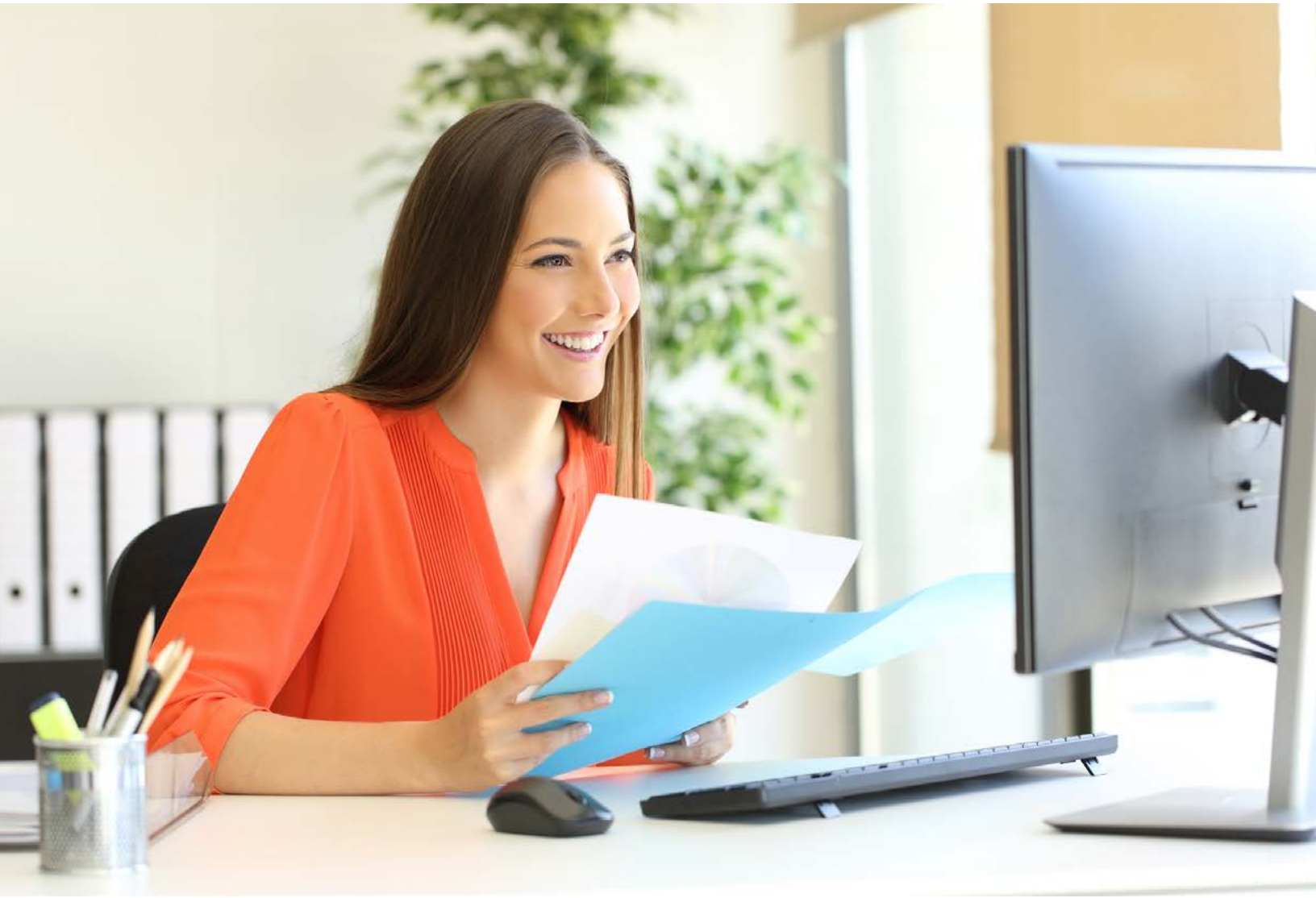
Billing and Information Technology:

A Toolkit for Behavioral Health Agencies

January 2018



The project described was supported by Funding Opportunity Number CMS-1G1-14-001 from the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. The contents provided are solely the responsibility of the authors and do not necessarily represent the official views of HHS or any of its agencies.

Introduction

The Healthier Washington initiative has set a statewide goal of financially integrating physical and behavioral healthcare, including substance use disorder (SUD) treatment, by January 2020. This change will impact billing processes, datasets, and electronic transactions. Behavioral health agencies (BHAs) will be required to send service billing information to the managed care organizations (MCOs) that will be administering these newly integrated services.

To prepare for the process changes, each BHA can:

- Complete an information technology (IT) and billing practice assessment
- Document its current state workflows/processes
- Identify gaps in process, IT capability and current state workflows

The materials provided in this toolkit are designed to assist BHAs in Washington State to assess their current state and gaps, create a transition plan and timeline to accomplish transition milestones, and prepare for a billing and IT transition.

Tools Included in This Kit:

Self-Assessment Tool

Transition Readiness Scoring Tool

Annotated Self-Assessment Tool

Transition Plan Template

Readiness Checklist

Capabilities Matrix

Getting Started

Begin this process using the Self-Assessment Tool to identify gaps and priority areas for attention as you begin this transition process.

If you are a facilitator or coach assisting an agency with this transition, the Annotated Self-Assessment Tool is designed to help you facilitate a productive assessment process.

The Transition Readiness Scoring Tool helps you evaluate your results from the Self-Assessment, and contains an optional dashboard to reflect multiple sites.

Then, review What Will Change Under the New Billing Model? to begin creating your transition plan.

What Will Change Under the New MCO Billing Model?

The table below lists differences in the current Behavioral Health Organization (BHO)-based reporting processes and the managed care organization (MCO) billing and reporting practices. It is based on a generic, managed care best-practice model. Specific details about data elements, formats, and other reporting requirements will be provided by individual MCOs.

In the table below, required process or system changes are outlined in the left-hand **Change** column with a corresponding **Impact** column suggesting actions that may be needed to meet the new requirement.

Process Change	Provider Impact
Each BHA will have its own electronic health record (EHR).	
Some BHAs are using medical record systems provided by the BHO and do not have an EHR of their own.	• Each BHA will need its own EHR[1] configured to meet the MCOs' requirements. • Each BHA will need to obtain support for its EHR by either using in-house staff or outsourcing system operations and data centers. • Historical client data in the BHO system may need to be extracted for the BHAs.
Each BHA will need to submit client and encounter data to each of the MCOs per the specifications of each MCO.	
The BHAs will not enter data into a single system but will be required to submit data to multiple MCOs.	• Each MCO may have slightly different requirements around data elements and batch editing requirements. The Washington State Health Care Authority (HCA) expectation is that MCOs will standardize to the maximum extent possible.
The service authorization procedures, from request through encounter submission, will be different. Not all services will require authorization.	• BHAs will need to revise authorization procedures based on each MCO's requirements. • The authorization procedure may require submission of requests via a HIPAA standard transaction (278) or through the MCO's provider portal.

[1]The Health Care Authority (HCA) encourages BHAs to consider the acquisition of certified EHR or Health IT technology. The Office of the National Coordinator for Health Information Technology (ONC) has established standard certification criteria for EHRs and health IT modules. Certified EHRs and health IT modules have been certified and found to meet the technological capability, functionality, and security requirements required by the Secretary of the U.S. Department of Health and Human Services and received certification by the Office of the National Coordinator (ONC). Certification can help providers considering the acquisition of an EHR system be confident that the EHR/health IT software has the capabilities the provider is considering acquiring, and that an EHR system is secure, can maintain data confidentially, and can work with other systems to share information.

Process Change	Provider Impact
Encounter data elements will be different. For example: • Reporting may be based on units instead of time. • Encounters will require a charge or cost. • ICD-10 procedure and diagnosis codes will be required in the majority of outpatient services.	• Each BHA will need its own EHR configured to meet the MCOs' requirements. • Reconfiguration of the BHA systems will be required to generate the encounters. • Templates used in the BHA's EHR may need to be changed to accept new procedure and diagnosis codes. • New guidelines for progress note documentation may need to be developed. • Staff will need training on new templates and procedures.
Encounters will be sent electronically to the MCOs for adjudication using standard HIPAA Electronic Data Interchange (EDI) transactions.	
BHAs currently send their service/encounter data to the BHO. The BHO submits the encounters to the State. Not all BHAs send that data to the BHO using a HIPAA EDI transaction. Additionally, some BHAs do not have the capability to generate a standard 837 encounter record. In return, the MCOs will be sending HIPAA standard transaction files that the BHA will need to upload into its systems. Not all BHA systems have the ability to upload these files into their EHRs.	• BHAs able to generate HIPAA EDI transactions for the BHO will need to reconfigure their systems to generate encounter EDI files to submit to the MCOs and receive transactions from the MCOs in return. • Procedures will need to be developed to monitor batch file creation and submission. Staff will need to be identified to monitor the data exchanges and will require training on the new procedures. • Some providers may have to acquire billing software and assistance to submit their encounters during an interim period until their systems can generate the required transactions. • Some providers may need to engage a clearinghouse to help them format and parse the encounters for the appropriate MCO. • All BHAs will need to run tests with each MCO prior to implementation.

Process Change	Provider Impact
Encounters will be adjudicated like claims and the results returned to the BHA.	
There will be more edits applied to the encounter data BHAs submit to the MCOs than prior BHO edits. The BHAs do not typically see the complete error reports that their BHO receives from the State. The BHO will take care of errors that are within its ability to correct. Errors the BHO cannot correct will be sent back to the BHA for review and correction. The MCOs will require more data elements in the encounters.	• All of the BHA systems will need to be modified to accept and apply the 835 transaction that will be returned post-adjudication. • All BHAs will need to establish a procedure to review the error files. Staff will need to be assigned to monitor the errors and distribute them to appropriate staff. • All BHAs will need to test their processes prior to implementation.
Rejected encounters must be corrected and resubmitted to the MCO.	
In the future, the BHA will be solely responsible for ensuring that all encounters are submitted to the appropriate MCO. Not all BHAs have control processes established to monitor service submission and acceptance to the BHO and the State. The BHAs are not tracking all service submissions to ensure that all services are forwarded on to the BHO and the State. The only checks that exist are the encounter data validation studies conducted annually by the BHOs and the State's EQRO contractor. Encounter data that are not complete or accurate will result in decreased payments to the MCO and BHA.	• Each BHA will need to establish reconciliation processes to track encounter submissions and the results. • New procedures will need to be created, and adequate staff will need to be assigned to correct and resubmit rejected encounters. • Each BHA will need to establish control processes to ensure that all services are reported and accepted by the appropriate MCO in the form of encounters. • Each BHA will need to create new reports to track encounter submissions and their results, and may wish to modify their systems to create these reports. • Each BHA will need to alter financial systems and reports to accommodate the encounter adjudication process. • System modifications may be required to eliminate systemic re-occurring encounter errors. • Each BHA will need to be able to respond in a timely manner to reporting requirement changes in the encounter data or risk increased rejected encounters.

Process Change	Provider Impact
Providers will be required to perform third-party liability (TPL) billing.	
The BHAs vary in their ability to bill TPL and private-paying clients. Not all TPL is being billed prior to submitting service data to the BHO.	• Each BHA will have to modify its systems and procedures to ensure that all other insurances are billed prior to submitting the encounter to the MCO. • Each BHA will need to modify its encounter generation processes to include the results received from TPL processing.
Non-Medicaid services delivered to Medicaid clients will be reported to the MCOs.	
Not all non-Medicaid services are reported to the BHO.	• Each BHA will have to modify its systems to ensure that all services to Medicaid clients are submitted to the MCOs as encounters, per the specifications of each MCO.
Providers need to have a National Provider Identifier (NPI) and be registered with the Washington State HCA.	
Not all non-Medicaid services are reported to the BHO.	• Each BHA will need to review its NPI status and submit provider data to each MCO per MCO requirements. The impact from this element should be minimal. • Credentialing processes may vary among the MCOs. BHAs may have to establish new processes to track deadlines and expiration dates.
Providers need to have a National Provider Identifier (NPI) and be registered with the Washington State HCA.	
Each MCO may have unique reporting requirements.	• Each BHA will need to be prepared to extract data and generate reports from its systems on a routine and ad hoc basis.

Utilizing the Transition Planning Template will help articulate the transition steps, task owners, and timeframe to create a roadmap to guide your agency through the necessary processes.

Utilizing the additional toolkit components as needed, take the information you have gathered throughout the toolkit and complete the Readiness Checklist in order to create a final timeline for milestone completion throughout the transition period.

Key Billing Processes

Revenue cycle management (RCM) is the current business term for the process of billing for patient care and ensuring that all services are billed as appropriate. The revenue cycle (RC) encompasses more than just the act of billing or reporting a service as an encounter. The Healthcare Financial Management Association (HFMA) defines the RC as "all administrative and clinical functions that contribute to the capture, management, and collection of patient service revenue." In the managed care environment, this includes verifying eligibility, recording service information, billing claims or submitting encounters, and correcting denied claims and encounters.

The table below highlights steps in the RC relevant to behavioral health agencies (BHAs) in managed care networks. It is intended to serve as a guide for the BHAs transitioning to the integrated managed care payment environment and stimulate thinking about how these processes can be integrated into a BHA's current business model.

The billing processes and payment mechanisms for managed care organizations (MCOs) will be defined in the individual contracts with each BHA. This document assumes that many MCOs will require "encounters" that will not be tied directly to a payment for each service performed. In some cases, an MCO may wish to pay on a fee-for-service basis that requires a BHA to submit "claims" for payment rather than an encounter. This document also assumes that fee-for-service claims will be required when billing other insurers, including commercial payers. The processes for submitting encounters or claims are the same, although details about the file submission process and file contents will differ. Each MCO and insurer will provide those details.

Key Processes and Activities in the BHA Revenue Cycle	
RC Process/Step[2]	**Description of Role/Characteristics/Function**
1. Initial Contact (Client presents for evaluation and/or treatment or contacts via telephone.)	***Activities:*** • Verify eligibility and/or insurance coverage. ▪ If Medicaid, identify MCO responsible for the client. • Remind the client to bring all insurance information and other documents to appointment. • Determine if prior authorization is required for the requested service. ▪ If yes, submit request for authorization, per payer guidelines. ***Notes:*** • Some practice management systems have the capability to automatically verify eligibility and insurance information.

[2]The HCA recommend that BHA's considering the acquisition / upgrade of EHR systems take into account the steps identified in this Toolkit as they identify some of the requirements that the BHA will need from an EHR system. As identified in this table, there is an interdependency between billing systems and information captured in patients' health records. Increasingly, BH billing systems are integrated with and EHR systems. Please refer to the section on Purchasing an Electronic Health Record: Factors to Consider.

Key Processes and Activities in the BHA Revenue Cycle	
RC Process/Step	**Description of Role/Characteristics/Function**
2. Appointment Check-in (Client Registration)	***Activities:*** • Re-verify eligibility and/or insurance coverage. • If Medicaid, re-verify MCO enrollment. • Ensure prior authorization requirements are met and on file. • Obtain other insurance information (if any). • Record insurance information in the EHR and/or scan/copy insurance cards. • If initial visit, complete all registration forms and collect all required demographic information. • Record information in the EHR and/or add to paper medical chart. ***Notes:*** • Obtaining other insurance information may be a new step for BHAs. It is required by the MCOs and essential for coordination of benefits. Medicaid is the payer of last resort. All other insurers must be billed for the service prior to submission to the MCO. • Consult with each MCO for its guidelines on billing other insurers or third-party liability. • There is potential for members to be enrolled as "behavioral health services only" with an MCO. Be sure to check for appropriate eligibility.

Key Processes and Activities in the BHA Revenue Cycle	
RC Process/Step	Description of Role/Characteristics/Function
3. Document Services	***Activities:*** • Deliver service to client. • Update notes and documentation in the EHR (and/or paper client chart). • Ensure a valid diagnosis(es) and procedure code(s) are present in the record. • Ensure provider sign-off on medical record notes. • If necessary, ensure second-level reviewer sign-off. ***Notes:*** • Off-site services and telephonic services also need to be captured in the EHR using the same guidelines. • After the service is completed, the clinician will update the EHR. Use of templates for documenting services is controversial but if used wisely can ensure that notes support billing codes. ▪ Template design and use may require technical assistance from the EHR vendor. • EHRs often provide the ability to develop templates for documenting services. Templates, when used properly, can ensure that the service documentation supports the procedure codes, diagnosis codes, and treatment plan goals. Defining and configuring templates may require technical assistance from the EHR vendor and/or subject matter experts to ensure compliance with documentation standards and regulations.

Key Processes and Activities in the BHA Revenue Cycle	
RC Process/Step	**Description of Role/Characteristics/Function**
4. Encounter/Claims Billing Preparation	***Activities:*** • Review the service, and edit and format it into an encounter. • Ensure that all services are documented and appropriate payersare assigned. ▪ Compare staff schedules to the services reported and/or the medical notes to ensure that all services are being submitted to the appropriate payer. • Correct any errors that are flagged by the EHR's error checker during the creation of the encounter/claim. Notes: • Most EHRs can be configured to create encounters. Configuring the system to create the encounter may be done by on-site IT staff or it may require assistance from the EHR vendor. • Many practice management systems' front-end edit capability will check for required data elements and procedure code/ diagnomatic checks performed, such as checking for the level of staff performing the service, i.e., a PhD may be required by Medicare to perform a specific procedure. These edits follow federal and State guidelines. • Ensure current timely filing deadlines for each payer are known and followed. • Errors detected during the edit process need to be corrected as quickly as possible to meet timely filing deadlines. It is critical that a staff member be assigned to monitor the submissions, identify the problems, and see that they are resolved. • Organizations using paper medical charts usually use encounter forms that are submitted to a billing specialist or data entry clerk.

Key Processes and Activities in the BHA Revenue Cycle	
RC Process/Step	**Description of Role/Characteristics/Function**
5. Encounter/Claim File Submission	***Activities:*** • Prepare the encounter/claim file and submit it to the payers. • Alternatively, submit service data to a clearinghouse to create the encounter/billing file for the appropriate payers in the acceptable format.
6. Receive and Review Results (Transaction Posting)	• Receive the MCO transaction file containing the results of the encounter/claim processing. • Upload transactions to either the EHR or billing system. • Match records to the encounter/claim records sent. ▪ Automated claim posting is a feature of many practice management billing systems. • Review error records returned. • For fee-for-service claims, post payments to the accounting system and client records. Initiate process to bill/report service to secondary payer.

Key Processes and Activities in the BHA Revenue Cycle	
RC Process/Step	Description of Role/Characteristics/Function
7. Denial/Rejection Management	***Activities:*** • Review and research errors from rejected claims/encounters. • Track errant encounters/claims to ensure that they are corrected and resubmitted per the payer's guidelines. • Initiate process to resubmit errant encounters. • Initiate process to submit encounter/claim to secondary payer. • Recheck eligibility on encounters that were incorrect due to eligibility issues. Resubmit encounters for services when eligibility is updated retroactively through update processes. ***Notes:*** • Timely action is critical in this step. Many of the errors will need to be corrected by the clinician who performed the service. A staff member should be assigned to monitor the returned files and oversee the correction process. • It may be necessary to file and appeal with the payer when wrongfully denied. • A denied claim may have to be written off in the financial system when it cannot be resolved. Each BHA will have to develop guidelines about when to write off unpaid claims. The guidelines must be in line with the agency's mission, finances, and staffing situation. • A staff member capable of producing ad hoc and routine reports from the EHR database may be required to assist in the correction process.

Reconciliation Processes

Reconciliation processes are very important in managed care or value-based arrangements. Unlike traditional fee-for-service billing, there may be no financial payments per encounter reported to post to the organization's accounts receivables. To ensure that all services are submitted to the appropriate payers and they have been accepted, it is important to institute reconciliation processes at various points in time. The chart below describes these conditions.

Fee-for-service claims are paid as the claim is processed by the MCO or insurer making payments; these services are easier to track and compare to financial transactions. It is still important to institute reconciliation processes to ensure that all services delivered have been reported to the payer via a claim or an encounter transaction.

Reconciliation Process	Reconciliation Process Description
1. Compare Encounters to Services Delivered Pre-submission to MCOs	• All Medicaid services delivered should have an associated encounter or claim. This includes non-covered services for Medicaid clients. Non-covered services still need to be submitted to the MCO. It is important for rate setting purposes and for consideration for future coverage. • Establish an internal reconciliation process to ensure that all services delivered are submitted to the appropriate MCO or third party. • This reconciliation process can be performed daily, weekly, or monthly. Most EHRs have the ability to generate reports to assist in this process. • Reconcile the services documented in the EHR with the services that were prepared for submission to the MCOs. Research and correct any discrepancies.
2. Compare EHR Encounters to MCO Encounters	• Ensure that the MCO has accepted and processed all of the encounters submitted by the BHA. • Obtain a report of encounters in the MCO database for the BHA. • Generate an internal report of encounters submitted to the MCO. • Compare the reports and research the discrepancies. • This MCO comparison step should be performed monthly. • If Medicaid, verify MCO affiliation.
3. Compare Encounters with ProviderOne (State)	• Ensure that the State has received all of the BHA's encounters submitted by the MCOs. • The MCOs should be reconciling monthly with ProviderOne and sharing the results with the BHAs. • Work with the MCOs to ensure all of the data have reached the State database. • Assist the MCOs with resolution of the omissions and errors.

Staffing Considerations

The table below lists billing process roles to be performed by staff at the BHA. The role descriptions are not intended to be job descriptions. They are descriptions of roles and functions that are needed to complete the billing process. They are intended to serve as guidelines for specific responsibilities specifically assigned to staff. The number of staff needed for each role will vary by organization. In some organizations, one person may be accountable for two or more of these roles. Other organizations may require multiple full-time staff serving in one of these roles, depending on size, locations, and client population.

Role/Function	Description of Role/Tasks
Eligibility Verification	• Medicaid eligibility verification needs to be performed at initial contact and at check-in for each appointment or service delivered. • For continuing clients, eligibility should be rechecked at the beginning of each month to ensure the client is still eligible. ***Ways to verify eligibility:*** • Eligibility may be looked up online in ProviderOne. • An MCO provider portal may be available for eligibility look-ups. Check with each MCO for access. • Monthly eligibility files from the MCOs may be available. These files can be uploaded into the EHR or into a separate file for agency use and reporting. Check with each MCO for availability. • Automated batch file inquiries to the MCOs and/or ProviderOne may be available. Check with each MCO for availability. ***Tasks:*** • Look up eligibility information online as indicated above. • It may be necessary to file and appeal with the payer when wrongfully denied. • Monitor eligibility of continuing clients, including proactively checking monthly file updates to ensure that current clients are still eligible.

Role/Function	Description of Role/Tasks
Insurance Verification	• Other insurance information should also be verified at initial contact and appointment check-in. ***Ways to verify insurance:*** • Online verification on individual insurance sites may be available. Check with each insurer for availability and access. • Verification may be conducted via a telephone call to the insurer or their agent. • An MCO provider portal may be available for eligibility look-ups. Check with each MCO for access. ***Tasks:*** • Confirm insurance coverage for clients. • Obtain billing information for other insurers.

Role/Function	Description of Role/Tasks
Billing Specialization	• Individual(s) within the organization need to be responsible for the generation, submission, and final resolution of claims and encounters. • These individuals should be knowledgeable about the detail of billing procedures. • They should also be knowledgeable about the detailed rules for completing and sending claims to each of the insurers billed. ***Tasks:*** • Prepare billing files of claims and encounters. • Review medical records to ensure that all services are reported. Ensure that procedure codes and diagnosis codes are aligned with the documentation in the client record. • Monitor claim and encounter file submissions. • Review rejected claim and encounter reports. • Research and resolve errors in rejected encounters and claims. • Ensure all encounters and claims are resubmitted after correction. • Serve as the liaison to insurance companies to resolve all billing issues.
Data Analysis/Report Generation	• Generation of standard and ad hoc reports is required to successfully manage the billing process and reconcile databases with payers. ***Tasks:*** • Create and generate reports to assist in reconciling encounters with MCOs. • Create and generate reports to assist in researching claim and encounter errors. • Research medical record documentation and client records in the EHR.

Role/Function	Description of Role/Tasks
Reconciliation of Encounters/ Claims	• Reports from the payer need to be compared to the data in the EHR to ensure all services are reported and that the databases are synchronized. ***Tasks:*** • Run comparisons of data files from different sources and review the results • Resolve discrepancies in the comparisons. • Work with contacts at the MCOs and other payers to resolve the discrepancies. • Individuals within the organization should collaborate with clinical and administrative staff to specify the functionality needed from EHR systems and understand how needed functionality will fit into/impact clinical workflow. See discussion below on "Purchasing an Electronic Health Record: Factors to Consider."
End User Support	• Individuals within the organization need to be available to provide immediate assistance to EHR users and answer questions about how to document services and update client records. • This may be a clinician, or a member of the administrative or IT staff, who is trained and knowledgeable about using the EHR. ***Tasks:*** • Respond to questions and problems from end users on how to use the EHR. • Triage requests for help from end users and escalate the request to IT staff or the vendor when appropriate. • Serve as the liaison to the EHR vendor and/or IT staff. • Develop best practice procedures for using the EHR and entering data. • Provide recommendations on enhancements to the system. • Provide training on functions and features of the EHR as needed. • Test new features and versions of the EHR software.

Role/Function	Description of Role/Tasks
EHR Support and Maintenance	• There should be individuals within the organization with administrative rights to the EHR who have some configuration capabilities and can maintain user profiles for access to the system. • They should also have the ability to schedule system updates and serve as liaisons to the EHR vendor and IT staff. They may be IT staff or hold other positions within the organization. ***Tasks:*** • Serve as liaison to the EHR vendor. • Recommend changes to the system for improvement in billing functions. • Keep current in changes to the EHR and communicate those changes to staff. • Configure system functionality such as billing templates, access profiles, valid values in edit tables, and error messages. • Apply updates to the EHR according to vendor instructions. • Organize tests of new versions of the system software and interim patches to the system software.

Purchasing an Electronic Health Record: Factors to Consider

Evaluating and Selecting a Behavioral Health Electronic Health Record[1]

The number, variety, and complexity of behavioral health electronic health records (EHRs) in today's market has made the procurement effort complex and sometimes intimidating. A deliberate and careful process for defining your agency's needs, priorities, technical abilities, and budgets—and evaluating those vendors best aligned with these requirements and constraints—will allow your organization to move knowledgeably and confidently toward a procurement of an EHR that will work best and meet the clinical and financial needs of the agency as you transition to an integrated MCO reimbursement model. The following milestone tasks will provide an effective, proven framework for ensuring your agency makes the best-informed procurement decision.

Form a Procurement Team

The EHR you choose will have a significant impact on all areas of your agency, so it is wise to include key individuals from all departments/areas in your system evaluation, selection, and implementation efforts. Optimally, the team should include a representative from the clinicians, administrators, front and back office operations, and technology team; if the agency is affiliated or part of another entity, a representative from that organization should be included as well. The team members selected should be enthusiastic, analytical, organized thinkers, and comfortable with the use of computers and technology. Last, your team members need to have the time to effectively participate in the process. This may mean occasionally providing interim support for their daily responsibilities to allow them the time to dedicate to the success of the project.

Ensure That Procurement Team Members Have an Understanding of Typical EHR Capabilities, Including Practice Management Functionality

While it is likely that most members of your agency's team have a working understanding of EHR functionality, it is important to ensure the team begins with a common basic understanding of modules, capabilities, and options available within EHR systems. This will be key in thinking through workflow implications, defining specific requirements, and envisioning future system use. Obtaining a common platform of understanding can be effectively accomplished through any of the following:

- Discussion with other agencies about their EHR experience
- Assigned reading of common, current articles on EHR features and implementation considerations
- Reviews of posted web-based demonstrations (not vendor coordinated)

[1]The Health Care Authority (HCA) encourages BHAs to consider the acquisition of certified EHR or Health IT technology. The Office of the National Coordinator for Health Information Technology (ONC) has established standard certification criteria for EHRs and health IT modules. Certified EHRs and health IT modules have been certified and found to meet the technological capability, functionality, and security requirements required by the Secretary of the U.S. Department of Health and Human Services and received certification by the Office of the National Coordinator (ONC). Certification can help providers considering the acquisition of an EHR system be confident that the EHR/health IT software has the capabilities the provider is considering acquiring, and that an EHR system is secure, can maintain data confidentially, and can work with other systems to share information.

It is very important that this exercise be clearly understood by all team members as an educational process only, rather than an evaluation process where preferences are determined. This is a beginning step, and there remains more to learn before choosing a system or vendor.

Ensure That Procurement Team Members Have an Understanding of the BHA's Current State, Desired Future State, and Gaps (both operational and technological, especially as related to the transition)

It is not uncommon for staff to have a working awareness of the processes they interact with, and less understanding of those that fall outside of their immediate purview. Therefore, it is advisable to spend some time familiarizing your team members with the full set of current clinical and operational workflows and processes used in handling a patient visit, from reception, through clinical care, to billing and reimbursement and reporting requirements. Once the team has an understanding of the flow of paper forms and/or information within the current system and the sharing of that information internally and externally, they can begin to identify opportunities for improvement and change through implementation of an effective EHR.

When envisioning EHR system use and redesigning work processes for a "future state," you will want to address all processes in the lifecycle of a care episode. These processes commonly include:

- Intake
- Eligibility/Authorization management
- Client scheduling
- Assessments
- Treatment planning
- Progress notes
- E-prescribing
- Medication management
- Laboratory results
- Medical records
- Case management
- Utilization review
- Billing
- Claims processing
- Electronic remittance posting

- Financial management (e.g., GL or A/R)
- Financial reporting
- Analytical reporting
- Other reporting (e.g., State, compliance)

For the revenue cycle workflows, much of the effort in documenting the current state, envisioning the future state, and identifying the gaps will be completed once your agency has worked through the Self-Assessment Tool included in this toolkit.

Ideally, a set of workflow descriptions, either diagrams or written lists, outlining the optimal flow for electronically supporting each process, should be developed and discussed. These descriptions, and the understanding gained from developing and discussing them, will create the best possible framework for identifying the specific EHR requirements for your agency, and establishing priorities among requirements.

Carefully thinking through how each of these workflows would be accomplished using an EHR will help you to identify optimal staffing and organization, needed clinical documentation content, outputs, interfaces, alerts, and external access requirements.

Define Your EHR Requirements and Create a "Capabilities Matrix"

Based on your agency's needs and longer-term operational goals, specific features and functions of EHRs will be more important to your agency than others. Understanding and identifying those EHR features required by your agency will help you focus on these during the system selection process, especially when demonstrations and discussions pull attention to the "bells and whistles" versus "must-have" needs. Most systems will have similar functionality (e.g., laboratory results); the difference will be in how they achieve that functionality. So when you define your requirements, the more specific the definition of how the requirement is achieved (e.g., allows electronic receipt of lab results into each ordering clinician's in-box with special flagging of urgent and abnormal results for immediate attention), the easier it will be to keep in mind the full needs and expectations when viewing alternative systems.

In addition to the functional requirements, it is important for the agency to understand the technical capabilities and requirements of the vendor's system, as well as to specify the technical requirements that the agency may have. Although most behavioral health system vendors now offer "cloud-hosted" solutions, there are still technical requirements, including system platform (e.g., network and system operating standards), network communications options (e.g., wireless vs. cables), input devices or methods (e.g., voice recognition capabilities, touch screens and tablets, smart phones, and PCs), workstation requirements, other equipment, security, interfaces, and data ownership, as well as system control needs that must be articulated.

Additional vendor expectations in terms of business focus, depth of knowledgeable resources, breadth of client base, financial status, research and development plans, etc., should be clearly articulated to help your team gain insight into viability of vendors for a long-term relationship. It is also important to clearly define the expectations your agency has of a vendor in terms of implementation and ongoing customer support, contract stipulations, interface development tasks, data conversion support, etc., to serve as a checklist for vendor discussions.

The last step is for the team to package these requirements, including functionality, technical, and vendor expectations, into a checklist or "capabilities matrix" (see sample Capabilities Matrix), with room for a written vendor response.

An example of the functional and technical requirements of EHR systems that will be important for a BHA to consider is the need for health information exchange with external partners (e.g., physicians, acute care hospitals, other behavioral health/social service providers). The HCA encourages providers to use certified EHR technology (CEHRT) systems that support the creation and exchange of standardized/interoperable documents (e.g., summary of care records (i.e., Continuity of Care Documents (CCDs), e-prescribing, electronic referrals).

To learn more from HCA regarding CEHRT requirements and availability, visit healthit.wa.gov or email HCA's HealthIT team at healthit@hca.wa.gov.

A Message From the Health Care Authority

The HCA designated OneHealthPort (OHP) as the statewide health information exchange organization in Washington. By signing-on to OHP services, OHP can assist BHAs with health information sharing tools and capabilities. Providers who use CEHRT and sign-on for services with OHP are able to send health information (e.g., CCDs) to the CDR and access claims, and prescription drug monitoring and other health data. Exchanging information via OHP services requires the BHA's EHR to have one interface/one connection (to the CDR) rather than multiple connections to multiple provider EHR systems. Reducing the number of needed interfaces/ connection points reduces the cost of an EHR system. To learn more about OHP and the services they provide, visit OHP's website at www.onehealthport.com.

The CDR is currently collecting production data and is available for testing by submitting organizations, and is expected to be open for use by providers with an HIE agreement who are registered (signed-on) with OHP in the Summer of 2018.

Talk with Other BHAs and Survey the Behavioral Health EHR Market to Get a "Short List" of Four to Five Vendors. Send Capabilities Matrix to Vendors.

The number of EHRs on the market is significant and ever changing, with mergers, acquisitions, and sunsetting of products occurring on a regular basis. Systems vary significantly in terms of ability to handle different mental health services, technology, scalability, and integration. The effort involved in adequately evaluating EHRs is significant, so narrowing the field of options to four to five EHRs that most effectively address the key priorities of your agency is critical.

One of the best ways to narrow the field of vendors is to talk to other similarly situated agencies. Ask them about the system they use or those they considered, as well as their current and procurement experiences. System reviews and comparisons are also compiled by mental or behavioral health associations and industry groups. By comparing the list of priority requirements you have defined to the ratings of system capabilities provided in these materials as well as through discussion with other BHAs, the team will be able to narrow down the vendors and systems with the initial best match for their needs. These vendors will represent the "vendor short list" of candidate systems warranting more detailed investigation. It is to those vendors that the BHA will send its capabilities matrix in order for the vendor to respond.

While most vendors are not overly willing to respond to a request for proposal (RFP) or request for information (RFI) from potential clients, especially smaller agencies, they typically become more open to this effort once they understand that, through an informed process, they have been selected as a "semi-finalist" vendor and that they will be asked to demonstrate their product. Further, ask these similarly situated agencies questions concerning whether the vendor provides implementation support, and if so, how and at what cost; and how responsive the vendor is to system modifications and at what costs. Ask each vendor on the short list to respond to requirements in writing prior to the demonstration of their system. The responses will yield more information as to vendor capabilities, and will point the team toward areas that need further clarification during the demonstration process. The written responses can also be used as part of the contract.

While not ideal, as an alternative to a written response to the capabilities matrix, it may be possible to schedule a longer period of time to go over and discuss each of the specific requirements during the vendor demonstration.

Know Your Total Costs

Be sure to discuss costs with those vendors who are under serious consideration, and do so—at least at a high level—fairly early in the evaluation process. These discussions should include estimates for license fees, subscription options, projected implementation and training, technical support, customized reports, interfaces, and any additional consulting fees that the vendor predicts might be required. Once the field of systems and vendors has been narrowed, the team can validate the various cost components with other similarly situated organizations that have implemented the systems under consideration.

Addressing costs early in the evaluation process will prevent the team from arriving at a selection decision only to find that the preferred system is beyond the budget of your agency. Knowing the financial constraints of your agency and determining vendor cost estimates as early as possible will help the team focus on the vendors and system options (e.g., modular-based systems where components can be added over time, alternatives for hosting and maintaining the system, etc.) within appropriate budget parameters. The team should keep in mind, however, that initial vendor cost quotes are "list prices" that can be negotiated to some extent. Vendors are very motivated to sign for new business and are often willing to devise creative pricing alternatives and favorable financial terms that will allow your agency to move forward with a contract.

Conduct Effective Demonstrations

System vendors are anxious to have the opportunity to show their products to prospective customers, and they may encourage you to schedule a demonstration as soon as possible. However, by preparing appropriately for this key step in your evaluation process, you will be in a position to make the best use of your time—and theirs—and gain the most information possible to help in your system decision.

Before scheduling a demonstration meeting, the team should carefully prepare a set of demonstration scenarios that address the specific types of visits and envisioned workflows of your agency.

Scenarios should address all aspects of use of the system, from intake through clinical care and billing for services, to ensure all key issues, data requirements, interfaces, and hand-offs of data are clearly demonstrated. Scenarios should also include examples of the more unusual circumstances faced by your

agency, including crisis situations, cancellations, etc. It is important to provide these scenarios to the vendors several weeks in advance of the scheduled demonstration dates to give them time to prepare. All demonstrations should be scheduled to occur within a few weeks of each other to leverage the memories of participants and help make comparisons easier.

Prior to the first demonstration, your team will need to develop an evaluation form to help participants document their findings (both positive and negative) and what items remain as open questions. It is very easy in the course of a demonstration to become focused on some functions and options and to forget others that may be equally critical. Also, vendors are careful to demonstrate their products in such a way as to highlight the strengths and hide or avoid exposing the weaknesses. Using both your initial requirements checklist and an evaluation tool that follows the prepared scenarios and allows space to capture impressions, questions, and concerns will help the demonstration participants ensure all scenarios are addressed and track their findings. It is wise to have as many individuals as possible from your agency involved in the demonstrations to help ensure that all perspectives are considered, and to help garner support through their involvement in the decision-making process. It is important that all participants ask questions, seek clarification, and document as much information as possible during the demonstrations. These individual documented evaluations will serve as a key component for final "apples to apples" comparisons of systems, and will also serve as an excellent source of information to jog memories following a number of varying demonstrations.

Check Vendor References

Reference checks at vendor client sites using the same product your agency is considering will provide a valuable opportunity for gaining insight into the effective use of the system in a "live" environment, as well as into the satisfaction with both the system and the vendor. Client sites are usually very willing to share their perspectives and "lessons learned," especially with a peer (i.e., provider to provider, biller to biller). It is valuable to query the references on how well the contract process and implementation efforts went with the vendor. This information will help in your final decision, in setting realistic implementation timelines, and in negotiating appropriate safeguards in the contract.

Visit a Client Site Using the EHR

Additional insight into how well the vendor and the system will work for your organization can be gained by visiting vendor system clients whose sites are most closely related to your own business structure and operations. These visits allow the team to observe the systems in use and question system users on vendor and operational issues and concerns. Additionally, if you decide to pursue a contract with the vendor, these visits provide an excellent opportunity to form relationships with other people who are already familiar with the system and implementation process. These contacts will be an excellent source of information and support as you proceed with your own implementation.

Reconfirm Key Issues and Understandings

Following reference checks and site visits, a number of questions will need to be clarified with the vendor(s). It is recommended that these questions be posed in writing, noting that the responses will be included in the final contract as binding. Additionally at this time, your team should have a clearer perspective on the equipment, implementation approach, conversion requirements, and other elements that are needed to obtain a reliable set of final quotes for licensing, implementation, hardware, etc. The team should reconfirm initial price quotes and clarify that all components discussed and shown du ring the demonstrations, and provided in response to capabilities/requirements questions, are included in the costs. This will set the baseline for price negotiation and help protect against unexpected add-ons during negotiations or at a later date.

Make Your Decision with Confidence

The above due diligence process includes all the critical steps to guide your procurement team in gathering the best vendor and EHR information possible, effectively comparing options, and gaining a comprehensive understanding of how the leading systems will work within your agency. All systems and vendors will have some shortcomings as well as some excellent features, and there will always be some trade-offs. What is critical at this stage is to make a decision and go forward with confidence and commitment.

The final decision should be based on a thorough review of the evaluation scores and information collected for all areas—functionality, vendor viability, technology, reputation with clients, supportiveness during the evaluation process, and cost. One vendor will invariably lead in the final vote. If the team and your agency are confident in the evaluation process and committed to making the system and the relationship with the vendor work, the groundwork for success is in place.

Negotiate Knowledgeably

Negotiating a successful contract with a systems vendor requires much more than just achieving favorable financial terms. License fee, maintenance, implementation, support, acceptance, payment terms, and other details must be spelled out carefully in the formal written agreement. Legal support during the negotiation process is strongly recommended. A clear, thorough contract will ensure a positive start to your relationship with the vendor and help avoid misunderstandings later.

The content in Purchasing an Electronic Health Record: Factors to Consider was adapted from content originally published by the Doctors' Office Quality-Information Technology Project (DOQ-IT) and previously distributed by Qualis Health.

Additional Resources

More detailed resources and accompanying tools for selecting and implementing new information systems can be found on the following websites:

The Office of the National Coordinator (ONC) for Health Information Technology provides a step-by-step guide to EHR implementation.

The Center for Integrated Health Services offers several documents that can be useful during EHR implementation, including a guide to key contract terms for EHR contracts.

The National Rural Health Resource Center Toolkit contains a magnitude of tools and resources covering a wide range of topics, including EHR security, an EHR roadmap, functional requirements, hardware and software, IT staffing, medication barcoding, issues management and change control, interoperability, overcoming health information technology barriers, process mapping, readiness, tales from the field, and much more.

For more information on the Healthier Washington Agency Transformation Support Hub

Hub Help Desk: (206) 288-2540 or (800) 949-7536 ext. 2540

Email: HubHelpDesk@qualishealth.org

Healthier Washington: www.hca.wa.gov/hw/

Qualis Health: www.QualisHealth.org/hub

Hub Resource Portal: www.waportal.org

Managed Care Organization Contacts for Billing Questions

Amerigroup

Please direct questions and issues to wa1provrelations@amerigroup.com

Community Health Plan of Washington
Donna Arcieri, HIA, MHP Phone: 206-613-8853; Main: 206-521-8833; Email: donna.arcieri@chpw.org

Coordinated Care
Contact the Provider Services Department at 1-877-644-4613 for IMC billing/IT assistance. Additionally, you can reference our Electronic Transactions page.

United HealthCare
Contact the appropriate contact for your BHO region:

Spokane, Greater Columbia- Marco Magana, 503-603-7399; marco.magana@optum.com

North Sound- Marissa Cook, 425-201-7076; marissa.cook@optum.com

King, Pierce- Renee Johnson, 425-201-7106; randi.johnson@optum.com

SW, Thurston Mason- Samuel Barajas, 503-603-7398; samuel.barajas@optum.com

Great Rivers, Salish- Christine Collins, 206-926-0224; christinecollins@optum.com

Molina Healthcare
Claims and Billing: Jammi Reese, 888-562-5442 x 140160; Jammi.Reese1@molinahealthcare.com

Encounters and Claims Testing: Corey Cerise, 425-424-1140; Corey.Cerise@molinahealthcare.com

Contract, Initial Roster: Megan Gillis, 425-424-7137; Megan.Gillis@MolinaHealthcare.com

sFTP set-up and WISe Enrollment: Megan Platz, 888-562-5442 x 144097; Megan.Platz@MolinaHealthcare.com