FFS permits the state additional control regarding the capture of FFP, with opportunities to utilize additional FFP garnered to improve the service system through increases in access, quantity or quality of services provided. Additional potential benefits were also noted, including:

More Closely Tie Funding to Persons and Services

Unlike grant-based funding to providers, FFS pays for specific services to specific individuals, making it more clear the individuals in service and the particular services they are receiving which are being paid for by state dollars. FFS permits state dollars to "flow" to the individuals receiving services. As such, FFS payments should more closely follow shifts in populations or services over time, with state funding flowing through FFS payments, for example, to providers experiencing an increase in service delivery due to increases in the provider's population base or its need for services.

Promote Consumer Choice

The current grant-based system is provider-centered, awarding specific dollar amounts to specific providers, regardless of consumer choice and not necessarily related to volume or quality of services delivered. Under FFS and within limits, the dollars follow consumers to their choice of providers and services.

Demonstrate Accountability

Under a grant-based system providers receiving state support can vary in the number of individuals served as well as the quantity, quality and type of services provided. Under FFS there is a more direct and accountable relationship between the number and quality of the services delivered and the state dollars received by the provider. This, in turn, provides an incentive for the efficient provision of services and enhances the likelihood of more efficient and effective expenditure of state dollars.

Increase Statewide System Consistency and Equity

A grant-based funding mechanism is well suited to supporting special projects or situations. Once funded, however, changes in the grant awards have typically been difficult to adjust, resulting in uneven services and support across the state. Characteristics of a FFS payment mechanism, including the need to be consistent in specifying the services being purchased, serve to enhance overall consistency as well as equity of payment for services across the state.

Enhance Clarity of Services and Individuals Supported by the State

The need to be more specific in specifying the services being purchased by the state under FFS have a parallel benefit of enhanced clarity. This, in turn, facilitates coordination and collaboration with other funders of mental health services as well as allied service systems important to the overall support of individuals with mental illness.

Enhance Information on Service Needs

A FFS payment mechanism provides an opportunity, if properly managed, to identify areas of unmet service needs, such as when the volume of services that can be billed by a particular provider exceeds the total state contract allocation available for the provider.

Alignment of Service Array with recovery and EBP

If carefully planned, the conversion to FFS can lay a foundation for improvement in the quality of services purchased. Although not necessarily required by a change in payment mechanisms, conversion to FFS provides an opportunity to enhance the services and the overall system's alignment with the most recent advances and thinking regarding mental health services, including a focus on recovery-based services which are evidence-based (supported by research and literature) or emerging best practices in the field.

Methodology and Process

Stakeholder Participation

The design and implementation of the Field Test involved a collaborative process that included the active participation of a wide range of stakeholders through the structure of various groups and workgroups.

System Restructuring Initiative Task Group (SRI)

A large group of concerned stakeholders meeting to discuss the conversion to FFS was reconfigured in June 2004 into the SRI Task Group, co-chaired by a consumer and the director of a consumer advocacy organization. In addition to representation from the Department of Public Aid and DHS staff, representation on this group included three additional consumer representatives, approximately nine providers, representation from three provider trade organizations, and representatives from the four legislative caucuses.

The SRI Task Group addressed a wide range of issues. Due to the range of issues addressed, and the urgency of some of these, a subgroup of the SRI Task Group, the SRI Steering Committee, was authorized to convene between regular meetings to address urgent issues and plan for the meetings of the full SRI Task Group.

Since July 2004, the SRI Task Group has been meeting on at least a monthly basis (minutes of these meetings are available at: http://www.dhs.state.il.us/mhdd/mh/sri/) with more frequent meetings of the SRI Steering Committee occurring to address pressing issues.

Per the MOU item #19, the focus of the SRI Task Group was on the design of the Field Test Evaluation. The SRI Task Group received and acted upon recommendations relative to the implementation of the Field Test.

Field Test Agencies Group

To more closely examine and evaluate the implementation of conversion to FFS, thirty (30) agencies were selected as participants in the Field Test. These thirty agencies were selected from over 70 agencies that volunteered for consideration. The thirty Field Test agencies were selected to be representative of the agencies

funded by the DHS/DMH for the provision of community mental health services, representing agencies from across the entire state that varied on the size of the funding received from DMH, their level of Medicaid billing, and their location (urban, rural, suburban). In addition, efforts were made to include agencies providing specialty services and services to minority populations.

The Chief Executive Office or designee of these thirty agencies, as well as other staff the agencies wished to assign, participated in monthly meetings of the Field Test Agencies (minutes available at: http://www.dhs.state.il.us/mhdd/mh/sri/). Agencies were explicitly encouraged to include participation of consumer representatives from their agency in these meetings.

Meetings of the Field Test Agencies permitted opportunities to provide information, such as the Field Test evaluation factors and other requirements of the MOU and MOA and the current status of operations relative to the conversion to FFS, as well as to receive information from a representative group of providers on their perspective of the FFS conversion. The Field Test Agencies Group:

- reviewed, discussed and interpreted the Field Test requirements as described in the MOU and MOA;
- reviewed and approved measures and processes used in the Field Test evaluation;
- reviewed and approved the "crosswalk" between MOU/MOA requirements and specific measures;
- reviewed and provided feedback and recommendations on training and technical assistance needs;
- reviewed and provided feedback on state system readiness and related issues.

The Field Test Agencies agreed to the formation of workgroups to address the above and other specific aspects and issues of the Field Test of the conversion to FFS. Information and recommendations from these workgroups were then returned to the Field Test Agency Group, which would review and consider for advancement to the SRI Task Group for their consideration.

Field Test Workgroups

During the period of the Field Test there was some evolution in the workgroups and their charges. By the last half of the six-month Field Test period, four workgroups were clearly defined, formed and actively fulfilling their charges, and one workgroup was proposed for future activation.

Pilot Workgroup

This workgroup assisted with the development of the methods and tools to complete the required Field Test activities under the MOU and MOA. This group's assignments included:

- Reviewing the evaluation methods and tools intended to gather information used to develop the report on the results of the Field Test process;
- Reviewing the safety net plan for providers and forwarding recommendations to the SRI Task Group;
- Reviewing the provider readiness assessment process and outcomes;
- Collecting and reviewing the impact of conversion to FFS on providers, including provider conversion costs, and means of financing the costs of conversion for the state and providers;
- Collecting information on technical assistance activities developed and offered by provider trade organizations to their members and others.

Services Workgroup

This workgroup examined the service array and underlying definitions, the breadth of the array for targeted populations, and how sufficient the array was in supporting a recovery focus to mental health services. Tasks for this group included:

- Articulating a recovery focus, beginning with examples from other states which had recently enhanced their recovery approach to services;
- Comparing the Illinois mental health service array to that in other states that have recently updated to rehabilitation and recovery-focused services;
- Completing a cross-walk of the specific mental services in the array to the Illinois Medicaid state plan;
- Completing a preliminary identifications of possible service gaps that can be further researched and evaluated as a part of the intended strategic planning process;
- Developing an analysis of the relative utilization of type of service (ranking of services highest to lowest based on total units or dollars), grouping services as needed for these analyses.

Financial Workgroup

This workgroup determined the types of analysis that needed to be completed to assess the financial results for the Field Test process along with the methodologies to be used to prepare the analyses. Analyses areas included:

- Assessment of the ability of providers to achieve FY05 Medicaid target billings, including stratification of the agencies that achieve/do not achieve targets to identify any trends that may be present for regional, urban, rural, agency budget size, or extent of service array;
- Preliminary development of proposed methodologies and corresponding models to determine the extent "capacity funding" is necessary to support certain types of service, such as crisis services;
- Examining existing funding levels for non-Medicaid services and consumers and the methodologies used to establish those funding levels;
- Develop recommendations for the DHS/DMH contract terms for FY06;
- Financial activities and processes required for implementation of post-service delivery FFS, including billing and claims processing flow and timelines for payment to providers.

Access and Eligibility Workgroup

This workgroup focused on the eligibility of Medicaid and non-Medicaid consumers and methods for assessing their access to services. Responsibilities for this group included:

- Structuring feedback on and outcomes from the eligibility/entitlement screening tool that was piloted by the Field Test agencies;
- Evaluating training that has been provided on use of the screening tool, examining evaluation forms, as well as the outcomes from use of the tool, and making recommendations regarding additional training needs;
- Developing a format for the analysis of the numbers of Medicaid and non-Medicaid consumers receiving services, the amounts of services being received (in total dollars, time or another measure) by

Field Test agency and region, and developing a regional Medicaid and non-Medicaid penetration rate estimate using Medicaid enrollees and total populations by region;

- Developing recommendations for assessing the impact of provider Medicaid financial performance targets on service access;

- Developing an estimate of the number of individuals dually eligible for Medicare and Medicaid by region and recommendations for further activities necessary for issues related to this population.

System Readiness Workgroup

This workgroup was considered by the Field Test Agencies, but meetings of this workgroup were deferred until tasks related to state readiness were identified that required workgroup input. This decision was due to: (a) state readiness issues were being handled on a case-by-case basis, and it was agreed that the group will be convened at the point input is needed on a state readiness area that can benefit from workgroup guidance for resolution, and (b) some of the systems which this group would evaluate were not yet operational long enough for an adequate assessment of readiness; and (c) some aspects of system readiness were being assessed by other workgroups. As described elsewhere in this report, it is proposed that a systematic assessment of state and system readiness be undertaken in the immediate future.

Field Test Report Team

At the end of the Field Test period, the Field Test Agencies agreed to the formation of a team to assist the DHS/DMH in the preparation of the draft report of the Field Test required by the MOU. This team consisted of one of the co-chairs of the SRI Task Group, the Chairs and/or designees of the four Field Test workgroups, two "at-large" providers (including one provider from an agency not participating in the Field Test), and two consumer representatives along with DHS staff. This group developed the outline of this report, prepared initial drafts of the report, and reviewed and commented on a revised draft prior to submission to the Field Test Agencies for their review.

Expert Consultative and Group Facilitation Support

The above groups were facilitated by and had the benefit of ongoing consultation and active participation by outside experts. Patrick Lanahan and his associates from Health & Human Services Consulting, LLC participated in meetings conducted through August 2004. Beginning in November 2004 consultants Parker Dennison & Associates initiated their consultation, facilitation and participation in meetings. In a collaborative process, the Illinois Association of Rehabilitation Facilities (IARF) and the Community Behavioral Healthcare Association (CBHA) funded additional consultative support; EP & P Consulting, led by Gretchen Engquist, actively participated in and provided ongoing expert consultation in the above groups.

Scope of Stakeholder Participation

Through the above structure, stakeholders consisting of consumers, advocates, providers, trade organizations, legislative staff, and staff from the Governor's Office, Department of Public Aid and the Department of Human Services participated and collaborated in the design and implementation of the Field Test. These individuals served as representatives of other stakeholder groups, providing a communication channel for input from and feedback to these groups. To enhance communication with consumers, during the Field Test a group of Consumer Liaisons was developed from the community provider agencies, which served to expand the input and involvement of consumers in the entire process. With information, support and guidance available from expert consultants, these stakeholders contributed to the process, plan, execution, analyses and reporting of Field Test activities. Individuals and organizations that participated as well as additional details on the group meetings are available in Appendix B.

It should be noted that rather than resisting the conversion to FFS, the participants in the above groups have generally been energetically focused on constructive processes to accomplish the conversion to FFS in a smooth and effective manner. This is especially true of the participants from provider agencies, who invested considerable time and effort into the statewide conversion process--efforts above and beyond what was required for changes at their own agency.

With the completion of this report, plans and efforts for the immediate future need to focus on building on this stakeholder participation in the progression from a Field Test process to a process and structure that involves the entire span of the DHS/DMH funded providers.

Current Field Test Status

As should be expected with the implementation of a complex and extensive change in state payment mechanisms for services, the implementation of the Field Test evaluation was not accomplished as initially conceived or outlined in the MOU and MOA. Four significant factors, in particular, complicated implementation of the evaluation.

First, several months before consideration was even given to changing to FFS processes were underway to revise the state's Mental Health Medicaid Rule (Rule 132). The Rule had not been significantly modified since its original drafting in the early 1990's, and it was anticipated that streamlining of the Rule and clarification of services would facilitate provider Medicaid certification and billings under the current context of a primarily grant-based payment mechanism to providers; that is, the Rule was revised, but not with an eye towards implementation under a FFS system. Finalization of the revision of Rule 132 occurred concurrent with initiation of plans to convert to FFS. This added level of complexity as well as other factors led to delays in adoption of the revised Rule, initially planned for July 1, 2004. The revised Rule was finally adopted with an effective date of August 1, 2004, but with a provision to permit providers to phase in their compliance with the revised Rule through November 1, 2004. Thus, during the first two months of the planned Field Test, all providers were not operating or reporting services in the same manner, with some providers continuing to operate and report under the old Rule 132 while others had converted their operations to be in compliance with the new revised Rule 132.

Second, expert consultants for the DHS/DMH changed during the Field Test period. From late May through September 2004 Patrick Lanahan and his associates from Health & Human Services Consulting, LLC served as expert consultants and group facilitators for the DHS/DMH FFS conversion activities; this arrangement then ended by mutual agreement. With the search for alternative consultants and the requisite contract approval process, it was not until November 2004, almost halfway through the Field Test period, that new consultants, Parker Dennison & Associates, were able to begin work.

Third, plans were made to implement numerous changes in the information systems and processes for provider billings, both Medicaid as well as non-Medicaid. Due to the extensiveness of these changes combined with the complications of the revised Rule 132 described above, completion of processing of provider bills and informational reports were not available until January 2005, four months into the Field Test evaluation process. This severely limited the ability of the providers and the DHS/DMH to assess and predict the likely impact of the conversion to FFS on agencies' revenue flow. This limitation is further complicated by the absence of findings from the cost analyses conducted concurrently with the Field Test and ambiguity about what "capacity grants' will be in the future.

Fourth, although several processes and measures were prescribed by the MOU and MOA, some crucial to transitioning to FFS were not included, such as assessment of cash flow and claims processing times. Such additional processes and measures were added to the Field Test evaluation processes and discussions in order to effectively advance the conversion to FFS. In contrast, some measures prescribed by the MOU and MOA are certainly of interest, but not necessarily crucial in the context of payment mechanism conversion or likely to reflect changes over a time period as short as the six months prescribed for the filed test.

Thus, not all Field Test measures and activities could be implemented and completed as implied in the MOU and MOA. The Field Test workgroups and the Field Test Agencies Group determined the measures that could be included as part of the overall evaluation within the available timeframe. The measures and their relationship to MOU and MOA requirements are reflected in Appendix C.

Values Underpinning the Evaluation

The MOU and MOA both contained statements of principles and values to guide the conversion to FFS as well as the Field Test evaluation activities (see especially items 1 through 4 of the MOU and Section B of the MOA). As the process was undertaken and with the benefit of information and guidance from the expert consultants, the principles and values underpinning the evaluation were further evolved by the groups. Four principles in particular might best reflect the thinking and opinions of the Field Test groups:

- Mental health services should be oriented toward consumer recovery;
- Access to mental health services should be preserved;
- The mental health system should provide effective and efficient mental health services;
- Funding for mental health services should be maximized to meet community needs.

Recovery and Resiliency

During the past few years, significant reports have been issued relevant to public mental health services that provide useful conceptual frameworks, assessments, guidance and recommendations for action. In 1999, the federal government issued *Mental Health: A Report of the Surgeon General* (http://www.surgeongeneral.gov/library/mentalhealth/home.htm) and followed it in 2000 with *Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda* (http://www.surgeongeneral.gov/topics/cmh/childreport.htm) and in 2001 with *Mental Health: Culture, Race and Ethnicity (http://www.surgeongeneral.gov/library/mentalhealth/cre/)*. These reports emphasized the scientific basis for several promising mental health services and treatments, and noted that: "A new recovery perspective is supported by evidence on rehabilitation and treatment as well as by the personal experiences of consumers." In 2001, the New Freedom Commission on Mental Health began a comprehensive study of our nation's public and private mental health delivery systems. The Commission's report, *Achieving the Promise: Transforming Mental Health Care in America. Final Report* (http://www.mentalhealthcommission.gov/reports/reports.htm) was released in April of 2003 after significant family and consumer testimony, and further laid out a conceptual and descriptive framework for a recovery-oriented service system. This Report offered the following definitions:

> *Recovery* refers to the process in which people are able to live, work, learn, and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms. Science has shown that having hope plays an integral role in an individual's recovery.
>
> *Resilience* means the personal and community qualities that enable us to rebound from adversity, trauma, tragedy, threats, or other stresses - and to go on with life with a sense of mastery, competence, and hope. We now understand from research that resilience is fostered by a positive childhood and includes positive individual traits, such as optimism, good problem-solving skills, and treatments. Closely-knit communities and neighborhoods are also resilient, providing supports for their members. (p. 13)

In its final report, the Commission recommended fundamentally transforming how mental health care is delivered in America, with the goal of this transformation being recovery for individuals with mental illness. The Field Test Group adopted this same principle as it considered the transformations associated with conversion to FFS. Findings documented in these report, including those of consumer and family testimony, significantly affected the Field Test Workgroup's direction in defining recovery-oriented services.

A philosophy of recovery places an overriding emphasis on the potential of individuals to recover from psychiatric illness. A recovery-oriented system of care is family and community support centered and consumer directed; it encourages independence, integration and a productive role in fully participating in their own and

their family member's plan for recovery. With a focus on recovery through growth, there must also be opportunities for regular updates to address changing needs built into consumer-centered treatment planning. To this end, consumers and their families must be able to choose the programs and providers that will help move them toward recovery. To achieve this, consumers must have access to a range of effective, community-based treatment options.

Alignment of System to Encourage and Support Recovery

Consumers and their families express a need to have a system that is aligned to encourage and support recovery. They need a system that is flexible, connecting one service to another, where efforts for independence are not impeded by the possible loss of critical medical benefits. They need a system that recognized their illness and provides a range of supports at each level of recovery.

It was recognized that in changing mental health services, Illinois should redefine and create a Comprehensive State Mental Health Plan, incorporating all of the essential recovery-oriented services and supports:

- Access to health care;
- Gainful employment opportunities (with no disincentives to employment, including loss of financial benefits or having to choose between employment and health care);
- Adequate, affordable and safe housing;
- Assurance of not being unjustly incarcerated.

More Closely Tie Dollars to Consumers and the Services of Their Choice

Consumer and their families express the need to have dollars tied more closely to the individual and for services of their choosing. Funding currently is distributed to providers from a number of sources; eligibility for these funds is often contradictory from one program to another, sometimes making it impossible to access preferred services.

Placing financial support increasingly under the management of consumers and families will enhance their choices and support their personal goals. By allowing funding to follow consumers, incentives will shift toward a system of learning, self-management and accountability. This program design will give people a vested economic interest in using resources wisely to obtain and sustain recovery. FFS payment mechanisms can be designed to support these principles.

Increase Ability of Consumers and Their Families to Shape the System That Serves Them

Consumers and their families must be influential in shaping the system that serves them. This, in fact, is listed as the second goal in the President's New Freedom Commission Final Report: "Mental health care is consumer and family driven."

Individuals must often navigate among multiple federal, state, and local agencies. These entities may themselves have limited influence and flexibility. Consumer and families must be included as partners in a coordinated effort of government agencies that influence mental health policy and funding.

It is critical to note that consumers and families currently have limited choice, and therefore either little or no experience in making critical choices and decisions. Experience teaches us to make choices; we have to develop a system that fosters collaboration and empowers consumers and families to make those choices. Evidence-based practices show us that consumers, family members, providers, funders and policy-makers all need to grow into this philosophy.

Consumers should play a significant role in shifting the current system to a recovery-oriented one by participating in planning evaluation, research, training and service delivery. Consumers' needs and preferences will drive the types and mix of services provided, considering the gender, age, language, development, and culture of consumers.

To support this effort, consumer and family participation in the Field Test activities was encouraged from the very beginning. Although initial participation by consumers or families was minimal, involvement grew over the course of meetings. To further support this growth, in January 2005 the DHS/DMH secured and made available funding to support consumer participation in SRI Task Group and Field Test meetings.

Enhance Access to Mental Health Services

For the past several years, the DHS/DMH contracts with community mental health providers have contained a requirement that services be provided to a priority population of adults with serious mental illness and children with serious emotional disturbance, defined by specific diagnostic and functional criteria (see: http://www.dhs.state.il.us/mhdd/mh/pdf/polpdf/targsmi.pdf and http://www.dhs.state.il.us/mhdd/mh/pdf/polpdf/targsed.pdf). After meeting the service needs of these priority populations, the DHS/DMH contracts have allowed any remaining state funds in a provider's grant to be used to support services to other individuals in need of mental health services.

Not contained in these contracts were requirements that services be provided only to individuals enrolled with the Department or an entitlement program, such as Medicaid. These other individuals that might be served could include the "working poor," those who have lost health benefits (perhaps due to loss of employment), the underinsured, legal immigrants, undocumented residents and others. Adults with serious mental illness or children and adolescents with serious emotional disturbance with no other resources need access to publicly funded services. Recent reports indicate that at a national level 26% of U.S. residents who have insurance have limited or no mental health benefits, and that 23% of Chicago residents have no insurance. Residents in Illinois who are underinsured or uninsured, but suffer from severe mental illness may not have any other options if not served by state-funded organizations. Additionally, there are people who cannot be enrolled to the system, such as the homeless, the undocumented, and some who out of distrust of public systems refuse to enroll for benefits but who need care. Moreover, even some consumers in the process of becoming eligible for Medicaid or other programs experience delays in eligibility during the same period they need mental health services, and some individuals with Medicare coverage and serious mental illness need coordinated access to services not covered by Medicare.

Thus, historically, with the benefit of this state funding, in many communities across the state the local mental health providers have been relied upon to provide a "safety net" of mental health services for these vulnerable members of the community. Since many of the community mental health centers funded by the DHS/DMH are an integrated part of the fabric of their local community, they are often in the best position to identify and respond to the unique mental health needs of vulnerable populations within their community.

Preserving this access in the Illinois mental health system is valued in itself, with an interest in ensuring that the conversion to FFS does not inadvertently disrupt access to mental health services, but rather enhances access. Of particular concern is that the focus and interest in Medicaid services and its FFP does not inadvertently displace services to individuals with serious mental illness that are not Medicaid eligible. These individuals would be served using a non-Medicaid FFS, so the same standards would apply to Medicaid and non-Medicaid recipients. The ultimate criterion, for those with inadequate personal financial resources, should be the need for care. An effective mental health system must support access to appropriate levels of service, defined by clinical criteria, from the point of entry into the mental health system to an on-going recovery oriented continuum of care.

Of equal importance, however, is the value of maintaining or, ideally, enhancing access to mental health services in order to avoid other costs the state may incur. This parity in access to mental health services is a key component in the President's New Freedom Commission Report, with the Commission noting that unmet needs and barriers to mental health care leads to "unnecessary and costly disability, homelessness, school failure and incarceration." Failure to adequately address access to mental health services not only has serious consequences for individuals but also to other state supported systems.

Under a grants-based system, however, the level of access has varied across the state. As the conversion to FFS progresses, not only should access to services by individuals not eligible for Medicaid be maintained, but

equity in access across the state should be assured. In addition, although not critical to FFS implementation, workgroup discussions during the Field Test noted that a review of the criteria for defining the priority populations for state supported mental health services is due.

Effective and Efficient Mental Health Services

Regardless of the payment mechanism employed, it is recognized that public mental health systems should be as effective and efficient as possible. The recovery orientation described above, as a value and principle, is consistent with effective and efficient services. By being consumer-centered and focusing on the aim of an individual's recovery, resources and efforts are coordinated to be maximally effective and congruent with the consumer's own needs, goals and efforts. The system should support and provide services that consumers and family members recognize as meeting their identified needs. In addition, by emphasizing services that are family and community-centered, natural and community supports are drawn upon and aligned with the overall goals of service, enhancing the effectiveness as well as the efficiency of mental health services.

An efficient system would also be one that is timely in screening, assessment and referral for mental health services. This, in fact, is the fourth goal noted in the President's New Freedom Commission Report: "Early mental health screening, assessment, and referral to services are common practice." In changing the public mental health service system in Illinois the potential for cost avoidance to the state through prevention and early detection services for mental illnesses should be considered.

The effectiveness of the mental health service system can be further maximized through support of evidence-based services and emerging best practices—that is, services and treatments that have demonstrated through research and been generally acknowledge as the most effective, "state of the art" practices and practices which appear promising but have not yet been as thoroughly researched. The President's New Freedom Commission Report notes how these evidence-based and emerging best practices support recovery:

Effective, state-of-the-art treatments vital for quality care and recovery are now available for most serious mental illnesses and serious emotional disorders. Yet these new effective practices are not being used to benefit countless people with mental illnesses. The mental health field has developed *evidence-based practices* (EBPs) - a range of treatments and services whose effectiveness is well documented. (p. 67)

To ensure that an effective and efficient service system is maintained, ongoing monitoring is necessary. Among the factors and benchmarks to be monitored would be:

- The recovery orientation of the mental health service system;
- Consumer satisfaction;
- Consumer access to services;
- Consistent adherence to service definitions and application across the state;
- Services provided which are clinically indicated, including compliance with payer requirements of clinical necessity and level of services or care.

Maximize Funding Available for Mental Health Services

It is recognized that entities assigned the public trust for the management of taxpayers' dollars should maximize available funding to meet the needs of the community. Thus, community mental health service providers, in general, understand and embrace the overall goal of increasing FFP (Federal Financial Participation) monies for the state within the context of related compliance requirements; the business sense of appropriately maximizing access to the available federal share of funding for covering the costs of mental health services is a value shared by the Illinois mental health provider network. This recognition comes in the context that many providers

in Illinois have already pursued and reached the limits of other sources of revenue to support mental health services, such as 708 and 553 County Board funding, United Way, local fund raising activities, etc.

It is also recognized the FFS payment mechanisms create an efficient system where the need and utilization of funding can be measured more directly. However, the effectiveness and proper incentives possible within this payment mechanism can only be realized if there is financial growth in the system or if funding is permitted to flow among providers (a condition currently prohibited by the MOU item #6).

The benefits of focusing the Illinois public mental health system on Medicaid eligible clients permit standardized financial criteria for services to be used consistently across the state. This standard eliminates disparity that might exist among providers and regions in the state left with the responsibility to create their own sliding fee scale based on criteria idiosyncratic to their own communities. Without question, persons qualifying for disability or persons who are poor and eligible for Medicaid have little discretionary resources to invest to improve their life circumstances. Often primary health care needs go wanting while resources are spent on such items as rent, clothing and food. FFS funding methodology focused on this Medicaid eligible population will target scarce resources to persons whose primary healthcare needs and mental health status are at risk.

As noted earlier, however, the value of the traditional role Illinois community mental health providers have played in the provision of "safety net" mental health services for all individuals within their community, regardless of entitlement eligibility, should be considered as well. That is, the maintenance of services to individuals with mental health needs who are not Medicaid eligible needs to be maintained.

Parker Dennison Report Summary

The following section summarizing the report by Parker Dennison & Associates represents their findings and professional opinions only, and not necessarily those of the DHS/DMH or the Report Team. The full report is available in Appendix I.

Executive Summary

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

Key Conclusions and Recommendations

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

- There are lessons to be learned from other states—Experience from other states that have converted from grant funding to fee for service for their mental health systems offer key insights into likely patterns and trends that may be experienced in Illinois, including the need for more financial supports than anticipated to support the conversion, with a short term drop in claiming followed by a significant, rapid

increase in Medicaid costs that must then be addressed through some type of cost controls. These issues should be incorporated into the planning process in Illinois.

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

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

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

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

- Revise SRI and advisory structure(s)—Although it has served as an important focus for gathering input and recommendations, especially from providers and consumers, the SRI group has struggled to find its role as either advisory or authorization/approval. As currently structured with provider associations and providers prominently among the members of SRI, there is an inherent conflict of interest if any action is recommended to be taken by the state that will result in financial or other perceived harm to any association members or provider peers. Therefore, it was recommended that the SRI structure be

revised to clarify its role as advisory through integration with existing advisory groups, that the group become responsible for a wider range of mental health issues, and that its membership better reflect consumer and community voice. (See Section 5, Recommendation #4)

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

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

- Readiness of state operating structures must be addressed—A comprehensive state readiness assessment could not be completed in the available time, although preliminary impressions indicate that state capacity issues do need to be addressed as a part of the implementation plan, particularly in the areas of claims and data management, clarity for priority populations, and network management and standards. A structured state readiness process must be completed in the near term and critical issues must be addressed prior to full implementation of fee for service. (See Section 5, Recommendation #8)

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

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

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

Report Structure

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

Section 1: Scope of Work
This section summarizes the scope of work for which Parker Dennison was hired and defines the areas of work that informed conclusions and recommendations.

Section 2: Structure for Transition
This section summarizes the conclusions regarding the effectiveness and adequacy of the structures supporting the fee for service transition.

Section 3: Conversion Experience from Other States
This section highlights patterns and issues experienced in other states making large system transformations including fee for service implementations. This section effectively predicts and/or confirms the typicality of issues Illinois is experiencing in this transition.

Section 4: System Readiness
Conclusions regarding consumer, provider, and state readiness to successfully and safely make the transition to fee for service are detailed in this section.

Section 5: Recommendations
Recommendations are divided into three global areas in and include:

Overall Recommendations:

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

Fee for Service Implementation Recommendations:

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

System Improvement Recommendations:

16. Expanded implementation of Recovery philosophy
17. Target/priority population clarification and monitoring

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

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

Appendix A – Provider Readiness Data Summary

Appendix B – Provider Training and Technical Assistance Plan

Appendix C – State Readiness Areas

Key Findings

During the period of the Field Test, much was learned. A deeper and more thorough level of understanding was gained about the feasibility, opportunities, complexities and risks of conversion to a FFS payment mechanism. This section focuses on the key findings of interest in considering the next steps in the conversion process:

- The viability of converting to FFS for the purchase of community mental health services in Illinois, especially as a means of enhancing FFP for the state;
- Maintenance of services during the conversion with a "safety net" for ensuring system stabilization;
- The fiscal impact of the conversion on state and provider operations;
- The system's readiness for the conversion;
- Supports needed to enhance the success of the conversion;
- The impact of the conversion on access to services;
- The impact of the conversion on the quality of services

Viability of moving to fee-for-service

Fee-for-Service as the Primary Payment Mechanism Is Viable

During the Field Test and for all community mental health providers in the current fiscal year of FY 2005, the DHS/DMH state contracts with providers specified performance target levels for three categories: (a) Medicaid FFS; (b) non-Medicaid FFS; and (c) capacity grants.

The experience with trial reconciliation conducted during the Field Test period illustrated the viability of FFS for payment for most community mental health services. Overall, mental health community service providers demonstrated ability to report and bill for services, and the state processed these trial "bills" and successfully filed claims for FFP for Medicaid eligible services (see results of provider billings and state processing in Appendix F). However, the Field Test experience with trial reconciliation also highlighted the limitations of this payment mechanism for certain services and conditions.

Services and conditions not suited for payment by fee-for-service

The Field Test experience reconfirmed the value and importance of utilizing methods other than FFS to support important services with unique characteristics. These included:

- Services that need to be available on an ongoing basis regardless of the number of individuals utilizing these services-- An example of these services would include assuring the availability of crisis intervention services for individuals with emergent mental health needs when the volume of services is so low that the schedule, frequency, or duration of these needs cannot be known, predicted or easily estimated. Also included would be situations in which ongoing assured access to specific services is desired, such as psychiatric services.

- Services delivered when the identification of specific individuals receiving services is not efficient, practical or desired-- Examples of these services could include activities such as outreach for mental health services, crisis interventions when the individual's identity cannot be obtained or confirmed, and other situations in which a client or consumer cannot or should not be specifically identified.

In addition, in the process of the conversion to FFS questions arose about the rates for services that were established under a primarily grant-based system. The nature of a grant-based system permitted a level of uncertainty and ambiguity about precisely what services and supports should or were being funded that were not considered part of the rate structure. During the Field Test an example of this was the provision of services when more than one staff person was required for a single client, such as crisis or other services delivered by more than one staff member due to safety concerns. Similar questions arose about other activities indicated by providers as being supported by the grant-based system, such as consumer involvement and advocacy, support for families, etc. as well as the provision of additional and necessary services for exceptional consumers with complex needs.

During the Field Test and the first year of the conversion to FFS "capacity grant" awards to providers were established as a means of sustaining those services not amenable to FFS payment mechanisms (such as crisis services and psychiatric access). During this initial implementation effort, capacity grants were also utilized for services and supports that did not yet have a clearly established statewide rate, typically due to the variability in the service characteristics as delivered by various providers (such as residential services). Finally, "capacity grants" were utilized to maintain programs consisting of a pool of funds for support of consumers in their communities (such as funding for psychiatric medications). In this early stage of FFS implementation, these capacity grants also served to maintain a minimal secure financial base for providers as they initiated billing for all other services. These factors led the Financial Workgroup and the SRI Task Group to recommend that the same types and level of capacity grants be maintained for FY06. However, the Workgroup also recommended that the nature and amount of capacity grants be re-examined prior to full FFS implementation. Of special concern is the maintenance of capacity grants or other methods to counter any inadvertent incentive to close desired programs, such as residential, that may occur with the conversion to FFS. A listing of the capacity grant programs is available in Appendix E.

Payment for services not covered under Medicaid

Although a primary rationale for converting to FFS was to enhance FFP, the experiences of the Field Test reconfirmed the importance of maintaining the funding for services not eligible for FFP as part of an effective public mental health service system. In addition to the "capacity grants" described above, there are services provided which are not Medicaid eligible for one of two reasons: (a) the service does not meet federal or state definitions required for compensation under the Federal Medicaid Program, or (b) the individual receiving the service is not Medicaid eligible.

Especially within the context of a recovery-oriented service system, some services, such as vocational services, are a crucial component to the overall service plan for individuals with mental illness. And, as noted earlier, Illinois community providers have historically served as a "safety net" for members of their community with mental health needs, regardless of the eligibility for entitlement programs, and service to these individuals may be especially cost-effective to the state in the long run.

Although not eligible for Medicaid, these services are valuable and can still be paid for and processed under a FFS payment mechanism. For the current fiscal year, the funding to support this was labeled "non-Medicaid", although it may be helpful to more accurately identify the nature of these services and corresponding funding as "safety net funding," "uncompensated care funding," or "indigent funding."

Utilizing FFS, There Are Opportunities for Increasing Federal FFP Monies for the State

In implementing FFS, the above issues can be accommodated and still allow Illinois to increase FFP for mental health services. Several strategies were identified in the course of the Field Test, both short and long term.

Short-term strategies for increasing FFP

The Field Test experience reconfirmed the importance of funding some services through mechanisms other than FFS and to ensuring maintenance of funding for services and individuals not necessarily eligible for Medicaid as important components of an effective public mental health service system. However, it also was clear that within the context of limited state resources and funding, opportunities to shift services to attain Medicaid eligibility need to be pursued where possible in order to maximize opportunities for increasing FFP,. Likewise, providers delivering a relatively high proportion of services that are not Medicaid eligible limit the state's opportunity to access available FFP; such providers may also experience difficulty as additional incentives for FFP are implemented as part of the conversion to FFS.

Thus, an initial short-term strategy was the identification of providers with the lowest levels of Medicaid billing. Analyses of the reasons for low billing were undertaken and corrective actions implemented. Corrective actions can be categorized into those best implemented by the state or those best implemented by the provider.

An example of corrective actions best implemented by the state was the analyses of high rates of denials of bills from providers. Although there were delays in processing FFS bills for the first half the Field Test period, once processing began it became apparent that the system was denying a much larger number of claims than in previous years. Analyses of some of these denials revealed that with the changes in the bill processing system, long-standing requirements for bills were now enforced, which caused claims that would have processed in the past to be denied. Medicaid enrollment of all treatment sites with the Department of Public Aid is an example of this type of requirement. Thus, the most effective course of corrective action for these types of denials was for the DHS/DMH to educate providers about the importance of such requirements. Part of this effort included issuing instructions on the most common reasons for denial of bills and corrective actions that could be taken (see: http://www.dhs.state.il.us/mhdd/mh/repCommServices/errorMaster.asp). Analyses also showed that some denials were occurring because the state system had not yet been modified to permit provider correction of bills, such as duplicate billings; correction of this state system problem is still underway.

Although the denial rate was initially very high, by the end of the Field Test and the completion of the second cycle of bill processing in February 14.64% of the dollars billed were denied, compared to the average monthly denial rate of 14.84% in FY04. (Denial rates for February by individual provider are available in Appendix F).

Other corrective actions required intervention on the part of the provider, although the DHS/DMH could provide guidance, technical assistance or referral to peer providers or experts. Under FFS, for example, the importance

of certain staff members, such as billing clerks, increases significantly, and, thus, the need to ensure sufficient capacity and back-up for these crucial services.

Beyond intervention at the individual provider level, continuation of statewide training events and conferences will establish the knowledge and skill foundations necessary for further increases in FFP. Over the past year the following statewide training events have occurred:

- Revised Mental Health Medicaid Rule 132 requirements and service taxonomy;
- Accessing and utilizing the state's system for viewing reports on statewide and provider activities (SIS On-line);
- Installing and utilizing the state-provided billing system (Reporting of Community Services, or ROCS) and its internal report-generating feature;
- Increasing Medicaid billings through correction of previous denials (due to errors) and retrospective claiming for individuals later identified as Medicaid eligible;
- Obtaining Medicaid eligibility for clients;
- Review of FAQ's on services, reporting, billing and the Revised Mental Health Medicaid Rule 132
- A conceptual framework and tool for assessing provider readiness for conversion to FFS

In addition to continuing some of the above training activities, additional training is planned for the following areas to further enhance opportunities for increased FFP:

- Allowable activities and services for Medicaid bills;
- Documentation necessary for Medicaid bills;
- Service and clinical model changes for a recovery-oriented approach and efficient Medicaid billing;
- Billable time management and improvement strategies for staff;
- Billing flow processes;
- Guidance on compliance systems for providers.

Long-term strategies for increasing FFP

As the Field Test has progressed, it became increasingly apparent that the restrictions of the MOU were limiting the amount of FFP that could potentially be garnered by providers. In particular, MOU requirement # 6 required that payments to providers for FY05 "be equal to the contract levels set in Fiscal Year 2004." Thus, providers have no financial incentive to generate billings above the amount specified in their contract for Medicaid.

To address this disincentive, the Field Test Financial Workgroup is developing recommendations to reallocate a proportion of dollars for FY06 providers' annual contract amounts based on providers' Medicaid billing performance. By limiting these reallocations to a limited proportion, the shift can be accomplished in a gradual manner to permit providers opportunities to adjust, but still make a real step toward provider funding changes that may occur naturally when FFS is fully implemented. These reallocations would comprise the first fiscal consequences aimed at preparing providers for full conversion to fee-for-service.

An additional recommended long-term strategy is to review and adjust rates where general fund dollars appear to be subsidizing Medicaid rates. An example of this situation seems apparent in rates paid to physicians for specialized psychiatric services. Currently physicians are paid for psychiatric services using the Medicaid fee

schedule published by the single state Medicaid agency, The Department of Public Aid. These rates are low given market conditions for psychiatrists. For example:

90801	Psychiatric diagnostic interview	$67.50
90862	Pharmacologic management including prescription, use and review of medication with no more than minimal medical review	$23.45

It is commonly accepted and understood that ready access to competent psychiatric services is an important component of an effective public mental health service system. Thus, to assure this access the DHS/DMH has utilized state funding to directly support psychiatric services by board-eligible and board-certified psychiatrists at community mental health centers over the past several years.

Although there may have been some resistance to differential rates for services provided by specialty physicians in the past, if rates were more in line with the market conditions for psychiatrists, it may be possible to assure psychiatric access in the public mental health system without the direct support of funding from the DHS/DMH or other sources. This would have the benefit of not only permitting additional capture of available FFP for such services, but also free up the DHS/DMH monies for other needs, such as support of non-Medicaid services and individuals in need.

Additional long-term strategies include continued adjustments in the definition of services to be purchased following modifications in the state's MH Medicaid Plan and MH Medicaid Rule; some of these changes could include the addition of new services that require increases in state support.

Fiscal Safety Net

Although implementation of FFS was originally planned for July 1, 2004, all parties (executive, legislative, providers, and the DHS) determined that implementation by that date was premature and appropriate safeguards were not in place to proceed. Of particular concern was assurance that access to mental health services would be maintained for consumers. Toward that aim, the parties executed the MOU and MOA specifying a more gradual approach to full FFS conversion informed and guided by the results of a Field Test. Thus, during FY05 and the period of the Field Test, the following provisions were agreed to as a means of assuring ongoing access to mental health services:

- Providers would receive contracts for FY05 at least equal to their contract levels awarded for FY04 (MOU item # 6);
- Advance grant-like payments to providers, rather than post-service delivery payments, would be maintained in FY05 and include an advance payment of estimated FFP for each provider, which in previous years was paid only after adjudication of Medicaid bills from the provider (MOU item # 11);
- Reconciliation of the advance payment for services would only occur as a "trial', and not result in any true fiscal reconciliation or revenue reductions on service delivery alone (MOU item # 18 and # 21);
- The Department would provide technical and physical support to providers having difficulty reaching projected FFS billings (MOU item # 26); statewide training events as well as technical assistance to individual providers were provided before and during the Field Test period in order to facilitate providers' success in the initial steps of the process of converting to FFS (see Appendix D for a listing of these events);
- The Department would provide a means to aid providers experiencing severe financial hardship as a result of conversion to FFS (MOU item # 27) (see: http://www.dhs.state.il.us/serviceProviders/HardshipPayments.asp);

- The conversion to post-service FFS payment mechanisms would be phased in over a span of at least two (2) years (MOU item # 6).

Recognizing that additional time is needed to transition the system, the DHS/DMH recommended that the system not be moved to full fee for service and that the general principles of the MOU related to financial terms be continued through at least December 31. 2005. In addition and as described above, the Financial Workgroup is developing recommendations for some financial adjustments beginning in FY06.

Although the above provisions have stabilized the provider network and maintained access to mental health services for consumers, it is recognized that additional steps in the conversion may require modifications to existing providers or new provisions to ensure ongoing access through the conversion process.

In addition, even with the above provisions, additional risks remain. These are briefly listed here and will be described in more detail later in the report. The challenges that must still be addressed include:

- Structure of the 718 Mental Health Medicaid Trust Fund to permit maintenance of a fund balance sufficient to pay provider contracts, especially late in the fiscal year;
- Timely and accurate data reports to monitor and analyze the impact on the system and providers of FFS conversion activities;
- Technical assistance and training needs of both providers and state staff for operating under a FFS environment;
- Sufficient cash reserves for providers to operate under FFS;
- Coverage of conversion costs to FFS incurred by providers as well as the state;
- Methods for reallocation of funds across providers on the basis of consumer needs and provider billing capacity;
- Equalization of services and access across the state for all consumers.

Fiscal Sustainability of the System

The primary factor necessary for the system to be fiscally sustainable in a FFS environment will be the providers' ability to successfully bill and the state's ability to process bills received effectively and efficiently. Also of importance, though, are cash flow issues for both the providers and the state.

State Cash Flow Issues: The 718 Mental Health Trust Fund

A current cash flow problem for the state is a function of the MOU's prescription for the first steps in the conversion to FFS. Unlike the practice of previous years, the MOU item # 11 directs that providers be advanced projected payments equivalent to the FFP payments they previously would have received only after delivering and billing for the services. Since the Trust Fund receives FFP no sooner than 90 days after services were provided, this means that within a given year advance payments for the twelve months must be drawn from a fund with a balance of no more than nine months of FFP deposits. This cash flow shortfall is further exacerbated by another provision of the MOU (item # 28) that diverts a portion of all mental health services FFP from the Trust Fund to the General Revenue Fund.

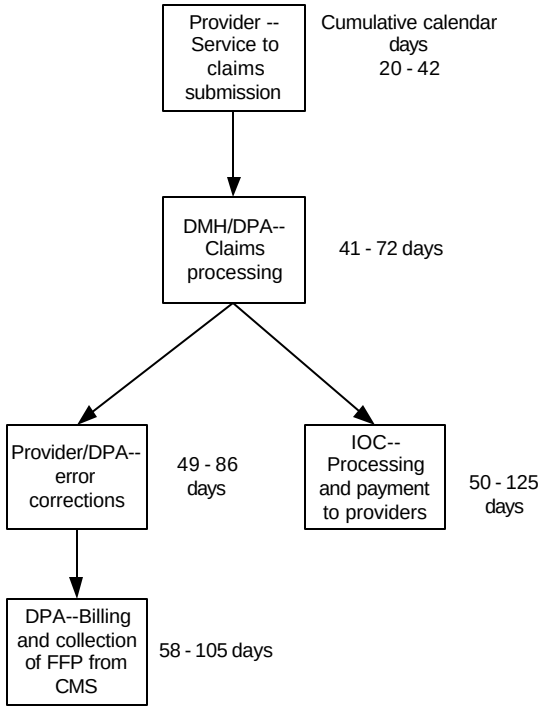
This cash flow problem for the state will be significantly minimized or disappear if post-service delivery FFS is implemented, or if advance payment to providers of amounts equivalent to the FFP are stopped. Otherwise, continuation of this cash flow problem for the state and the resulting delays in payment to providers may continue in subsequent years. Given the generally fragile fiscal condition of most community mental health

service providers, delayed payments to providers as a result of this cash flow problem has the potential of destabilizing the provider network and public mental health service system in Illinois.

Provider Cash Flow Issues

The Field Test Financial Workgroup, including representatives from providers, the DHS/DMH and the DPA, developed a bill processing flow analysis. This bill processing flow summarized provider and state activities from date of service through bill processing and payment. The time line includes time estimates reflecting the shortest and longest amount of time typically required for each task. A summary of the timeline is provided in the following flowchart:

Bill Processing and Payment



The chart highlights two key issues for providers' cash flow under fee-for-service reimbursement structures and state cash flow for FFP:

- The time line shows that it may require 50 – 125 calendar days for providers to receive post service delivery payments from date of service, which greatly exceeds cash reserves available for many providers and reasonable business expectations for non-profit organizations;

- It requires 58 – 105 calendar days for DPA to claim and collect FFP, which creates potential cash flow problems in the Mental Health 718 Trust Fund as described above if advances of FFP are being made to providers.

The Field Test Financial Workgroup identified several strategies that could assist in shortening the bill processing and payment cycles:

- Tighten provider time lines: More timely internal requirements for provider processes, such as completion of initial treatment plans and submission of billing data, would improve billing time lines.

Under current structures of bimonthly DHS/DMH bill processing, providers' internal standards for time from date of service to claims submission should be 15 – 20 calendar days.

- Move to bill submission using File Transfer Protocol (FTP): For the past several years the DHS/DMH providers have reported services and submitted bills by mailing in diskettes. The DHS/DMH is currently implementing file transfer protocols (FTP) to permit electronic submission of bills, which will save 6 – 13 calendar days for providers who chose to move to utilize the FTP method.

- Increase the frequency of the DHS/DMH claims processing: DMH currently processes bills twice per month and payment cycles could be shortened by approximately 7 calendar days if weekly processing were available and providers and DPA increased their billing cycles in a corresponding manner.

- Directly bill to DPA: If claims were submitted directly to DPA, processing time would be reduced by at least 10 – 14 days. Because DPA has dedicated funds for Medicaid payments to providers, the comptroller pays these bills within 24 hours as long as there are dollars in the fund; this could produce an additional 9 to 53 day reduction in the payment process. Plans are being developed for this bill processing change. Issues being addressed include how the DHS/DMH will obtain non-billing data that is currently available from the current reporting system (ROCS) and needed for other funding and mental health policy requirements, how the DHS/DMH will access their billing data, and the need for many providers to acquire and implement HIPAA compliant bill processing software. Many providers are solely reliant on ROCS for billing and would be unable to submit HIPAA compliant electronic bills at this time. Because of uncertainties associated with this option, it should be considered as a long term strategy, subject to actual testing prior to implementation.

- Establish a dedicated fund—If a dedicated fund was available for claims payment that was not considered general revenue funds (GRF), payment cycles through the Comptroller's Office could be streamlined significantly. The feasibility of a dedicated fund is unknown.

As evident in the above analyses, state processing of bills currently contributes significantly to the timeline between the provision of service and possible receipt of payment from the state to the provider. For a network of primarily non-profit mental health service providers, payment by the state within thirty (30) days of receipt of a bill is a reasonable standard utilized by expert consultants and other states. Thus, to address the issue provider cash flow and establish a reasonable level of assurance for their fiscal sustainability the Financial Workgroup recommended as options:

- the state pay provider bills for mental health services within 30 calendar days of receipt. This includes the processing times of the DHS/DMH, the DPA and the Comptroller's Office combined. For non-profit organizations it is unreasonable to expect maintenance of cash reserves sufficient to sustain their organizations for the current estimated payment time line of up to 83 calendar days after bill submission. Note that even with this 30 day standard providers will need to have cash reserves in excess of 30 days (ideally 60 days) to support the time from date of service to claims submission and for normal levels of billing denials that need to be re-billed; or

- providers be advanced funds equivalent to the amount of payment delay beyond 30 days; or

- that payments continue to be advanced with true retrospective reconciliation (paybacks or additional payments) on services delivered. If advance payments continue it will become more important that they approximate expected billing levels so that providers are prevented from relying on cash advances that will be recouped upon reconciliation.

Provider and State Billing Performance

As noted earlier, an expected benefit and reason for conversion to a FFS payment mechanism was to increase the system's overall amount of Medicaid billing and, thus, increase the amount of the state's claiming of available FFP. Item # 24 of the MOU notes that the FY05 contract for each community mental health service provider will contain Medicaid billing targets relative to this goal.

The overall goal for the system of community mental health providers was a 36% increase in Medicaid billing, increasing system-wide performance from $140 million in Medicaid bills to over $180 million and producing an estimated increase of $25 million in FFP. Although the method for assigning FY05 Medicaid targets to each provider becomes complex (and is described further in Appendix E.), a few principles were followed in determining the calculation. Since previous levels of Medicaid billing varied greatly across providers, the amount each provider had in their contract as a *potential* for improved Medicaid billing (that is their total contract minus amounts for capacity grants and existing Medicaid billing) was assigned the same proportional increase in Medicaid billing, subject to certain restrictions: (a) no provider would have a targeted increase in Medicaid billing greater than 20% of their entire contract amount; (b) for most providers clearly serving non-Medicaid clients, a minimum amount of 10% of their total contract was reserved for these non-Medicaid services. However, the allocation methodology resulted in a small number of providers (12) receiving no non-Medicaid FFS allocation, but all providers did receive capacity grants. The Financial Workgroup is presently engaged in an analysis of this methodology and development of alternative methods for establishing Medicaid billing targets for individual providers for the upcoming fiscal year, although the overall statewide target will remain the same.

For all Medicaid bills submitted by providers by March 15th, 2005, statewide billing performance was estimated to be at about 68% of the targeted amount; that is, about $37 million or 32% below the expected prorated target for this point in the fiscal year. Current FY05 billings were at about 103% of the to year-to-date (YTD) Medicaid billings submitted by providers during the same time period last year—an increase of about $2.15 million more than FY04. (Note that these data are based on the dates bills are submitted to the DHS/DMH, and not necessarily the dates services were provided).

Statewide Medicaid Billings Compared to Prorated Target and FY04

	FY 05 Total Contract Medicaid Target Amount	FY 05 YTD Medicaid Target Prorated through February	FY 05 YTD Actual Medicaid Billed through March Cycle 2	FY 04 YTD Actual Medicaid Billed through March Cycle 2	FY05 YTD Actual Medicaid Billed through March Minus FY04 YTD Actual Medicaid Billed through March	FY05 YTD Actual Medicaid Billed through March Minus FY05 YTD Medicaid Target prorated through February
Statewide Total	$187,442,212	$124,961,475	$87,958,001	$85,808,000	$2,150,001	-$37,003,473

Note: FY04 includes the Screening, Assessment and Support Services (SASS) Program, while FY05 does note.

Similarly, for total billings from providers, Medicaid and non-Medicaid, performance was estimated to be at about 62% of the targeted amount; that is, about $65.6 million or about 38% below the expected prorated target for this point in the fiscal year.

Statewide Total Billings (Medicaid and non-Medicaid) Compared to Prorated Target (not applicable for FY04, thus no available data)

	FY05 Total FFS Contract Target (Medicaid and Non-Medicaid)	FY 05 Prorated YTD Total Target FFS through February (advanced payments)	FY 05 Actual Billings through March Cycle 2			FY 05 Actual Billings through March Cycle 2 Minus FY 05 Prorated Target
Statewide Total	$261,970,019	$174,646,679	$109,046,084			-$65,600,595

Data on individual providers are available in Appendix F. These data indicate that of the 162 community mental health service providers involved, 21 or about 13% of providers were billing at or above their expected Medicaid target billing levels at this point in the fiscal year, while 31 or about 19% were below but within 20% of their expected target billing levels. That is, 52 or about 32% of providers were billing within 20% of their Medicaid target at this point in the fiscal year. Thus, nearly 70% of providers are billing at less than 80% of target billing levels, indicating these providers could have substantial revenue reductions upon conversion to FFS if billing levels do not increase. These data reflect the approximate number of providers who could possibly be sustainable today if FFS or true advance and reconciliation on services were implemented.

Statewide provider Medicaid billing patterns from previous fiscal years offer further context for understanding the above year-to-date results. Statewide, and for many individual providers, billings usually increase later in the fiscal year, providing a possibility that billings may yet increase significantly as the current fiscal year comes to a close.

Since the inception of the Mental Health Medicaid program in the early 1990's, Medicaid billings have increased almost every year. However, experiences from other states that have converted their payment systems for mental health services, typically to FFS, indicate that that a decline in Medicaid billings is a common during the period of conversion, frequently for 12 – 18 months until the system re-stabilizes following the conversion. A similar pattern of no increase in Medicaid billing occurred in the Illinois' Mental Health Medicaid program in FY 2000 with the installation of new reporting software (ROCS) to address anticipated Y2K problems. Although monitoring and assessment will continue, information obtained so far from provider interviews and analyses indicates the following as some of the reasons why provider billings are lower than targeted:

- agency management issues, such as staff coverage and training issues;
- information systems changes and problems;
- slow reporting processes;
- billing denials and rejection problems;
- state bill processing system not yet updated to permit provider correction of some billing denials (e.g., duplicate billings).

The above reflect some of the "provider readiness" issues, with additional issues also captured in the survey completed by some providers and reported in Parker Dennison's Report in Appendix I.

As noted earlier, as the Field Test has progressed, it became increasingly apparent that the provisions of the MOU were limiting the amount of FFP that could potentially be garnered system-wide. In particular, MOU requirement # 6 required that payments to providers for FY05 "be equal to the contract levels set in Fiscal Year 2004." Without the ability to reallocate state funds from one provider to another, state match is not available to providers who have the capacity to general additional Medicaid billings. Thus, providers have no incentive to generate billings above the amount specified in their contract. Until payments to providers are actually made on the basis of a FFS rate, billings, including Medicaid billings and associated FFP, will not reach its full potential.

System readiness

The Field Test and conversion efforts provided information and opportunities to consider the readiness of various components of the public mental health system in Illinois to convert to FFS: consumers, providers, state agencies, and service descriptions.

Consumers

Two key elements for consumer readiness for conversion to FFS are: (1) that there are opportunities to become aware of and understand the conversion change, and (2) that there are opportunities for active involvement and input into shaping the conversion process and the final product.

Although some level of consumer participation was in place through the SRI Task Group, additional consumer participation in the Field Test process was encouraged right from the initial stages of the development of the Field Test. However, more intensive and successful efforts were made to secure consumer representation when the Field Test workgroups coalesced and became more active in December 2004. And halfway through the Field Test period, each of the thirty (30) agencies in the Field Test were formally asked to identify two Consumer Liaisons to represent consumer needs and issues in the overall process, both at the local level and statewide. To date, twenty-five (25) of the 30 agencies (83%) have appointed Consumer Liaisons. This effort has further enhanced overall consumer participation in the Field Test, with Consumer Liaisons participating in monthly statewide meetings and workgroups of the Field Test.

A Curriculum committee was formed, composed of consumer leadership and the DHS/DMH Director of Training, to develop materials and conduct training for the Consumer Liaisons from the Field Test agencies. The curriculum was designed to account for the wide range of variation across agencies, including in their level of readiness for FFS as well as their level of recovery-orientation toward services. The Committee developed key materials for Liaisons, which will be further refined into a printed resource book. The curriculum and training materials provide an overview of the FFS conversion, knowledge to represent a consumer perspective in various venues, and role expectations for Consumer Liaisons, including their responsibility to serve as an informational resource and link at their local agency regarding the FFS conversion and implementation at their facility, as well as opportunities for participation at statewide levels to provide input an influence the statewide conversion process. A longer-range goal is to train consumers who desire more advanced advocacy skills to act as advocates on access issues during the conversion process and to advocate for recovery-oriented services.

In addition to informal orientation sessions that had been being held for consumers, beginning in January 2005 formal orientation and training sessions were conducted for the Field Test Consumer Liaisons, both in face-to-face meetings and via teleconference.

As a function of these efforts, Field Test agencies have reportedly increased the involvement of their Consumer Liaisons in local planning processes. And at the statewide level, consumer input was especially pertinent in two Field Test activities. The Field Test Services Workgroup developed "A Philosophy of Recovery-Oriented Services in Illinois." This document benefited from considerable consumer discussion and input, and was adopted by the SRI Task Group as a framework to guide conversion and Field Test activities. Although this document and accompanying definitions will continue to be modified as the conversion process continues, it serves as an important foundational guide for the conversion process that was crafted with extensive consumer input. As part of the development of the Recovery Statement, a listing of services essential in a recovery-oriented mental health service system was developed, serving as valuable input to the Field Test Services Workgroup as they review the array of services to be purchased and their definitions.

Consumer Liaisons can be the best source for alerting the system of disparities in services or unintended consequences occurring from the conversion process. Continued training efforts will help them have the knowledge, understanding, and terminology to articulate adverse impacts that quantitative data cannot easily detect or explain.

Consumers sometimes have limited financial resources that inhibit their ability to cover the routine costs of trainings or their participation in Field Test meetings. In order to support the ongoing participation and involvement of consumers in this significant project, a statewide fund was developed through which consumers can apply for a stipend to cover travel expenses and other incidentals related to participation in Field Test or SRI Task Group meetings away from their local agencies. Unfortunately, this fund did not become operational until February 2005, the end of the Field Test period. Nonetheless, its importance is recognized for future continuation at least throughout the conversion process.

A consumer responsive system would allow consumers to make their needed contribution without adding to already strained financial circumstances. The State system or provider sponsor must cover reasonable expenses to assure continued participation of consumer liaisons. Field Test participants emphasized that a long-term commitment to supporting ongoing consumer involvement is an important component of a recovery-oriented mental health service system centered on consumers and their families.

Providers

An important component of the Field Test process was to determine the readiness of community mental health providers to convert to a system funded by client service fees and their sustainability in such a system. As described earlier, thirty (30) community agencies were selected to represent the scope of agencies in the Illinois mental health system. Providers represented different sizes of organizations, their focus of services, geographic locations, rural and urban, government and nonprofit. Each agency contributed their personal experiences and expertise to identify special circumstances which may affect their readiness for fee-for-service. Agencies contributed significantly in areas of administration, clinical services, financial, and consumer input. Participating agencies committed hundreds of hours of professional time and related expenses to the readiness evaluation within their agencies as well as for numerous outside Field Test meetings and workgroups.

Survey of provider readiness

The thirty Field Test agencies and thirty-four Non-Field Test agencies completed a provider readiness questionnaire developed and administered by Parker Dennison & Associates. The following areas of readiness were addressed in the surveys:

- Services Readiness addresses the agency's preparedness regarding clinical services including clinical staff training, timeliness and accessibility of services to consumers, and implementing positive service delivery changes. An important component of services, but not separately scored, is recovery readiness. Recovery Readiness addresses the agency's preparedness to provide services that are evidence-based, driven by consumer needs and preferences, with emphasis on access, skill building, and supports to address consumer goals of a higher quality of life, in living, learning, social and working environments. Many providers are familiar with the concept of recovery, but service definitions and reimbursement have not encouraged a recovery approach. A philosophy of recovery incorporated into agency operations will require technical assistance and training.

- Financial Readiness addresses the agency's ability to collect and submit billings in a timely manner, it's awareness of operating costs, it's cash availability for operations and it's cash reserves.

- Compliance Readiness addresses the agency's ability to perform its services within the scope of contractual and governmental rules and obligations, avoiding recoupment of fees and fraudulent behaviors.

- Management Information Systems Readiness addresses the agency's ability to gather and manage information on client demographics, dates, and other important information for business decision-making. Twenty-eight percent of agencies surveyed used ROCS (the DHS/DMH billing and reporting system for mental health services) as their only billing system. Since the ROCS system is designed for billing and reporting and not overall agency management, the system provides only a modest amount of client demographic and other information, requiring agencies to keep important information by hand or make the investment in a more sophisticated system. Ideally, agencies would address this deficiency through investment in an information system designed for overall agency management. Agencies that fail to effectively manage the limitations of ROCS are vulnerable to financial losses and other problems that may not be identifiable with ROCS system alone. As more providers implement alternatives to ROCS, DHS should strive to facilitate the transitions by drawing upon its previous experiences interfacing between these systems and the DHS billing system

- Access and Intake Readiness pertains to 'front door' operational systems that appropriately combine clinical and resource/funding triage, including timely access to crisis, assessment and initial service planning, eligibility screening, and effective business practices (sliding scale, co-pay collection, etc).

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

- Governance and Leadership Readiness addresses if the agency's governance structure involves consumers and stakeholders, understands the organizational changes dictated by fee for service, and

has the operational leadership to lead an organization through a substantive change process in a structured manner.

Additional details and results of these survey questionnaires, including the average score levels for each area, are available in the full report by Parker Dennison & Associates (see Appendix I).

Billable Time

An unfortunate characteristic of grant-based funding is that it does not necessarily provide an incentive for efficient business practices in the delivery of community mental health services. For example, it does not direct the attention of organization to the efficient use of staff time, such as available "billable time" for the delivery of services. Grant-based funding encourages business and clinical practices that will not be effective as the system moves to FFS. Identifying billable service time will be important to increasing revenue coming into the provider agency under a FFS payment system, and will be a crucial factor in determining a provider's overall fiscal and strategic position. Both providers and the state can contribute to improvements in this area.

Rather than through simply more effort, an agency's clinical service productivity and billable time may sometimes be increased through more strategic management of its resources. Activities such as restructuring and streamlining work time, ensuring as much staff time as possible is spent on billable rather than non-billable activities, and by identifying when a service may actually be billable are some methods that could be explored. Changes a provider could implement that may positively affect billable time include: providing case management services within the community rather than within the mental health facility; monitoring and revising appointment schedules; monitoring and investigating client "no shows;" scheduling hours of operation around consumer needs and desires; documentation of services during the clinical intervention (rather than "outside" of the service delivery time); implementing procedures to assure timely treatment planning; and implementing procedures for daily submission of billing information. Implementation of several of these changes will require the development of new skills on the part of the agency and its staff—skills that may not have been developed or maintained in a grant-funded service environment.

The state can also help providers maximize billable time by providing clear guidelines and consistent surveys and interpretation about services and activities that are billable, documentation and related requirements. Additional recommendations regarding services are provided in a separate section below.

State

During the course of the Field Test, the benefits of the provider readiness assessment tool and process described above became clear. Application of a similar tool and assessment approach to state readiness is likely to be at least equally valuable. The use of such a tool provides a common conceptual framework for communicating about issues and actions that need to occur to successfully convert to a FFS payment approach. Because of this, the DHS/DMH plans to implement a formal state readiness assessment within the next few months.

Nonetheless, the Field Test process highlighted several important points regarding the state's readiness to implement FFS.

Bill processing

In implementing the first phase of FFS, the decision was made to have all provider bills, Medicaid as well as non-Medicaid, processed through DPA. This change, combined with the numerous other changes inherent in the planned change to FFS, the implementation of a new covered services listing under the revised Mental Health Medicaid Rule (Rule 132), and implementation of new processes and systems for compliance with the federal Health Insurance and Portability and Accountability Act (HIPPA) all led to an extensive delay before bills from providers could be processed. As a result of the delay and backlog, processing of provider claims was not current and "caught up" until late December 2004. This delay, in turn, prevented providers and state staff from receiving any substantial feedback on billing performance and systems operations until January 2005. Beginning in January, however, provider and state staff began to identify problems and issues, initiate investigations and analyses, and implement correctives actions.

A bill processing readiness barrier of considerable concern is that the system presently does not have a function to permit the correction of provider bills that have been denied, such as duplicate bills for the same service on the same day. It's expected that this function will be corrected and available on the system by the end of May.

In preparing for full implementation of FFS, additional preparatory steps for the state system are necessary. The state has already taken some steps toward timelier processing of bills. A more efficient and timely means for providers to submit their bills through electronic file transfer protocol (FTP) was made available to all providers in March 2005, and processing of bills increased from twice to three times per month for November, December and March due to the volume to be processed. However, an effective FFS system should process provider bills on at least a weekly basis, not only to minimize cash flow problems but also to permit timely identification and correction of billing denials or errors. In addition, improvements in the state's system for tracking and reporting on the status of bills are needed, including efficient means of returning the results of bill processing to the providers in a timely manner.

Data analyses and reports

The delay in bill processing, of course, caused parallel delays in data analyses and report production. In addition, though, implementation of a new approach to paying providers required new information and the development and testing of new types of reports, followed by training on understanding the new reports, assessment of their accuracy, and correction and refinement of the report production and format. Moreover, in addition to the design and development of routine standard reports, issues and questions surrounding the implementation of FFS precipitated numerous requests for special or "ad hoc" reports to address specific questions and concerns. This demand for data analyses and report production created a backlog and need for prioritization of report requests.

Accurate and timely data analyses and report production takes on an increased level of importance in a FFS environment than exists in the current grants-based system. As the FFS conversion continues it will be important to monitor the state's ability to produce the data analyses and reports essential for effective management of a FFS payment system.

Provider relations

Provider-relations functions similarly assume a higher level of importance in a FFS environment than in a grants-based payment system. Provider-relations functions typically include the front-line communication with providers for problem solving, training and technical assistance. Understanding of the services purchased and the criteria, conditions and processes for payment become crucial for the very existence of a provider organization under FFS, and consistent and uniform application of service purchasing standards are essential for the state's effective management of the system. Although numerous training and technical assistance activities occurred prior to and during the Field Test as part of FFS implementation (see Appendix D), a coordinated program of ongoing training and technical assistance services will be needed. Moreover, the focus of these training, technical assistance as well as monitoring activities needs to expand to encompass aspects of operations that would not be of equal concern under a grant-funded system. Thus, new resources and tools for provider-relations activities need to be obtained or developed for deployment and consistent statewide application.

Funding flexibility

As noted earlier, even under the trial advance and reconciliation process adopted for the current fiscal year, the potential for increased FFP for the state is limited by the state's inability to increase funding to providers demonstrating a capacity to effectively provide and bill for Medicaid services; additional funding for such providers is not available, and the MOU prohibits redirecting funding from the contracts of providers that are not effective in Medicaid billing to those who are (MOU item # 6). Flexibility in this area in the future is essential--not only to achieve the desired increase in FFP, but will also serve as an appropriate incentive for desired provider performance.

During the Field Test process, even under the trail advance and reconciliation condition, the "capacity grants" provided psychological security as a base level of funding, assuring some level of system stability. Likewise, assurance of ongoing funding for "safety net" services to individuals who were not Medicaid eligible was also valued. Continuation of these funding allocations and flexibility in their administration will facilitate the provider network's transition to a FFS environment.

As the conversion process continues the likelihood of potential problems in access to mental health services due to financial hardship conditions experienced by a provider increases. There will continue to be a need for provisions to address provider financial hardship situations that threaten consumer access. Such "safety net" processes for providers will need to be modified and adjusted as the requirements and conditions evolve over the course of implementing FFS.

Alignment of other state structures

The value of coordination amongst state departments (such as Children & Family Service, Aging, Public Aid, and Public Health), divisions and offices (such as within DHS: Human Capital Development, Rehabilitation Services, Alcoholism and Substance Abuse, Developmental Disabilities, Office of Clinical and Program Support, Office of Contract Administration) becomes more evident from the perspective of a FFS payment system. Coordination and facilitation of expedient decisions on Medicaid eligibility reduces administrative costs for providers and increases the rate and amount of likely FFP capture for the state. The system will benefit from the further development of the eligibility screening tool and application monitoring process begun with Field Test agencies, and the process will be of significant value when automatic notifications to case managers and similar staff can occur regarding a consumer's potential eligibility and the status of their application for entitlements.

DHS is already exploring means for enhancing the coordination of its contract monitoring efforts, including with accreditation processes. This effort and its likely implications for "deemed status" for some state requirements will lead to increased efficiencies for both providers and the state. In addition to this increased coordination, the conversion to FFS invites an examination of not just the "what and how" of monitoring, surveying and auditing by the state, but also what the desired impact or focus of these activities should be--that is, use of these state review activities to provide additional incentives complementary to those which are the aim of the conversion to FFS.

Finally, given the importance of cash flow in a FFS environment, coordination within the state to assure timely payment of bills from providers will facilitate the implementation of FFS, whether this is through special payment procedures implemented at the Comptroller's Office, establishment of a special fund to facilitate prompt payment, or other measures.

Services

Mental health services in Illinois have historically been directed toward symptom management. While medical intervention is important for the stabilization of symptoms it does not necessarily improve an individual's ability to function within their family, community, socially, or at work, nor does it promote a higher quality of life. To function successfully in these major arenas individuals with mental illness need skills training and environmental supports.

Through the Field Test Services Workgroup a "Philosophy of Recovery Oriented Services in Illinois" was developed with the collaboration of consumers, community mental health providers, and payors. This statement emphasizes the potential of all individuals to recover from the impact of psychiatric illness and describes a comprehensive array of service supports to achieve this goal. This recovery document provides a consumer-focused and recovery-oriented direction for service definitions, service development, and strategic planning for mental health services for Illinois consumers.

However, the current regulations that serve as the framework for mental health services in Illinois are not in alignment with this recovery-orientation. The section of the Illinois Medicaid State Plan covering mental health services was first written in 1991and last revised in 1996. Recommended services, service definitions and interpretations change over time, so it is not surprising that a gap between a plan established years ago and services currently preferred would occur. Thus, the Field Test Group recommended and the SRI Task Group endorsed a request that the Department of Public Aid, as the state Medicaid Authority, open the mental health portion of the State Plan to language revisions. Opening the State Plan would allow for revision to appropriate recovery-oriented language, clarification of services and definitions where service gaps appear to exist, and facilitate alignment of preferred services with the Plan.

Section 59ILAC Part 132, known as the Illinois Mental Health Medicaid Rule or Rule 132, was revised in August of 2004. While positive changes resulted, the recovery-orientation for services was not a goal of that revision.

An in depth review by the Field Test Services Workgroup of existing service definitions resulted in recommendations for a number of additional changes in this Rule. One example of these is realigning existing services into a new service definition for "residential supports", to be paid on a per diem basis with up to three levels of intensity. This and the other recommendations are designed to emphasize a recovery-orientation for services as well as improve the definitional clarity for each service. Some existing services would simply be renamed, some service definitions expanded, some definitions condensed, and some definitions restructured or regrouped. In sum, the recommendations for changes in Rule 132 are cost neutral. These changes will provide increased clarity of the services to be provided, benefiting the funder of the services as well as the community providers

The State Plan and Rule revision recommendations have been provided to the Department of Public Aid for their consideration. These revisions will also require the collaboration of the four State agencies that utilize this Rule (the Departments of Human Services, Corrections, Children & Family Services, and Public Aid).

On a longer- term basis, following the above Plan and Rule revisions, it is anticipated that recommendations for additional services, such as wellness maintenance, which do not currently exist in the Plan or Rule will be developed. These services would support recovery and be Medicaid reimbursable, but require supplemental funding.

Supports needed for successful transition to FFS

Current Levels of Support

Although considerable effort and supports have already been invested in the conversion of the Illinois public community mental health system to FFS, the Field Test experience highlighted not only the need for maintenance of this support, but also the need for additional supports in order to achieve a successful conversion to FFS.

Consumer Education and Support Needs

Efforts are well underway to establish a network of consumer liaisons who can serve as communication channels and educators of other consumers regarding the conversion to FFS and its implications for their services, especially the increased focus on recovery-oriented services. However, additional formal educational activities for consumers, their families and support networks need to be developed and supported as the conversion process continues. Since change of any type typically engenders anxieties, it is important that steps be taken to minimize engendering unnecessary anxieties or concerns amongst consumers and their families, or allowing the administrative anxieties of staff to spill over to consumers. Education and coaching of consumers to represent their interests and needs is one important means of managing this.

The network of consumer liaisons will also serve as a foundational structure for consumer input into the FFS conversion efforts, especially as it unfolds at their local provider agency. However, the FFS conversion would benefit from additional support of consumer participation, involvement and input at the regional and statewide levels. Late in the Field Test period a fund and process was established to help defray the costs consumers incurred when participating in regional and statewide Field Test and FFS meetings. This funding and support needs to not only continue in the future, but expand to match the desired and planned expansion of consumer participation in these meetings. This support is essential in order to permit consumers and their families a degree of control over the development of a mental health system meant to serve them.

Provider Support Needs

Recovery orientation and services

As the Illinois community mental health service system moves to operate with a recovery orientation based on a FFS payment model, a paradigm shift from a formerly provider-driven system to the vision of a consumer-driven system is expected. Regardless of whether a provider is facilitating or merely adapting to this shift, training, technical assistance and support for managing this change will facilitate the provider's conversion to FFS and recovery-oriented services.

Consumers will need consistent, expansive orientation in order to fully appreciate and utilize the empowering attributes of recovery. This orientation will further equip them to make truly informed choice about the services they are receiving. The community mental health provider is often the entry point into the system and, thus, will likely have the responsibility to communicate this system of recovery-oriented services and FFS payment processes to existing and new consumers. Support is needed for training and technical assistance to providers so that: (a) provider staff develop a thorough understanding of recovery-oriented services, FFS processes and the implications of both for consumer involvement, choice and empowerment, and (b) provider staff are prepared to explain and appropriately support consumers in the new and evolving service system resulting from the FFS conversion.

Provider operations

Support is needed for training and technical assistance in other aspects of provider operations as well. The Provider Readiness Survey described earlier suggests areas of relative need if providers are to successfully transition to FFS. The Field Test Pilot Workgroup reviewed these results and generated a listing of training and technical assistance needs:

- Productivity Management
- Compliance
- Recovery
- Information Systems
- Service Documentation
- Functional Assessment Tools
- Expanding Community Based Services
- Business Office Practices
- Financial analysis in a Fully Fee for Service Market
- Providers Operation Competencies

Provider conversion costs

The Field Test Pilot Workgroup also identified a number of additional costs associated with a provider's conversion to FFS:

- Billing software and other information system modifications or development necessary for agency operations in a FFS environment and to interface with changes in the state's billing systems;
- Revision or development of administrative systems, such as compliance and fiscal reporting and forecasting systems;
- Development and production of new forms and processes;
- Training and development of staff (clinical and administrative) on changes required for the new FFS system (including travel expenses);
- Communication to agency stakeholders regarding the changes in the service system and their implications, including management of consumers that may no longer have services funded under FFS;

- Loss staff productivity due to multiple aspects of the conversion process, including training, adjustment to new systems, troubleshooting/repair or accommodation to problems precipitated by installation of new systems or processes, and completion of additional surveys and other assessments of the conversion process;

- Potential loss in service volume (and thus payment under FFS) due to the common phenomena of a decline in consumer satisfaction following large changes in the service system.

It should be noted that Field Test workgroups recognized that transition from a grant-based system to fee-for-service requires commitment and change on the part of providers as well as the state. That even with access to training and technical assistance, it is ultimately the responsibility of the community mental health agency board and administration to become informed of the process, identify relevant procedural changes, communicate procedures to staff, and see these procedures through to implementation to achieve sufficiently productive staff and a fiscally sustainable organization.

However, even provider organizations that embrace the change and conversion to FFS may be severely limited by their financial position. The provider readiness survey completed by Parker Dennison & Associates indicated that over 40% of the agencies had less than a 60 day liquid asset/cash reserve, making it difficult for these entities to absorb the above conversion costs without assistance. Means of assisting such agencies, including exploration of available support from state resources, will have to be determined.

DHS/DMH Support Needs

Expert consultation and technical assistance

Conversion to an alternative payment system is difficult and complex. Since other states have already undergone such conversions, being able to learn and gain from their experiences is not only efficient, but also valuable in terms of minimizing repetition of the problems and mistakes made previously. The most effective means of accomplishing this is through the use of consultants with expertise and experience with the conversion efforts of other states.

During the conversion process in Illinois, the DHS/DMH and stakeholders have benefited immensely from the availability of consultants. In addition to their knowledge and experience, consultants also have the benefit of providing a broader perspective to the process and issues, and frequently have ready access to information and other resources that facilitate and benefit the process. The value of ongoing access to outside consultants was repeatedly demonstrated throughout the Field Test. To continue to expedite the conversion to FFS in Illinois, ongoing support of expert consultants is necessary.

Provider relations

In managing a public mental health system under a FFS payment structure, provider relations assume a much higher level of importance. Clarity and statewide consistency in the purchasing of services, including the nature of services as well as the criteria and processes for the purchase of the services, are essential. And without the security and regularity of the payments provided under a grant-based system, the risk of provider financial difficulties and resulting service disruption is greater, requiring a higher level of monitoring by the state in order to ensure ongoing access to mental health services for consumers.

To effectively meet these provider relation needs, a structured, ongoing program of provider monitoring, training and technical assistance is needed. Although current DHS/DMH staff have provided considerable training and technical assistance thus far in the conversion process, the limitations of these resources became apparent during the Field Test process. It is expected that the need for such provider relations will become greater as the conversion process evolves, and especially in the area of monitoring; the experiences of other states indicate that as the conversion proceeds, the need for additional monitoring and control increase immensely.

With limited previous experience in managing a FFS system, the DHS/DMH staff have a need for additional training and technical assistance themselves regarding management of a mental health system based on FFS. Thus, additional and ongoing support is needed to support the above functions, either through the DHS/DMH staff or a contractual arrangement, an approach used by many other states.

Information services

As noted earlier, the Field Test and conversion experience thus far has highlighted the limitations of the current level of information management support. Such support is crucial to the management of a FFS mental health system; ready and ongoing access to analyses and reports are required for effective system and provider monitoring as well as for problem identification, resolution and service system improvement. Again, additional and ongoing support is needed to support the above functions, either through the DHS/DMH staff or a contractual arrangement, also an approach used by many other states.

Community Support Needs

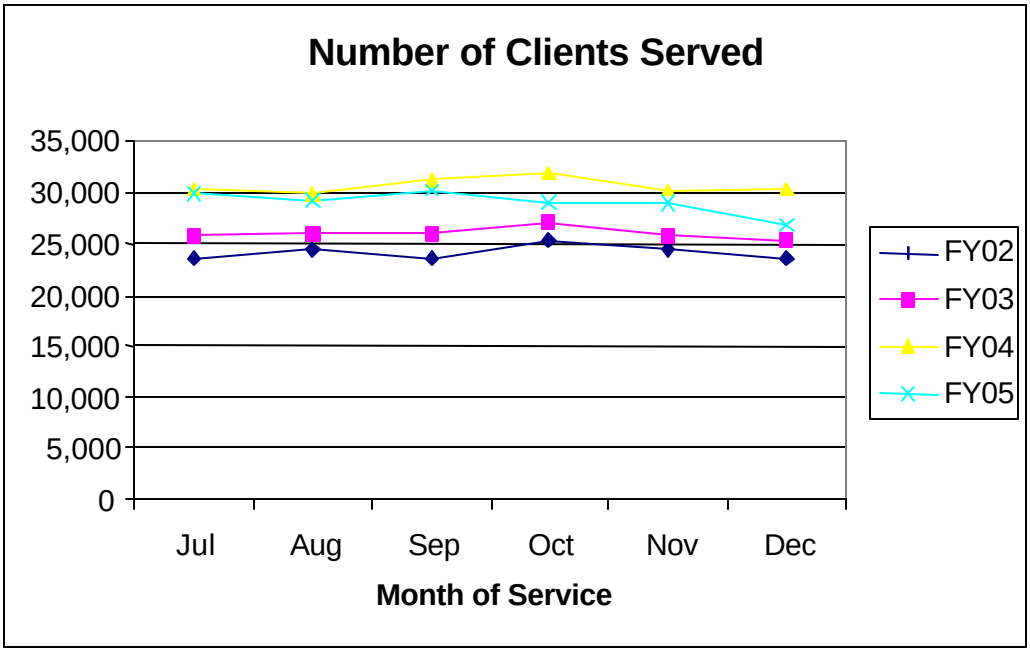
Support is needed to ensure that there is sufficient public and community understanding of the FFS conversion and shift to recovery-oriented services that barriers do not develop based simply on anxieties engendered by the change. Moreover, it is important that other mental health service providers, as well as other social service and allied agencies, are able to understand the change and its implications. Public mental health services are not delivered in isolation, but in the context of a larger community and network of support services, and individuals with mental illness often have exceptional needs for these ancillary supportive services. Thus, it is important that support be available for establishing and maintaining processes for informing other government, public, non-profit and private entities about the conversion process. This information and linkage will serve to enhance collaboration, coordination and efficient use of resources toward improved services for consumers.

Impact on Access to Services

As part of the Field Test process, there were limitations in assessing the impact of the initial conversion efforts on consumer access to services. First, no true conversion of payment approaches has yet been implemented, and even so, it may be too early in the process to detect changes. Second, not all providers have submitted bills and reported the services delivered during the months of the Field Test period this year, making comparisons unequal with data from previous years that included longer reporting and billing periods. Third, given the numerous changes and concerns with the conversion process, especially with fiscal issues, production of reports on consumer access became a lower priority during the period of the Field Test.

For these reasons, the Access and Eligibility Workgroup of the Field Test focused on determining measures and process that should be used to establish a baseline and to monitor access into the future for both Medicaid and non-Medicaid clients as the conversion to FFS progresses. This workgroup reviewed the measures and processes outlined in the MOU and MOA and considered others as well. After their review, for example, the workgroup advised against implementing the Washington Circle Model approach to measuring access mentioned in MOA item S. The workgroup did arrive at two primary methods for the initial approach to assessing access: review of client data obtained from provider billing and service reporting, and surveys of provider and consumer self-report and perception of access issues.

Using data from provider billings and service reporting, the number of clients reported being served for the first six month of this fiscal year is slightly less than last year, but more than the numbers served in the preceding two fiscal years.



	Jul	Aug	Sep	Oct	Nov	Dec
FY02	23,687	24,408	23,617	25,461	24,567	23,672
FY03	25,870	25,946	26,091	27,045	25,731	25,408
FY04	30,393	29,978	31,180	31,846	30,120	30,406
FY05	29,876	29,321	30,121	29,103	28,854	26,948

Note: Years prior to FY05 include clients served in the Screening, Assessment and Support Services (SASS) Program (totaling for the entire year: 7,119 in FY04; 6,920 in FY03; and 6,559 in FY02), while FY05 data does not include SASS clients.

In addition to monitoring overall access, the workgroup and others have noted the need to also monitor the impact of the conversion to FFS on special populations, noting that the conversion and its rates for specific services may establish certain incentives for providers to increase or decrease services to special sub-populations. Populations of interest and concern include the following groups of consumers:

- deaf and hard of hearing;
- non- or limited-English speaking ;
- undocumented immigrants;
- homeless;
- dually diagnosed, both those with co-occurring substance abuse disorders and those with developmental disabilities;
- older adults, including individuals with dementia or related disorders and those with dual Medicaid and Medicare eligibility;
- children (due to the potential impact of time-limited services from the new Screening, Assessment and Support Services (SASS) program;
- individuals between age 18 and 21 (due to differences across state agencies in defining adulthood).

Appendix G provides a table showing the number of clients served in some of the above categories as well as several others. Methods and processes for obtaining client counts on some of the sub-populations of interest still need to be developed so that monitoring can occur on all categories of interest to detect access issues in the future which need to be addressed.

The conversion to FFS and the institution of Medicaid targets or allocations creates an incentive for providers to facilitate the establishment of Medicaid eligibility for their clients. For the past several years the DHS/DMH contracts with providers have specified individuals with serious mental illnesses or emotional disturbance and impaired functional levels as the priority population for services. Thus, the incentive embedded in the FFS conversion could serve to enhance the establishment of eligibility for entitlement programs for these clients, not just for mental health services, but for other critical services as well, such as physical medical care. To assist providers in obtaining eligibility for Medicaid and other entitlement programs for their clients, the DHS/DMH has developed a screening tool and application tracking process. This tool is currently being piloted by some Field Test agencies and reviewed by the Access and Eligibility Workgroup.

A possible undesired result of the above incentive, however, could be a disinclination to serve individuals who are not Medicaid eligible. Of special concern would be those individuals in the priority population, such as those with severe mental illness, that have reduced access to public mental health services as a result of the incentives embedded in the FFS conversion. Throughout the Field Test and meetings of the workgroups there was strong interest and concern in monitoring the impact of the conversion on individuals with mental health service needs who are not Medicaid eligible. A further concern and interest within the Access and Eligibility Workgroup is to explore modifications to the definition employed by the DHS/DMH for the priority population.

Data available thus far does not yet show any significant shifts in services to Medicaid clients, with 39,474 Medicaid eligible clients served in the three months of the first quarter of FY05 as compared to 40,860 served in FY04, paralleling the trend of a slight reduction in the overall number of individuals served illustrated above. Data for the second quarter appears incomplete. As noted, given the short time frame, these data serve as the beginning baseline for monitoring the future impact of the conversion. The workgroup is examining possible expansion of these analyses to incorporate available data form DPA for the calculation of service penetration rates for the Medicaid population, both statewide and by service areas.

The other method of assessing access is through surveys. A FFS "provider readiness" survey was competed by the 30 Field Test agencies and additional 34 agencies that volunteered. On this survey, the providers indicated relatively few plans to add or drop services in response to the conversion to FFS; from a listing of 25 services, the 64 providers as a total group indicated an intent to add 22 services and delete seven from their organizational operations. In this same survey, 67% of these providers indicated that the average time from first call to the initiation of assessment at their agency was ten days or less. And when indicated by clinical need (urgent /emergent), 94% of these providers indicated that they could provide face-to-face assessment on the same day, but only 28% could provide an appointment with a psychiatrist on the same day. Since these measures were not obtained in a similar manner previously, no assessment of changes due to the FFS conversion efforts can be made yet, although these measures can serve as baseline information for ongoing monitoring as the conversion unfolds.

Another survey measure being obtained is consumer perception of access. The MHSIP Consumer Survey was administered at Field Test agencies, with over 1,500 responses received. These responses are currently being entered and analyzed, and will also provide a valuable baseline measure of consumer perceptions.

Discussed as part of the Field Test but remaining to be developed and implemented is a standardized statewide method of assessing consumer need. This measure compared to services actually provided will permit identification of access gaps, including whether individuals most in need are able to access community mental health services.

Impact on Quality of Services

The MOU (item # 19) prescribed that the evaluation of the Field Test should include an assessment of the quality of services funded. Similar to assessing the impact on access, there were limitations in assessing the impact of the initial conversion efforts on the quality of services as well. In addition to the limitations noted earlier, there existed no general system-wide definition or baseline measure of the quality of services prior to the Field Test. A certain level of quality has been presumed in that all community mental health service providers funded at any significant level by the DHS/DMH maintain accreditation through one of the national organizations. In addition, the quality of particular programs funded by the DHS/DMH, such as Assertive Community Treatment (ACT) and Psychosocial Rehabilitation (PSR), have frequently been closely evaluated for quality, including the completion of fidelity measures; however, these activities do not provide an overall measure of quality across all providers, either in the Field Test or statewide.

Consumer surveys of their perception of quality are one means of assessment for this area. However, although many providers conduct such surveys, there is not a shared or common statewide instrument to permit aggregation and ready comparisons. The DHS/DMH has administered the MHSIP Consumer Survey over the past several years, which contains measures of consumer satisfaction as well as assessment of consumer perception of quality. However, the sample sizes thus far have been small, limiting generalizability and comparisons both among providers and across time. As part of the Field Test effort, however, the MHSIP Consumer Survey was administered at Field Test agencies, with over 1,500 responses received, which are currently being entered and analyzed. These data can serve as a beginning to the establishment of baseline measures on quality.

Related to quality is the scope or range of services providers make available. As noted earlier, providers thus far have indicated relatively few plans to add or drop services in response to the conversion to FFS.

Thus, remaining to be developed are more specific processes and measures of the quality of services being purchased. The measures and methods selected should permit a standardized and uniform assessment across providers and over time as FFS is implemented. It is anticipated that initially a number of process measures of quality will be needed, and that measures should reflect the level of adoption and utilization of evidence-based services and emerging best practices. To adequately assess quality on an ongoing basis will require additional data and reporting from providers, and these data must be analyzed and utilized by the state to shape management of the system if improvements in overall service quality are to be achieved.

Conclusions

Recommended Time Line

During the course of the Field Test, members of the Financial Workgroup closely observed and discussed the changes occurring in the system. They monitored billing submissions, processing of the bills, billing levels compared to the previous year and the FY05 target, and the availability and accuracy of data and reports on these processes. On the basis of their observations, the Financial Workgroup generally concurred with the recommendations of the DHS/DMH regarding FY06 and future year contracts with providers.

First, they recommended that “capacity grants” for FY06 remain the same as they were for FY05, except for minor adjustments to correct errors, etc.

Second, they recommended that the terms of the FY06 contract, particular with respect to advance payments and reconciliation processes remain the same through December 31, 2005 (that is, for the first six months of the next fiscal year) as they were for FY05.

Third, they recommended that for the second six months of FY06 that limited reallocation of FFS funding occur among providers. This reallocation would be based on bills submitted as of December 31, 2005, or some point earlier, and would be based on provider billings relative to their prorated FFS performance target. Contract amounts would be reduced for providers billing below 70 – 75% of their prorated target and reallocated to providers billing above 50% of their prorated target. In addition, provider billings will be monitored through the first quarter of the fiscal year (September 30, 2005), with technical assistance offered to providers with billings significantly below their prorated targeted levels. The date of these reallocations may be delayed for the system if statewide processing problems occur, or for a single provider with a significant and justifiable rationale for a delay (such as installation of a new information system).

The Financial Workgroup is also exploring the possibility of a limited reallocation at the beginning of next fiscal year, FY06. They are considering recommending that a small portion, up to 5% of FY05 Medicaid and non-Medicaid allocations, be made available for reallocation in the FY06 contracts based on claims submitted for dates of service during the first half of the current fiscal year, July 1 through December 31, 2004.

Fourth, that conversion to full retrospective FFS occur no earlier than July 1, 2006 (the beginning of FY07), but only if there is assurance that provider bills can be paid by the state within 30 days of submission or an alternative mechanism is employed for assuring adequate cash flow to providers. If the alternative mechanism involves advance payments to providers, the amount of these payments should be based on a provider's billing performance (such as through March 31, 2006) to minimize difficulties that could arise if the amount of the advance greatly exceeds the amount of billings a provider is able to produce.

It was felt that the above timeline of changes, combined with provider technical assistance, possibly some bridge funding, and contingency plans to assure consumer access to services, would provide a basis for a smooth transition from the current grant-based system to FFS. However, the progress of the conversion should also be based on the achievement of some critical benchmarks.

Recommended Benchmarks

Without the achievement of some critical benchmarks as the system progress toward FFS, difficulties, if not failure of the conversion, is likely. The most critical benchmarks would include the following:

Cash Flow

A process to ensure timely payments to providers for services provided needs to be in place. Although important under any circumstances, the timeliness of payment becomes even more important under the reduced level of certainty of payment amounts under FFS than that which occurs under a grant-based system. A reasonable standard of payment within 30 days of receipt of a bill should serve as a benchmark, or alternative processes be implemented to address the difference between this standard and when payments by the state can actually be executed. This could include a one-time advance payment for the difference between actual payment and the 30 day standard, or maintenance of an advance and reconcile payment system.

Achievement of the above benchmark rests on two other criteria being fulfilled. The first is that the state must have a cash flow process that permits timely payments to providers; in particular, if advance payments are being made to providers there must be a way to ensure that sufficient state funds are available at the time the payments are to be processed. The second criteria is that the bulk of the provider community must have sufficient cash reserves of at least 30 days (and ideally 60 days) to manage their operations between the time of service delivery and payment 30 days later. In order to achieve this, if retrospective FFS is implemented there will be a need for bridge funding to providers to achieve this transition. This bridge funding becomes necessary because the current provider community, for the most part, has not grown a pool of assets or cash reserves. Almost all of the current provider community consists of non-profit or local government organizations whose very purpose is not the accumulation of assets and cash, but rather the fulfillment of their mission of service delivery. In addition, the requirements of the long-standing grant-based system expected full expenditure of grant dollars on service, rather than the accumulation of reserves.

Flexibility to Reallocate Funding Among Providers

The provisions this year (from the MOU) restricting the reallocation of funds among providers needs to be eliminated if the benefits of the conversion to FFS are to be realized. Given the reality of a finite amount of state funding, maximizing the desired increases in FFP cannot be achieved if providers are limited in their billings due to the requirement that other providers not billing retain their funding levels from the state. Even more important, however, is that this lack of flexibility in adjusting funding to providers prevents the purchase of additional services in areas where there is demonstrated increase in demand for services from consumers.

Technical Assistance for Providers

The Provider Readiness Survey illustrates the need for additional preparation of the provider network. Even though some training and technical assistance has been provided before and during the course of the Field Test., a gap remains between the current level of provider understanding, skills and operation and what is needed to successfully provide services under FFS. Thus, before full implementation of FFS additional statewide as well targeted technical assistance and training needs to be completed. Statewide efforts need to focus on enhancing the entire provider network's understanding of critical readiness functions required for the conversion to FFS, including the assessment and monitoring of productivity levels and alignment of clinical models with FFS and recovery-focused services. Although targeted technical assistance to every provider may not be possible, some intensive technical assistance to select providers will be necessary in order to achieve the maximum benefits of the conversion; such targeted assistance could be supplied with an expectation that the targeted provider offer subsequent peer-to-peer assistance to other providers.

State Readiness for FFS

Prior to full implementation of FFS, an assessment of the state systems necessary for FFS must be completed with confirmation that all critical systems are functioning at levels adequate for the success of the conversion.

Manageable Revenue Gap Between Grant and FFS Funding

Significant service disruption and destabilization of the service system will occur if large numbers of providers experience significant financial hardships when the conversion to FFS occurs. Providers in these situations will not be able maintain services at adequate levels, resulting in reductions or elimination of service access unless considerable interventions occur. To avoid this situation, several conditions must be met. First, a significant number of providers must be operating at levels where the difference between their current grant base and their likely state revenue under FFS is manageable, such as less than 15%. Secondly, revenue allocated for those providers who are not able to operate at levels equivalent to their grant base must be retained in the system for allocation to providers who can fill in those services and retain access under FFS. And, lastly, if the gap remains for a significant number of providers, interim transitional support, such as increased amounts in "capacity grants" should be established for a limited period, such as one year or less, to facilitate provider transition to the new FFS system.

Reasonable Billing Denial Rates

Billing denial rates should be a direct function of the effectiveness of the state readiness assessment as well as the training and technical assistance offered to providers, but can service as a benchmark for the system's readiness to convert to FFS. Denial rates equivalent to those prior to the conversion would serve as a reasonable standard.

Alignment of Medicaid State Plan, Rule and Service Definitions

Although not a benchmark or requirement for the conversion to FFS, modification to the Medicaid State Plan, MH Medicaid Rule (Rule 132) and service definitions to be in better alignment with a FFS and recovery-oriented system would facilitate the conversion effort. Because of this, the Field Test Services Workgroup has recommended that these changes be completed by July 1, 2006, concurrent with the planned conversion to FFS. It should be noted, however, that this timeline is not completely under the control of the state, since the modification to the State Plan is dependent upon the federal approval process.

Maintenance of Services to Individuals Not Enrolled in Medicaid

As the conversion to FFS evolves, as well as after its complete implementation, access to mental health services by vulnerable populations not enrolled in Medicaid should be monitored. Of particular concern is

assurance that the system will be accessible to individuals in the priority population who are not Medicaid eligible prior to full implementation of FFS.

Monitoring System Re-stabilization and Evolution

In addition to assuring achievement of the above critical benchmarks necessary for the successful implementation of FFS, an effective public mental health system requires a means of ongoing monitoring. The state as well as the providers must have information systems capable of collecting, processing and reporting data of interest. Maintenance of these systems can address questions regarding changes in the service system, both during the conversion to FFS as well as the system's continued evolution following the conversion. Questions from the following areas would be of importance:

- changes in the number or characteristics of consumers served by the system;
- changes in the nature or amount of services provided;
- changes in the fiscal characteristics of the system and its providers, including FFP, relative costs of services, etc.;
- changes in the number or types of providers, both at the individual staff level as well as the agency level;
- changes in the result, outcome, or impact of services

In order to have available accurate and reasonably complete data to address the above questions, it is recognized that additional data reporting and processing requirements will be necessary for the providers and the state.

Appendices

Appendix A: MOU and MOA Status

Memorandum of Understanding	**DHS/DMH Action**
This Memorandum of Understanding, is entered into this 2nd day of July, 2004 by and between the Illinois Department of Human Services Division of Mental Health (hereinafter "the Department"), the Governor's Office of Management and Budget, Mattie Hunter, Vice-Chairperson of the Senate Health and Human Services Committee, Dale Righter, Republican Spokespersons for the Senate Health and Human Services Committee, Rosemary Mulligan, the Republican Spokesperson for the House Special Committee on Fee-For-Service Initiatives and Barbara Flynn Currie, Chairperson of the House Special Committee on Fee-For-Service Initiatives, and hereinafter referred to as "the parties".	
Whereas, the State of Illinois has an obligation to provide for the health, safety, and welfare of its citizens;	
Whereas, the primary mental health mission of the Division of Mental Health is to help maximize community supports and develop skills for persons with serious mental illness and children with serious emotional disturbance;	
Whereas, A steering group of the stakeholders in the conversion to fee-for-service payment methodology will be developed to represent the interests of the larger stakeholder group while facilitating timely discussion and decisions on matters requiring immediate resolution. This steering group is to include one representative from each of the following organizations: Community Behavioral Healthcare Association of Illinois, Illinois Association of Rehabilitation Facilities, National Alliance for the Mentally Ill, Illinois Hospital Association, two consumer representatives, legislative representation and a supportive housing provider whenever discussions are held on housing matters;	
Whereas, the DHS and the stakeholders have agreed upon the selection of an expert consultant, Health and Human Services Consulting, LLC, with specific and broad expertise with regard to community mental health programs financed in part by Title XIX. DHS has or will enter into separate contractual arrangements with the expert consultant and nothing in this memorandum will impose any contractual obligations upon the expert consultant or grant to the expert consultant any rights as a third party beneficiary or any related rights with regard to the fee-for-service conversion;	
Whereas, beginning on July 1, 2004 Mental Health providers in the State of Illinois will begin the first step in a phased-in conversion to a fee-for-services payment methodology;	
Whereas, it is the agreement of the parties that this Memorandum of Understanding is entered into in order to make a smooth transition to a fee-for-service methodology; but it is not intended to expand entitlement programs beyond those that already exist, or may in the future be enacted, under federal or state law.	
The Parties Agree to these Good Faith Provisions: 1. The Department and related Mental Health care providers will develop reinvestment and enhancement strategies to expand resources and increase efficiency;	In process. The Field Test Financial Workgroup is in the process of developing strategies for FY06 contract.
2. The fee-for-service reinvestment and efficiency strategy will promote consumer access and choice, as well as provider sustainability, based upon equitable reimbursement for quality services provided in response to demonstrated need;	In process. The Field Test Workgroups are identifying ways to measure consumer access (Services) and provider sustainability (Financial and Pilot).
3. Strategies should include long-term solutions and include a review and assessment process. Planning must occur to develop an appropriate infrastructure for the fee-for-service initiative reinvestment and efficiency strategy. Client choice, financial and programmatic accountability, access and continuity of care will guide planning decisions;	In process. The Field Test workgroups, expert consultants and the Department have identified short and long-term strategies to convert the system to a fee-for-service structure.
4. The Mental Health care providers will assist the State in ensuring the availability of affordable, accessible, accountable, and quality community services by working to increase federal funds capture, as appropriate, while ensuring a system that facilitates serving consumers with easy access to services and supports, utilizing fee-for-services, grants, and any other necessary financing vehicles along with the necessary technology and business services. Each provider's rights and obligations with respect to the Department are set forth in its annual award agreement with the Department, and nothing in this Memorandum shall impose any contractual obligations upon the providers or grant to the providers any rights as a third party beneficiary or any related rights with regard to the fee-for-service conversion. The necessary technology and business services will included, but not be limited to: processes sufficient to maintain/track/improve access to services; enable appropriate retroactive claiming; increase appropriate Medicaid claiming; implement appropriate administrative support and claiming; and participate in system	In process. Representative from the thirty Field Test agencies have been instrumental in identifying system changes that are necessary to a successful conversion to a Fee-For-Service structure. Identified changes are recommended in both state ad provider systems and are both financial and qualitative in nature.

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planning, implementation, and monitoring according to the plans developed by the Steering Committee in consultation with the expert consultant;	
The Parties Agree to these Requirements: 5. The Department will retain the services of Health and Human Services Consulting, LLC, the expert consultants selected by the stakeholders and the Department, to provide facilitation, technical assistance, guidance, and expert consultation necessary to actualize the requirements of this Memorandum of Understanding. The Department will make periodic progress reports to the Senate Health and Human Services Committee, the House Special Committee on Fee-For-Service Initiatives (or its successor in the 94th General Assembly, if any) and the Governor over the next several months, specifically including reports in September, October, November, and December of 2004, and bi-monthly thereafter through June 30, 2005;	Completed. Parker Dennison and Associates were retained as expert consultants in October, 2004 and have provided guidance to the SRI Steering Committee, Field Test Group and Workgroups and DMH. The Department has submitted reports to the Senate Health & Human Services Committee and the House Special Committee on Fee-For-Service Initiatives as prescribed by the MOU.
6. Mental health providers will begin the initial steps of the planned phase-in of the conversion from a grant-in-aid to a fee-for service payment system will span at least two (2) years. Each contract with a community mental health service provider will provide that, upon meeting its contractual service requirements, payments to that provider will be equal to contract levels set in Fiscal Year 2004, with the exception of any adjustments made in the enacted budget, through at least June 30, 2005;	In Process. DHS approved contract increases totaling $3,314,741 to 85 community mental health providers for mental health Medicaid services which were under-projected in their FY2005 contracts. The Department is increasing the awards for these providers on a proportional basis based on the difference between the actual and estimated amounts. This proportional increase is a function of the Department not changing the FY2005 contract amounts for those providers who fell below those estimates.
7. The Department will compose a service taxonomy that reflects the new system and further determine how to facilitate the transition between a billing code and service title. The service taxonomy will include actual text describing what the service does and does not include. Included in this are specifications in the form of a covered services section of a provider manual that details service definitions, billing codes, billing procedures, documentation requirements, provider qualifications, units of service and rates, on a service-by-service basis;	Completed. Revised service taxonomy pursuant to the changes in Rule 132 adopted in July, 2004 was published in August, 2004 and is available on the DHS website.
8. The Department, with stakeholder input, will finalize the service taxonomy, including services not previously claimed as Title XIX. This information will be distributed to all providers at the earliest possible date. The Department will conduct an orientation training for the Field Test participants two weeks before the Field Test begins. The service taxonomy will be designed to advance investment and efficiency strategies, and comply with all applicable federal laws and requirements. Any services that have not previously been billed to Medicaid such as vocational supports must be carefully defined in terms of what is and is not reimbursable through Medicaid; the Expert Consultant will provide technical assistance to the Department with regard to service taxonomy and Medicaid reimbursement issues:	In process. Rule 132 Service Taxonomy was revised in July, 2004 and multiple provider training events were conducted prior to the November 1, 2004 deadline to implement the revised rule. The Field Test Services Workgroup reviewed this taxonomy and forwarded recommendations for revisions to the SRI Steering Committee. The Workgroup also recommended that revisions be made to the State Medicaid Plan and Rule 132. These recommendations were approved and DHS is initiating discussions with other state agencies.
9. In collaboration with the expert consultant, the Department will produce a "Strategic Vision Report for Mental Health" similar to the "Getting Reports on the Developmental Disabilities System". This Strategic Vision Reports will be completed by April 30, 2005, and will serve as the foundation for subsequent analysis and discussion of rate methodologies and services provided under the community mental health system;	In process. John Hornick, Advocates for Human Potential, has been retained as expert consultant and has facilitated multiple meetings involving a wide range of stakeholders to do strategic planning. A final report is being prepared and will

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	be completed by April 30, 2005.
10. Once the Department has issued a provider manual and conducted orientation training for providers not participating in the Field Test, these providers will begin reporting service units on a monthly basis in order to develop familiarity with the fee-for-service process;	In process. Most community providers have been submitting service data and claims on a monthly basis yet claiming is lower than was projected. Reasons for the lower amount of claiming were identified on both the provider and state level. Considerable effort has been made by both entities and an increase in claiming has been observed in March, 2005. Providers have access to multiple claiming reports via SIS-Online.
11. Effective July 1, 2004, Mental Health providers will begin receiving monthly advances. In Fiscal Year 2005 this will include projected Federal Financial Participation (based on Fiscal Year 2004) in contract amount;	In process. Providers are continuing to receive monthly advances including projected Federal Financial Participation.
12. The Department will continue to pay equal rates for the same service, regardless of the source or funding (Medicaid or non-Medicaid);	Completed and Ongoing. The Department pays equal rates for the same service, regardless of the source or funding (Medicaid or non-Medicaid).
13. The Department and providers will continue efforts at retrospective claiming. Providers have already begun this process and the Department will continue to identify previous billings that may be resubmitted for Medicaid match. The Department will provide ongoing technical assistance regarding retroactive billing to providers as needed;	In process. Lessons learned from the retrospective claiming effort were incorporated into technical assistance protocol that is being provided to individual agencies through the regional networks.
14. Unique client identifiers will be implemented by the Department as soon as possible but no later than July 1, 2004. The Unique Client Identifiers will be: Provider oriented – no cards will be issued to the client; A two-phase process – The Department will match agencies' existing client data for the past two years and assign, as needed, by July 2, 2004. For new clients, agencies will access the unique client identifier via a 1-800 telephone number, fax machine number, or email;	Completed. Every registered client is assigned a Recipient Identification Number (RIN). The Department will soon initiate an electronic process for providers to obtain RINs, called eRIN.
15. The Department should provide Community Agencies with the option of submitting ROCS data via electron will File Transfer Protocol (FTP) with July 2004 service reporting in order to more rapidly and easily submit data; and	Completed. The Department has made available the File Transfer Protocol and as of March 31, 2005, 72 mental health agencies are registered.
16. The Department will address confidentiality issues, and provide technical assistance to providers with regard to practices and safeguards providers can adopt in order to comply with HIPPA health related information confidentiality requirements;	Completed. The Department's claim system is HIPAA compliant and MIS has provided technical assistance on HIPAA issues to providers when requested.
17. The providers will work with the Department to test the premises of the conversion by doing system runs of the Department's Federal Financial Participation proposal beginning July 1, 2004;	In process. Providers have access to reconciliation reports for claims submitted through the first March cycle.
18. Trial advance and reconciliation will begin during the 2nd Quarter of Fiscal Year 2005 for a limited Field Test of providers, with initial reconciliation in the 3rd Quarter of Fiscal Year 2005: a) Thirty agencies will be selected or allowed to volunteer for the Field Test with selection criteria based on representative samples reflecting differences in agency size, geographic location, level of Medicaid billing, and orientation to special populations or services; b) The Department shall report to the Senate Health and Human Services Committee, the House Special Committee on Fee-For-Services Initiatives (or its successor in the 94th General Assembly, if any) and the Governor on the success of the reconciliation with these thirty providers in the Field Test prior to moving any other providers to the Fee-For-Service methodology. The expert consultant shall conduct an evaluation of the completed Field Test involving the initial 30 test providers and submit a report to the Senate Health and Human Services Committee, the House Committee on Fee-For-Service Initiatives and the Governor, together with any recommendations for change that should be taken into consideration in any expansion;	a) Completed. Thirty agencies have been identified and are participating in Field Test activities. b) Report to the legislature is being prepared and will be submitted April 29, 2005.

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c) DHS will have authority to expand the limited test group taking into consideration the evaluation and recommendations of the expert consultant, but at no time earlier than the start of the 3rd Quarter. The providers included in any expansion of the Field Test may do so an a strictly voluntary basis; d) A preliminary written evaluation of the advance and reconcile billing system will be completed by December 30, 2004; e) To assist all agencies in the transition to Fee-For-Service, all agencies will receive technical assistance and training beginning in the 2nd Quarter of Fiscal Year 2005; f) The results of the field test will inform refinements in the system on an ongoing basis; g) Trial reconciliation will begin for all agencies in the 4th Quarter of Fiscal Year 2005 for services and reporting in the 3rd Quarter of Fiscal Year 2005; h) Upon the conclusion of all successful field testing, the Department may proceed toward full reconciliation beginning in fiscal year 2006 based on the recommendation of the expert consultant and the signatories to this Memorandum. In the event substantial refinement is recommended by the expert consultant based on the field analysis, the Department shall make adjustments based on those recommendations before proceeding to full conversion	c) No decision to expand the Field Test has been made at this time. d) Completed and submitted. e) Completed. Agencies are receiving various forms of technical assistance through DMH regional networks and Central Office. f) Report to the legislature is being prepared and will include recommendations for future system of care. g) Not yet required. h) The expert consultants recommended and SRI and DHS approved that full reconciliation not begin until FY07.
19. The evaluation of the Mental Health Conversion Field Test should be designed to focus on consumers ability to receive services, quality of the services funded, the fiscal sustainability of the involved provider agency, the impact on the conversion initiatives primary objectives, the benefits and viability of moving to Fee-For-Service, and an assessment of conversion impact on each individual providers. The design of this evaluation will be the focus of the Mental Health Stakeholders Workgroup and the outside consultant and the results of the analysis are to be submitted in writing to all the members of the Senate Health and Human Services Committee, the House Special Committee on Fee-For-Service Initiatives (or it successor in the 94th General Assembly, if any) and the Governor by April 30, 2005;	In process. The Field Test Evaluation Report is being developed and will be submitted to the legislature April 29, 2005.
20. After the initial Field Test and prior to the inclusion of the voluntary groups, additional terms and conditions may be added to the Field Test if deemed necessary by the Department and the expert consultant and upon the agreement of the signatories of this Memorandum;	The Department is working with the expert consultants and SRI to plan for the next phase of evaluation and implementation.
21. Participants in the fee-for-service Field Test will not be at any risk of any revenue reductions due to reconciliation with reported service units. Providers will be accountable only for expenses as is the current practice. Providers will be expected to submit adequate data to allow Medicaid claiming to be done;	In process.
22. The Department will be responsible for developing a monthly meeting schedule for the Chief Executive Officers or agency directors of the thirty providers in the Field Test to meet with the Department consultant and a representative of the Department of Public Aid to review predetermined outcomes of the field test and address issues concerning access, fiscal changes, and programmatic changes;	Completed. Monthly meetings of the 30 Field Test agencies have been held.
23. The Department must develop an internet-based communication system among the participants in the Field test to ensure a rapid exchange of information on issues related to the conversion;	Completed. Pertinent information is routinely posted on the DHS DMH website and email is the preferred means of communication among stakeholders.
24. The contracts themselves will include (or be amended to include): The requirement that all services must meet the conditions of 59 ILAC 132 (as amended from time to time); Provisions for the reconciliation of payments with services; and Medicaid billing targets, and incorporate by reference the Department's provider manual once promulgated;	a) Completed. b) Completed. c) Completed.
25. The State will seek the services of a contractor to develop an appropriate State plan amendment with regard to pursuing administrative and support claims; the Department's expert consultant will provide oversight to ensure that the administrative and support claiming mechanisms are consistent with the fee-for-services claiming process and applicable federal law;	In process. The State is in the process of issuing an RFP to develop a methodology for obtaining federal matching funds for administrative costs.
26. Transition to fee-for-service will include a safety net to ensure that access to services is not disrupted by providing technical and physical support for providers having difficulty reaching projected fee-for-service billings. This proposal is to be developed in writing. The expert consultant will assist the Department in acquiring expertise and availability to provide technical support as a safety net provision of the conversion process. The Department will identify the technical assistance teat members and contact information that agencies can contact if assistance is needed. This information will be distributed to the Field Test providers prior to the 2nd Quarter of Fiscal Year 2005 and distributed to the remaining providers during the 2nd Quarter of Fiscal Year 2005;	In process. A technical assistance plan is being developed by the Department and expert consultants.
27. The Department will process billing information and vouchers for payment to	In process. The Department

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providers in a timely and efficient manner. Beginning January 1, 2005, the Department will identify providers who experience severe financial hardship as a result of the conversion to a fee-for-service payment methodology pursuant to criteria and procedures established for that purpose. The Department will request the assistance of the Illinois Office of the Comptroller, as necessary, to give providers experiencing severe financial hardship priority payments in accordance with established inter-agency policies and practices;	has identified providers who may experience severe financial hardship and is providing technical assistance to them. Procedures for requesting assistance in cases of "financial hardship" are posted on the website and one agency has applied for priority payment.
28. There will be a revised distribution of Mental Health Trust Fund receipts. Beginning with State Fiscal Year 2005, the first $95,000,000 received by the Department shall be deposited 26.3% into the General Revenue Fund and 73.7% into the Community Mental Health Medicaid Trust Fund. Amounts received in excess of $95,000,000 in fiscal years 2005 and 2006 shall be deposited 50% into the General Revenue Fund and 50% into the Community Mental Health Medicaid Trust Fund. This policy will be reexamined prior to fiscal year 2007;	Completed.
29. The Department will employ an independent 3rd party consultant to undertake an analysis of the historical cost of all community services provided through the Division of Mental Health with stakeholder involvement. This analysis should evaluate historical costs within the system against other publicly funded programs including other states' programs and other private sector programs and existing fiscal policy and articulate the relationship between expenditures, individual and quality. The expert consultant will be available to assist the Department. An extensive status report must be completed and reported to all members of the Senate Health and Human Services Committee, the House Special Committee on Fee-For-Service Initiatives (or its successor in the 94th General Assembly, if any) and the Governor in writing by March 31, 2005 with a final analysis due by April 30, 2005;	In process. DHS has retained Max Chmura, PNP Associates, to conduct a review of historical costs for DMH and DDD. Navigant Consulting, which is the vendor retained by DPA is doing a cost analysis of the SASS program, and CHBA/IARF consultant EP&P has participated in the design features of the study. A summary report will be presented to the legislature by 4-30-05.
30. If the Governor's Office of Management and Budget imposes a general reserve requirement across most or all State agencies, this reserve will not be imposed upon Mental Health community providers;	No reserve has been placed on mental health agencies.
31. Any written report agreed to be provided by any party to this Memorandum of Understanding must also be provided to the Speaker of the House, the House Minority Leader, the President of the Senate, and the Senate Minority Leader.	In process. Evaluation reports will be shared with appropriate legislators.
IN WITNESS WHEREOF, the Parties have caused this Memorandum of Understanding to be executed by their authorized representatives on the 2nd day of July, 2004. For the Governor's Office of Management and Budget: John Filan, Director For the Department of Human Services: Carol L. Adams, Secretary Barbara Flynn Currie, Chairperson, House Special Committee on Fee-For-Service Initiatives Rosemary Mulligan, Republican Spokesperson, House Special Committee on Fee-For Service Initiatives Mattie Hunter, Vice-Chairperson, Senate Health and Human Services Committee Dale Righter, Republican Spokesperson, Senate Health and Human Services Committee	

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A. PURPOSE OF THE AGREEMENT: Illinois's system of publicly funded mental health services and supports is in need of significant change to improve its ability to meet the expectations of consumers, families of individuals needing services, taxpayers, elected officials, payers, and providers. Moreover, the continuing effects of the state's fiscal condition require the mental health system to make some immediate changes. It is important that changes made in the short term are managed so that they do not hinder Illinois's ability to maintain its current level of access or make the longer term restructuring impossible. This Agreement establishes a framework for the Illinois System Restructuring Initiative, which encompasses short term and longer term activities directed toward this end. The Agreement delineates the responsibilities of DHS and reconstitutes the "FFS Task Group" as the "SRI Task Group." The SRI itself will consist of a structured, facilitated, and collaborative proc ess for identifying, testing, adjusting, and implementing a series of activities, including expanding Fee for Service reimbursement, as part of the state's effort to address short and longer term strategies necessary to ensure the availability of affordable, accessible, accountable, high quality community services that respect and are responsive to individuals from all cultures and ethnic groups.	Severe pressures on the State budget and a renewed focus on accountability became the impetus for proposed changes in the funding mechanisms. A House Special Committee on Fee-for-Service Initiatives was convened in the Illinois General Assembly to review the planned transition and to gather input on the impact of the proposed changes. Following a series of hearings with input from consumers, families, advocacy groups, providers of care and representatives of the Administration, DHS and DMH, an agreement was reached on a process for field testing and development of a phased-in conversion to a fee-for-service payment methodology. The Field Test process and the related activities have been guided by the MOU and the MOA and provide the structure of evaluating and reporting the results of specified activities.
B. CORE PRINCIPLES FOR THE SRI PROCESS DHS and the SRI Task Group agree that above all the mental health system must strive to become more recovery and consumer oriented, maintain fiscal sustainability, and improve efficiency and accountability. In addition, the DHS and the SRI Task Group agree to adopt these principles during the SRI process:	Throughout this process, DMH has worked to ensure that our core values are maintained in the system regardless of its funding mechanisms. DMH and its stakeholders have worked throughout this process to ensure the system is committed to values of recovery and appropriate consumer access to effective and efficient services while maximizing available funding
a) The DHS funded mental health system will continue to serve Medicaid and non-Medicaid consumers, placing priority on individuals with severe mental illnesses and emotional disturbances, using the definitions of target population and eligibility currently in place.	Starting in FY 2005, DMH created funding streams for Medicaid and non-Medicaid billing and grants. Clinical priorities have been maintained.
b) The SRI must be managed. DHS and the SRI Task Group will manage the process under the direction of and with support from (an) expert consultant(s). A Steering Committee will be formed to represent the issues of the larger SRI Task Group while facilitating timely discussion and decisions on matters requiring immediate resolution.	DMH has been guided and advised throughout this process by expert consultants, the Steering Committee, the SRI Task Group and the Field Test Group.
c) The SRI must include a Test Phase and Evaluation component.	DMH began meetings with stakeholders to plan the Test Phase in August.
d) The Evaluation component will use baseline system descriptors to determine whether SRI changes advance or retreat from the baseline and these principles.	Mandatory benchmarks have been identified that the system must meet to move forward.

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e) The ability of the mental health system to provide access to services based on consumer and community needs, during and after short term activities of the SRI transition, is one of the key performance indicators the Test Phase and Evaluation components of SRI will monitor.	Access to services was a key benchmark in the Test Phase evaluation.
f) During the transition, the identical rates will be paid for the same services, regardless of the source of state or federal funding.	Medicaid and non-Medicaid rates for the same service are identical.
g) Strategies that expand available resources and improve system efficiency should be identified and, as appropriate, be agreed to by the legislative and executive branches and stakeholders.	This has been a goal throughout the SRI and Field Test process.
h) The SRI process will include activities designed to identify and eliminate redundant state rules, regulations, monitoring and data reporting requirements.	DMH is working with DPA on the possible revision of the Illinois State Plan.
i) Provider sustainability is to be promoted, based on equitable reimbursement for quality services in response to demonstrated need.	The fiscal safety net has maintained monthly payments to providers on an advance and reconcile basis.
j) Strategies should include long-term solutions and a review and assessment process.	This has been a goal throughout the SRI and Test Phase process.
k) Planning must occur to develop an appropriate infrastructure to implement the SRI.	DMH staff have worked with the SRI Task Group on planning.
l) The SRI will use strategies intended to promote consumer access, choice/portability, culturally and multiethnic competent services, and continuity of care.	Preserving consumer choice and access to appropriate services is a key benchmark in the Test Phase evaluation.
m) The SRI will be implemented in a manner that is consistent with the provisions of the July 2, 2004 Memorandum of Understanding between DHS, Governor's Office of Management and Budget, the Vice-Chairperson and Republican Spokesperson for the Senate Health and Human Services Committee, the Chairperson and the Republican Spokesperson of the House Special Committee on Fee-For-Service Initiatives, and federal and state law (as amended from time to time). The Memorandum of Understanding (Attachment A) is incorporated herein as if fully set forth. Strategies, assumptions, and current state and provider system performance will be assessed and, as applicable, field tested before they are mandated in the field.	DMH has complied with the MOU during all phases of the Test Phase.
RESPONSIBILITIES OF DHS AND THE SRI TASK GROUP DHS and the SRI Task Group agree to:	
a) Use the activities, assumptions and timeline set forth in Attachment B as the foundation for developing and implementing a more detailed plan to improve the state's services, financing, billing and monitoring systems consistent with the purpose of this Agreement. The detailed SRI plan and implementation process must enable Illinois to: (1) Articulate a shared strategic vision for its mental health system; (2) Identify and begin to implement long term, specific strategies to realize the vision (3) Continue, refine, test, and implement a purchase of service (fee for service) payment mechanism to generate $25 million additional Medicaid revenue, seeking to minimize increased risks to DHS, providers, and consumers.	John Hornick, Advocates for Human Potential, has been retained as expert consultant and has facilitated multiple meetings involving a wide range of stakeholders to do strategic planning. A final report is being prepared and will be completed by April 30, 2005.
b) DHS and the SRI Task Group agree to manage the transition to a FFS payment mechanism during FY05. DHS and the SRI Task Group agree to work collaboratively and to make all reasonable efforts to increase appropriate Medicaid claiming throughout FY05 to achieve the $25 million target.	DHS and the SRI Task Group have worked collaboratively during this project.
c) Achieving the goals described in this section of the Agreement requires DHS and the SRI Task Group to:	

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(1) Improve state and provider processes associated with continued retroactive claiming, including moving toward the use of automated processes to the greatest extent possible	Lessons learned from the retrospective claiming effort were incorporated into technical assistance protocol that is being provided to individual agencies through the regional networks.
(2) Increase state and provider capacity to submit Medicaid reimbursable claims and to have adequate documentation to support the claims being submitted	Revised service taxonomy pursuant to the changes in Rule 132 adopted in July, 2004 was published in August, 2004 and is available on the DHS website.
(3) Implement a purchase of service reimbursement system in a phased approach, beginning with a Test Phase and Evaluation. Upon completion of the necessary FFS transition tasks, projected to occur during the 3rd quarter of FY05, the state and providers will be prepared to implement FFS claiming for 4th Q trial reconciliation.	The expert consultants recommended and SRI and DHS approved that full reconciliation not begin until FY07.
(4) Assess the achievability of the Medicaid targets during the Test Phase	The Test Phase Financial Workgroup has been charged with this assessment.
(5) Utilize a project and change management approach that involves consumers, providers, and the state as equal partners charged with accomplishing these activities	Consumers, providers and their trade groups and DMH staff have collaborated throughout this process.
(6) DHS and the providers associations and agencies participating as members of the SRI Task Group will work with consumers to provide them with easy access to needed services.	Access to services was a key benchmark in the Test Phase evaluation.
(7) DHS and the SRI Task Group agree to work with consumers and provider agencies throughout the state to achieve an orderly and successful transition to increase the use of Fee for Service purchasing and reimbursement, in conjunction with advances, grants-in-aid, and other financing vehicles, utilizing financial, technological, and administrative infrastructures to access and account for such funding sources.	Consumers, providers and their trade groups and DMH staff have collaborated throughout this process to affect a successful transition.
(8) DHS and the SRI Task Group will oversee a process of articulating a shared Strategic Vision for the mental health system, and the identification and implementation of short and long term strategies to realize the vision.	John Hornick, Advocates for Human Potential, has been retained as expert consultant and has facilitated multiple meetings involving a wide range of stakeholders to do strategic planning. A final report is being prepared and will be completed by April 30, 2005.
(9) DHS and the SRI Task Group agree to ensure that consumers and families are given adequate opportunities to "speak for themselves" on matters assigned to the SRI Task Group and to be able to voice directly their own statements of principles, vision, strategies, proposals, and concerns about the mental health system.	The voices of consumers and their families have been welcomed during the SRI process and several consumer representatives are regular members of the SRI Task Group. Test Phase meetings and workgroups have drawn increasing consumer participation.
(10) Similarly, the SRI Task Group will afford organization-based advocates and agency providers and organizations adequate opportunities to speak for their organizations.	Organization-based advocates and agency providers are regular members of the SRI Task Group.
(11) DHS and the SRI Task Group agree to recognize that support for consumers and families is an essential element of the System Restructuring Initiative (SRI). DHS and the SRI Task Group will identify consumer and family support needs for an infrastructure to encourage organized participation in system governance and management, training, and communication.	The voices of consumers and their families have been welcomed during the SRI process.
(12) DHS agrees to retain an expert consultant(s), to provide facilitation, technical assistance, guidance, expert consultation necessary to actualize the requirements of this Agreement. The expert consultant(s) will serve as SRI project manager. The expert consultants will assist DHS to make periodic reports to the Senate Health and Human Services Committee, the House Special Committee on Fee-For-Service Initiatives (or its successor, if any, in the 94th General Assembly) and the Governor.	DMH continues to work with Parker Dennison and Associates Consulting on these activities.
(13) DHS and the SRI Task Group, with direction and support from the project managers, will work to: (a)Remove barriers to improved access to services (b) Improve state and provider billing practices and compliance monitoring to increase appropriate Fee For Service claims drawing down FFP (c) Explore methods for accessing additional funds through Medicaid Administrative support and claiming (d) Advise DHS regarding more equitable and strategic methods for distributing FFP available to DHS (e) Access expertise and experiences of other states (f) Facilitate the exchange of knowledge between departments and divisions within departments, across branches of state government, and among consumers and providers to improve the system (g) Evaluate, define, refine, implement, and monitor key components of the SRI plan	These tasks have been addressed through the Test Phase workgroups with the guidance of Parker Dennison and Associates Consulting.

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(h) Reduce inefficiencies, including redundant state rules, regulations, procedural and reporting requirements, and explore the feasibility of standardized clinical forms.	
D. EFFECT ON OTHER CONTRACTS Nothing in this Agreement precludes DHS and/or an agency provider from proposing amendments to the FY05 Contract. Contracts for FY05 require all services to be delivered consistent with all applicable federal, state, and local rules and regulations, including the Medicaid Rule 132. Providers not now certified pursuant to Rule 132 will become certified. The contracts include capacity grants-in-aid and Medicaid targets. The contracts introduce flexibility in what services are provided. DHS and the SRI Task Group agree to evaluate the terms of the FY 05 and FY06 Contracts in relation to the assessments and evaluations of the SRI.	DMH has contracted with providers in a manner consistent with this Agreement. The Test Phase Financial workgroup is charged with examining financial issues associated with the contracts.
E. RECONCILIATION OF ADVANCE FUNDING TO FEE FOR SERVICE CLAIMS In FY05, providers will continue to reconcile services to the Grant Funds Recovery Act, using the FY 04 methodologies for grants-in-aid, Medicaid funds during the transition period, including until the transition test phase is completed and conversion for all providers is to occur. Attachment B includes target dates for trial reconciliation. Providers' FFS claims in FY05 will be used to model the performance of the FFS reimbursement system as if claims were reconciled to advances, with no financial risk to providers during the transition period.	The expert consultants recommended and SRI and DHS approved that full reconciliation not begin until FY07.
F. RETROSPECTIVE FEE FOR SERVICE CLAIMING TO CONTINUE Retrospective Fee for Service claiming will continue on a statewide basis so that the mental health system can continue its progress toward achieving the $25 million additional FFP target, while preparing to implement FFS claiming and reconciliation on a statewide basis. Evaluation information resulting from the Test Phase may lead to proposals from DHS or the providers to amend the implementation plans, and/or recommendations from the expert consultant, in order to correct, adjust, and improve any element of the SRI.	Lessons learned from the retrospective claiming effort were incorporated into technical assistance protocol that is being provided to individual agencies through the regional networks.
G. ADVANCED PAYMENTS TO PROVIDERS/RECONCILIATION Payments to providers for FY05 will continue to be advanced to providers in 1/12 payments before the provider reports service data. A projection for federal Medicaid reimbursement, based on FY04 estimated federal Medicaid revenue, is included in the 1/12 advance payments received by providers. The achievability of the Medicaid performance targets for each Test Phase agency provider will be assessed during the Test Phase.	Providers are receiving payment consistent with this Agreement. The Test Phase Financial workgroup is assessing the achievability of the target amounts.
H. UNIQUE CLIENT IDENTIFIERS Medicaid Recipient Identification Numbers (RINs), or unique client identifiers, will be used for all mental health community and state facility consumers, effective FY05. For existing consumers without RINs, the Department agrees to distribute the RINs by July 2, 2004. For new consumers, provider agencies will access RINs via by use of various technologies including a toll free telephone line, facsimile, or electronic communications including e-mail. RINS are not required in order to begin providing services to a consumer but are required for service reporting. The RINs will not have to change if the consumer's Medicaid eligibility changes. Non-Medicaid eligible clients will be tracked as DHS only. The RINS will be maintained to preserve confidentiality. Other DHS clients without Medicaid eligibility will also have RINs. Consumers with a RIN and no Medicaid eligibility will not receive a card. Initial training has occurred during FY04. Additional training responsibilities, frequency and evaluation will be formulated as part of the SRI work plan development. Directions and access numbers were provided via the DMH website June 30, 2004. As part of the SRI Test Phase, steps to refine or improve the RIN process will be identified, if any.	Every registered client is assigned a Recipient Identification Number (RIN). The Department will soon initiate an electronic process for providers to obtain RINs, called eRIN.

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L. LEGACY INFORMATION SYSTEMS CHANGES (ROCS/CRS/FTP) DHS and the SRI Task Group acknowledge that state and provider data systems will continue to require updates and enhancements. Such activities are a "cost of doing business." Costs associated with the interim changes should be addressed through the reconciliation to the Grants Recovery Act process. Costs associated with subsequent, more substantial information system changes should be identified and a plan for funding devised. Previously, third party v endors were provided with specifications for interim changes. Moreover, all third party vendors have been identified for contact on future updates. Beginning with July 2004 service reporting, providers will be able to submit data electronically (File Transfer Protocol, FTP). Providers in the process of transitioning to FTP may continue sending diskettes, at least until the end of service reporting for the first quarter in FY05. DHS and the SRI Task Group acknowledge that coordinating specifications and timing for changes with third party vendors can be challenging, and the ability of providers and their third party vendors to respond to these changes varies by provider and vendor, and also varies with the scope, frequency, and timeframes for the changes. As part of the SRI, DHS and the Task Group agree to examine data systems design and performance (expected and actual), funding mechanisms, HIPAA compliance, and measure retrospectively the ability of vendors to make the initial changes. The SRI will include recommendations for improving future performance and resource utilization to support future changes, if recommended.	The Department has made available the File Transfer Protocol and as of March 31, 2005, 72 mental health agencies are registered. The Department's claim system is HIPAA compliant and MIS has provided technical assistance on HIPAA issues to providers when requested. State readiness issues related to Information Systems and data are being more closely examined beginning in April 2005.
J. STATUS, TRAINING, 90 DAY HOLD HARMLESS WITH REGARD TO REVISED RULE 132 As of the Agreement's effective date, proposed revisions to Rule 132 are pending before the Joint Committee on Agency Rules. The proposed revisions seek to streamline requirements in the existing rule, at the providers' request, and to improve providers' ability to maximize Medicaid claiming. JCAR is expected to consider proposed changes at the July 13, 2004 meeting. Following JCAR approval of the rule, providers will be given 90 days to come into compliance with the new rule. During the ninety day period, providers must comply with either the current rule, or the new rule. Training on the new rule will be scheduled to commence immediately following adoption of the rule and will include training on the definitions of and documentation requirements for covered services. Training is scheduled to occur on July 27, 28, and 29, August 3 and 4, 2004, but these dates are subject to change if JCAR does not pass Rule 132 at its July meeting.	Rule 132 Service Taxonomy was revised in July, 2004 and multiple provider training events were conducted prior to the November 1, 2004 deadline to implement the revised rule.
K. TRAINING AND TECHNICAL ASSISTANCE DHS and the SRI Task Group agree to address all of the following in its detailed SRI work plan: 1) Responsibilities, frequency, and method for training and technical assistance; 2) Utilizing Peer-Based and Learning Environment approaches; 3) Resources available and needed to support training and technical assistance effort; 4) Topics will include, but not be limited to, Rule 132, RIN, ROCS, CRS, FTP, and other topics DHS, the SRI Task Group, and the expert consultants identify; 5) Resources and technical assistance SRI Task Group members can make available to the constituents and organizations they represent; and 6) Methods for evaluation of training and technical assistance provided.	Agencies have been and continue to receive various forms of technical assistance through DMH regional networks and Central Office.
L. COVERED SERVICES Attachment C sets forth the covered mental health services/service taxonomy being funded by DHS in FY05. The SRI, at the earliest	The Rule 132 Service Taxonomy was revised in July, 2004 and multiple provider training events were conducted prior to the November 1, 2004 deadline to implement the revised rule. The Field Test Services Workgroup reviewed this taxonomy and

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possible date, will assess the extent to which these covered services (and the related detailed service definitions, billing codes, billing procedures, documentation requirements, provider qualifications, units of service and rates): 1) are consistent with prevention, recovery and resiliency oriented approaches to service delivery; 2) advance investment and efficiency strategies; 3) can reasonably be expected to be consistent with the mental health system Strategic Vision to be articulated during FY 05; 4) can be adequately documented for compliance and Medicaid reimbursement purposes; and 5) correspond to the current service needs of adults, children and their families, especially the priority populations, and individuals with "special needs" and the provider system's capacity to deliver them. The expert consultant will provide technical assistance to DHS with regard to service taxonomy and Medicaid reimbursement issues. Implementing recommended changes to covered services funded by Medicaid will require further revisions to Rule 132, and the submission of a Medicaid state plan amendment to the Center for Medicare and Medicaid Services, to occur during FY05 per the activities and timeline in Attachment B.	forwarded recommendations for revisions to the SRI Steering Committee. The Workgroup also recommended that revisions be made to the State Medicaid Plan and Rule 132. These recommendations were approved and DHS is initiating discussions with other state agencies.
M. CONSUMER AND FAMILIES SYSTEM GOVERNANCE ROLE DHS and the SRI Task Group agree to foster broad and meaningful participation and decision making by consumers and families in the SRI, the Test Phase, the Evaluation, the assessment of the covered services, and the Strategic Vision process.	The voices of consumers and their families have been welcomed during the SRI process and several consumer representatives are regular members of the SRI Task Group. Test Phase meetings and workgroups have drawn increasing consumer participation.
N. OTHER STATE AGENCIES DHS and the SRI Task Group agree that during the SRI Strategic Vision phase state agencies other than DHS will have an opportunity to identify additional services which could be useful to advance consumers' recovery and resilience or to enhance investment and efficiency strategies.	The SRI Task Group has sought the input of the stakeholder-run Test Phase Services workgroup on services issues.
O. RETROSPECTIVE CLAIMING AND ERROR CORRECTION TO CONTINUE JULY 1, 2004 The mental health system and DHS will continue efforts at retrospective claiming and error correction. The SRI will include an assessment of the current efforts. The SRI will address technical assistance needed to improve the system's ability to obtain Medicaid reimbursement, as appropriate. DHS will utilize its website to post instructions for error correction, etc. As part of the Test phase, DHS and the SRI Task Group will use an expert consultant to automate the process, assess results of the current retrospective claiming and error correction efforts, including the current approach's ability to maintaining program integrity, and to identify information that should be incorporated into the overall transition process.	Lessons learned from the retrospective claiming effort were incorporated into technical assistance protocol that is being provided to individual agencies through the regional networks.
P. STRATEGIC VISION REPORT DHS and the SRI Task Group will oversee a participatory process which will result in DHS producing a Strategic Vision report to serve as the foundation for subsequent analysis and system improvements. The DHS, SRI Task Group, Test Phase participants, other state agencies, members of DHS committees and work groups, community consumers, families and system stakeholders, and others, will be convened to begin to develop a Strategic Vision for the mental health system. The Strategic Vision will recommend additional services which could be useful to advance consumers' health through prevention, recovery and resiliency, increase efficiency, and to make optimum use of available resources, including allowable Medicaid reimbursed services. The Strategic Vision Report will be completed by April 30, 2005. Service changes will be included in further revisions to Rule 132. The Department will submit a state plan amendment to the Center for Medicare and Medicaid Services as necessary.	John Hornick, Advocates for Human Potential, has been retained as expert consultant and has facilitated multiple meetings involving a wide range of stakeholders to do strategic planning. A final report is being prepared and will be completed by April 30, 2005.
Q. TEST PHASE	

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DHS and the SRI Task Group agree that a Test Phase will precede the full, statewide transition to FFS. Of 63 agencies volunteering, DHS selected 30 agencies as Test Phase Participants utilizing stakeholder-determined criteria (agency size, geographic location, level of Medicaid billing, special populations or services, providers of services for youth and for adults). The Test Phase will begin as soon as practicable following JCAR approval of the revisions to Rule 132, and is tentatively scheduled to begin in September 2004. In the event that Revised Rule 132 is not approved by August, 2004, the Test Phase will proceed using the current rule. The Test Phase will continue for 6 months. Prior to September 2004 DHS will provide extensive training to the Test Phase agencies. Beginning January 2005 the Test Phase agencies will participate in trial modeling of the effects of reconciliation to contract advance using fee for service claiming and service reporting. DHS, the SRI Task Group (especially its consumer and advocate members), the expert consultant, and the Test Phase Participants will identify ways to help consumers receiving services in the agencies understand what the SRI is, what the Test Phase is, and to ensure consumers and families are involved in all aspects of the SRI, including educating providers, payers and policymakers regarding service needs and efficiency strategies, as well as being directly involved in problem-solving, quality monitoring, and the development of the Strategic Vision.	Thirty agencies have been identified and are participating in Field Test activities, which began in August 2004. Agencies are receiving various forms of technical assistance through DMH regional networks and Central Office. DMH has also held several training sessions to educate consumers on the SRI process.
R. MONTHLY MEETINGS SRI TASK FORCE AND TEST PHASE PARTICIPANTS DHS and the SRI Task Group agree to meet at least monthly. DHS will also organize monthly meetings with the Test Phase Participants. The project manager may require that the groups meet together on occasion. DHS will record and distribute meeting minutes, and post draft and approved minutes on its website.	Both the SRI Task Group and the Test Phase group have met on a monthly basis. The Test Phase group assigned tasks to workgroups, who met both in-person and by teleconference throughout the Test Phase. Minutes of the meetings are available at the DMH website at http://www.dhs.state.il.us/mhdd/mh/sri/.
S. TEST PHASE EVALUATION COMPONENTS During the FFS Test Phase, the expert consultant will assist DMH and the SRI Task Group to evaluate system performance. The expert consultant's evaluation design will focus on the following elements:	The Field Test Evaluation Report is being developed and will be submitted to the legislature April 29, 2005. The Department is working with the expert consultants and SRI to plan for the next phase of evaluation and implementation.
1) Access to services (penetration, intake and utilization patterns for grants vs. FFS reimbursement)	Addressed by the Test Phase Access and Eligibility workgroup.
2) Feasibility and costs of using the Washington Circle Model's approach to measuring access	Consideration was given to test Washington Circle Model with small subgroup of Field Test Agencies. On 1/19/05 the Access and Eligibility workgroup recommended to the SRI Task Group that the WC Model not be used for mental health services at this time.
3) Feasibility and costs of measuring service quality through fidelity scales for Evidence Based Practices	As the Services work group recommends new services, will note whether the service is an EBP and where data is available, will identify costs from other states to implement the recommended EBP.
4) Methods for, and feasibility and costs of, closing service quality gaps	Service quality issues were addressed by the Services workgroup.
5)Consumer satisfaction (MHSIP and/or Consumer Quality Reviewers) and targeted surveys with regard to how consumers and families feel about changes occurring in the system during FY05	The MHSIP Consumer Survey was administered at Test Phase agencies, with over 1,500 responses received. These responses are currently being entered and analyzed, and will also provide a valuable baseline measure of consumer perceptions.
6) Current and Test Phase system performance with regard to maintaining program integrity	Addressed by the Test Phase Services workgroup.
7) Whether fee for service reimbursement, in combination with all other public funding accessed by a particular provider agency, is reasonably consistent with efficiency, economy, and quality of care, as required by federal Medicaid law , adequately reimburses providers for care the state is purchasing, and can result in fiscal sustainability (sufficient revenue and cash flow for agencies and the Department)	Addressed by the Test Phase Financial workgroup.
8) Validity of agency provider-specific Medicaid claiming targets	Addressed by the Test Phase Financial workgroup.
9) The impact of the conversion initiative's primary objectives	The Test Phase Services workgroup has worked to evaluate if

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	services would be negatively impacted by the conversion initiative.
10) The benefits and viability of converting to FFS	Benefits and viability of conversion is covered in the Evaluation Report.
11) The impact of conversion on each individual provider participating in the Test Phase	Impact of conversion is addressed in the Evaluation Report.
12) Effectiveness of state and provider claims processes in increasing Medicaid revenue	Potential increase in FFP is addressed in the Evaluation Report.
13) State and provider system improvements to advance consumer ownership, recovery, resilience and program integrity and estimating costs and/or savings associated with implementing the improvements	The Services Workgroup developed a Recovery/Resiliency Philosophy that will serve as the foundation in future works with service taxonomy.
14) Clinical/utilization changes caused by the changed reimbursement methodology	The Test Phase Services workgroup has worked to evaluate if services would be negatively impacted by the conversion initiative.
15) Whether the streamlined Rule 132 reduces or increases the proportion of Medicaid reimbursable services, and whether it increases or decreases compliance risks/costs	The Field Test Services Workgroup reviewed the Rule 132 service taxonomy and forwarded recommendations for revisions to the SRI Steering Committee.
16) Evaluation of training and technical assistance provided, future needs and financing for training and technical assistance	A training and technical assistance protocol is being provided to individual agencies through the regional networks.
17) Identification of and methods for financing state and provider conversion costs	The issue of transition costs is addressed in the Evaluation Report.
18) The service and case mix of Medicaid and non Medicaid consumers that can be supported by the state and provider delivery system once it moves to increased reliance on FFP.	The provider readiness review suggests that there is very limited waiting to access assessment and services for either Medicaid or non-Medicaid system wide.
The SRI Task Group will refine the evaluation design at the earliest date possible. A preliminary written evaluation report will be completed by December 30, 2004. A final written evaluation report, with recommendations, will be completed by April 30, 2005. The preliminary interim report and the final report, along with recommendations for adjustments to address findings for each evaluation component, will be presented to the SRI Task Group and the Test Phase participants, which will consider the findings and make recommendations to DHS. DHS agrees to provide a written response to these recommendations. The reports, recommendations of the SRI Task Group and Test Phase Participants' Group, and the DHS responses will be submitted in writing to all members of the Senate Health and Human Services Committee and of the House Special Committee on Fee-For-Service Initiatives (or its successor in the 94th General Assembly, if any), Legislative Leadership, and the Governor.	DMH is following the recommended process and timelines and will submit the final evaluation report by April 30, 2005.
T. RISK MANAGEMENT (SAFETY CUSHION) DURING TRANSITION DHS and the SRI Task Group agree to monitor the extent to which the SRI is being implemented without increasing risks to consumers and providers. SRI components intended to reduce these risks include 1) financial arrangements for F05, including no financial risk and trial reconciliation of FFS claims to advances; 2) assessment of retrospective billing, including compliance risks; 3) maintaining current consumer eligibility; 4) utilizing regular meetings in the collaborative project management process to allow for early identification of problems; 5) the Test Phase and Evaluation reports; 6) training and support initiatives for providers and for consumers; 7) the use of the expert consultant as project manager, facilitator, and technical and strategic advisor; and 8) close supervision of the process by the executive and legislative branches.	DMH has followed these recommendations to reduce FFS related provider destabilization.
U. EFFECTIVE AND EFFICIENT SRI COMMUNICATIONS DHS and the SRI Task Group recognize that ongoing and efficient communication is essential to the success of the transition. Using peer based and learning environment approaches, the department will establish a web-based mechanism to facilitate rapid exchange of information on issues relevant to the SRI. A "contact us" or email address will be provided where individuals can ask questions; answers will be posted/sent as soon as possible. Draft and approved minutes will be utilized to record the meetings associated with the FFS implementation. Drafts of documents will be distributed to solicit feedback. DHS and the SRI Task Group will monitor the types of questions and problems being encountered during the transition and propose training and support activities, as well as adjustments to the overall strategy, to address persistent and unresolved issues.	Pertinent information is routinely posted on the DHS DMH website and email is the preferred means of communication among stakeholders.
V. IMPROVING ACCESS TO MEDICAID ELIGIBILITY	DHS has provided multiple tools and training opportunities for state

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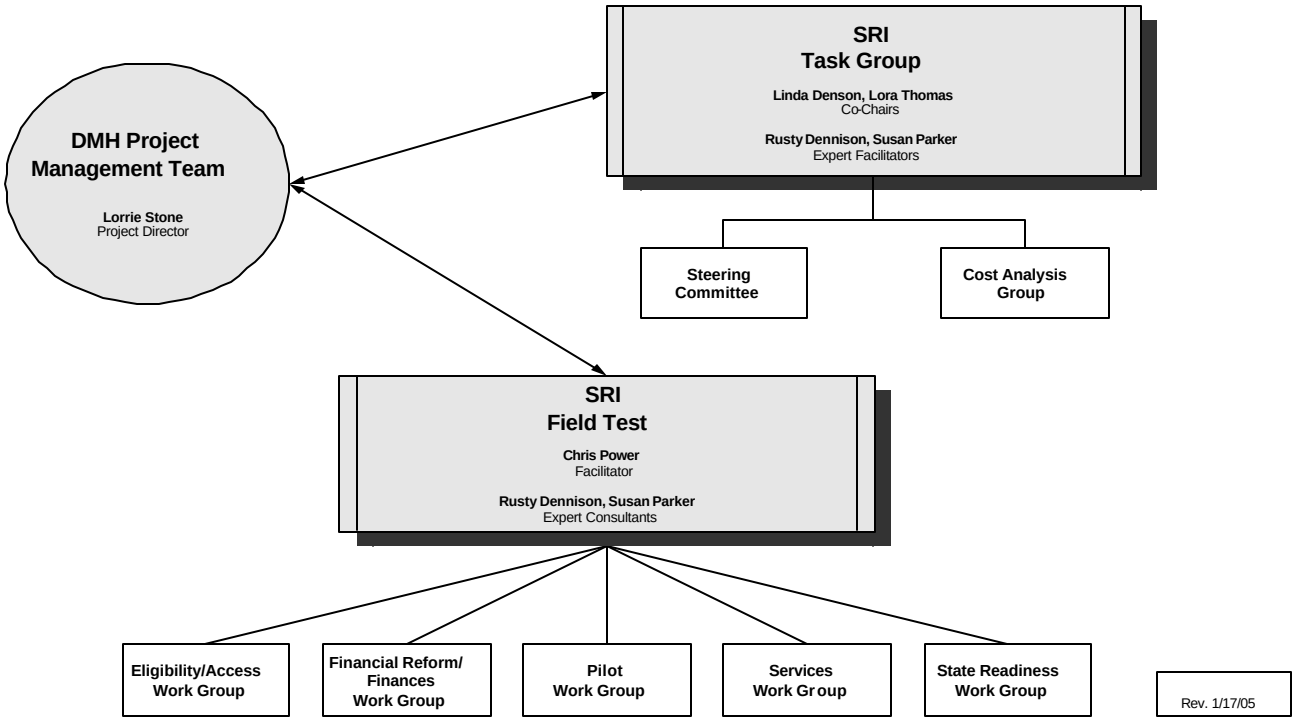
DHS agrees to implement state and provider processes to ensure that persons with serious mental illnesses or emotional disturbances, who otherwis e meet Medicaid eligibility requirements, actually gain or retain that Medicaid eligibility. Tools and training will be provided, first to state hospital staff and community hospitals with contracts with DMH (CHIPS), and then to community agencies and other hospitals. DHS agrees to continue its efforts with the Department of Public Aid to ensure that mental health consumers retain their eligibility for Medicaid while receiving services in State mental health hospitals. Although Medicaid eligibility will not be automatically lost by a person residing in an Institute for Mental Diseases, federal law prohibits Medicaid from paying for *any* Medicaid services during the person's residence in an IMD. The change to keep open these person's Medicaid eligibility, effective July 1, 2004, ensures that consumers can link with needed mental health services and get other Medicaid services upon discharge. The SRI Task Group agrees to encourage all providers to pursue Medicaid eligibility on behalf of consumers as an es sential part of the case management process.	and community hospital staff and community agency staff. See "Summary of Training and Technical Assistance Initiatives in Support of SRI" in the Field Test Evaluation Report Appendix.
W. DEVELOPMENT OF PROPOSAL FOR MEDICAID ADMINISTRATIVE FUNDS The Department will solicit a contractor to assist the state in developing the State Plan amendment and implementing the necessary processes to claim Medicaid administrative support in the community mental health system. In consultation with the SRI Task Group, the expert consultant will provide oversight to ensure that the proposals are consistent with fee-for-service reimbursement mechanisms and applicable federal law. In reviewing the proposals, the expert consultant will include an assessment of compliance risks, the status of the infrastructure required to implement the proposals, and any ancillary or direct impacts on clinical services and/or the fee-for-service reimbursement system.	The State is in the process of issuing an RFP to develop a methodology for obtaining federal matching funds for administrative costs.
X. COUNTERPARTS, ELECTRONIC EVIDENCE OF EXECUTION DHS and the SRI Task Group members agree to execute this Agreement in the most efficient means possible, and agree to accept in lieu of a handwritten mark a received electronic mail message indicating "I agree" along with identification of the sender and the date. Such handwritten marks and electronic mail messages will operate to execute the Agreement.	

Appendix B: Field Test Structure

Department of Human Services (DHS)
Division of Mental Health (DMH)
SYSTEM RESTRUCTURING INITIATIVE (SRI) ORGANIZATION



NOTE: SEE REPORT SECTION "METHODOLOGY AND PROCESS" FOR DETAILED ASSIGNMENTS AND GOALS OF THE FIELD TEST GROUPS.

System Restructuring Initiative (SRI) Task Group Members

NAME	AFFILIATION / AGENCY
Brian Allen *President*	Mental Health Centers of Central Illinois (MHCCI)
Salim Al Nurridin *Executive Director*	Healthcare Consortium of Illinois
Frank Anselmo, MPA *Chief Executive Officer* **Marion Sleet** (alternate) *CBHA Consultant*	Community Behavioral Healthcare Association of Illinois (CBHA)
Mike Boyle *President/CEO*	Fayette Companies
MaryLynn M. Clarke *Health Policy and Regulation*	Illinois Hospital Association
Luberta Conner *Consumer Engagement Specialist*	Community Mental Health Council
Caroll Cradock, Ph.D. *Director*	Behavioral Health Services - Advocate Illinois Masonic Medical Center
Linda Denson, Co-Chair of SRI *Executive Director*	Sankofa Organization of IL, Inc.
Frederica Garnett, Rh.D. *Executive Director*	Delta Center, Inc.
Frank Kopel *Chief, Bureau of Program and Reimbursement Analysis*	Department of Public Aid
Tony Kopera, Ph.D. *Executive Director* **Victoria (Tory) C. Ruder** (alternate) *Chief Fiscal Officer*	Community Counseling Centers of Chicago
Nanette Larson *Director, Consumer Services Development*	DHS Division of Mental Health
Orville Mercer *Executive Director*	Chestnut Health Systems
Lena Raimondo *Consumer Engagement Specialist*	Thresholds
Janet Stover *Executive Director*	Illinois Association of Rehabilitation Facilities
Hayward Suggs *Senior Vice President* **Renee Terrell** (alternate)	Community Mental Health Council (CMHC)
Lora Thomas, Co-Chair of SRI *Executive Director*	NAMI Illinois
Robert W. Vyverberg, Ed.D *Chief of Staff*	DHS Division of Mental Health
Frank H. Ware *Executive Director*	Janet Wattles Center
Donald P. Wells *Consumer Engagement Specialist*	Fayette Companies
Anthony Zipple *Executive Director*	Thresholds

LEGISLATIVE

NAME	AGENCY
Angie Sidles	Senate Republican Staff
Cynthia Riseman	House Republican Staff
Kurt R. Deweese	House Democratic Staff (Speaker's Staff)
Marina Y. Martinez	Senate Democratic Staff (Senate President's Staff)

SRI CONSULTANTS

NAME	AGENCY
Susan Parker	Parker Dennison & Associates, Ltd.
Rusty Dennison	Parker Dennison & Associates, Ltd.
Gretchen Engquist	E P&P Consulting

Field Test Agencies

Ada S McKinley Comm Serv Inc
Association House
Call for Help Inc
Coles Co Mental Hlth Assn Inc
Community Counseling Ctr Chgo
Community Counseling of N Madison
Community Mental Hlth Cncl Inc
Crosspoint Human Services
Delta Center
Dewitt County
Dupage County
Egyptian Public & Mental
Family Services of Oak Park
Hancock County Mental Health
Heartland Human Services
Heritage Behavioral Health Ctr
Human Resources Dev Inst Inc
Janet Wattles Center
Kenneth Young Center
Mental Health Center of Champaign
Mental Health Ctrs of Cntrl IL
Metropolitan Family Services
Montgomery County
Mount Sinai Hosp Medical Ctr
Perry County Counseling
Pilsen-little Village Mental
Robert Young Center
Thresholds
Will County
Youth Services of McHenry

Field Test Meetings and Participants

Minutes of Field Test meetings are available at the DMH SRI website at http://www.dhs.state.il.us/mhdd/mh/sri/.

FIELD TEST MEETINGS	08/11/04	08/18/04	08/26/04	09/09/04	10/14/04	11/30/04	01/18/05	02/22/05	03/29/05
Ada S McKinley Comm Serv Inc Consumer or Consumer Liaison: M.M. K.V.			Hans Schuster Leatrice Allen		Hans Schuster Leatrice Allen	Hans Schuster	Hans Schuster Leatrice Allen	Hans Schuster Leatrice Allen Mark Moses	Hans Schuster Leatrice Allen Pat Henninger Consumer 1 Consumer 2
Association House of Chicago			Gustavo Espinosa		Gustavo Espinosa Wanda Figueroa	Javier Santoyo			
Chestnut Health Systems	Orville Mercer	Orville Mercer							
Call for Help Inc			Johnnie Pennelton Angela Barnes Ivette Maldonado	Johnnie Pennelton			Johnnie Pennelton Tonya Williams-Jones		
Coles Co Mental Hlth Assn Inc Consumer or Consumer Liaison: A.H			Kathleen Roberts Judy Hester Lynnette Ashmore	Kathleen Roberts Judy Hester Lynnette Ashmore	Kathleen Roberts	Kathleen Roberts	Kathleen Roberts Lynnette Ashmore	Kathleen Roberts	Consumer 1
Community Counseling Ctr Chgo	Tory Ruder	Tony Kopera Tory Ruder	Tony Kopera		Tony Kopera Tory Ruder	Tony Kopera Tory Ruder	Tony Kopera	Tony Kopera Tory Ruder	
Community Counseling of N Madison			Karen Sopronyi Amy Frey	Karen Sopronyi	Karen Sopronyi		Karen Sopronyi		Karen Sopronyi Kelly Norris
Community Mental Hlth Cncl Inc Consumer or Consumer Liaison L.C. B.B.			Hayward Suggs Tommie Williams David Goodlow		Hayward Suggs	Hayward Suggs Patricia Smith-Huntoon Pat Havis Consumer 1	Consumer 1	Patricia Smith-Huntoon Gia Buckner-Hayden Consumer 1 Consumer 2	Hayward Suggs Patricia Smith-Huntoon Gia Buckner-Hayden Consumer 2

FIELD TEST MEETINGS	08/11/04	08/18/04	08/26/04	09/09/04	10/14/04	11/30/04	01/18/05	02/22/05	03/29/05
Crosspoint Human Services B.J.			Thom Pollock Jeana Johnson Carol Pichon Consumer 1	Carol Pichon	Thom Pollock Jeana Johnson	Thom Pollock Jeana Johnson Carol Pichon Consumer 1	Thom Pollock	Thom Pollock Consumer 1	Thom Pollock Consumer 1
Delta Center	Frederica Garnett	Frederica Garnett	Frederica Garnett Lisa Tolbert Donna Abeln		Lisa Tolbert	Frederica Garnett	Frederica Garnett	Frederica Garnett	
Dewitt County			Cheryl Lietz	Cheryl Lietz	Cheryl Lietz	Cheryl Lietz			Cheryl Lietz Elizabeth Buccini
Dupage County Consumer or Consumer Liaison: G.C.			David Christiansen	David Christiansen		David Christiansen John-Marc Bilzikian	David Christiansen	David Christiansen	Consumer 1
Egyptian Public & Mental Consumer or Consumer Liaison: G.S. D.S.			Angie Hampton John Oglesby Troy Milligan	Angie Hampton	Angie Hampton	Angie Hampton Camille Harris	Angie Hampton		Angie Hampton Consumer 1 Consumer 2
Family Services of Oak Park			Dan Kill	Dan Kill	Dan Kill	Dan Kill	Dan Kill	Dan Kill Virginia Goldrick	
Hancock County Mental Health				Sean Eifert	Sean Eifert		Sean Eifert		Sean Eifert Jim Yager
Heartland Human Services Consumer or Consumer Liaison J.L			Cheryl Compton Celeste Garrett Linda Cummins Lisa Ballinger Brooke Durbin	Cheryl Compton	Cheryl Compton	Cheryl Compton	Cheryl Compton Linda Cummins Brenda Bower		Cheryl Compton Celeste Garrett Linda Cummins Consumer 1
Heritage Behavioral Health Ctr			Diane Knaebe Candace Clevenger Terry Haru	Diane Knaebe	Diane Knaebe	Diane Knaebe	Diane Knaebe	Candace Clevenger	Diane Knaebe Candace Clevenger Cindy Sargent Drake Dickerson Danny Hill Dallas Miller
Human Resources Dev Inst Inc			Evelyn Willis R. Richardson Victor Sutton			R. Richardson Victor Sutton Nicole Brown L. McMillan Pat Kates	Evelyn Willis	Evelyn Willis R. Richardson Pat Kates	Evelyn Willis

FIELD TEST MEETINGS	08/11/04	08/18/04	08/26/04	09/09/04	10/14/04	11/30/04	01/18/05	02/22/05	03/29/05
Janet Wattles Center Consumer or Consumer Liaison: B.G.	Frank Ware Teresa Lower		Frank Ware Teresa Lower Joan Lodge	Frank Ware	Frank Ware			Frank Ware Teresa Lower Joan Lodge Tanya Hoemke Consumer 1	Frank Ware Tanya Hoemke Consumer 1
Mental Health Center of Champaign			Sheila Ferguson Susan Gregory Wanda Burnett	Sheila Ferguson Susan Gregory Wanda Burnett	Sheila Ferguson		Sheila Ferguson	Wanda Burnett	Wanda Burnett
Mental Health Ctrs of Cntrl IL Consumer or Consumer Liaison: P.C.	Brian Allen	Brian Allen	Brian Allen Robyn Luke	Robyn Luke	Brian Allen		Brian Allen		Brian Allen Consumer 1
Metropolitan Family Services Consumer or Consumer Liaison: P.G.			Colleen Jones Dennis Hurley Craig Deutch	Sally Frau Craig Deutch	Colleen Jones Dennis Hurley Sally Frau	Dennis Hurley Sally Frau	Colleen Jones	Colleen Jones Consumer 1	Suzanne Strassberger
Montgomery County			Kurt Simon Hugh Satterlee				Kurt Simon Hugh Satterlee		Kurt Simon Hugh Satterlee
Mount Sinai Hosp Medical Ctr			Beverly Robinson		Dave Wilson		Dave Wilson		Dave Wilson
Perry County Counseling			John Venskus		John Venskus	John Venskus	John Venskus		John Venskus
Pilsen-little Village Mental			Francisco Cisneros Nora Navarro Alma Ladesma Rebecca Hill	Nora Navarro				Sarah Godinez	Sarah Godinez Charles DaFuria
Robert Young Center			Rich Murphy Diane Zogg Michael Freda	Rich Murphy Diane Zogg Michael Freda	Rich Murphy Diane Zogg Michael Freda	Rich Murphy Michael Freda		Rich Murphy Michael Freda	
The Kenneth W Young Centers			Gongmin Mou Beth Thomas	Gongmin Mou Susan Reynolds		Gonmin Mou Susan Reynolds Mitch Bruski		Mitch Bruski	Mitch Bruski
The Thresholds Consumer or consumer Liaison: L.R. J.G R.B.			Doug Kolasinski Carrie Mastoris	Carrie Mastoris	Doug Kolasinski	Doug Kolasinski	Carrie Mastoris Virginia Goldrick Consumer 1	Virginia Goldrick	Anthony Zipple Virginia Goldrick Geo Langston Consumer 2 Consumer 3

FIELD TEST MEETINGS	08/11/04	08/18/04	08/26/04	09/09/04	10/14/04	11/30/04	01/18/05	02/22/05	03/29/05
Will County			Randy Bultran Joe Roche		Joe Roche	Randy Bultran Joe Troiani	Randy Bultran		Randy Bultran Joe Roche
Youth Services of McHenry					Susan Krause		Susan Krause	Susan Krause	
DHS Central Office	Carolyn Kopel		Carolyn Kopel						
DHS/DMH Central Office	Chris Power	Chris Power Mary Smith	Chris Power Mary Smith Mike Pelletier Brittan Harris Fred Nirde Barb Drabing	Chris Power Mary Smith Mike Pelletier Brittan Harris Fred Nirde Barb Drabing	Chris Power Mary Smith Mike Pelletier Brittan Harris Fred Nirde	Chris Power Mary Smith Mike Pelletier Brittan Harris Dennis Smith Jackie Manker Wei Shin Wang Ricardo Rivera Jamal Nasir Kathie Nee	Chris Power Mary Smith Mike Pelletier Brittan Harris Jackie Manker	Chris Power Mary Smith Mike Pelletier Brittan Harris Dennis Smith Jackie Manker Bob Vyverberg Nanette Larson	Chris Power Jackie Manker Dennis Smith Barb Drabing Nanette Larson Joyce Lane
DHS/DMH Metro North			Dan Wasmer Ann Reiher	Dan Wasmer Carol Vollendorf	Dan Wasmer Carol Vollendorf	Ann Reiher	Dan Wasmer Ann Reiher	Dan Wasmer	Kathy Houchins
DMS/DMH Metro West			Bob Granger Gordon Reiher	Bob Granger	Bob Granger Gordon Reiher	Gordon Reiher	Gordon Reiher		Gordon Reiher
DHS/DMH Metro South			Brenda Hampton	Brenda Hampton	Brenda Hampton	Bob Granger	Bob Granger	Bob Granger	Bob Granger
DHS/DMH Greater IL North			Chuck Hoffman	Chuck Hoffman	Chuck Hoffman	Chuck Hoffman		Chuck Hoffman Bruce Bonecutter	Bruce Bonecutter
DHS/DMH Metro C&A			Dessie Trohalides	Kathy Houchins	Dessie Trohalides Kathy Houchins	Kathy Houchins	Kathy Houchins		
DHS/DMH Greater IL Central			Steve Medhurst Ruth Hibberd-Anderson Jordan Litvak Rick Long	Steve Medhurst Ruth Hibberd-Anderson Jordan Litvak Rick Long	Steve Medhurst	Steve Medhurst Ruth Hibberd-Anderson	Steve Medhurst Jordan Litvak Ron Johnstone	Steve Medhurst Ruth Hibberd-Anderson	Ruth Hibberd-Anderson Steve Medhurst Jordan Litvak Ron Johnstone
DHS/DMH Greater IL South			Jim Ingram Michael Len Monica Bert Tracy Williams	Jim Ingram Michael Len Monica Bert Tracy Williams	Jim Ingram Michael Len Monica Bert Tracy Williams	Jim Ingram Michael Len Monica Bert Tracy Williams Debbie Dyle	Michael Len Monica Bert Tracy Williams Debbie Dyle	Michael Len Monica Bert	Michael Len Monica Bert Tracy Williams Rhonda Keck

FIELD TEST MEETINGS	08/11/04	08/18/04	08/26/04	09/09/04	10/14/04	11/30/04	01/18/05	02/22/05	03/29/05
DPA Staff				Frank Kopel	Frank Kopel Jackie Ellinger	Frank Kopel Jackie Ellinger Greg Wilson	Greg Wilson		Frank Kopel Greg Wilson
Other Consumers or Consumer Liaisons:	L.D.Sankofa Org. L.T.NAMI D.W.DHS/DMH	L.D. Sankofa Org. L.T.NAMI D.W.DHS/DMH	L.D. Sankofa Org.	L.D. Sankofa Org.	L.D. Sankofa Org. C.C McFarland MHC	L.D. Sankofa Org. C.C .McFarland MHC	L.D.Sankofa Org. C.C.McFarland MHC	L.D.Sankofa Org. C.C.McFarland MHC D.W.DHS/DMH	L.T.NAMI C.C.McFarland MHC D.W.DHS/DMH
Consultants: Susan Parker/Parker Dennison Rusty Dennison/Parker Dennison Patrick Lanahan Max Chmura			Patrick Lanahan		Susan Parker Rusty Dennison	Susan Parker Rusty Dennison	Susan Parker Rusty Dennison Max Chmura	Susan Parker Rusty Dennison	Susan Parker Rusty Dennison
Trades: Marian Sleet CBHA Heather Eagleton IARF Janet Stover IARF	Heather Eagleton Janet Stover	Heather Eagleton			Marion Sleet	Marion Sleet		Marion Sleet	Marian Sleet Heather Eagleton

Field Test Workgroups

Minutes of Workgroup meetings are available at the DMH SRI website at http://www.dhs.state.il.us/mhdd/mh/sri/. Workgroups met frequently outside of the main workgroup meetings to solve specific issues. Those "sub-workgroup" meetings did not produce formal minutes so their products and decisions are represented in the main workgroup minutes.

ACCESS/ELIGIBILITY WORKGROUP	Teleconference 12/20/05	1/18/05	2/24/05
Ada S McKinley Comm Serv Inc		Leatrice Allen	Leatrice Allen
Association House of Chicago			
Call for Help Inc			
Coles Co Mental Hlth Assn Inc			
Community Counseling Ctr Chgo	Tony Kopera	Tony Kopera	Tony Kopera
Community Counseling of N Madison			
Community Mental Hlth Cncl Inc Consumer or Consumer Liaison: L.C.		Patricia Smith-Huntoon Consumer 1	Patricia Smith-Huntoon Consumer 1
Crosspoint Human Services Consumer or Consumer Liaison: B.J.	Consumer 1	Consumer 1	Consumer 1
Delta Center			
Dewitt Co Human Resource Ctr			
Dupage County		John-Marc Bilezikian	John-Marc Bilezikian
Egyptian Public & Mental			
Family Service MHC of Oak Park	Dan Kill	Dan Kill	Dan Kill
Hancock County Mental Health	Sean Eifert		
Heartland Human Services	Lisa Ballinger Celeste Garrett		
Heritage Behavioral Health Ctr	Diane Knaebe		
Human Resources Dev Inst Inc			

ACCESS/ELIGIBILITY WORKGROUP	Teleconference 12/20/05	1/18/05	2/24/05
Janet Wattles Center			
Mental Health Center of Champaign	Susan Gregory	Sandy Lewis	Sandy Lewis
Mental Health Ctrs of Cntrl IL			
Metropolitan Family Services	Kathy Antos	Kathy Antos	Kathy Antos
Montgomery County			
Mount Sinai Hosp Medical Ctr			
Perry County Counseling Center			
Pilsen-little Village Mental		Greg DeSadier	Greg DeSadier
Robert Young Center for			
The Kenneth W Young Centers	Gongmin Mou		
The Thresholds			Mary Anzilotti
Will County			
Youth Services of McHenry County	Susan Krause	Susan Krause	Susan Krause
DHS/DMH	Ruth Hibberd-Anderson Kathy Houchins Michael Pelletier Mary E. Smith Tracey Williams	Mike Pelletier Jackie Manker Ruth Hibberd-Anderson Gustavo Espinosa Mary E. Smith	Mike Pelletier Jackie Manker Ruth Hibberd-Anderson Gustavo Espinosa Mary Smith
DPA Staff	Jacqetta Ellinger	Jackie Ellinger	Jackie Ellinger
Consultants: Susan Parker/Parker-Dennison Norman Brier/Hornick and Associates		Susan Parker	Susan Parker Norman Brier

FINANCIAL WORKGROUP MEETINGS	1/13/05	Teleconference 1/28/05	Teleconference 2/04/05	Teleconference 2/14/05	2/22/05
Ada S McKinley Comm Serv Inc					
Association House of Chicago	Javier Santoyo	Javier Santoyo	Javier Santoyo	Javier Santoyo	Javier Santoyo
Call for Help Inc	Ivette Maldonado-Oritz	Ivette Maldonado-Oritz	Ivette Maldonado-Oritz	Ivette Maldonado-Oritz	Ivette Maldonado-Oritz
Coles Co Mental Hlth Assn Inc	Crystal Stapleton	Crystal Stapleton, Kathy Roberts	Crystal Stapleton Kathy Roberts	Crystal Stapleton Kathy Roberts	Crystal Stapleton
Community Counseling Ctr Chgo	Tory Ruder Tony Kopera	Tory Ruder	Tory Ruder	Tory Ruder Tony Kopera	Tory Ruder
Community Counseling of N Madison					
Community Mental Hlth Cncl Inc Consumer or Consumer Liaison: B.B.	Tommie Williams	Tommie Williams Glenda Russell	Tommie Williams Glenda Russell	Tommie Williams Glenda Russell	Tommie Williams Glenda Russell Consumer 1
Crosspoint Human Services	Thom Pollack	Thom Pollack		Thom Pollack	Thom Pollack
Delta Center	Frederica Garnett	Frederica Garnett Lisa Tolbert	Lisa Tolbert		Frederica Garnett
Dewitt Co Human Resource Ctr	Cheryl Lietz	Cheryl Lietz			
Dupage County					
Egyptian Public & Mental					
Family Service MHC of Oak Park					
Hancock County Mental Health					
Heartland Human Services	Cheryl Compton Celeste Garrett	Cheryl Compton Celeste Garrett	Cheryl Compton Celeste Garrett	Cheryl Compton Celeste Garrett	Cheryl Compton Celeste Garrett
Heritage Behavioral Health Ctr	Candy Clevenger	Candy Clevenger	Candy Clevenger	Candy Clevenger	Candy Clevenger
Human Resources Dev Inst Inc	Evelyn Willis R. Richardson Patrician Kates	Evelyn Willis	Evelyn Willis R. Richardson	Evelyn Willis R. Richardson	Evelyn Willis Patricia Kates
Janet Wattles Center					
Mental Health Center of Champaign	Wanda Burnett	Wanda Burnett	Wanda Burnett	Wanda Burnett	Wanda Burnett
Mental Health Ctrs of Cntrl IL					
Metropolitan Family Services	Dennis Hurley	Dennis Hurley			Dennis Hurley
Montgomery County					
Mount Sinai Hosp Medical Ctr	David Wilson	David Wilson		David Wilson	David Wilson
Perry County Counseling Center					

FINANCIAL WORKGROUP MEETINGS	1/13/05	Teleconference 1/28/05	Teleconference 2/04/05	Teleconference 2/14/05	2/22/05
Pilsen-little Village Mental	Sarah Godinez	Sarah Godinez		Sarah Godinez	Sarah Godinez
Robert Young Center for	Rich Murphy	Rich Murphy	Rich Murphy	Rich Murphy	Rich Murphy
The Kenneth W Young Centers	Beth Thomas	Beth Thomas	Beth Thomas	Beth Thomas	Beth Thomas
The Thresholds	Doug Kolasinski Elise Askren	Doug Kolasinski Elise Askren	Doug Kolasinski	Doug Kolasinski, Elise Askren	Doug Kolasinski
Will County					
Youth Services of McHenry					
DHS/DMH Central Office	Chris Power Dennis Smith Randy Pletcher Fred Nirde Mike Pelletier	Chris Power Dennis Smith Randy Pletcher Mike Pelletier	Chris Power Dennis Smith Randy Pletcher	Chris Power Dennis Smith Randy Pletcher Mike Pelletier	Chris Power Dennis Smith Mike Pelletier
DHS/DMH	Steve Medhurst Tracy Williams Monica Bert Mike Len Jordan Litvak	Steve Medhurst Chuck Hoffman Jordan Litvak	Steve Medhurst Chuck Hoffman Mike Len Jordan Litvak	Steve Medhurst Chuck Hoffman Mike Len Jordan Litvak	Steve Medhurst Chuck Hoffman Mike Len Jordan Litvak
DPA Staff Greg Wilson Frank Kopel	Greg Wilson	Greg Wilson		Greg Wilson Frank Kopel	Greg Wilson
Consultants: Susan Parker/Parker-Dennison Gretchen Engquist/EP&P Lana/EP&P	Susan Parker Gretchen Engquist EP&P	Susan Parker Gretchen Engquist	Susan Parker Gretchen Engquist	Susan Parker Lana EP&P	Susan Parker Gretchen Engquist
Trades: Marion Sleet/CIBHA Mike Bach/CIBHA Heather Eagleton/IARF	Marion Sleet Mike Bach Heather Eagleton	Mike Bach	Marion Sleet Heather Eagleton	Marion Sleet	Marion Sleet Heather Eagleton

PILOT TEST WORKGROUP MEETINGS	12/09/04	01/18/05	02/24/05
Ada S McKinley Comm Serv Inc	Hans Schuster	Hans Schuster	
Association House of Chicago			
Call for Help Inc			
Coles Co Mental Hlth Assn Inc	Kathy Roberts	Kathy Roberts	Kathy Roberts
Community Counseling Ctr Chgo Consumer or Consumer Liaison: M.S.C4	Tony Kopera Consumer 1		 Consumer 1
Community Counseling of N Madison			
Community Mental Hlth Cncl Inc Consumer or Consumer Liaison: L.C.	Tommie Williams David Goodlow	Tommie Williams	Tommie Williams David Goodlow Consumer 1
Community Mental health of Champaign			Sandy Lewis
Crosspoint Human Services	Thom Pollack		Thom Pollack
Delta Center	Frederica Garnett	Frederica Garnett	Frederica Garnett
Dewitt Co Human Resource Ctr			
Dupage County			
Egyptian Public & Mental			
Family Service MHC of Oak Park	Jason Kinnan		
Hancock County Mental Health			
Heartland Human Services	Cheryl Compton Darrell Webb		
Heritage Behavioral Health Ctr			
Human Resources Dev Inst Inc Consumer or Consumer Liaison: J F.,C.P. M.M.	Evelyn Willis Charlene Bruhl Victor Sutton Consumer 1 Consumer 2	Charlene Bruhl Cynthia Gardener	Charlene Bruhl Wanda Collins Consumer 3
Janet Wattles Center	Frank Ware	Frank Ware	Frank Ware
Mental Health Center of Champaign			
Mental Health Ctrs of Cntrl IL			
Metropolitan Family Services			
Montgomery County			
Mount Sinai Hosp Medical Ctr			
Perry County Counseling Center			
Pilsen-little Village Mental			
Robert Young Center for	Rich Murphy	Rich Murphy	Rich Murphy

PILOT TEST WORKGROUP MEETINGS	12/09/04	01/18/05	02/24/05
The Kenneth W Young Centers	Gongmin Mou	Mitch Bruski	Mitch Bruski
The Thresholds	John Mays		Tony Zipple
Will County			
Youth Services of McHenry			
DHS Central Office			
DHS/DMH Central Office	Brittan Harris Chris Power Mary Smith	Brittan Harris Chris Power Mary Smith	Brittan Harris Chris Power Mary Smith
DHS/DMH Metro North			
DMS/DMH Metro West			
DHS/DMH Metro South			
DHS/DMH Greater IL North	Dan Wasmer		Dan Wasmer
DHS/DMH Metro C&A			
DHS/DMH Greater IL Central	Jackie Manker		
DPA Staff			
Trades: Marian Sleet CIBHA Frank Anselmo CIBHA Heather Eagleton IARF	Marion Sleet	Marion Sleet Frank Anselmo	Marion Sleet Heather Eagleton
Consultants: Rusty Dennison/Parker Dennison	Rusty Dennison	Rusty Dennison	Rusty Dennison
Other Consumer Liaisons: L.D.Sankofa Org.	1	1	

SERVICES WORKGROUP MEETINGS	12/02/04	01/13/05	02/22/05
Ada S McKinley Comm Serv Inc	Hans Schuster		Mark Moses
Association House of Chicago			
Call for Help Inc			
Coles Co Mental Hlth Assn Inc		Kathy Roberts Lynette Ashmore	Kathy Roberts
Community Counseling Ctr Chgo	Bruce Seitzer		Bruce Seitzer
Community Counseling of N Madison	Kelly Norris	Kelly Norris	
Community Mental Hlth Cncl Inc Consumers or Consumer Liaison: L.C. B.B.	Rene Chandler Pat Havis	Luwanda Aldridge Consumer 1 Consumer 2	Chrystele Johnson Pat Havis Patricia Smith-Huntoon Consumer 1 Consumer 2
Crosspoint Human Services Consumers or Consumer Liaison: B.J.	Jeana Johnson Carol Pichon	Jeana Johnson Consumer 1	Consumer 1
Delta Center	Frederica Garnett		
Dewitt Co Human Resource Ctr	Cheryl Lietz	Cheryl Lietz	Cheryl Lietz
Dupage County Consumers or Consumer Liaison: G.C D.C.	Dave Christiansen	 Consumer 1 Consumer 2	Dave Christiansen
Egyptian Public & Mental			Angie Hampton
Family Service MHC of Oak Park			
Hancock County Mental Health			
Heartland Human Services		Linda Cummins Lisa Ballinger	
Heritage Behavioral Health Ctr	Candace Clevenger	Diana Knaebe	
Human Resources Dev Inst Inc	Latina McMillan Cynthia Gardner Evelyn Willis		
Janet Wattles Center Consumers or Consumer Liaison: B.G.	Consumer 1	Consumer 1	Consumer 1

SERVICES WORKGROUP MEETINGS	12/02/04	01/13/05	02/22/05
Mental Health Center of Champaign	Sheila Ferguson Susan Gregory		
Mental Health Ctrs of Cntrl IL			
Metropolitan Family Services			
Montgomery County			
Mount Sinai Hosp Medical Ctr	David Wilson		
Perry County Counseling Center	John Veskus	John Veskus	John Veskus
Pilsen-little Village Mental	Sarah Godinez Nora Navarro		
Robert Young Center for	Vivian Swanson	Vivian Swanson	Michael Freda
The Kenneth W Young Centers	Susan Reynolds	Susan Reynolds	Susan Reynolds
The Thresholds	Doug Kolasinski Ginnie Fraser	Doug Kolasinski Ginnie Fraser	Ginnie Fraser
Will County			
Youth Services of McHenry			
DHS/DMH Central Office	Brittan Harris Chris Power Dennis Smith Linda Bollensen Randy Pletcher Jackie Manker	Chris Power Linda Bollensen Jackie Manker	Jackie Manker
DHS/DMH Metro North	Carol Vollendorf Ann Reiher	Carol Vollendorf	Ann Reiher Gordon Reiher
DMS/DMH Metro West			
DHS/DMH Metro South			
DHS/DMH Greater IL North	Chuck Hoffman		
DHS/DMH Greater IL Central		Jackie Manker	Jackie Manker
DHS/DMH Great IL South	Monica Bert	Monica Bert	Monica Bert

SERVICES WORKGROUP MEETINGS	12/02/04	01/13/05	02/22/05
DPA Staff: Mary Noburn Greg Wilson Frank Kopel	Mary Noburn Greg Wilson	Frank Kopel	Frank Kopel
Other Consumer Liaisons:			
C.C.McFarland MHC	1	1	1
Consultants: Rusty Dennison/Parker Dennison Gretchen Engquist/EP&P Lena Hiilivirta/EP&P	Rusty Dennison Gretchen Engquist Lena Hiilivirta	Rusty Dennison Lena Hiilivirta	Rusty Dennison Lena Hiilivirta
Trades: Frank Anselmo CIBHA Marion Sleet CIBHA	Frank Anselmo Marion Sleet	Marion Sleet	

Appendix C: Field Test Evaluation Matrix

FIELD TEST EVALUATION TRACKING AND CROSSWALK

(Showing Field Test Measures Assigned to Workgroups)

REVISED PER WORKGROUP COMMENTS 1/21/05

New #	Old #	Domain (DMH Lead)	MOU(Item 19)/MOA Crosswalk	Measure/Activity	Notes
Pilot Test Workgroup					
1	2	Agency/ provider (Power)	MOU—Benefits and viability of moving to fee-for service MOA--10. The benefits and viability of converting to FFS MOA--7. Whether fee for service reimbursement, in combination with all other public funding accessed by a particular provider agency, is reasonably consistent with efficiency, economy, and quality of care, as required by federal Medicaid law,	Conclusion of evaluation of field test activities. To be addressed in narrative of final report.	No unique data sets required.
2	4	Agency/ provider (Lane)	MOA--16. Evaluation of training and technical assistance provided	Formal post-training evaluation summaries prepared for each training event; evaluations supplemented by focus-group type feedback from 30 Field Test agencies to identify future training needs.	
3	5	Agency/ provider (Power)	MOU—Assessment of conversion impact on each individual provider MOA--11. The impact of conversion on each provider participating in the Test Phase	A. Provider readiness process that will include all domains in the assessment tool and will compare results from site visit and self report field test agencies. B. "Reconciliation" reports comparing reimbursement provided (advances) as compared to amount billed for each agency and across 30 field test agencies; follow-up analyses of outliers and impact on providers' combined DMH/Medicaid funding levels (from 3 and under financial analysis workgroup)	Available on SIS Online. Mental Health Networks provide technical assistance to outliers.
4	6	Agency/ provider (Power; M. Smith)	MOA--13. Provider system readiness to advance consumer ownership, recovery, resilience and program integrity and	A. Provider readiness process that will include all domains in the assessment tool and will compare results from site visit and	

New #	Old #	Domain (DMH Lead)	MOU(Item 19)/MOA Crosswalk	Measure/Activity	Notes
			costs to implement improvements	self report field test agencies. B. Administration of the Recovery Oriented System Indicators (ROSI). The ROSI data will be reported as a baseline measure that will be compared to later ROSI measures after the pilot test phase.	
5	7	Agency/ provider (Power)	MOA--17. Identification of and methods for financing state and provider conversion costs	A. Research activities and funding strategies used by GA, DC and LA for system changes (including activities, efforts and funding by other state trade associations) B. Identify list of transition/conversion costs.	
6	New	Agency/ provider (Pletcher)	Other—Review safety plan	Review safety plan and make recommendations to the SRI Task Group regarding the specific components that should be included in a safety plan. Per the SRI Steering Committee 12/10/2004 decision, "a discrete safety plan is not needed because components are incorporated into the overall Field Test process and specific work group activities."	
Eligibility and Access Workgroup					
7	10	Consumers/ clients (Power)	From July 14th column –Demographics of clients	A. Develop possible sources of data for undocumented individuals and new legal immigrants B. Non-Medicaid funding should consider this population since these individuals cannot be converted to Medicaid. C. Request DMH policy clarification regarding ability to use non-Medicaid funding for this population.	Financial group requested EP&P explore the means of collecting these data.
8	11	Consumers/ clients (Power)	MOA--18. The service and case mix of Medicaid and non Medicaid consumers that can be supported once Illinois moves to increased reliance on FFP.	A. Analysis of consumer access including (1) number of Medicaid/non-Medicaid consumers receiving services, the amounts of services being delivered by agency and	

New #	Old #	Domain (DMH Lead)	MOU(Item 19)/MOA Crosswalk	Measure/Activity	Notes
				region, and (2) Development of regional Medicaid and non-Medicaid penetration rate estimates using Medicaid enrollees and total populations by region	
9	12	Consumers/ clients (M. Smith; Power)	MOU—Consumers' ability to receive services MOA--1. Access to services (penetration, intake and utilization patterns for grants vs. FFS) Other—Has there been a change in the number of individuals with mental illnesses in jails or homeless shelters?	To develop a baseline analysis to facilitate measurement of access over a longitudinal period: A. Using current data system, develop analysis of number and percentage of clients served during FY04 for: target population; Medicaid clients. B. Using current data system, calculate the average hours of service per client delivered during time periods in FY04. C. Obtain Medicaid population data and calculate penetration for general population, estimated individuals with SMI, and Medicaid population. D. Assess "waiting time" by using existing administrative data set and calculating time from initial crisis and assessment contact to service delivery contact. E. Develop other measures that should be incorporated into a longitudinal access analysis so that data can be captured from data systems.	
10	13	Consumers/ clients (M. Smith)	MOA--2. Feasibility and costs of using the Washington Circle Model's approach to measuring access	Consideration was given to test Washington Circle Model with small subgroup of Field Test Agencies. On 1/19/05 the workgroup recommended to the SRI Task Group that the WC Model not be used for mental health services at this time.	
11	14	Consumers/ clients (M. Smith; Larson))	MOA--5. Consumer satisfaction (MHSIP and/or Consumer Quality Reviewers) and targeted surveys with regard to how consumers and families feel about changes occurring in the	A. DMH centrally administers MHSIP survey to sample of clients at 30 Field Test agencies; compare results to previous statewide surveys and national norms. Will be coordinated with ROSI and	

New #	Old #	Domain (DMH Lead)	MOU(Item 19)/MOA Crosswalk	Measure/Activity	Notes
			system during FY05 MOA—Quality of the services funded	completed by 2/28.	
12	New	Consumers/ clients (Pelletier)	Other—Impact of dual eligibles	Estimate the number of individuals dually eligible for Medicare/Medicaid and make recommendations regarding further activities necessary to address issues related to coordination of benefits for these individuals	
Financial Analysis Workgroup					
13	3	Agency/ provider (Stout)	MOU—Fiscal sustainability of the involved provider agency MOA--7. (continued) adequately reimburses providers for care the state is purchasing, and can result in fiscal sustainability 12. Effectiveness of state and provider processes in increasing Medicaid revenue	A. Using reconciliation reports from SIS, develop analysis of FY05 performance by Medicaid and non-Medicaid against targets, and compare total funding, including capacity grants, for FY05 and FY04. B. Results from cost analyses	Rates and costs may need to be incorporated into analysis depending upon revenue levels. Measure 12 moved from #15 per Pelletier 2/4/05
14	16	Fiscal (Stout)	MOA--8. Validity of agency provider-specific Medicaid claiming targets	Workgroup to review FY05 allocation methods for Medicaid, non-Medicaid and capacity grants and offer recommendations that improve the methodology at the system level.	
15	17	Fiscal (Pletcher; Stout)	MOU—The impact on the conversion initiatives primary objectives MOA--9. The impact of the conversion initiative's primary objectives	Comparison of actual Medicaid billing against $95 million target	
16	18	Fiscal (Manker; Cumpston)	MOA--15. Whether the streamlined Rule 132 reduces or increases the proportion of Medicaid reimbursable services, and/or compliance risks/costs	A. Post payment reviews for educational purposes of some of the 30 Field Test agencies by BALC to assess level of compliance risks/costs based on Rule 132 post 11/1/04. B. Providers subject to BALC reviews will share "Lessons Learned" with all providers for educational purposes.	

New #	Old #	Domain (DMH Lead)	MOU(Item 19)/MOA Crosswalk	Measure/Activity	Notes
17	25	Programs/ services (Power)	Other—Is the amount of funding the capacity grants appropriate?	A. Analysis of non-Medicaid funding by region to population by region to determine per capita non-Medicaid funding; consider levels of undocumented individuals by region where available B. Analysis of number of Medicaid enrolled persons by region to facilitate examination of any relationship or variance in per capita non-Medicaid funding by region to number of Medicaid enrolled persons C. Review list of programs/activities funded by capacity grants to determine if alternative methodologies are indicated.	
18	19, 20,21	Information Systems (Harris)	Other—Is the information system functioning effectively and efficiently to facilitate submission and processing of claims?	No specific measure determined at this time. May be re-visited if information system issues are identified.	
19	22	Information Systems (Pletcher)	Other—Are existing claims processing and payment flows and timelines sufficient to support provider cash flow needs in full fee-for-service environment?	Development of claims process and time line from delivery of service through claims payment, showing both provider and state activities and times required.	
Services Workgroup					
20	23	Programs/ services (Power)	MOA--6. Current and Test Phase maintenance of program integrity	A. Addressed through provider readiness review process. Includes a table of services currently provided and those providers anticipate discontinuing. Results will be summarized in report.	
21	24	Programs/ services (Manker)	Other—Are there important services to clients that are not included in the list of covered services or capacity grants?	A. Comparison of the Illinois mental health service array to that present in other states that have recently updated their rehabilitation and recovery-focused services. B. Preliminary identification of possible service gaps that can be researched and evaluated further as a part of the strategic planning process	
22	25	Programs/ services	MOA--14. Clinical/utilization changes	A. Calculate the percentage of services	

New #	Old #	Domain (DMH Lead)	MOU(Item 19)/MOA Crosswalk	Measure/Activity	Notes
		(Pletcher/Manker)	caused by the changed reimbursement methodology	delivered off-site during time periods in FY04 and compare to same measure for FY05. B. Calculate # of service units and # of clients for specific service activity codes, matching old codes to new codes (i.e., revised MH Medicaid Rule 132) as possible. C. Extent and necessary additional clinical changes will be part of readiness assessment D. Analysis of the relative of type of service (ranking of services highest to lowest based on total units or dollars	
23	26	Programs/ services (Manker)	MOA--3. Feasibility and costs of measuring service quality through fidelity scales for Evidence Based Practices	As work group recommends new services, will note whether the service is an EBP. Where data is available, will identify costs from other states to implement the recommended EBP. Evaluation report should address in narrative methods used in other systems to ensure quality and fidelity to service definitions and EBP.	Note "C" moved from 27 B.
24	27	Programs/ services (Manker)	MOA--4. Methods for, and feasibility and costs of, closing service quality gaps	Work group recommends that the Strategic Vision project geo map access to services for inclusion in their report. No specific quality problems are noted in the MOA. Accordingly, it is impossible to specifically address specific methods, feasibility and costs of closing service quality gaps. The narrative report will address this in more general terms. No separate data tracking is indicated.	
25	18	Programs/ services (Manker)	MOA—13. State system readiness to advance consumer ownership, recovery, resilience and program integrity and costs to implement improvements	Workgroup determined that no specific measure/activity needed. Analysis of service array/definitions for recovery elements is sufficient to fulfill requirements.	Moved from Finance section.
26	Other	Programs/Services	Other – Readiness of Medicaid state	Identification of recommended changes in	

New #	Old #	Domain (DMH Lead)	MOU(Item 19)/MOA Crosswalk	Measure/Activity	Notes
		(Manker)	plan, Rule 132, and service definitions to support a recovery approach to services and facilitate state and provider compliance with federal rules and guidance.	the definitions for current services Cross-walk current and recommended mental health services to the Illinois Medicaid state plan and with applicable federal rules, guidance and reference materials.	

Appendix D: Training, Technical Assistance and Materials to Support the Conversion

Summary of Training and Technical Assistance Initiatives in Support of FFS & SRI

Training or TA event	Location	Date	# Attending/ participating	Overall evaluation (1 poor – 5 excellent)
Provider Readiness Assessment Tool	Mt Vernon	01-12-05	19	4.72
	Springfield	01-21-05	40	4.85
	Chicago	02-01-05	117	4.27
	Multiple Teleconference Sites	02-18-05	81	4.32
Consumer Orientation and Training	Springfield	01-18-05	15	
	Peoria	02-22-05	13	4.0
	Teleconference	03-01-05	??	??
	Elgin	03-22-05	23	3.77
Network Readiness Report "Lessons Learned"	Metro Regions Chicago	03-11-05	78	
	Greater Illinois Central, Springfield	03-15-05	28	
	Greater Illinois North Elgin	03-22-05	34	
	Greater Illinois, South	03-28-05	42	3.77
New Partnership Medicaid Eligibility and Outreach	Tinley Park	7-8-04	25	Content and Process: 4.11 Achievement of Training Objectives: 3.95
	Peoria	7-14-04	25	Content and Process: 3.28 Achievement of Training Objectives: 3.78
	Springfield	6-21-04	75	
	Rockford	6-23-04	20	
	Alton	6-29-04	75	
	Anna	6-30-04	55	
	Elgin	7-7-04	65	
	Chicago-Read	7-16-04		
	Springfield	9-17-04	15	
	Rend lake	9-21-04	45	
	Springfield	9-22-04	55	
	Rockford	9-24-04	40	
	Chicago	9-27-04	175	
SIS On Line Training	Elgin MHC	12-10-04	55	
	Madden MHC	12-15-04	68	4.39
	Springfield	12-17-04	45	
	Choate MHC	01-11-05	16	5.0
	Chicago-Read	01-27-05	14	4.57
ROCS system changes				

Training or TA event	Location	Date	# Attending/ participating	Overall evaluation (1 poor – 5 excellent)
for FY05				
	Chicago	4-16-04	150	.
	Springfield	4-20-04	50	
	Springfield	5-05-04	15	
	Springfield	6-22-04	15	
	JRTC, Chicago	6-24-04	125	
	Phone	9-7-04	165 lines	
	Phone	11-9-04	120 lines	
	Phone	12-14-04	128 lines	
	Phone	1-11-05	125 lines	
		ROCS EVALUATION OF MODERATED TELECONFERENCES:	1) Objectives of the sessions were clearly stated	%96 endorsed Yes N=56
			2) Format of sessions helpful	%98 endorsed Yes N=56
			3) Topics presented were informative.	%96 endorsed Yes N=56
			4) The sessions helped us to resolve billing problems.	%78 endorsed Yes N=56
			5) Written Q & A document after each teleconference was helpful	%81 endorsed Yes N=56
			6) Additional teleconferences should be scheduled.	%86 endorsed Yes N=56
Rule 132 training	JRTC, Chicago	7-27-04	225	
	JRTC, Chicago	7-28-04	225	
	Rockford	7-29-04	100	
	Springfield	8-3-04	225	
	Rend Lake	8-4-04	150	
Other Training/ Technical Assistance on Medicaid Application- Billing Retrospective Billing- Error Resolution	Elgin	3-30-04	20	
	Elgin	4-13-04	45	
	Elgin	4-27-04	15	
	Elgin	5-30-04	20	
	Telephone	4-30-04	125	
	Telephone	5-04-04	75	
	Telephone	5-12-04	50	
	Springfield	5-13-04	15	
	Telephone	5-14-04	10	
	Telephone	5-17-04	75	
	Telephone	5-20-04	15	
	Telephone	5-27-04	15	
	Telephone	6-3-04	15	
	Telephone	5-27-04	15	
	Telephone	6-10-04	15	
	Telephone	6-17-04	15	
	Telephone	6-24-04	15	
	Springfield	6–22-04	25	
	Telephone	7-29-04	15	
	Telephone	8-5-04	15	
	Telephone	8-19-04	15	

Training or TA event	Location	Date	# Attending/ participating	Overall evaluation (1 poor – 5 excellent)
	Telephone	8-26-04	15	
	Telephone	9-2-04	10	
	Springfield	9-8-04	10	
	Telephone	9-9-04	15	
	Telephone	9-16-04	15	
	Telephone	9-30-04	10	
	Telephone	10-7-04	15	
	Telephone	10-14-04	15	
	Telephone	10-21-04	15	
	Chicago	10-26-04	25	
	Telephone	10-28-04	15	
	Telephone	11-04-04	15	
	Telephone	11-10-04	15	
	Quincy	3-17-05	30	
Error codes and their resolution	e-mail, Internet	3-11-05	Broadcast to all providers	

Technical Assistance Manuals and Supporting Documentation

Technical Assistance Manuals/Documents	Subjects	Links Available at the DMH Internet site:
ROCS-Tag Error Code Resolution	Technical Support: "Common Error Codes and Their Resolution"	http://www.dhs.state.il.us/mhdd/mh/repCommServices/errorMaster.asp
Revised Rule 132	(59 ILAC 132)	http://www.ilga.gov/commission/jcar/admincode/059/059parts.html
	Training Slideshow	http://www.dhs.state.il.us/revisedRule132/
Revised Rule 132 Q&A	"Rule 132 Training Q & A" "Q & Q Oct. 2004" "Q & Q Nov.-Dec. 2004"	http://www.dhs.state.il.us/revisedRule132/dhs_rr132_revisedRule132qa.asp
ROCS	"ROCS System Manual," "OBRA System Updates, " "DHSCRS System Software" "Summary of DHSCRS Revisions" "Q&A ROCS Teleconferences" "09-07-04", 11-09-04", 12-14-04", "01-11-04"	http://www.dhs.state.il.us/mhdd/mh/repCommServices/
	For ROCS Technical Support Contact:	ROCS@DHS.STATE.IL.US
Non ROCS Users	"FTP Registration Form & "Instructions" "Manual with Specific File Specification for Providers who use Their Own System"	http://www.dhs.state.il.us/mhdd/mh/repCommServices/
General SRI Information and Important Documents	"SRI Strategic Vision Statement" "Memorandum of Understanding" "Memorandum of Agreement" "Provider Readiness Assessment Tool" "FFS Progress reports" "Minutes from SRI Field Test Workgroup Meetings"	http://www.dhs.state.il.us/mhdd/mh/sri/
Fee for Service Homepage	"MOA,MOU Changes" "Required Activities" "Q&A Retrospective Billing" "RIN Assignment"	http://www.dhs.state.il.us/ffs/
Medicaid Information	"Medicaid Manual" "Medicaid Crosswalk" "Rule 132" "Medicaid Newsletter"	http://www.dhs.state.il.us/mhdd/mh/medicaidInformation/
SIS Online	Main Menu "Advance and Reconciliation" "ROCS" "CAPS" "CARS" "Adhoc Reports"	https://sisonline.dhs.state.il.us/
For SIS User Tech. Support Contact:		dhsmh@dhs.state.il.us.
"Provider/Consumer Guide to Mental Health Services "	Links to Related Topics About Mental Health	http://www.dhs.state.il.us/mhdd/mh/

Appendix E: Establishment of FY 2005 Contracts

Capacity Grants

COMPONENTS OF FY05 COMMUNITY MENTAL HEALTH CAPACITY GRANTS BY PROGRAM

	Program	Percent	
121	Juvenile Justice	100.00%	$2,966,368
131	Child/Adolescent Wrap	100.00%	$1,311,447
211	Psychosocial Rehabilitation	10.00%	$3,301,278
233	ACT Supervised Residential	50.00%	$1,685,582
350	Psychiatric Leadership	100.00%	$16,661,840
540	Geropsychiatric	100.00%	$530,641
572	Client Transition Subsidies	100.00%	$2,243,439
573	Child/Adolescent Transition	100.00%	$20,293
574	Psychiatric Medications	100.00%	$3,612,397
580	Crisis Services	60.00%	$9,992,150
620	CILA Residential	50.00%	$9,669,634
820	Supported Residential	25.00%	$5,188,506
830	Supervised Residential	50.00%	$12,624,158
860	Crisis Residential	60.00%	$3,006,639
950	Emergency Psychiatric Serv	100.00%	$4,378,126
	Outpatient additions to 350	29.47% of some	$5,419,038
Program Sub-total			$82,611,536
Other Components			
	Special grants		$2,626,735
	Pooled loans		$1,597,751
	Other adjustments		$1,450,995
Other Component Subtotal			$5,675,481
Capacity Grant Totals			$88,287,017

Medicaid Billing Targets

Summary of the Method for Distributing FY2005 Community Mental Health Contract Amounts By Capacity Grants and Medicaid and Non-Medicaid Fee-for-Service Targets

I. General principles:

A. The method was to apply to agencies which had contracts in FY2004 to provide outpatient services under the range of DMH programs (110, 120, etc.).

B. The method was not to apply to entities which had contracts only for Individual Care Grants (ICG), for supportive services for inpatient care in state psychiatric hospitals, or for inpatient psychiatric care in privately operated hospitals (CHIPS).

C. The method was to apply uniformly to all agencies identified in point I.A..

D. Total funding for the agencies identified in point I.A. was to be equal to grant contract amounts for FY2004 (less any targeted cuts) minus the amount of grant funding awarded in FY2004 for program 130 (SASS, or Screening, Assessment, and Support Services) plus the projected amount to be paid to Medicaid billing agencies for FY2004 services through the Mental Health Medicaid Trust Fund (718 fund). This calculation was applied individually to each agency contract.

E. FY2005 contracts were to be awarded as three types of funding: capacity grants, Medicaid billing targets, and non-Medicaid billing targets. The initial expectation was that capacity funding would be awarded as grants, subject to the Grants Recovery Act (under which retention of the funding was to be based exclusively upon appropriate expenditure). The expectation for Medicaid and non-Medicaid targets was that the retention of the funds was to be based upon service provision and billing.

F. Funding in capacity grant awards was expected to cover a wide range of activities which would not be billable as Medicaid or non-Medicaid services under the current structure of DMH covered services and rates. These activities included residential and residential support programs, a proportion of crisis programs, psychiatric leadership, and other funding historically awarded to community mental health agencies which did not clearly fit into covered billable services as of July 2004. The amount of funding statewide allocated to capacity grants was limited as noted in II.C..

G. Every agency identified in point I.A. was to receive a portion of the FY2005 contract as a capacity grant even if the agency had not historically received funds identified in point I.F.. This was viewed as an important consideration to be equitable that every agency received some portion of funding which was more stable and not subject to recoveries based upon service delivery and billing.

H. The state's expectations for Medicaid billing in FY2005 was a total of $190 million ($140 million based upon projections of billing for FY2004 and an additional $50 million beyond that amount)

I. To reach the increased Medicaid billing target for the state, it was expected that every agency which had not fully matched all available grant funding with Medicaid billing would increase billing over FY2004 levels by a uniform statewide proportion of unmatched funding.

J. Since the range of past Medicaid billing activity varied widely among agencies identified in point I.A., a limit on Medicaid targets was set as a maximum proportion of the agencies total contract amount for FY2005. The idea here is for agencies with a history of relatively low Medicaid billing, a target set by a formula alone might be impossible to meet (see II.D).

K. For agencies which had not demonstrated through past Medicaid billing practices that they saw Medicaid services as their primary community mental health focus for DHS, funding a minimum level of funding for non-Medicaid services was set at a uniform statewide proportion (see II.E.).

L. DMH was committed to treating agencies uniformly according to these principles even if this produced some apparent anomalies.

II. Critical parameters

A. The FY2005 contracts were based upon FY2004 grant awards for outpatient programs (110, 120, etc.) minus awards for program 130 plus payments for FY2004 services from the 718 funds projected and annualized as of March 2004.

B. Medicaid billing expectations were increased by $50 million ($25 million in federal matching funds) to meet the target set by the Governor's Office of Management and Budget.

C. Capacity grant funding was to be limited to 23% of total funding statewide, although this proportion could vary among providers.

D. The increase in Medicaid billing for FY2005 over FY2004 was limited to 20% of each agency's total FY2005 funding (as identified in point II.A.).

E. Agencies identified as those which had demonstrated a primary commitment to providing Medicaid services were those for which projected FY2004 Medicaid billing was 90% or more of available matchable DHS funding for FY2004. These are agencies which would not be subject to the statewide minimum proportion for non-Medicaid services (see point I.K.).

F. For agencies which did not demonstrate a primary commitment to providing Medicaid services (point II.D.), a minimum proportion of available fee-for-service funding (total FY2005 funding less capacity grants) was set at 10%.

G. Within these parameters the uniform statewide proportion for calculating the increase in Medicaid targets over projected FY2004 levels of billing was 45% of total FY2005 awards less capacity funding.

III. The sequence of calculation

A. Given these parameters, the sequence of calculations is important.

B. The sequence used in calculations for FY2004 awards was as follows:

1. Computation of FY2004 grant awards less program 130 funds and any other funding which did not fit into outpatient programs (110, 120, etc.)

2. Projection and annualization of payments from the 718 trust fund for FY2004 services.

3. Calculation of FY2005 funding base (sum of III.1. and III.2.)

4. Calculation of capacity grant amounts.

5. Computation of fee-for-service base (III.3. minus III.4.)

6. Determination of agencies with a primary commitment to Medicaid services.

7. Calculation of each agency's increased Medicaid billing amount over FY2004 (at 45% of amount in III.5.).

8. Check on limits of the increase in Medicaid billing at no more than 20% of the amount in III.3.

9. Check on limits for non-Medicaid targets at no less than 10% of the amount determined in III.5. for agencies not found to have a primary commitment to Medicaid services.

10. Minor adjustments to calculated targets to assure some agencies had flexibility to make necessary payments on pooled loans.

IV. Important points in review

A. Adherence to these principles without ad hoc changes produced a few apparent anomalies.

B. Anomalies included:

1. For some very high Medicaid billing agencies FY2005 Medicaid targets were less than projected FY2004 billing amounts because the agencies were guaranteed some of their contract funds in capacity grants which they had not received before. DMH felt that even though these agencies had billed Medicaid higher in prior years they also deserved the security and certainty of receiving a portion of FY2005 funding in grants. However, the offer was made to all these agencies to move capacity grant funding into fee-for-service targets if they wished.

2. For some agencies there is no target for non-Medicaid services. This is true only for agencies which were determined to have demonstrated a primary commitment to Medicaid services and, therefore, were not subject to the non-Medicaid target minimum. In addition, many of these agencies also had funding shifted into capacity grants for the reason described in point IV.B.1., reducing their total fee-for-service funding base. Any of these agencies may move capacity grant funding to the Medicaid or non-Medicaid targets if they wish.

C. DMH contract managers were instructed how these calculations were made and were given so that they could assist each agency to go through the calculations if they wished to understand their new contracts. DMH central office staff offered to participate in these calculations and sat in on about 25.

Appendix F: FY 2005 Billing Performance

Total Medicaid Billings YTD Through March Compared to FY04 and FY05 Prorated Target

Note	Agency Name	FY 05 Total Contract Medicaid Target Amount	FY 05 YTD Medicaid Target Prorated through February	FY 05 YTD Actual Medicaid Billed through March Cycle 2	FY 04 YTD Actual Medicaid Billed through March Cycle 2	FY05 YTD Actual Medicaid Billed through March Minus FY04 YTD Actual Medicaid Billed through March	FY05 YTD Actual Medicaid Billed through March Minus FY05 YTD Medicaid Target prorated through February
	ABRAHAM LINCOLN CENTER	$658,838	$439,225	$252,502	$270,883	-$18,382	-$186,723
	ADA S MCKINLEY CMNTY SVCS INC	$1,038,156	$692,104	$265,606	$348,452	-$82,846	-$426,498
	ADAPT OF ILLINOIS INC	$3,894,678	$2,596,452	$2,819,950	$3,508,942	-$688,992	$223,498
	ADVOCATE NORTHSIDE HEALTH SYS	$546,164	$364,109	$38,981	$43,760	-$4,779	-$325,128
	ALEXIAN BROTHERS NORTHWEST	$1,208,629	$805,753	$519,489	$385,878	$133,611	-$286,264
	ALLENDALE ASSOCIATION	$200,508	$133,672	$114,715	$110,331	$4,385	-$18,957
	ALLIANCE FOR THE MENTALLY ILL	$316,148	$210,765	$119,425	$64,890	$54,535	-$91,341
	ASIAN HUMAN SERVICES INC	$763,010	$508,673	$250,167	$463,973	-$213,807	-$258,507
	ASSOCIATION FOR INDIVIDUAL	$1,801,128	$1,200,752	$775,926	$831,434	-$55,508	-$424,826
	ASSOCIATION HOUSE OF CHICAGO	$1,632,290	$1,088,193	$791,629	$704,017	$87,612	-$296,565
	BEACON THERAPEUTIC SCHOOL INC	$992,000	$661,333	$941,079	$1,189,259	-$248,180	$279,745
	BEHAVIORAL HLTH ALTERNATIVES	$408,854	$272,570	$245,512	$278,439	-$32,927	-$27,058
	BEN GORDON CENTER	$864,370	$576,247	$350,826	$404,228	-$53,402	-$225,421
	BOBBY E WRIGHT CCMHC	$2,383,794	$1,589,196	$933,515	$881,630	$51,885	-$655,681
	BOND COUNTY	$143,272	$95,515	$76,445	$78,632	-$2,187	-$19,070
##	BRIDGEWAY INC	$3,182,976	$2,121,984	$887,612	$1,251,755	-$364,144	-$1,234,372
	BROWN COUNTY MENTAL HEALTH CTR	$983,072	$655,381	$431,196	$433,364	-$2,168	-$224,185
	CALL FOR HELP INC	$339,416	$226,277	$167,836	$92,933	$74,902	-$58,442
	CASS COUNTY MENTAL HEALTH ASSN	$174,030	$116,020	$49,627	$58,166	-$8,539	-$66,393
##	CENTER FOR CHILDRENS SERVICES	$800,948	$533,965	$521,509	$684,235	-$162,727	-$12,457
	CENTER ON DEAFNESS INC	$420,244	$280,163	$232,866	$123,552	$109,315	-$47,296
	CHALLENGE UNLIMITED INC	$6,252	$4,168	$2,020	$0	$2,020	-$2,148
	CHESTNUT HEALTH SYSTEMS INC	$3,560,936	$2,373,957	$1,917,529	$1,554,796	$362,733	-$456,428

Note	Agency Name	FY 05 Total Contract Medicaid Target Amount	FY 05 YTD Medicaid Target Prorated through February	FY 05 YTD Actual Medicaid Billed through March Cycle 2	FY 04 YTD Actual Medicaid Billed through March Cycle 2	FY05 YTD Actual Medicaid Billed through March Minus FY04 YTD Actual Medicaid Billed through March	FY05 YTD Actual Medicaid Billed through March Minus FY05 YTD Medicaid Target prorated through February
**	CHICAGO CITY OF	$4,302,494	$2,868,329	$1,885,390	$1,536,944	$348,445	-$982,940
	CHILDRENS CENTER FOR BEHAVIORA	$175,514	$117,009	$68,247	$79,772	-$11,525	-$48,762
	CHILDRENS HOME & AID SOC OF IL	$373,440	$248,960	$228,411	$191,627	$36,784	-$20,549
	CHILDRENS HOME ASSOC OF IL	$610,124	$406,749	$187,612	$290,651	-$103,039	-$219,137
	CHRISTIAN COUNTY MENTAL HEALTH	$437,252	$291,501	$153,628	$139,806	$13,822	-$137,873
	CIRCLE FAMILY CARE INC	$1,486,840	$991,227	$554,647	$450,217	$104,430	-$436,580
	COLES CO MENTAL HLTH ASSN INC	$1,327,732	$885,155	$844,856	$631,359	$213,497	-$40,299
##	COMMUNITY CARE OPTIONS	$1,798,849	$1,199,233	$531,028	$694,625	-$163,598	-$668,205
	COMMUNITY CNSLNG CTRS CHICAGO	$6,637,134	$4,424,756	$2,581,568	$3,020,782	-$439,214	-$1,843,188
	COMMUNITY COUNSELING CENTER OF	$2,012,552	$1,341,701	$1,057,048	$1,072,191	-$15,143	-$284,653
	COMMUNITY MENTAL HEALTH BOARD TOWN OF OAK PARK	$130,190	$86,793	$72,073	$72,366	-$293	-$14,720
	COMMUNITY MENTAL HLTH CNCL INC	$4,552,240	$3,034,827	$2,518,271	$1,358,076	$1,160,195	-$516,556
	COMMUNITY RESOURCE & COUNS ELIN	$384,912	$256,608	$191,558	$197,398	-$5,840	-$65,050
	COMMUNITY RESOURCE CENTER INC	$2,258,582	$1,505,721	$1,323,196	$1,404,137	-$80,941	-$182,525
	COMMUNITY WORKSHOP & TRAINING	$43,504	$29,003	$1,663	$8,980	-$7,317	-$27,339
**	COMPREHENSIVE MENTAL HLTH CTR	$1,672,640	$1,115,093	$788,123	$537,865	$250,258	-$326,970
	COOK COUNTY	$96,524	$64,349	$34,655	$33,183	$1,472	-$29,694
	CORNERSTONE SERVICES	$1,119,062	$746,041	$844,671	$783,865	$60,806	$98,630
	COUNSELING CENTER OF LAKEVIEW	$1,356,812	$904,541	$728,186	$554,079	$174,107	-$176,355
	COUNSELING CENTER OF PIKE CO	$61,536	$41,024	$27,074	$16,156	$10,919	-$13,950
	CROSSPOINT HUMAN SERVICES	$1,368,408	$912,272	$676,118	$646,927	$29,191	-$236,154
	CUMBERLAND ASSOCIATES INC	$178,120	$118,747	$89,709	$89,550	$159	-$29,038
	DAY SCHOOL	$93,278	$62,185	$75,692	$48,495	$27,197	$13,507
	DELTA CENTER INC	$1,667,192	$1,111,461	$1,063,612	$1,032,242	$31,370	-$47,850
	DEPAUL UNIVERSITY C/O MENTAL HEALTH CTR	$345,240	$230,160	$52,307	$111,753	-$59,447	-$177,853
	DEWITT CO HUMAN RESOURCE CTR	$192,828	$128,552	$95,312	$86,113	$9,200	-$33,240

Note	Agency Name	FY 05 Total Contract Medicaid Target Amount	FY 05 YTD Medicaid Target Prorated through February	FY 05 YTD Actual Medicaid Billed through March Cycle 2	FY 04 YTD Actual Medicaid Billed through March Cycle 2	FY05 YTD Actual Medicaid Billed through March Minus FY04 YTD Actual Medicaid Billed through March	FY05 YTD Actual Medicaid Billed through March Minus FY05 YTD Medicaid Target prorated through February
	DOUGLAS COUNTY MENTAL HEALTH	$614,820	$409,880	$446,196	$403,531	$42,665	$36,316
**	DUPAGE COUNTY HEALTH DEPARTMENT	$3,099,906	$2,066,604	$1,553,978	$860,451	$693,527	-$512,626
	ECKER CENTER FOR MENTAL HEALTH	$1,403,926	$935,951	$751,831	$413,400	$338,431	-$184,119
	EGYPTIAN PUBLIC & MENTAL HEALTH DEPARTMENT	$1,825,098	$1,216,732	$1,382,431	$1,043,065	$339,367	$165,699
	ELM CITY REHABILITATION CENTER	$56,728	$37,819	$0	$0	$0	-$37,819
**	EVANSTON NORTHWESTERN HEALTH	$154,302	$102,868	$5,302	$0	$5,302	-$97,566
	FAMILY ALLIANCE INC	$185,346	$123,564	$158,589	$37,321	$121,268	$35,025
	FAMILY COUNSELING CENTER INC	$901,762	$601,175	$562,335	$468,685	$93,649	-$38,840
	FAMILY SERVICE & CMNTY MENTAL HEALTH CNTR OF MCHENRY COUNTY	$581,016	$387,344	$261,279	$360,921	-$99,642	-$126,065
	FAMILY SERVICE & MENTAL HEALTH	$216,206	$144,137	$54,518	$57,969	-$3,451	-$89,620
	FAMILY SERVICE ASSOCIATION OF GREATER ELGIN	$186,862	$124,575	$54,472	$148,703	-$94,231	-$70,102
**	FAMILY SERVICE MHC OF OAK PARK & RIVER FOREST	$295,960	$197,307	$134,472	$134,152	$319	-$62,835
	FARM RESOURCES	$113,999	$75,999	$0	$0	$0	-$75,999
	FOX VALLEY		$0	$0	$128,429	-$128,429	$0
**	FRANKLIN-WILLIAMSON HUMAN SERVICES, INC.	$3,704,750	$2,469,833	$3,001,093	$2,457,259	$543,834	$531,260
	GATEWAY FOUNDATION INC	$435,398	$290,265	$49,185	$0	$49,185	-$241,080
	GRAND PRAIRIE SERVICES	$4,558,005	$3,038,670	$2,010,371	$2,077,008	-$66,637	-$1,028,299
	GROW IN ILLINOIS	$221,324	$147,549	$0	$0	$0	-$147,549
	GRUNDY COUNTY HEALTH DEPT	$85,376	$56,917	$66,540	$31,749	$34,791	$9,622
	HABILITATIVE SYSTEMS INC	$783,454	$522,303	$217,257	$304,025	-$86,768	-$305,046
	HANCOCK COUNTY MENTAL HEALTH	$280,144	$186,763	$216,486	$139,523	$76,963	$29,723
	HEARTLAND HEALTH OUTREACH	$1,849,843	$1,233,229	$1,013,429	$980,745	$32,683	-$219,800
	HEARTLAND HUMAN SERVICES	$1,789,949	$1,193,299	$945,291	$1,019,601	-$74,310	-$248,009
##	HELEN WHEELER CTR COMM MNTL HL	$293,265	$195,510	$125,740	$181,288	-$55,547	-$69,770
	HEPHZIBAH CHILDRENS HOME ASSN	$319,016	$212,677	$8,360	$0	$8,360	-$204,317

Note	Agency Name	FY 05 Total Contract Medicaid Target Amount	FY 05 YTD Medicaid Target Prorated through February	FY 05 YTD Actual Medicaid Billed through March Cycle 2	FY 04 YTD Actual Medicaid Billed through March Cycle 2	FY05 YTD Actual Medicaid Billed through March Minus FY04 YTD Actual Medicaid Billed through March	FY05 YTD Actual Medicaid Billed through March Minus FY05 YTD Medicaid Target prorated through February
	HERITAGE BHVRL HEALTH CTR INC	$2,374,120	$1,582,747	$810,859	$1,049,954	-$239,095	-$771,888
	HOUSING OPTIONS F T MI	$90,088	$60,059	$3,711	$0	$3,711	-$56,348
	HUMAN RESOURCES CENTER 0F EDGAR AND CLARK COUNTIES	$208,634	$139,089	$133,813	$81,057	$52,756	-$5,276
	HUMAN RESOURCES DEV INST INC	$4,479,014	$2,986,009	$2,177,155	$2,387,023	-$209,868	-$808,854
	HUMAN SERVICE CENTER HUMAN SERV CTR PEORIA	$3,208,921	$2,139,281	$1,466,289	$1,265,122	$201,167	-$672,991
	HUMAN SUPPORT SERVICES	$858,012	$572,008	$527,755	$496,345	$31,410	-$44,253
	HUMAN SVC CTR S METRO EAST OF SOUTHERN METRO EAST	$883,226	$588,817	$621,902	$491,692	$130,210	$33,085
	INDEPENDENCE CENTER	$663,896	$442,597	$259,872	$299,630	-$39,757	-$182,725
	INFANT WELFARE SOCIETY OF CHGO	$72,050	$48,033	$12,374	$21,652	-$9,277	-$35,659
	INSTITUTE FOR HUMAN RESOURCES	$733,980	$489,320	$296,663	$335,093	-$38,430	-$192,657
	IROQUOIS MENTAL HEALTH CENTER	$533,310	$355,540	$300,790	$285,594	$15,196	-$54,750
**	JANE ADDAMS	$960,968	$640,645	$239,478	$433,452	-$193,974	-$401,167
	JANET WATTLES CENTER	$5,352,014	$3,568,009	$3,227,118	$2,565,329	$661,789	-$340,892
	JASPER COUNTY HEALTH DEPARTMENT	$153,104	$102,069	$73,160	$60,050	$13,110	-$28,910
**	JEFFERSON COUNTY COMPREHENSIVE	$739,352	$492,901	$466,826	$264,072	$202,754	-$26,076
	JEWISH CHILDRENS BUREAU OF DBA RESPONSE CENTER	$38,564	$25,709	$8,950	$13,532	-$4,581	-$16,759
	JEWISH VOCATIONAL SERVICES	$1,168,042	$778,695	$928,145	$444,963	$483,182	$149,451
	JOSSELYN CENTER FOR MENTAL	$313,402	$208,935	$63,885	$58,224	$5,661	-$145,050
	LAKE COUNTY	$2,283,890	$1,522,593	$770,213	$951,127	-$180,914	-$752,380
	LARKIN CENTER FOR CHILDREN	$197,276	$131,517	$101,136	$68,800	$32,336	-$30,382
	LAWRENCE COUNTY HEALTH DEPARTMENT	$457,453	$304,969	$325,423	$243,135	$82,287	$20,454
	LESTER AND ROSALIE ANIXTER CTR	$628,445	$418,963	$287,456	$315,766	-$28,311	-$131,508
	LEYDEN FAMILY SVCS & M H CTR	$877,607	$585,071	$405,989	$336,542	$69,447	-$179,082
	LORETTO HOSPITAL	$805,424	$536,949	$288,467	$383,203	-$94,736	-$248,482
	LOYOLA UNIVERSITY MEDICAL CNTR	$24,142	$16,095	$0	$0	$0	-$16,095

Note	Agency Name	FY 05 Total Contract Medicaid Target Amount	FY 05 YTD Medicaid Target Prorated through February	FY 05 YTD Actual Medicaid Billed through March Cycle 2	FY 04 YTD Actual Medicaid Billed through March Cycle 2	FY05 YTD Actual Medicaid Billed through March Minus FY04 YTD Actual Medicaid Billed through March	FY05 YTD Actual Medicaid Billed through March Minus FY05 YTD Medicaid Target prorated through February
	LUTHERAN SOCIAL SERVICES OF IL	$2,705,830	$1,803,887	$1,218,373	$1,437,012	-$218,639	-$585,513
##	MACOUPIN COUNTY MENTAL HEALTH	$667,028	$444,685	$390,714	$304,287	$86,427	-$53,971
	MAINE CENTER INC	$384,676	$256,451	$142,150	$75,736	$66,414	-$114,301
	MASSAC COUNTY MENTAL HEALTH MASSAC CTY MH & COUNS	$530,270	$353,513	$375,824	$303,448	$72,376	$22,311
	MCHENRY CO YSB	$188,024	$125,349	$174,192	$485,705	-$311,513	$48,843
	MCHENRY COUNTY OF ILLINOIS BOARD OF HEALTH	$495,372	$330,248	$91,895	$63,160	$28,736	-$238,353
**	MCLEAN COUNTY CTR HUMAN SRV IN	$2,351,281	$1,567,521	$1,120,911	$1,067,858	$53,053	-$446,610
	MENTAL HEALTH CENTER OF CHAMPAIGN COUNTY	$3,702,682	$2,468,455	$1,799,709	$1,885,718	-$86,009	-$668,745
	MENTAL HEALTH CTRS OF CNTRL IL	$4,875,348	$3,250,232	$2,384,708	$2,480,203	-$95,495	-$865,524
	MERCY HOSPITAL & MEDICAL CTR	$117,734	$78,489	$0	$0	$0	-$78,489
##	METROPOLITAN FAMILY SERVICES	$2,069,745	$1,379,830	$501,036	$573,250	-$72,214	-$878,794
	MONTGOMERY COUNTY	$409,364	$272,909	$179,913	$178,918	$995	-$92,996
	MOULTRIE COUNTY BEACON	$91,889	$61,259	$39,247	$43,231	-$3,984	-$22,012
	MOULTRIE COUNTY COUNSELING CTR	$145,678	$97,119	$106,710	$87,979	$18,731	$9,591
	MOUNT SINAI HOSP MEDICAL CTR	$2,329,497	$1,552,998	$207,533	$971,332	-$763,799	-$1,345,465
##	NORTH CENTRAL BEHAVIORAL HEALTH SYSTEMS INC	$3,104,766	$2,069,844	$794,400	$1,356,975	-$562,575	-$1,275,444
	NORTHPOINTE ACHIEVEMENT CENTER	$116,390	$77,593	$65,440	$34,521	$30,920	-$12,153
	NORTHWESTERN MEMORIAL HOSPITAL	$688,912	$459,275	$0	$0	$0	-$459,275
	OCCUPATIONAL DEVELOPMENT CTR	$22,398	$14,932	$0	$0	$0	-$14,932
	PEDIATRIC CENTER OF CHICAGO LT	$86,872	$57,915	$10,001	$7,945	$2,056	-$47,914
	PERRY CNTY COUNSELING CTR INC DBA SOUTHER IL BEHAVIORAL SVCS	$373,992	$249,328	$164,430	$185,209	-$20,780	-$84,898
	PIATT COUNTY M H CENTER	$215,680	$143,787	$143,225	$75,793	$67,431	-$562
	PILSEN-LITTLE VILLAGE MENTAL HEALTH CENTER,INC	$1,478,538	$985,692	$522,796	$509,114	$13,682	-$462,896
	PIONEER CENTER MCHENRY COUNTY	$710,546	$473,697	$569,649	$516,376	$53,274	$95,952
	PROVISO FAMILY SERVICES INC	$2,644,123	$1,762,749	$572,428	$663,999	-$91,570	-$1,190,320

Note	Agency Name	FY 05 Total Contract Medicaid Target Amount	FY 05 YTD Medicaid Target Prorated through February	FY 05 YTD Actual Medicaid Billed through March Cycle 2	FY 04 YTD Actual Medicaid Billed through March Cycle 2	FY05 YTD Actual Medicaid Billed through March Minus FY04 YTD Actual Medicaid Billed through March	FY05 YTD Actual Medicaid Billed through March Minus FY05 YTD Medicaid Target prorated through February
	RESIDENTIAL OPTIONS	$814,964	$543,309	$474,974	$494,245	-$19,271	-$68,335
	ROBERT YOUNG CENTER FOR COMMUNITY MH	$2,344,784	$1,563,189	$1,068,197	$900,534	$167,663	-$494,993
	ROCK RIVER VALLEY SELF HELP	$4,314	$2,876	$0	$0	$0	-$2,876
	ROSELAND CHRIST MINISTERIES	$30,226	$20,151	$0	$0	$0	-$20,151
	SCHUYLER COUNSELING & HLTH SVC DBA SCHUYLER COUNTY HLTH DEPT	$47,362	$31,575	$37,427	$19,684	$17,743	$5,852
	SEARCH DEVELOPMENTAL CENTER	$37,738	$25,159	$0	$0	$0	-$25,159
	SERTOMA CENTRE INC C/O BUSINESS OFFICE	$454,607	$303,071	$235,804	$334,889	-$99,085	-$67,267
	SHELBY COUNTY COMM SERV INC	$435,232	$290,155	$252,991	$201,668	$51,323	-$37,164
	SINNISSIPPI CENTERS INC	$2,811,464	$1,874,309	$1,058,247	$1,419,281	-$361,033	-$816,062
	SOUTH CENTRAL COMMUNITY HEALTH	$271,074	$180,716	$97,132	$97,246	-$114	-$83,584
	SOUTH SIDE OFFICE OF CONCERN	$98,418	$65,612	$31,745	$39,619	-$7,873	-$33,867
	SOUTHEASTERN IL COUNSELING	$1,036,632	$691,088	$488,299	$502,294	-$13,995	-$202,789
	SOUTHERN IL REGIONAL SOCIAL SERVICE INC	$2,525,438	$1,683,625	$1,507,840	$1,669,363	-$161,523	-$175,785
	SOUTHERN ILLINOIS UNIVERSITY DEPT OF PSYCHIATRY	$526,208	$350,805	$246,220	$46,658	$199,561	-$104,586
	SOUTHWEST COMMUNITY SVCS INC	$802,052	$534,701	$371,353	$314,325	$57,028	-$163,348
	ST CLAIR ASSOCIATED VOCATIONAL	$1,726	$1,151	$0	$0	$0	-$1,151
	ST MARY OF NAZARETH HOSPITAL	$235,900	$157,267	$28,447	$24,526	$3,922	-$128,820
	STEPPING STONES OF ROCKFORD IN	$2,787,367	$1,858,245	$1,605,755	$1,801,567	-$195,813	-$252,490
	STICKNEY PUBLIC HEALTH DIST	$80,080	$53,387	$34,094	$20,428	$13,666	-$19,293
	TAZWOOD MENTAL HEALTH CTR INC	$1,277,684	$851,789	$619,998	$494,751	$125,246	-$231,792
	THE CATHOLIC CHARITIES OF THE ARCHDIOCESE OF CHICAGO	$235,454	$156,969	$75,781	$116,723	-$40,941	-$81,188
	THE KENNETH W YOUNG CENTERS	$1,079,633	$719,755	$511,236	$382,793	$128,443	-$208,519
	THE THRESHOLDS DBA MOTHERS PROJECT	$13,751,428	$9,167,619	$6,365,688	$5,299,993	$1,065,695	-$2,801,931
	TRADE INDUSTRIES DBA HAMILTON CO ASSOC FSU	$7,936	$5,291	$0	$0	$0	-$5,291
**	TRANSITIONS OF WESTERN IL INC	$1,308,798	$872,532	$0	$389,815	-$389,815	-$872,532

Note	Agency Name	FY 05 Total Contract Medicaid Target Amount	FY 05 YTD Medicaid Target Prorated through February	FY 05 YTD Actual Medicaid Billed through March Cycle 2	FY 04 YTD Actual Medicaid Billed through March Cycle 2	FY05 YTD Actual Medicaid Billed through March Minus FY04 YTD Actual Medicaid Billed through March	FY05 YTD Actual Medicaid Billed through March Minus FY05 YTD Medicaid Target prorated through February
	TRICITY FAMILY SERVICES	$54,476	$36,317	$36,827	$26,865	$9,962	$510
	TRI-COUNTY COUNSELING CENTER	$721,386	$480,924	$291,357	$359,786	-$68,428	-$189,567
	TRILOGY INC	$2,651,017	$1,767,345	$828,744	$1,111,540	-$282,797	-$938,601
	TRINITY SERVICES INC	$1,130,761	$753,840	$1,042,164	$865,235	$176,929	$288,324
	TURNING POINT BEHAVIORAL HEALTH	$873,632	$582,421	$328,440	$370,803	-$42,364	-$253,982
	UNION COUNTY COUNSELING SVC	$983,532	$655,688	$528,327	$519,355	$8,972	-$127,361
	UNIVERSITY OF ILLINOIS	$50,676	$33,784	$46,453	$0	$46,453	$12,669
	VICTOR C NEUMANN ASSOCIATION	$1,914,402	$1,276,268	$823,626	$795,519	$28,106	-$452,642
	WABASH COUNTY HEALTH DEPT	$308,346	$205,564	$118,348	$167,912	-$49,564	-$87,216
	WASHINGTON COUNTY VOCATIONAL COMMUNITY COUNSELING CENTER	$23,044	$15,363	$13,244	$7,992	$5,252	-$2,119
	WILL COUNTY HEALTH DEPARTMENT	$1,126,100	$750,733	$576,179	$339,222	$236,957	-$174,554
	WILPOWER INC	$758,402	$505,601	$355,396	$336,335	$19,061	-$150,205
	YMCA OF METROPOLITAN CHICAGO	$201,108	$134,072	$83,753	$69,844	$13,909	-$50,319
	YOUTH GUIDANCE	$68,076	$45,384	$1,428	$7,531	-$6,104	-$43,956
						$0	$0
		$187,442,212	$124,961,475	$87,958,001	$85,808,000	$2,150,001	-$37,003,473

** agencies with small error in actual billing amounts for March cycle only (which is being corrected)
agencies with correct target amounts shown, but that do not match SIS-Online amounts due to error (which is being corrected)

Total Billings (Medicaid and Non-Medicaid) YTD Through March Compared to FY05 Prorated Target

Note	Agency Name	FY05 Total FFS Contract Target (Medicaid and Non-Medicaid)	FY 05 Prorated YTD Total Target FFS through February (advanced payments)	FY 05 Actual Billings through March Cycle 2	FY 05 Actual Billings through March Cycle 2 Minus FY 05 Prorated Target
	ABRAHAM LINCOLN CENTER	$953,687	$635,791	$255,132	-$380,660
	ADA S MCKINLEY CMNTY SVCS INC	$1,483,116	$988,744	$271,747	-$716,997
	ADAPT OF ILLINOIS INC	$3,894,678	$2,596,452	$2,884,954	$288,502
	ADVOCATE NORTHSIDE HEALTH SYS DBA RAVENSWOOD HOSPITAL	$1,844,967	$1,229,978	$41,743	-$1,188,235
	ALEXIAN BROTHERS NORTHWEST	$1,847,231	$1,231,487	$782,009	-$449,478
	ALLENDALE ASSOCIATION	$268,406	$178,937	$115,924	-$63,013
	ALLIANCE FOR THE MENTALLY ILL	$842,076	$561,384	$159,279	-$402,105
	ASIAN HUMAN SERVICES INC	$814,785	$543,190	$579,737	$36,547
	ASSOCIATION FOR INDIVIDUAL	$2,468,476	$1,645,651	$919,130	-$726,521
	ASSOCIATION HOUSE OF CHICAGO	$2,082,034	$1,388,023	$982,887	-$405,135
	BEACON THERAPEUTIC SCHOOL INC	$1,029,863	$686,575	$1,028,651	$342,075
	BEHAVIORAL HLTH ALTERNATIVES I BEHAVIOR HEALTH ALTERNATIVES	$423,976	$282,651	$255,162	-$27,488
	BEN GORDON CENTER	$1,111,707	$741,138	$509,386	-$231,752
	BOBBY E WRIGHT CCMHC	$3,427,427	$2,284,951	$1,013,622	-$1,271,329
	BOND COUNTY	$186,231	$124,154	$98,586	-$25,568
##	BRIDGEWAY INC	$4,298,912	$2,865,941	$1,139,781	-$1,726,160
	BROWN COUNTY MENTAL HEALTH CTR	$1,315,317	$876,878	$466,182	-$410,696
	CALL FOR HELP INC	$605,696	$403,797	$434,116	$30,318
	CASS COUNTY MENTAL HEALTH ASSN	$374,231	$249,487	$60,252	-$189,235
##	CENTER FOR CHILDRENS SERVICES	$851,158	$567,439	$526,220	-$41,219
	CENTER ON DEAFNESS INC	$480,283	$320,189	$255,169	-$65,020
	CHALLENGE UNLIMITED INC	$28,131	$18,754	$4,889	-$13,865
	CHESTNUT HEALTH SYSTEMS INC	$5,215,363	$3,476,909	$2,653,848	-$823,061

Note	Agency Name	FY05 Total FFS Contract Target (Medicaid and Non-Medicaid)	FY 05 Prorated YTD Total Target FFS through February (advanced payments)	FY 05 Actual Billings through March Cycle 2	FY 05 Actual Billings through March Cycle 2 Minus FY 05 Prorated Target
**	CHICAGO CITY OF	$8,130,194	$5,420,129	$1,978,401	-$3,441,729
	CHILDRENS CENTER FOR BEHAVIORA	$253,265	$168,843	$71,620	-$97,224
	CHILDRENS HOME & AID SOC OF IL	$462,765	$308,510	$254,864	-$53,646
	CHILDRENS HOME ASSOC OF IL	$802,958	$535,305	$220,798	-$314,508
	CHRISTIAN COUNTY MENTAL HEALTH	$754,823	$503,215	$209,517	-$293,699
	CIRCLE FAMILY CARE INC	$2,188,752	$1,459,168	$673,691	-$785,477
	COLES CO MENTAL HLTH ASSN INC DBA COLES CO M H CENTER	$1,795,507	$1,197,005	$963,654	-$233,351
##	COMMUNITY CARE OPTIONS	$2,667,507	$1,778,338	$614,836	-$1,163,502
	COMMUNITY CNSLNG CTRS CHICAGO	$8,558,088	$5,705,392	$3,336,681	-$2,368,711
	COMMUNITY COUNSELING CENTER OF	$2,489,135	$1,659,424	$1,290,631	-$368,793
	COMMUNITY MENTAL HEALTH BOARD TOWN OF OAK PARK	$157,998	$105,332	$78,042	-$27,290
	COMMUNITY MENTAL HLTH CNCL INC	$9,176,236	$6,117,491	$3,105,285	-$3,012,205
	COMMUNITY RESOURCE & COUNSELIN	$490,343	$326,895	$232,799	-$94,096
	COMMUNITY RESOURCE CENTER INC	$2,290,857	$1,527,238	$2,290,857	$763,619
	COMMUNITY WORKSHOP & TRAINING	$128,295	$85,530	$1,839	-$83,691
**	COMPREHENSIVEMENTAL HLTH CTR	$2,331,987	$1,554,658	$1,087,477	-$467,181
	COOK COUNTY	$223,297	$148,865	$60,504	-$88,361
	CORNERSTONE SERVICES	$1,119,062	$746,041	$880,971	$134,929
	COUNSELING CENTER OF LAKEVIEW	$2,221,480	$1,480,987	$1,065,503	-$415,483
	COUNSELING CENTER OF PIKE CO	$229,747	$153,165	$50,733	-$102,432
	CROSSPOINT HUMAN SERVICES	$1,756,499	$1,170,999	$684,170	-$486,829
	CUMBERLAND ASSOCIATES INC	$239,414	$159,609	$121,642	-$37,967
	DAY SCHOOL	$137,354	$91,569	$85,029	-$6,541
	DELTA CENTER INC	$1,667,192	$1,111,461	$1,104,976	-$6,486
	DEPAUL UNIVERSITY C/O MENTAL HEALTH CTR	$624,051	$416,034	$56,211	-$359,823
	DEWITT CO HUMAN RESOURCE CTR	$281,554	$187,703	$139,262	-$48,441

Note	Agency Name	FY05 Total FFS Contract Target (Medicaid and Non-Medicaid)	FY 05 Prorated YTD Total Target FFS through February (advanced payments)	FY 05 Actual Billings through March Cycle 2	FY 05 Actual Billings through March Cycle 2 Minus FY 05 Prorated Target
	DOUGLAS COUNTY MENTAL HEALTH & FAMILY COUNSELING ASSN, INC.	$652,964	$435,309	$467,565	$32,256
**	DUPAGE COUNTY HEALTH DEPARTMENT	$5,627,171	$3,751,447	$2,568,125	-$1,183,322
	ECKER CENTER FOR MENTAL HEALTH	$2,295,702	$1,530,468	$1,232,594	-$297,874
	EGYPTIAN PUBLIC & MENTAL HEALTH DEPARTMENT	$2,199,749	$1,466,499	$1,598,537	$132,038
	ELM CITY REHABILITATION CENTER	$225,868	$150,579	$0	-$150,579
**	EVANSTON NORTHWESTERN HEALTH	$637,702	$425,135	$23,120	-$402,015
	FAMILY ALLIANCE INC	$187,261	$124,841	$160,504	$35,663
	FAMILY COUNSELING CENTER INC	$1,066,722	$711,148	$586,174	-$124,974
	FAMILY SERVICE & CMNTY MENTAL HEALTH CNTR OF MCHENRY COUNTY	$602,855	$401,903	$283,118	-$118,785
	FAMILY SERVICE & MENTAL HEALTH	$498,182	$332,121	$102,265	-$229,856
	FAMILY SERVICE ASSOCIATION OF GREATER ELGIN	$231,410	$154,273	$54,654	-$99,619
**	FAMILY SERVICE MHC OF OAK PARK & RIVER FOREST	$408,958	$272,639	$167,851	-$104,787
	FARM RESOURCES	$569,999	$379,999	$0	-$379,999
	FOX VALLEY	$0	$0	$0	$0
**	FRANKLIN-WILLIAMSON HUMAN HUMAN SERVICES, INC.	$3,742,310	$2,494,873	$3,560,111	$1,065,237
	GATEWAY FOUNDATION INC	$899,300	$599,533	$52,157	-$547,377
	GRAND PRAIRIE SERVICES	$6,123,300	$4,082,200	$3,171,913	-$910,287
	GROW IN ILLINOIS	$734,206	$489,471	$0	-$489,471
	GRUNDY COUNTY HEALTH DEPT	$155,109	$103,406	$110,622	$7,216
	HABILITATIVE SYSTEMS INC	$1,184,242	$789,495	$217,257	-$572,238
	HANCOCK COUNTY MENTAL HEALTH	$363,300	$242,200	$275,571	$33,371
	HEARTLAND HEALTH OUTREACH	$2,327,084	$1,551,389	$1,045,102	-$506,288
	HEARTLAND HUMAN SERVICES	$1,913,708	$1,275,805	$1,019,452	-$256,353
##	HELEN WHEELER CTR COMM MNTL HL	$480,633	$320,422	$217,543	-$102,879
	HEPHZIBAH CHILDRENS HOME ASSN	$357,769	$238,513	$8,360	-$230,152

Note	Agency Name	FY05 Total FFS Contract Target (Medicaid and Non-Medicaid)	FY 05 Prorated YTD Total Target FFS through February (advanced payments)	FY 05 Actual Billings through March Cycle 2	FY 05 Actual Billings through March Cycle 2 Minus FY 05 Prorated Target
	HERITAGE BHVRL HEALTH CTR INC	$3,318,319	$2,212,213	$1,047,966	-$1,164,247
	HOUSING OPTIONS F T MI	$417,086	$278,057	$4,686	-$273,371
	HUMAN RESOURCES CENTER 0F EDGAR AND CLARK COUNTIES	$378,555	$252,370	$183,719	-$68,651
	HUMAN RESOURCES DEV INST INC	$5,084,038	$3,389,359	$2,761,752	-$627,607
	HUMAN SERVICE CENTER HUMAN SERV CTR PEORIA	$4,860,655	$3,240,437	$1,935,098	-$1,305,339
	HUMAN SUPPORT SERVICES	$907,465	$604,977	$577,208	-$27,769
	HUMAN SVC CTR S METRO EAST OF SOUTHERN METRO EAST	$930,806	$620,537	$669,482	$48,945
	INDEPENDENCE CENTER	$839,212	$559,475	$392,893	-$166,582
	INFANT WELFARE SOCIETY OF CHGO	$161,718	$107,812	$15,615	-$92,197
	INSTITUTE FOR HUMAN RESOURCES	$995,115	$663,410	$410,662	-$252,748
	IROQUOIS MENTAL HEALTH CENTER	$689,008	$459,339	$312,938	-$146,400
**	JANE ADDAMS	$1,266,068	$844,045	$285,468	-$558,578
	JANET WATTLES CENTER	$6,685,436	$4,456,957	$3,612,262	-$844,696
	JASPER COUNTY HEALTH DEPARTMENT	$247,238	$164,825	$75,390	-$89,436
**	JEFFERSON COUNTY COMPREHENSIVE	$1,037,815	$691,877	$535,367	-$156,509
	JEWISH CHILDRENS BUREAU OF DBA RESPONSE CENTER	$83,809	$55,873	$13,865	-$42,007
	JEWISH VOCATIONAL SERVICES	$1,881,953	$1,254,635	$1,357,881	$103,246
	JOSSELYN CENTER FOR MENTAL	$833,007	$555,338	$192,341	-$362,997
	LAKE COUNTY	$3,524,290	$2,349,527	$1,117,573	-$1,231,954
	LARKIN CENTER FOR CHILDREN	$345,572	$230,381	$154,712	-$75,669
	LAWRENCE COUNTY HEALTH DEPARTMENT	$482,453	$321,635	$367,619	$45,984
	LESTER AND ROSALIE ANIXTER CTR	$841,134	$560,756	$333,861	-$226,895
	LEYDEN FAMILY SVCS & M H CTR	$1,325,848	$883,899	$587,599	-$296,300
	LORETTO HOSPITAL	$937,009	$624,673	$427,877	-$196,795
	LOYOLA UNIVERSITY MEDICAL CNTR	$85,140	$56,760	$0	-$56,760

Note	Agency Name	FY05 Total FFS Contract Target (Medicaid and Non-Medicaid)	FY 05 Prorated YTD Total Target FFS through February (advanced payments)	FY 05 Actual Billings through March Cycle 2	FY 05 Actual Billings through March Cycle 2 Minus FY 05 Prorated Target
	LUTHERAN SOCIAL SERVICES OF IL	$3,402,331	$2,268,221	$1,753,525	-$514,696
##	MACOUPIN COUNTY MENTAL HEALTH	$889,978	$593,319	$395,974	-$197,345
	MAINE CENTER INC	$956,358	$637,572	$146,966	-$490,606
	MASSAC COUNTY MENTAL HEALTH MASSAC CTY MH & COUNS	$615,849	$410,566	$421,220	$10,654
	MCHENRY CO YSB	$188,024	$125,349	$185,571	$60,221
	MCHENRY COUNTY OF ILLINOIS BOARD OF HEALTH	$1,547,051	$1,031,367	$106,287	-$925,080
**	MCLEAN COUNTY CTR HUMAN SRV IN	$3,061,546	$2,041,031	$1,532,831	-$508,200
	MENTAL HEALTH CENTER OF CHAMPAIGN COUNTY	$3,825,717	$2,550,478	$1,916,408	-$634,070
	MENTAL HEALTH CTRS OF CNTRL IL	$6,209,310	$4,139,540	$2,868,065	-$1,271,475
	MERCY HOSPITAL & MEDICAL CTR	$442,003	$294,669	$0	-$294,669
##	METROPOLITAN FAMILY SERVICES	$3,729,268	$2,486,179	$566,437	-$1,919,741
	MONTGOMERY COUNTY	$570,064	$380,043	$182,653	-$197,389
	MOULTRIE COUNTY BEACON	$92,532	$61,688	$39,247	-$22,441
	MOULTRIE COUNTY COUNSELING CTR	$195,498	$130,332	$119,476	-$10,856
	MOUNT SINAI HOSP MEDICAL CTR	$3,438,940	$2,292,627	$277,739	-$2,014,888
##	NORTH CENTRAL BEHAVIORAL HEALTH SYSTEMS INC	$4,361,882	$2,907,921	$945,766	-$1,962,155
	NORTHPOINTE ACHIEVEMENT CENTER	$264,409	$176,273	$150,782	-$25,491
	NORTHWESTERN MEMORIAL HOSPITAL	$1,835,456	$1,223,637	$0	-$1,223,637
	OCCUPATIONAL DEVELOPMENT CTR	$100,791	$67,194	$0	-$67,194
	PEDIATRIC CENTER OF CHICAGO LT	$240,343	$160,229	$10,032	-$150,197
	PERRY CNTY COUNSELING CTR INC DBA SOUTHER IL BEHAVIORAL SVCS	$511,251	$340,834	$225,141	-$115,693
	PIATT COUNTY M H CENTER	$445,183	$296,789	$208,015	-$88,773
	PILSEN-LITTLE VILLAGE MENTAL HEALTH CENTER,INC	$2,332,892	$1,555,261	$578,368	-$976,893
	PIONEER CENTER MCHENRY COUNTY	$710,546	$473,697	$615,326	$141,628
	PROVISO FAMILY SERVICES INC	$2,884,093	$1,922,729	$719,683	-$1,203,046
	RESIDENTIAL OPTIONS	$814,964	$543,309	$479,512	-$63,797

Note	Agency Name	FY05 Total FFS Contract Target (Medicaid and Non-Medicaid)	FY 05 Prorated YTD Total Target FFS through February (advanced payments)	FY 05 Actual Billings through March Cycle 2	FY 05 Actual Billings through March Cycle 2 Minus FY 05 Prorated Target
	ROBERT YOUNG CENTER FOR COMMUNITY MH	$3,491,628	$2,327,752	$1,521,172	-$806,580
	ROCK RIVER VALLEY SELF HELP	$16,177	$10,785	$0	-$10,785
	ROSELAND CHRIST MINISTERIES	$151,128	$100,752	$0	-$100,752
	SCHUYLER COUNSELING & HLTH SVC DBA SCHUYLER COUNTY HLTH DEPT	$118,923	$79,282	$39,918	-$39,364
	SEARCH DEVELOPMENTAL CENTER	$94,345	$62,897	$0	-$62,897
	SERTOMA CENTRE INC C/O BUSINESS OFFICE	$454,607	$303,071	$302,051	-$1,020
	SHELBY COUNTY COMM SERV INC	$578,866	$385,911	$303,364	-$82,547
	SINNISSIPPI CENTERS INC	$3,361,434	$2,240,956	$1,070,374	-$1,170,582
	SOUTH CENTRAL COMMUNITY HEALTH	$393,128	$262,085	$99,217	-$162,868
	SOUTH SIDE OFFICE OF CONCERN	$157,839	$105,226	$33,004	-$72,222
	SOUTHEASTERN IL COUNSELING	$1,398,845	$932,563	$579,679	-$352,884
	SOUTHERN IL REGIONAL SOCIAL SERVICE INC	$2,625,917	$1,750,611	$1,608,319	-$142,292
	SOUTHERN ILLINOIS UNIVERSITY DEPT OF PSYCHIATRY	$612,715	$408,477	$280,250	-$128,226
	SOUTHWEST COMMUNITY SVCS INC	$1,356,902	$904,601	$485,715	-$418,886
	ST CLAIR ASSOCIATED VOCATIONAL	$6,469	$4,313	$0	-$4,313
	ST MARY OF NAZARETH HOSPITAL	$648,665	$432,443	$30,618	-$401,825
	STEPPING STONES OF ROCKFORD IN	$2,787,367	$1,858,245	$1,608,632	-$249,613
	STICKNEY PUBLIC HEALTH DIST	$170,465	$113,643	$103,213	-$10,430
	TAZWOOD MENTAL HEALTH CTR INC	$1,987,875	$1,325,250	$827,840	-$497,410
	THE CATHOLIC CHARITIES OF THE ARCHDIOCESE OF CHICAGO	$343,671	$229,114	$99,546	-$129,568
	THE KENNETH W YOUNG CENTERS	$2,040,844	$1,360,563	$1,019,566	-$340,997
	THE THRESHOLDS DBA MOTHERS PROJECT	$19,957,984	$13,305,323	$7,629,216	-$5,676,107
	TRADE INDUSTRIES DBA HAMILTON CO ASSOC FSU	$19,841	$13,227	$0	-$13,227
**	TRANSITIONS OF WESTERN IL INC	$1,742,193	$1,161,462	$0	-$1,161,462
	TRICITY FAMILY SERVICES	$107,580	$71,720	$39,072	-$32,648

Note	Agency Name	FY05 Total FFS Contract Target (Medicaid and Non-Medicaid)	FY 05 Prorated YTD Total Target FFS through February (advanced payments)	FY 05 Actual Billings through March Cycle 2	FY 05 Actual Billings through March Cycle 2 Minus FY 05 Prorated Target
	TRI-COUNTY COUNSELING CENTER	$982,282	$654,855	$379,848	-$275,006
	TRILOGY INC	$3,637,184	$2,424,789	$1,247,099	-$1,177,690
	TRINITY SERVICES INC	$1,431,381	$954,254	$1,067,831	$113,577
	TURNING POINT BEHAVIORAL HEALTH	$1,238,510	$825,673	$475,851	-$349,823
	UNION COUNTY COUNSELING SVC	$1,147,221	$764,814	$543,455	-$221,359
	UNIVERSITY OF ILLINOIS	$204,671	$136,447	$48,211	-$88,236
	VICTOR C NEUMANN ASSOCIATION	$2,612,690	$1,741,793	$1,018,271	-$723,523
	WABASH COUNTY HEALTH DEPT	$398,489	$265,659	$153,970	-$111,689
	WASHINGTON COUNTY VOCATIONAL COMMUNITY COUNSELING CENTER	$61,289	$40,859	$17,144	-$23,715
	WILL COUNTY HEALTH DEPARTMENT	$1,734,463	$1,156,309	$1,063,511	-$92,798
	WILPOWER INC	$991,322	$660,881	$424,762	-$236,119
	YMCA OF METROPOLITAN CHICAGO	$386,516	$257,677	$83,838	-$173,839
	YOUTH GUIDANCE	$181,950	$121,300	$1,672	-$119,628
		$261,970,019	$174,646,679	$109,046,084	-$65,600,595

** agencies with small error in actual billing amounts for March cycle only (which is being corrected)
agencies with correct target amounts shown, but that do not match SIS-Online amounts due to error (which is being corrected)

FY05 Billing Denial Rates

February Cycle 1 & 2 Billing Denials by Agency

		Billing Records		Billing Dollars	
Agency Name	Note	Denial % Rate by Billing Records	Total Billing Denials	Denial % Rate by Billing $	Total Billing Denials $
ABRAHAM LINCOLN CENTER		0.36%	3	0.45%	$145.00
ADA S MCKINLEY CMNTY SVCS INC		67.86%	38	63.82%	$1,430.56
ADAPT OF ILLINOIS INC		1.32%	185	1.45%	$2,650.07
ADVOCATE NORTHSIDE HEALTH SYS DBA RAVENSWOOD HOSPITAL	**	97.42%	302	24.79%	$228.04
ALEXIAN BROTHERS NORTHWEST		2.96%	366	4.50%	$16,741.21
ALLENDALE ASSOCIATION		8.53%	25	9.33%	$1,514.44
ALLIANCE FOR THE MENTALLY ILL (Transitions)		0.47%	3	1.36%	$410.15
ASIAN HUMAN SERVICES INC	**	0.00%	0	0.00%	$0.00
ASSOCIATION FOR INDIVIDUAL		13.07%	467	27.21%	$34,052.65
ASSOCIATION HOUSE OF CHICAGO		13.57%	886	12.03%	$20,586.42
BEACON THERAPEUTIC		62.19%	403	63.75%	$30,038.22
BEHAVIORAL HLTH ALTERNATIVES		3.70%	4	1.82%	$81.80
BEN GORDON CENTER		7.20%	120	5.72%	$3,558.69
BOBBY E WRIGHT CCMHC		8.36%	219	7.50%	$9,278.42
BOND COUNTY	**	8.26%	18	9.45%	$1,034.94
BRIDGEWAY INC		12.53%	91	4.43%	$3,231.62
BROWN COUNTY MENTAL HEALTH CTR		5.50%	204	4.82%	$4,165.96
CALL FOR HELP INC		3.42%	13	1.67%	$265.85
CASS COUNTY MENTAL HEALTH ASSN	**	16.67%	1	11.96%	$31.46
CENTER FOR CHILDRENS SERVICES		21.57%	121	17.38%	$12,518.33
CENTER ON DEAFNESS INC	**	15.41%	334	19.02%	$10,215.03
CHALLENGE UNLIMITED INC	**	2.08%	1	0.93%	$22.80
CHESTNUT HEALTH SYSTEMS INC	**	99.93%	2711	99.92%	$51,745.35
CHICAGO CITY OF	**	64.14%	1964	41.92%	$39,130.11
CHILDRENS CENTER FOR BEHAVIORA	**	12.24%	29	11.17%	$956.52
CHILDRENS HOME & AID SOC OF IL		3.82%	11	5.73%	$1,036.93
CHILDRENS HOME ASSOC OF IL		0.15%	1	0.59%	$209.40
CHRISTIAN COUNTY MENTAL HEALTH	**	14.81%	89	13.81%	$3,341.51
CIRCLE FAMILY CARE INC		17.53%	313	15.90%	$11,569.85
COLES CO MENTAL HLTH		3.63%	170	2.82%	$4,519.10
COMMUNITY CARE OPTIONS		12.78%	133	11.86%	$6,442.27
COMMUNITY CNSLNG CTRS CHICAGO		93.14%	407	91.22%	$14,437.54
COMMUNITY COUNSELING CENTER OF N Madison		6.78%	279	10.67%	$9,837.33
COMMUNITY MENTAL HEALTH BOARD TOWN OF OAK PARK		4.33%	20	6.44%	$805.42
COMMUNITY MENTAL HLTH CNCL INC		16.01%	955	13.77%	$43,052.29
COMMUNITY RESOURCE & COUNSELIN	**	9.33%	261	8.87%	$14,350.18
COMMUNITY RESOURCE CENTER INC		24.64%	1922	22.27%	$60,604.30
COMMUNITY WORKSHOP & TRAINING	**	100.00%	2	100.00%	$20.52

		Billing Records		Billing Dollars	
Agency Name	Note	Denial % Rate by Billing Records	Total Billing Denials	Denial % Rate by Billing $	Total Billing Denials $
COMPREHENSIVE MENTAL HLTH CTR	**	12.58%	508	19.75%	$48,899.15
COOK COUNTY	**	25.68%	38	21.42%	$1,301.15
CORNERSTONE SERVICES	**	0.07%	2	0.10%	$106.42
COUNSELING CENTER OF LAKEVIEW	**	16.11%	317	17.53%	$17,750.99
COUNSELING CENTER OF PIKE CO		3.28%	4	4.50%	$296.84
CROSSPOINT HUMAN SERVICES	**	12.37%	1132	13.27%	$27,558.68
CUMBERLAND ASSOCIATES INC		7.38%	9	5.78%	$400.96
DAY SCHOOL	**	1.92%	2	2.41%	$196.68
DELTA CENTER INC	**	9.49%	237	13.92%	$12,554.03
DEPAUL UNIVERSITY C/O MENTAL HEALTH CTR		5.00%	9	2.71%	$285.60
DEWITT CO HUMAN RESOURCE CTR	**	1.35%	6	1.71%	$399.98
DOUGLAS COUNTY MENTAL HEALTH	**	0.00%	0	0.00%	$0.00
DUPAGE COUNTY HEALTH DEPARTMENT	**	0.00%		0.00%	
ECKER CENTER FOR MENTAL HEALTH	**	11.46%	1072	8.84%	$24,249.35
EGYPTIAN PUBLIC & MENTAL HEALTH DEPARTMENT		1.88%	95	1.57%	$4,340.89
ELM CITY REHABILITATION CENTER	**	0.00%		0.00%	
EVANSTON NORTHWESTERN HEALTH	**	0.00%		0.00%	
FAMILY ALLIANCE INC		0.00%	0	0.00%	$0.00
FAMILY COUNSELING CENTER INC		5.75%	146	5.63%	$5,264.67
FAMILY SERVICE & CMNTY MENTAL HEALTH CNTR OF MCHENRY COUNTY		65.34%	1529	70.63%	$101,312.87
FAMILY SERVICE & MENTAL HEALTH	**	51.15%	312	55.14%	$16,743.38
FAMILY SERVICE ASSOCIATION OF GREATER ELGIN	**	0.00%	0	0.00%	$0.00
FAMILY SERVICE MHC OF OAK PARK & RIVER FOREST	**	59.50%	1969	65.82%	$67,940.38
FARM RESOURCES	**	0.00%		0.00%	
FOX VALLEY	**	0.00%		0.00%	
FRANKLIN-WILLIAMSON HUMAN HUMAN SERVICES, INC.	**	19.42%	1173	15.41%	$73,950.45
GATEWAY FOUNDATION INC	**	0.00%		0.00%	
GRAND PRAIRIE SERVICES	**	4.89%	886	5.36%	$32,198.80
GROW IN ILLINOIS	**	0.00%		0.00%	
GRUNDY COUNTY HEALTH DEPT	**	17.56%	36	18.07%	$2,132.70
HABILITATIVE SYSTEMS INC	**	0.09%	1	0.05%	$14.77
HANCOCK COUNTY MENTAL HEALTH		6.65%	32	6.32%	$1,375.16
HEARTLAND HEALTH OUTREACH INC DBA HEALTH CARE INTERPRET SERV		7.60%	395	5.63%	$8,917.04
HEARTLAND HUMAN SERVICES		0.08%	4	0.11%	$137.51
HELEN WHEELER CTR COMM MNTL HL		4.32%	42	2.87%	$1,372.29
HEPHZIBAH CHILDRENS HOME ASSN	**	65.97%	221	70.59%	$42,518.19
HERITAGE BHVRL HEALTH CTR INC	**	2.63%	349	2.57%	$8,143.53
HOUSING OPTIONS F T MI		5.26%	4	2.87%	$145.60
HUMAN RESOURCES CENTER 0F EDGAR AND CLARK COUNTIES		29.99%	293	28.65%	$14,842.93
HUMAN RESOURCES DEV INST INC	**	12.89%	1330	13.35%	$55,220.96
HUMAN SERVICE CENTER HUMAN SERV CTR PEORIA	**	6.69%	963	6.64%	$51,788.03

		Billing Records		Billing Dollars	
Agency Name	Note	Denial % Rate by Billing Records	Total Billing Denials	Denial % Rate by Billing $	Total Billing Denials $
HUMAN SUPPORT SERVICES		3.57%	99	2.67%	$2,327.48
HUMAN SVC CTR S METRO EAST OF SOUTHERN METRO EAST		2.32%	34	5.30%	$2,720.02
INDEPENDENCE CENTER	**	4.59%	987	4.76%	$14,541.76
INFANT WELFARE SOCIETY OF CHGO	**	0.00%	0	0.00%	$0.00
INSTITUTE FOR HUMAN RESOURCES		9.62%	272	5.86%	$5,625.81
IROQUOIS MENTAL HEALTH CENTER	**	0.68%	16	1.60%	$653.98
JANE ADDAMS	**	92.47%	86	88.04%	$12,666.53
JANET WATTLES CENTER		8.19%	1487	11.69%	$64,797.24
JASPER COUNTY HEALTH DEPARTMENT	**	0.45%	1	0.48%	$62.92
JEFFERSON COUNTY COMPREHENSIVE		48.42%	107	36.16%	$4,387.09
JEWISH CHILDRENS BUREAU OF DBA RESPONSE CENTER		10.00%	5	5.32%	$379.25
JEWISH VOCATIONAL SERVICES		5.13%	164	4.20%	$8,949.49
JOSSELYN CENTER FOR MENTAL	**	4.21%	90	4.12%	$4,915.82
LAKE COUNTY		23.67%	2783	22.16%	$96,459.46
LARKIN CENTER FOR CHILDREN	**	6.02%	87	7.63%	$2,606.45
LAWRENCE COUNTY HEALTH DEPARTMENT	**	0.39%	8	0.30%	$154.63
LESTER AND ROSALIE ANIXTER CTR		14.08%	156	14.16%	$7,254.75
LEYDEN FAMILY SVCS & M H CTR	**	2.61%	73	3.54%	$3,851.54
LORETTO HOSPITAL		1.86%	29	3.88%	$3,406.05
LOYOLA UNIVERSITY MEDICAL CNTR	**	0.00%		0.00%	
LUTHERAN SOCIAL SERVICES OF IL		0.87%	74	1.74%	$9,222.42
MACOUPIN COUNTY MENTAL HEALTH	**	0.81%	19	1.98%	$1,041.67
MAINE CENTER INC		20.51%	298	27.58%	$16,329.95
MASSAC COUNTY MENTAL HEALTH		0.28%	2	0.58%	$312.17
MCHENRY CO YSB	**	83.60%	2544	74.08%	$240,108.73
MCHENRY COUNTY OF ILLINOIS BOARD OF HEALTH	**	0.00%		0.00%	
MCLEAN COUNTY CTR HUMAN SRV IN		8.45%	145	6.61%	$4,938.80
MENTAL HEALTH CENTER OF CHAMPAIGN COUNTY	**	70.89%	7978	78.34%	$235,024.75
MENTAL HEALTH CTRS OF CNTRL IL		6.45%	214	7.86%	$9,199.29
MERCY HOSPITAL & MEDICAL CTR	**	0.00%		0.00%	
METROPOLITAN FAMILY SERVICES	**	6.18%	139	6.87%	$7,548.19
MONTGOMERY COUNTY	**	1.77%	27	3.01%	$728.95
MOULTRIE COUNTY BEACON	**	0.00%	0	0.00%	$0.00
MOULTRIE COUNTY COUNSELING CTR	**	1.39%	5	2.11%	$353.73
MOUNT SINAI HOSP MEDICAL CTR	**	29.41%	5	35.79%	$357.60
NORTH CENTRAL BEHAVIORAL HEALTH SYSTEMS INC		1.97%	100	2.04%	$3,980.78
NORTHPOINTE ACHIEVEMENT CENTER	**	0.00%		0.00%	
NORTHWESTERN MEMORIAL HOSPITAL	**	0.00%		0.00%	
OCCUPATIONAL DEVELOPMENT CTR	**	0.00%		0.00%	
PEDIATRIC CENTER OF CHICAGO LT		0.00%	0	0.00%	$0.00
PERRY CNTY COUNSELING CTR INC DBA SOUTHER IL BEHAVIORAL SVCS		7.39%	21	3.50%	$480.52

		Billing Records		Billing Dollars	
Agency Name	Note	Denial % Rate by Billing Records	Total Billing Denials	Denial % Rate by Billing $	Total Billing Denials $
PIATT COUNTY M H CENTER		4.41%	23	3.18%	$843.21
PILSEN-LITTLE VILLAGE MENTAL HEALTH CENTER,INC		1.40%	42	1.67%	$1,462.56
PIONEER CENTER MCHENRY COUNTY	**	7.30%	170	4.30%	$3,789.50
PROVISO FAMILY SERVICES INC		2.48%	68	2.45%	$3,027.66
RESIDENTIAL OPTIONS INC DBA LEWIS AND CLARK MANOR		5.28%	423	5.48%	$7,045.02
ROBERT YOUNG CENTER FOR COMMUNITY MH		6.60%	612	5.93%	$15,816.48
ROCK RIVER VALLEY SELF HELP	**	0.00%		0.00%	
ROSELAND CHRIST MINIS TERIES	**	0.00%		0.00%	
SCHUYLER COUNSELING & HLTH SVC DBA SCHUYLER COUNTY HLTH DEPT	**	3.05%	4	2.05%	$122.70
SEARCH DEVELOPMENTAL CENTER	**	0.00%		0.00%	
SERTOMA CENTRE INC		0.93%	32	1.10%	$481.12
SHELBY COUNTY COMM SERV INC	**	3.81%	73	3.29%	$1,499.14
SINNISSIPPI CENTERS INC	**	42.05%	2417	35.74%	$71,346.56
SOUTH CENTRAL COMMUNITY HEALTH	**	4.94%	20	3.53%	$560.38
SOUTH SIDE OFFICE OF CONCERN	**	9.14%	31	8.57%	$524.23
SOUTHEASTERN IL COUNSELING	**	0.57%	17	0.79%	$769.76
SOUTHERN IL REGIONAL SOCIA L SERVICE INC		7.52%	512	6.02%	$13,951.04
SOUTHERN ILLINOIS UNIVERSITY DEPT OF PSYCHIATRY	**	32.89%	49	29.93%	$1,017.22
SOUTHWEST COMMUNITY SVCS INC	**	4.91%	213	5.48%	$4,630.22
ST CLAIR ASSOCIATED VOCATIONAL	**	0.00%		0.00%	
ST MARY OF NAZARETH HOSPITAL		4.55%	1	7.31%	$139.60
STEPPING STONES OF ROCKFORD IN		9.83%	1792	10.87%	$50,722.64
STICKNEY PUBLIC HEALTH DIST	**	5.56%	19	3.65%	$645.55
TAZWOOD MENTAL HEALTH CTR INC	**	1.20%	33	1.30%	$1,612.20
THE CATHOLIC CHARITIES OF THE ARCHDIOCESE OF CHICAGO	**	0.00%		0.00%	
THE KENNETH W YOUNG CENTERS	**	6.30%	233	0.00%	$9,129.29
THE THRESHOLDS		0.00%	0	0.00%	$0.00
TRADE INDUSTRIES DBA HAMILTON CO ASSOC FSU	**	0.00%		0.00%	
TRANSITIONS OF WESTERN IL INC		94.93%	2904	83.43%	$75,209.23
TRICITY FAMILY SERV ICES	**	77.14%	27	72.41%	$1,893.48
TRI-COUNTY COUNSELING CENTER		1.87%	11	1.45%	$403.19
TRILOGY		10.20%	638	9.29%	$12,872.92
TRINITY SERVICES INC		4.63%	200	4.26%	$5,971.44
TURNING POINT BEHAVIORAL HEALT	**	0.00%		0.00%	
UNION COUNTY COUNSELING SVC		0.72%	22	1.34%	$1,328.40
UNIVERSITY OF ILLINOIS	**	0.00%	0	0.00%	$0.00
VICTOR C NEUMANN ASSOCIATION	**	9.78%	911	16.74%	$23,685.37
WABASH COUNTY HEALTH DEPT	**	21.06%	183	18.60%	$7,646.41
WASHINGTON COUNTY VOCATIONAL		0.00%	0	0.00%	$0.00
WILL COUNTY HEALTH DEPARTMENT	**	5.85%	234	6.66%	$9,816.66
WILPOWER INC	**	11.75%	306	8.69%	$5,857.14

		Billing Records		Billing Dollars	
Agency Name	Note	Denial % Rate by Billing Records	Total Billing Denials	Denial % Rate by Billing $	Total Billing Denials $
YMCA OF METROPOLITAN CHICAGO	**	0.00%		0.00%	
YOUTH GUIDANCE	**	0.00%	0	0.00%	$0.00
Statewide Totals		**12.85%**	**56,462**	**14.23%**	**$2,135,828.40**
Median		**6.24%**	**89.50**	**5.68%**	**3,373.78**
Average		**15.57%**	**397.62**	**14.64%**	**15,041.05**

** Vendor is Feb Cycle 1denials
All others is Vendor Feb Cycle 2 denials

Denial % Rate by Billing Records = Total denied (rejected) billing records divided by all billing records processed by DPA
Denial % Rate by Billing $ = Total denied (rejected) bills in dollars divided by all bills in dollars

Appendix G: Consumers Accessing Mental Health Services: FY04 vs. FY05

Note: FY04 for the first two quarters include 4,222 clients served in the Screening, Assessment and Support Services (SASS) Program (7,119 served in the entire year), while FY05 does not.

	FY05 7/1/04 - 12/31/04 YTD TOTAL	FY04 7/1/03 - 12/31/03 YTD TOTAL	FIRST SIX MONTHS OF FY05 AS A PERCENT OF FIRST SIX MONTHS OF FY04	FY04 TOTAL FOR THE YEAR
Total Clients Served	112,097	121,315	92.40%	168,032
Medicaid	52,872	53,124	99.53%	70,158
Non-Medicaid	62,398	71,738	86.98%	97,874
SSI – SSDI Eligibility				
Not Applicable	48,097	54,199	88.74%	77,096
Eligible, receiving payments	28,175	29,659	95.00%	37,024
Eligible, not receiving payments	1,421	1,422	99.93%	1,856
Eligibility determination pending	3,358	3,379	99.38%	4,424
Potentially eligible but has not applied	5,096	5,919	86.10%	7,804
Determined to be ineligible	1,096	1,177	93.12%	1,552
Unknown	24,854	25,559	97.24%	37,786
Unknown - blank		1	0.00%	490
Age				
0 - 2	200	233	85.84%	426
3	83	127	65.35%	195
4 - 12	11,058	12,392	89.23%	17,276
13 - 17	10,120	11,794	85.81%	17,829
18 - 20	3,892	4,449	87.48%	7,174
21 - 30	17,236	18,554	92.90%	27,475
31 - 45	33,961	36,909	92.01%	50,279
46 - 64	30,826	31,178	98.87%	39,687
65 - 74	3,213	3,574	89.90%	4,383
75+	1,501	1,928	77.85%	2,592
Not Available	7	177	3.95%	716

	FY05 7/1/04 - 12/31/04 YTD TOTAL	FY04 7/1/03 - 12/31/03 YTD TOTAL	FIRST SIX MONTHS OF FY05 AS A PERCENT OF FIRST SIX MONTHS OF FY04	FY04 TOTAL FOR THE YEAR
Gender				
Male	53,225	57,859	91.99%	80,260
Female	58,872	63,455	92.78%	87,282
Unknown - blank		1	0.00%	490
Citizenship				
Non-U.S. Citizen	2,668	2,879	92.67%	3,953
U.S. Citizen	104,069	110,686	94.02%	154,782
Unknown	5,360	7,749	69.17%	8,807
Unknown - blank		1	0.00%	490
Diagnosis				
Attention Deficit	6,868	7,043	97.52%	9,608
Conduct Disorder	3,000	3,648	82.24%	5,295
Mental Retardation, Autism & Specific Development	455	521	87.33%	677
Other Childhood Disorders	253	258	98.06%	379
Schizophrenia	19,733	20,916	94.34%	25,147
Other Psychotic Disorders	4,045	4,653	86.93%	6,570
Bipolar Disorders	14,506	14,217	102.03%	19,184
Major Depression	25,379	27,493	92.31%	37,984
Other Mood Disorders	12,033	13,359	90.07%	20,288
Dementia, Delirium & Other Related Disorders	495	726	68.18%	1,030
Substance Abuse	1,169	1,469	79.58%	2,263
Anxiety	7,256	7,732	93.84%	10,528
Personality Disorder	2,166	2,540	85.28%	3,634
No Diagnosis, Deferred, Not Available	2,395	3,543	67.60%	5,185
Other Mental Health Diagnosis	12,344	13,197	93.54%	20,260
Target/Eligible Population				
Eligible	105,873	112,919	93.76%	158,456
Target within Eligible	61,596	64,560	95.41%	85,181
Non-Eligible	6,017	7,986	75.34%	11,434
Dual Diagnosis				

	FY05 7/1/04 - 12/31/04 YTD TOTAL	FY04 7/1/03 - 12/31/03 YTD TOTAL	FIRST SIX MONTHS OF FY05 AS A PERCENT OF FIRST SIX MONTHS OF FY04	FY04 TOTAL FOR THE YEAR
MI/DD	2,776	2,942	94.36%	3,720
MI/SA	9,810	10,399	94.34%	14,587
Employment Status				
Employed, including on vacation or sick leave	3,768	4,394	85.75%	6,111
Employed full time	7,058	7,615	92.69%	10,804
Employed part time	6,553	6,969	94.03%	9,301
Employed full or part time in subsidized or supported employment	1,301	1,427	91.17%	1,724
Attending vocational/day program ,including programs funded by DHS or other entities	2,110	2,216	95.22%	2,646
Unemployed	41,866	45,645	91.72%	62,181
Not in the labor force (retired, homemaker, student, resident/inmate of institution)	35,578	38,674	91.99%	55,326
Other (not seeking employment/vocational services)	4,799	4,298	111.66%	5,628
Unknown	9,064	10,076	89.96%	13,821
Unknown - blank		1	0.00%	490
Forensic Legal Status				
Not applicable	93,853	101,418	92.54%	140,292
Department of Corrections client	2,099	2,235	93.91%	3,170
Unable to Stand Trial	67	91	73.63%	111
Unable to Stand Trial – ET	42	49	85.71%	57
Unable to Stand Trial – G2	10	8	125.00%	13
Not Guilty by Reason of Insanity	98	95	103.16%	111
Civil court-ordered treatment	158	185	85.41%	261
Criminal court-ordered treatment	864	889	97.19%	1,215
Court-ordered evaluation/assessment only	282	297	94.95%	475
Forensic Status Unknown	14,624	16,047	91.13%	21,837
Unknown - blank		1	0.00%	490

	FY05 7/1/04 - 12/31/04 YTD TOTAL	FY04 7/1/03 - 12/31/03 YTD TOTAL	FIRST SIX MONTHS OF FY05 AS A PERCENT OF FIRST SIX MONTHS OF FY04	FY04 TOTAL FOR THE YEAR
Hispanic Origin				
Not of Hispanic Origin	91,821	100,402	91.45%	140,279
Mexican/Mexican American	4,758	5,132	92.71%	7,601
Puerto Rican	2,470	2,556	96.64%	3,363
Cuban	142	135	105.19%	174
Central or South American	394	379	103.96%	545
Other Hispanic	1,052	787	133.67%	1,224
Unspecified Hispanic	352	1,075	32.74%	1,576
Unknown, not classified	11,108	10,848	102.40%	12,780
Unknown - blank		1	0.00%	490
Household Status				
Lives Alone	20,341	21,791	93.35%	28,456
Lives with one or more relatives	67,588	71,932	93.96%	102,277
Lives with non-related person	14,581	16,481	88.47%	22,558
Unknown	9,587	11,110	86.29%	14,247
Unknown - blank		1	0.00%	494
Race				
Caucasion	72,283	74,783	96.66%	101,937
African American	28,851	32,510	88.75%	46,327
Asian	1,181	1,258	93.88%	1,609
American Indian/Alaskan Native	296	285	103.86%	400
Pacific Islander	89	95	93.68%	132
Other	2,615	9,296	28.13%	12,983
Unknown	6,782	3,087	219.70%	4,154
Unknown - blank		1	0.00%	490
Residential Status				
Homeless	4,375	4,799	91.16%	7,270
Private Residence-client supervised	28,143	31,269	90.00%	44,620
Private Residence – client unsupervised	60,402	64,064	94.28%	87,386
Other Residential Setting – client supervised	4,489	4,885	91.89%	6,344

	FY05 7/1/04 - 12/31/04 YTD TOTAL	FY04 7/1/03 - 12/31/03 YTD TOTAL	FIRST SIX MONTHS OF FY05 AS A PERCENT OF FIRST SIX MONTHS OF FY04	FY04 TOTAL FOR THE YEAR
Other Residential setting – client unsupervised	1,124	1,275	88.16%	1,705
State Operated Facility	334	431	77.49%	508
Jail or correctional facility/institution	338	265	127.55%	540
Other institutional setting	1,825	2,214	82.43%	2,848
Boarding School	9	15	60.00%	20
Other	2,336	2,696	86.65%	3,421
Unknown	8,722	9,401	92.78%	12,876
Unknown - blank		1	0.00%	494

Appendix H: Responses to the Field Test Draft Report

April 5, 2005

To: Members of the SRI Committee

From: MaryLynn McGuire Clarke, Illinois Hospital Association and Member, SRI Planning and Steering Committees

Subject: Comments on the Field Test Evaluation Report by Parker & Dennison

I am writing to respond to certain statements in the Parker & Dennison Field Test report that are factually incorrect and cast a negative light on hospital-based community mental health providers.

There are approximately 13 hospital-based CMHCs in Illinois, many of which were established in the 1970s pursuant to the Federal Community Mental Health Act. Because of their affiliation with an acute care institution, these organizations have been able to provide to persons with mental illness access to a continuum of care that includes inpatient and outpatient services. Payment rates and methodologies for these services is established by the Illinois Department of Public Aid. All of these services are eligible for Federal Matching Funds, and these services are delivered on a fee-for-service basis. Outpatient services are described as Psychiatric Clinic A and Clinic B. They are considered clinic services, not rehabilitative services, and are categorized like any hospital outpatient clinic services. This means that they may only be delivered within the walls of the licensed hospital and services must be medically necessary. A study by the Lewin Group in 2003 found that outpatient services under the Medicaid program in Illinois pay providers less than 40% of their costs.

Among the short term strategies recommended in the Parker & Dennison Field Test Evaluation report is to reduce "DMH funding for FY06 by Medicaid mental health rehabilitation services billed directly to DPA" by hospital-based community mental health centers. The report further states that these providers bill DPA and "deprive the mental health system of the federal match associated with services funded in part by DMH." Further, that hospitals prefer to bill DPA because it "assists with subsidizing fully allocated hospital costs for rehabilitative mental health services."

The following is our response:

1. Psychiatric Clinic A and Clinic B services were established many years before the Medicaid Rehabilitation Option Program(MRO) was established in Illinois. They are viewed as clinic services, not rehabilitative services, and are subject to all of the federal and state laws that govern the delivery of Medicaid services. It is incorrect to refer to these services as "rehabilitative" services.

2. Hospitals have no power over the manner in which the State of Illinois directs its health care and mental health care dollars. The federal funds the State receives for services delivered by hospitals goes into the General Revenue Fund. It is, therefore, ludicrous and misguided to assert that hospitals that bill IDPA for services as they are directed to do are somehow responsible for the lack of an adequately funded DMH fund. This is an interdepartmental issue, not a hospital issue. And, it diverts attention from the real issue, which is an under funded mental health system.

3. Hospitals, just like other CMHCs, were not responsible for establishing Medicaid targets for this fiscal year. If these targets are incorrect, DHS should correct them. Questions about the options available to certain providers under the Medicaid programs in Illinois should be addressed within the context of a State Plan, and with full consideration of the needs of patients/consumers and how these various programs meet those needs.

4. Hospital-based programs are not using DHS or other funds to cover fully allocated costs. Absent a handful of specialty providers, I do not know of a hospital in this state that is able to cover fully allocated costs in its psychiatric program or that would consider it possible for them to do so. The statement is made in a negative manner and ascribes intentions to providers that the authors could have no way of knowing. There have been no conversations with any of these providers during the months in which this report has been written. The statements are conjecture.

5. It is true that the Medicaid psychiatric payment system is irrational and has contributed in large part to the closure of many inpatient and outpatient psychiatric programs throughout the state, especially those in other urban and rural areas. It is also true that, in some areas of our state, there are no acute care services available.

6. Clinic A and B services are different from MRO services. MRO services provide the provider options about the place of service delivery, including the client's home, and many professionals may bill under the MRO option who would not be permitted to bill under the hospital Clinic services. Thus, these services will be provided by different clinicians in different settings. The ability of a hospital-based provider to offer their patients options for care should be viewed as positive.

7. In a recommendation about physician services, the report suggests that, although these services are billed to IDPA, they are matchable and thus free funds from DMH that can be used for other mental health services. Why would this argument not apply to hospital-based CMHC's.

The mental health system should be designed according to a Plan that considers and responds to the needs of persons with mental illness and youth who are emotionally disturbed. It is shortsighted to single out a small component of the system as contributing to the lack of adequate mental health funds. It also polarizes providers at a time when everyone should be focused on the same goals: ensuring continued access to essential mental health services to those persons in Illinois who are poor or uninsured.

I request that the paragraph on pages 29 and 30 of the Field Test report be revised to reflect these comments or stricken until there is provided an opportunity for these providers to discuss this issue with DHS.

<end IHA response>

April 19, 2005

I received your full report. You did an excellent job at putting this all together. As a SASS and Test agency, we continue to be invested in the success of the State's transition planning to FFS. I do have one set of comments:

1. The Rate Study included but did not break out SASS cost studies. As SASS and FFS have been on parallel tracks, I think a separation would have been important and useful, particularly as SASS is an immediate operational as well as learning experience that was not really referenced in the report.

2. C& A services in general were lumped into the total data reporting. There are definite differences in the C&A populations, particularly in urban communities where outreach and in-home outpatient services are a primary mode of service intervention. The impact of this type of outpatient service in terms of Medicaid billables cannot be under-estimated.

3. The number of C&A dual diagnoses (MI/SA) and (MI/DD) are significant and have impact upon integrated planning and delivery strategies.

4. The non-medicaid eligible populations in our communities is significant. The paper well discussed this, but again did not make any particular reference to C&A services nor the Children's Mental Health Partnership which has been made part of Illinois Mental Health policy.

Again, I think this report is an excellent work product. I just want to highlight the need for C&A services to be fully included.

Mark E. Moses
Ada S. McKinley Community Services

<end Ada S. McKinley response>

April 20, 2005

IARF (via Janet Stover and me) has had the opportunity to provide oral and written comments on numerous occasions and we are happy to see the many of them got incorporated into the report. I have just two more. I have encouraged our members to submit comments as well. Thanks for all the hard work!

Here are the comments:

Page 12, Potential Benefits and Opportunities with Fee for Service

Should add the point that one of the benefits of FFS is that it provides for the opportunity to grow the system. That's provided the state would allow for the potential growth (i.e., no Medicaid caps and allowing 100% of all FFP to go back into the system)

Page 12, Demonstrate Accountability:

How does moving to a FFS system impact quality of services? Providers were/are held to the same number of audits and accreditation requirements in grant system as a FFS system. Perhaps it allows for changes in the type of services, as alluded to under Page 13 "Alignment of Service Array."

Thanks again.
Heather Eagleton
IARF

<end IARF response>

April 21, 2005

Listed below are comments from Metropolitan Family Services regarding the Field Test Report, which was distributed on April 15:

Parker and Dennison note a number of times throughout their report (the full report found at the back of the packet) various concerns regarding information systems:

- In the 5 other states Parker and Dennison reference as having gone through this transition, each state either hired an outside vendor to manage their data, purchased a new system, or substantially re-programmed their existing system using an outside vendor.

- Under their data management and analysis section, P&D mention the Department's problems with getting basic data; unduplicated counts, Medicaid populations, target populations, and others. They note insufficient state resources, historical data structures and absence of sufficient controls and causes of these problems.

P&D recommend that "Readiness of state operating structure must be addressed."
In looking for the States response to these types of concerns, I found little. The current action that DHS noted on this within the MoA response is only that the "State readiness issues related to information systems and data are more closely examined beginning in April 2005."
Given the problems that DHS had in even converting ROCs to reflect the new Medicaid Rule last year, it is difficult to imagine how they will pull off the type of changes / upgrades needed if they are only now beginning to examine this. I recommend that we ask for much stronger language for how the state will upgrade or replace their existing system, including a project plan with activities and timelines, provider input, testing and validation pilots, etc.

This second set of comments are specific to the section of the report titled "Maximize Funding Available for Mental Health Services"

1. As the stewards of taxpayer dollars, it is the responsibility of the state administrators to recommend ways to "get the most" out of the investment of General Revenue funds in mental health services. **One strategy** is to maximize access to federal Medicaid federal funds which match, dollar for dollar, the state funds. **Another strategy** is to provide a safety net of community based services for those individuals with mental illness who can not pay for services. Done well, this decreases institutionalization, either in hospitals or in correctional facilities. This both humane and cost-effective. *(I think the strategy needs to be said upfront; not added on weakly at the end.)*

2. For the FFS payment system to act as an incentive to increase delivery of billable service hours and to direct funding where the need is greatest as well as be protected in the case of a Federal audit, the state must demonstrate that its data collection processes are both valid and reliable. *(Both the consultants and the providers have strong criticisms of the current system.)*Failure to do this puts the state at risk in capturing federal dollars and at risk for being accused by the Legislature of cronyism in the distribution of state resources. This must happen first before the possibility of shifting funding among providers can be considered.
3. The statement "FFS funding methodology focused on this Medicaid eligible population will target scarce resources to persons whose primary healthcare needs and mental health status at risk" ignores those are who equally poor and desperate but who are ineligible for Medicaid due to being homeless or to immigration status or to being uninsured or to being only Medicaid eligible for part of the year. This statement should not be in this section because it implies that maximizing funding is based on focusing on the Medicaid eligible population *(and so dismisses all the other ways of maximizing funding including increasing the numbers registered for Medicaid and the range of and hours of services billed, decreasing the amount of administrative time of both the state and community providers by streamlining and increasing the accuracy of first touch*

documentation and billing processes, increasing the reliability and validity of the data collections, etc.)

Thank you for providing this opportunity for comment on the report. If you have any questions regarding these comments please do not hesitate to call or e-mail me.

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<end Metropolitan Family Services response>

Appendix I: Parker Dennison Report (including Provider Readiness Survey summary)

FINAL REPORT

FIELD TEST EVALUATION

ILLINOIS DIVISION OF MENTAL HEALTH

SUSAN PARKER
RUSTY DENNISON

MARCH 24, 2005

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Table of Contents

Executive Summary

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

Key Conclusions and Recommendations

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Report Structure

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

Section 1: Scope of Work

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

Section 2: Structure for Transition

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

Section 3: Conversion Experience from Other States

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

Section 4: System Readiness

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

Section 5: Recommendations

Recommendations are divided into three global areas in and include:

Overall Recommendations:

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

Fee for Service Implementation Recommendations:

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

System Improvement Recommendations:

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

Appendices

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

Appendix A – Provider Readiness Data Summary

Appendix B – Provider Training and Technical Assistance Plan

Appendix C – State Readiness Areas

Section 1: Scope of Work

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

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

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

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

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

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

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

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

Section 2: Structure for Transition

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

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

Issues that need to be addressed:

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

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

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

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

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

Section 3: Conversion Experiences From Other States

Conversion Variables

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

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

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

Implementation Patterns and Trends

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

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

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

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

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

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

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

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

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

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

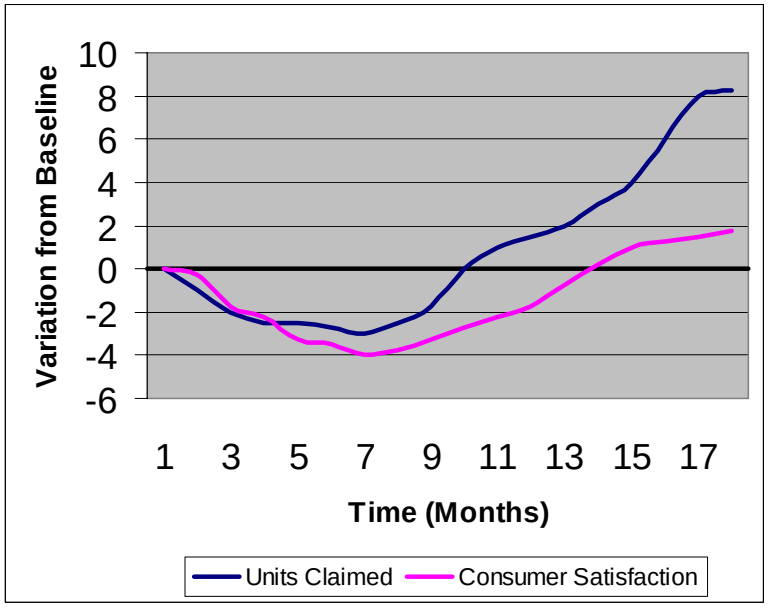
- **Unexpected costs due to conversion and/or compliance concerns** – since fee for service conversions impact services, billing, coding, and documentation several states have experienced unexpected costs.

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

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

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

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



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

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

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

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

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

Section 4: System Readiness

Consumers

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

Evidence of growing consumer involvement includes:

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

Provider Readiness

Operational Domains

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

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

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

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

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

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

Assessment Process

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

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

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

Network Profile

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

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

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

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

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

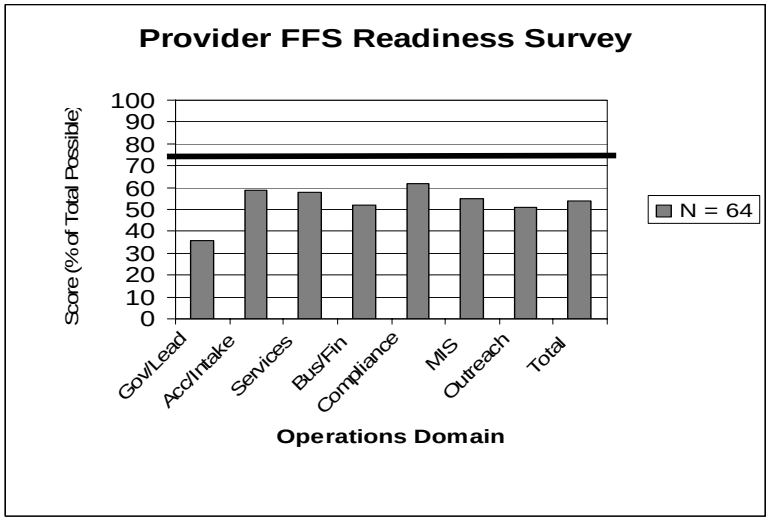
- **Serve high levels of Medicaid eligibles** – 68% of the sample reported that more than 50% of the clients they serve under DMH contracts are currently eligible for Medicaid. This level of Medicaid penetration is favorable to eventually achieving substantial levels of Medicaid billing. It should be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

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

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

Provider Readiness Results

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



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

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

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

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

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

Future Use of Provider Readiness Review

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

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

Areas of Need Identified from Provider Readiness Review

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

- **Productivity management**

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

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

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

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

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

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

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

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

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

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

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

State Readiness

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

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

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

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

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

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

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

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

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

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

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

Section 5: Recommendations

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

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

Overall

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

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

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

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

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

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

Fee for Service Implementation

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

System Improvements

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

    a. Additional funding to support consumer development and participation

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

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

d. Expansion of consumer peer supports as a funded service

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

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

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

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

x. Mental Health Intensive Outpatient

xi. Activity Therapy

xii. Intensive Family Based Services

xiii. Residential Supports, inclusive of:

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

xiv. Short Term Diagnostic and Mental Health Services

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

xvi. Peer Supports

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

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

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

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

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

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

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

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

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

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

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

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

Appendices

Appendix A—Provider Readiness Data

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

Demographics and General Information

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

2. Ownership structure:

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

3. Total annual budget size of the total organization

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

4. Percentage of annual budget from DMH contracts

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

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

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

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

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

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

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

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

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

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

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

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

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

Information systems in use in sampled provider group:

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

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

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

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

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

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

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

Appendix B–Provider Training and Technical Assistance Plan

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

Provider Training and Technical Assistance Plan

June 1 – August 31, 2005

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

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

- **Provider training**

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

September 1 – December 31, 2005

- **Additional provider site visits**

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

- **Provider training**

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

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

- **Provider forums**

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

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

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

- **Implementation training**

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

January 1 – June 30, 2006

- **Provider training**

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

- **Provider forums**

  - Continued from preceding section.

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

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

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

July 1, 2006 – June 30, 2007

- **Post-implementation training**

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

- **Written FAQs**

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

- **Provider site visits**

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

- **Other training**

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

Appendix C—State Readiness Areas

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

State Fee for Service Readiness Outline

I. Leadership and experience

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

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

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

1. Can be supplemented with contracted resources

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

II. Staffing levels

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

III. Claims processing

A. Staffing—amount and credentials/experience

B. Processing flow, edits, timelines and internal controls

C. Standard reports

D. Interface with DPA

E. Pends/denials

F. Testing routines and capacity

IV. Network management and provider relations

A. Staffing

1. Amount

2. Credentials/experience

3. Organizational structure/supervision

B. Performance measures and data

1. Provider monitoring

2. Process for identifying and addressing access/coverage issues

C. Defined provider responsibilities and interface

D. Documents and materials

1. Service definitions

2. Billing procedures

3. Frequently asked questions (FAQs)

4. Training schedule

5. Website

V. Information systems and data management

A. Hardware/software

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

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

3. Data warehouse capacity

4. Reliability--History of scheduled/unscheduled downtime

5. HIPAA transaction compliance

6. File transfer protocol (FTP)

B. Reporting capabilities

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

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

3. Flexibility

VI. Quality management, compliance and audits

A. Provider performance standards

B. Tools

    1. Service fidelity

    2. Medical necessity

C. Audits

    1. Staffing—levels and credentials/experience

    2. Scope and purpose for audits

    3. Tools

    4. Interface with DPA