Indianapolis Continuum of Care

Administrative Models for Medicaid Funding Services

A Resource for Housing and Homeless Programs

Considering Options for Billing for Medicaid Eligible Services

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Key Terms

Administrative Services Organization: An Administrative Services Organization or ASO is an organization whose line of business includes administrative functions to physicians or services providers that lack the capacity to complete administrative functions on their own, including billing or quality assurance functions. ASOs develop contracts with these practices or agencies to specifically meet their administrative needs.

Braided Funding: Braided funding refers to a process of weaving different funding sources together to support a program or service. Braided funding often includes state, federal, and private funding streams, and may also require integration of program strategies or different outcomes tracking.

Managed Care Organization: Managed Care Organizations are often called MCOs and are private health insurance companies or health plans that manage the benefits of specific group of health insurance enrollees. In Indiana, MCOs are commonly referred to as Managed Care Entities or MEs

Medicaid: Established in 1965, Medicaid is a joint federal and state program that helps with medical costs for some people with limited income and resources. Medicaid also offers benefits not normally covered by Medicare, like case management, nursing home care and personal care services.

Medicaid Billable Agency: A Medicaid Billable Agency can provide eligible services and bill directly to the Medicaid state office for reimbursement.

Medicaid Expansion: Medicaid expansion refers to an optional expansion of eligibility launched through the Affordable Care Act (ACA) to persons with low incomes, but not requiring a disabling condition as well. The expansion allows states to provide Medicaid coverage to individuals under 65 with very low incomes who would not otherwise be eligible for Medicaid services. Indiana is a Medicaid expansion state.

Medicare: Medicare is an additional health insurance program for all individuals over 65, younger populations with disabilities such as persons with permanent kidney failure or serious mental illness.

1115 Waiver: States may apply for an 1115 waiver to develop research and demonstration projects that test, evaluate, and expand Medicaid services or delivery system and payment options. Indiana received an 1115 waiver approval for Substance Use Disorder (SUD) services that includes tenancy support services as reimbursable service. The tenancy support services benefit has not yet been defined in detail, but the goal is to offer services designed to help clients obtain and maintain housing.

Supportive Housing and Medicaid

Supportive Housing Providers offer permanent, affordable, stable housing and supportive wrap-around services to residents to assure long-term stability. Supportive Housing is an evidence-based intervention that has proven to be successful with people experiencing homelessness, especially the chronically homeless. Effective implementation of these programs has been shown to reduce criminal justice engagement, healthcare costs, and other public expenses, as well as increase health and housing stability for participants.

In some models, the same provider offers both the housing and supportive services, while in other models, the housing and the services are offered collaboratively by two different organizations, one focusing on services and the other focusing on housing. Supportive services are most effective when offered in a client choice model and may include coordinating multiple services to meet each client's specific needs. Funding a supportive housing program can be complicated. Ongoing rental subsidies through federal programs can support housing/rental costs, but agencies are then frequently left with the need to find funding for the services through other sources. Seeking private funding for his purpose is usually limited as many foundations prefer not to support ongoing programs. Instead, Supportive Housing Providers are increasingly considering Medicaid reimbursements for supportive services as a key and ongoing funding solution.

Three significant factors are accelerating this process. A high proportion of supportive housing is funded through the federal Department of Housing and Urban Development's (HUD) McKinney Vento Program[1]. And while HUD recognizes the increase in Fair Market Rents (FMR) over the years[2] and increases grants accordingly, funding for supportive services was cut rather than increased over the past decade. In many cases, grants allowed for rental subsidies but required services funding from alternative sources such as Medicaid.

HUD has also asked projects to target and prioritize serving the "most vulnerable" or most in need. By definition, a person more vulnerable is likely to have greater service needs than a person less vulnerable. These service needs include such factors as addiction and/or mental health treatment, physical illnesses, developmental needs, and other issues that often require the assistance of a licensed clinician, which can lead to the need for more specialized staff and increased personnel expenses.

Finally, as supportive housing resident's age, many need services and support to remain in their homes similarly to other older Americans. Persons with histories of homelessness, as they age typically face functional and physical issues much earlier in life and at a much greater rate than the average population. Once housed, these persons often face additional issues that make it difficult to age in place without the supportive services, often needing a qualified clinician.

With this changing landscape, supportive housing providers and homeless service organizations must consider strategies to enhance their services through partnerships or through securing new resources, such as building an infrastructure to become a Medicaid Billable Agency. Agencies

[1] https://www.hudexchange.info/homelessness-assistance/

[2] https://www.huduser.gov/periodicals/ushmc/winter98/summary-2.html

that desire to integrate Medicaid services into their housing models have new options for ongoing reimbursement support.

Selecting an Administrative Model

Once an agency has committed to integrate Medicaid services, the first key decision is to determine the administrative model that is the best fit. This resource outlines three possible administrative models and the resources needed for implementing them effectively. An agency should understand that Medicaid is not generally a sole funding source and must be braided with other sources to create strong service delivery systems. Medicaid will pay only for services deemed "medically necessary and additional services may be needed for tenants to be successful in the community. For the agency, costs associated with a program will be affected by which services an agency offers and the amount of time staff spend directly with clients on billable services. Additionally, an organization may need to cover costs associated with providing services to clients who may not be enrolled in Medicaid at time of service delivery or who may not be Medicaid eligible.

The administrative model that an agency selects will better determine long-term program needs and the fiscal sustainability plan needed by the agency. Choosing which model fits should include discussions with Board of Directors, leadership staff and residents/clients to determine which aligns best with an agency's mission and long-term vision. Each strategy has its strengths and challenges, but they provide an agency with a sustainable funding stream for services and can offer tenants the quality services and supports that they need with an enhanced level of staffing. Agencies that can use Medicaid billing should expect a lower client to tenant ratio as well as the ability of access staff with more experience and qualifications such as Licensed Clinical Social Workers (LCSWs) or Registered Nurses (RNs).

As an agency considers the different administrative models, there will be some key data elements that will be helpful in making decisions. Conducting an internal assessment will help inform which model is the best fit for an organization. Key questions to ask include:

- Who are you serving and what public benefits do they receive?
- What public benefits are your clients eligible for?
- What is the cost benefit ratio to help a client to obtain and sustain Medicaid eligibility?
- What are state and Managed Care Entities (MCEs) requirements and qualifications for delivering the service?
- What activities are direct care staff engaged in on a daily basis?
- How does your agency hold all employees accountable for completing their activities?
- How much time do they spend face to face with clients? Are employees meeting privately with clients or as a group? How much time is spent in each category?
- How much time does the staff spend in training? How much time in supervision?
- What other activities are important, but will not result in billable activities?
- What new administrative staff will need to be added to accommodate the new billable functions?

You may know the answers to these questions already or you may need to collect some data to make a strategic decision. You can find answers to these questions by reviewing information collected in your data base systems, implementing a time analysis study for employee activities,

or by hiring a consultant to help you answer these questions. Some of these will be addressed later in this resource. The answers to these questions are important as they will inform which administrative model might be best for an agency. This resource will explore three key administrative models:

1. Becoming a Medicaid billable agency
2. Collaborating with an agency that bills Medicaid to serve your residents.
3. Contracting with an Administrative Services Organization to complete billing on your behalf while your agency continues to deliver supportive services

Each model requires a different level of commitment and investment from an organization and each will require some cultural shifts. Therefore, as your agency makes this decision, these questions and answers for your agency should be reviewed and considered as part of an organization's strategic planning process, with engagement from the Board of Directors and senior staff members. Incorporating Medicaid services or becoming a Medicaid Billable Agency will certainly affect the culture and service delivery model of an agency or program. However, there are great benefits that can come from considering these options, including improved health outcomes for clients, sustainable funding for supportive services for the agency, and the ability to grow an agency to meet the changing needs of clients and the community.

Indiana's 1115 Waiver

Billing Medicaid for supportive services depends largely on whether a state's Medicaid office offers eligible services. Medicaid optional services include Targeted Case Management, Peer Support Services or Psychiatric Rehabilitation services, all of which could be considered a component of supportive services in supportive housing. States may apply for an 1115 waiver to test, evaluate, and expand different Medicaid service delivery and payment options. In 2017, the state of Indiana received approval for an 1115 Medicaid Waiver for persons with Substance Abuse Disorder (SUD). This new benefit expands stays in institutions, residential care, and addiction recovery management services. As part of the waiver, tenancy supports will become a reimbursable service. The tenancy support benefit has not yet been defined in Indiana, but these services are designed to help clients be successful in achieving and retaining housing.

The 1115 waiver will roll out in 2018. The tenancy support benefit is planned to become available later in the year. In states that have taken this route to fund tenancy supports services, those services have included activities such as housing stability plans, housing search and placement, application assistance, moving assistance, sustaining services, landlord dispute resolution, care coordination and job training services. These services will likely be considered as part of the tenancy support eligible services, but agencies should avoid assuming any of them will be included until they are approved.

Model 1

Becoming a Medicaid Billable Agency

In Model 1, an organization makes the decision to become a Medicaid Billable Agency and needs to build the infrastructure necessary to bill directly for Medicaid eligible services. In this model, the agency undergoes a long-term process to transition from dependence on grant and other private funding for supportive services to primarily depending on Medicaid reimbursement for supportive services, though other funding will be needed for long term success.

The need for private funds will not disappear immediately or even entirely. Private funding (such as foundation grants, individual giving, corporate sponsorships) and other government grants will be necessary for these reasons: 1.) Some programs and services will not be eligible for Medicaid reimbursement but may be valuable for an agency to maintain; 2.) Some clients will engage in services but will not be eligible for Medicaid services; 3.) Some initial encounters with clients will not be eligible for reimbursement (outreach and engagement services for example); 4.) Some clients will be difficult to enroll due to lack of documentation and may need to be served until these items are secured; or 5.) Medicaid reimbursement rates may not be sufficient to fully cover program costs. Therefore, it's good to consider a multi-year planning process to create a sustainable funding model. Creating a transition budget plan will help assure agency and program stability during the transition.

Billing for Medicaid services requires a far greater administrative burden than most grant funding, so an agency must add new staff such as billing staff or quality assurance staff. These will manage billing services and ensure that requirements are met. The agency many need new services staff because qualifications may differ from the state of MCEs. Understanding how the state Medicaid office structures the benefit has not yet been determined for Indiana, so much of this is difficult to determine at this time. For example, some states will fund services on a per member, per month basis, while other states use per diem basis and still others on 15-minute increments. Conversations in some states include a consideration of a monthly payment for supportive housing providers and Washington State is likely to implement this model through their 1115 waiver process. While these administrative models allow agencies outwardly to remain a single entity offering services and housing, the climb to achieve this agency transition can be both slow and steep. An agency will need a detailed implementation plan, point people for various topics and activities, and an explicit process for how the board is updated. However, when the process is done, the agency will have maintained the mission and developed a sustainable services funding plan within the management for the foreseeable future.

Considerations

Before an agency embarks on this transition to become a Medicaid Billable Agency, the leadership should consider each of the following activities and the financial, consultative and staffing resources needed to make the agency successful in this process. If an agency cannot address each of these areas, then considering Models 2 and 3 could be the necessary course of action to work towards sustainable services or services funding for the agency.

Board Engagement

The transition to Medicaid funding for services is likely a multi-year process and is rarely completed in 1-2 years. This transition of revenue streams will bring significant changes to an agency and will likely need substantial time and money to support the change. For these reasons, board approval and support for this transition will be critical to project success. Board members can also be resources as the agency ventures into new territory. Lastly, agencies would do well to consider having persons with the following expertise on their boards to help guide them in this transition:

- Health Systems
- Managed Care
- Information Technology Solutions in Health Care

Eligible Services and Populations

Agencies need to learn in greater detail about the benefits their residents/clients are eligible for and what benefits they are enrolled in. Agency efforts to ensure that residents are enrolled in and maintain all benefits will be financially worthwhile in the long run. Then, agencies need to determine what services they offer can be eligible for which Medicaid eligible populations. Many supportive housing providers have admitted their tenants based upon homelessness history, with limited consideration of other specific disabilities, such as serious mental illness (SMI), HIV/AIDS and/or addiction. Determining how many current residents or clients will qualify is essential. These analyses need to be conducted prior to major investments into this transition. Additionally, agencies helping lease new tenants will need to consider these questions (benefits and disabilities) as they consider this transition.

The agency will also need to determine what services currently provided are Medicaid billable and whether their agency would be able to bill for those services. Through Indiana's Medicaid Rehabilitation Option (MRO), only Community Mental Health Centers (CMHCs) can bill the state on a Fee for Service (FFS) basis for services such as case management, peer supports and life skills.[3] Most state Medicaid plans cover some case management services or other types of Care Coordination services such as Health Homes. Other states cover Psychiatric Rehabilitation Services (PRS). Some of the life skills services historically have been covered with greater expertise in a psychiatric rehabilitation model. All of these are optional services and are not required of states to operate their Medicaid program. Indiana is in the process of implementing a tenancy support services benefit for persons with Substance Use Disorders. The state Medicaid office has key decisions to make in 2018 to determine how this benefit is structured and what requirements for offering the service will be.

[3] http://provider.indianamedicaid.com/about-indiana-medicaid/member-programs/special-programs/medicaid-rehabilitation-option-(mro).aspx

Information Technology (IT)

Generally speaking, agencies do not invest in the complicated information technology infrastructure needed for health care claims, unless their revenue streams demand those systems. As a result, most agencies seeking to become a Medicaid biller will be transitioning to new IT systems as part of this process. However, finding the right IT system, with the right support for an agency, that can gather the data needed for contracting with Managed Care takes significant time and expertise. Few systems are compliant with myriad of funders that agencies are balancing, including Homeless Management Information Systems (HMIS) and Health Insurance Portability and Accountability Act (HIPPA) compliance. Agencies will need support, outside expertise and guidance, as well as time to make these key decisions. Making the right decision on an IT system will have implications for an agency's long-term sustainability and requires the time and care to be done in a manner that works for the whole agency.

Licensure/Certification/Enrollment in State and Managed Care Entities (MCEs)

Both the state of Indiana and the MCEs will have a variety of requirements as you make this transition. Specifically, many states will have a licensure requirement for a service being delivered, such as case management, life skills or peer support services. State licenses often require staff with educational requirements, qualifications and licenses of their own, such as Licensed Clinical Social Workers or LCSWs. Most states also require either specific trainings or a certain number of trainings over a year that occur within a certain time period after staff are hired. Certain, specific trainings or a specified amount of trainings may need to occur annually. Furthermore, an agency will need a method to track these trainings and ensure that staff meet requirements. Overall, an agency will need to review all requirements and ensure that they can be met. Agencies will need to determine which specific services they plan to bill as well.

States generally have a process for enrolling an agency in the state Medicaid system. States have significant requirements to report to the Center for Medicare and Medicaid Services, or CMS, regarding their provider network, and they need information from an agency to meet these requirements. The agency will need staff who are dedicated to this effort and to know specifically what benefits their residents are enrolled in, as this information generally also comes from a state online system. Ensuring that residents' benefits remain active can be the difference between getting paid and not getting paid for an agency's services.

Finally, MCEs have a process of their own for bringing a provider agency into their network. The four MCEs in Indiana have expressed interest in developing similar processes as they implement the new tenancy support benefit. As the process develops, it must ensure that all state required licenses and certifications are up to date, as well as the MCOs credentialing process. MCOs have state requirements to meet and may add additional requirements, as part of their own individual credentialing process. Credentialing is one of the ways MCOs ensure that they are paying for a quality service. Most importantly, agencies must negotiate rates or how much they will be paid for their services. It is critical for agencies to establish their own internal cost benefit analysis to determine what it costs to deliver the services, both in staffing and in administrative supports. Administrative costs for health care services are generally higher than in any housing program, and this fact must be considered in a rate negotiation.

Review of Staff Activities – Time Study

As most agencies make this transition, they will need to do a time study to determine staff activities and how much of those activities are billable under state regulations and guidelines. Agencies need to ensure that they can draw down enough revenue from the Medicaid contracts to cover costs related to delivering the service. The time study needs to determine what services are billable in the state Medicaid plan and if the rates are set at a specified level. Ideally, agencies can perform this analysis before rate negotiations with MCEs so that an agency goes into those negotiations knowing what rates they need to make this transition a success for the agency. Additionally, an agency may identify services that it is not offering but would like to begin to offer. These need to be realistically planned for because an overestimation could lead to a shortfall later.

Resources Needed

All of these activities will take time and funding from agency budgets that seldom have large margins. IT activities often require the purchase of an information system and an outside consultant to guide an agency through this process. Some agencies have used philanthropic resources, state or local foundations, or state grants, while others have used Substance Abuse and Mental Health Services Administration (SAMHSA) grants to fund this work. Staff will need to be assigned specific roles, and the Human Resources department will have a large part to play in assuring qualified candidates are recruited and maintained. All in all, it's a significant planning and operations effort for any agency, and one that needs an explicit and intentional plan to ensure success.

Summary Model 1

If an agency decides to go this route, it's important to know it comes with distinct advantages and disadvantages. As noted in the chart below, it is the most labor intensive of the three administrative options, but also offers the most growth and stability options for the long term.

Model 1: Becoming a Medicaid Billable Agency	
Advantages	**Challenges**
• Alignment with current mission and service delivery • Retains current leadership of the program • Long term a program will look much the same to the outside world. • Facilitates opportunities for service growth and enhancement	• Most labor intensive of administrative options • Need Resources for an analysis of current operations and alignment with Medicaid billable activities. • Must invest in new Information Systems (often both hardware and software) • Possible need for different staff with different qualifications

Model 2

Collaborating to Increase Services

In Model 2, an agency retains its housing or homeless role, but expands clinical services through partnership with another provider. In this model, a housing provider understands that their strengths and capacity lie primarily in the housing realm and are open to partnerships with other agencies that are providers of supportive services and have the capacity to bill Medicaid. While the short-term learning and investment is likely smaller than in Model 1, the partnership will take internal staff time and resources at the start and some attention long term.

Considerations

This section explores the key activities that an agency will need to complete to transition to model 2. The most important aspect of this model is finding the right partner.

Finding the right partner

For any partnership to maintain long term, the mission of both agencies must align. Agency values and goals should have strong similarities even before the partnership is considered. Ideally, each partner can complement the other's work without duplicating it. This balance between agencies expertise can include types of clients served, geographic areas covered, different funding streams, and various other arenas.

Many primary health care and behavioral health care service agencies are recognizing the value of housing but also may have a steep learning curve in this arena. An agency such as this would be an ideal partner for a supportive housing agency that wishes to consider this partnership model. The health care sector is learning about outreach and engagement models, and Supportive Housing providers are community experts in this topic area. As activities shift, so may staff, depending upon expertise and experience.

In an ideal scenario, each partner is aware of the other's strengths and perhaps has worked together before either at the individual, program or system level. Perhaps some of the residents of supportive housing projects already receive their clinical services from the other agency. The agencies may both serve on the Continuum of Care or other community boards. Most importantly, mutual understanding, respect and trust between partners will be needed during the beginning, middle and ongoing journey of the partnership.

Developing a Memorandum of Understanding (MOU)

A formal MOU or other legal document should be established to cement the partnership, clarify roles and help prevent potential conflicts. MOUs should be reviewed annually and need to cover a variety of areas, including the following:

- Broad expectations for each entity. What is the purpose of the partnership?
- Clearly outline reporting and supervision responsibilities.
- Clearly define communication between key parties in a variety of situations.

- Determine technology needs and data sharing expectations
- Crisis response
- Joint reporting to each other's board and key stakeholders.
- Establishing a common agreement about success and desired outcomes.
- Considerations for future collaborations

Transition of Services

In this model, the implementation of supportive services will be offered by a different entity than the housing provider. The transition for residents, direct service staff and leadership from both agencies can be difficult as two agencies integrate. Residents need to know as soon as possible about the transition and what it will mean for their experience of services, as well as the people they have come to rely on. It's likely that the delivery of services will be different and may include expanded options. If the housing provider will continue to provide some services or allows other service providers onsite, it's critical that clients understand which provider to go to for which service, and to set up a clear communication process between the providers.

If you are the housing provider, the new service agency will likely have education and experience requirements for staff that current staff may not meet. Both parties need to be clear regarding those requirements, and the questions following will help establish such requirements:

- Are there any current licenses that an agency holds or is required to hold?
- What are the educational and licensing requirements of the supportive services staff?
- Could current services staff with the supportive housing agency could be hired by the new services agency?
- How will supervisory relationships work with mingling of staff?
- What activities can be added, what activities will remain and what activities will cease?

All parties need to be clear about changes in how services are offered. It is recommended that a formal date for service transition be decided six months in advance so that all parties understand the implications of the transition.

Documentation requirements are likely to be more intensive than prior to the transition. Residents will also need to be educated about this transition, before they are asked to sign many documents. Any direct service staff who can transition to the new agency will need training and support, for the new documentation requirements.

The two agencies may opt for an 'incubation period' in which staff from both organizations work together to assure smooth transitions for clients/tenants. Agencies should avoid 'double dipping' in this transition period. For example, as activities transfer from one agency to another, one agency may be billing grant funding and the other may be billing Medicaid. This is likely to occur and expected, but what cannot occur is two agencies billing the same source of funding. Medicaid billing rules must be followed anytime the expectation is for Medicaid billing to occur. MCOs can often assist with this transition, as their staff are well versed in Medicaid billing requirements.

Finally, the supportive housing agency will need to determine their role regarding data collection for benefits eligibility of their current residents. For instance, if the housing provider already collects some documentation or needs to collect this for other purposes, the two organizations may want to set up a sharing protocol using a Release of Information (ROI).

Maintaining the Partnership

A variety of questions need to be intentionally considered and eventually answered for two agencies to work together on a project or projects. Many of these questions will need to be answered as they establish the partnership through an MOU. However, maintaining the partnership will also require effort. Some key questions you can ask each other include:

- What roles will each partner accept? Are there roles that one partner is not willing to take?
- Will there be joint reporting on the projects or separate based on staff?
- How often and with whom will regular communication be established?
- How often will the partnership be evaluated and how will each partner define success?
- Are there regular check-ins between agencies, particularly in the transition phase of the project?

The partnership may naturally evolve over time, and the partners may even deliberately grow or reduce the partnership. The original MOU should outline how often the partnership is reconsidered and evaluated.

Summary Model 2

In Model 2, the key success factors involve selecting the right partner, clearly outlining each partner's roles in an MOU, and revisiting the partnership for success over time. The chart below highlights some key advantages and challenges.

Model 2: Outsourcing Services	
Advantages	**Challenges**
• No change to housing-based role. • Limited one-time resources needed in the change. • Builds on strengths and allows for low investment growth.	• Loss of services role • Need to clearly define roles with partner • Establishing common success

Model 3

Contracting with an Administrative Services Organization (ASO)

In Model 3, a housing or homeless provider contracts with an Administrative Services Organization to complete billing on their behalf while the agency continues to deliver supportive services. In this model, the supportive housing agency continues to provide both housing and services but contracts with an Administrative Services Organization, or ASO, to perform the Medicaid billing functions, and thus charging a fee for this service to the supportive housing provider. This type of arrangement does not require the significant upfront costs that transitioning to billing requires, as costs are smaller and spread out over many years. The agreement becomes more of a business relationship than a collaboration and requires a legal contract rather than an MOU. An agency will still need to consider braided funding options with a variety of funding sources to be successful.

Considerations

Many of the activities in this process mirror the process of Model 1, when an agency decides it will bill directly for Medicaid services. The primary shift becomes less emphasis on technology and administrative billing functions and more emphasis on determining a rate for the ASO service. In the end, the rate must be reasonable enough that the agency is able to maintain its bottom line. Agencies must also consider whether staff meet licensure requirements from the state and credentialing requirements from the MCE. Staffing may need to change to meet these requirements.

Eligible Services and Populations

As in Model 1, the agency will need to determine what services currently provided are Medicaid billable, which services will be offered as part of the business relationship, and how the agency will be submitting claims. Case management, care coordination, and peer supports all remain options if the tenants are Medicaid eligible and the services are covered in your state's Medicaid plan. Psychiatric Rehabilitative Services are not in Indiana's Medicaid plan covers many of the essential services in supportive housing. Again, as with Model 1, an agency will need to determine staffing requirements, client eligibility, and state or MCE requirements for whatever services they will deliver. Agency processes for new tenants will again need to consider these questions (benefits and disabilities) as the agency considers this transition.

Information Technology (IT)

While the agency in this model may not need to completely adopt a new data system, with the ASO submitting claims for payment, but the agency will need to clearly understand the ASO requirements for data submission and if their current system can meet these requirements. Policies and procedures regarding data transfers and payment will need to be developed as well.

Licensure/Certification/Enrollment in State and Managed Care Entities (MCEs)

Even if the ASO is doing the billing activities, staff delivering the service still need to meet the state and MCE requirements for that service. Requirements can include licenses of staff, training requirements and supervisory requirements. Agencies need to be sure that the current staff can meet those requirements or consider a transition plan. The agency will also need to review these qualifications and ensure that they can be met. Otherwise, the claims you submit can be rejected and not paid.

Even though the ASO is submitting the claims, the MCEs will still review the records of the agency that is delivering the service. MCEs will likely still credential the agency, even though the ASO is submitting the claims. The agency will have to meet MCE credentialing requirements and ensure that all state required licenses, certifications and trainings are up to date. The MCEs still must meet state requirements as part of their own individual credentialing process.

Finally, agencies must negotiate rates, or how much they will be paid for their services. Since an ASO is part of this process, those costs must be included in rate negotiations between supportive housing providers and either MCEs or the state. Agencies will have their own internal cost benefit analysis to determine what it costs to deliver the services, both in their agency's activities and in the ASO costs.

Review of Staff Activities - Time Study

In this model, an agency will still need to do a time study to determine staff activities and how much of those activities are billable under state regulations and guidelines. Agencies need to ensure that they can draw down enough revenue from the Medicaid contracts to cover costs related to delivering the service, the agency's administrative costs and the ASO costs. The time study will help an agency know what agency activities are billable in a state Medicaid plan and covered by either the state or the MCEs in a community. As in Model 1, agencies can perform this analysis before rate negotiations with MCEs, so that an agency goes into those negotiations knowing what rates they need to make this transition a success for their agency.

ASO Costs and Delivery

A contract with the ASO needs to be developed, as well as a regular schedule of data submission that is agreeable to all parties. The ASO will likely be a resource as you develop internal processes and procedures for this transition. They are being paid for their expertise in Medicaid billing practices and use that expertise at all junctions in this process. The ASO may already have contracts with the local MCE and can support an agency in this transition process.

Summary Model 3

In Model 3, many of the same strategies exist as in Model 1, but the ASO takes over the billing function. This may be desirable for agencies that have a strength in service delivery but have lower capacity for administrative functions. The service provider does not have to invest as heavily into new staff and functions but does lose some control and autonomy as the administrative

functions become part of a legal contract and part of the reimbursement funding is instead given to the ASO.

Model 3: Billing with the support of an Administrative Services Agency	
Advantages	**Challenges**
• Builds on agency strengths • Less up-front resources needed than option #1	• Sharing payment with a biller. • Agency staff still need to meet state and MCO requirements.

Recommendations

Next Steps for Agencies

Leveraging Medicaid eligible opportunities is an excellent way to fiscally sustain your agency, enhance your supportive services and is a national best practice. Reviewing the three administrative models outlined here should be considered a starting discussion on moving your agency toward this important expansion opportunity. Each comes with its own set of complications, but the end result can enhance your services funding, and better serve your tenants. Understanding the advantages and weaknesses of these models, will help your agency make a strategic decision for the future. The chart below highlights key activities from an overall assessment, planning, implementation and evaluation perspective.

Assessment Phase: What do we need to know?
1. Assess the three administrative models for Medicaid supportive services and determine which one best fits your organization. This is a key strategic decision and should include board members, staff leaders, and feedback from clients. The model you select will affect all other aspects of your planning and implementation phases. 2. Assess current clients/residents to determine how many are actively enrolled in Medicaid and how many are eligible but not enrolled. This provides a basis for how successful your agency might be in billing directly for Medicaid eligible services. If you have very few Medicaid eligible clients, you will have a much bigger transformation than if you have a significant number. 3. Determine which services you currently offer that are eligible for Medicaid reimbursement. This process needs to consider how many clients are currently enrolled in Medicaid and what kinds of services you provide, as well as services that you could easily add that are needed by your clients. This assessment is a key factor in assuring that you are making data driven decisions and will influence the development of a sustainability budget later.
Planning Phase: Where do we want to go?
1. Integrate your Medicaid services plans into your strategic plan and board engagement. The board and senior staff should be educated about and ultimately support the changes that a model will bring. 2. Apply for and secure any agency licensure/certification that is required by the model you select. You may need to talk with the state Medicaid office or with MCEs depending on your model. 3. Complete a feasibility assessment that clearly determines short-term funding needs for transitioning, anticipated income from Medicaid reimbursements, and ongoing funding needs (infrastructure and staffing) to support the model you select. Make sure that your assessment includes braided funding opportunities. 4. Complete a staff time assessment the determines how much current staff spend directly with clients on billable hours, and how much they would need to spend to achieve financial stability in the future. Understand that staff activities may need to change. Based on how many clients you anticipate serving, you will need to select an appropriate staffing structure that considers caseloads, training needs, and supervision requirements. You will also need to consider licensure, training and supervision requirements. Only in the partnership model with an outside services provider, will the housing provider may not need to concern themselves with these activities.

5. Create an implementation plan with clear timelines for phased funding, implementation over time, and success measures. This should be a supplemental document to your strategic plan and should focus on the functional implementation of this new services structure. Parts of the plan will need to address infrastructure needs (IT and staff), clinical service staff, evaluation, ongoing operations, etc.

Implementation Phase: What do we need to do?

1. Oversight of the implementation plan should be managed by a team of people, including board members, senior staff, and direct service staff.
2. Determining the needed staffing structure and rightsizing to that level and appropriate qualifications can take time, especially if existing staff transition out.
3. Determine what technology upgrades you will need, including what software tracking and billing systems you will need to invest in and a determination if your existing hardware will support them.
4. Establish key collaborative partners and roles. If you are selecting Model 2, you should establish an MOU and in Model 3 a contract with the ASO. In both Models 1 and 3, you will need to establish relationships will the MCEs and determine certification/licensing requirements.

Evaluation Phase: How will we know we are successful?

1. Create a success matrix. Regardless of which model you select, you will want to clearly understand how you will measure success. Creating a simple matrix that tracks billable goals, service goals, and shared outcomes will help you and your partners understand the successes of the model.
2. Seek feedback. It's important to get feedback from staff, partners, and clients to understand how the process is going and be willing to make changes based on that feedback.
3. Reaffirm your administrative model. As part of the ongoing assessment of your services, you should determine whether your agency might shift to a different model over time. For instance, it's possible that your organization starts in collaborative services model, but has the ultimate goal of becoming a Medicaid biller or securing the services of an ASO. Alternatively, you might seek to be a Medicaid billable agency, but find along the way that a collaborative model is a better fit.

Additional Resources

Making the shift to Medicaid billable services won't be easy. You might find the process overwhelming and feel like you need help. There are many resources out there to help you.

CHIP can help your organization think through the options highlighted in this resource if you request it. Additionally, CHIP can secure a consultant to help you through this process or to help you complete a feasibility or business plan.

The Corporation for Supportive Services (CSH) has a local office that can also help consider Medicaid billable options. CSH has a growing list of templates and training options that can support your agency, no matter what model you choose.

Below is also a list of online resources that might help you:

- http://www.csh.org/health/
- www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-06-18-12.pdf
- http://kff.org/medicaid/issue-brief/premiums-and-cost-sharing-in-medicaid/
- http://kff.org/medicaid/issue-brief/an-early-look-at-medicaid-expansion-waiver-implementation-in-michigan-and-indiana/
- CSH Home Page
- CSH's Supportive Housing Training Center
- Subscribe to CSH's Newsletter
- Dimensions of Quality Supportive Housing Toolkit
- Supportive Housing Evidence and Research