



Connecting with Medicaid: Strategies and Options for Providers of Substance Use Services

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Part of a series of briefs developed by the Technical Assistance Collaborative, Inc. (TAC) to assist policy makers, providers, and advocates to understand and capitalize upon opportunities in the Affordable Care Act to help improve the lives of people with disabilities.

On June 28th the Supreme Court upheld the constitutionality of the majority of the Affordable Care Act (ACA). In doing so, it preserved many provisions that could have a positive effect on the health and well-being of the estimated 20.6 million Americans classified as substance abusing or dependent.¹ Greater access to affordable health insurance coverage will help the 37% of people indicating that lack of health insurance coverage was a barrier to receiving substance use treatment.²

One of the most important changes resulting from passage of the ACA is the expansion of Medicaid to a larger and more diverse group of people. The high court's decision that states could not be required to expand their Medicaid programs makes the previously mandatory expansion optional. However, many states are likely to move forward with expanding Medicaid eligibility to cover childless adults under age 65 with incomes up to 133% of the federal poverty level (FPL). This is because the federal government will pay 100% of the medical costs associated with the expansion for the first three years, with the percentage gradually decreasing to 90% by 2020. Today, in most states, childless adults under 65 who are not disabled, even those at or below the federal poverty level, are not eligible for Medicaid. As of 2009, more than half of all states did not cover single adults through the Medicaid program.³

Further, adults with a sole substance use disorder are not considered disabled under Social Security rules and

therefore are not eligible for Supplemental Security Income (SSI), a common pathway to Medicaid enrollment in many states. Thus, childless adults with substance use disorders are particularly likely to benefit from the expansion of the Medicaid program.

For states that do expand, the ACA requires that state Medicaid programs offer at minimum a "benchmark" or "benchmark equivalent" benefit to newly eligible people. These benchmark plans must include at a minimum certain essential health benefits which include mental health (MH) and substance use disorder (SUD) treatment services. Additionally these services must be provided "at parity" with physical health care services in compliance with the Mental Health Parity and Addictions Equity Act. While the type of SUD treatment services covered under a state's benchmark plan may vary, the ACA guarantees that newly eligible Medicaid beneficiaries in need of treatment will have access to some level of SUD treatment services.

As more people with SUD gain access to health insurance, along with greater parity and coverage for SUD treatment services, the type and amount of services that state substance use authorities (SSUA) will purchase going forward, will change as a result. The Substance Abuse and Mental Health Services Administration (SAMHSA) signaled to SSUA that they need to think differently about how they allocate their resources as a result of health reform by making changes to the Substance Abuse Prevention and Treatment and Community Mental Health Block Grant application process. In the changes to the block grant application, SAMHSA specified that SSUA should prioritize block grant funding for treatment and support services not covered by Medicaid or other insurance carriers.

With budgets tight and more people becoming eligible for Medicaid, states are increasingly turning to managed care as a tool to help them control costs, drive quality

¹ Substance Abuse and Mental Health Services Administration. (2012). *Results from the 2011 National Survey on Drug Use and Health: Summary of National Findings*, NSDUH Series H-44, HHS Publication No. (SMA) 12-4713. Rockville, MD: Author.

² Substance Abuse and Mental Health Services Administration. (2010). *Results from the 2009 National Survey on Drug Use and Health: Volume I. Summary of National Findings* (Office of Applied Studies, NSDUH Series H-38A, HHS Publication No. SMA 10-4856Findings). Rockville, MD.

³ Kaiser Commission on Medicaid and the Uninsured. (2009). *Where are the States Today? Medicaid and State-Funded Coverage Eligibility Levels for Low-Income Adults*. Author.

improvements, and coordinate care for people with chronic health issues. Developing skills in working in a managed care environment such as third-party billing, setting staff productivity standards, and understanding how to apply medical necessity criteria will become critical to a provider's ability to compete in the behavioral healthcare marketplace.

As these examples suggest, the landscape for how substance use treatment services are financed, delivered, and purchased is dramatically changing. For providers of substance use treatment services, these changes present great opportunity to serve more people by tapping into Medicaid funding. According to the 2010 National Survey of Substance Abuse Treatment Services (N-SSATS), approximately 55% of facilities⁴ surveyed reported accepting Medicaid.⁵ With the role of Medicaid as a purchaser of substance use treatment services greatly expanding, substance use providers will need to become familiar how the program operates and what opportunities exist for providing Medicaid funded substance use treatment services.

For providers only familiar with utilizing state or county contracts, grants, or philanthropic funding to support their operation, the transition to Medicaid and managed care can be daunting and many may struggle with where to start. Other organizations may not want to directly provide Medicaid services, but are interested in identifying concrete strategies for connecting people with SUD to services and supports offered by Medicaid. This brief will summarize various options for providers interested in establishing clearer pathways or connections with Medicaid, including key questions to consider for providers interested in delivering Medicaid services.

Option 1: Become a Medicaid Provider

Becoming an established Medicaid provider can seem like an intimidating process and many organizations are

unsure of where to begin. Medicaid is a complex program with a myriad of rules and regulations that can be difficult to navigate. A good place to start is by learning about the Medicaid program in your state. While the federal government shares in the cost of each state's Medicaid program and sets general guidelines that state's must follow, states have broad discretion about what services are covered, who can deliver those services, and who is eligible.⁶ This is why the Medicaid program in Florida looks very different from the Medicaid program in Oregon. At the most basic level, you can see this state-to-state variation reflected in the names of the Medicaid program across the country; some states refer to it as, Medical Assistance (MA), some call it simply Medicaid, while others have unique names: MassHealth (Massachusetts), Medi-Cal (California), SoonerCare (Oklahoma), and TennCare (Tennessee).

Structural Elements

There are some key features of your state's Medicaid program that are important to understand. First, find out about the *structure* of the Medicaid delivery system in your state. Most states have multiple service delivery systems that include both traditional Medicaid fee-for-service systems and managed care. In fee-for-service Medicaid, providers are reimbursed for the services they provide directly by the Medicaid authority. In managed care systems, providers must become part of the provider network for that managed care company(s) in order to receive reimbursement for services they provide. Alaska for example does not operate a Medicaid managed care system. Providers in Alaska who want to deliver Medicaid covered services apply directly to the state's Medicaid agency to become a provider and receive reimbursement directly from the state. Ohio (as is the case in most states) has both managed care and traditional fee-for-service delivery systems.⁷ In this scenario, providers who meet the qualifications for the service(s) they want to deliver (see section on provider qualifications below) can be both a

⁴ N-SSATS collects information from all facilities in the United States, both public and private that provide SUD treatment.

⁵ Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2011). *National Survey of Substance Abuse Treatment Services (N-SSATS): 2010. Data on Substance Abuse Treatment Facilities*, DASIS Series: S-59, HHS Publication No. (SMA) 11-4665, Rockville, MD: Substance Abuse and Mental Health Services Administration.

⁶ There are some mandatory services and populations that State Medicaid programs must cover but a wide array of optional services and populations that can also be covered at the option of each State.

⁷ According to a 2010 survey conducted by the Kaiser Commission on Medicaid and the Uninsured, only three States, Alaska, New Hampshire, and Wyoming did not operate comprehensive Medicaid managed care programs. See: *A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey*. (2010). Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation.

Medicaid fee-for-service provider and a managed care network provider or fee-for-service only or managed care only. This would mean that the provider would need to apply directly with the Medicaid agency and complete a separate application process for each managed care company for which they want to provide services.

To determine whether to pursue becoming a fee-for-service provider or a provider in a managed care network or both, you should learn who is served through primarily (or only) through the fee-for-service system and who is served through managed care. Typically, different populations of Medicaid covered individuals are served through the fee-for-service structure and managed care. Some states require certain populations such as low-income families with children to enroll in managed care. Other populations, such as people who are dually eligible for Medicare and Medicaid, have been exempted from enrollment in managed care. More and more states are requiring enrollment in managed care for populations that have traditionally been served through fee-for-service including people with disabilities.⁸

Depending on the population(s) your organization serves (e.g. adolescents, people experiencing homelessness on SSI, etc.) it might make sense to only pursue becoming a provider in a managed care network or only a fee-for-service provider. Typically the information about who is required to enroll in managed care and who is “exempt” can be found on the website of the state’s Medicaid agency. States sometimes also offer easily accessible statistics on the percentage of Medicaid beneficiaries covered by managed care and those who remain in fee-for-service. This information can be useful to help you decide which delivery system in which you want to participate.

Learning about what services are provided primarily through managed care or fee-for-service will also help you decide whether to enroll as a fee-for-service or managed care provider or both. Some services might only be covered under managed care while others are only available through the traditional Medicaid fee-for-service

Medicaid Managed Care Enrollment Brokers

Some states use an “enrollment broker” to help people enroll in managed care. If your state uses an enrollment broker the website for this broker often provides very clear information about who can (and cannot) enroll in managed care. The [website](#) for the enrollment broker for the state of Illinois offers a good example of this.

system. For example, in many states Medicaid mental health and substance use benefits are “carved-out” of the traditional fee-for-service Medicaid program and covered through a managed behavioral healthcare organization (MBHO). Iowa has this type of arrangement for its Medicaid mental health benefits. In other states, like Rhode Island and Tennessee, there might be multiple managed care companies operating in a particular area, each with a separate process for becoming a network provider. The state Medicaid agency (and/or its contracted managed care enrollment broker) should have information on their website identifying the managed care organization(s) serving the state.⁹

State Medicaid agencies can also delegate operation of certain Medicaid benefits or programs to another state agency or to county governments. This is often the case for developmental disability services, mental health and substance use benefits, and certain 1915(c) home and community-based services waiver programs. For example, in Pennsylvania, the state Medicaid agency delegates responsibility for administration of Medicaid mental health and substance use benefits to the state Office of Mental Health and Substance Abuse Services (OMHSAS). OMHSAS then negotiated contracts with 31 county governments to provide Medicaid behavioral health services at the local level.¹⁰ These county governments in

⁸ In States like Tennessee that have managed care organizations (MCO) that are responsible for providing coverage of both physical and behavioral health benefits, sometimes the Medicaid contracted MCO will subcontract with a managed behavioral health organization (MBHO) to manage the behavioral health portion of the benefit. For example, Neighborhood Health Plan (NHP), one of the several Medicaid MCOs in Massachusetts, subcontracts with Beacon Health Strategies, a MBHO, to cover behavioral health benefits. Providers who want to deliver mental health and substance use services to NHP members, must apply to become a network provider directly with Beacon.

¹⁰ There are two counties where the county chose not to enter into a contract with OMHSAS to administer these services. In those cases, OMHSAS

⁸ Kaiser Commission on Medicaid and the Uninsured (2012). *Medicaid Managed Care: Key Data, Trends, and Issues*. Washington, D.C.: Kaiser Family Foundation.

turn each *subcontract* with a MBHO to administer the behavioral health benefits for that county. So in this scenario, organizations interested in becoming a Medicaid provider of one or more behavioral health services in a particular county apply directly with the county's contracted behavioral health organization.

Sound complicated? It can be. Often the most efficient way to learn about whom to approach about becoming a Medicaid provider is to reach-out to a familiar provider in your area. As an established provider of Medicaid services they have successfully navigated the system and can tell you the best place to start. The provider trade organization in your state might also be a good place to go for information and technical assistance around how to become a Medicaid provider. They could partner with managed care organizations and the Medicaid agency to host trainings about how to work with managed care companies, provide technical assistance on topics such as compliance, third-party billing, and health information technology. Additional resources are located at the end of this document.

Provider Qualifications

Regardless of the delivery system, all Medicaid services have requirements, sometimes referred to as "credentialing criteria" that describe the qualifications necessary to provide any given Medicaid service. There are several places you can locate the provider qualifications for a service you want to provide. The provider qualifications for fee-for-service Medicaid providers are typically located in a state's Medicaid plan, a state's Medicaid provider manual, and/or in a state's regulations governing their Medicaid program.

Keep in mind that sometimes a state's Medicaid regulations might require that a provider first be accredited or licensed by another entity such as the state's Public Health Department or the National Committee on Quality Assurance. For example, New York requires that *before* providers interested in delivering Medicaid-funded substance use services can apply to become Medicaid

contracted directly with managed care organizations to cover MH/SUD benefits for Medicaid beneficiaries living in those counties.

providers, they must first be certified by the state's Office of Alcoholism and Substance Abuse Services.

It is important to distinguish here the *provider type* (e.g. clinic, hospital, nursing home, Federally Qualified Health Center, etc.) from the *practitioners* who can deliver the service (e.g. social workers, physicians, licensed alcohol and drug abuse counselor, etc.). Sometimes there are multiple provider types eligible to deliver a given Medicaid service. For example, in some states outpatient substance use counseling can be delivered by professionals in a *licensed outpatient clinic* and by a *licensed individual practitioner* (in this case the acceptable provider types are clinics AND individual practitioners). Other times there might be only one allowed provider type (e.g. hospital) for a given service. Both the allowed provider type and practitioner requirements are important to learn about for a particular service.

If your organization is interested in becoming a provider in a managed care network you should contact the managed care company(s) in your area to learn about their provider credentialing process. In most cases, if you want to be a provider in a managed care network only you do not have to make a separate application to the state Medicaid agency, though you will still have to meet the provider qualifications they set (e.g. licensed outpatient clinic). Sometimes the MCO will have additional criteria that a provider must meet in order to gain entry into that MCO's network. For example, a MCO might require that the organization be accredited by the Joint Commission or the Council on Accreditation (CoA) or carry a certain amount of malpractice insurance.

Infrastructure Requirements

In addition to the provider qualifications above, there are some other organizational infrastructure requirements for providers who want to deliver Medicaid reimbursable services. Providers must develop systems for billing, documentation, supervision of staff, monitoring quality of care, and measuring and monitoring staff productivity. These additional organizational competencies can sometimes be difficult to implement, especially for smaller organizations that do not have the resources to devote to developing these capacities. Again, talking with an

established Medicaid provider will offer you a good sense of what is required in order to be a successful provider.

For organizations that remain interested in becoming a Medicaid provider, the steps outlined in the Appendix will help your organization begin a self-assessment process to determine if becoming a Medicaid provider makes sense for your organization.

Option 2: Subcontracting with a Medicaid Provider

After reviewing the list of requirements, some providers might feel overwhelmed or discouraged about the prospect of becoming a Medicaid provider. For providers who want to deliver a service, but either are not eligible or do not have enough clients to develop and support the necessary infrastructure, subcontracting with an established Medicaid

As part of its own health care reform efforts, Massachusetts provided multi-year grants to 51 community-based organizations including community-health centers, hospitals, and multi-service centers to hire outreach workers who offer education about health insurance, conduct outreach to potentially enrollees, and assist people with health insurance enrollment and re-enrollment. New York State operates a similar program where community-based organizations provide “facilitated enrollment” in the state’s health insurance programs for low-income persons including Medicaid.

provider could be a viable option. This arrangement would allow an organization to deliver services without having to devote resources to developing a billing infrastructure for example, because billing would be done by the contracted provider. Under this type of arrangement an organization would still have to deliver the service in accordance with any established service requirements (e.g. completing an initial assessment within one business day). It also does not waive requirements for the type of staff persons who can deliver a service (e.g. certified alcohol and drug counselor, nurse, etc.). However, subcontracting arrangements are often a good option for smaller organizations with experience in working with special or

underserved populations. For example, an organization with experience in working with people who are homeless might have the expertise to deliver substance use counseling services to people who have a SUD and are also homeless; but otherwise might not meet the qualifications to be a Medicaid provider (e.g. the state requires the provider to be a community mental health center). Even if such a provider met the Medicaid provider qualifications, it is also unlikely that the small volume of clients that the organization could serve through this program could generate enough Medicaid billing revenue to develop the necessary infrastructure (e.g. billing, documentation, etc.). In this case, subcontracting with a Medicaid provider who has a contract to provide substance use disorder services would make it possible for the provider to deliver this service without directly becoming a Medicaid provider.

When considering subcontracting it is important to also make sure that there are not any restrictions on subcontracting as is sometimes the case with certain services. It is also important to research established providers with whom you would like to partner, considering factors such as number of years serving Medicaid beneficiaries, financial solvency, experience with subcontracting, reputation in the community, and their operational and supervisory infrastructure. In negotiating a subcontract with an identified partner organization, it will be important to consider factors such as liability, how intakes will be managed, supervisory and reporting requirements, maintenance of medical records, how billing will be handled, and the fee that the contractor will charge for providing services such as billing.

Option 3: Making Connections

Many organizations simply do not want to directly provide Medicaid services or might not have the necessary infrastructure or qualifications to do so. However, most organizations that work with people with SUD recognize the important role Medicaid services play in helping them gain access to treatment services.

One option is to dedicate staff or other resources to facilitating people’s enrollment in Medicaid. Some states offer grants to community-based organizations so they can

What is a Health Insurance Exchange?

The ACA requires states to establish a health insurance Exchange by 2014. An Exchange is a “virtual marketplace” where consumers can go to shop for approved health plans. These Exchanges must also be coordinated with Medicaid to allow eligible people to apply for Medicaid through a state’s Exchange.

hire staff people to conduct Medicaid outreach and enrollment activities. Other states like Oklahoma, offer free trainings and technical assistance to community organizations who can then participate as “SoonerEnroll” partners. As a result of health care reform, there are likely to be a variety of new opportunities for community-based organizations and other groups who work with “hard-to-reach” populations, such as people who are homeless, to connect people with Medicaid. States are actively planning for and designing their health insurance Exchanges and activities related to the expansion of Medicaid, both slated for 2014. Learning about your state’s plans for health insurance outreach and enrollment is critical to ensuring that the needs of persons with SUD are considered in the design and development of these systems.

Conclusion

Health reform is transforming how SUD treatment services are purchased, financed, and delivered in this country. In particular, the Medicaid program will become an increasingly important purchaser of SUD treatment services. As such, learning about the Medicaid program in your state and the opportunities and challenges that exist for substance use providers is an important task in preparing your organization for the changes resulting from health care reform.

For More Information

See below for additional information about the Medicaid program and resources for providers on health care reform and working with managed care.

The Medicaid.gov website operated by the federal **Centers for Medicare and Medicaid Services** provides information about the Medicaid program including state-specific details on managed care enrollment, state plan amendments and waivers, eligible populations, and spending.

<http://www.medicaid.gov/>

The **Substance Abuse and Mental Health Services Administration’s** website details information about how health reform affects people living with mental health and substance use disorders. The site includes an archive of health-reform related webinars.

<http://www.samhsa.gov/healthReform/>

NIATx provides technical assistance, training, and resources for mental health and substance use providers on improving how care is delivered. The NIATx site includes resources such as a Third-Party Billing Guide and an interactive tool for assessing your organization’s readiness for health reform.

<http://www.niatx.net/>

The **National Council for Community Behavioral Healthcare** is a national mental health and substance use provider trade organization. The National Council is an excellent resource for tools and information about how to work with Medicaid and in a managed care environment.

<http://www.thenationalcouncil.org/>

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Appendix: Self Assessment for Evaluating Organizational Capacity and Readiness to Become a Medicaid Provider

Step 1: Identify Those Services that are Covered by Medicaid in Your State

The first activity will be to clarify what services are currently covered by Medicaid in your state. You can locate this information in your state's "state plan". Each state that operates a Medicaid program must have a state plan that serves as a "master document" outlining the features and functioning of that state's Medicaid program. However, the state plan is not the only place to locate information about a state's covered services nor should it be your only source of information. This is because states do not always have their plan available online. Even when they do, the plan might not always be up-to-date and can be difficult to navigate. In states with Medicaid managed care, a managed care organization's member handbook and website, might offer more accessible information about benefits for Medicaid enrollees.¹¹ Health New England, a MCO serving Medicaid enrollees in Massachusetts, has their [member handbook](#) available online, which details the covered services available to members.

A state or county's Medicaid provider manual or regulations governing the operation of their Medicaid fee-for-service program, can also provide the necessary details about Medicaid covered services. These manuals can usually be found on the state Medicaid agency's website. Florida's [Medicaid provider manuals](#) offer a good example of this. Conducting interviews with existing Medicaid providers, Medicaid staff, or a local trade or advocacy organization will also yield valuable information about a state's Medicaid covered services and benefits.

For each service you should gather the following information:

- **Who is eligible for the service?** Some services are only available to persons of a certain age (e.g., youth under 21) or gender (e.g., pregnant women). The clinical eligibility, sometimes referred to as the "medical necessity criteria" for a particular service is also important to learn about. Many places have adopted the American Society for Addiction Medicine (ASAM) Patient Placement Criteria for making decisions about eligibility for SUD treatment services.

- **What are the necessary provider qualifications?** Is the service limited to providers in certain categories such as hospitals, licensed clinics, or community mental health centers? It is important to distinguish here the *provider type* (e.g. clinic, hospital, nursing home, etc.) from the *practitioners* who can deliver the service (e.g. licensed social workers, physicians, licensed alcohol and drug counselors, etc.). For a service such as outpatient substance use counseling, eligible *providers* might be limited to those who are certified by a state's Department of Alcohol and Drug Programs as a substance use clinic. The *practitioners* who the clinic can then employ to deliver counseling services might then be further defined as those persons who are certified or licensed by the state to provide substance use counseling such as licensed social workers, or certified alcohol and drug abuse counselors. Both the allowed provider type and practitioner requirements are important to learn about for a particular service.

In states with managed care, learning the requirements of the managed care organization (MCO) for becoming a provider of the service is also important. Sometimes the MCO will have additional criteria that a provider must meet in order to gain entry into that MCO's network. These might include requirements about the amount of malpractice insurance the provider must have after-hours availability, or required staff or positions such as a Medical Director.

- **Where can the service(s) be provided/delivered?** Some services can only be provided in a clinic or a hospital setting. Other services can be provided in homes and other community-based locations, such as shelters.

¹¹ There are usually at least two Medicaid managed care organizations operating in a State or jurisdiction. Sometimes the mental health and substance use services are "carved-out" or subcontracted to another organization known as a managed behavioral health care organization.

- **How must the service be performed?** Some states and Medicaid MCOs have created specific operational protocols or specifications that detail the particular activities that must be performed by the practitioners of a service, such as completing a diagnostic assessment or developing an individualized service plan. As mentioned earlier, there are some activities that providers of a Medicaid service must perform, while other activities are not permissible. For example, [Title 22 of the California Code of Regulations \(CCR\)](#), specifies how providers of certain Drug Medi-Cal (DMC) services are required to deliver Medicaid covered substance use treatment services. Cross-walking these service descriptions with the activities performed by your organization will help you understand what adjustments will need to be made to how your organization currently delivers the service.
- **What is the current rate for the service and in what increments is the service billed (e.g. 15 minutes, per day, per hour, etc.)?** Knowing this information will help your organization develop a budget and business plan. It is important to note here that Medicaid managed care organizations set their own rates for the services they cover. If your organization is interested in contracting with more than one Medicaid managed care company, you should be aware that rates for the same service are likely to vary from company to company.

Step 2: Identify and Inventory Services Your Organization Offers

The next step is to crosswalk the services offered now by your organization with those that are reimbursable under Medicaid. In conducting this inventory of current services, you will need to clearly identify the various activities that are associated with each service. For example, if your organization provides “case management” services, what activities do staff perform as part of that service? Do they create a plan of care? Do they take people to doctor’s appointments? Do they help people search for housing? Understanding these components is critical because within a particular Medicaid service category there are some activities that *must* be performed. Under the Medicaid Targeted Case Management (TCM) option for example, case managers are required to perform certain activities, such as conducting an assessment to determine service

needs and developing an individualized plan of care. There are also activities that *cannot* be performed. For example, some providers offer assistance with job search, employment coaching and support, and pre-vocational counseling. Some of these activities may be reimbursable, depending on your state’s Medicaid plan; however, certain activities, such as teaching job specific skills, are never permissible under Medicaid.

Step 3: Learn about the Necessary Organizational Infrastructure

In addition to developing a picture of the Medicaid services and necessary provider characteristics, it is also important to learn about the associated activities and infrastructure that are required in order to successfully provide Medicaid services. Some organizations might need to make substantial adjustments to their operations and infrastructure in order to deliver Medicaid services. Some of these requirements include:

- **Record-keeping and service documentation:** All Medicaid providers must have a system (e.g. paper or electronic) for documenting Medicaid service activity. A state’s Medicaid provider manual and/or regulations can provide you with the requirements for maintaining medical records. All Medicaid providers are subject to audits by the state Medicaid authority as well any Medicaid managed care organizations you contract with. Providers that do not follow the requirements for maintaining these records are at risk of possible sanctions and/or re-payment.
- **Third-party billing:** For providers typically used to providing services under cost-reimbursement contracts or grant funding, learning how to bill Medicaid or a MCO can be challenging. Providers will need to have the necessary infrastructure and staff to: submit claims (sometimes to multiple Medicaid MCOs with different submission procedures); monitor service use against number of visits authorized or permitted; and manage and monitor staff productivity. The NIATx project developed an excellent [guide](#) designed to assist agencies in transitioning to third-party billing.

- **Insurance verification and eligibility monitoring:** In order for a provider to receive reimbursement for a Medicaid service, the individual who was the beneficiary of the service must be eligible and enrolled in Medicaid at the time the service was delivered. Unfortunately it is common for people to lose their Medicaid eligibility or experience a temporary gap in coverage. Rhode Island's Medicaid agency recently reported that 1 in 4 Medicaid enrollees experienced a gap in coverage during a 12 month period.¹² Providers must develop systems for keeping track of the Medicaid eligibility of the people they serve or risk having claims denied and money lost.
- **Quality management and compliance monitoring:** Medicaid providers must have strategies for monitoring the quality of services they deliver. Medicaid managed care organization's contracts with providers often contain provisions related to quality. Some require providers to collect and report data on a client's clinical functioning using standardized outcomes tools, or conduct regular client satisfaction surveys. In addition, due to the high risk of sanctions or financial penalties resulting from inadequate documentation, providers must devote resources to reviewing client records and training staff on proper billing and documentation procedures. In fact, under health care reform, as a condition of enrollment in the Medicaid program, providers must develop a compliance program

Step 4: Next Steps

If after reading this document and performing this self-assessment, your organization still wants to pursue becoming a provider of Medicaid services you should:

- Develop a leadership team at your organization who will help you prepare applications, compile information, get ready for site visits, and identify and plan for any necessary structural or personnel changes. This group should also serve as champions of your effort. It is not too early to begin talking with management and other employees about why (e.g. the vision and purpose) your

organization is pursuing becoming a Medicaid provider and helping them prepare for upcoming changes to the workplace.

- Obtain copies of any necessary licensing applications or provider enrollment packets. These should be used as a guide to help you develop a work plan. You should also contact your Medicaid agency to see if there are any information sessions or readiness materials. Most Medicaid agencies operate a Provider Services Center that is available to assist providers with questions.
- If you intend to pursue becoming a provider in a managed care network, contact the managed care company(s) to learn about their credentialing and application processes.

¹² Summer, L. and Mann, C. (2006). *Instability of Public Health Insurance Coverage for Children and Their Families: Causes, Consequences, and Remedies*. The Commonwealth Fund.