APPENDIX 2

SOLANO COUNTY HEALTH & SOCIAL SERVICES DEPARTMENT - MENTAL HEALTH ELECTRONIC HEALTH RECORD (EHR) READINESS PROJECT

Managed Care Unit/Access
Summary Report

Prepared by:

6263 North Scottsdale Road, Suite 200
Scottsdale, AZ 85250
(480) 423-8184
www.foxsys.com

REVISION HISTORY

Date	Version	Description
22-Mar-10	Draft v1.0	First draft to County Project Manager
24-May-10	Final v1.0	Final draft to client

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LIST OF ACRONYMS

The following acronyms are used throughout this document:

Acronym	Definition
CAC	County Administrative Center
CBO	Community Based Organization
CMAC	California Medical Assistance Commissions
CMSP	County Medical Services Program
CNS	Clinical Nurse Specialist
COHS	County Organized Health Systems
CP	Commercial Plan
CY	Calendar Year
DEA	Drug Enforcement Agency
DHCS	Department of Health Care Services
DMH	Department of Mental Health
DMHC	Department of Managed Health Care
DOB	Date of Birth
DOS	Date of Service
Dx	Diagnosis
EHR	Electronic Health Record
ENAC	External Network Advisory Committee
EOB	Explanation of Benefits
F/U	Follow Up
FF	Fairfield
FFS	Fee for Service
GMC	Geographic Managed Care
IE	Internet Explorer
IFAS	Integrated Fund Accounting System
IMD	Institute for Mental Diseases
IP	In Patient
IT	Information Technology
JAD	Joint Application Development
LI	Local Initiative
LOC	Level of Care
LOS	Length of Stay
MC	Managed Care
MCU	Managed Care Unit
MEDS	Medi-Cal Eligibility Data System
MFT	Marriage and Family Therapists
MN	Medical Necessity
MMCD	Medi-Cal Managed Care Division
NOA	Notice of Action
NPDB	National Practitioner Data Bank
OA	Office Assistant

Acronym	Definition
OP	Out Patient
OTR	Outpatient Treatment Request
PCP	Primary Care Provider
PHF	Psychiatric Health Facility
PHC	Partnership HealthPlan of California
PMM	Psychiatric Medication Management
POA	Point of Authority
POS	Point of Service
QI	Quality Improvement
SCMH	Solano County Mental Health
SOC	Share of Cost
SQL	Structured Query Language
SRA	Service Authorization Request
SSN	Social Security Number
TAR	Treatment Authorization Request
UBH	United Behavioral Health
UM	Utilization Management
UR	Utilization Review

1 INTRODUCTION

This document summarizes the discussions from numerous meetings with the Managed Care Unit Staff from December 2009 to February 2010. This report captures the findings from these sessions for eventual inclusion in the final version of Deliverable 5 (JAD Summary Report).

This report captures the following information:

- Background of the Solano County Mental Health Plan Managed Care
- Key “as-is” processes performed by the Managed Care Unit (MCU)
- Identify gaps in current processes and areas of improvement
- Identify “to-be” improvements and automation “wish list” items that include potential system requirements for billing and financial functions

2 SOLANO MENTAL HEALTH PLAN MANAGED CARE

The State of California Medi-Cal Managed Care Division (MMCD) contracts[1] for health care services through established networks of organized systems of care, which emphasize primary and preventive care. Approximately 3.8 million Medi-Cal beneficiaries in 25 California counties receive their health care through one of three models of managed care:

- **Two-Plan Model:** In most Two-Plan model counties, there is a "Local Initiative" (LI) and a "commercial plan" (CP). The Department of Health Care Services (DHCS) contracts with both plans.
- **Geographic Managed Care (GMC):** In GMC counties, DHCS contracts with several commercial plans. This provides several choices for beneficiaries, so the health plans may want to try different ways to deliver care to members.
- **County Organized Health Systems (COHS):** In these counties, DHCS contracts exclusively with a health plan created by the County Board of Supervisors to administer the Medi-Cal program for that County. Partnership HealthPlan of California (PHC) is the plan serving Solano County. Solano County was approved for operations under the COHS model in 1994.

Under the COHS model, a County is paid a set amount based on Medi-Cal aid code per enrolled member each month, known as a capitated rate. The COHS includes most services covered under traditional Medi-Cal fee for service (FFS), but it is possible for a county to make a special arrangement with DHCS for some services, such as nursing home care, to remain FFS. Enrolled beneficiaries receive Medi-Cal services from contracted COHS providers who participate in the managed care plan's provider network.

Partnership HealthPlan of California began operations in May 1994 as a public/private organization designed to provide a cost-effective health care delivery system to Medi-Cal recipients in Solano, Napa, Yolo, and Sonoma Counties[2]. PHC is the "health authority" that is contracted with the State for administration and oversight of the County's Medi-Cal managed care health plan[3].

[1] Actually, the California Medical Assistance Commission (CMAC) is responsible for negotiating contracts with managed care plans and hospitals on behalf of the Department of Health Care Services.
[2] PHC is an outgrowth of the Solano Coalition for Better Health, formed in 1988 to address the problem of health care for the County's growing number of medically uninsured and underserved. Initial representation included the County Medical Society, Kaiser Permanente, NorthBay Healthcare Systems, Sutter Solano Medical Center, Solano County Department of Health & Social Services, the Agricultural Workers' Health Center of Dixon, Vacaville Community Clinic, Planned Parenthood, the Council of Cities, and the Solano County Office of Education.
[3] PHC has also been involved in several community healthcare programs other than Medi-Cal. From 2002 to 2005, it served 5,200 members enrolled in the Solano County CMSP program. In November 2005, the California Department of Managed Health Care (DMHC) licensed PHC to offer a Healthy Kids program for members ages 0 to 18. In January 2007, it launched Partnership Advantage, a Medicare Advantage Special Needs Plan for members with Medi-Cal and Medicare in Solano, Napa, and Yolo Counties.

In 1994, Solano County became the first local mental health authority in the State to move all its FFS Medi-Cal recipients to managed care. Approximately, 30,000 clients receive specialty mental health services through the County's mental health carveout. These services include outpatient mental health services provided by mental health professionals and psychiatric inpatient services.

In the initial year of operation, Solano contracted with PHC to provide technical services, operate the managed service program in partnership with the County's mental health staff, and provide assistance to the County in developing procedures, protocols, and guidelines, as well as developing a 24-hour telephone access and referral system and automation to integrate the various functions. Starting after the first year of operation, responsibility for all clinical intake, assessment, care management, and member services related to mental health managed care transferred to Solano County Health & Social Services where the Mental Health Managed Care Unit (MCU) is responsible for these activities today. In 1994, United Behavioral Health (UBH) provided authorization and data entry services as well as processed claims. In 1996, a clinical nurse specialist was hired to perform QI and UM functions for Managed Care.

Figure 1 shows the major areas into which the MCU is currently organized by function and the major responsibilities of each area.

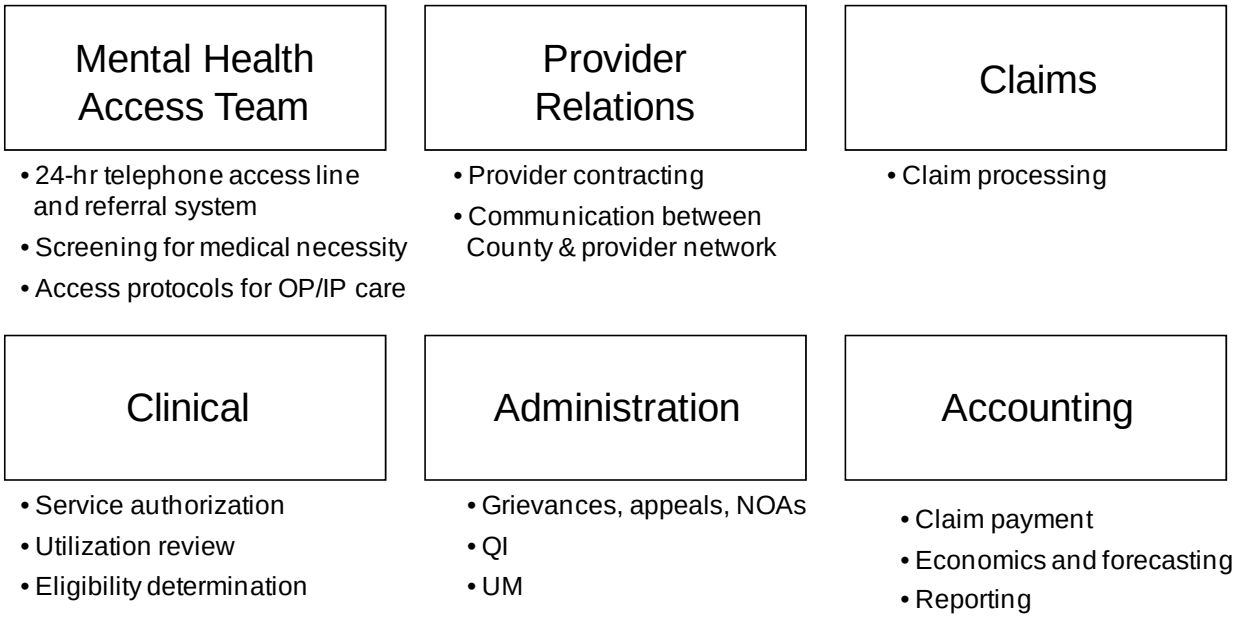


Figure 1: Managed Care Unit (MCU) Organization

3 "AS-IS" DISCUSSION

Managed Care processes break down into several major areas as follows:

- **Access:** This involves the initial consumer contact through the County's integrated Access Team and the subsequent triaging of the call according to County rules.
- **Authorization:** The MCU provides authorization for both inpatient and outpatient services. Outpatient authorization occurs once the decision is made to refer the consumer to a provider that is part of the external network. Inpatient authorization occurs when the MCU is notified by either Mobile Crisis or the hospital itself that a consumer has been admitted. Mobile Crisis is the initial point of authorization for psychiatric inpatient hospital services.
- **Utilization Review (UR):** The MCU Care Manager must follow-up with the utilization review of the hospital records. The methods used to capture information include using the Share Care "secure" note and also faxing of the information between the entities.
- **Billing:** Providers submit invoices to MCU. All claims are managed as paper. Information is collected every two weeks and checks are processed. Note: Many County providers are Marriage and Family Therapists (MFT) and are not eligible to bill Medicare.
- **Provider Management:** The MCU Provider Relations is responsible for provider contract management including verifying licenses are current and in good standing as well as credentialing and re-credentialing. Provider Relations also sets up agreements between non-contracted hospitals and the County for a specific consumer only.
- **Complaints, Grievances, Appeal, NOAs, State Hearings:** These functions are handled by QI/UM of Managed Care.

Each of these major process areas is further discussed in the following section.

4 CONSUMER ACCESS

The MCU Access Team is responsible for handling the first initial contact from a consumer (or a consumer representative), providing an initial screening, and determining the initial referral for the consumer. Figure 2 outlines the process as a cross-functional diagram or "swimlane" to indicate the roles involved as well as the decision tree and is keyed to the following steps.[4]

1. Consumer, PCP, and/or consumer representative contacts Solano County Mental Health.

   The Access Line is a toll-free telephone line available to callers 24 hours a day. During the County work week (i.e., M-F), the MCU Access Team supports the line from 8:30 a.m. to 5:00 p.m. Mobile Crisis staff answers the phone during the off-hours, weekends, and holidays. When a consumer is in immediate need of intervention by crisis services (i.e., danger to self or others, in highly acute state), the Access Care Manager will warm transfer the consumer to Mobile Crisis.

2. MCU Access Team logs the contact in the ShareCare call logging screen.

   For after-hours callers, Mobile Crisis will complete a call log, print the call log information, and fax the information to the MCU Access Team. An Access Care Manager will call the consumer back during normal business hours, screen, and triage the consumer based on the levels of their stated symptoms and functioning.

3. MCU Access Team gathers consumer information.

   The staff gathers consumer information including demographics, presenting problem, and other relevant information.

4. MCU Access Team screens for consumer's current insurance.

   If the consumer has insurance, the Access Care Manager will direct the referral as follows:

Type of Insurance	Referral
Private Insurance	Behavioral Health Contact
Kaiser Medi-Cal (Over 6 yrs.)	Kaiser
Kaiser Medi-Cal (0 to 5.)[5]	Mental Health Clinical Supervisor, Foster Care Unit 0 to 5
Healthy Families	SCMH Childrens Clinic
Healthy Kids	United Behavioral Health
Partnership Advantage	If target population, refer to County clinic If not target population, contact Partnership Advantage

[4] This section was developed from meetings with MCU and the Access Line protocol documentation provided by MCU.
[5] Referrals to the Foster Care Unit occur through the end of the child's 5th year.

5. Access Care Manager screens for Medical Necessity.

   For consumers that are Medi-Cal, CMSP, or no insurance, the Access Care Manager will screen the consumer according to Target Population and Level of Care (LOC) guidelines to determine how to triage the consumer.

6. Determination of Medical Necessity/Target Population for Short Doyle/Medi-Cal

   If the consumer needs to be referred (i.e., triaged) to a Solano County Mental Health (SCMH) Clinic, based on Target Population and Level of Care Guidelines, the following process is followed:

   Referring to SCMH Adult Clinics: The Access Care Manager refers the consumer to the appropriate County clinic. The Access Care Manager completes the call log, arranges for a face-to-face intake assessment appointment for the consumer at either the Fairfield (FF) or Vallejo Adult Outpatient Clinic, and faxes the call log to the appropriate clinic with the screening information that has been collected.

   Referring to SCMH Children's Clinics: The Access Care Unit manager refers a consumer is referred to the appropriate County clinic. The Access Care Manager completes the call log, arranges for a face-to-face intake assessment appointment for the consumer at the Fairfield, Vacaville, or Vallejo Children's Outpatient Clinics, and faxes the call log to the appropriate clinic with the screening information that has been collected.

   Note: The person scheduling the appointment for the child consumer is advised that both the adult who is legally responsible for the consumer (Social Worker from County of Origin if foster child) must attend the assessment appointment. The child will not be assessed without the adult(s) present.

   For children in foster care, SCMH adheres to SB 785 when arranging and delivering mental health services.

7. Determination of PHC/Medi-Cal

   If the consumer does not need to be referred to a SCMH Clinic, based on Target Population and Level of Care Guidelines, the Access Care Manager will determine whether the consumer is PHC/Medi-Cal eligible. If the consumer is not PHC/Medi-Cal, see Step 9 Referral to a Community Resource.

8. Referral to External MC Provider (i.e., external provider network)

   The Access Care Manager has already determined that the consumer has a higher level of functioning than the target population for the clinics and that the consumer is

PHC/Medi-Cal eligible. The Access Care Manager does a manual search to find a provider in, or as close to as possible to, the consumer's location. The Access Care Manager also looks for a provider that specializes in the mental health treatment that the consumer needs.

When a provider is located, an authorization is completed by the MCU. Both consumer and provider are given necessary contact information in order to complete the appointment.

9. Referral to a Community Resource

For consumers that can be referred to a community resource, the Access Care Manager finds local resources and makes the referral. An Access Care Manager may utilize the 2-1-1 United Way number or the United Way Website to make appropriate referrals.

Figure 2: Top Level Flow/Decision Tree for Initial Contact, Screening, and Referral Process

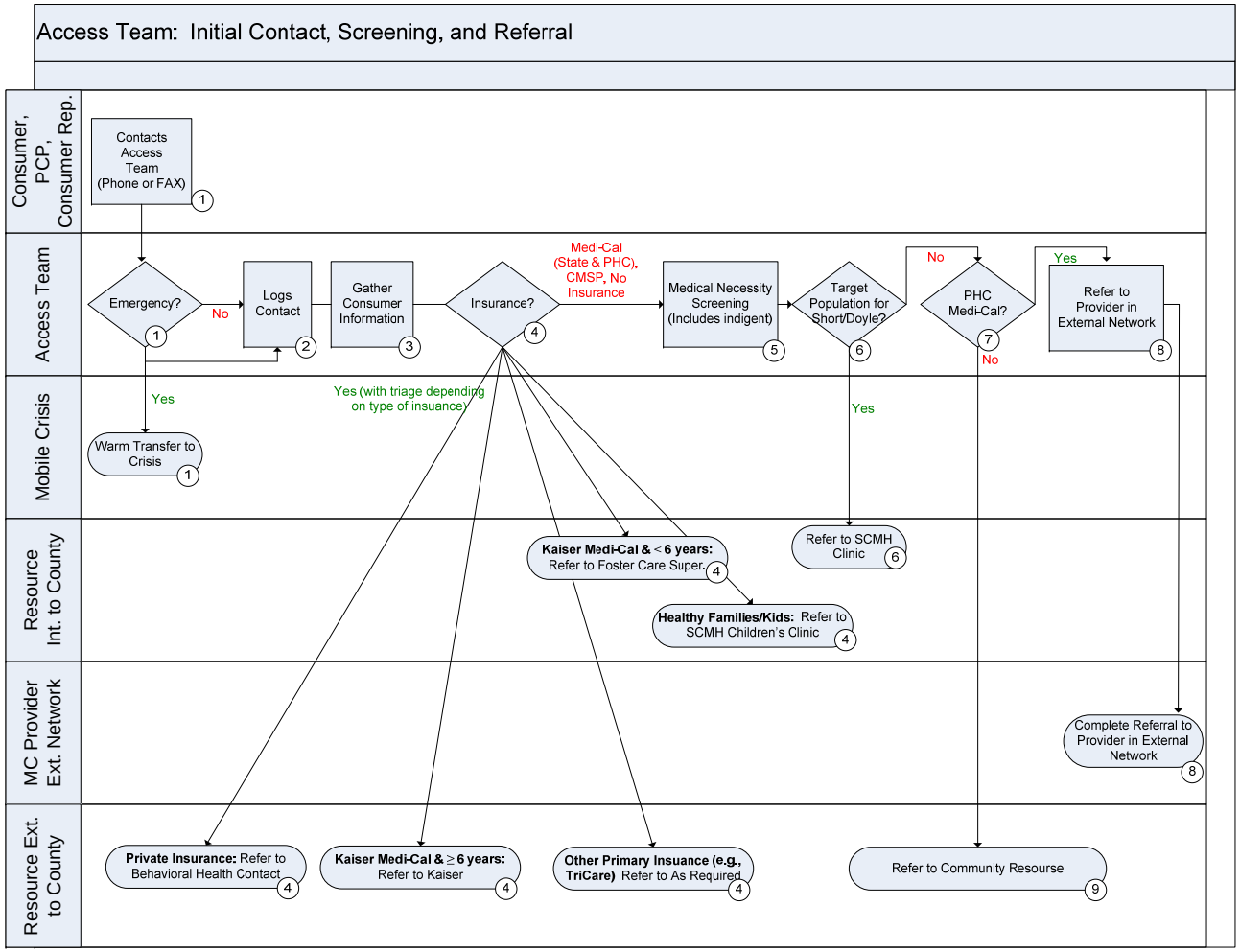


Table 1: Access (doing MCU Function)

ACCESS (DOING MANAGED CARE UNIT FUNCTION)[6]					
Activity Step	Activity Description	Role	Trigger (Start/End)	Reference Data (Form)	Data Output (Report)
1.	Client enters system	Access			
1.1	MCU Access Team takes phone call	Access	Phone call		
1.2	Access receives FAX from Primary Care Provider (PCP)	Access	FAX		
1.3	Access receives Service Authorization Request (SRA) for Out of County Foster Child	Access/Provider Relations	Phone call/FAX		
2.	Prescreen for medical necessity and level of care (internal/external) – Is client in crisis?	Access			
3.	Determines client eligibility ▪ Must be PHC Medi-CAL[7]	Access	PHC Medi-Cal eligible		
4.	Screen (Provide referral to external provider network) ▪ Determine whether client functions at level that can be referred to external network ▪ Go through provider directory to find suitable provider o Is client appropriate fit for provider services? o What is provider's competency re: populations, problems, and Mental Disorders? o What are geographical area & hrs. of service? o Determine whether Medi-Medi o Wheelchair bound o Spanish/non-English speaking → require translator o Requires specialty area (like Psychological Test) ▪ Provide referral to provider or Special Accommodation for specialty service, out-of-county[8]	Access		Provider directory (paper-based) Provider privileging form	
5.	Provide referral to external provider ▪ Contact client directly if PCP FAX	Access			ShareCare log PCP referral

[6] SYSTEM REQUIREMENT: The system shall support an electronic provider directory. MCU would like to be able to automate the loop with the PCP – the system can automatically route the disposition to the PCP, most likely by FAX.
[7] Must be PHC Medi-CAL. NOT Partnership Advantage (Medicare) → in this case, County does not get capitation.
[8] Special Accommodations can apply to either County residents that need special services or out-of-county, foster child not a County resident

ACCESS (DOING MANAGED CARE UNIT FUNCTION)[6]					
Activity Step	Activity Description	Role	Trigger (Start/End)	Reference Data (Form)	Data Output (Report)
	▪ Complete ShareCare log ▪ Complete PCP dropdown in ShareCare ▪ Complete disposition on PCP referral form				form
6.	Follow-up with PCP ▪ Inform PCP whether client being referred and where	Access			

4.1 Outpatient Processes

The following section documents the outpatient processes from initial authorization through billing for the OP services. Figure 3 provides a high-level view of the whole process.

Figure 3: High-Level Outpatient (OP) Process Flow

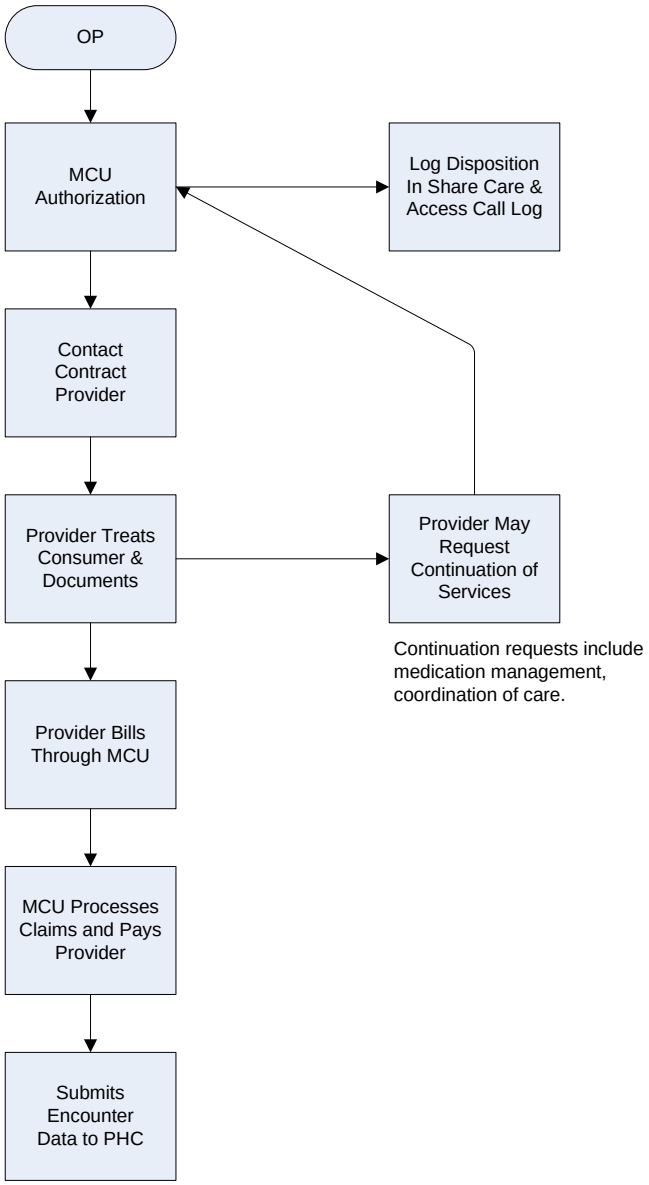


Table 2: Initial Authorization for Outpatient Services

Activity Step	Activity Description	Role	Trigger (Start/End)	Reference Data (Form)	Data Output (Report)
1.	Provide guidelines for issuing initial authorization to external provider for approved number of sessions ▪ Adult: 12 is initial, 18 max per year[9] ▪ Child: 10 initial, 25 max per year ▪ Maximum is not approved up front ▪ Gap in service[10] may be treated as initial authorization	Access		Call log	
1.1	Psychotherapy[11]				
1.2	Medication management				
1.3	Both psychotherapy & medication management				
1.4	Case consultation → requires separate authorization				
1.5	Out of office call (e.g., out of office service at school, client home) → requires authorization for travel (Note: ShareCare forces process)				
2.0	Contact referring provider by phone with authorization # to bill	Access			MCO authorization
3.0	Generate client letter w/ required informing materials	Clerical			Letter to client
4.0	Generate provider letter	Clerical			Letter to provider and forms
5.0	Client receives service from external provider	Provider			

[9] Year is considered from date of service based on initial authorization – seems like this can effectively be considered a sliding window.
[10] A gap in service is usually considered as a gap of three (3) to four (4) months within the authorization year. If a new provider is assigned to the client, a new authorization is generated. This definition applies to both medication management and psychotherapy. In general, a gap in service refers to the same year, same provider.
[11] SYSTEM REQUIREMENT: County has had issues with the letters for authorization generated by Share Care. Need to be more user friendly to use and ability to generate in a more timely fashion. Need to automate delivery to the providers.

Table 3: Billing for Outpatient Services

Step	Activity Description	Role	Trigger (Start/End)	Reference Data (Form)	Data Output (Report)
1.	Receive claim from provider ▪ Paper as original signatures are required ▪ Via mail, no FAX	MCU Acct.[12]	Receive claim from provider	Paper claim from provider	
2.	Re-check/confirm eligibility (again) ▪ Note: Providers are supposed to check eligibility with PHC	MCU Acct.			
3.	Review claim	MCU Acct.			
4.	Confirm authorization (via Share Care) ▪ Approve / Deny	MCU Acct.			
5.	Adjudicate[13] and pay claim	MCU Acct.	Approved		
5.1	Post claim in Share Care (daily)	MCU Acct.			
5.2	Enter in to Microsoft Access for EOBs[14]	MCU Acct.			
5.3	Generate summary of what will be paid to providers	MCU Acct.			
5.4	Enter into IFAS (Auditor's Accounting System)	MCU Acct.			
5.5	Cut checks	Audit/County			
5.6	Pick up checks	MCU Clerical			
5.7	Compare to EOB	MCU Clerical			
5.8	Mail to providers	MCU Clerical			
6.0	Deny claim	MCU Acct.			
6.1	If not eligible[15]	MCU Acct.			
6.1.1	Enter into ShareCare and Access EOB	MCU Acct.			
6.1.2	Inform provider of denial	MCU Acct.			
6.2	If missing information	MCU Acct.			
6.2.1	Generate letter informing provider of missing information	MCU Acct.			
6.2.2	Mail letter to provider	MCU Acct.			

[12] Should actually be MCU Acct./Claims – shortened for table spacing. This role is handled by two (2) people.
[13] Adjudication and payment is every two weeks.
[14] MCU uses Access as Share Care EOBs are not correct.
[15] Need to document rules such that results in denial of claims such as service are not compliant with authorization, no Medi-Cal/Medicare EOB.

Note: MCU processes approximately 500 claims every two weeks with an estimate that less than 25% are denied, 3 to 5% are actually denied due to not meeting billing rules.
Note: County sends monthly encounter data to PHC for claims submitted for inpatient and outpatient service. This does not currently include SD/MC data, though PHC would like that information.

Table 4: Additional Authorization for Outpatient Services

Step	Activity Description	Role	Trigger (Start/End)	Reference Data (Form)	Data Output (Report)
1.	Provider requests additional authorization for a client via FAX/mail ▪ Outpatient Treatment Request (OTR) -- psychotherapy ▪ Psychiatric Medication Management (PMM)	Provider	Receipt of OTR or PMM	OTR PMM	
2.	Check eligibility insurance (again)	Case Mgr.			
3.	Perform utilization review (UR)	UR			
3.1	Assess quality/correctness of the documentation ▪ Are primary elements for the determination of medical necessity (i.e., Dx, symptoms, severity, and level of functioning) documented? ▪ Is the treatment plan sound? ▪ Do the services match up with original authorization? Is progress being made? ▪ Is medication adequate?	UR			
3.2	Assess benefit for client to continue to receive services from the external provider network → level of care ▪ If no, refer to County clinic or other ▪ If yes, process OTR/PMM ▪ If stable & medication services only, consider move to Primary Care	UR[16]		Orig. authorization[17] NOA-B if terminate or reduce services prev. authorized	
4.	Perform authorization	UR			
4.1	Assign new authorization number for OTR in ShareCare[18] **Note**: The original & new author. #'s must be	UR			

[16] UR staff includes both therapist and nurses (for medication review).
[17] The authorization is currently scanned into Share Care.

Step	Activity Description	Role	Trigger (Start/End)	Reference Data (Form)	Data Output (Report)
	related and tracked manually as the cross-check can't be automated or the original author. # assigned to the re-authorization in ShareCare				
4.1	Authorize additional services OR	UR			
4.2	Determine # sessions for coordination of care → transfer client out of MCU	UR			
4.3	Request closing summary from provider[19]	UR			
5.	Generate and send out letters informing of disposition	UR			
5.1	Client	UR			
5.2	Provider	UR			
6.0	Provide tracking reports • # of initial authorizations per month • # of additional authorizations per month	MC			

[18] SYSTEM REQUIREMENT: The system should be able to assign one authorization number for the initial authorization and any additional sessions (i.e., OTR). This will allow easy reference back to the original authorization. It should also track the initial author and the number of additional authorization made per month. The new EHR system should support this.
[19] 'High utilizers' are an exception case → may need additional resources based on need.

4.2 Inpatient Processes

The following section documents the inpatient processes. Figure 4 provides a high-level view of these processes.

Figure 4: High-Level of Inpatient (IP) Processes

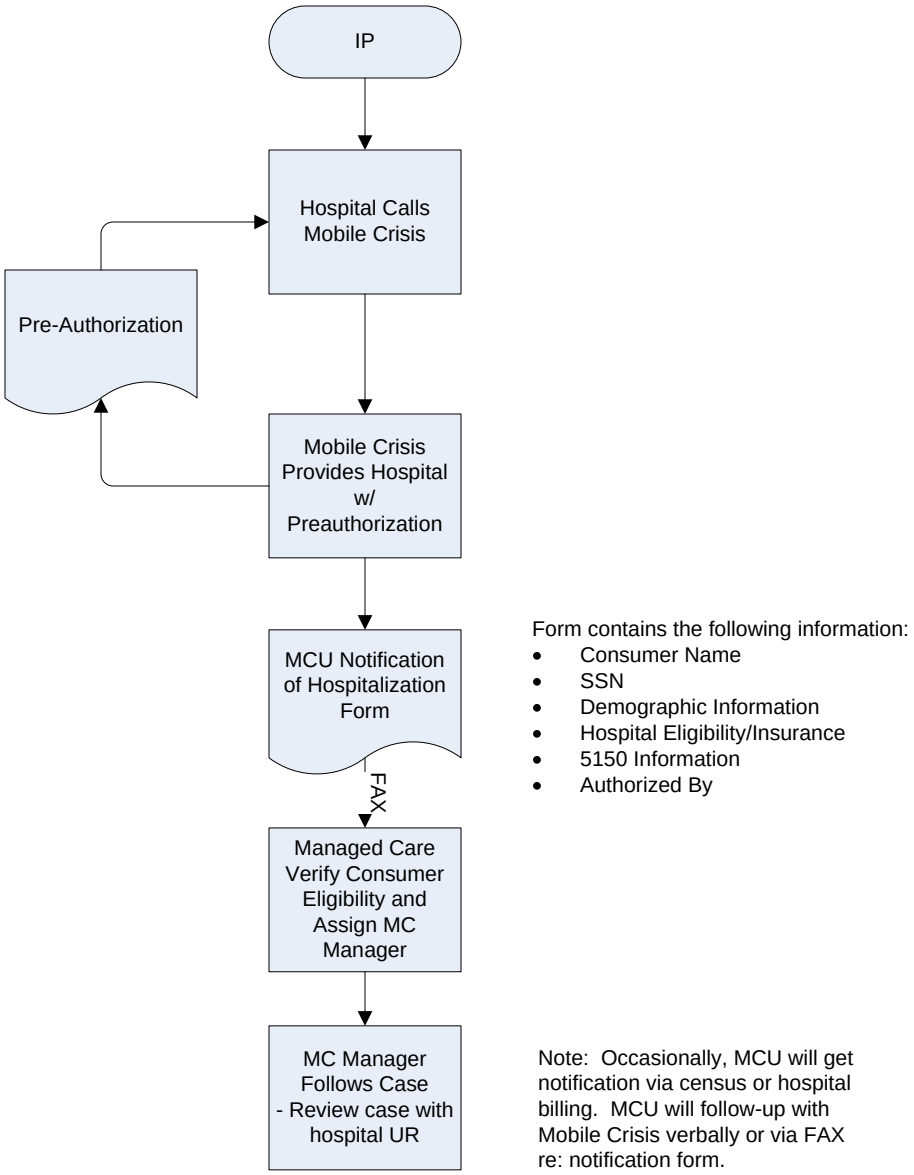


Table 5: Inpatient Admission and Notification

Activity Step	Activity Description	Role	Trigger (Start/End)	Reference Data[20] (Form)	Data Output (Report)
1.	Crisis Point of Authorization (POA) notified of inpatient client admission, involuntary or voluntary[21]				
1.1	Receives Managed Care Form via FAX from Mobile Crisis	MCU Clerical	FAX	Managed Care Form	MCU open electronic "Call Logging"
1.2	Receives call from admitting hospital as part of UR	MCU Clerical/Care Manager	Phone call or FAX	Request Crisis POA FAX (Possible NOA-C)	
1.3	Receives unanticipated (& unauthorized) claim from admitting hospital[22]	MCU Clerical /Accounting Clerk	Claim	Request Crisis POA FAX (Possible NOA-C)	
1.4	Contacted by PHF ▪ Client presents ▪ PHF staff evaluates for 5150[23] ▪ PHF admits client ▪ PHF faxes Managed Care Form to MCU for sign-off/authorization (same as #1.1)	MCU Clerical	PHF contact		
2.	Enter the following information into hospital call log (Excel)[24] ▪ Date of admission and facility admitted to ▪ Client Name, DOB, SSN ▪ Insurance status (State/CMSP → TAR, Indigent → County general fund, private, Medicare → care managers need to	MCU Clerical	FAX or chart retro-review		

[20] Managed Care will provide data forms/formats used
[21] An inpatient admission can be voluntary but must meet the criteria for medical necessity → dx, IP impairment, IP level of care needed, treatment plan is both valid and being followed
[22] Under Title 9 regarding Point of Authorization (POA), there is no option to deny the authorization provided that it can be documented that the hospital contacted the County POA within ten (10) days of admission on a 5150.
[23] Each 5150 is considered a new admission and a new authorization.

Activity Step	Activity Description	Role	Trigger (Start/End)	Reference Data[20] (Form)	Data Output (Report)
	check number of bed days usually by calling hospital directly ▪ Dates of coverage for benefits ▪ Funding source				
3.	Check eligibility ▪ SSN checked against PHC Medi-Cal ▪ SSN checked against Medi-Cal eligibility POS website ▪ Medi-Cal checked for dates of service (DOS)	MCU Clerical			
4.	Complete call-logging screen in ShareCare (i.e., Access call log)[25]	MCU Clerical		Call log	
5.	Care manager assigned based on start. letter of client last name	MCU Clerical			
6.	Client packet given to assigned care manager	MCU Clerical			
7.	Start either concurrent or retro UR process → IP facility and/or care manager initiate contact	Care Manager			

[24] SYSTEM REQUIEMENT: Need one log. The hospital call log is essentially the same as the Access call log that is maintained in ShareCare.
[25] There was some discussion whether or not a client was made a consumer if he/she were not PHC. This issue was not fully resolved during the FOX meetings with Managed Care.

Table 6: Inpatient Utilization Review

Activity Step	Activity Description	Role	Trigger (Start/End)	Reference Data (Form)	Data Output (Report)
1.	Evaluate client for medical necessity	UR			
2.	Document review 1. Enter into comm. log[26] on ShareCare or 2. Form that is scanned, uploaded to ShareCare and attached to client record	UR			ShareCare comm. log of form
3.	Determine authorization at end of stay/discharge[27]	UR			
3.1	Authorize full rate →client **is** PHC and meets medical necessity	UR			
3.2	Authorize admin days → client is PHC and has previously met medical necessity during hospital stay and now meets admin days[28]	UR		Call log	NOA if billed days as acute Letter to provider
3.3	Deny and send letter to provider	UR		NOA-C/Post Service Denial	Letter to provider
3.4	Request Special Accommodation when the client is capitated to County, receives services from non-contracted hospital/provider	UR	Contact provider relations		Single care agreement
Variations by funding source					
A.	State Medi-Cal (i.e., client no Medi-Cal PHC) 1. MCU receives TAR from hospital upon client discharge 2. Clerical logs TAR and gives to assigned care manager 3. Care manager completes TAR within 14 days of date that Clerical logs as received by MCU 4. Clerical faxes completed TAR to State Medi-Cal		TAR (2 may be sent if billing for acute and admin days)		

[26] SYSTEM REQUIREMENT: The problem with ShareCare is that all data is alterable. The communications log provides the needed security in ShareCare, but its use means that the information it contains lives outside the normal processes and needed displays of information. The information is not present on the client summary page.
[27] An overall authorization can be any combination of 3.1, 3.2, and 3.3.
[28] This is essentially a second authorization for admin days / different rate

Activity Step	Activity Description	Role	Trigger (Start/End)	Reference Data (Form)	Data Output (Report)
B.	CMSP 1. Same process as Medi-Cal but with different rules as to what is covered (e.g., 6 days for initial hospitalization, maximum of 10 days per CY) 2. Fax is to different location		TAR		
C.	Contract hospitals → similar to PHF process above				
D.	Special accommodations → single case agreement where the County will negotiate with a Solano County non-contracted (Medi-Cal) facility on behalf of a specific client, usually when out-of area services are rendered to that client. County will reimburse at inpatient Medi-Cal county contract rate. The County reimburses at DMH regional average rate (listed yearly on DMH web site) when the Host Hospital has not entered into a contract with the Host County.[29]				

[29] All counties have to report negotiated rates with hospitals to the State by June 1. The results are averaged and DMH uses this average to set the regional rate.

Other Notes Related to Inpatient Processes

1. The utilization review (UR) process description is based on the PHF utilization review process. There are multiple exceptions and rules surrounding this process.

   Take, for example, the case of a Medi-Medi client. If Medicare psychiatric bed days are left, the County will pay the Medicare deductable or a prorated portion. If the client is out of lifetime Medicare psychiatric bed days, the County will go straight to Medi-Cal reimbursement as outlined in the example below.

   Example One: Client has Medicare and Medi-Cal and has remaining Medicare psychiatric bed days remaining that will cover the entire stay
   - Assume a 10 day stay at $1K/day
   - Medi-Cal will cover the $10K (at a per diem rate) but Medicare coverage for the stay will be $8K. This is a difference of $2K.
   - The Client has a $1K Medicare deductable.
   - The County will pay the lesser of the two amounts (i.e., the Medicare deductable). The remaining balance is written off.

   Example Two: Client has five bed days left under Medicare, prorate
   - Assume a 10 day stay at $1K/day
   - For the first 5 days, coverage is handled similar to Example One:
     - Medi-Cal will cover the $5K (at a per diem rate) but Medicare coverage for the stay will be $3K. This is a difference of $2K.
     - The Client has a $1K Medicare deductable.
     - The County will pay the lesser of the two amounts at the pro-rated amount. The balance is written off.
   - For the remaining 5 days:
     - Medi-Cal would pay $846/days for 5 days

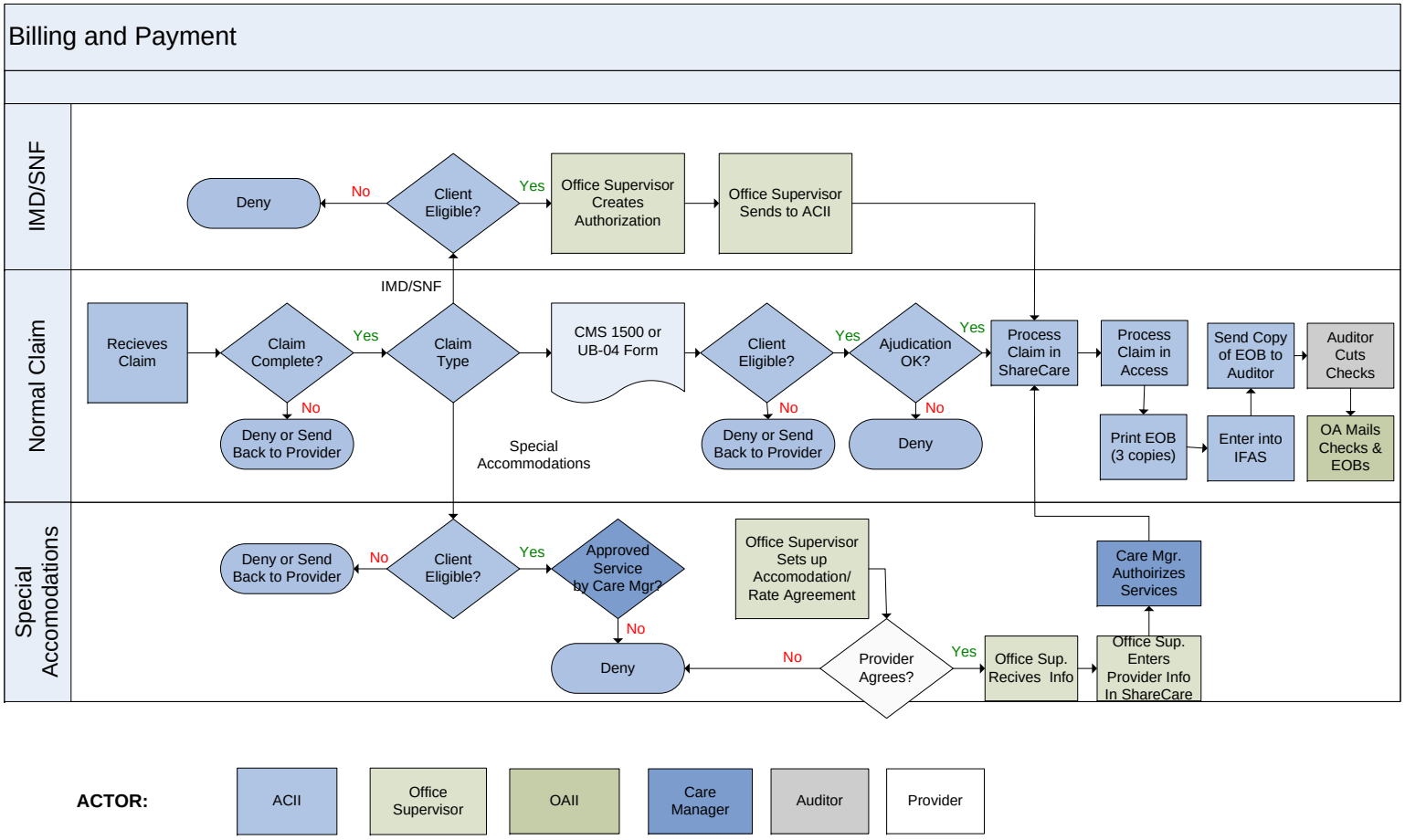
   Example Three: Client is out of Medicare; the coverage is straight Medi-Cal and handled accordingly.

2. An automated way to report length of stay (LOS) is desired.

4.3 Billing and Payment Process (OP and IP)

The billing process was outlined above. The following flow was developed, based on information provided by MCU outlining the end-to-end billing and payment process. FOX has organized the “swimlane” by the type of claim and color-coded each step in the process to indicate the actor performing that activity.

Figure 5: Billing and Payment Process by Claim Type



ACTOR: ACII | Office Supervisor | OAII | Care Manager | Auditor | Provider

4.4 Provider Relations

Provider Relations is responsible for maintaining the external provider network, including credentialing a new provider, monitoring and updating current provider information, and ensuring that providers are re-credentialed every three (3) years.

1. Credentialing a New Provider

   The steps in this process are:
   a. Provider Relations sends Credentialing Application Packet to applicant with Provider Manual
   b. Applicant completes Application Packet and returns to Provider Relations
   c. Provider Relations checks the returned application and requests any missing information both to credential and re-credential, noting the 180 day timeframe as measured from the earlier of the following two dates – the date the applicant signs the attestation and the date that the applicant signs the release of information. This is considered a legal document. The application may be automatically returned to the applicant for any issues such as white out on the application.
   d. Provider Relations checks the applicant's background:
      i. Run a check with the National Practitioner's Data Bank (NPDB).
      ii. Checks with the State Licensing Board.
      iii. Checks the Medical Board "Hot Sheet"
      iv. Checks the Medi-Cal Suspended and Ineligible List
   e. The Credentialing Committee meets to review and approve the application.
      i. If the application is approved:
         1. Director of Mental Health signs the signature pages.
         2. Provider Relations sends the approval letter to the applicant with the signature page and a privileges form.
      ii. If any sanctions against the applicant are found by Provider Relations, these will be discussed by the Credentialing Committee. The Committee will determine what further actions are to be taken determined.
   f. Provider Relations opens a provider file
      i. Inputs the provider information into appropriate databases
      ii. Email Claims, Auditors, and Care Managers information on the new provider.
      iii. Creates mailing labels.
   g. If subsequently, the applicant is not approved to be a contract provider to the County, Provider Relations will send a reject letter.

2. Monitoring and Updating Current Provider Information

Provider Relations monitors and updates provider information on a regular basis, including:

   a. Run monthly reports from MCU Access database

b. Check providers' current status on various source databases to include: State License Board. Business License, Malpractice Insurance, and DEA certificate.
c. Sends providers reminder letters as needed to request information updates and logs the updated information in both ShareCare and the Access database.
d. Monitors provider availability
    i. Update MCU Access database and ShareCare as needed
    ii. Informs Care Managers of provider status
e. Track dates for provider re-credentialing, ensuring that all providers re-credential every three years.
    i. Answer any provider questions
    ii. Assist Care Managers as needed with provider information

3. Re-Credentialing Providers

These activities are performed for current providers every three years. The steps in this process are:

a. Provider Relations sends Re-credentialing Application Packet to the provider.
b. Provider completes and returns the application to Provider Relations.
c. Provider Relations checks the returned application, noting the 180-day timeframe.
d. Provider Relations requests any missing information from the provider.
e. Provider Relations checks the provider's background.
    i. Run a check with the National Practitioner's Data Bank (NPDB).
    ii. Checks with the State Licensing Board. "Hot Sheet"
    iii. Checks the Medi-Cal Suspended and Ineligible List
f. Credentialing Committee meets to review the provider's application
    i. If any sanctions against the applicant are found, these will be identified for discussion by the Credentialing Committee and further actions to be taken determined.
    ii. If the application is approved, the Director of Mental Health signs the signature pages.
    iii. Provider Relations sends the approval letter to the applicant with the signature page and a privileges form.
g. Provider Relations updates the provider's information in the appropriate databases.
h. If subsequently, the applicant is not approved to be a contract provider to the County, Provider Relations will send a reject letter.

In addition, Provider Relations supports claims processes for IMD claims related to populations that are greater than 64 years and less than 22 years of age and Special Accommodations. For IMD claims, this involves:

1. Receipt of IMD claims on a monthly basis
2. Checking IMD claims against the census
3. Verifying client eligibility, rate, and share of cost (SOC) to ensure that the math is correct
4. Authorizing service for the client in ShareCare, capturing the authorization number

5. Ensuring the following are available with the claim:
    a. Service code(s) on the bottom of the claim
    b. Authorization number
    c. Signatures and initials
6. Provide the claim(s) to Accounting Clerk for payment

Additionally, Provider Relations is responsible for provider communications, meetings and surveys with the MCU, conducting the External Network Advisory Committee (ENAC), the quarterly provider advisory meeting and subsequent minutes.

4.5 Grievances/Complaints/Appeals

FOX met with the clinical nurse specialist (CNS), a member of MCU UM/QI, who is responsible for "Phase One" in the grievance review process[30]. In "Phase One", the CNS establishes the initial contact with the consumer. If the case cannot be resolved at this level, it enters "Phase Two" and will be elevated to the SCMH Quality Improvement (QI).

The CNS outlined the "Phase One" process as follows:

1. The CNS receives a grievance or complaint.
    a. The contact can be verbal (i.e., a phone call) or in writing (i.e., a letter).
    b. It can come from a consumer or a provider.
2. The CNS logs the contact and responds in accordance with applicable regulations and County policy (ADM 1.7 and ADM 1.8).
3. The CNS looks to the urgency and/or acuity of the issue and responds in accordance with applicable regulations.
4. The CNS researches the grievance/complaint, including interviews with provider and client.
5. The CNS discusses the issue further with the parties who submitted the grievance or complaint, trying for resolution at the first level.

There are four (4) parts to NOA documentation:

1. Documenting the fact finding – chronological events
2. Clinical documentation
3. Recommendations
4. Additional documentation from "Phase Two" conducted by SCMH QI

The confidential nature of the grievance needs to be maintained throughout the process. Currently, all documentation is created and managed in Word. The CNS has improvised a numbering system. There is the possibility of using SharePoint to capture the information, as

[30] In accordance with California Code of Regulations, Title 9, Rehabilitation and Developmental Services, Division 1 (Department of Mental Health), Chapter 11 (Medi-Cal Specialty, Mental Health Services), Subchapters 5 (Problem Resolution Processes), Article 1 (Beneficiary Problem Resolution Processes), 1850.205 (General Provisions), and the SCMH MHSA agreement with PHC.

long as privacy and security issues are observed. SCMH QI is beginning to use an application based on SharePoint. There is also the concern of e-discovery. This information should be kept in a separate system from the EHR to limit the amount of e-discovery that might occur in the case of an incident.

The following information is tracked in a log:

1. Name
2. Grievance date
3. Nature of grievance or request to change provider
4. Date grievance received (Staff initial)
5. Date appeal received (Staff initial)
6. Dates expedited appeal received (Staff initial)
7. Final disposition
8. Date to be sent to beneficiary (Staff initial)
9. Reason for no disposition, appeal, or expedited appeal

5 GAPS AND AREAS OF IMPROVEMENT

The following gaps and areas of improvement should to be addressed for Managed Care during the procurement of the new EHR system.

5.1 Gap #1: Access Procedures / Call Log

MCU Access Team fills out the call-log in ShareCare. The system presents a 'canned' log but Access needs additional information, such as ethnicity, marital/partnership status and eligibility, available in the system. Currently, the staff has to check for eligibility across several systems including other services in Insyst, State POS, and the PHC website.

Potential Solution: Develop specific requirements for the new EHR around the Access workflow, required data elements, and needed interfaces (e.g., MEDS, PHC website).

The County also needs to track the disposition of the referral – due at the first visit to the referred provider. Closing the loop on the disposition process, however, is problematic as the call/contact logs are maintained on several different systems that include: SharePoint lists for IMD clients, Short-Doyle, ShareCare for Managed Care and varying systems/procedures for external providers, especially on the outpatient side.

Potential Solution: Fully document "to-be" process surrounding client access, logs, and tracking to insure that the new EHR system supports an integrated process for client access, referral, and tracking of dispositions, including an interface with SharePoint.

5.2 Gap #2: Inefficiencies in Workflows Due to ShareCare

MCU demonstrated ShareCare to FOX and discussed the negative impact on workflow efficiency within the MCU. Examples include:

- **Admission:** ShareCare requires that a client be admitted in order to bill. The workflow in the system, however, does not prompt for admission. Care managers occasionally just forget and the omission is caught at the back end by the MCU billing staff.
- **Claim Reduction:** Echo created a claim adjudication screen in ShareCare for Solano. The staff can reduce claim amounts in accordance with consumer benefits, such as client has Medicare eligibility. The staff can also reduce the claim amount by a percentage if the claim is over 6 months. The system, however, limits the staff to only one reduction. For example, if a client is eligible Medicare AND has an aged claim, the whole amount needs to be manually calculated and then entered. Echo cannot fully track the full history of all reductions being made.
- **Overpayment Credit:** There is no way presently to credit a provider for overpayment. Billing uses a Microsoft Access database to handle EOBs with having to enter the same information as in ShareCare. Reconciliation is done with tape totals from an adding machine.
- **Inability to Check Share of Cost (SOC):** A user cannot check SOC in ShareCare. Adjustments have to be done manually in the system, with daily reductions until they

reach SOC. **Note:** This specific issue may be a limitation of not having the complete ShareCare system, only the Managed Care module.

- **Explanation of Benefits (EOB):** There are numerous issues with implementation of EOBs in ShareCare, such as the system overriding the desired EOB date with today's date, difficult reports surrounding EOBs, and the need to export EOBs to Word for editing. The MCU has not used ShareCare EOB functionality since the system went live in October, 2008.

Potential Solution: Document specific requirements for the new EHR system related to current inefficiencies around ShareCare for Managed Care workflows.

5.3 Gap #3: Letters to Provider

The process to generate follow-up letters to providers and consumers through Share Care to providers and consumers is cumbersome. Echo has been slow to correct the problem. At this point, the consumer letter is all right, but there are still some issues related to Medi-Cal. Staff would also like the ability to change County contact phone number(s) and address as needed without having to have Echo/system technical assistance on letter templates.

Potential Solution: Ensure that these requirements are clearly stated in the RFP for the new EHR system and the evaluation criteria are documented.

5.4 Gap #4: Session Management in ShareCare

There are various issues surrounding user session management in ShareCare, including:

- **Session Timeout:** The ShareCare system session "times out." Specifically, if a user in the call log/communication note has to hit the update tab within 20 minutes or be logged out. If this occurs, the system "times out" and all data is lost. As a result, the MCU staff maintains a backup record on a shared network drive, making the information difficult to find.
- **Session Recovery:** There is no session recovery if the network goes down, the system times out, etc.
- **Internet Explorer Issues:** ShareCare will close a user out of other open IE windows or tabs. Reviewing the situation, ShareCare actually kicks the user out of the primary tab.

Potential Solution: Internet Explorer issues may be due to browser configuration and MCU should work with IT to see if they can be resolved. However, the session timeout and recovery issues are current limitations in the ShareCare architecture and need to be resolved with the vendor.

5.5 Gap #5: ShareCare Security

The MCU has identified various issues with the implementation of security with ShareCare.

These items include:

- **Ability to Change Sensitive Information:** For example, any user can change authorization information. ShareCare does not have any internal controls to prevent this and does not provide an obvious change history more than one user back.
- **Deletion:** Deletion from the record is permanent with no log maintained as to who did the deletion and when it was deleted.
- **Linking with External Data:** The County needs to know how sensitive information, from external sources, such as images, are linked to the database so that proper protections of this information, if managed separately from the actual data in ShareCare/SQLServer. (e.g., OP treatment, closing summaries, assessments, and other documents.)

Potential Solution: The County/MCU should request information from Echo as to the security architecture of their system, specifically as ShareCare is hosted external to the County. Additionally, Echo should provide documentation and training to the County on the auditing and user management capabilities within ShareCare. The County should require that the vendor document its security architecture and help the County develop its IT security plan for the new EHR system.

5.6 Gap #6: Consistency of Authorization Tracking Number

ShareCare requires that the MCU assign a new number to an authorization that represents a re-authorization of original services. This requires that the MCU staff manually track the relationship between the original authorization and the re-authorization.

Possible Solution: Submit a change request to Echo that requires ShareCare to retain the number from the original authorization as part of the re-authorization and develop a report that can be used for tracking this information. Ensure that the requirements for the new EHR address this issue.

5.7 Gap #7: Provider Billing

In the past, there has been no consistency in the timing of when providers bill, although the provider manual states the rule in regards to this process. Some providers are billing weekly, others once a year. This creates workload variations within the MCU Billing and Accounting section. Managed Care is addressing this through a process-improvement effort that includes the development of new policies and procedures and the enforcement of existing ones to help even out the MCU workload.

The overall process for provider billing is also paper-based. Because of some of the limitations in ShareCare, it also requires double data entry between ShareCare and the Access EOB interface.

Potential Solution: Investigate feasibility of implementing a capability for providers to submit electronic claims. Ensure that EOB requirements (driven by current ShareCare limitations in EOB functionality) are documented and can be met by the new system.

5.8 Gap #8: Special Accommodations / SB 785

Managed Care also serves the SB785 population -- foster care children placed out of County of Origin. The bill clarifies responsibility for treatment authorization for adopted and kin care youth. It transfers the responsibility for the provision of services to the host county, while keeping the financial responsibility to authorize and pay for services with the county of origin.

Potential Solution: At this point, handling of the SB 785 population is not really a gap, as the processes have not been fully developed. The process needs to be documented and requirements for the new system developed to ensure that the requirements of this legislation can be met.

5.9 Gap #9: Inpatient Documentation Processes

There is currently limited standardization in documentation of inpatient processes, depending on the process. The current situation exists due to attempts to manage an overall efficient workflow despite staff with inconsistent automation skills and experience.

Potential Solution: Identify training / education needs of current staff related to the use of automation in preparation for the new system. Require the new EHR system to have the ability to adjust workflow to meet necessary variations in the documentation workflow process. Note: This type of gap is always a balancing act between flexibility in the automation and staff skills.

6 AUTOMATION "WISH LIST" ("TO-BE" PROCESSES)

The group identified their top system automation "wish list" features for the new EHR system. FOX has collected these items into the following table, loosely grouping them according to the area where they might apply. Many of these items came from the demonstration of ShareCare. Additional work should be done to ensure that any additional system features identified as part of the gap analysis are also included in this list.

Table 7: "Wish List" Items for Automation by Area of Application

Area of Application	"Wish-list" Features
Authorization	Require that re-authorizations retain the same number or are linked to the original authorization number
Claims	Support electronic claims for provider billing Develop interface that links claims with authorizations
Eligibility	Be able to check client eligibility in one place, rather than Insyst, MEDS, and PHC websites
FAX	Provide network interface to FAX server for ease of faxing from and receiving FAXes from partners outside the system
Image Management	Be able to link to external images to information in the consumer record
Letters - Provider/Consumer	Provide ability to customize letters
Notice of Actions	Provide an automated NOA Allow the ability to populate NOA in the system as opposed to manually. Provide pop-up reminder that a NOA is needed for service denied or terminated.
Provider Search and Match	Provide capability for electronic search and match regarding credentials of providers
System-to-Systems Interfaces	Include automated interfaces between new system and: ▪ MEDS (eligibility) ▪ PHC website (eligibility) ▪ ShareCare (call log) ▪ SharePoint (call log)
Usability	Auto fill-in for fields Pre-canned text for presenting problems during Access (with ability to modify) Standard text for County-designated fields
Referrals	Provide capability for electronic referrals
Reporting	A report to track the number of initial (outpatient) authorizations as well as the number of additional (outpatient) authorizations per month