Draft

Guide For Family And Consumer Run Organizations Seeking To Expand Their Funding By Becoming A Part Of A Managed Care Network

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1. Introduction

Most States are struggling to cover their budgets. As a result, state funding for consumer and family run programs is getting cut or eliminated all together. With many people out of work, and more people experiencing job cuts, less money is being donated to non profit organizations such as consumer and family run organizations.

Sustainable income is the dream of most non profit organizations. Strategic minded CEOs consider the question" Who out there will purchase what I uniquely have to offer? "; and "who will do this in a way that I can depend on receiving sustainable income from year to year? " For some groups, becoming a part of a managed care organization (MCO) network, and being paid for offering a service that helps consumers or family members, may offer the opportunity to obtain this sustainable income .

This could also be a huge benefit for the systems of care in America. As more consumer and family run organizations become a part of the mainstream delivery of services, there will be enhanced access to recovery-oriented services, and greater access to the right combination of programs and services for a successful recovery. This ultimately will increase exposure to this approach for service delivery, which will influence the culture of all systems of care.

The process is not easy. If you are looking for a simple 1-2-3 step process to become a part of a MCO network, you will be very frustrated. It will take time and a creative and persistent approach:

- Consumer and family groups will need to carefully consider what they have to offer that a managed care company would want or need.
- These services must clearly show how they will increase recovery and decrease hospitalization/utilization. You will also need to shape that service so it fits within the way a managed care company does business. For example, most managed care companies to do not send frequent mailings to the people they serve, so offering a consumer education series based on mailings will not fit well within the MCO process. However, MCOs are often looking for respite programs or step down services to help people get back on their feet after hospitalization or as an alternative to full hospitalization.
- Consumer and family groups will need to go through the same process other providers go through to become a part of a network which includes obtaining certain provider numbers from the government and filling out applications.

- There is a billing process that demands a certain level of security for all consumer records
- And there will be a quality and audit process that groups will go through to ensure you are meeting the standards expected of any provider organization.

It is not simple, but it is a promising way to begin achieving sustainable income while at the same time helping to transform the system of care from coast to coast. For those patient and creative enough, the rewards for both their organizations and for the entire system of care will be substantial.

2. Managed Care 101

What is now called "managed care" began in the 1940s with Health Maintenance Organizations (HMOs). Families getting medical care at HMOs were urged to get yearly checkups, and to seek preventive care and early treatment in case of illness. This proved to be cost-effective, so as health care costs rose, employers, for their employees, began to sign contracts with companies offering to "manage" health care. Since the 1980s, more and more employee benefit programs have contracted with managed care companies, resulting now in hundreds of managed care companies.

According to the United States National Library of Medicine, the term "managed care" encompasses programs intended to reduce unnecessary health care costs through a variety of mechanisms, including:

- economic incentives for physicians and patients to select less costly forms of care;
- programs for reviewing the medical necessity of specific services;
- increased beneficiary cost sharing;
- controls on inpatient admissions and lengths of stay;
- the establishment of cost-sharing incentives for outpatient surgery;
- selective contracting with health care providers;
- and the intensive management of high-cost health care cases.

In general, managed care is the integration of providers and payors into an organized system designed to offer quality, cost effective care, while assuring consumer satisfaction with services. In addition to cost savings, which helps to make healthcare more affordable, shared electronic records, and pre-set clinical guidelines help to improve consumer health outcomes.

States are now looking to the managed care industry to provide public health care, including mental health and related services. In the past, State and local governments allowed service providers to bill Medicaid and Medicare directly, after the services were provided, on a "fee for service" basis. With managed care, providers are under contract with the managed care company to determine, along with the consumer, what is the appropriate course of treatment.

Managed care brought a focus on medical necessity and cost that resulted in an expansion of available treatment settings. We have progressed from a system that essentially offered two options to one that offers a continuum of services. Thus we have greater flexibility in meeting the needs of consumers and greater success in managing costs.

The introduction of managed care has improved access to behavioral health services for millions of consumers. Experience in the public and the private sector has shown that the number of people seeking and receiving services has

increased since the introduction of managed care. Managed care not only yields an expansion of services but also results in their redistribution. Hospitalization rates and average lengths of stay typically declined with managed care, whereas the use of other treatment settings increased.

Managed care introduced accountability to a system that lacked it. Although many people continue to adjust to this change, it was a needed measure that has benefited consumers, payers, society, and providers.. The influence of managed care has helped shift practice patterns in the behavioral health care arena in a way that has led to more effective and more efficient treatment.

The managed behavioral health industry has not only imposed accountability on others, it has embraced it for itself. The American Managed Behavioral Healthcare Association has worked closely with other mental health and substance abuse treatment organizations to find common ground on appropriate performance measures and to develop national standards and accreditation programs.

. Despite the benefits to the system that managed care has made possible, no one would argue that it is a perfect solution. In many ways, we have made great strides because of it, but we have additional work ahead of us if we want to continue to improve the system. Managed care must become less burdensome for consumers and practitioners. In addition, managed behavioral health care companies must do a better job of streamlining processes, reducing paperwork and micromanagement, and meeting obligations to practitioners to operate efficiently.

Despite the challenges, there is reason for real optimism. The science continues to advance. More effective diagnostic and treatment alternatives emerge. Traditional but unsubstantiated therapies and practice patterns are giving way to evidence-based practice. To further build on these opportunities, clinicians and managed care companies must work together to bring the best that the field has to offer to people in need in the most effective and efficient manner.

How Does Managed Care Operate?

In the managed care environment, consumers, providers, payers, and the managed care organization must collaborate to provide a system of care that supports inclusion and help for consumers to successfully cope with life challenges, not just manage systems. This includes embracing the following:

- Self-Direction
- Individualized and Person-Centered
- Empowerment
- Holistic
- Non-Linear

- Strengths Based
- Peer Support
- Respect
- Responsibility
- Hope

Those principles and values can be measured in areas of:

- Employment Outcomes
- Housing Outcomes
- Community Participation/Citizenship
- Income Support
- Satisfaction with their own lives and services
- Wellness

Our responsibility becomes to encourage and foster hope, ensure individuals have the opportunity to set direction (goals) for themselves in each of these life areas and that the values we espouse are reflected in our actions.

Who are the players in managed care?

It is necessary to know who the key players are and the roles each plays in the health care systems;

- Consumers
- Providers (doctors, clinics, hospitals etc who provide the care)
- Employers (those who purchase the insurance and determine the level of benefit offered for private plans)
- Local, state, and federal governments (those who purchase the insurance and determine the level of benefit offered for public plans)
- Insurers (Those who implement the contracts determined by the employers or local/state/federal government)

What is the role of the Case Manager?

The title "case manager" or "care manager" is used to mean different things in different places. If a person goes by such a title, ask him or her what they see as their role and what they do.

The case manager working for a public or nonprofit human service agency may be your advocate. Acting as a broker, this person may try to get you more services. This person may also act as your therapist.

At the managed care company, the case manager's job is to assure quality care and to help the member receive the services necessary to meet their needs.

The utilization manager is often a person at the end of a phone, working with providers regarding what the managed care plan will pay for. In most plans they must approve, in advance, each day of hospital care and each session of outpatient care. The managed care reviewer or utilization manager may:

- Authorize the requested treatment,
- Suggest a lower-cost alternative, or
- Deny further treatment such as more hospital days or more out patient sessions.

The managed care case manager is likely to be a social worker or nurse. Consumers may have little contact with their case manager. It is usually the medical/behavioral health provider who tells the case manager about a consumer's situation.

Why does a case/utilization manager seek to "manage care" by authorizing or refusing treatment?

We have an odd system in the United States, providers (doctors, clinics, hospitals, talk therapists, etc) are paid a fee for each service they offer a member. The more services they offer, the greater their fee is. Providers may also seek as many tests as possible to be absolutely certain of a diagnosis and course of treatment. Each test also provides a fee. Because of the increasing cost of health care, managed care is one attempt to find a middle ground between paying for everything and paying for nothing. This middle ground in based on research and evidence about what works. Limits are put in place based on 1) what is reasonable based on research 2) what the employer/state/government determines they will authorize. A "rich" benefit plan allows more options than a "streamlined" plan. A managed care company must then manage the member's benefit based on the plan purchased by the employer or the government entity.

While most providers are very ethical and seek only to do the very best job they can do for their patients, unfortunately a very few are not so scrupulous. Managed care is also charged with monitoring waste and ensuring providers who are not ethical are also not paid. For example, recently a group of doctors were denied claims they made because they were charging patients for talk therapy**.**

The patients were living with advanced Alzheimer's disorder and were unable to communicate. As a family member, wouldn't you rather have that money spent on something that might actually help your loved one? In another example, it was discovered that an exceptionally high hospitalization rate in one county was directly attributable to a provider who immediately hospitalized any mental health consumer who came to him because he had a financial interest in the profitability of the hospital. Wouldn't you rather avoid hospitalization if you did not really need it?

What is the role of Membership Services?

With managed care, every employer, group, or State has a different contract. Contracts may change from year to year. Enrollees need someone to call with questions.

Managed care companies have a well-publicized toll-free phone number called membership services or customer services. The larger plans can be phoned 24 hours a day, 7 days a week. This unit may pre-authorize an evaluation and refer you to a suitable medical provider in the group. Membership or customer services:

- Can explain benefits. For mental health care, your plan may include limited numbers of hospital days and outpatient therapy sessions a year.
- Can tell you what benefits you have already used. For example, if you have used 8 outpatient sessions, 12 sessions might remain.
- Can negotiate. You can ask: Is there flexibility? Can I substitute an alternative service for inpatient days?
- Collects complaints about providers. Based on complaints, the plan may make changes in the services being provided, improve quality, or stop using a therapist or hospital.

What Are Grievance Procedures in Managed Care?

When asked to authorize care, the managed care company worker or case manager follows a set of guidelines.

The company should have published procedures describing an appeal or grievance process.. For mental health care, some contracts say that medical providers, not consumers, may appeal in a dispute. The appeal process is often two layers, based on phone calls and a review of your medical records. The therapist asks for a review by a physician, and then perhaps another review by a second physician, both usually employed by the managed care company.

The most consumer-sensitive contracts may establish a committee, including consumers and medical providers, to examine areas of dispute and to advise the managed care company.

So what is the cycle within managed care?

1. Managed care organization (MCO) and employer group/government entity agree to a contract which outlines the benefits and limitations of services for the population being served. Medication management is usually through a separate organization

2. MCO seeks providers for a network based on the needs outlined in the employer contract

3. Providers agree to a contract that sets the fees

4. Consumers are referred to providers within the network

5. Some services require authorization before access based on contract

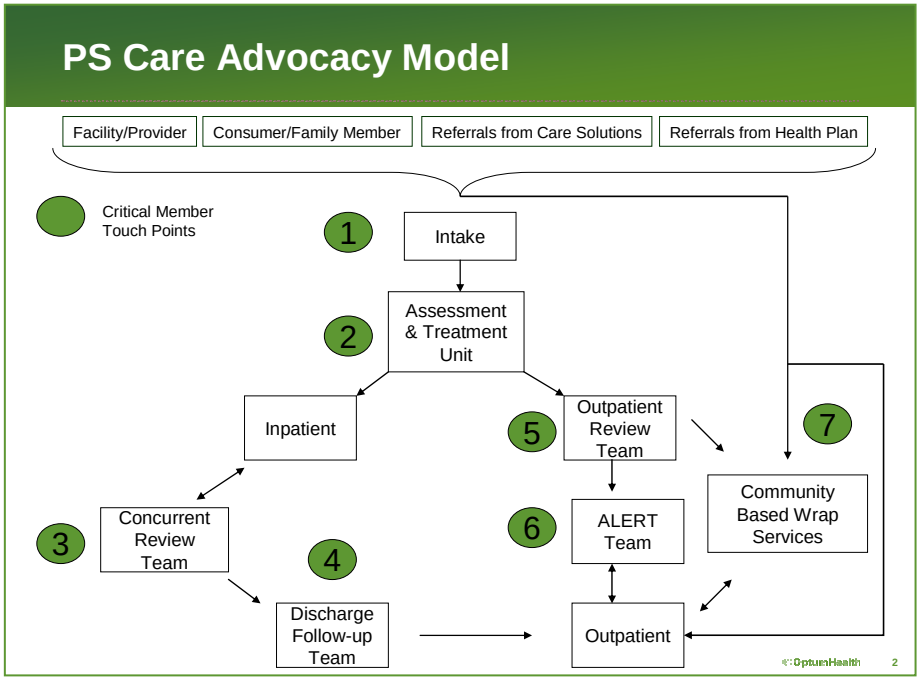
    1. Consumer who are heavy users of services will be assigned a case manager aka care advocate to help them access enriched services including community support

6. Providers submit payment for the service using the federal codes and modifiers agreed to for the services

7. MCO reviews submission to ensure it is within the contracted services for each different employer contract

8. Checks are cut

9. Quality and Compliance Audits are done



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Key Take Away Points:

1. The MCO Process Works as Follows:
   - Providers are credentialed
   - Agreements are signed
   - Services are provided
   - Claims are submitted and paid, based on negotiated rates
   - Quality monitoring is on-going; and
   - Consumer and provider satisfaction is tracked and trended.

2. The “Sweet Spots” for Managed Care include increasing wellness/recovery and decreasing utilization /hospitalization in as cost effective manner based on hard data and research

3 What Kinds Of Services Would A Managed Care Company Contract For From A Consumer/Family Run Organization?

As a managed care organization we are constantly looking for behavioral health services that promote recovery and resilience, are known as best practice or evidence based practice through a formal evaluation and rendered by a consumer and/or family run organization. In many states Peer Support and Family Support Services have been recognized as a best practice and billable through Medicaid dollars.

To help you understand the types of services currently being rendered and billed here are examples and descriptions of current programs/services that have been contracted with consumer and/or family run organizations:

- Psychiatric Rehabilitation (PRor PSR): PR/PSR is typically provided in a way to identify and build on a person's strengths to aid in the development of coping skills and strategies that help/support the Consumer to become as independent as possible. PR/PSR promotes recovery/resilience and community integration. These services are individualized and person-centered to help the person develop life goals based on their choice.

- Peer Support/Drop-in Center (PSC): PSC is usually consumer-run and provides a supportive and non-judgmental environment. There are usually and array of educational/social programs provided by the PSC some of which could be billable (WRAP, BRIDGES, Daily Living Skills). Some of the social activities (parties, art classes, social outings) are not billable through Medicaid dollars.

- Peer Support: Peer Support (PS) is provided by persons who have been diagnosed with mental illness at some point in their life. The "lived experiences" is what makes this service successful. PS, to be billable, must be provided by a consumer who has been certified by the state in which they work as meeting all of the specific requirements mandated through their governmental agency (For example in TN it is the Department of Mental Health). There are several words that have been used to define PS; teach, model, mentor and coach are more common. PS services can assist someone in development of a recovery plan, teach how to use and navigate the mental health system, provide education on many topics related to behavioral health or living within the community and talking with your doctor. One emerging program is the peer or family wellness coach that helps consumers and families cope with co morbid

conditions like diabetes and depression and that help consumers increase their healthy lifestyles in an effort to decrease the mortality gap faced by those of us living with mental illnesses.

- Bridger/PeerLINK Programs: These services typically begin while someone is in an inpatient psychiatric hospital. The person providing this service is a Peer Specialist (PS) and they begin by developing a relationship with the consumer before the consumer is discharged, including assisting the consumer with discharge planning. Once discharged the PS will stay in touch with the consumer and provide support and education of navigating the system.

- Employment: Several employment programs that are contracted through managed care companies are consumer and/or family agencies. The services provided are education and skill building activities that will help a consumer to gain or maintain employment. Many times employment services are provided through a psychiatric rehabilitation program but this is not a requirement.

- Housing: Typically, housing services for consumers are provided by mental health agencies but there are some consumer run programs in existence as well.. Housing services should include education and support of a consumer in gaining and maintaining the level of housing that best meets their needs, whether it is supported housing or home ownership.

- Respite: Peer Run Respite allows consumers to take a break from the day-to-day stressors and seek care before needing full blown hospitalization when things begin to break down. Who better to know and understand what's needed during a crisis than someone who has lived experience. There are several Consumer and/or Family crisis programs across the country: http://buzz.freeshell.org/wlines/pdf/respite-programs.pdf . This link provides location and information on a few of these programs.

- Specialty Programs/Services: There are many specialty programs "out there" they provided a needed benefit to consumers. Some of which are; trauma-informed groups, Double Trouble, BRIDGES, WRAP, IMR just to name a few. These services can compliment existing mental health services by providing the additional education and support needed for consumers to move beyond their illness and grow in their recovery.

The above list is not exhaustive but only meant to give you an idea of what could be available in your community. Additionally, we would like to hear what you do, what has worked and proven to benefit recovery and resilience that could be offered to managed care members.

Key Take Away Points:

1. Offer only services you uniquely can offer that build on your strengths
2. Be creative about what you can package that you can show has an effect on adherence/recovery outcomes/decreased hospitalization and a decreased use of other services (ER visits etc)

4. What managed care companies look for when considering whether and how to add a consumer/family run organization to the network?

Introduction

Before considering the specifics of what managed care companies look for when considering whether, and how to add a consumer/family run organization to the network, it is important to acknowledge that the benefits of hiring consumers as providers exist on multiple levels. There is the benefit to the recipients of services, benefit to the consumer-provider themselves, and ultimately the benefit to the managed care system of care.

Benefits to the consumers receiving services:

- Consumers can benefit from the mental health systems knowledge of consumer-providers, and their experience in navigating the system.
- Typically, consumers have an easier time engaging with consumer-providers because they are "street smart", and have experienced similar life courses.
- Consumers may see consumer-providers as role models because of their success with employment, education and independent living, which is a powerful way to instill hope.
- Consumers benefit from the consumer-provider's personal experience with use of medications, coping strategies, and lessons learned in recovery.
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Benefits to Consumer-Provider:

- Empowers the consumer-provider by increasing their sense of value and self worth.
- Offers the consumer-provider an opportunity for self-growth and development.

Benefits to Managed Care System of Care

- Consumer-providers can educate and heighten staff awareness and sensitivity to struggles faced by consumers.
- They add a different perspective, and bring understanding and diversity to the organization.
- Increases the likelihood that the consumer voice is integrated in planning, evaluation, and delivery of services.
- Consumer providers may help to fill a gap in service delivery, especially for the severely mentally ill.
- Transform the system by helping providers see the treatment process from a different vantage point.
- Offer innovative and creative alternatives or enrichment to traditional services

What do managed care organizations look for?

Three key factors that guide managed care organizations in decisions related to network participation are:

1) assuring high quality services that are also compliant with state and federal regulatory requirements;
2) assuring services achieve positive, measureable results; and
3) supporting the principle of health care affordability, which result in a cost effective approach to services.

Managed care organizations have an obligation to their customers, whether that is publicly funded programs, such as Medicaid/Medicare or health plans, or private health plans, to make sure that services are cost-effective, of high quality, and meet any regulatory requirements.

Each state Medicaid program has specific regulations that guide the qualifications to perform each type of service. For example, typically only independently licensed providers (psychiatrists, nurses with behavioral health experience and training, licensed masters level social workers or counselors.) can perform traditional outpatient services. However, depending on the state, non-licensed individuals are also able to perform services. These services might include peer support services, psychosocial rehabilitation, and case management. If you are unsure about which services are covered, the network management, provider relations, and/or credentialing staff within the managed care agency are a good resource to help identify the services, which consumer and/or family-run organizations can provide.

Managed care organizations are expected to demonstrate measurable and positive outcomes for the consumers. While challenging to measure behavioral health outcomes, many measures are used to monitor what are deemed best practices. For example, one such behavioral quality measure is assuring that a consumer has a follow-up appointment within 7 days of inpatient discharge. Peer Bridger programs have been utilized to help bridge the gap between psychiatric hospitals and the community for many consumers. Organizations that can provide data or assist in helping a managed care organization meet important performance measures will be most likely to be recruited for network participation

Managed care organizations are continuously seeking opportunities to provide the best quality of care in the least restrictive setting, and assuring that care is cost-effective for the managed care customer. Consumer and family run programs typically can provide high value at a lower cost. For example, many family-run organizations offer targeted case management, which offers more

face-to-face interaction than traditional outpatient methods which can be costly. Consumer and family run organizations facilitate social networking and provide social support through arranging activities, home visits, and social interactions in a less formal setting, which engages the consumer at a lower level of care with out sacrificing the quality of the services provided.

What are some of the factors that might compel an MCO to recruit and contract with a peer or family run organization?

1) Client/Customer expectation – Many states across the country are including requirements for covering peer support as a distinct service in Medicaid programs. In response, managed care organizations are having dialogues with their customers about this, and including the provisions of these services in Request for Proposals (RFPs).

2) Managed Care Company's orientation and philosophy - Managed care organizations have adopted the recovery and resiliency philosophy as the basis for much of the service delivery to persons with mental illness. Consumer-providers are utilized to teach social and coping skills essential to increasing resiliency and providing a model of recovery.

How do MCO's engage consumers in the contracting process?

Regulations regarding the use of consumer-providers vary from state to state. Additionally, quality standards for contracting with consumers must be defined in collaboration with the managed care organization and regulatory entities.

The typical steps in managed care contracting with providers are:

1. Confirm network need. Managed care organizations continuously evaluate whether a sufficient service array exists for its members. This includes looking at measures such as the number of providers by type (e.g., psychiatrist, psychologist, inpatient settings, etc.) for the number of consumers served. While the standard analysis should include evaluation of peer support groups and services that family and/or consumer-run organizations provide, it might be valuable to establish direct contact with the regional provider relations or network manager to discuss current needs and what your organization has to offer. Establishing this relationship can go a long way in helping to support and expedite the recruitment process.

2. Complete application and paperwork necessary to participate. Most organizations have a credentialing application that provides both the criteria for network participation and supports the data collection process necessary to complete credentialing, contracting and data loading to

support referrals and claims payment. Managed care organizations must successfully select and retain qualified healthcare providers who will provide quality services to consumers. This process of selection and retention is known as credentialing. It is the process of review and verification of the information of a health care provider who is interested in participating with the managed care organization.

3. Credentialing is organized by provider type and level of care (outpt, psr, IOP, day tx, case management), with specific criteria for each provider type or level of care. The MCOs provider relations specialist or network manager can provide details on the criteria or where to locate (e.g., web-site) if this isn't supplied in the application packet. If your organization isn't accredited by a national healthcare accreditation body (such as Joint Commission or CARF), be prepared to participate in an on-site environmental review to confirm safety, compliance with privacy requirements defined by HIPAA, including proper handling of protected health information (PHI)

4. .Participate (as feasible) in the contract negotiation process. In some instances, the reimbursement fees are negotiable. Typically the managed care organization will provide a fee schedule with the application. If not, request one and confirm whether the rate is negotiable. Compare the reimbursement rate with your operating costs to help determine whether the arrangement will meet your financial needs.

5. 6.. Maintain copies of all of your paperwork (application, signed or executed contract) and confirm with the managed care organization that your information has been loaded into the information system to support referrals and claims payment. Typically the managed care organization will send you a welcome letter, a copy of your signed and executed contract and other information related to requirements (e.g., provider handbook, websites that provide additional information, etc.).

6. Participate in any provider information forums or training. Typically, managed care organizations conduct training (either face-to-face, web-based and/or teleconferences) to explain requirements and offer assistance (e.g., information on claims submissions, toll-free customer service lines, pre-authorization requirements, etc.).

What if I'm rejected for participation by the managed care organization?

Contact the managed care organization to determine the rationale. It could be that licensure requirements are not met or the organization hasn't yet considered creative vehicles to incorporate peer or family support programs. Be prepared to identify the measurable and valuable service your organization can offer (e.g., support MCO in meeting required performance measures).

Key Take Away Points:

1. Position your services as unique and able to increase positive outcomes
2. Be prepared to track outcomes and show quality in what you do
3. Work collaboratively with MCO network staff to identify network needs that you can uniquely fill
4. Complete necessary paperwork with attention to detail and in a timely manner
5. Follow up, fix what was missing and try again, be persistent.

5 Things Consumer Providers Need To Have In Place.

Managed care organizations must successfully select and retain qualified health care providers who will provide quality services to its members. When considering adding consumer/family run organizations (and any other provider agency/organization) to the network, there must be a standard process in place for review and verification of information. The following information must be reviewed and verified for approval to join the MCO's network:

- The agency must have completed an application to join the network, and received an acceptance letter;
- Maintain a list of current location(s) and hours of operation, including after hours coverage;
- Copy of certification/licensures;
- Copy of General and Professional Liability, Proof of Insurance
- Tax ID or Social Security #;
- Medicaid #;
- Copy of curriculum vitae or work history (explanation of any gaps)
- Background check (summary of any convictions or alleged crimes);
- List of References;
- Must possess resources to ensure the delivery of quality care in an appropriate and timely manner, including but not limited to an office, with reasonable furnishings, place for locked clinical records, phone, fax, computer, internet access;
- Must participate in on-going training to increase knowledge and skill working with consumers. Training may include, but not be limited to such areas as setting limits, orientation to treatment indicators, case management, code of ethics, and HIPPA laws.

Key Take Away Points:

1. Start the process to receive your Medicaid/Medicare number immediately

2. Insure you have addressed each item on the list above and that you have the paper work that verifies each item.

6 **How Consumer Providers Get Paid**

Consumer Providers will be paid based on negotiated rates, included in their Provider Agreements. Claims must be submitted, typically, on a standard CMS 1500, with the appropriate CPT codes and or the appropriate CMS healthcare common procedure coding. Review your contract to identify timely filing requirements (e.g., submission of claims must be made within 12 months of the date of service).

Due to the unique nature of consumer and/or family run services some MCOs also allow alternative billing procedures (e.g., invoice billing). An invoice would typically include date of service, description of service, location of service, and identifying information for the consumer. Check with the MCO on the billing requirements.

Most organizations also offer a "direct deposit" alternative such as electronic funds transfer (EFT) or electronic payment system (EPS).

Questions that need to be addressed to confirm payment is accurate and timely:

1. What are the established service limits for this type of service? Is there a need to modify this in any way? (For example, case management might be limited to four 15-minute sessions per day/week; others?)
2. Is pre authorization required? For example, if the consumer is moving and requires services that extends beyond the typical billing hours, would pre-authorization be required?
3. What coordination of benefits issues are there? Some consumers may have Medicare coverage that will need to be coordinated to make sure that primary and secondary issues are addressed.

Key Take Away Points:

1. Clarify Payment terms as you develop the contract

2. Do not be afraid to ask for what you need but do not be surprised if there are tight limits to what can and can not be negotiated.

7.`Weighing The Pros And Cons Of Becoming A Part Of A Managed Care Network

In these tough economic times, it may be tempting to just jump right into becoming a part of a managed care network as a way to build a more consistent income stream, one that can be relied on from year to year and is not based on variables of the state budget . However, it is extremely important to weigh the pros and cons of this move and be sure you can meet the administrative burden and contracting expectations before starting. It is also critical to analyze what kind of staffing you will need to do to meet the terms of any contract and what level of payment will be needed to sustain that staffing.

Most family and consumer run organizations will need to look carefully at both their administrative support staff capacity and their financial management capacity. Do you have enough administrative staff to be able to provide a managed care company with the kinds of records and reports they will be seeking? Do you have enough financial management staff available to be able to bill a managed care company for your work? There are often very long lag times between delivering the service, billing for the service and receiving payment for the service so you will need to consider how to front load your investment on administrative staff before receiving any reimbursement. You should prepare for a six month lag between billing and payment in your considerations.

Its not just administrative staff you need to consider. If you need to add staff to deliver a program, for example adding more peer/family specialists to handle a contract, you will need to consider how to pay for those staff before receiving reimbursement for services. Some consumer and family groups have negotiated contracts where they receive a lump sum at the beginning of a contract and then bill against that sum as a way to manage the upfront costs. It is critical, however, that you not add staff before you are sure you can sustain them, so start small and build staff based on demand rather than “hoping” demand will meet your increased staffing.

When you contract with a managed care company, many times you will be essentially a subcontractor to medicare/medicaid. You must meet the obligations of the contract or you risk Medicaid fraud – a very serious problem that could possibly result in jail time along with closure of your company. Many of us in the non profit work have allowed timeframes to slip on projects or have wrongly seen a contract as a “donation” rather than a deliverable we are responsible for. Do not make this mistake in considering whether to join a network. Your organization will be held to the same standard as any other provider group and no amount of arguing for leniency because you are a non profit run by consumers or family members will have any bearing at all when it comes to deliverables in this kind of contract.

Key Take Away Points:

1. Do not rush into a contract, be very clear what the return on your investment will be and what it will take to sustain your organization over time.

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2. Add staff slowly – do not “hope” that demand will be great enough to balance the cost of new staff, go slowly enough to ensure that any staff additions will be covered by additional business.

8. Tips For Success and Barriers you Will Need to Overcome Should You Decide To Join A Managed Care Network

Here are a few ideas that may help you if you do decide to become a part of a managed care network:

a. Contract for part time back office support (billing, finance, claims) through an agreement with a local provider's office, a local non profit or even an independent service that several groups in your areas buy into.

b. Negotiating start up fees in a contract by asking for a lump sum at the beginning and then bill against that lump sum for a period of time. This can give you some operating capital while you wait for payment to be processed through the system.

c. Consider starting with six to twelve month trial program with a company to allow both you and the managed care company to "work the bugs out" of a program before going into a full blown contract.

d. Start up slow. If you are going to start a Peer or Family Bridge Program, start with the volume you can handle without adding any more staff. If all you can handle at first are 20 consumers or families, then start that way and add staff only as the demand increases to the point that you can sustain additional staff.

e. Add additional managed care companies. Most markets will have many different companies offering different "products" to different audiences in your area. One or more groups may have contracts with the state, other groups may have an AARP contract, a large employer contract, or they may subcontract on a large VA project. So start with one company and as you become confident, begin talking with other managed care companies to build your business. Provider groups accept many different kinds of insurance, why shouldn't you?

f. Build relationship with providers. One of the keys to success is having providers feel comfortable with what you offer so they recommend your service or at least do not scare consumers and family members away from using your services. Create relationships with the local provider groups, offer seminars at state wide provider meetings. Go in and do in service training for staff at facilities. One of the greatest barrier we have faced in implementing peer run services in our network is provider resistance so it is important that you prepare in advance and educate providers in a professional, data and research based way

about what you will be doing and how it will help them serve the consumers they feel responsible for.

g. Make sure call center staff are trained around your services so they refer effectively in managed care companies. Managed care staff (case managers, care advocates, care support specialists) are some of the people who refer consumers and families to services. Make sure you are working with the call center and other staff so they understand what you are offering, they can easily identify when your service is the right one. Often a company will have a formal “evaluation of care” document that guides when each service is to be used. Have a conversation with the various staff to make sure the service you offer is written into the level of care document. This way staff feel confident in making the referral. Offer to go in and do formal training of staff around what you have to offer. Be sure that this training incorporates information about what you offer and the research that backs up why your program will help consumers and family members. Another barrier faced in some managed care companies has been the lack of understanding about the service by staff. If they are not prepared for the addition of this service, they will not refer members to the service and the consumer or family run service will not be paid.

Key Take Away Points:

1. Be creative and collaborative in how you meet your administrative needs
2. Spend time building provider awareness and understanding of what you will be offering so you do not fail because of their resistance to your involvement
3. Make very sure that you have done enough training with care advocate/call center staff so they understand what you offer, when to refer consumers to you and have confidence in what you are doing or they will not send consumers to your service.

9 How To Begin The Process

There are many things that need to happen BEFORE the process of contracting with a MCC begins. First, you need to develop a clear and detailed description of the services your agency is willing to provide. Some of the questions that will need to be address in your description are:

1) List the service(s) your organization is willing to provide and include; city & county to be served, your organizations experience and any outcome data available.
2) List type of license your organization has and if additional license will need to be obtained.
3) Provide a detail description of the service(s) and how it relates to recovery & resilience principles and practices. In this section you will include the days/hours of operation, staff to consumer ratio and age group to be served.
4) Describe the anticipated length of stay for individuals utilizing this service and the number of individuals you plan to serve within a year.
5) Identify where you propose referrals to come from and your marketing strategy to inform those sources of the service once established.

The above questions are the starting point of the contracting process. Once you have the description in place with pertinent information you can contact the managed care company to inform them of your interest. For OptumHealth you call the 800 # and request to speak with provider relations. As you begin the dialogue with the managed care company (MCC) you should begin working on other tasks such as your EIN, NPI number, Medicaid number, etc. Additional clarifications for these are below:

EIN: Your organization should have an Employer Identification Number (EIN) also know as a tax number or Federal Tax ID Number. If not, you will need to obtain in order to get the other numbers needed below. More information can be obtained at the following website:
http://www.irs.gov/businesses/small/article/0,,id=98350,00.html

NPI: National Provider Identifier; The purpose of the National Provider Identifier (**NPI**) is to uniquely identify a health care provider in transactions, such as health care claims. NPIs may also be used to identify health care providers in internal files to link proprietary provider identification numbers and other information, in coordination of benefits between health plans, in patient medical record systems, in program integrity files, and in other ways. HIPAA requires that covered entities (i.e., health plans, health care clearinghouses, and those health care providers who transmit any health information in electronic form in

connection with a transaction for which the Secretary of Health and Human Services has adopted a standard) use NPIs in standard transactions by the compliance dates. For additional information please visit this website: https://nppes.cms.hhs.gov/NPPES/StaticForward.do?forward=static.npistart

Medicare/Medicaid Number: You will need to obtain a Medicaid and/or Medicare ID number before contracting with a MCC. Before you can apply for this number you will have to have your NPI number. The following website will help you to understand more about Medicare and Medicaid and apply for your number:
http://www.cms.hhs.gov/home/medicaid.asp

The above can be vary daunting but don't give up! Remember, you can contact the provider relations staff and/or contracting staff to help provide clear direction.

Once you've completed the above (or during the process) another need is insurance, both professional liability and general liability. Required coverage for outpatient services is 1,000,000/3,000,000 for professional liability and 1,000,000/1,000,000 for general liability. Please contact your insurance carrier for additional information.

Other things to remember are to provide any research/outcome data to back up your claim of having a beneficial service. Do you or your staff have a 'specialty' or specific area of focus? What and how much experience do you have? And, any other information you believe will support your request.

Key Take Away Points:

1. Think through what you you have to offer, to the point you have written out a one page overview that contains the information most network staff will want to have prior to engaging in conversation

2. Getting your Medicaid number will take time and may take many attempts be persistent and start immediately.,

10 Conclusion

Managed Care Organizations are beginning to understand the value of having peer and family run services as a part of their network of providers. The key to success in becoming a part of a network is to illustrate with hard data how what you can uniquely offer will increase consumer wellness, decrease hospitalization, increase adherence, decrease remission. There are several federal forms you must complete in advance that provide you with “numbers” that managed care companies will need prior to contracting with you. You should weigh the pros and cons of working with a managed care company carefully before signing up. You will be liable for the timely fulfillment of your contract just like any of the provider and the penalties of not doing so are quite harsh.

Adding consumer and family services to the networks of managed care companies provide sustainable income for these groups that is not dependant of the whims of state financing or individual donations. It also helps transform the way care is delivered in the US by offering alternatives and enhanced services that help support the recovery of the consumer and families being served.

Good luck on your journey

Appendix

A. **Worksheet to help you determine what you offer that could be funded through a managed care company**

B. **Checklist to help you consider what you need to get in place before contracting with a managed care company**

C. **Worksheet, evaluating the pros and cons**

D. **Worksheet: step I need to take moving forward**

E. **NPI: National Provider Identifier Form**

F. **Medicare/Medicaid Number application form**

G. **Sample Credentialing Form**

H. **List by state of the guidelines /qualifications for working as a consumer or family specialists**