Managed Care Readiness Training Series: Utilization Management, Revenue Cycle Management, & Outcomes
I. MCTAC Intro: 9:00AM
II. Utilization Management Part 1: 9:30-10:30AM
III. Break: 15 minutes
IV. Utilization Management Part 2: 10:45-11:45AM
V. Lunch Break: 11:45AM-12:45PM
VI. Revenue Cycle Management: 12:45-2:45PM
VII. Break: 15 minutes
VIII. Outcomes: 3-4pm
Updated NYS Managed Care Timeline

• **NYC-based Providers**: starting October 1, 2015
• For providers outside of NYC around the rest of the state, the **start date will be no earlier than April 2016**.
• **Children’s Providers**: Will transition in 2017.
The Managed Care Technical Assistance Center

EFFICIENT PRACTICES. EFFECTIVE CARE.

McSilver Institute
for Poverty Policy and Research

NYU Silver School of Social Work

CASA

Columbia

CCSI

Coordinated Care Services Inc.

ICL

People Get Better With Us

MCTAC

THE MANAGED CARE TECHNICAL ASSISTANCE CENTER OF NEW YORK

EFFICIENT PRACTICES • EFFECTIVE CARE

IDEAS

NYAPRS

*Partners in Recovery*
Managed Care Technical Assistance Center Overview

What is MCTAC?
MCTAC is a training, consultation, and educational resource center that offers resources to all mental health and substance use disorder providers in New York State.

MCTAC’s Goal
Provide training and intensive support on quality improvement strategies, including business, organizational and clinical practices to achieve the overall goal of preparing and assisting providers with the transition to Medicaid Managed Care.
MCTAC is partnering with OASAS and OMH to provide:

- Foundational information to prepare providers for Managed Care
- Support and capacity building for providers
  - tools
  - informational training & group consultation
  - assessment measures
- Information on the critical domain areas necessary for Managed Care readiness
- Aggregate feedback to providers and state authorities
## MCTAC Offerings

### Upcoming Offerings
- Contracting Workshop Series
- NPI Webinar
- HCBS Day-long Training
- Learning Communities:
  - Revenue Cycle Management
  - Utilization Management

### Future Offerings
- Outcomes Training Series
- Tools & Resources
Project Overview

Currently in development, the Managed Care Plan Matrix is a comprehensive and interactive online tool that will provide agency staff with the information needed to successfully engage with MCOs.
Why a Matrix?

Providers have expressed the need for a centralized location to access information for the respective plans by county/region.

1. Feedback received during MCTAC kickoffs and contracting forums.

2. Numerous inquiries to MCTAC.info@nyu.edu that the plan matrix tool would easily address.

3. Both the creation of the tool and working with MCOs across New York to update the Matrix quarterly will save agency staff countless hours finding and keeping up-to-date this centralized information.
Planned Matrix Features

- An interactive map tool to search MCOs by region in NYS

- Contact information for MCO departments including member relations, provider relations, finance, and case management

- Provider Manual

- Authorization procedures including: pre-authorization, level-of-care determination, quality improvement standards, complaint and grievance procedures, and reauthorization

- Claims and billing information: a checklist of required fields across plans, as well as a list of non-standard requirements for each plan

- Save and print features for users to keep helpful information handy
Tool Development and Release

*Anticipated release: June 15, 2015*

MCTAC is working with providers, state agencies, the NY Health Plan Association, and MCOs, to finalize the concept and scope of the Matrix.

During Spring of 2015, MCTAC will provide plans with an easy-to-complete template to collect relevant information.

The Matrix will be expanded to upstate plans closer to their later implementation date and will eventually include reimbursements beyond Medicaid managed care.

MCTAC is excited to work with Alamini Creative Group, who programmed and designed the MCTAC website, glossary tool & Output to Outcomes Database.
# Pre-Day One Buckets

<table>
<thead>
<tr>
<th>Title</th>
<th>Training Content</th>
<th>Audience</th>
<th>Type of Training</th>
</tr>
</thead>
</table>
| **HCBS Services Foundations Training** | - Will provide foundational knowledge of each HCBS service  
- Clear distinctions between MH v SUD  
- Explore how HCBS services match with other state services, what they are, what they do, how they fit into a consumer’s plan of care | HCBS Providers  
Health Home Staff | Web Based & In Person |
| **HCBS Service Process**            | - Step by step process by which a consumer accesses HCBS services: Including assessment, care planning, referral, authorization for services                                                                 | HCBS Providers  
Health Home Staff | In Person & Web Based  
(To be followed by Learning Communities as needed) |
| **HCBS Provider Readiness Training** | - Contracting (completed)  
- How to become Medicaid provider (if needed)  
- Billing and coding  
- Record keeping – clinical and administrative record keeping  
- Staffing  
- OMIG requirements, HIPAA training | HCBS Providers | In Person & Web Based  
(To be followed by Learning Communities as needed) |
| **Health Homes Trainings**          | - All training in Foundation and Service Categories  
- Education on workflow for a health home care manager  
- Provide MC 101 training for Health Home staff  
- Care Planning | Health Home Staff | In Person & Web Based |
## Health Home Care Management Training

<table>
<thead>
<tr>
<th>Type of Training</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MCO 101, HCBS Foundations training</strong>: for Health Home senior staff and Health Home Care Managers Training</td>
<td>May 2015</td>
</tr>
<tr>
<td><strong>InterRAI Training</strong>: for all health home care management staff and <strong>NOT DELIVERED BY MCTAC</strong></td>
<td>May/June 2015</td>
</tr>
<tr>
<td><strong>Work flow, step by step process for assessment</strong>: What workflow looks like both generally and specifically for HH care managers.</td>
<td>May/June 2015</td>
</tr>
</tbody>
</table>
# HCBS Agency Training

<table>
<thead>
<tr>
<th>Type of Training</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HCBS foundational training:</strong> provide foundational knowledge of each HCBS service</td>
<td>May 2015</td>
</tr>
<tr>
<td>HCBS Administrative training</td>
<td>May/June 2015</td>
</tr>
<tr>
<td><strong>HCBS Work Flow training:</strong> What workflow looks like both generally and specifically for HH Administrators.</td>
<td>May/June 2015</td>
</tr>
<tr>
<td>HCBS Operational Training</td>
<td>May/June 2015</td>
</tr>
<tr>
<td>Term</td>
<td>Explanation</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Mainstream Managed Care Organization (MCO)</td>
<td>Qualified Mainstream Managed Care Organization that meets the qualifications established by this RFQ to manage behavioral health services for Medicaid beneficiaries.</td>
</tr>
<tr>
<td>Managed Care Plans</td>
<td>Includes the Mainstream MCO, Managed Care Organizations, and Health and Recovery Plans.</td>
</tr>
<tr>
<td>Managed Care Technical Assistance Center (MCTAC)</td>
<td>Provides trainings and resources to support BH providers in New York State with the successful transition to Medicaid Managed Care.</td>
</tr>
<tr>
<td>Managed Long Term Care (MLTC)</td>
<td>A care management program for individuals in the community as an alternative to a nursing home or health-related facility.</td>
</tr>
<tr>
<td>Medicaid Redesign Team (MRT)</td>
<td>The Medicaid Redesign Team was established by Governor Cuomo in January 2011 as a means of finding new ways to lower Medicaid spending in New York State (CHC NYS).</td>
</tr>
<tr>
<td>Medical Loss Ratio (MLR)</td>
<td>The percent of premium an insurer spends on claims and expenses that improve health care quality. New York State will determine what qualifies as an eligible claim and expense for determining medical loss ratios.</td>
</tr>
</tbody>
</table>
Visit www.mctac.org to view past trainings, sign-up for updates and event announcements, and access resources.
Performance Measures

• Medicaid rate lock-in for 2 years
• Medical Loss Ratio (MLR)
• State will be reviewing UM protocols
• Procedures being developed to monitor:
  i. Access to Care
  ii. Denials
  iii. Timely payments to providers
  iv. Availability and utilization of HCBS services
Utilization Management

Overview:
What is UM and why is it important?

Presenters: Boris Vilgorin, MPA (McSilver Institute)
Charles Neighbors, PhD, MBA (CASA Columbia)
Elizabeth Peterson-Vita, PhD (ICL)
Christine Mangione, RN, BS, CCM (CCSI)
TOPICS TO BE COVERED

• What is Utilization Management and why is it a part of the work of an MCO?

• What we know about Utilization Management expectations tied to Medicaid Managed Care Transformation

• Review examples of UM practices for inpatient services, outpatient services and HCBS services from MCOs across the country

• What can providers do today to prepare for UM within Medicaid Managed Care?
What is Utilization Management and why is it a part of the work of an MCO?
What is Utilization Management?

• The process by which an MCO decides whether specific health care services, or specific level of care are appropriate for coverage under an enrollee’s plan

• Primary purpose of the program is to ensure that services are medically necessary, appropriate, and cost-effective

• Maintain fidelity and integrity of service provisions while meeting UM standards and requirements
What is the Difference Between Utilization Management and Utilization Review?

- Utilization Management is a function performed by MCOs as payer.

- Utilization Review is a regulatory requirement that requires utilization review of open cases. Therefore providers will need to complete the Utilization Review regulatory requirements as well as Utilization Management requirements.
Why do MCOs Conduct Utilization Management?

• Managed Care is an integrated system that manages health services for an enrolled population rather than simply providing or paying for the services (outcomes, service quality and service expenditures).
• Generally MCOs are paid for health benefits administration on a capitated basis (a fixed amount for each member each month/Per Member Per Month -PMPM).
• The MCO’s role is to make sure the individual receives the least restrictive care.
• Involves a determination of whether the service is medically necessary and appropriate for the patient’s symptoms, diagnosis, and treatment and recovery. Also reviews for the appropriate length of care.
• UM applies chiefly to diagnostic and evaluative services, hospital services, and certain specialty services including HCBS; primary care services are not typically subject to prior authorization or concurrent review.
• The core function of the UM program is to ensure that the MCO pays for only those services that are “medically necessary.”
What does it mean to be Medically Necessary?

• Involves a determination of whether the service is necessary and appropriate for the patient’s symptoms, diagnosis, treatment, and recovery.
• Many MCO contract definitions of “medically necessary” state that services may not be provided primarily for the convenience of the patient or the provider.

• New York State Department of Health requires the following definition of Medically Necessary:
  • Medically necessary means health care and services that are necessary to prevent, diagnose, manage or treat conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person’s capacity for normal activity, or threaten some significant handicap.
Types of Reviews?

UM will occur at different points in the healthcare delivery cycle:

• **Prior authorization**: provider must request permission from the MCO before delivering a service in order to receive payment

• **Concurrent review**: occurs during an ongoing course of treatment (such as inpatient hospital admission) to ensure that such treatment remains appropriate

• **Discharge Review**: For inpatient, this review occurs prior to discharge to assure that plans are in place for a safe and supported re-entry into the community

• **Retrospective review**: review that takes place, on an individual or aggregate basis, after the service is provided
1. **Prior to calling the MCO**
   - Review Level of Care (LOC) criteria for the service being requested/discussed
   - Review the specific information regarding the individual (presenting problem, current symptoms, medications, recent treatment) and formulate a rationale for the requested LOC and anticipated service units

2. **Contact the MCO representative**
   - Provide patient name, Date of Birth (DOB), Medicaid number (CIN) and your name, facility name and contact number
   - Identify the start date for treatment being requested
   - Request the services and number of service units (days, visits, etc.) necessary to deliver these services
   - Present rationale for request
3. Discuss planned treatment changes (if any) and anticipated service units.

4. Always include overview of the long term treatment/support plan (including discharge planning steps if the individual is in an inpatient setting)
   - Communication with treatment providers (new, existing)
   - Family meetings
   - Medications (new, existing, changes)
   - Patient involvement (person centered approach)
   - If inpatient, discharge plans: to home, HWH, transfer to another facility, etc..

5. Obtain decision from MCO, document and schedule next review if necessary
   - If adverse decision:
     i. request rationale
     ii. consider MD to MD review
     iii. appeal
What if the Parties Disagree?
Dealing with Denials: Appeal and Grievance Process

1. What if your organization cannot support the decision of the MCO?
   • Conflict Resolution (both external and internal)
   • Are there liability issues in not providing a service, even if the MCO denies payment?

2. The first step, for Utilization Managers faced with an adverse decision, is to request that a call take place between the MCO and the treating provider.

3. If the respective clinicians do not agree on a plan of action, the next step is to formally submit an expedited appeal. Mandated timeframes guide this process for both the facility making the appeal as well as the MCO and must be adhered to.

4. The next steps in the appeal process is the Standard Appeal or External Appeal.

Each Managed Care Organization may have specific guidelines for initiating any of these options. They will all be similar but it is important for you to become familiar with the process for each MCO you work with.

Medicaid Managed Care Provider Guide
A reminder:
The Member Bill of Rights...
What is the Member Bill of Rights

Article 44 of the New York State Public Health Law gives these rights to enrollees of managed care organizations. You may also ask the health plan for this information before you join the plan.

• You have a right to know what health care must be given to you by the plan, as well as any limits on care, and which types of health care are not covered.

• You have a right to know about any treatments or health care which your plan needs to approve in advance.

• You have a right to know what steps you can take if the plan will not cover a service. This includes the toll-free phone number of the person who will review the plan's action, how long it will take until the review is done, how to appeal the plan's action, and how to file an independent external appeal with the State. You also have a right to have someone speak for you in any disputes with the plan.

• You have a right to know, each year, how the plan decides on how much it will pay to doctors and health providers who belong to the plan.

• You have a right to know about any fees you will have to pay, any amount you have to pay yourself before the plan will start paying, and any caps (maximums) or yearly limits on plan payments. You also have a right to know what you will have to pay for health care not covered by the plan.

• You have a right to know about what you will have to pay if you go to a doctor who is not part of the plan, or if you get care that the plan has not approved in advance.

• You have a right to file a grievance about any dispute between you and the plan, and you have a right to know just how a grievance should be made.

• You have a right to go to the emergency room 24 hours a day for any health problem that threatens your life. You do not need the plan to approve this in advance.

• You have a right to a list of the plan's doctors, as well as to learn which doctors are taking new patients.
Member Bill of Rights
continued

• You have a right to know how you can change to a new doctor within the plan.
• You have a right to see a doctor outside the plan if the plan does not have a doctor who can meet your health needs, but your primary doctor must set this up for you.
• If you need to keep on seeing a special doctor (specialist), you can ask to be allowed to see that doctor as needed, without going through your primary doctor. Your plan must explain to you how you can do this.
• If you have a very bad health problem that requires you to be seen by a special doctor for a long time, you can ask to have your special doctor be your primary doctor. The plan must tell you how to make such a request.
• If you have a very bad health problem that requires you to be seen by a special health care center (for example, a hemodialysis center) for a long time, you can ask to go there when you need to, without going through your primary doctor. The plan must tell you how to make such a request.
• You have a right to know how you can have input in how the plan makes its rules.
• You have a right to know how the plan meets the needs of plan members who don't speak or read English.
• You have a right to know the correct mailing address and phone number to be used by plan members who need to know something or who need the plan to approve a health service.
• You have a right, as a female enrollee, to see a plan gynecologist or obstetrician for at least two exams per year and for all pregnancy care, without a referral from your primary doctor.
• You have a right to a list that the plan updates once a year, of the name, address and phone number of each health care provider who belongs to the plan. This includes special doctors (specialists). You also have a right to know the level of training that the plan's doctors have, and which ones have advanced training so they can practice in special health areas (board certification).
How Does Utilization Management Relate to Billing/Collections

In a nutshell:

• If it’s not authorized (either initially or via appeal and grievance) it will not be paid for.

• The member is not liable for payment of these services

• The facility will not be reimbursed
Role of Agency in Utilization Management Process...

Secure the optimal care for your clients...
What do we know about UM expectations tied to Medicaid Managed Care Transformation?
What we know....... And Do Not Know.....

- Additional Behavioral Health services will be covered by Medicaid Managed Care so expect that UM requirements of the MCOs will expand to cover other services.

- The State has provided guidelines for Utilization Management practices in the RFQ for Behavioral Health Benefit Administration of the Medicaid Managed Care Program. More on this topic follows.

- The State has indicated that they want to approve the UM practices of the MCOs.

- We have not yet been able to secure any specific Admission, Continuing Stay or Discharge criteria for the array services to be covered by the transformed Medicaid Managed Care Program.
What are the New York State Expectations for Medicaid Managed Care Utilization Management?

• Plans will use Medical Necessity Criteria (MNC) to determine appropriateness of new and ongoing services

• Person-Centered approach to be used

• Ongoing conversations are taking place at the State level concerning what requirements will be placed upon the MCOs. Upon receipt of those policy guidelines, the MCOs will develop their Utilization Management practices.
NYS State UM Expectations

• MCOs shall develop and implement BH-specific UM protocols, including policies and procedures and level of care guidelines, that comply with the following requirements:
  • UM protocols and guidelines as well as any subsequent modifications to the protocols and guidelines shall be submitted to the State for prior review and approval.

• The Plan’s UM system shall follow national and state standards and guidelines, promote quality of care, and adhere to standards of care, including protocols that address the following:
  • Review of clinical assessment information, treatment planning, concurrent review, and treatment progress
  • Promotion of recovery principles
  • Promotion of relapse/crisis prevention planning.
NYS State UM Expectations

• The MCO will have all BH admission and continued stay authorization decisions are made by a qualified behavioral health professional.

• The MCO shall:
  • Educate members and providers about its UM protocols and level of care guidelines
  • Educate UM staff in the application of UM protocols, clearly articulating the criteria to be used in making UM decisions
  • Ensure consistent application of review criteria regarding requests for initial and continuing stay authorizations.
  • Establish criteria to identify quality issues, other than medical necessity, that result in referral to BH clinical peer reviewer for review and consultation.
The MCO shall establish protocols for addressing discharge planning during initial and continued stay reviews. Protocols shall include:

- Identifying comprehensive discharge plans that address not only treatment availability, but also community supports necessary for recovery
- Identifying and reducing barriers to access
- Confirming post-discharge appointment availability and adherence
- Procedures for concurrent review for enrollees requiring extended inpatient care due to poor response to treatment and/or placement limitations
- Corrective action expectations for ambulatory providers who do not follow up on people discharged from inpatient settings, when appointments are missed.
- Timeframes for each of the above.

The Plan shall comply with NYS Medicaid guidance.
NYS State UM Expectations

• The MCO shall utilize information acquired through QM/UM activities to make annual recommendations to the State on the continuation or adoption of different practice guidelines and protocols.

• The MCO should follow the grievance and fair hearings process as per the NYS Medicaid managed care contract.

• The MCO shall ensure that decision makers on BH denials, grievances, and appeals meet the requirements in Section 3.3 for clinical peer reviewers and have clinical expertise in treating the member’s condition or disease.

• In general, denials, grievances, and appeals must be peer-to-peer.

• In addition:
  • A physician board certified in general psychiatry must review all inpatient level of care denials for psychiatric treatment.
  • A physician certified in addiction treatment must review all inpatient level of care denials for SUD treatment.
NYS State UM Expectations: HARP Specific

- UM requirements for Home and Community Based Services (HCBS) services must ensure that a person centered plan of care meets individual needs
- MCOs offering a HARP shall develop concurrent review protocols for the HCBS
- MCOs establishing concurrent review protocols for Home and Community Based Services must consider the following factors: Life goals, Person-directed services, Recovery focused, Admission criteria, Utilization of rehabilitation services and supports and Need for off-site services
- HCBS will be managed in compliance with new CMS HCBS rules
- The HARP shall develop a data driven approach to identify service utilization patterns that deviate from any approved HCBS plan of care and conduct outreach to review such deviations
- Prior authorization of the HCBS plan of care is required to determine medical necessity
More about the OASAS
LOCADTR.......
LOCADTR: Background

Transition to Managed Care Carve In

- Want to ensure access to care
- Need tool for provider-patient-plan communication
- Tool aligned with NY treatment system

Goals

- Reliable/valid/credible
- Include collective understanding of level determination
- Placement in least restrictive yet appropriate setting
- Simplified and expedient administration
Reflects OASAS clinical judgment about the appropriate level of care

- Based on ASAM
- Tailored to NY:
  - Policy to increase MAT for opioids
  - Residential redesign
- Required for MMC services
  - OASAS would like to extend beyond Medicaid

Training Needs:

- Diverse workforce:
  - Designed for someone with SUD clinical background
  - Eventually will be used by other providers
- Working with managed care to develop workflow
LOC Principles

• Treatment should occur in the least restrictive setting that is likely to be successful.

• Resources may be added to increase the likelihood that the client can succeed in a lower level of care including care coordination through a health home, peer or other support services.

• Failure at an outpatient level of care, by itself, should not necessarily lead to a higher level of care.

• Access to a higher level of care that is needed should not be denied because the client has not failed at a lower level of care.
What We Want in a Tool

- **Speed** - Able to be completed in minutes
- **Relevance** - Includes Levels of Care known and understood in New York
- **Reliability** - Predictability and accurately recommends the best level of care
- **Credibility** - Plans and providers accept the tool and agree that there is evidence to support the tool, face validity and empirical support
- **Clinical Support** - Provides information to clinicians to support level of care decisions to payers and auditors
LOCADTR: Online Tool

Health Commerce System:
• The LOCADTR is a web-based application
• Currently found on the Department of Health-Health Commerce System (HCS)
• Users need to have a health commerce account with a user name and password

Online tool offers an opportunity for streamlined conversations with Plans:
• Plans will have access to LOCADTR
• Ability to speak the same language to help with conversations with managed care plans
LOCADTR Assessment Layers
Examples of UM practices from MCOs across the country
Individual Arrives in Emergency Room. Inpatient admission determined by ED Staff to be appropriate (Hospital ED)

Hospital submits a Notice of Admission with 24 hours via the MCO portal (Hospital)

Initial Review takes place within 72 hours of admission. Treatment History is shared (See Initial Review Template) (Hospital and MCO)

Does individual meet MCO admission criteria?

If no

Appeal begins: MD to MD conversation takes place

If no

Denial Letter is sent by MCO. Formal Appeal may take place. Formal appeals may be made to the MCO and thru the State’s external appeal process

If no

Does individual meet criteria?

If yes

MCO agrees and establishes LOS (number of days) until next review

Concurrent (or continuing stay review takes place) at established time frames (See Concurrent Review Template)

Concurrent reviews continue stay review takes place at established time frames

Discharge Review Completed (See Discharge Review Template)

If yes

Plans are made for a safe discharge of the individual or the provider absorbs the cost of the stay

Does individual meet criteria?
<table>
<thead>
<tr>
<th>Categories</th>
<th>Questions</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Basic Identifying Information</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Identifiers</td>
<td>Name, MCO ID Number, DOB, County of residence, Gender</td>
<td>Sufficient to Match with patient in MCO record</td>
</tr>
<tr>
<td>Treating Facility</td>
<td>Provider Name and Entity ID Number</td>
<td>To Verify where services are being provided</td>
</tr>
<tr>
<td>Type of admission</td>
<td>Inpatient: Mental Health; Rehab or Detox</td>
<td>To verify what type of service is being provided</td>
</tr>
<tr>
<td>Reporter name and contact information</td>
<td>Name and contact information of the individual providing the information to the MCO from the Treatment facility</td>
<td>To verify name of provider contact</td>
</tr>
<tr>
<td>Date of Admission</td>
<td>Actual date of admission</td>
<td>To verify correct admission date</td>
</tr>
<tr>
<td><strong>Information Supplied by MCO</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MCO provided information</td>
<td>The MCO will notify the provider re: past claims history as well as prior service history available via MCO record. Provide contact name and number for MCO reviewer.</td>
<td></td>
</tr>
<tr>
<td><strong>Information Supplied by Provider</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical information</td>
<td>Presenting Problem and Current symptoms</td>
<td>What brought the individual to the hospital, what symptoms are being exhibited, MSE, is the individual at baseline?</td>
</tr>
<tr>
<td></td>
<td>Lethality assessment, risk factors and MSE</td>
<td>Suicidal/homicidal ideation; factors that may be contributing to these symptoms, access/ability to act on these impulses.</td>
</tr>
<tr>
<td>Diagnostic Categories</td>
<td>Please provide Axes I - V</td>
<td>A Mental Health Axis I diagnosis is required all inpatient psychiatric hospitalizations. A Substance Use Axis I diagnosis is required for all inpatient Detox and Rehab admissions. Deferred (799) is not considered an acceptable option for Axis I.</td>
</tr>
<tr>
<td>Location prior to hospitalization</td>
<td>Community or Institution</td>
<td>Where were they living before hospitalization?</td>
</tr>
<tr>
<td>Health Home</td>
<td>Is the individual enrolled in, or eligible for, a Health Home?</td>
<td>To determine whether we should follow up with Health Home or facilitate linkage if the individual has not yet been enrolled.</td>
</tr>
<tr>
<td>Categories</td>
<td>Questions</td>
<td>Explanation</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>----------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Discharge Plan</strong></td>
<td>What is the discharge plan? Include name, and “type” of provider (MH, SU, PH, etc.).</td>
<td>Discussion regarding services to be implemented upon discharge. May be useful should another admission occur.</td>
</tr>
<tr>
<td><strong>Length of Stay</strong></td>
<td>What is the anticipated length of stay?</td>
<td>Expected discharge date so that the MCO can f/u regarding the discharge and assist providers with compliance.</td>
</tr>
<tr>
<td><strong>Reason for admission</strong></td>
<td>Options:</td>
<td>Discussion should also include/explore possible root cause for admission, such as, what is your understanding for the reason for admission.</td>
</tr>
<tr>
<td>Medication non-adherence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of engagement with outpatient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drug and/or alcohol use</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (note reason in free text)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Additional History</strong></td>
<td>History of psychiatric illness and substance use.</td>
<td>Include the individual history as well as family history with diagnosis whenever possible.</td>
</tr>
<tr>
<td>Tox screens, BAC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>For SU Admissions (Rehab and Detox):</td>
<td></td>
<td>Also collect info for MH admissions if positive for Substance Use on admission.</td>
</tr>
<tr>
<td>Substance(s)</td>
<td></td>
<td>Include all</td>
</tr>
<tr>
<td>Last use and duration</td>
<td>Date and time</td>
<td></td>
</tr>
<tr>
<td>Method</td>
<td>IM, IV, nasal, oral smoke</td>
<td></td>
</tr>
<tr>
<td>Age/first use</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quantity</td>
<td>Amount and frequency</td>
<td></td>
</tr>
<tr>
<td>Previous periods of sobriety</td>
<td>Please include dates whenever possible</td>
<td></td>
</tr>
<tr>
<td>Co-occurring psychiatric diagnosis</td>
<td></td>
<td>Dual diagnosis treatment implications</td>
</tr>
<tr>
<td>For Detox only:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vital signs: temp, BP, Pulse, Respiations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CIWA - COWS-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Withdrawal symptoms:</td>
<td>Include risk factors such as history of DTs and seizures</td>
<td></td>
</tr>
<tr>
<td>Please include diagnosis and treatment for any other illness including the treating providers.</td>
<td>Medications other treatments.</td>
<td></td>
</tr>
<tr>
<td><strong>Medications including dosage and frequency</strong></td>
<td>All meds whenever possible (psychiatric and medical).</td>
<td></td>
</tr>
<tr>
<td><strong>History of trauma</strong></td>
<td>Brief explanation w/dates or age when the trauma occurred.</td>
<td></td>
</tr>
<tr>
<td>Concurrent Review Template</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Categories</strong></td>
<td><strong>Questions</strong></td>
<td><strong>Explanation</strong></td>
</tr>
<tr>
<td>Current symptoms including lethality risk factors and a mental status exam</td>
<td>Existing symptoms that interfere with functioning and require treatment in an inpatient setting.</td>
<td>Any symptom the individual is displaying that presents as a barrier to discharge, including suicidal/homicidal ideation, history of suicide attempt or violent behavior, access/ability to act on these feelings.</td>
</tr>
<tr>
<td>Have you developed any additional insight for the root cause(s) for this admission?</td>
<td></td>
<td>The reason(s) for disengagement from care.</td>
</tr>
<tr>
<td><strong>Treatment Plan</strong></td>
<td><strong>Review of the providers plan for treatment including goals for this hospitalization.</strong></td>
<td>Indicators that factors leading to (re)admissions were assessed and addressed in the current treatment plan and d/c plan.</td>
</tr>
<tr>
<td>Name of the Attending MD and phone number</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medications prescribed during this admission</td>
<td></td>
<td>Indicate if this is a newly prescribed medication so that a complete prescription history can be obtained in addition to that provided by the individuals and found in PSYCKES.</td>
</tr>
<tr>
<td>Did the individual (or family for a child under 18) participate in the treatment planning process?</td>
<td>Yes/No</td>
<td></td>
</tr>
<tr>
<td>Is the individual adherent to the treatment plan as well as the medication regimen?</td>
<td>Yes/No</td>
<td></td>
</tr>
<tr>
<td><strong>Care Coordination/Discharge Plan</strong></td>
<td><strong>What is the plan?</strong></td>
<td>Discussion regarding services to be implemented upon discharge which address root cause(s) for this admission.</td>
</tr>
<tr>
<td></td>
<td>Have service gaps been identified?</td>
<td>If yes, please explain:</td>
</tr>
<tr>
<td><strong>Discharge Support Questions</strong></td>
<td>What can the MCO do to be helpful regarding:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Transition to outpatient</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SPOA</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Housing</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Enlisting Peer support</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Health Home</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>Categories</td>
<td>Questions</td>
<td>Explanation (If using an MCO portal)</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>----------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Treating Facility</td>
<td>Provider Name and Entity ID number</td>
<td>Verify where services are being provided?</td>
</tr>
<tr>
<td>Type of Admission</td>
<td>Inpatient: Mental Health; Rehab or Detox</td>
<td>Verify what type of service is being provided?</td>
</tr>
<tr>
<td>Reporter Name and Contact Information</td>
<td>Name and contact information of the individual providing the information to the MCO from the Treatment Facility.</td>
<td>Please include telephone and fax numbers.</td>
</tr>
<tr>
<td>Date of Admission</td>
<td>Actual date of admission</td>
<td></td>
</tr>
<tr>
<td>Date of Discharge</td>
<td>Actual date of discharge</td>
<td></td>
</tr>
<tr>
<td>Date of Notification of Discharge</td>
<td>Date of MCO was notified of the discharge by the provider</td>
<td>Was the MCO notified within 24 hours of discharge?</td>
</tr>
</tbody>
</table>

**Episode Management**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>AMA</td>
<td>Did the patient leave the inpatient provider against medical advice?</td>
</tr>
<tr>
<td>Health Home</td>
<td>Was the individual enrolled in a Health Home prior to the inpatient event?</td>
</tr>
<tr>
<td>Outpatient</td>
<td>Was the current or prior Mental Health outpatient provider contacted during the stay in the facility?</td>
</tr>
</tbody>
</table>

**Discharge Diagnosis**

<table>
<thead>
<tr>
<th>Diagnostic Categories</th>
<th>Please provide Axes I-V</th>
<th>The State Offices require that we capture this information.</th>
</tr>
</thead>
</table>

A Mental Health Axis I diagnosis must be provided for all inpatient psychiatric hospitalizations. A Substance Use Axis I diagnosis must be provided for all inpatient Detox and Rehab admissions. Deferred (799) is not an acceptable option for Axis I. Please be sure to provide more than one diagnosis for each Axis if appropriate.

<table>
<thead>
<tr>
<th>Housing Status at Admission</th>
<th>Where was the person residing prior to admission?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Categories</td>
<td>Questions</td>
</tr>
<tr>
<td>------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Scheduled Outpatient Appointments</strong></td>
<td>Was an appointment for outpatient MH Treatment part of the D/C Plan?</td>
</tr>
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<tr>
<td></td>
<td>Was a case summary sent to the outpatient provider?</td>
</tr>
<tr>
<td></td>
<td>Was an appointment for SUD Treatment part of the D/C Plan?</td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Was a case summary sent to the outpatient provider?</td>
</tr>
<tr>
<td><strong>Health Home</strong></td>
<td>If the person had a care manager, were they notified of this admission</td>
</tr>
<tr>
<td></td>
<td>prior to discharge? Did the HH participate in discharge planning? Did the</td>
</tr>
<tr>
<td></td>
<td>HH assist in the transition into the community?</td>
</tr>
<tr>
<td><strong>Physical Health</strong></td>
<td>Were physical health care needs requiring post hospital f/u identified?</td>
</tr>
<tr>
<td></td>
<td></td>
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</tbody>
</table>
Outpatient UM Process

Examples from Value Options (2014)
Outpatient Review

Current Impairments: (Please select/circle one value for each type of impairment)
Scale: 0 = none 1 = mild/mildly incapacitating 2 = moderate/moderately incapacitating
3 = severe or severely incapacitating na = not assessed

- Mood Disturbance (Depression or Mania) 0 1 2 3 na
- Anxiety 0 1 2 3 na
- Psychosis/Hallucinations/Delusions 0 1 2 3 na
- Thinking/Cognition/Memory/Concentration Problems 0 1 2 3 na
- Impulsivity/Reckless/Aggressive Behavior 0 1 2 3 na
- Activities of Daily Living Problems 0 1 2 3 na
- Weight Change Associated with a Behavioral Diagnosis 0 1 2 3 na
  Select: Gain Loss
  Qnt: of
  lbs. in last three months
  Current weight = lbs. Qnt: Height = ft. inches Qnt:
- Medical/Physical Condition 0 1 2 3 na
- Substance Abuse/dependence 0 1 2 3 na
- Select all that apply: Alcohol Illicit Drugs Other
- Job/School Performance Problems 0 1 2 3 na
- Social/Relationship/Marital/Family Problems 0 1 2 3 na
- Legal Problems 0 1 2 3 na

Treatment Plan: Reason for continued treatment (please select primary reason)
- Remains symptomatic
- Prepare for discharge within coming month
- Maintain
- Facilitate return to work

Please indicate type(s) of service provided BY YOU, and the frequency.
- Medication Management 064
- Indv. Psychotherapy (30 min) 90832
- Indv. Psychotherapy (45-60 min) 90834
- Family Psychotherapy (45-50 min) 90847
- Group Therapy (60-90 min) 90853
- Other

Please indicate type(s) of service provided BY OTHERS (select all that apply):
- Medication Management
- Indv. Psychotherapy
- Family Psychotherapy
- Group Therapy
- Community Program(s)
- Self Help Group(s)

Are the patient’s family/supports involved in treatment? Yes No

Has patient been evaluated by a psychologist? Yes No

Current Psychotropic Medications: Dosage Frequency Usually adherent?
1. YES NO
2. YES NO
3. YES NO

Treating Provider’s Signature: Date:

Updated Mailing Address: 
City/State/Zip: 

Page 1 of 2 ValueOptions revised 08/28/14
To support effective symptom resolution and timely restoration of optimal health for the member, providers are requested to endorse their use of evidenced based clinical practice guidelines and interventions as part of their treatment with this member. This information is required and informs the clinical review process.

The patient’s chart reflects that:

1. I am treating this patient according to national evidence based treatment guidelines. [For additional reference, see ValueOption endorsed national guidelines at: http://www.valueoptions.com/providers/Handbook/treatment_guidelines.htm]
   - Y ☑ N ☐ NA

2. I am coordinating this patient’s case with other providers as appropriate.
   - Behavioral: ☐ Y ☑ N ☐ NA
   - Medical: ☐ Y ☑ N ☐ NA

3. The treatment plan was developed with the patient and has measurable, time-limited goals. ☐ Y ☑ N ☐ NA

STANDARD GUIDELINE BASED INTERVENTIONS:

☐ Co-occurring health conditions, in addition to the primary presenting condition, have been assessed, addressed, coordinated, and documented if applicable in treatment plan, including:
   - Co-occurring substance use conditions
   - Co-occurring psychiatric conditions
   - Co-occurring physical health conditions

☐ Pharmacological treatment, when indicated as a primary treatment intervention per Evidence Based Practice guidelines, has been addressed:
   - Presented as a treatment option with supporting education to patient/care giver
   - Evaluated by a (PCP/Psychiatrist/ Nurse with Prescriptive Authority)
   - Prescribed by a provider
   - Not addressed, rationale: ____________________________
   - Assessed as not applicable based on condition type/ low level severity

☐ Treatment process includes one or more evidenced based psychosocial treatment modalities:
   - Cognitive behavioral therapies including social skills training, destabilization prevention, relapse prevention, standard cognitive therapy
   - Motivational Enhancement therapy
   - Illness management skills/ contingency planning
   - Family interventions/ therapy as indicated; care giver support/education
   - Community based self-help organizations, peer support/recovery groups, after-care programs
   - Other evidence based treatment(s) (specify): ____________________________

☐ Treatment progress has been demonstrated within 90 days of treatment onset or, if not, the patient’s condition has been re-evaluated and adjustments in treatment plan made accordingly. Treatment progress is defined as treatment plan goal attainment and/ or remission of symptoms / improvement in functioning using validated clinical rating scale(s) with repeat measures.
   - Name of rating scale: ____________________________
   - [For access to no cost rating scales, see:
     http://www.valueoptions.com/providers/News/OutTrack/OnTrack_Training.htm
     http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures/]

☐ Risk issues have been assessed and addressed in treatment plan and are continually monitored during treatment.

For Eating Disorders:

☐ Treatment plan includes monitoring and documentation of target weight and rate of progress.

☐ Patient is receiving nutritional counseling by a trained provider.

Additional Clinical Notes if needed:
INSTRUCTIONS
COMPLETING THE VALUEOPTIONS OUTPATIENT REVIEW

Please note: For most efficient and timely service – use of authorization request flow on ProviderConnect® is the preferred method of submitting requests for network Providers. For providers that are not part of the ValueOptions network or who do not have access to the web-based application the following instructions should be followed for completing the Outpatient Review. To ensure timely processing of your Outpatient Review, please complete ALL sections prior to submission to ValueOptions.

TYPE or PRINT LEGIBLY  
Check/circle responses where applicable.

MEMBER AND PROVIDER DEMOGRAPHICS:

<table>
<thead>
<tr>
<th>Information requested</th>
<th>How to complete this section</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member’s ID#</td>
<td>This is usually the ID# from the member’s benefit card. However for some plans it is still the policy holder’s SSN or Alternate ID#.</td>
</tr>
<tr>
<td>Insured’s Employer/Benefit Plan</td>
<td>This is either the policy holder’s employer’s name or the Health Plan the member belongs to, depending on who holds the contract with ValueOptions.</td>
</tr>
<tr>
<td>Is the member currently receiving disability benefits?</td>
<td>This could be for either Medical or Psychiatric reasons.</td>
</tr>
<tr>
<td>Provider Program/Clinic (if applicable)</td>
<td>If provider is billing through a facility/clinic rather than as an individual provider.</td>
</tr>
<tr>
<td>ValueOptions Provider # (if known)</td>
<td>This is the Provider’s ValueOptions ID number or GHI PIN# (if applicable).</td>
</tr>
<tr>
<td>Service Address</td>
<td>Address where services are rendered.</td>
</tr>
</tbody>
</table>
### Current Risk Assessment:

<table>
<thead>
<tr>
<th>Information requested</th>
<th>How to complete this section</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member’s risk to self:</td>
<td>Indicate member’s level of, or absence of, suicidality by circling the appropriate value.</td>
</tr>
<tr>
<td></td>
<td><em>This must be completed.</em></td>
</tr>
<tr>
<td>Member’s risk to others:</td>
<td>Indicate potential for, or absence of, violence and/or abuse by circling the appropriate</td>
</tr>
<tr>
<td></td>
<td>value. <em>This must be completed.</em></td>
</tr>
</tbody>
</table>

### Current Impairments: (please select/circle one value for each type of impairment – this must be completed.)

<table>
<thead>
<tr>
<th>Rating</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 = none</td>
<td>No evidence of impairment</td>
</tr>
<tr>
<td>1 = mild</td>
<td>Occasional impairment or difficulties, but no interference with normal daily activities</td>
</tr>
<tr>
<td>2 = moderate</td>
<td>Currently experiencing difficulties, frequent disruption in daily activities, requires periodic or continuous assistance with some tasks.</td>
</tr>
<tr>
<td>3 = Severe</td>
<td>Currently experiencing severe symptoms, potential risk of harm to self/others, severe distress and/or disruption in daily activities</td>
</tr>
<tr>
<td>NA = not assessed</td>
<td>Impairment was not assessed – Please note use of NA may result in additional Phone calls with ValueOptions to ascertain this information.</td>
</tr>
<tr>
<td>Information requested</td>
<td>How to complete this section</td>
</tr>
<tr>
<td>---------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Behavioral Diagnosis</td>
<td>Minimum requirement of primary behavioral diagnosis. List Primary; add additional as appropriate. Please list appropriate ICD code and description. Please see DSM-5 for further instructions.</td>
</tr>
<tr>
<td>Social Elements Impacting DX</td>
<td>Options include:</td>
</tr>
<tr>
<td></td>
<td>• Educational problems</td>
</tr>
<tr>
<td></td>
<td>• Financial problems</td>
</tr>
<tr>
<td></td>
<td>• Problems with access to health care services</td>
</tr>
<tr>
<td></td>
<td>• Problems related to interaction w/legal system/crime</td>
</tr>
<tr>
<td></td>
<td>• Problems with primary support group</td>
</tr>
<tr>
<td></td>
<td>• Housing problems</td>
</tr>
<tr>
<td></td>
<td>• Occupational problems</td>
</tr>
<tr>
<td></td>
<td>• Problems related to social environment</td>
</tr>
<tr>
<td></td>
<td>• Other psychosocial &amp; environmental problems (list details)</td>
</tr>
<tr>
<td></td>
<td>• Unknown</td>
</tr>
</tbody>
</table>
Medical Diagnosis

Options include:

- Infectious & Parasitic - Other
- Infectious & Parasitic - HIV
- Cancer & Neoplasms
- Blood, blood-forming organs, & immunological
- Endocrine, nutritional & metabolic - Thyroid
- Endocrine, nutritional & metabolic - Diabetes
- Endocrine, nutritional & metabolic - Other
- Endocrine, nutritional & metabolic - Overweight
- Mental, Behavioral, Neurodevelopmental
- Nervous system - Other
- Nervous system - Parkinsons, EPS
- Nervous system - Multiple Sclerosis
- Nervous system - Migraine, Epilepsy, Stroke
- Nervous system - Chronic pain, other
- Eye - Other
- Eye - Blindness
- Circulatory system - Other
- Circulatory system - Hypertension
- Circulatory system - Heart
- Respiratory system - Other
- Respiratory system - COPD, Asthma, Emphysema
- Digestive system - Other
- Digestive system - Liver
- Skin & subcutaneous tissue
- Musculoskeletal system & connective tissue
- Genitourinary system - Kidney
- Genitourinary system - Other
- Pregnancy, childbirth
- Perinatal period
- Congenital malformation, deformation, & chromosome abnormality
- Symptoms, signs & abnormal clinical/lab
- Injury, poisoning & other effects of ext causes - TBI
- Injury, poisoning & other effects of ext causes - Other
- External causes of morbidity
<table>
<thead>
<tr>
<th>Functional Assessment</th>
<th>Optional. May enter functional assessment from following list and score:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• WHO_DAS</td>
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<tr>
<td></td>
<td>• GAF</td>
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<tr>
<td></td>
<td>• SF12</td>
</tr>
<tr>
<td></td>
<td>• SF36</td>
</tr>
<tr>
<td></td>
<td>• FAST</td>
</tr>
<tr>
<td></td>
<td>• CDC HRQOL</td>
</tr>
<tr>
<td></td>
<td>• OMFAQ</td>
</tr>
<tr>
<td></td>
<td>• Other</td>
</tr>
</tbody>
</table>

| Psychiatric Treatment in the Past 12 Months | This should **not** include the member’s current course of outpatient treatment. |
| Substance Abuse Treatment in the Past 12 Months | This should **not** include the member’s current course of outpatient treatment |
| Treatment Compliance (Non-Med)              | This is compliance with outpatient behavioral health treatment, not medication compliance. |
| Please indicate type(s) of service provided BY YOU, and the frequency | This should only include treatment that you are providing to the member. |
| Please indicate type(s) of service provided and frequency | If you are checking the “Other” Box please indicate the specific CPT codes and/or frequency you are requesting. |
| Please indicate type(s) of service provided BY OTHERS | This should only include treatment the member might be receiving from other providers. Please check all that apply. |
| Are the Member’s family/supports involved in treatment? | This must be completed. |
| Coordination of care with other behavioral health providers? | This must be completed. |

Clinical Practice Guidelines: (Page 2) This section must be completed with all applicable guidelines endorsed as appropriate – accurate completion of this section ensures timely processing of information needed for accurate claims processing and/or authorization processes.
Sample Admission, Continuing Stay and Discharge Criteria for Outpatient BH Services

- Outpatient Mental Health : Source - Blue Care Network
- Intensive Outpatient Substance Use: Source - Blue Care Network
- ACT Services: Source – Magellan
- Peer Supports: Source - Magellan
Outpatient UM: Mental Health Example
Blue Care Network

ADMISSION CRITERIA (all must be met)

1. The member meets criteria for a non-V-Code DSM Diagnosis.

2. As a result of their DSM diagnosis, the member has clearly identified symptoms, or is exhibiting clearly defined behaviors, that significantly impair their social/occupational/educational functioning.

3. There is a reasonable expectation that the member’s identified symptoms, behaviors and functioning will significantly improve as a result of treatment.

4. Psychotherapy and/or medication monitoring by a psychiatrist is necessary in order to achieve this significant symptomatic, behavioral and/or functional improvement.

5. The member’s substance use, if any, can be addressed in the course of Mental Health treatment; or, a referral for substance abuse treatment has been made.

6. If any of the following are present then an evaluation by a psychiatrist is offered:
   a) Moderate to severe symptomatology
   b) Prior positive response to psychiatric medication
   c) Family history of medication response during treatment for the same or similar disorder
   d) Differential diagnosis includes conditions for which clear biological etiology is known (e.g., depression, bipolar disorder, schizophrenia, other psychotic illness, obsessive-compulsive disorder, panic disorder, generalized anxiety disorder and attention-deficit hyperactivity disorder)
CONTINUED STAY CRITERIA

1. The member continues to meet admission criteria for outpatient mental health services.
2. There has been measurable, observable improvement in the target symptoms/behaviors.
3. The member is voluntarily and actively participating in face-to-face treatment and demonstrates satisfactory compliance with treatment recommendations by, for example, following through on psychiatric referrals, performing homework assignments, consistently attending outpatient appointments, etc..
4. For adolescents, regular face-to-face family therapy is a defined and active part of treatment.
5. The Treatment Plan reflects each of the following:
   a) Care is being rendered in a clinically appropriate manner and is focused on member outcomes as described.
   b) The treatment promotes self-efficacy and independent functioning.
   c) A change in diagnosis or in treatment modality is accompanied by clinical data that sufficiently justifies the change.
6. The Treatment Plan contains each of the following elements:
   a) Defined and behaviorally measurable goals
   b) Expected and reasonable timeframes for goal achievement
   c) A psychiatric referral for conditions for which psychotropic medications have demonstrated efficacy.
   d) Medication dosage and change history when applicable
   e) Anticipated changes in the treatment plan if goals are not achieved
   f) Termination plan (e.g., in the case of medication management treatment, there is a plan to transition the member to maintenance treatment.)
Outpatient UM: Mental Health
Blue Care Network

Discharge Criteria (One or more of the following is met)

1. The member is assessed as no longer meeting the DSM Diagnostic criteria for Mental Disorders.

2. The member has completed treatment goals and objectives.

3. The member is able to maintain pre-morbid level of functioning.

4. The member has failed to achieve treatment goals and objectives despite revisions in treatment plan and symptoms warrant the use of another level of care or different treatment setting.

5. The member has failed to achieve treatment goals and objectives despite revisions in the treatment plan, another level of care or different treatment setting is not appropriate, and the member’s symptom level and functional impairment are not expected to improve significantly as a result of the proposed treatment.

6. The Primary Care Physician (PCP) has assumed any medication management. Blue Care Network staff will initiate discussion with the treating provider regarding the appropriateness of referring member to the PCP for medication management under the following circumstances:
   a) Treating psychiatrist states that the member’s medication treatment is stable and/or in maintenance mode.
   b) There is no indication that there is a therapeutic gain by having the care managed by the psychiatrist as opposed to the PCP.
   c) PCP is willing and available to manage the member’s psychiatric medication management.
   d) Member is agreeable to changing care settings.

7. Each of the following criteria is met:
   a) The member’s level of functioning is not expected to significantly decline upon termination of therapy.
   b) The member’s substance use, if any, has decreased or stabilized and can be managed at the member’s discretion; or, any symptoms related to substance use have been determined to be interfering with treatment and warrant treatment in a substance abuse setting.
ADMISSION CRITERIA (all must be met)

1. The member has received a substance abuse assessment by a Blue Care Network practitioner and meets the diagnostic criteria for Substance Dependence Disorder from the DSM.

2. If member is having withdrawal symptoms, the symptoms are not life threatening and no need for detoxification has been established; or, member has successfully completed inpatient detoxification (see admission criteria for outpatient detoxification). For adolescents, they should not manifest any overt physiological signs of withdrawal.

3. The member's biomedical conditions and problems, if any, are stable or are being concurrently addressed and will not interfere with treatment at this level of care.

4. If the member has been diagnosed with a co-morbid psychiatric disorder, this disorder can be managed within the context of the Intensive Outpatient treatment setting and it will not interfere with treatment in this level of care.

5. The member is a willing, active and voluntary participant.

6. Despite active participation at a less intensive level of care, the member is experiencing an intensification of addiction symptoms (i.e., difficulty postponing immediate gratification and engaging in other drug seeking behaviors) or, the member’s condition is such that outpatient treatment would clearly be inadequate due to address the member’s needs for recovery.

7. There is at least moderate impairment in social, educational and or occupational functioning affected by substance use. These areas have not been adequately addressed and require more intense observation and care in order to make recovery likely.

8. There is reasonable expectation that this treatment will lead to sustained recovery, and without the proposed treatment, eventual sustained recovery is unlikely.
CONTINUED STAY CRITERIA

The member continues to meet admission criteria for intensive outpatient substance abuse services.

2. The member either continues to maintain abstinence, or if there has been relapse, the relapse has been brief and adequately addressed.

3. The member recognizes and understands that s/he is responsible for addressing his/her illness.

4. The member does not manifest any withdrawal symptoms.

5. Complies with drug screens as requested by provider or Blue Care Network.

6. The member's emotional/behavioral conditions/complications are as follows:

   a.) If the member is at risk for engaging in addiction related abuse/neglect of spouse, children or significant others, this has started to decrease

   b) If the member has an active psychiatric disorder that continues to require monitoring and or management to prevent distracting the member from recovery or treatment then each of the following criteria is met;

      i. The required treatment is not available in a less restrictive environment
      ii. This disorder is not preventing the member from making the expected progress in therapy.

   iii. If the member is at risk for causing harm to self, others or property this risk is mild (e.g. vague or infrequent suicidal/homicidal ideation with no active plan) and not serious enough to warrant supervision in a less restrictive environment.

7. Regarding the member's social support system, one or more of the following criteria is met.

   a) The member has a sufficient support to aid in recovery

   b) If the member does not have sufficient support, s/he has demonstrated motivation and willingness to build her/his support

   c) If the member does not have sufficient support intensive professional intervention is required in order for the member to build it AND there is a reasonable expectation that with this intervention the member will be able to build it.

8. The member recognizes and understands their particular relapse triggers.

9. The member’s treatment has adequately addressed their development of necessary skills to avoid triggers and relapse.

10. For adolescents, the family continues to actively participate in the treatment.
Intensive Outpatient UM: Substance Abuse Blue Care Network

**DISCHARGE CRITERIA**

1. The member no longer meets any of the continued stay criteria to warrant treatment at this level of care.

2. The member has maintained continuous abstinence for 2-4 weeks or more and does not manifest withdrawal symptoms.

3. The member's biomedical conditions and problems, if any, have diminished, decreased or stabilized and can be managed through outpatient appointments, or member's biomedical condition is interfering with the treatment and needs to be addressed in another setting.

4. The member's risk for engaging in addiction-related abuse/neglect of spouse, children or significant others, has decreased the point where it can be safely managed in outpatient care.

5. Symptoms of any psychiatric disorder have diminished or stabilized to the point where they can be safely managed in outpatient care.

6. The member no longer requires intensive clinically directed interventions.

7. The member recognizes and understands that s/he is responsible for addressing his/her illness.

8. The member recognizes and understands relapse triggers and does not meet continued stay criteria; or, the member is experiencing an increase in addiction symptoms (e.g. return to regular use, increase craving, etc.) despite revisions in treatment plan and warrants a more intensive level of care (partial hospital, inpatient or residential).

9. The member's social and interpersonal environment have improved with treatment and is supportive of recovery or, if the member's environment has not improved or continues to be non-supportive, then member has developed, within reasonable expectation, sufficient coping skills to deal with her/his environment and/or has secured an alternative environment.

10. The member no longer appears to be at significant acute risk for relapse.
Assertive Community Treatment (ACT) is a comprehensive and intensive outpatient service delivered within the community, such as in the consumer’s home or residence and/or in other community settings. These services are directed toward the rehabilitation of behavioral/social/emotional deficits and/or amelioration of symptoms of mental disorder. Such services are primarily for consumers with severe and persistent mental disorders and/or complex symptoms that require multiple mental health and support services to maintain the consumer in the community. Such services are active and rehabilitative in focus, and the clinician initiates them when there is a reasonable likelihood that such services will lead to specific, observable improvements in the consumer’s functioning and will assist the consumer in achieving and/or maintaining community tenure. The Magellan ACT Team participates in all mental health services provided to consumers.

(Magellan Behavioral Care of Iowa, Inc., http://dhs.iowa.gov)
HCBS UM: A.C.T.
Magellan Behavioral Health Care of Iowa

Admission Criteria (all must be met):

1. Validated principal DSM-IV TR Axis I consistent with a serious and persistent mental illness.

2. Exclusion of diagnosis of primary substance disorder, developmental disability, or organic disorders.

3. Level of Stability must meet a or b, and all of c, d, and e:
   a. a pattern of repeated treatment failures with at least 2 hospitalizations within the previous 24 months
   b. the consumer needs multiple and/or combined mental health and basic living supports to prevent the need for more an intrusive level of care
   c. low consideration of risk to self, others, or property (although without treatment or support, the consumer’s potential risk in these areas may increase)
   d. the consumer is medically stable and does not require a level of care that includes more intensive medical monitoring
   e. the consumer lives independently in the community or demonstrates a capacity to live independently and transform from a dependent residential setting to independent living.

4. Degree of Impairment must meet a and b and may meet c:
   a. individual does not have the resources or skills necessary to maintain an adequate level of functioning in the home environment without assistance or support, and he or she exhibits impairments arising from a psychiatric disorder that compromises his or her judgment, impulse control, and/or cognitive perceptual abilities
   b. individual exhibits significant impairment in social, interpersonal, or familial functioning, arising from a psychiatric disorder that indicates a need for assertive treatment to stabilize or reverse the condition
   c. individual exhibits impairment in occupation or educational functioning, arising from a psychiatric disorder that indicates a need for counseling, training, or rehabilitation services or support to stabilize or reverse the condition.
Continued Stay Criteria (all must be met):

1. Validated DSM-IV TR Axis I diagnosis with resilient symptoms, which continues to have a broad and persistent effect on the consumer’s ability to effectively manage day-to-day activities of living and self support on an independent basis.

2. There is a reasonable expectation that the consumer will benefit from the ACT program. As measured by an observable positive or beneficial response to treatment, including, but not limited to, medication adherence, homework assignments, and collaborating with the ACT team in treatment.

3. Individual is making attempt/progress toward goals and is benefiting from the plan of care, as evidenced by attainment of therapeutic rapport, lessening of symptoms over time, and stabilization of psychosocial functioning through service planning, homework, and team involvement.

4. Treatment promotes individual self-efficiency and maximizes independent functioning. Employment of treatment techniques encourages use of natural support systems to promote a consumer’s mastery of his or her environment.
Peer Support services include:

- person-to-person
- telephonic
- peer supervision in community

Peer Support interventions are collegial services delivered within the community, such as at the consumer’s home or residence and/or in other community settings. The services support a consumer with a serious and persistent mental illness and/or a substance abuse disorder. Such services are supportive and may be rehabilitative in focus, and are initiated when there is a reasonable likelihood that they will benefit the consumer’s functioning and assist him or her in maintaining community tenure.

(Magellan Behavioral Care of Iowa, Inc., http://dhs.iowa.gov)
Admission Criteria: The consumer must have a validated principal DSM-IV TR Axis I or II Diagnosis, and all of the following must apply:

1. Primary diagnosis of developmental disability disorders is excluded.

2. Level of Stability must meet a, b, and c
   - a. the individual presently is under the psychiatric care of a board-eligible psychiatrist or other qualified physician
   - b. risk to self, other, or property is considered to be low; if risk is present, a determination is made that the current clinical team can manage it within the existing environment
   - c. the consumer is medically stable and does not require a level of care that includes more intensive medical monitoring. If the consumer is not medically stable, then he or she has the necessary medical resources to medically stabilize

3. The individual is accepting of this intervention.

4. The degree of impairment must meet a and b
   - a. the consumer demonstrates a need for assistance in community living, for example, medication non-adherence; an assessment confirms that this intervention will not interfere with the present treatment plan
   - b. an assessment confirms that this intervention will assist in these functioning areas for consumers who are served; the assessment should show that expected benefits from this intervention cannot be provided by other resources available to the consumer.
Continued Treatment Criteria:
Must meet 1-4:

1. The consumer must continue to meet admission criteria.

2. Based on an individualized treatment plan with measurable goals and objectives, there is a reasonable expectation that the consumer will benefit from the Peer Support Program.

3. Transition plans for the consumer focus on developing independent support from peers via modeling the Peer Support relationship.

4. The consumer continues to express a desire to continue with this intervention.
STRATEGIES FOR MAXIMIZING UTILIZATION MANAGEMENT OUTCOMES...

What can providers do today to prepare for UM within Medicaid Managed Care?
Top 10 things to consider

1. Understand medical necessity criteria per service
2. Documentation integrity (i.e., dx and tx must match)
3. Examine LOS per service, identify outliers
4. Reference EBTs/Best Practices
5. Proactively staff cases of concern/high risk
Top 10 things to consider

6. Have practical, individualized crisis plans that are up to date
7. Participate in any MCO workgroups
8. Have fully functional IT systems for reports and tracking
9. Be prepared for appeals, & know how to staff a case
10. Bump up any concerns!
UM Strategies: Prepare all of your agency staff

- Identify and service volume caps or limits and make sure staff are aware of these limits.
  - Example: Peer Supports within a HARP are limited to no more than a total of 500 hours in a calendar year.

- Understand any requirements or qualifications for staff delivering the services and address any gaps in staff preparedness
  - Example: Peer Support providers must have certification as one of the following: OMH established Certified Peer Specialist or OASAS established Peer Specialist

- Review and fully understand Level of Care admission, continuing stay and discharge criteria
  - Examples to follow

- Understand MCO expectations for the review process

- Understand and embrace the MCO language tied to UM

- Practice reviews with Case Studies to gain comfort with the process

Note: MCOs vary in how they conduct Utilization Management. Understanding the LOC criteria and being fully prepared for the review is what’s most important in obtaining a positive outcome (approval)
UM Strategies: Effective Agency Practices

- Develop internal workflows with responsibilities clearly designated for staff members
- Develop population level reporting strategies to identify outliers by program by staff and client level
- Routinely assess service “Discharge Readiness” of the individual
  - Develop an assessment tool based upon the discharge criteria for the specific service and routinely complete and share with treatment team
- Develop crisis plan with the individual and make sure they have a copy
- Routinely communicate with primary supports (family, friends, community)
- Routinely monitor the quality of the service being provided and look for improvement opportunities.
- Seek feedback (degree of satisfaction) from those individuals receiving the services
UM Strategies:
Qualifications for staff Participating in UM

- A person with expertise in the service being reviewed, e.g. OMH services, OASAS services, HCBS services
UM Strategies:
Leadership/Supervisory Success Requires...

- Experience/Education as previously noted
- Utilization Management experience
- Supervisory experience, including the ability to manage team-based performance expectations
- The ability to interpret UM metrics and practices to staff
- Knowledge of MCO outcomes/requirements, e.g.: HEDIS
- Knowledge of what is unique to each MCO in their review process
- Excellent written and oral communication skills
- Self-motivated, able to prioritize multiple issues, excellent organizational skills
- Ability to track multiple projects/tasks and follow through as needed
- Ability to manage and coordinate with internal and external departments
- Ability to deal with internal/external conflict related to UM and facilitate resolution
- Experience interacting with Managed Care
UM Strategies: Supervisor Activities

- Weekly supervision
- Case conferences
- Record audits
- Silent listening
- Oversee training of UM staff
- Identify process improvement opportunities
UM Strategies:
Effective Practices for all types of UM Reviews

The Agency’s Utilization Management staff member:

- Is a member of the treatment team and a part of the conversation
- Effectively communicates MCO concerns to the team
- Understands MCO terminology, treatment volume caps and effectively communicates with the MCO.
- Understands the treatment being provided and is not just extracting information from a client note or record
- Is familiar with all covered services under the Plan: OMH/OASAS Inpatient, Outpatient, clinic, PROS, HCBS, etc..
- Well informed of treatment modalities being utilized including medications
- Tracks the success of the individual in the service being provided and can articulate the success to the MCO
- Able to articulate the long term services plan developed to move the individual towards recovery and how the current service supports the long term plan.
The Utilization Management staff participates in effective discharge practices

- Discharge planning starts on day 1 of admission and is clearly and thoroughly documented
- The Individual is an active participant in this process
- Adjustments/changes are made according to individual’s progress and preference
- Address immediate concerns that could be barriers to discharge unrelated to immediate health concerns: safe housing, support, finances
- Identifies and addresses issues that could be contributing factors to a readmission
- Addresses Behavioral and physical health service needs of the individual during hospital stay
- Verify PCP or secure referral to PCP if none
- Secure consent and verify communication w/individual’s treatment providers (BH, PH) prior to discharge
- Ensure that the treatment team has made efforts to invite identified providers and primary supports to participate in Discharge Planning
- Consult w/Managed Care Utilization Manager regarding MCO Case Management and Disease Management programs for individual
- Secure appointments prior to discharge
- Explore and coordinate any barriers to getting to the first appointment (transportation, child care, work conflicts, etc.)
- Assess for Health Home referral. If meets criteria, refer prior to discharge and arrange for Care Coordinator visit prior to discharge for support during transition to community
Next Steps – Webinars/Learning Communities to be offered

• Developing and Implementing Effective Utilization Management Practices within Your Organization
  – Also answers the question: What if you do not have dedicated UM staff and supervisors?

• Developing Effective Practices for those Supervising Utilization Management staff

• Developing an Effective Utilization Management staff

• Utilization Management Overview for the Front-Line Staff: What is it and How will it Impact My Work?

• Utilization Management Case Studies
Conclusion

• Preparation- you can never be “too prepared” for an MCO UM review

• Discharge Planning- essential for every review

• Person Centered approach- a component of all treatment planning, implementation, assessment and review
Questions and Answers
Break for Lunch
Revenue Cycle Management

**Presenter:** David Wawrzynek, MS, MBA
Revenue Cycle Defined

All administrative and clinical functions that contribute to the capture, management, and collection of client service revenue. This describes the life cycle of a client account from creation to payment collection and resolution. The client account cycle is supported by a number of additional activities necessary to assure that all encounters are billable, meet regulatory requirements and revenue collection is maximized.
Scheduling & Pre-registration → Point of service registration & collection → Charge Capture & Coding → Claim Submission → Payer follow-up → Remittance processing → Appeal, collections, and analysis

Contract Management
Quality Assurance
Utilization review
Credentialing
Regulatory Compliance
### Example Agency Readiness Assessment

**Introduction.** Readiness Assessments from 333 agencies were analyzed. The following data is included in your report:

- **Average Score** – the mean of the population (N=333) in the domain, which could range from 0 - 5
- **Agency Score** – the agency’s individual score in the domain, which could range from 0 - 5
- **Percentile** – percentage of agencies scoring less than the agency’s score

<table>
<thead>
<tr>
<th>Domain</th>
<th>Average Score</th>
<th>Agency Score</th>
<th>Percentile (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understanding MCO Priorities &amp; Present Managed Care Involvement</td>
<td>3.30</td>
<td>3.1</td>
<td>37%</td>
</tr>
<tr>
<td>MCO Contracting</td>
<td>3.18</td>
<td>3.33</td>
<td>57%</td>
</tr>
<tr>
<td>Communication /Reporting (Services authorization, etc.)</td>
<td>2.63</td>
<td>5.0</td>
<td>91%</td>
</tr>
<tr>
<td>IT System Requirements</td>
<td>3.19</td>
<td>2.08</td>
<td>16%</td>
</tr>
<tr>
<td>Level of Care (LOC) Criteria / Utilization Management Practices</td>
<td>2.75</td>
<td>0.92</td>
<td>4%</td>
</tr>
<tr>
<td>Member Services/Grievance Procedures</td>
<td>2.78</td>
<td>4.0</td>
<td>64%</td>
</tr>
<tr>
<td>Interface with Physical Health, Social Support and Health Homes</td>
<td>3.94</td>
<td>2.8</td>
<td>10%</td>
</tr>
<tr>
<td>Quality Management/Quality Studies/Incentive Opportunities</td>
<td>2.62</td>
<td>2.11</td>
<td>31%</td>
</tr>
<tr>
<td><strong>Finance and Billing</strong></td>
<td><strong>3.23</strong></td>
<td><strong>2.45</strong></td>
<td><strong>25%</strong></td>
</tr>
<tr>
<td>Access Requirements</td>
<td>3.33</td>
<td>0.67</td>
<td>0%</td>
</tr>
<tr>
<td>Demonstrating Impact/Value (Data Management &amp; Evaluation Capacity)</td>
<td>2.42</td>
<td>4.0</td>
<td>86%</td>
</tr>
<tr>
<td><strong>Overall Score</strong></td>
<td><strong>3.05</strong></td>
<td><strong>3.8</strong></td>
<td><strong>77%</strong></td>
</tr>
</tbody>
</table>

**Recommendation**

Review the Assessment / Work Plan Development Tool at
Phases of the Revenue Cycle

• Prior to Service
  – Pre-registration including eligibility verification and authorization
  – Scheduling

• During Services
  – New client registration
  – Eligibility verification
  – Collection of fees
  – Charge capture and coding

• Following Services
  – Claims submission
  – Payer follow-up
  – Remittance processing and posting

• Ongoing
  – Analysis
  – Process improvement
Prior to Service

Eligibility verification

• When possible insurance eligibility and benefit verification should take place before the initial visit and checked regularly after that.
• Staff should have a working knowledge of the most commonly seen insurance plans and coverage options
• Many payers have their own web portals or phone verification systems that can be used to verify eligibility

Authorization

• Some plans may require clinical authorizations that should be identified when verifying eligibility
• Each payer will have a unique process for securing authorizations
• Most authorizations will have visit limits that will need to be tracked
<table>
<thead>
<tr>
<th>IT System Requirements</th>
<th>Not ready</th>
<th>Somewhat ready</th>
<th>Moderately ready</th>
<th>Mostly ready</th>
<th>Definitely ready</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate the capability of your organization’s IT system to handle the following functions:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Centralized scheduling</td>
<td>19.9% (n=61)</td>
<td>14.7% (n=45)</td>
<td>18.3% (n=56)</td>
<td>20.6% (n=63)</td>
<td>26.5% (n=81)</td>
</tr>
<tr>
<td>• Clinical data with a Meaningful Use Certified Electronic Health Record (treatment plans, medication prescribing &amp; management, progress notes, etc.)</td>
<td>22% (n=67)</td>
<td>13.4% (n=41)</td>
<td>21.3% (n=65)</td>
<td>19.7% (n=60)</td>
<td>23.6% (n=72)</td>
</tr>
<tr>
<td>Rate the capability of your IT system to integrate functions for client information; services utilization and financial information, including payer type by client</td>
<td>17.9% (n=55)</td>
<td>20.5% (n=63)</td>
<td>22.5% (n=69)</td>
<td>17.3% (n=53)</td>
<td>21.8% (n=67)</td>
</tr>
</tbody>
</table>
Prior to Service (continued)

Scheduling

– When possible scheduling should be centralized and electronic

– If an insurance plan requires specific staff credentials care must be taken to schedule clients with providers that are reimbursable under the plan

– Efficiencies can be gained through “medical model” scheduling. In this model initial appointments are scheduled by front office staff, follow-up visits are set by front office staff based upon the clinicians instructions, and processes are put in place to “back fill” canceled visits.
During Service

New client registration

• Efficiently collect information necessary to establish a new client record including basic demographics, financial information, and financial agreements.

• Clients need to be made aware of fee policies and any payment responsibility they may have.
Eligibility Verification

Medicaid Fee for service and Medicaid Managed care verifications can be done by:
- Telephone
- VeriFone Vx570
- ePACES
- Batch upload (270)

- The most efficient means to verify Medicaid eligibility is the electronic transmission of a 270 directly from the billing component of your EMR or billing software. A 271 will be returned to your billing system which should create a variance report for reconciliation.

- Eligibility verification is also a service that can be provided by a billing clearinghouse.
Collection of Fees

Process by which client out of pocket fees are collected (sliding fees, copays, and deductibles)

- Client out of pocket fees need to be quantified and clearly communicated to the client
- Effort should be made in all cases to collect fees at the point of service. Fees not collected at the point of service are costly to recover.
- A clear collection policy and procedure should be in place that will address at a minimum:
  - Fee schedules
  - Actions to be taken when clients do not make payments
  - Clinician and clinical supervisors responsibilities in the collection process
  - Payments during clinical emergencies
During Service (continued)

Charge capture and coding

Documenting the type and duration of the client encounter and transforming that into a data set necessary to support a clean claim.

- When ever possible charge capture should be standardized behind the scenes in the EHR with the system selecting the correct CPT codes based upon documentation of service, duration, and provider.

- EHR setup should make it easy to identify when a modifier should be applied to the basic charge. The proper selection of modifiers is critical to revenue maximization because in many instances they are associated with higher reimbursement rates.

- If charge are not captured through the EHR then:
  - Staff should be provided with a charge master that they can use to cross walk from the service they provided to the proper billing code.
  - An efficient process must be in place to record, verify, and accurately report services provided to be entered into the billing program.
  - Care must be taken to assure that minimum duration standards are met and that the CPT code for the transaction matches the start and end time on the clinical documentation.
Evaluation and Management Coding (E/M)
Apply to Physicians, Psychiatrists, and Nurse Practitioners
CPT codes are selected based upon:
- Client type (new or established)
- Setting of service (outpatient or hospital)
- Level of evaluation and management services provided (complexity of the visit)
Documentation must clearly support the CPT code selected
Secondary review of the documentation and the code selected is recommended.
Improper or inaccurate coding carries a significant risk of disallowance upon subsequent audit
Strong quality assurance programs must be in place to assure codes are correct and supported by the clinical documentation.
It is essential that staff understand the billing rules that guide their practice and documentation
Claim submission

Submission of billable fees to the insurance company via the required universal claim form.

• Claim data can be submitted directly to the payer or through a clearinghouse
• Processes must be in place to “scrub” claims to assure that they are clean.
• Some common tests should be:
  – Was the claim formatted correctly and are all required data elements present
  – Was the service of the required duration for the code
  – Was the documentation completed properly:
    » Progress note was completed
    » Service was on the treatment plan
    » Treatment plan was up to date
• Claims should be submitted as soon as feasible
Improper claiming can be very costly

- Each claim that is rejected due to improper formatting must be “touched” and resubmitted
- Claims that are submitted without adherence to documentation regulations create a huge risk for disallowance upon audit

Clearinghouses can do a good job at scrubbing claims with technical errors but only an EMR with a billing component can evaluate claims for compliance with documentation requirements. An EMR can suspend claims and alert staff to errors that renders the claim unbillable and support quality improvement efforts and regulatory compliance.

If there is no EMR scrubbing of claims it is essential that there is an active Quality Assurance process that identifies improper claims and voids them when necessary.
Payer follow-up - Insurance

- Review each denied claim and determine the cause
- Some common denials are:
  - Claim was submitted after the allowable time period
  - Visit was not authorized
  - Client was not eligible
  - Provider was not credentialed
  - Claim had incorrect client or provider data
  - Provider technical error
  - Payer technical error

- Adjudicate claims, correct errors and resubmit promptly
- Identify preventable denials and apply a quality improvement process to correct
Payer follow-up – Client fees

- Outstanding client fee collection is difficult and labor intensive
- You must be able to demonstrate reasonable due diligence in attempting to collect all fees owed to you
- Some considerations:
  - Will you send outstanding client fees to collection after a reasonable effort to collect them
  - What do you consider a reasonable effort to collect
  - What will you do when terminated clients with an outstanding balance return to treatment.
After Services (continued)

Remittance processing and posting

Posting and applying payments and adjustments to client accounts and posting payments in aggregate amounts to the General Ledger

- Post payments in a timely fashion
- Compare payments received to amounts billed and reconcile differences
- Review adjustments made by the payer to individual claim. Appeal adjustments when warranted
Ongoing

Analysis

Review and evaluate the effectiveness of your revenue cycle management and the performance of your payers.

• Create and analysis standard metrics to identify issues and processes that may need improvement
• Quantify issues related to payers and discuss with your customer service representatives
• Some standard metrics
  - Collection ratio: a total collected to total billed reviewed by payer and payer class
Aged accounts receivable: Dollar value of accounts receivables tracked by amount of time they have been outstanding:

- Less than 30 days
- 30 – 60 days
- 60 – 90 days
- 90 – 120 days

Denial report – percentage and amount of claims denied by reason, clinician, and payer

Percentage of claims paid upon initial submission

Process improvement

Formalized process using your analytics to identify problems, create solutions, implement change, and measure the results.
Update

• Managed Care Organizations will be designating a billing contact per Plan to support providers and address questions.

• MCTAC is expecting Plan representatives to participate in our upcoming RCM Learning Communities.
How is the revenue cycle unique as an organizational process?

• Brings together workgroups and staff who do not work together in any other context
• Interdependencies exist across non-naturally occurring workgroups
• Revenue generation is the cornerstone of fiscal viability
• Inefficiencies, errors, and oversights can have a devastating impact
• Clinical priorities and fiscal/billing priorities are not always aligned
How might you address the operational challenges?

• Clearly articulate measurable performance standards for all staff with involvement in the revenue cycle process
• Measure against these standards regularly and differentiate people problems from system problems
• Address people problems quickly and effectively
How might you address the operational challenges?

• Provide staff with the tools and information they need to successfully carry out their tasks.
• Implement a quality improvement process to address system problems.
• Assure that Executive, Clinical, and Finance leadership are on the same page and speak with a single voice regarding revenue and the critical role it plays in supporting the mission of the organization.
A full featured properly implemented EMR with a strong billing component can bring significant efficiencies and accuracy to the revenue cycle process:

- Provide electronic scheduling to maximize the use of clinical capacity
- Efficiently evaluate insurance eligibility
- Track authorizations and alert staff when they are approaching thresholds
- Behind the scenes management of charge capture and coding to eliminate errors, maximize revenue and minimize audit risk
- Catch and suspend claims that do not meet payer and documentation requirements minimizing audit risk
- Efficiently post payments to maintain accurate client accounts
- Provide reports necessary to address staff, system, and payer performance issues
Short of a fully functional EMR a strong Revenue Cycle Management system, here are some essentials:

- Outsourcing billing services is an option
- In house stand alone billing systems are available
- A combination of in house billing systems (either EMR or stand alone based) and a clearinghouse claims processor is a popular option.
Cloud based EMR and Revenue Cycle Management solutions

Many EMR and Revenue Cycle management vendors are providing cloud based software solutions (SaaS – software as a service)

Pros:

• Agencies do not need to build out and support the infrastructure necessary for in-house solutions.
• Patches and updates are provided by the vendor
• Depending on the vendor some customization to support your unique workflow is available
• Internet access at the desktop is all that is required
• Ramp up time for a new solution is shorter than an in-house solution

Cons:

• Internet outages or poor internet speeds will adversely effect system availability
• Direct access to your entire data set may be limited to canned reports or limited filtering and or reporting capabilities
Next steps: What should you do when you leave today?

- Examine your population (who are they covered by? % of total financial picture)
- Make projections of revenue
  - using different assumptions based on billing lag
  - time delays 30, 60, 90 (pure delay (AR) vs. denial)
- Compare to your cash resources
- Having a conversation with your banker (your line of credit)
Next steps: What should you do when you leave today?

• Setting up the structures for billing
  - have analytic reporting capacity for billing
  - Build vs. Buy

• HCBS designated providers should review the list of HCBS services they are designated for and consider the financial impact

...and make plans accordingly
Upcoming Learning Communities

The four content areas for the RCM Series are:

#1 Scheduling & Pre-registration and Point-of-service registration & collection
#2 Charge capture & coding
#3 Claim Submission and Payer follow-up
#4 Remittance processing and Appeals, collections, and analysis
<table>
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<tr>
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<th>Monday</th>
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<td>5/18-5/22</td>
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<td>5/25-5/29</td>
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<td>#3 Webinar General Overview (NYC providers)</td>
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</table>

*All Webinars and Office Hours will be held from 12pm-1pm*
## Learning Community - Rest of the State (Tentative)

### July-August

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<td>7/13-7/17</td>
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</table>

*All Webinars and Office Hours will be held from 12pm-1pm*
15 Minute Break
Outcomes

Presenters: David Wawrzynek, MS, MBA
Shifting from Volume to Value: Identifying and Tracking Quality Outcomes

What is next for your Organization
Rationale for the Transition to Managed Care

**Better Care, Better Health, Lower Costs**

“Ever rising health care costs are a national challenge. The United States currently spends 16 percent of its GDP on health care which is nearly twice as much as any other nation. At the same time, key health indicators suggest that we are not getting our money’s worth”

*NYS DOH, Plan to Transform the Empire State’s Medicaid Program*
### Healthcare Rankings
The Commonwealth Fund

<table>
<thead>
<tr>
<th>COUNTRY RANKINGS</th>
<th>Top 2*</th>
<th>Middle</th>
<th>Bottom 2*</th>
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#### EXHIBIT ES-1. OVERALL RANKING

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<tr>
<th>OVERALL RANKING (2013)</th>
<th>AUS</th>
<th>CAN</th>
<th>FRA</th>
<th>GER</th>
<th>NETH</th>
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<td>Cost-Related Problem</td>
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<td>Timeliness of Care</td>
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<td>4</td>
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<td>Healthy Lives</td>
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</tbody>
</table>

#### Health Expenditures/Capita, 2011**

|                  | $3,800 | $4,522 | $4,118 | $4,495 | $5,099 | $3,182 | $5,669 | $3,925 | $5,643 | $3,405 | $8,508 |

Notes: * Includes ties. ** Expenditures shown in $US PPP (purchasing power parity); Australian $ data are from 2010.
Current environment

Evolution of the behavioral healthcare field

• Evidence Based Best Practices
• Managed Care
• Pay for Performance Model
• Outcomes, Outcomes, Outcomes
  – As the field moves forward so do we
  – Internally it provides staff and clients with measures to determine ways to improve upon existing work
  – Answers questions about the work we’re doing and offers deeper insights about what is or isn't going on
  – All agencies will have to collect and focus their efforts on data collection to be able to document that clients are making progress
Some of the current NYS quality metrics related to behavioral health

<table>
<thead>
<tr>
<th>Measure</th>
<th>Specifications To Use</th>
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<tbody>
<tr>
<td>Adherence to Antipsychotic Medications for People with Schizophrenia</td>
<td>HEDIS 2014</td>
</tr>
<tr>
<td>Antidepressant Medication Management</td>
<td>HEDIS 2014</td>
</tr>
<tr>
<td>Diabetes Monitoring for People with Diabetes and Schizophrenia</td>
<td>HEDIS 2014</td>
</tr>
<tr>
<td>Diabetes Screening for People with Schizophrenia or Bipolar Disorder Using Antipsychotic Medications</td>
<td>HEDIS 2014</td>
</tr>
<tr>
<td>Follow-Up After Hospitalization for Mental Illness</td>
<td>HEDIS 2014</td>
</tr>
<tr>
<td>Initiation and Engagement of Alcohol &amp; Other Drug Dependence Treatment</td>
<td>HEDIS 2014</td>
</tr>
<tr>
<td>Identification of Alcohol and Other Drug Services</td>
<td>HEDIS 2014</td>
</tr>
<tr>
<td>All Cause Readmission</td>
<td>HEDIS 2014</td>
</tr>
<tr>
<td>Mental Health Utilization</td>
<td>HEDIS 2014</td>
</tr>
<tr>
<td>Satisfaction with the Experience of Care</td>
<td>CAHPS 5.0H</td>
</tr>
<tr>
<td>Satisfaction Survey</td>
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</tr>
</tbody>
</table>
What is in development

• The quality strategy for behavioral health is being developed by OMH and OASAS and will embrace NY State vision of a system that is:
  ▪ Person centered
  ▪ Recovery oriented
  ▪ Integrated and,
  ▪ Outcome driven
Outcome measures will support the following goals:

- Improve access to and engagement in community-based behavioral health services, including
- Services designed to improve and maintain independent functioning and quality of life
- Increase provider implementation of evidence based practices that integrate behavioral and physical health services, including addiction pharmacotherapy
What is in development
continued

- Improved health care coordination and addresses continuity of care
- Reduced avoidable behavioral health and medical inpatient admissions and readmissions.
- Continuous quality improvement at the clinical, program, plan, and population levels.
- Reduce disparities in health outcomes for people with behavioral health conditions as compared to the population at large.
Data already exists

The key is to identify it and use it to inform the process

- Choose and define the outcomes of focus
- Capture the data and understand it so that it informs:
  - The client
  - The program
  - The agency
  - The payer
  - Referral Sources
- “Data” must be accessible and actionable by everyone
Taking outcomes to scale

- Medical Necessity isn’t new
  - We have always needed outcomes at the Treatment (Individual) level
- However, the transition to Managed Care vastly expands our thinking in this area and mandates that we take small outcomes work to scale, and capture data in a way that is:
  - Routine
  - Easily reportable
  - Provides information about both client improvement and the impact of care
What now:

Step 1: Determine where you fit in

• Create your VALUE PROPOSITION
  ▪ Define the problems and goals that your organization is best suited to address in the new behavioral health care environment
  ▪ Evaluate the processes, resources, and talents that will be necessary to be a successful and valued partner.
  ▪ Measure your current effectiveness and efficiencies
  ▪ Clearly articulate how your agency will play a part in the triple aim of health care reform:
    » Improving Care
    » Improving Health
    » Reducing Costs
Step 2: Determine what you are going to need

- Undertake a gap analysis to determine skill sets, processes, organizational structures and technologies that will be necessary to achieve your value proposition. Focus on:
  
  **Staffing and training**
  
  - Does your staff have the skills to interact effectively with the integrated physical and behavioral health treatment communities
  - Do you have the data analytic and financial modeling skills and tools necessary to move from Volume/Cost to Outcome/Cost monitoring

  **Organizational Structure**
  
  - Do you have organizational silos that are barriers to effective and efficient care
  - Are your organizational incentives supporting volume over quality
Step 2: Determine what you are going to need (continued)

- **Technologies**
  - Can you quantify and collect the outcome data you will need to evaluate your performance?
  - Can you electronically share clinical data with other service providers in a secure fashion?
  - Do you have tools and data sets necessary to shift to population management and evaluate Outcome/Cost across agency episodes of care?

- **Processes**
  - Quality Assurance Program
    - How do you use the information gleaned from this process?
  - Quality Improvement Process
  - Utilization Management Process
Step 3: Develop a plan for managing outcomes and stick to it

- Design and implement a plan that will get you from where you are today to where you need to be tomorrow.
  - Prioritize and address low hanging fruit immediately
  - Set benchmarks and timelines and hold yourself accountable
  - Look to secure resources where ever possible
  - Solicit input from all levels of your organization
  - Embrace change for the value it will bring to the quality of your services and the value it will return to the clients, families, and communities you serve.
## Develop your plan

### Quality Improvement Planning Process

<table>
<thead>
<tr>
<th>Plan</th>
<th>Do</th>
<th>Study</th>
<th>Act</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify where to focus first</td>
<td>Implement</td>
<td>What were the results?</td>
<td>Based on the findings, what next?</td>
</tr>
<tr>
<td>- Most Critical Area?</td>
<td></td>
<td>Benchmarking</td>
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<tr>
<td>- “Low Hanging Fruit”</td>
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<td>Monitor</td>
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<tr>
<td>- Biggest Barrier?</td>
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<td>- Creating a Scorecard</td>
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</tr>
<tr>
<td>- What will be implemented to address the identified area?</td>
<td>- Measure – Articulate change through data</td>
<td>- What do you do with the information? Making it Actionable.</td>
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</table>

### Tools to use

- Logic Modeling
- Strategic Planning
Primary Goal: To help behavioral health providers improve their quality of care while lowering healthcare costs.

Achieve goal by:

• Agencies will be able to access standardized outcome measurement tools and metrics (database) designed to facilitate and improve use of evidence based practices.
• Agencies can determine effectiveness of treatment modalities for prevalent mental health disorders.
• Best practices/model programs will be identified and disseminated.
• Identify clinics and practitioners that are not achieving minimum outcome benchmarks
Primary Project Activities

- Create assessment database for practitioners and organization decision-makers to identify and access clinical outcome and process measures.

- Create/identify digital platform for clinics to upload and view outcome data and performance metrics.

- Build provider capacity around outcomes and disseminate project tools through trainings and learning collaborative/community.
Helping mental health agencies integrate outcome measures into their clinical treatment.

Search Now

WE'VE STREAMLINED THE PROCESS FOR YOU.
Find valid measure options for your clinical case work in less time.
Business Intelligence can be defined as a set of methodologies, processes, and technologies that transform raw data into meaningful and useful information used to enable more effective strategic and operational insights and decision-making.
It will be important to incorporate data from a number of sources to begin understand what are the services and their costs that contribute to positive outcomes. The data will include:

- Client demographic data that includes behavioral and physical health conditions
- Service data at the client, program, and episode of care level
- Financial data cost per service, cost per episode of care, base revenue, and performance revenue
- Outcome data for clinical outcomes, social outcomes, and system utilization outcomes
Components of a Business Intelligence system

• **Measurement** – process that creates performance metrics and benchmarking that informs staff, management, and payers about progress towards goals and objectives.

• **Analytics** – program that builds quantitative analytical processes for an agency to arrive at optimal decisions and to generate additional knowledge about their business.

• **Reporting/Enterprise Reporting** – program that builds an infrastructure with a transparent and easy to understand visual reporting platform to support the management of the organization.

• **Collaboration/Collaboration platform** – program that allows staff in the agency to work together through data sharing and electronic data Interchange.

• **Knowledge Management** – program that supports an environment where the agency data supports and enables adoption of insights and changes that return value to the organization and its consumers.
Business Intelligence Skills

• For many organizations the skills necessary to use these tools are the same skills that are necessary to produce good administrative data:
  - Intermediate Excel skills
  - Basic understanding of data structures
  - Ability to create charts and tables

• Look to the skill sets that you have different departments, e.g. finance, quality improvement, IT, HR, and other administrative departments, you may find you are further down this road than you think

• Find ways to make the skills that are residing in other areas a resource available to the entire agency.
Resources you may find helpful

- OMH: Online access to Statistical Data
  https://www.omh.ny.gov/omhweb/statistics/
Resources (continue)

• **Client or Program specific outcome data you may have access to:**
  – Psychiatric Clinical Knowledge Enhancement System (PSYCKES)
  – Children & Adult Information Reporting System (CAIRS)
  – Integrated Program Monitoring and Evaluation System (IPMES)
Guidance and Direction

- Quality Strategy for the New York State Medicaid Managed Care Program

- 2015 Quality Assurance Reporting Requirements

- Directory of Managed Care Plans by County

- Plan Specific Reports of NYS Medicaid Managed Care Plans
Other resources

- SAMHSA – Data, Outcomes, and Quality
  http://www.samhsa.gov/samhsa-data-outcomes-quality/samhsas-efforts
- National Committee for Quality Assurance (NCQA)
  http://www.ncqa.org/
- Atlas of Integrated Behavioral Health Care Quality Measures
  http://integrationacademy.ahrq.gov/atlas
Thank you for participating!

Please visit http://www.ctacny.com/ and http://www.mctac.org/ to sign up for additional offerings and trainings.

Please fill out the feedback forms found in your folders, thank you!