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ORIGINAL PAPER

An Assessment of The New York State Behavioral Health System's Readiness to Transition to Medicaid Managed Care

Mary Acri[1] · Ashley Ann Fuss[1] · Patricia Quintero[1] · Meaghan Baier[1] · Claire Connolly[1] · Kara Dean-Assael[1] · Dan Ferris[1] · Lydia Franco[1] · Morgan McGuire[1] · Boris Vilgorin[1] · Andrew Cleek[1]

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Abstract
New York State has one of the most richly funded Medicaid programs in the United States. In an effort to achieve the triple aim New York State is undergoing a significant redesign of its Medicaid program including transitioning nearly all Medicaid funded behavioral health services into Medicaid managed care. In preparation for this transition, a state funded technical assistance center assessed the behavioral health care system's readiness to undergo this reform across 11 domains. Between September and November, 2014, the TA center electronically distributed a readiness survey to 897 mental health and substance abuse agencies: 313 (n = 269, 33%) organizations completed the assessment. As a whole, the sample felt partially ready to transition; analysis by domain revealed agencies were most ready to interface with managed care providers, and least ready to collect and evaluate outcome data. Significant differences in readiness were found depending by organizational characteristics (number of programs, licensure, and region). In anticipation of large-scale reforms, states would benefit from an initial needs assessment to identify gaps in knowledge and skills, which in turn, can then guide preparatory efforts and provide needed supports to facilitate major changes in service delivery and billing.

Keywords Technical assistance center · Managed medicaid reform · Systems change

Introduction

New York State (NYS) is home to one of the costliest Medicaid programs in the United States. In 2013, Medicaid spending approximated $54.5 billion dollars, and costs are anticipated to rise by almost $700 million during the 2018–2019 fiscal year (DiNapoli 2015). In addition to increased enrollment, costs have been driven upward due to the preventable utilization of high-cost services, such as hospital and emergency room usage; avoidable complications and readmissions; and disparities in access and outcomes among persons of color living in poverty (DiNapoli 2015).

Over the past two decades, New York State has enacted a set of reforms to lower Medicaid expenditures. Most recently, NYS made a series of policy decisions based upon the principles and goals articulated in the Affordable Care Act, and created a local version of priorities summarized in the New York State Medicaid Redesign Team's Behavioral Health Workgroup report. Key components of this report include a shift of Medicaid beneficiaries with serious mental illnesses from fee-for-service to managed Medicaid, and the provision of integrated care management for all Medicaid beneficiaries with complex needs (New York State Medicaid Redesign Team's Behavioral Health Workgroup Report, New York State Department of Health 2013).

In fulfillment of these reforms, provider organizations are required to make fundamental changes; they are required to build relationships and contract directly with managed care organizations, and to move away from care models that incentivize the number of services delivered (volume) towards those that incentivize quality of services delivered (value).

In order to support this transition, the New York State Office of Alcoholism and Substance Abuse Services (OASAS) and the NYS Office of Mental Health (OMH) contracted to create the Managed Care Technical Assistance Center (MCTAC). OMH operates and licenses ambulatory mental health service providers, and OASAS operates and

✉ Mary Acri
Mac2281@nyu.edu

[1] McSilver Institute for Poverty Policy and Research, New York University Silver School of Social Work, 41 East 11th Street, 7th floor, New York, NY 10003, USA

certifies ambulatory substance use disorder service providers across New York State. These categories are inclusive of all subpopulations, such as children, adolescents and adults.

Technical assistance centers have long been used both in the United States and globally to facilitate the enactment of initiatives, policies, and programs (Le et al. 2016) in areas such as prevention (Mitchell et al. 2002), education (Fixsen et al. 2009; McInerney and Hamilton 2007), health (Roeseler et al. 2011), mental health, and substance use (National Association of State Mental Health Program Directors. New York State Department of Health 2012). While TA centers vary across initiatives, as they are tailored to a specific program, setting, or service system, they all share the common thread of providing a range of supports and resources to enhance knowledge and skills, coupled with training, supervision and consultation (Le et al. 2016).

Aware that other states did not feel prepared for similar transitions, which resulted in substantial fiscal viability and client access issues (i.e., Burson et al. 2013), the first step undertaken by the TA center was to gauge provider readiness to convert to Medicaid managed care. The purpose of this study is to describe the results of this assessment, and specifically, perceptions of organizational readiness in key areas including finance, communication, and managed care priorities. Additionally, this study intended to better understand associations between organizational characteristics, such as agency size (measured by the number of programs within the agency), license type, and geographic location, and perceived readiness.

Given Medicaid reform across the country, there is a clear need to identify existing capacities and needs of providers in order to guide quality improvement plans and infrastructure. Further, assessments such as these can be potentially helpful as a planning resource to guide organizations in their preparation and decision making activities in the face of reforms.

Method

Procedure and Participants

Between September and November, 2014, the MCTAC electronically distributed a readiness survey to the population of 812 agencies licensed by OMH and OASAS located across New York State. A list of eligible agencies was obtained from NYS Office of Mental Health and the Office of Alcoholism and Substance Abuse Services. Across New York State, 393 (48.4%) organizations were licensed by NYS OMH, 260 (32%) agencies were licensed by OASAS, and 159 (19.6%) agencies were dually-licensed by OMH and OASAS.

Questionnaires were sent to agency directors. After the initial distribution, a minimum of three additional attempts were made to the population of OMH and OASAS agencies. Further, each agency was asked to complete a single readiness assessment regardless of the number or licensed programs in its portfolio. If an agency completed more than one readiness assessment the most recent version of the assessment was used in analysis.

Measurement

Agency characteristics, including number of programs operated by the agency, region that the agency was located in, and license, were collected through analysis of program licensure databases made available by New York State.

Readiness to transition to Medicaid Managed Care was measured via the Managed Care Readiness Self-Assessment instrument. The instrument consists of 86 items to assess 11 domains of processes, practices, and activities needed to effectively prepare for and function during the early stages of a business relationship with a Managed care organization. Examples include finance and billing, IT (the adoption of software applications for purposes of communicating and processing claims for services provided), and data-driven decision making (e.g., analyzing the information collected from consumers to evaluate and drive service provision). Each item is anchored on a 5-point Likert scale, ranging from 1, "*not at all ready*" to 5, "*definitely ready right now*." Items are summed, and the average computed for an overall, aggregate score as well as individual scores for each domain. Average scores between 1 and 2.99 were considered to mean the organization was "*not at all ready*," between 3.0 and 3.99 was considered "*partially ready*," and 4 and above was considered *"definitely ready right now."* A copy of the measure is in the Appendix.

Data Analysis

Analyses were conducted using SPSS 24. Univariate statistics were conducted to examine perceived readiness of the behavioral healthcare system in response to Medicaid reform across 11 domains. Differences between agencies who completed and did not complete the readiness assessment were examined using Chi square tests.

Analysis of variance (ANOVA) tests were conducted to examine differences in readiness by agency region (agencies with programs located in NYC, the rest of the state, or both) and license type (OMH, OASAS, or dually-licensed), and an independent samples t-test was conducted to examine differences in readiness based upon agency size (defined as having five or more vs. less than five programs).

Results

One-third of agencies (n = 269, 33%) completed the assessment. Chi square tests of association indicated that agencies who completed the readiness assessment were significantly more likely to be located both in New York City and the rest of the state ($\chi^2 = 22.09$, $p < .001$), were dually-licensed ($\chi^2 = 16.07$, $p < .001$), and had five or more programs ($\chi^2 = 50.04$, $p < .001$). Table 1 presents these results.

Among the sample of agencies that completed the assessment, more than one-third (n = 118, 43.9%) were OMH-licensed agencies, followed by 77 agencies (28.6%) that were OASAS-licensed agencies, and 74 agencies (27.5%) that were dually-licensed. Geographically, 36.4% (n = 98) were located in the New York City region and 55.8% (n = 150) were located in another region in New York State (Central, Hudson, Long Island, or Western). More than half (56.5%, n = 152) of agencies who completed the assessment operated less than five programs. These results are presented in Table 2.

Cumulatively, the average level of readiness reported by the sample was 3.09 (*SD* = 0.92), indicating organizations felt partially ready to convert to Medicaid managed care. Individual scores from each agency showed almost half of the agencies (n = 124, 46%) did not feel at all ready to convert to Medicaid managed care (M = 2.28, SD = 0.53), 95 (35%) felt partially ready (M = 3.44, SD = 0.30), and 50 (19%) reported they were definitely ready to transition to Medicaid managed care (M = 4.42, SD = 0.27).

Table 2 Agency demographics and readiness completion by license, region, and number of programs

	Completed		Not completed	
	n	%	n	%
License type				
OMH only	118	43.9	275	50.6
OASAS only	77	28.6	183	33.7
Both	74	27.5	85	15.7
Total	269	100	543	100
Region				
NYC	98	36.4	190	35
Rest-of-state	150	55.8	345	63.5
Both	21	7.8	8	1.5
Total	269	100	543	100
Number of programs				
< 5	152	56.5	435	80.1
> 5	117	43.5	108	19.9
Total	269	100	543	100

Analysis of readiness by domain found agencies felt most ready in the *Interface* domain (M = 3.99, *SD* = .85), defined as readiness to interact and communicate with Medicaid managed care providers, and least ready in the area of *Data Management & Evaluation* domain (M = 2.43, *SD* = 1.23), which assessed readiness and capacity to demonstrate the

Table 1 Readiness completion by region, license, and number of programs

Readiness completion	Agency region		
	New York city	Rest of state	Both
Completed	98 (34%)	150 (30.3%)	21 (72.4%)
Not completed	190 (66%)	345 (69.7%)	8 (27.6%)

$\chi^2 = 22.09$***, df = 2. Numbers in parentheses indicate column percentages
***p < .001

Readiness completion	License type		
	OMH only	OASAS only	Both
Completed	118 (30%)	77 (29.6%)	74 (46.5%)
Not completed	275 (70%)	183 (70.4%)	85 (53.5%)

$\chi^2 = 16.07$***, df = 2. Numbers in parentheses indicate column percentages
***p < .001

Readiness completion	Number of programs	
	Less than five	Five or more
Completed	152 (25.9%)	117 (52%)
Not completed	435 (74.1%)	108 (48%)

$\chi^2 = 50.04$***, df = 1. Numbers in parentheses indicate column percentages
***p < .001

impact of services on outcomes (value). Table 3 presents these results.

Results from the analysis of variance (ANOVA) and post hoc analyses using Tukey's HSD indicated that agencies licensed by OMH had significantly lower readiness scores than dually-licensed agencies [$F(2, 266) = 6.62$, $p = .002$]. Analysis by domain revealed significant differences, except for *Data Management & Evaluation*, by license type. Specifically, in the *MCO Priorities, Contracting, Communication, IT, Quality, Finance*, and *Access* domains OMH agencies had significantly lower readiness scores than dually-licensed agencies. In the *IT* and *Interface* domains OASAS-licensed agencies had significantly lower readiness scores than dually-licensed agencies. Furthermore, in the *Level of Care, Member Services*, and *Quality* domains, OASAS agencies demonstrated greater levels of readiness than OMH agencies.

An independent-samples t-test indicated agencies with less than five programs perceived themselves as significantly more ready in the *Member Services* domain, defined as being aware of the policies and procedures regarding coverage; *Finance* (e.g., billing and financial procedures); and the *Access* domain (defined as access to treatment services) than agencies with more than five programs [t (263) = 2.19, p = .03]. However, in the area of *Interface*, agencies with less than five programs were significantly less ready than agencies with more than five programs. These results are displayed in Table 4.

Table 3 Readiness completion by domain category and aggregate

Readiness domains	Descriptive statistics			Mean	Std. deviation
	N	Minimum	Maximum		
MCO priorities	267	.80	5.0	3.35	.98
Contracting	267	0	5.0	3.24	1.16
Communication	268	.40	5.0	2.68	1.62
IT	268	0	5.0	3.23	1.08
Level of care	268	.75	5.0	2.76	1.10
Member services	268	.50	5.0	2.81	1.53
Interface	269	1.4	5.0	3.99	.85
Quality	269	.56	5.0	2.84	1.12
Finance	269	.82	5.0	3.25	1.15
Access	269	.67	5.0	3.39	1.28
Evaluation	269	.50	5.0	2.43	1.23
Aggregate	269	.84	4.94	3.09	.92

Discussion

Many states have turned to Medicaid managed care with an articulated vision that this transformation will be associated with a range of benefits from better clinical outcomes as described in the Affordable Care Act's Triple Aim-namely, to enhance care coordination and the quality of services while reducing costs and improving population health (Berwick et al. 2008). Aware of the difficulties in transitioning across other states, New York State attempted to circumvent similar difficulties by making technical assistance available to providers and assessing their readiness. This study reflects an initiative by MCTAC to better understand the pulse of the public mental health and substance abuse service systems on their readiness to transition to a managed care platform, and identify areas to direct TA resources and supports.

Consistent with reports from other states, the main result of this assessment was that agencies were, as a whole,

Table 4 Readiness domain scores by number of programs

Readiness domains	Less than five			Five or more			95% CI for mean difference	t	df
	M	SD	n	M	SD	n			
MCO priorities	3.35	1.01	152	3.35	.95	115	−.24 to −.24	.03	265
Contracting	3.32	1.19	152	3.12	1.12	115	−.48 to .08	− 1.39	265
Communication	2.76	1.60	152	2.58	1.64	116	−.58 to .21	−.92	266
IT	3.19	1.16	152	3.28	.96	116	−.16 to .35	.74	264.22
Level of care	2.86	1.14	152	2.64	1.03	116	−.49 to .40	− 1.67	266
Member services	3.01	1.54	152	2.54	1.49	116	−.83 to −.10	− 2.48*	266
Interface	3.89	.89	152	4.11	.78	117	.02 to .42	2.19*	262.92
Quality	2.93	1.19	152	2.73	1.02	117	−.46 to .07	− 1.44	264.01
Finance	3.39	1.16	152	3.07	1.11	117	−.59 to −.04	− 2.26*	267
Access	3.55	1.24	152	3.18	1.30	117	−.68 to −.06	− 2.38*	267
Evaluation	2.50	1.32	152	2.34	1.12	117	−.46 to −.38	− 1.11	264.38
Aggregate	3.16	.97	152	3.00	.85	117	−.38 to −.38	− 1.46	261.69

*p < .05

largely unprepared for the shift to a managed Medicaid behavioral health care system. As described previously, the overall mean score of the assessment was on the low end of being partially ready to transition; moreover, almost half of respondents did not feel at all ready to convert to Medicaid managed care and an additional third only partially ready to transition. Further, agencies expressed variability in their readiness to convert across domains; as a whole, they felt most ready in interfacing with Medicaid managed care (*Interface*), and least ready in measuring and evaluating outcomes (*Data Management & Evaluation*).

Taken together, we can anticipate that systems of care will require substantial supports in order to adopt and adapt to large-scale reforms, and that supports should be tailored to specific areas of need. For example, agencies seemed to perceive that their interaction with managed care providers was an area they were comfortable and competent with, perhaps because many have already interfaced with a range of providers on behalf of their clients. However, they felt largely unprepared in data collection and evaluation efforts, which suggest that a strategic use of MCTAC's resources would be to focus on data collection and methods to evaluate client outcomes.

Also of note, examination of the relationship between organizational characteristics and perceived readiness found OMH and OASAS-licensed agencies perceived their readiness as significantly lower than dually-licensed organizations overall and across domains. One explanation may be that OMH-licensed agencies tend to be smaller in size and have fewer resources to support a transition than dually-licensed organizations, which are larger, have more resources, tend to have more sophisticated data collection systems, and have prior experience interacting with a range of insurers.

Yet contrary to expectations, organizations with fewer than five programs perceived themselves as more ready in several key domains, including awareness of the policies and procedures regarding coverage, billing and financial procedures, and access to treatment services in comparison to agencies with five or more programs. This finding warrants further exploration, for it would be expected that smaller organizations would feel less prepared in these areas than larger organizations. It also illustrates the lack of knowledge about the intersection of organizational factors and readiness to adopt new reforms, and the need for a theory-driven research agenda.

The field of implementation science may be helpful in this endeavor: Although it focuses largely on the processes associated with the uptake and long-term adoption of evidence based treatments, it examines barriers and facilitators to uptake that occur on multiple levels, as treatments are administered by individuals nested within organizations that have their own unique processes, and which are, in turn, embedded within a larger environmental context that has accompanying financial, legislative, and political influences (Aarons et al. 2011, 2014; Willging et al. 2015). In a similar way, viewing readiness as a composite of factors on multiple levels, including organizational factors (e.g., size, resources), provide factors (e.g., have providers been trained in new billing practices), and other internal and external influences may move our knowledge about large scale reforms affecting systems of care forward.

In sum, needs assessments can provide fruitful information about gaps in knowledge and skills, and guide technical assistance centers as to what extent, resources, and supports are needed in order to enhance preparedness and successfully transition to new procedures and practices. As a whole, this study was informative and established the need for future inquiry. Nonetheless, several limitations should be considered when interpreting these results. First, 65% of the population did not return the assessment, despite multiple attempts. One possible interpretation is that agencies may have been concerned they would be penalized in some way if they responded and did not feel ready, given the TA's ties with their licensing entities (OMH and OASAS). Future endeavors to capture this information should consider the possibility that agencies may be reluctant to participate for a variety of reasons, and that enhanced assurances regarding confidentiality may be required.

Along these lines, it isn't clear why responders were significantly more likely to be located both in New York City and the rest of the state, dually-licensed, and had five or more programs. These organizational factors may indicate that responders were larger and may have had more resources and staff to dedicate to completion of the assessment, but here, also, future investigation is needed in order to contextualize this finding.

Additionally, while the readiness measure was created with the input of experts with extensive knowledge of the skills and capacities needed to be prepared for the transition, the psychometrics of the assessment measure are unknown. Future testing of this measure is needed in order to anchor the findings of this study, and can be of enormous value to the field, given a lack of existing measures and information about how to assess for readiness.

And lastly, it is important to recognize that agencies reported on how prepared they felt, but it is unclear whether their actual level of readiness corresponded with their self-report. Future research that measures readiness in several ways, including but not exclusively via self-report, such as analyzing actual billing practices and evaluation methods, would provide greater information about how prepared agencies truly were.

Limitations notwithstanding, this study raises important questions about how to best support a statewide system of care in the face of major reform. Considering 2.5–3 million New Yorkers are insured by Medicaid for their behavioral health alone (DiNapoli 2015), and other states are moving towards a managed care system, an assessment of readiness, coupled with a systematic research agenda to identify high-risk organizational characteristics, has much potential in focusing TA centers to direct deliberate and targeted supports, and optimally enhance a fluid transition.

Appendix

Managed Care Technical Assistance Center Medicaid Managed Care (MMC) Readiness Assessment Tool

This MMC Readiness Tool is designed to provide organizations with 11 categories of processes, practices and change management activities needed to effectively prepare for and function during the early stages of a business relationship with a Managed Care organization. When completed, the self-assessment tool offers a snapshot of the organization's current level of readiness as well as an assessment of the need for technical assistance. This tool may be helpful as a planning resource to guide organizations in their preparation and decision making activities. Statements presented will be answered either as **Yes/No** or on a scale from 1 to 5 as defined below:

5 = We are *definitely* ready right now (we currently have the needed knowledge, resources, infrastructure, and plans in place)
4 = We are *mostly* ready (we are unlikely to need technical assistance to get this done on our own in a timely manner)
3 = We are *moderately* ready (we may or may not need technical assistance to get this done on our own in a timely manner)
2 = We are *somewhat* ready (we are likely to need technical assistance to get this done in a timely manner)
1 = We are *not at all* ready (we will definitely need technical assistance and guidance to get this done in a timely manner).

The Managed Care Technical Assistance Center strongly suggests that an agency bring its leadership team together and respond to the series of statements collectively. The discussion will not only assure that the answers are an accurate reflection of managed care readiness, but may also represent the beginning of your planning process to address any opportunities identified during the conversation.

Readiness item	Readiness rating (1–5) or yes/no
Understanding MCO priorities and present managed care involvement	
Your organization currently holds contracts with one or more managed care organizations	Yes or no
Your organization has identified a point person in the organization who is responsible for understanding MCO priorities; directing agency policy and interactions	Yes or no
Your organization knows which managed care organizations reimburse for services you provide in our service region	Yes or no
Your organization has held meetings with leadership of the MCOs to understand their expectations and discuss opportunities to work together on system priorities	Yes or no
Your agency/facility leadership team knows and understands the array of BH services provided within your system	Yes or no
Your organization's board is actively involved in planning for the transition to managed care	Yes or no
Your organization's board would benefit from technical assistance specifically targeted for board members	Yes or no
Rate your organization's readiness to meet with MCO leadership to understand their expectations and discuss opportunities to work together on system priorities	
Rate your organization's readiness to market services to an MCO	
MCO Contracting	
The organization has identified an individual to be responsible for providing oversight to MCO contracting	Yes or no
Rate your organization's capability to understand the requirements of the managed care contracts you have	
Rate your organization's capability of assessing compliance with the requirements of the managed care contract you have	
Rate your fiscal staff's capability of assisting with pricing issues during contract negotiations	
Rate your fiscal staff's ability to readily compare actual to anticipated revenue and expense by contract	
Rate your organization's understanding of CMS compliant codes that will be used for billing	
Communication/reporting (services authorization, etc.)	
Your organization has a designated liaison responsible for communication and reporting with the MCOs	Yes or no
Your organization knows the reporting requirements for the MCOs in your region with which you contract	Yes or no
Your organization knows the name and contact information for the Provider Relations Department for each MCO with which you contract	Yes or no

Readiness item	Readiness rating (1–5) or yes/no
Rate your organization's knowledge of the MCO data exchange requirements and the required formats for submission	
Rate your organization's knowledge of the steps for member verification for each plan and who within the plan to contact when questions arise	
IT system requirements	
Your organization has determined whether there are specific IT system requirements with which you will need to comply when working with the MCOs	Yes or no
Rate the capability of your organization's IT system to handle the following functions	
• Centralized scheduling	
• Clinical data with a meaningful use certified electronic health record (treatment plans, medication prescribing and management, progress notes, etc.)	
• Submission of claims electronically (using both 837i and 837p billing formats)	
• Financial accounting and revenue cycle management tools	
• Reporting	
• Quality assurance	
Rate the capability of your IT system to integrate functions for client information; services utilization and financial information, including payer type by client	
Your IT infrastructure meets HIPAA security standards and your access controls adequately mitigate the risk of breaching PHI	Yes or no
Rate the capability of your organization to run formatted and ad hoc reports from your electronic health record and billing applications	
Your organization understands the clinical information that must be available /maintained for the members you are serving	Yes or no
Your organization is connected to the Regional Health Information Organization (RHIO) for your service area	Yes or no
Rate the capability of your IT system to report out client and services information to all major payers	
Level of care (LOC) criteria/utilization management practices	
Your organization has an individual responsible for knowing MCO requirements and procedures regarding communication of level of care for each MCO	Yes or no
Your organization has an individual responsible for knowing MCO requirements and procedures regarding utilization management practices for each MCO	Yes or no
If yes to above statement, this individual has information concerning LOC and utilization management for each MCO in your region	Yes–partially–no
Rate your organization's readiness to meet MCO service authorization requirements, including time frames	
Rate the capability of your clinical supervisors to understand the MCO utilization management requirements and supervise staff to practice accordingly	
Rate the capability of staff members in your organization to understand and effectively meet MCO LOC and utilization management expectations	
Rate your staff members' capability to articulate the clinical need for services, including the ability to translate psycho-social issues, such as homelessness, into a clinical need	
Regular training is provided to assure a current understanding of LOC and utilization management expectations	Yes–partially–no
Your organization is capable of assessing whether staff are able to effectively work within the LOC/UM expectations established by the MCO	Yes–partially–no
Your organization has a mechanism for providing feedback to/having discussions with MCOs concerning LOC, UM, denials and appeals expectations	Yes–partially–no
Rate the capability of your organization to monitor ongoing authorizations and prompt staff to seek initial and re-authorizations when appropriate	
Your organization has an individual responsible for knowing MCO requirements and procedures for obtaining authorizations for covered services	Yes or no
Your organization has an individual responsible for knowing MCO requirements and procedures for transition of care	Yes or no
Member services/grievance procedures	
Your organization has assigned a person to be responsible for understanding MCO member services expectations	Yes or no
Your organization has assigned a person to be responsible for understanding MCO complaints, grievances and appeals processes	Yes or no
Rate your organization's ability to train staff regarding MCO Member Services	
Rate your organization's ability to train staff regarding MCO complaints, grievances and appeals processes	
Interface with physical health, social support and health homes	
Rate your organization's ability to effectively interact with physical health providers on behalf of the recipients you serve	
Rate your organization's ability to effectively interact with social services providers on behalf of the recipients you serve	

Readiness item	Readiness rating (1–5) or yes/no
Rate your organization's ability to effectively interact with health homes on behalf of the recipients you serve	
Your organization works closely with inpatient and/or detox providers to coordinate linkages and transition to and from levels of care	Yes or no
Your organization has contracted with one or more health homes	Yes or no
Quality management/quality studies/incentive opportunities	
Your organization has an individual responsible for managing the quality assurance/quality study expectations of MCOs	Yes or no
Your organization has sufficient staff assigned to the QA function	Yes or no
Staff members in your organization have been made aware of the MCO quality expectations and QA procedures have been shared with staff	Yes or no
Rate your organization's understanding of QARR and HEDIS measures for Physical Health and Behavioral Health services	
Rate the capability of your organization's clinical practices to meet established MCO quality assurance/quality study expectations	
Rate the capability of the organization's QA function to closely tie to your management information system	
Rate the capability of your supervisors and clinical staff to receive and then act on regular QA reports	
Rate the capability of the organization's QA function to maintain records of managed care appeals and suggest strategies for improving relationships and/or modifying service delivery to reduce denials	
Patient satisfaction surveys or Perception of Care tools are a function of your organization's QA process	Yes or no
Finance and billing	
Your organization has an individual (or a financial management consultant) who has experience billing MCOs	Yes or no
Rate the ability of your organization to submit clean claims to MCOs on a timely basis	
Your organization understands the appeals process for denials of claims	Yes or no
Rate your organization's ability to appeal denied claims: read remittances and resubmit	
Rate the ability of your organization to accurately capture and report the unit costs of services being reimbursed by the MCOs by program and location	
Rate the ability of your organization to translate unit costs into episode of care costs	
Rate the ability of your organization to monitor the differential between the medicaid payment and your cost, by service type as well as by episode of care	
Rate the capability of your organization to regularly communicate cost, revenue, and service value information to all staff	
Rate the success of your revenue cycle management infrastructure, building on the service delivery process, to capture and collect every dollar owed to the organization by all payers. Good process would include monitoring and addressing billing collection issues on a daily or weekly basis	
Rate the capability of your business office to conduct internal service audits to ensure that documentation of services in patient records can withstand an external audit	
Rate the capability of your organization's corporate compliance process: does it include a bullet-proof compliance plan led by a designated compliance officer and supported by internal monitoring and auditing?	
Access requirements	
Rate the familiarity if your organization with managed care plan requirements for timely access to services	
Rate the capability of your organization to demonstrate that it can meet managed care plan requirements for timely access to services	
Do you have a system in place to identify the payor source at the point of service?	Yes or no
Demonstrating impact/value (data management and evaluation capacity)	
Your organization has identified, trained, and provided the appropriate software application support to an individual responsible for data analysis	Yes–partially–no
Rate the ability of your organization to collect data related to the volume of services provided	
Rate the ability of your organization to collect data related to the clinical impact on the consumers of services provided (quality of care)	
Your organization considers both internal as well as external data sources (such as Medicaid claims viewed through PSYCKES) as you look for evidence of your clinical impact	Yes or no
MCO quality expectations have been shared with staff members	Yes or no
Clinical staff members routinely review data being collected about key service delivery processes and clinical outcome measures	Yes–partially–no
Rate the ability of your organization to demonstrate the value of your services (the cost/quality equation) to payers compared to benchmarks	
Your organization has the necessary information to understand the outcomes and related measures that define success for the MCOs with which you work	Yes–partially–no

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