

**Pre-Application Technical Assistance Reports for the
Access to Recovery Grant Program**

Report on Technical Assistance to New Mexico

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Consultation between Erik Stone and Michael Allen and the State of New Mexico Written Report

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Introduction (Purpose of TA)

The State of New Mexico (the State) requested assistance with developing fiscal and cost accounting mechanisms for tracking the implementation of vouchers for the Access to Recovery (ATR) grant program. Under Task Order with CSAT, the American Institutes for Research (AIR) contacted Erik Stone of Signal Behavioral Health Network (Signal) to assist the State.

Methodology

The consultation took place via teleconference on May 21, 2004. Participants included staff from Signal Behavioral Health Network (Erik Stone and Michael Allen) and representatives from the State of New Mexico (Michael Coop, Elaine Benavidez, Pamela Kooster, Mindy Hale, and Pam Martin). The teleconference lasted approximately 1 hour. (For the background and experience of the two consultants, see the last section of this report.)

Content of TA Discussion

The State requested a review of the Lessons Learned slides from the presentation at the ATR technical assistance meetings. This formed the general structure of the TA provided on the conference call, with the consultants describing Signal's on-line authorization system for child welfare services in Colorado, which is conceptually similar to a voucher system.

Questions and answers from this consultation session are as follows:

Review of 1st lesson learned – “Make the system web-based”

No questions asked of consultants. New Mexico has already determined that a web-based system will be needed.

Review of 2nd lesson learned – “Build in ongoing system training”

No questions asked of consultants.

Review of 3rd lesson learned – “Have a simple rate structure”

NM: How many rates do you use?

Signal: For Denver County, we currently have rates for about 30 treatment services.

NM: Do you think that will be sufficient for treatment services throughout the State?

Signal: Yes, we think so. This is one area where HIPAA has helped us by forcing us to use HIPAA compliant codes and transactions. This resulted in simpler rate structures.

Review of 4th lesson learned – “Directly link the voucher to billing”

No questions asked of consultants.

Review of 5th lesson learned – “Develop detailed, standardized billing procedures”

NM: Do you create an electronic voucher that leads to electronic billing?

Signal: We use the word “authorization” in our system, but the concept is the same. Our authorizations are entered into our data system, linked to the admission and the subsequent services, and the bills are generated by the services entered into the system.

NM: Do the counties in your system want to review the voucher prior to billing?

Signal: Some do, some don’t. Of the counties who do want a review, some have a clinical review process where a team reviews the voucher before it is issued. Others have an administrative process where only one person reviews the voucher.

NM: Do you use an electronic signature?

Signal: No, we don’t. The system is password protected with Signal and providers controlling the passwords and their associated permissions. Only specific staff are able to issue authorizations.

NM: How does the voucher become a payment after services are rendered?

Signal: The issuer enters the voucher into our system. The provider is able to see the voucher in the system immediately after entry, but we require the issuer to contact the provider to inform them of the voucher. The provider contacts the client to arrange for admission. The provider then enters the admission data into the system and links it to the voucher. Services are entered at least monthly and are linked to the voucher and admission. The bills are generated from the services entered. Signal pays only for services entered into our data system. This has helped greatly with compliance on data entry.

NM: You pay every two weeks or once a month and then reconcile with the providers?

Signal: We pay once a month. Providers must enter services by the 10th day of the month following the month in which the services were delivered. We lock the system so that services entered late are not counted and generate the bill that we reconcile with the county. When we receive payment from the county, we pay the provider. We recommend that you be very clear with the providers about when they will be paid. We try to be very up front with our providers and tell them that they will be paid only when we receive payment from the county. And unfortunately we have some counties that do not pay in a timely manner.

NM: Under what circumstances, do you lock your system?

Signal: In terms of billing, we lock the system to prevent entry of new services after the deadline for monthly data entry. Then we reopen the system and services entered late

will show up on the next billing cycle. In terms of fiscal management, we would lock the system when the money is running short. We have the capability of locking out services by modality, by provider, or by county. Actually, we would probably not prevent entry of services; we would simply exclude them from our billing reports. And we have the capability to prevent new vouchers from being issued.

Review of 6th lesson learned – “Develop automated fiscal management reports”
No questions asked of consultants.

Review of 7th lesson learned – “Pay attention to confidentiality issues”
No questions asked of consultants.

Review of 8th lesson learned – “Expect extreme variation between providers”
No questions asked of consultants.

After the review of the Lessons Learned slides, the State asked additional questions.

NM: What did you do to develop minimum competencies among your providers in areas such as confidentiality?

Signal: We currently require that all our treatment providers be licensed by the State. And the State requires, in its treatment standards, compliance with confidentiality regulation. Signal also has its own Quality Assurance manual that incorporates many of the most important standards. And we incorporate those in our contracts with providers. In an ATR environment, you would not have contracts, but you would still need to communicate what your expectations and requirements are of the ATR providers. Also we held a lot of community and provider meetings when our system was first established to explain the system. We offer training on things we feel are important. For example, we require use of the Addiction Severity Index (ASI), the American Society of Addiction Medicine’s (ASAM) placement criteria, and a mental status exam for assessment of adult clients. We provide training on the ASI and the ASAM criteria. You might ask the New Mexico node of the Clinical Trials Network if they are willing to open up their ASI trainings to non-CTN people. Signal participates in the Rocky Mountain node, and we are able to do that.

NM: In your presentation, you estimated that you would need two FTE’s for each additional 10,000 vouchers added to your system. How did you come up with that? This seems like a lot.

Signal: It is a rough estimate, but we believe that with each voucher will come a variety of ongoing service requests. And it will take time, and hence money, to respond. For example, providers may identify problems in their bills that require action. Currently Signal provides minimal technical assistance, moderate levels of training and quality assurance and report functions, and high levels of data validation and cleaning. Higher or lower levels of these services would affect our estimate. Additionally, Signal hosts its own website and servers. A higher volume of data may require expenses, such as upgrading servers or adding a new one.

Signal: We haven’t talked yet about having a cap on the amount of the vouchers. Planning on what, if any, maximum amount you will have will be important in your fiscal management strategies. We also suggest that you consider how you will manage changes in levels of care and

the new vouchers needed for this purpose. In our system, this has been a significant issue. Typically providers issue the authorization for changes in levels of care. More recently counties have been requesting more oversight.

NM: Do individual providers have the capacity to modify vouchers?

Signal: Yes, in our current child welfare system.

NM: Does this raise issues about monitoring for fraud and abuse?

Signal: Yes, it does. However, we used to have a higher level of monitoring of this and did not detect any problems. And it takes a lot of staff time to do a good job of monitoring this activity. We could hire a staff member to approve and/or monitor changes in level of care. That would take away dollars currently earmarked for treatment, and we have not chosen to do that. In an ATR environment, where you are adding new providers and possibly providers with whom you have little familiarity, you may need a higher level of monitoring.

NM: How is this aligned with the ATR vision on choice?

Signal: The providers issuing the vouchers for new levels of care are instructed to use all the providers in the Signal system and to allow for client choice. However, in some areas, we have few providers from which to choose, so if we were in an ATR environment, we would have to tweak the system to encourage a full range of choices. Also, we do monitor the dollars going to different providers and will intervene if we think there is not an equitable distribution of funds.

NM: Perhaps we would need to closely monitor if providers are allowed to modify vouchers to permit higher dollar amounts.

Signal: Yes, you might. We also periodically look at the length of stay and the intensity of services. We were concerned that providers would be tempted to keep our child welfare clients in treatment longer than non-child welfare clients or to provide more intensive and unnecessary services. So far we have not detected those types of problems.

Recommendations

Signal appeared able to answer most of the State's questions. No specific recommendations for additional technical assistance were generated during the conference call. The State will take the information provided under consideration in designing their proposed ATR system.

Outcomes

The State did not indicate any need for further technical assistance on this topic and no further conference calls were scheduled.

Background of Consultants for the New Mexico TA Teleconference

Erik Stone, M.S., CAC III, is the Director of Compliance and Quality Improvement at Signal Behavioral Health Network. He has worked in the substance abuse treatment field since 1983 as a clinician, supervisor, administrator, and trainer. He is currently responsible for Signal's quality improvement and contractual compliance activities, which include such activities as provider site visits, credentialing procedures, and client and provider satisfaction surveys. He currently sits on Colorado's Clinical Advisory Group and has served on multiple State policy workgroups. He participates in the Rocky Mountain Node of NIDA's Clinical Trials Network and serves on the Board of Advocates for Recovery, a Colorado grassroots organization advocating for the recovery community.

Michael Allen, LCSW, CAC III, is the Director of Child Welfare Services for Signal Behavioral Health Network, a managed service organization which contracts with the Alcohol and Drug Abuse Division of the Colorado Department of Human Services to manage publicly funded treatment dollars for 34 Departments of Social Services and 18 service providers throughout the State of Colorado. As the Director of Child Welfare Services, Michael negotiates and manages contracts and memorandums of understanding between service providers and counties, provides services utilization review, oversees child welfare billing, and manages a child welfare substance abuse budget of approximately \$2 million. Michael has more than 10 years experience in the substance abuse treatment field, including direct service, program development, and administration. He has served on numerous local committees and task forces, including the Colorado Works Substance Abuse Task Force, Colorado Drug-Endangered Children Project, Preventing Adolescent Suicide in Colorado Initiative, and the Colorado Technical Assistance Grant Steering Committee with the National Center for Substance Abuse and Child Welfare.