

Baltimore City Substance Abuse: Strategies to Maximize Medicaid Billing
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Baltimore Substance Abuse Systems, Inc.

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Executive Summary

Until recently, Medicaid coverage for adults in Maryland was limited to extremely low-income parents and adults with disabilities. In 2008, the Medicaid program began covering low-income parents and over-time benefits are to be added to the Primary Adult Care (PAC) program to fully expand Medicaid benefits to low-income adults. Budget pressures have delayed the full expansion of benefits to the PAC program; however, substance abuse benefits are schedule to be added to the PAC program beginning in January 2010. The Medicaid coverage expansion and the addition of substance abuse treatment to PAC create a new environment, potentially making Medicaid a major funding source for treatment services. This is a new opportunity, but the shift from grant funding to Medicaid billing requires a different business model than is currently in place for many providers.

In March 2009 Baltimore Substance Abuse Systems, Inc. (bSAS) began a project to help providers access Medicaid financing of substance abuse treatment by increasing billing to Medicaid managed care organizations (MCOs). This report summarizes the activities and results of this project.

The key findings of the project are:

- Some treatment providers are billing MCOs with this accounting for at least 20% of their revenue;
- Half of treatment providers surveyed have little to no experience billing MCOs;
- Billing Medicaid MCOs is complex, with inconsistent policy and financial incentives, and frustrating operational barriers; and
- The PAC expansion presents an opportunity to increase funding for treatment.

The following recommendations are made:

- A. Align funding policy with the goal of encouraging more Medicaid MCO billing.
- B. Assist providers with working capital.
- C. Support efforts to increase PAC enrollment, which is critical to increased treatment revenue.
- D. Develop strategies to include eligibility verification and enrollment outreach early in the referral process.
- E. Provide clear and coordinated guidance on policy and operational issues.
- F. Facilitate a contract with an outside billing agency.
- G. Support access to practice management systems.
- H. Support learning among provides by facilitating user groups.
- I. Advocate for institutional support of billing and collection activities for affiliated programs.
- J. Explore the technical assistance needs of youth programs.

1. Introduction

The financing and delivery of substance abuse services to low income Marylanders has been the subject of study and policy discussions since Maryland began its Medicaid Managed Care program in the mid-1990s. There have been significant efforts to improve access to treatment for Medicaid enrollees, but the fundamental design of the financing and delivery systems has remained unchanged since HealthChoice, Maryland's Medicaid managed care program, began in 1997.

With support from the Open Society Institute - Baltimore, Baltimore Substance Abuse Systems, Inc. (bSAS) began a project to help providers access Medicaid financing of substance abuse treatment by increasing billing to Medicaid managed care organizations (MCOs). Because Medicaid is partially funded by federal revenue, Medicaid financing brings new federal dollars into Maryland. This report summarizes the activities and results of this project to assess the readiness and capabilities of treatment providers to bill Medicaid for services. The report identifies policy and operational barriers to increasing fee-for-service billing and ways in which bSAS could provide assistance to providers to increase fee-for-service billing.

2. Background

Until 2007, relatively few adults were covered by Medicaid. While Medicaid was still an important funding stream for some substance abuse treatment, the majority of individuals seeking treatment were not eligible for Medicaid coverage. The primary financing for substance abuse treatment has remained a general fund grant program, through which local jurisdictions receive an annual capped allotment. In Maryland in recent years, approximately 60,000 individuals received substance abuse treatment services annually through this grant funded program, while 22,000 individuals with Medicaid received some treatment services. In terms of dollars, about \$140 million was spent on the grant funded program and DHMH estimates that \$27 million was spent on outpatient substance abuse treatment by Medicaid.

In 2007 Maryland passed legislation expanding Medicaid coverage for adults. When and if fully implemented, this legislation will have a significant impact on the financing of substance abuse treatment for low income Marylanders. This expansion was to be phased in over a number of years. The first phase expanded Medicaid coverage to parents and caretaker relatives. This was implemented in July 2008 and, since then; over 45,000 adults have gained Medicaid coverage (10,000 in Baltimore City). The second part of the Medicaid expansion was to phase in coverage for adults without children at up to 116% of the federal poverty level or \$12,552 in annual income for an individual. The plan was to phase in benefits over three years to Maryland's Primary Adult Care Program (PAC). The PAC program provides very limited benefits, covering

only primary care physician services, prescription drugs and mental health services. Currently, PAC does not pay for any substance abuse treatment services but does cover the medication buprenorphine.

Due to a lack of State funds, the plan to expand PAC benefits to include all Medicaid-covered services was indefinitely rolled back. However, during the 2009 legislation session, HB 739 – Maryland Medical Assistance Program – Substance Abuse Services accelerated the expansion of substance abuse benefits to PAC enrollees. Beginning in January 2010, PAC benefits will include most Medicaid-covered substance abuse treatment services and the Medicaid fees will be increased to treatment providers funded with a reduction in the general-funded grant program. Statewide, \$3.3 million was transferred from the ADAA grant funds—\$2 million from Baltimore City. The fiscal note for HB 739 estimates that the shift to Medicaid financing will result in a \$6.7 million increase in treatment funding through Medicaid because of the federal matching funds. This estimate is based on the current enrollment levels in the PAC program.

The PAC expansion closely follows an effort by DHMH, providers and MCOs to improve access to substance abuse treatment. In 2008, a Medicaid Substance Abuse Treatment Workgroup made numerous recommendations to improve access to substance abuse treatment. Many of these recommendations are currently being implemented.

Based on this Workgroup's recommendation, the Substance Abuse Improvement Initiative (SAII) is being incorporated into regulation (with some modifications of the original standards), rather than remaining the voluntary initiative that it has been. The SAII was the product of a 2001 effort to improve substance abuse access under Medicaid by permitting enrollees to self-refer to treatment. It was an effort by MCOs and providers to develop common procedures and rules for Medicaid coverage of self-referred substance abuse treatment services. This allows an individual to receive treatment services from providers, regardless of whether they have a contract with the MCO, if the provider meets certain requirements laid out in the SAII. MCOs are obligated to pay the Medicaid fee-for-service rate to non-contracted providers. The Medicaid fee schedule for substance abuse treatment services is slated to increase in January 2010, another of the Substance Abuse Treatment Workgroup's recommendations. This increase in the fee schedule makes it more likely that providers will view the reimbursement rates for self-referred services under the SAII as adequate compensation; and therefore makes the SAII a potentially more palatable option for non-contracted providers.

The addition of substance abuse treatment services to the PAC benefit package will increase the potential for treatment providers to bill Medicaid MCOs. Anticipating this change, bSAS began its project to assess provider readiness and assist providers prepare for increased fee-for-service billing.

3. Project Description

In March 2009 bSAS engaged Riverside Consulting, LLC to lead its project to help prepare providers for the January 2010 PAC expansion. The goals of the project were to assess providers' current state of readiness for increased billing of Medicaid MCOs, identify operational and policy barriers to increasing billing of Medicaid MCOs and provide technical assistance activities to support providers' efforts to bill and collect from MCOs. Riverside Consulting assembled a project team with expertise in Medicaid policy, MCO operations and provider billing.

In April 2009 the Riverside project team conducted a survey of bSAS-funded treatment providers that offer methadone, outpatient, or non-residential youth treatment programs. These programs provide services that most likely would be covered by Medicaid and HealthChoice MCOs. Medicaid does not cover residential services for adults or halfway house services, so these providers were not included in the survey. bSAS provided the Riverside project team with a list of 41 methadone, outpatient and youth programs, representing 36 different providers. The survey was sent to all 41 programs on April 8, 2009 with responses due by April 24th. Follow-up emails were sent by the Riverside project team as well as by bSAS to encourage participation. By May 2009, 34 of 36 providers responded to the survey. Five of those providers operate two different programs, enabling survey findings to be compiled for 39 out of 41 programs.

Following the survey, the Riverside project team completed interviews with 12 program directors and other staff. The goal of these interviews was to explore questions and issues a survey could not capture. The team heard directly from the program staff their views on increasing their Medicaid MCO billing; how they were preparing for the transition; what resources might be helpful to them; and their sense of operational and policy barriers to increased Medicaid billing. Additionally, two phone interviews were completed with a member of the Riverside project team.

Working with bSAS, two providers were selected to pilot technical assistance activities. The selection was based on the size of the programs, the willingness of the providers to engage in this process and the diversity of programmatic issues. Because the survey found that more methadone providers had MCO contracts with billing systems in place and were already billing Medicaid MCOs, the technical assistance pilot sites were focused on outpatient and youth programs. Participation in the technical assistance pilot required a significant time commitment from the program director and key staff.

The Riverside project team also met with bSAS, DHMH, and other stakeholders to gather information and identify policy and operational issues. DHMH's website, MCOs' websites and

other programmatic information was reviewed. The project team gathered pertinent information and insight from bSAS, DHMH, and the MCOs.

4. Findings and Analysis

The key findings of the project are:

- Some treatment providers are billing MCOs with this accounting for at least 20% of their revenue;
- Half of treatment providers surveyed have little to no experience billing MCOs;
- Billing Medicaid MCOs is complex, with inconsistent policy and financial incentives, and frustrating operational barriers; and
- The PAC expansion presents an opportunity to increase funding for treatment.

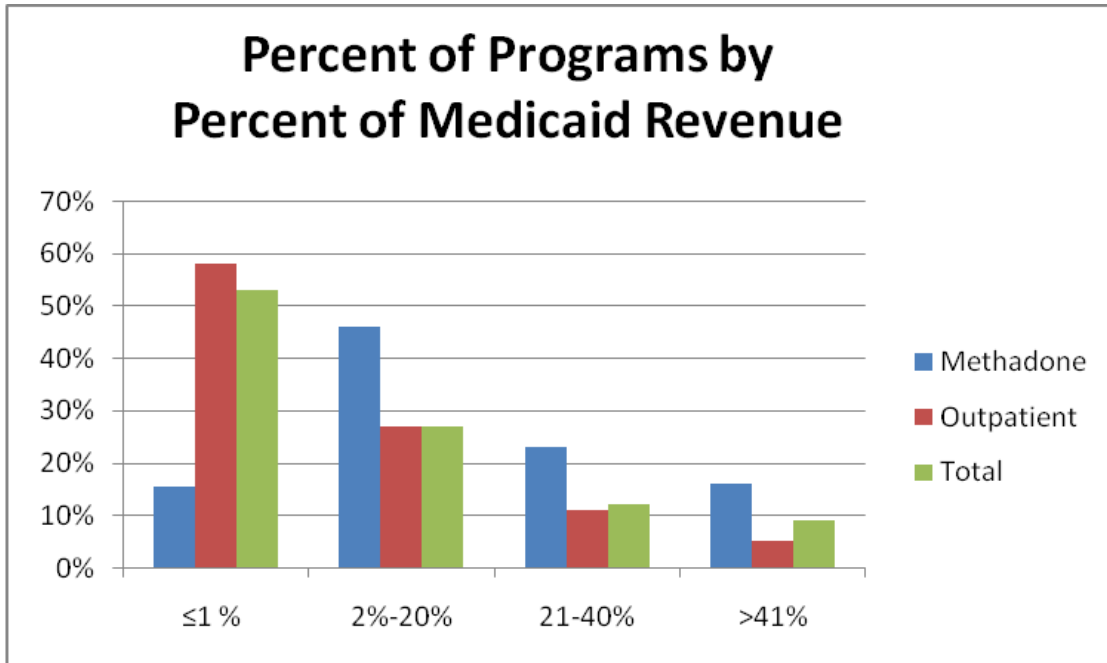
Complete findings are summarized in six key areas: Payer mix; MCO Contracting; Billing Systems; Youth Programs; Lessons from Experienced Billers; and PAC Revenue Potential.

a. Payer Mix

Medicaid revenue is negligible for half of providers, but significant for others. A provider's payer mix (the amount of revenue generated from grant funds, Medicaid, commercial insurers or other sources) is an indicator of its experience billing third-party payers. A majority of providers appear to have little experience billing Medicaid or other third-party payers, while others receive a considerable portion of revenues from Medicaid. Slightly more than half (53%) of providers report Medicaid reimbursement as less than one percent of their revenue. For these providers, almost all (90% to 100%) revenue came from bSAS funds or other grant or charitable contributions. In contrast, 21% of providers report Medicaid reimbursement as more than 20% of revenue, and three providers report over 40% of revenue from Medicaid.

For providers reporting revenues from third-party payers (commercial insurers, Medicare or Medicaid), Medicaid represents the vast majority of all third-party payments. Only one provider reported third-party revenue without any revenue from Medicaid or MCOs. Thus, the survey suggests that if providers are able to bill any third-party payers, they are billing Medicaid or Medicaid MCOs.

Chart 1



Payer mix varies by program type. Payer mix and the capacity to bill Medicaid and other third-party payers vary greatly by program type. Close to 40% of methadone programs report that greater than 20% of total revenue is from Medicaid MCOs. Only 16% of outpatient programs report that greater than 20% of total revenue is from Medicaid MCOs and no youth programs report meaningful Medicaid billing.

Many treatment programs are based in other institutions – hospitals or federally qualified health centers (FQHCs). There is variation in payer mix among institutionally-based programs. Some of the institutionally-based programs have very limited billing of Medicaid and MCOs. In addition, differences in billing experience exist even among programs associated with the same institution. This suggests that institutional partners provide different levels of support to their associated programs for billing and reimbursement.

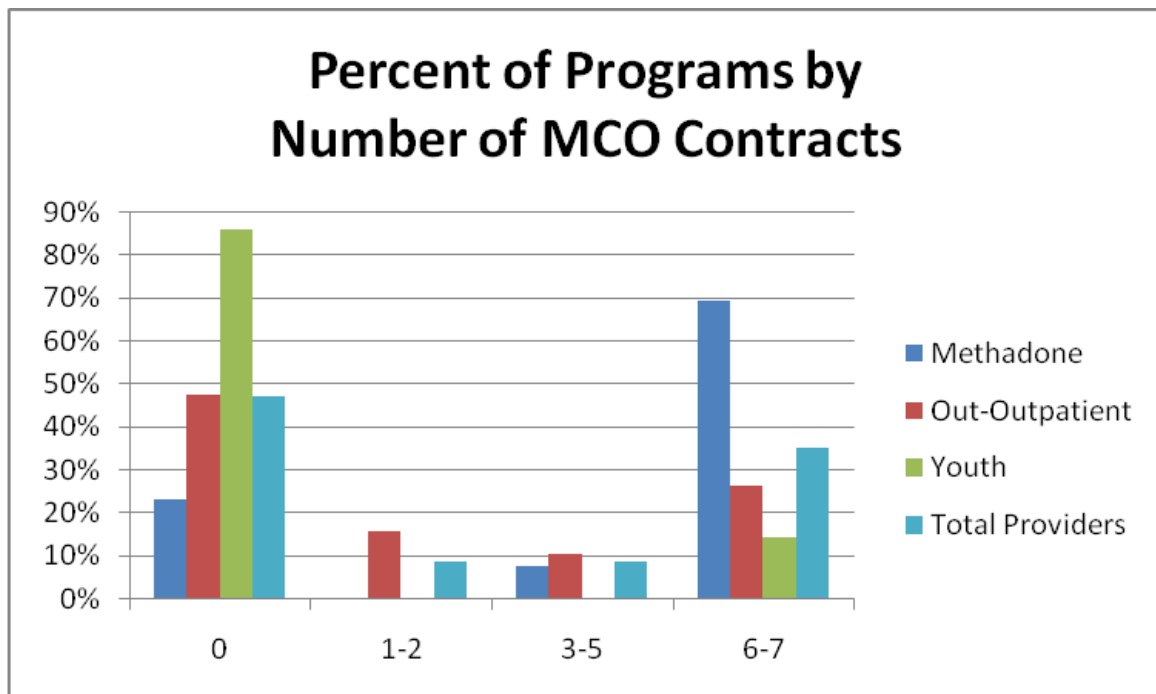
b. Contracting with Medicaid MCOs

Typically, the first step for any type of provider to begin billing a Medicaid MCO is to contract with the MCO. However, because of the SAIL it is possible for non-contracted provider to bill Medicaid MCOs for substance abuse treatment. Providers may bill MCOs as non-contracted providers if they follow specified notification and documentation requirements. The MCO is obligated to pay the provider at least the Medicaid fee schedule for these services. Currently, the Medicaid fee schedule is much lower than MCOs' reported reimbursement to contracted providers. This creates a financial incentive for providers to contract with MCOs. In January 2010, the Medicaid fee schedule for substance abuse

treatment is scheduled to increase, potentially decreasing the importance of contracting with MCOs. In addition to the current financial incentive of having MCO contracts in place, the presence of a contract can be beneficial to the billing and reimbursement process through the development of stronger relationships between provider and MCO.

The presence of a contract does not necessarily mean that a provider is billing and being paid for services. However, the survey finds a direct relationship between contracts and revenue. Providers that have MCO contracts have greater levels of Medicaid revenue. And, those providers with greater levels of Medicaid revenue all have contracts in place.

Chart 2



MCO contracting practices vary among providers and by program type. The survey found that 35% providers have contracts with most or all MCOs. However, almost half (47%) reported having no MCO contracts. As with payer mix, MCO contracting practices vary by program type. The majority (69%) of methadone programs report contracts with most MCOs, but only 26% outpatient programs report contracts with most MCOs. Only one outpatient youth programs reported any MCO contracts.

There is little evidence that MCOs reject provider contract requests as a widespread practice. Only five providers (19% of respondents) reported being turned down by a MCO for a contract. Three of these have multiple MCO contracts in place. The other two reported being turned down by as many as four MCOs. Of the 16 providers reporting no contracts, only one reports having been turned down by an MCO. This suggests those providers

without MCO contracts are not actively seeking contracts with MCOs. The scope of the survey did not include the reasons contracts were rejected or what constituted a provider's attempt to contract. There was a high non-response rate to this section of the survey. Non-responders were providers without MCO contracts.

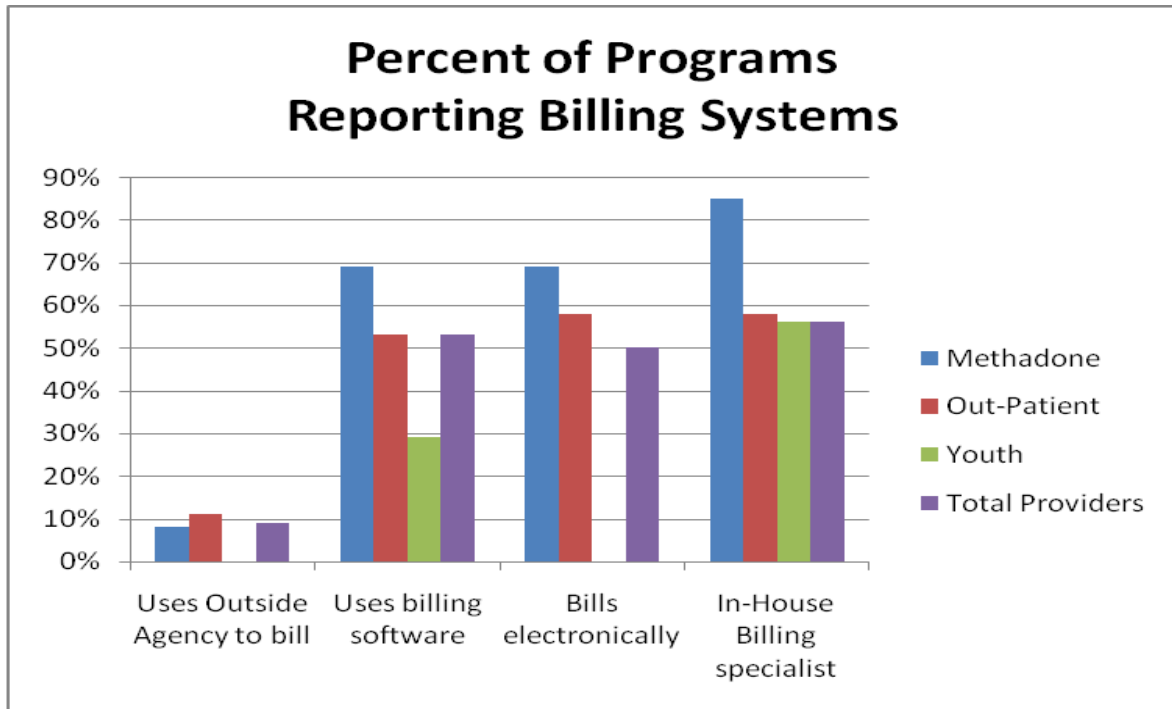
There is an opportunity to streamline MCO contracting. Through the technical assistance pilot projects and program director interviews, we found that MCO contracting is an overly complicated process. Clear and accurate information about application processes is lacking. It is difficult to get the correct application, requiring multiple calls to different staff. Often the received application was designed for individual practitioners rather than certified addictions programs. Even though the survey data did not find that providers were often rejected in attempts to contract, the perception that this is the case may be related to the need to clarify communication with the MCOs and streamline the contracting process.

MCOs contract with non-bsAS funded providers. The project team reviewed information provided by MCO staff and websites regarding their substance abuse networks. This information was largely consistent with the contractual relationships reported by providers. Some of the inconsistencies with the provider survey may reflect different names associated with providers. Appendix 1 lists providers in Baltimore City with whom the MCOs report contracting and providers with bsAS funding for levels of care that include Level 1, 2 or OMT – those services that are also most likely to be Medicaid covered benefits. It is notable that MCOs report contracting with a number of Baltimore City providers that are not bsAS-funded providers. In fact, the MCO network data showed that most of the treatment providers with MCO contracts in Baltimore City are not funded by bsAS.

c. Provider Billing Systems

Most providers have billing systems, but are not necessarily billing Medicaid MCOs. One of the ways to assess provider readiness to bill and collect from MCOs is to examine current business practices for billing third-party payers. Over half the providers surveyed report having billing software, billing electronically and/or having an in-house billing specialist. Only three of 34 providers report using an outside billing agency or a claims clearinghouse to complete their billing. The billing systems are most likely to be found in methadone programs followed by outpatient programs and then youth programs.

Chart 3



While these billing systems indicate a readiness to bill third-party payers, it is unclear how extensively or effectively these systems are being used. The providers with at least 25% or more of their revenue from third-party payers all have an internal billing specialist, use billing software, and/or bill electronically. However, many of the providers with limited third-party revenue also have billing systems in place. This suggests that while billing systems are associated with the ability to receive Medicaid reimbursement, a billing system alone is insufficient. For example, from interviews and discussions with providers we know that some do not have systems in place to verify clients' Medicaid or PAC eligibility. One of the first steps of a billing process is to identify individuals who may be eligible for Medicaid. Providers who do not establish eligibility are not likely to have an effective billing process regardless of what else is in place.

d. Youth Programs

There is potential for the youth programs to increase Medicaid revenue. The youth programs stand out as having very limited Medicaid billing experience. This lack of Medicaid billing could represent a missed opportunity given that a higher proportion of clients served by youth programs are likely to be eligible for Medicaid. Medicaid covers children at higher incomes, up to 300% of the federal poverty level or \$36,000 annually for a family of three. The survey did not adequately address the unique issues identified by youth providers during interviews. They include difficulty identifying eligibility status because

social security numbers are not always in the Electronic Verification System (EVS) for children; confidentiality issues making billing third-party payers difficult; and the fact that youth programs are often school-based. The scope of this project did not explore issues specific to youth programs.

e. Lessons from Experienced Billers

Billing MCOs not easy, but doable: The interviews with providers, discussions at different provider meetings, and our work with two technical assistance pilot sites confirm that billing Medicaid MCOs is complex. In addition to inconsistencies in policy and conflicting financial incentives, the operational barriers alone are difficult to overcome. The lack of clarity in operational procedures makes navigating the world of billing for those just beginning to operate in this new environment even more challenging. A few providers have experience billing Medicaid MCOs and have MCO revenue that is over 20% of their total program revenue, demonstrating that have had some success billing Medicaid MCOs. Their success demonstrates that it is possible to work through the challenges in billing.

Build Relationships with MCOs: One of the first things most experienced billers said was that they built working relationships with the MCOs. Some acknowledged the natural tensions that exist between provider and insurer, but these providers describe the first step as developing a first name working relationship with MCO staff approving authorizations for services, recognizing this does not have to be a contentious working relationship. They describe these relationships as taking time to build, but worth their investment. Providers told us that it helped to figure out the nuances of each MCO process and work within that process.

It takes leadership and an organizational commitment: It was clear from discussions with providers that leadership is essential to resolving administrative hurdles to achieving an effective billing process. Leadership can come from the director or senior managers, and consists of committing time and resources to working through administrative challenges and identifying issues and working with MCOs, DHMH or others to resolve operational barriers. Some providers report that they had assigned the MCO working relationship to more junior staff that already had full time workloads. This was understandable given the concern some providers raised about their lack of resources to staff new administrative responsibilities. However, it seems that involvement from higher-level organizational leaders is associated with greater success.

Experienced Medicaid billers all have staff dedicated to billing, and these staff function as part of a team. Clearly, one dedicated person is not enough to support a successful billing and collection process. Rather, it takes the entire staff. All staff, including clinical staff,

needs to be a part of the cultural shift from grant funding to Medicaid billing. The clinical staff needed to be invested in the new workflows and timelines required to support billing and collections.

Approach Billing and Collections as a Process, Not a Single Event: Experienced billers clearly recognized that successfully billing MCOs involves more than submitting a bill. Management systems are necessary to assure that the provider identifies as many people as possible with Medicaid coverage; verifies current eligibility; manages authorization processes; documents services adequately to support billing and manages accounts receivable. Providers also shared that their clinical staff needed to buy into the business workflows to support billing and collections. For example, grant funded services do not require a treatment plan to be produced quickly, whereas billing a MCO requires an initial treatment plan in just a few days.

Adapt to New Timeframes: Billing requires a sense of urgency and adherence to deadlines different from those in the grant world. The need to notify MCOs about treatment plans within specific timeframes requires support throughout the organization and management tools to track key information. For example, the SAII requires a provider notify the MCO and submit an initial treatment plan within 3 days of admission to Level 1 therapy services (outpatient Services – individual, family and group therapy).

Familiarity with Self-Referral Initiative and other policies is empowering: Medicaid eligibility and coverage policies are complex. Experienced providers report that understanding the SAII and other policies supports the relationship with the MCO. Sometimes the initial response from an MCO staff member may not take into consideration Maryland's unique self-referral process.

f. PAC Expansion Revenue Potential

The PAC expansion is an opportunity to increase funding for treatment. The addition of substance abuse treatment services to the PAC benefit package creates a new incentive for providers to optimize their Medicaid billing. The change to PAC is important because it:

1. brings new federal Medicaid funds to substance abuse treatment services in Maryland, allowing State funds to go further if grant funds are not cut and reimbursement is realized;
2. has the potential to increase treatment funding as more individuals are enrolled in PAC;
- and 3. stabilizes treatment funding given PAC is currently treated like an entitlement program – coverage is not capped according to available funding.

The addition of substance abuse treatment to the PAC benefit package is possible through a shift from the grant funding model to a Medicaid model, using MCOs. This shift is relatively small; statewide, the annualized reduction in grant funds to support the PAC expansion is less than five percent. In Baltimore City, the PAC expansion shift represents about 8% of all ADA A grant funds.

Still, any reduction in grants is important given the context of the larger State fiscal crisis. The table below shows cuts to the FY 2010 ADA A Budget. It is also possible that there will be cuts in the future as the revenue projections for the State continue to look bleak. This further emphasizes the need for providers to take advantage of funds available through Medicaid billing.

FY 2010 ADA A Budget Reductions to Baltimore City				
	During Legislative Session		Actions of the Board of Public Works	
	Adjustment based on Reversions	6-month PAC expansion Shift to Medicaid	July 22 .9% across the Board	August 26
Statewide	\$1.25 million	\$3.34 million	\$1.22 million	\$1.65 million
Baltimore	\$155,991	\$1.98 million \$4 million – annualized	\$488,931	\$658,628
Data provided by ADA A, 10/09. The \$1.25 million adjustment includes a \$1 million adjustment made by the General Assembly and a \$250,000 adjustment made by ADA A, but applied at the same time.				

There is limited data on how many individuals currently served by the grants could receive substance abuse treatment through PAC, either because they are already enrolled in PAC or will have a new incentive to enroll because of the expanded benefit package. bSAS data on self-reported income suggest that most clients would meet income eligibility requirements and anecdotal information from providers bears this out as well.

The best currently available estimates of the numbers of individuals who may actually enroll in PAC and receive substance abuse treatment through PAC come from Baltimore Health Care Access' (BHCA's) addiction outreach project. Assuming half of the currently uninsured will enroll in PAC, approximately 2,000 individuals currently served through grant funds could receive treatment billable to Medicaid. This could result in approximately \$5 million in PAC substance abuse treatment revenue in the first full year of implementation - or an increase of \$1 million over the amount reduced from grant funding to support the PAC expansions. Critical assumptions used to develop this estimate were: 1. Half of the currently uninsured would actually enroll in PAC; 2. It would take 4 months to enroll in the PAC program so the previously uninsured would only be enrolled in PAC for 8 out of 12 months of the year; 3. 80% of the Level 1, 2 or OMT services currently paid for with bSAS

funds in non-HSCRC regulated settings would be reimbursed by the MCO; and 4. MCOs reimbursement rates would be consistent with current grant funding. This estimate was developed based on available, but limited data to illustrate the potential for PAC revenue. How the PAC expansion is actually implemented will significantly affect whether these revenue projections are realistic.

In addition to creating a funding source for additional numbers of individuals, the shift from the grant to the Medicaid billing model also has the advantage of stabilizing provider revenue streams. This is because PAC is currently treated as an entitlement program. While the State does have statutory authority to cap PAC if funds are limited, the federal stimulus bill requires the State to maintain eligibility while it receives enhanced federal matching fund through December 2010. This creates a strong disincentive for the state to cut eligibility. Under a grant program funds are capped; when the funds are gone, no more services may be provided unless new funds are appropriated. In contrast, the funding for an entitlement program will grow to meet the demand for services. In order to reduce the budget for entitlement programs, policy makers must make programmatic decisions that are assumed to provide savings – for example cutting eligibility or benefits.

5. Providers Activities to Support Billing and Collections

The PAC substance abuse expansion will only create new funding for substance abuse treatment and increase capacity if providers can successfully bill and collect from Medicaid MCOs. The shift from grant funding to Medicaid billing may require new business practices among some providers. It is essential that providers recognize billing and reimbursement as a process that involves administrative as well as clinical staff. The decision to pursue MCO contracts and identifying the changes necessary to workflows to support a billing and collection process are two parallel processes that providers need to address.

Advantage of MCO Contracting

Because of the SAIL, providers do not have to contract with MCOs to bill for treatment services. Securing contracts with Medicaid MCOs could have advantages. The existence of a contract facilitates the establishment of a positive and supportive working relationship. There may be enhanced resources for contracted providers, such as provider relations support or web resources for tracking administrative issues. MCOs may refer clients to contracted providers. Finally, while none of the MCOs report that it is their policy to redirect a client back to a network provider after the self-referral authorization expires, there is no regulation or policy that prevents a MCO from doing this. For example, under the SAIL, a non-contracted provider may provide up to 26 weeks of treatment for methadone, following which it is up to the MCO whether they will continue

to approve treatment with the non-contracted provider. Having a contract would assure providers a client would not be redirected to another provider after the self referral authorization expires. For providers who will have a long-term and intensive relationship with clients inclusion of substance abuse treatment within the MCO network could include coordination of care.

Key Administrative Steps to Billing and Collection

In order to successfully bill and collect for services, providers will need to assure that their administrative processes have several key elements. These include: 1. identifying eligible individuals; 2. securing authorizations; 3 documenting services; 4. creating and submitting a bill; 5. reviewing Explanation of Benefits (EOB); and 6. managing accounts and improving processes. Providers can begin to address the changes that will be needed to their administrative workflows before the January 2010 PAC expansion begins.

6. Summary Conclusions

Until recently, Medicaid coverage for adults was limited to extremely low-income parents and adults with disabilities. Therefore the opportunity for substance abuse providers to bill for their services was limited. There was little incentive for providers to invest the resources in billing processes. The Medicaid expansion and the addition of substance abuse treatment to PAC create a new environment, potentially making Medicaid a major funding source for treatment services. This is a new opportunity, but the shift from grant funding to Medicaid billing requires a different business model than is currently in place for many providers.

The findings from this project show that billing Medicaid MCOs is doable, but complex. Half of all providers have little or no experience billing. The past coverage limitations explain why many providers have little to no billing experience. It is understandable that providers have legitimate concerns about taking on the new role as biller, particularly given the many steps and the complexity of the billing process.

Those providers that are already successfully billing are likely to adjust relatively well to the new billing opportunities under PAC. Some of the less experienced providers are actively preparing to work through the challenges of the new business model.

7. Recommendations

A. Align funding policy with the goal of encouraging more Medicaid MCO billing.

The shift from grant funding to billing and collections has the potential to increase funding for treatment in Maryland. However, this presents legitimate challenges for providers. For years,

providers have built and refined business models responsive to the grant-based system of funding. Now they are faced with the need to bill third-party payers. Not only must providers adopt a new business model, they must do so at the same time they continue to operate in the grant world. If this were not complex enough, the financial incentives of the grant system and the billing system are often contradictory.

Grant funding has been the primary and stable funding source, whereas the volume of potential revenue from billing is somewhat uncertain given that it is based on projections estimated from current PAC enrollment and without data regarding MCO spending on treatment. It is understandable that a provider's first priority will be to protect its grant funding. bSAS should consider how it can advance its mission of serving the uninsured through grant funds and promoting increased enrollment and billing of third parties.

Policy makers should align providers' financial incentives to be consistent with the State's interest in enrolling as many eligible individuals as possible into Medicaid and PAC and drawing down federal funds for treatment. Policy makers can achieve this in the following ways:

- bSAS's current utilization requirements can create a financial disincentive to promote enrollment and bill third-party reimbursement. The current utilization requirements require providers to fill all their bSAS slots to fully draw down their grant funds. This creates a financial disincentive to assisting currently uninsured individuals to enroll in the PAC program. bSAS should consider removing the disincentive created by utilization requirements until providers have greater experience billing MCOs and the potential PAC enrollment is more certain.
- The State's "over-collections" policy requiring providers to return grant funds when exceeding estimates of third-party reimbursement creates a financial disincentive for maximizing collections. Allowing providers to keep all third-party payer collections will create a more explicit incentive to maximize Medicaid and PAC enrollment. Through bSAS performance based contracts this issue has been addressed for Intensive Outpatient and Outpatient services.
- Increased third-party reimbursement will require a new business model with new administrative activities and accounting policies. bSAS should assist providers by sharing clear information about how expenses should be accounted for and clarifying how grant funds could be used to support administrative activities to increase billing and collections.
- The transition to a financing system with greater uncertainty will require enhanced capability for quick and responsive decision-making and processing. bSAS should work with providers to expedite budget amendments that may be necessary to address changes.

B. Assist providers with working capital.

Providers may face disruptions in cash flow as they shift from the grant model to the billing model. Providers will have a need for working capital as they make this change, particularly if they are expected to expand capacity. Policies that take back funds from providers when uninsured utilization targets are not met or when third-party collections are underestimated contribute to the difficulty providers will have in maintaining reliable cash-flow. State and City policy makers should consider how to help providers address cash flow issues during the transition to increased fee-for-service.

C. Support efforts to increase PAC enrollment, which is critical to increasing treatment revenue.

Increasing treatment funding by drawing down new federal revenue through Medicaid and PAC is only possible by increasing Medicaid and PAC enrollment. Because providers are the ones on the ground interacting with individuals, they are uniquely situated to direct their uninsured clients to resources that may help them enroll in PAC and encourage enrolled clients to maintain their eligibility at annual redeterminations. Eligibility is complicated. Providers need support to enable them to play a key role in promoting enrollment. Shifting uninsured individuals that are currently supported through grant funds to PAC-enrolled individuals supported through Medicaid financing is critical to increasing treatment funding.

D. Develop strategies to include eligibility verification and enrollment outreach early in referral processes.

Many clients are referred to providers through other state agencies, the judicial system, or other community providers. However, it is not clear that many of the referral sources have assessed whether an individual has already enrolled in Medicaid or PAC or whether they may be eligible for programs and should apply. The ADAA's data reporting system, the Statewide Maryland Referral Processes Automated Records Tracking (SMART), does not include information on an individual's eligibility status and whether they are enrolled with a Medicaid MCO. This information is critical to expediting enrollment in Medicaid and PAC and increased Medicaid financing. It is also important to increase coordination and continuity of care by referring clients with Medicaid or PAC to providers who are billing Medicaid MCOs, if clinically appropriate.

E. Provide clear and coordinated guidance on policy and operational issues.

Significant opportunity exists to clarify and share information. There is a need to overcome the technical language of different stakeholder groups and describe policies and action steps in clear and simple language. The fact that each provider, MCO, and DHMH agency has

multiple staff contributes to complexity. Assuring common understanding of policy and operational issues will also help identify legitimate policy or operational barriers that need to be addressed. bSAS should work collaboratively with DHMH to help ensure that providers receive clear and consistent guidance.

bSAS can support communication among providers and other stakeholders. BSAS can act as the central clearinghouse for helpful information, for example posting relevant DHMH policies; eligibility information; and MCO contract applications on its website. DHMH has helpful information on the SAI on its website. bSAS could make this more easily accessible by adding direct links to its own website. bSAS could post and maintain a resource for providers on Frequently Asked Questions.

There is much uncertainty about MCO contracting practices and an important first step is clarifying regulatory requirements and the contracting policies that are at the discretion of the MCOs. In October 2009 DHMH posted all the MCO provider applications to their website. While this was a basic first step, it did address a legitimate concern that providers have that it is difficult to even begin the process of seeking contracts. DHMH also plans a provider contracting forum in late October 2009. It will be important to follow-up on any issues that continue to be confusing for providers regarding contracting and credentialing.

F. Facilitate a contract with an outside billing agency.

Many providers are new to billing, and could benefit from the expertise and resources offered by an outside billing agency. bSAS can explore how to consolidate this administrative function across multiple providers in order to achieve economies of scale. It is essential to understand that the functions of a contracted billing agency are only part of the billing and collections process. Even if certain administrative functions are contracted out by an individual provider or by bSAS, each provider must still develop strategies to managing other parts of billing and collections process such as identifying eligible individuals, managing authorizations, documenting services. Ultimately, providers may want to consider new data systems to support these activities. Some of the data systems have the capacity to generate and submit claims electronically so providers may want to make decisions about an outside billing agency as they consider their data system needs.

bSAS should convene a workgroup of interested providers to solicit and review bids from billing agencies. bSAS would facilitate the contract across providers, but would not fund the contract. The contract could be structured so that the billing agency is paid based on a percentage of claims paid.

G. Support access to practice management systems.

Practice management software systems help providers track data, such as authorizations, needed for billing. There are data systems supported by DHMH or bSAS, but neither provides the management tools necessary for operating in a billing and collections environment. bSAS should convene a workgroup of providers to identify gaps in available systems and identify potential tools and strategies to fill gaps. This effort should coordinate with efforts to facilitate a relationship with an outside billing agency because these are different approaches to managing parts of the billing and collection process.

H. Support learning among providers by facilitating user groups.

Given the range of experience among providers, there is great value in sharing the lessons learned of more experienced providers with less experienced providers. Topics of user groups could include: best practices and lessons from experienced billers; strategies to maximize eligibility; MCO contracting and legal support for contract review; and accounting and financial management in grant and third-party reimbursement models. bSAS could facilitate user groups through a variety of avenues, such as regular in-person roundtables, conference calls, or web-based vehicles such as a listserv or frequently asked questions and answers. Regardless of the avenue, it is important to link administrative and clinical staff to support the team environment that is essential for the successful billing processes.

I. Advocate for institutional support of billing and collection activities for affiliated programs.

Large institutions have resources devoted to maximizing reimbursement. The survey findings suggest that institutional partners provide different levels of support to their affiliated substance abuse treatment programs. Institutions are faced with many competing priorities, and may not recognize the existence of untapped funding for substance abuse treatment. Policy makers should advocate for institutional support of billing and collection activities among smaller affiliated substance abuse treatment programs.

J. Explore the technical assistance needs of youth programs.

Youth programs have the largest proportion of clients eligible for third-party reimbursement because of the high coverage levels of the Maryland Children's Health Program (MCHP). This project focused on billing and collection for PAC, an adult program. Therefore it did not delve into issues faced specifically by youth programs. Given that the opportunity may exist to dramatically increase billing and collection among youth programs, bSAS should better understand the specific technical assistance needs of these providers and other factors that create barriers to seeking third-party reimbursement.

**Appendix One: Baltimore City Substance Abuse Treatment Providers
With bSAS Funding or MCO Contracts**

Provider	BSAS Funded	MCO Contract
A Helping Hand, LLC		✓
A.W.A.R.E.		✓
ADAPT Cares	✓	✓
Baltimore Behavioral Health		✓
Baltimore Community Resource Center	✓	✓
Bon Secours - New Hope Treatment Center	✓	✓
Bon Secours - Next Passage	✓	✓
Bridge House	✓	
Build Fellowship, Inc.	✓	
Buprenorphine Bulk Medication	✓	
Center for Addiction Medicine		✓
Chase Brexton Health Services Inc.		✓
Community Institute of Behavioral Resources		✓
Cornerstone	✓	✓
Counseling Center (formerly Jones Falls)		✓
Crossroads Centers		✓
Daybreak Rehabilitation Program	✓	✓
Druid Heights Treatment and Counseling Center, Inc.	✓	✓
Echo House	✓	
EPOCH Counseling Center		✓
Family Health Centers of Baltimore	✓	✓
First Step Day Program		✓
Gaudenzia Park Heights	✓	✓
Gaudenzia Woodland	✓	
Glass Substance Abuse Program	✓	✓
Glenwood Life Counseling Center	✓	✓
Harbel Prevention and Recovery Center	✓	
Health Care for the Homeless	✓	✓
Instit. for Behavioral Res. REACH Mobile Health Services	✓	✓
Jai Medical Center		✓
JHH - Ambulatory Detox Program		✓
JHH - Bayview Addiction Research Center	✓	✓
JHH - Bayview Adolescent Substance Abuse Program	✓	
JHH - Bayview Alcoholism Treatment Services	✓	✓
JHH - Bayview Chemical Dependency Unit		✓
JHH - Bayview Comprehensive Treatment Center		✓

Provider	BSAS Funded	MCO Contract
JHH - Bayview Medical Addiction Treatment Services	✓	✓
JHH - Bayview Medical Center for Addiction and Pregnancy	✓	✓
JHH - Comprehensive Women's Center		✓
JHH - Early Recovery Clinic		✓
JHH - Extended Recovery Clinic		✓
JHH - Methadone Maintenance Clinic		✓
JHH - Programs for Alcoholism		✓
JHU - Behavioral Pharmacology Research Unit	✓	✓
M.L. Birch & Associates - Acupuncture	✓	
Man Alive, Inc.	✓	✓
Mountain Manner - Highlandtown		✓
Mountain Manor		✓
Northwest Baltimore Youth Services	✓	
Park West Health System		✓
Partners in Recovery	✓	✓
People Encouraging People	✓	
Peoples Community Health Center Inc		✓
Pine Heights Treatment Center		✓
Powell Recovery	✓	✓
Recovery in Community	✓	
Reflective Treatment Center (multiple sites)	✓	✓
Sinai Hospital Addictions Recovery Program	✓	✓
Total Health Care, Inc.	✓	✓
Treatment Resources for Youth, Inc.	✓	
Tuerk House	✓	✓
Turning Point Clinic	✓	✓
UMMS - Alcohol & Drug Abuse Program Walter P. Carter Building (ADAP)	✓	
UMMS - Drug Treatment Center/Methadone	✓	
UMMS - Harambee Treatment Center	✓	
Universal Counseling Services	✓	✓
University of Maryland Psychiatry		✓
Warwick Manor Behavioral		✓

Note: BSAS funded providers include those with Level 1, 2, or Opioid Maintenance Therapy (OMT) - those levels of care most likely to be covered by Medicaid. Providers listed with MCO contracts is based on data from MCO websites and provider lists provided by MCOs. MCO data does not include Coventry and Medstar, which do not participate in the PAC program. There are inconsistencies in names used for providers, which may explain some variation between MCO network data and BSAS funded providers.