COMMONWEALTH of VIRGINIA

NELSON SMITH
COMMISSIONER

DEPARTMENT OF
BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
Post Office Box 1797
Richmond, Virginia 23218-1797

Telephone (804) 786-3921
Fax (804) 371-6638
www.dbhds.virginia.gov

December 16, 2024

To: The Honorable L. Louise Lucas, Chair, Senate Finance & Appropriations Committee
The Honorable Luke E. Torian, Chair, House Appropriations Committee

From: Nelson Smith, Commissioner, Department of Behavioral Health and Developmental Services

RE: Targeted Review Process to Assess CSB Billing for Medicaid-Eligible Services

Pursuant to Item 295 OO.4 of the 2024 Special Session I, Appropriations Act, directs the Department of Medical Assistance Services (DMAS) and the Department of Behavioral Health and Developmental Services (DBHDS) to develop and implement a targeted review process to assess the extent to which CSBs are billing for Medicaid-eligible services. The language reads:

> *4. The Department of Medical Assistance Services, in cooperation with DBHDS, shall (i) develop and implement a targeted review process to assess the extent to which CSBs are billing for Medicaid-eligible services they provide, (ii) determine if additional technical assistance and training, in coordination with Medicaid managed care organizations, is needed on appropriate Medicaid billing and claiming practices to relevant CSB staff, and (iii) evaluate the feasibility of a central billing entity, similar to the Federally Qualified Health Centers, that would handle all Medicaid claims for the entire system. The Department shall report the results of these targeted reviews, any technical assistance or training provided in response, and on the feasibility of central billing to the Chairs of the House Appropriations and Senate Finance and Appropriations Committees by December 1, 2024.*

cc: The Honorable Janet V. Kelly, Secretary of Health and Human Resources

DBHDS
Virginia Department of Behavioral Health and Developmental Services

Report on CSB Billing for Medicaid Eligible Services

(Item 295 OO.4, 2024 Special Session I, Appropriations Act)

December 1, 2024

DBHDS Vision: A Life of Possibilities for All Virginians

1220 Bank Street • P.O. Box 1797 • Richmond, Virginia 23218-1797
Phone: (804) 786-3921 • Fax: (804) 371-6638 • Web site: www.dbhds.virginia.gov

Preface

Pursuant to Item 295 OO.4 of the 2024 Special Sessions I, Appropriations Act, directs the Department of Medical Services (DMAS) and the Department of Behavioral Health and Developmental Services to develop and implement a targeted review process to assess the extent to which CSBs are billing for Medicaid-eligible services. The language reads:

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Item 295 OO.4 CSB, CSB Billing for Medicaid Eligible Services Report

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Executive Summary

Community Service Boards (CSBs) bill Medicaid for the majority of Medicaid eligible services they provide. CSBs provide approximately 11 percent of Medicaid behavioral health services statewide and Medicaid payments account for 30 percent of CSB revenue. CSBs have significant documentation burden associated with Medicaid services as well as their numerous other federal, state, and local funding lines and report that these numerous requirements have made the transition to managed care more difficult for CSBs from a documentation and infrastructure perspective. Specifically, the difficulty associated with the transition to managed care include the credentialing process, service authorization process, and general administrative requirements of working with five Medicaid managed care organizations (MCOs). In general, some CSBs have implemented modernized revenue cycle management (RCM) systems to successfully participate as Medicaid providers in the managed care context. This includes increased billing and coding staff, expertise, EHR improvements, and additional back-end systems features. Other CSBs have not achieved this modernization frequently due to resource constraints or competing priorities. Some ambivalence regarding investment in RCM systems appears to be driven by uncertainty regarding the future of CSB payment structures, including the possibility of implementing an alternative payment model for STEP-VA services, such as a prospective payment system (PPS) akin to federal models. Through the review completed for this study, the Department of Medical Assistance Services (DMAS) and Department of Behavioral Health and Developmental Services (DBHDS) provide three recommendations for consideration which include:

1. Follow-up technical assistance for any unbilled Medicaid services and increased collaboration and training opportunities in coordination with MCOs.
2. Implementation of key performance indicators (KPIs) so that billing and claims issues can be tracked at the CSB or state level for more actionable insights.
3. Technical assistance for CSBs on how they can manage their revenue cycles.

A single, required central billing solution is not recommended at this time as no feasible concept for this type of solution emerged during the study. The method for this study focused on a review of the CSBs. The MCOs were not interviewed for this study, but any recommendations that move forward will be implemented collaboratively with MCOs.

Background

Virginia has 40 locally operated public CSBs that provide critical behavioral health services for Medicaid members as well as uninsured and other community members. Historically, the CSB system was initially state grant and local government funded, until the early 1990s. During that time, many Medicaid rates were established, but many of those decades-old rates have only recently been updated or are planned for updates in 2026. A number of systems changes have occurred in publicly funded behavioral health services in Virginia, which are important context to understand Medicaid billing for CSBs today.

- 2016: Virginia completes planning grant for Certified Community Behavioral Health Clinic (CCBHC) implementation, the federal model for community behavioral health core services and alternative payment model in Medicaid (akin to the Federally Qualified

Health Center (FQHC) model for physical health, with certification being built at the state instead of the federal level)
- 2017: Medicaid behavioral health services were carved into whole health, capitated managed care contracts
- 2018: STEP-VA was codified, requiring CSBs to provide the CCBHC service array but not implementing the alternative payment model in Medicaid
- 2019: Medicaid expansion (coverage for all individuals up to 138 percent FPL). Medicaid expansion included a $30 million budget cut to CSBs from state general funding
- 2019 to present: ongoing state general fund investment in STEP-VA service array at CSBs, without implementation of alternative payment model in Medicaid
- 2020: COVID-19 pandemic flexibilities for telehealth
- 2021: Project BRAVO services were implemented, which enhanced behavioral health services for Virginia Medicaid. These services overlapped the STEP-VA service array for mobile crisis services as well as other key CSB-provided services
- 2024: The General Assembly authorized the redesign of legacy community mental health rehabilitative services, with overlap in STEP-VA service array for case management and psychiatric rehabilitation

Scope and Approach

The Department of Medical Assistance (DMAS) and the Department of Behavioral Health and Developmental Services (DBHDS) designed a targeted review process for this study. A survey was disseminated to all 40 CSBs to gather broader perspectives and an in-depth review of three CSBs was conducted with an extensive data review, virtual visits, and additional correspondence. Interviews were conducted with two additional CSBs.

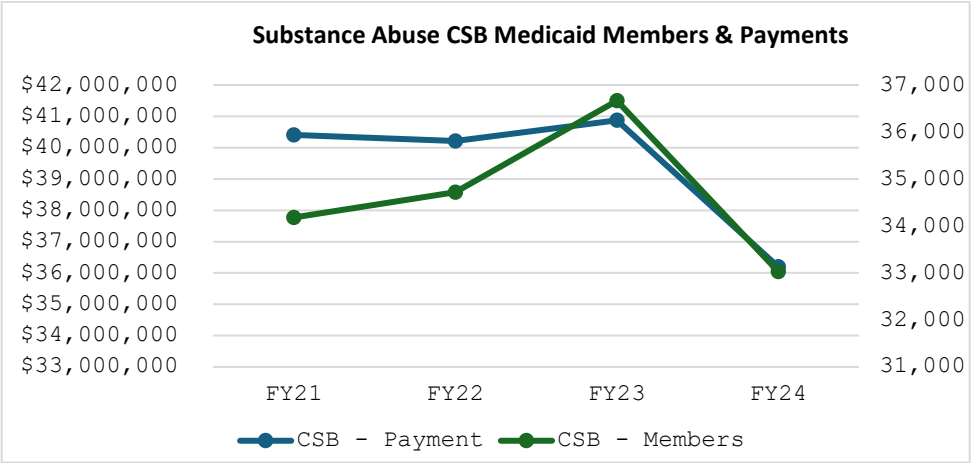
Medicaid Claims Data Analysis

The CSB Medicaid Claims Data Analysis was conducted using the DMAS Medicaid data export for FY 2021 through FY 2024. This data was organized by substance use services (Addiction and Recovery Treatment Services, or "ARTS") and Mental Health Services. The analysis focused on the number of claims, members, and payments for Virginia Medicaid and the MCOs. An additional request was made to include the CSB National Provider Identifiers (NPIs), units of services billed, and billed amounts within the CSB Medicaid data file. However, this information was not available at the time of the study.

The charts below illustrate the trends in CSB services provided to Medicaid members and Medicaid payments from FY 2021 through FY 2024 for Substance Abuse and Mental Health services. These numbers include services provided through managed care as well as fee-for-service Medicaid. Importantly, the total $2.04 billion in FY 2024 Medicaid payments to behavioral health providers, payments made to the CSBs account for $230.7 million (11.3 percent). The remaining 88.7 percent of Medicaid payments are provided to private practice therapists, mental health clinics, substance use treatment centers, residential treatment centers

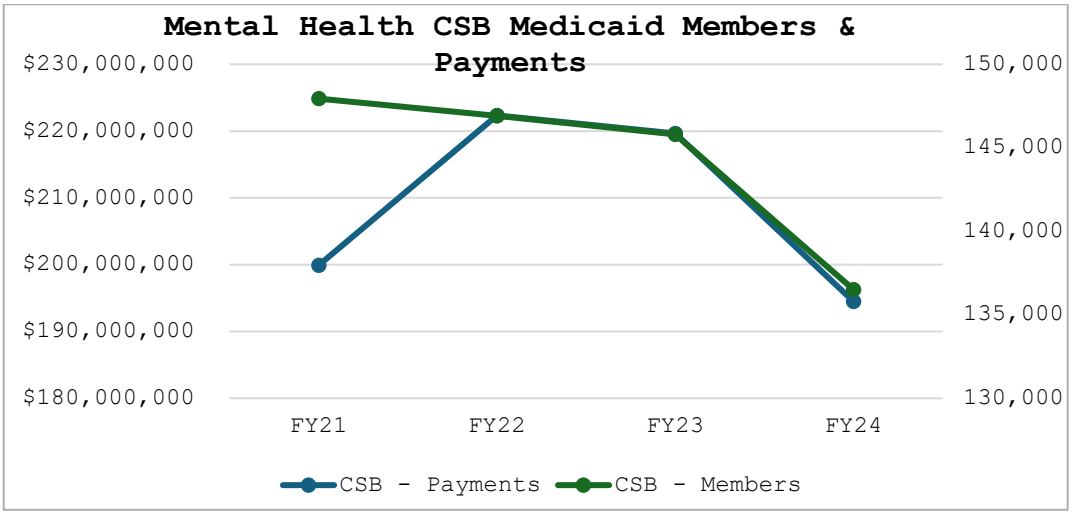
and psychiatric hospitals. Additionally, the fiscal year runs from July through June, and there may be lags in claims data. While Virginia Medicaid has a timely filing period of 12 months, it is recommended that services be billed on a weekly or monthly basis to ensure accurate data and timely payments.

Figure 1.



The four-year average of CSB payments related to Medicaid Substance Abuse services is $39,422,411 (Figure 1). In FY 2024, CSB Medicaid Substance Abuse payments decreased by 8.2 percent compared to the average and by 11.4 percent compared to FY 2023. The four-year average of CSB Medicaid members receiving Substance Abuse services is 33,029. In FY 2024, the number of CSB Medicaid members receiving Substance Abuse services decreased by 4.7 percent compared to the average and by 9.9 percent compared to FY 2023.

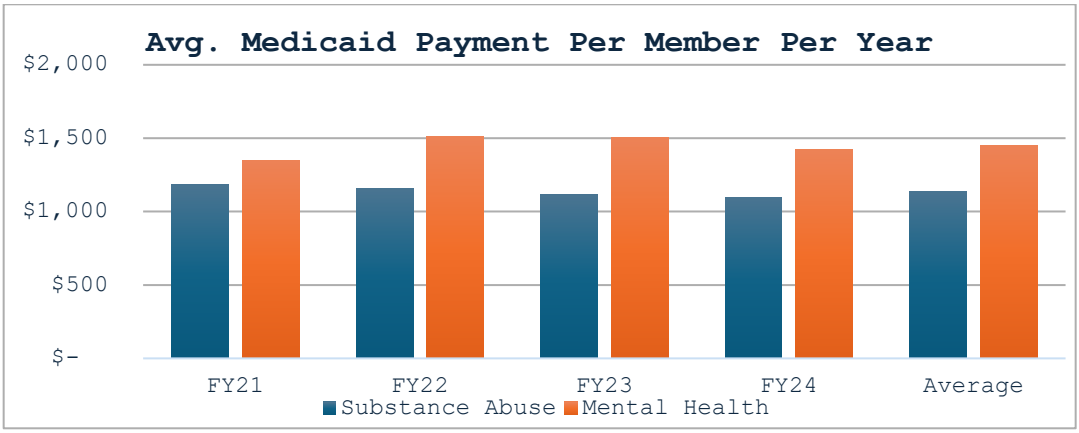
Figure 2.



The four-year average of CSB payments related to Medicaid Mental Health services is $209,104,949 (Figure 2). In FY 2024, CSB Medicaid Mental Health payments decreased by seven percent, compared to the average; and by 11.4 percent compared to FY 2023. The four-year average of CSB Medicaid members receiving Mental Health services is 144,295. In FY

2024, the number of CSB Medicaid members receiving Mental Health services decreased by 5.4 percent compared to the average and by 6.4 percent compared to FY 2023. Please note, Post-COVID, the Virginia Medicaid program implemented a revalidation process to ensure that members meet ongoing eligibility requirements. Figure 3, below, displays the average CSB Medicaid payment per member on a fiscal year basis (managed care and fee-for-service).

Figure 3.



The four-year average for CSB Medicaid annual payments per member is $1,138 for Substance Abuse services and $1,449 for Mental Health services. In FY 2024, the average annual payment per member for Substance Abuse services decreased by 1.7 percent compared to the four-year average and by 5.4 percent compared to FY 2023. Similarly, the average annual payment per member for Mental Health services in FY 2024 decreased by 3.7 percent and by 1.7 percent compared to FY 2023. Table 1, below, summarizes the fiscal year CSB Medicaid payments for Substance Abuse Services through managed care and fee-for-service.

Table 1.

SUB. Service	FY21	FY22	FY23	FY24	Total	FY Average
ASAM Level 0.5	$69,288	$50,736	$63,594	$24,510	**$208,127**	**$52,032**
ASAM Level 1.0	$9,020,672	$8,222,812	$8,321,965	$7,467,385	**$33,032,834**	**$8,258,20**
ASAM Level 2.1	$6,296,624	$6,407,873	$5,988,998	$5,199,64	**$23,893,135**	**$5,973,28**
ASAM Level 2.5	$681,500	$883,092	$693,375	$441,438	**$2,699,405**	**$674,851**
ASAM Level 3.1	$688,625	$833,047	$643,574	$517,155	**$2,682,400**	**$670,600**
ASAM Level 3.3/3.5	$7,139,830	$8,379,754	$10,509,331	$10,469,22	**$36,498,141**	**$9,124,53**
ASAM Level 3.7	$550,507	$716,808	$1,205,461	$1,431,75	**$3,904,527**	**$976,132**
CM	$3,491,285	$3,854,682	$3,898,210	$3,352,48	**$14,596,657**	**$3,649,16**
Lab	$327,105	$411,925	$505,434	$409,995	**$1,654,460**	**$413,615**
OBOT/OTP	$12,101,121	$10,418,446	$8,959,509	$6,693,034	**$38,172,110**	**$9,543,02**
Peer Recovery	$29,115	$18,957	$68,379	$176,616	**$293,066**	**$73,267**
Pharmacy	$1,163	$2,262	$2,703	$2,295	**$8,423**	**$2,106**
Telemedicine	$10,144	$12,537	$13,513	$10,165	**$46,359**	**$11,590**
Total	**$40,406,979**	**$40,212,931**	**$40,874,046**	**$36,195,69**	**$157,689,645**	**$39,422,41**

The largest category among all Substance Abuse Services, Opioid Treatment Programs (OTP) and Office-Based Opioid Treatment (OBOT), account for $38,172,110 in payments from FY 2021. Peer Recovery Services payments increased by 158 percent from FY 2023 to FY 2024, while ASAM Level 0.5 payments decreased by 61 percent. Table 2 summarizes fiscal year CSB Medicaid payments for Mental Health Services for managed care and fee-for-service.

Table 2.

BH Service	FY21	FY22	FY23	FY24	Total	FY Average
23-Hour Crisis Stabilization	$0	$11,961	$292,579	$693,673	$998,213	$249,553
Applied Behavior Analysis	$0	$105,531	$236,130	$321,350	$663,011	$165,753
Assertive Community Treatment	$0	$24,792,705	$21,893,311	$20,662,161	$67,348,177	$16,837,044
Behavioral Therapy Program	$218,912	$104,875	$0	$0	$323,788	$80,947
Community Stabilization	$0	$1,612,531	$1,073,763	$613,273	$3,299,568	$824,892
Crisis Intervention	$5,581,705	$2,534,270	$0	$0	$8,115,975	$2,028,994
Crisis Stabilization	$8,944,467	$4,106,856	$0	$0	$13,051,323	$3,262,831
Day Treatment/ Partial Hospitalization	$47,196	$0	$0	$0	$47,196	$11,799
Functional Family Therapy (FFT)	$0	$42,596	$83,152	$95,892	$221,640	$55,410
Intensive Community Treatment	$18,567,782	$0	$0	$0	$18,567,782	$4,641,946
Intensive In-Home Services	$1,448,103	$928,409	$678,590	$367,224	$3,422,326	$855,581
Mental Health Case Management	$113,760,806	$120,650,684	$116,007,018	$98,387,798	$448,806,307	$112,201,577
MH-IOP	$0	$0	$43,143	$12,258	$55,402	$13,850
MH-PHP	$0	$74,973	$0	$48,223	$123,196	$30,799
Mental Health Skill Building	$7,362,322	$6,205,761	$4,942,446	$4,311,460	$22,821,989	$5,705,497
Mobile Crisis Response	$0	$8,271,837	$13,787,292	$12,119,927	$34,179,056	$8,544,764
Multisystemic Therapy (MST)	$0	$191,383	$305,645	$271,890	$768,918	$192,229
Outpatient Psychiatric Services	$9,498,730	$9,380,420	$10,029,775	$8,485,621	$37,394,547	$9,348,637
Outpatient Psychotherapy	$25,500,158	$26,529,752	$27,409,286	$24,438,334	$103,877,531	$25,969,383
Peer Recovery Support Services	$9,751	$55,637	$134,527	$345,664	$545,579	$136,395
Psychiatric Residen-tial Treatment	$14,114	$0	$0	$0	$14,114	$3,528
Psychosocial Rehabilitation	$6,565,361	$8,384,938	$8,810,603	$8,213,573	$31,974,475	$7,993,619
Residential Crisis Stabilization	$0	$4,360,470	$8,034,535	$9,394,567	$21,789,572	$5,447,393
Therapeutic Day Treatment	$2,408,352	$4,000,668	$5,871,233	$5,729,861	$18,010,114	$4,502,529
Grand Total	**$199,927,761**	**$222,346,258**	**$219,633,029**	**$194,512,750**	**$836,419,798**	**$209,104,949**

Mental Health Case Management accounts for 54 percent of the fiscal year average payments. Peer Recovery Support Services saw a 157 percent increase in payments from FY 2023 to FY 2024, and 23-Hour Crisis Stabilization saw a 137 percent increase. However, Intensive In-Home services saw a decrease of 46 percent from FY 2023 to FY 2024, and Community Stabilization services saw a decrease of 43 percent.

Survey Results

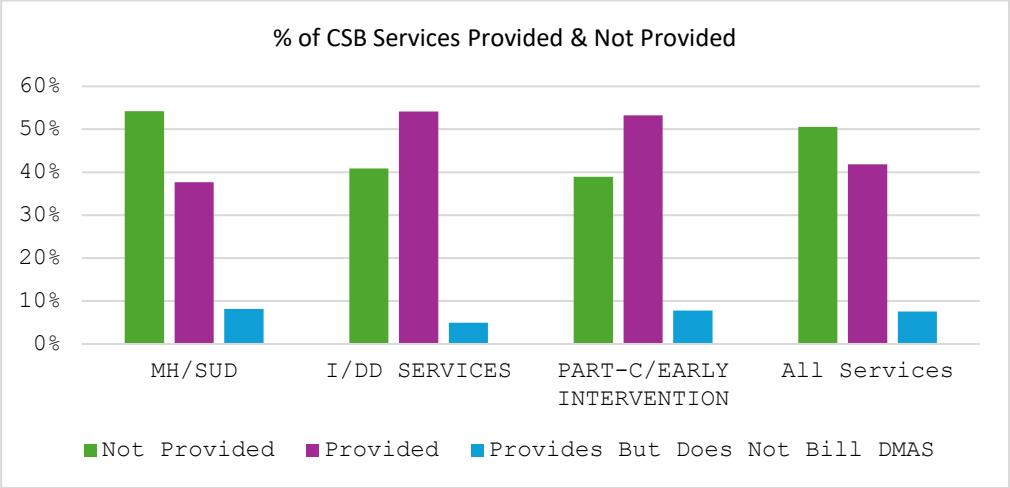
A survey was distributed to all CSBs, providing a listing of 62 Mental Health (MH)/ Substance Abuse (SUD) services, 15 Intellectual Disability/Developmental Disability (ID/DD) services, and 7 Part C/Early Intervention services. Table 3 outlines the survey results by CSB regions.

Table 3.

Region	CSBs	Survey Responses	Completed %
1	9	8	89%
2	5	5	100%
3	10	10	100%
4	7	6	86%
5	9	6	67%
Total	**40**	**35**	**88%**

A breakdown of the CSBs by region is provided in Appendix 1.1. Overall, the survey response rate was 88 percent, with the lowest response rate by region being Region 5 at 67 percent. Figure 4 summarizes the number of CSBs that provide services, do not provide services, and provide services but do not bill to DMAS. A copy of the survey is in Appendix 1.2.

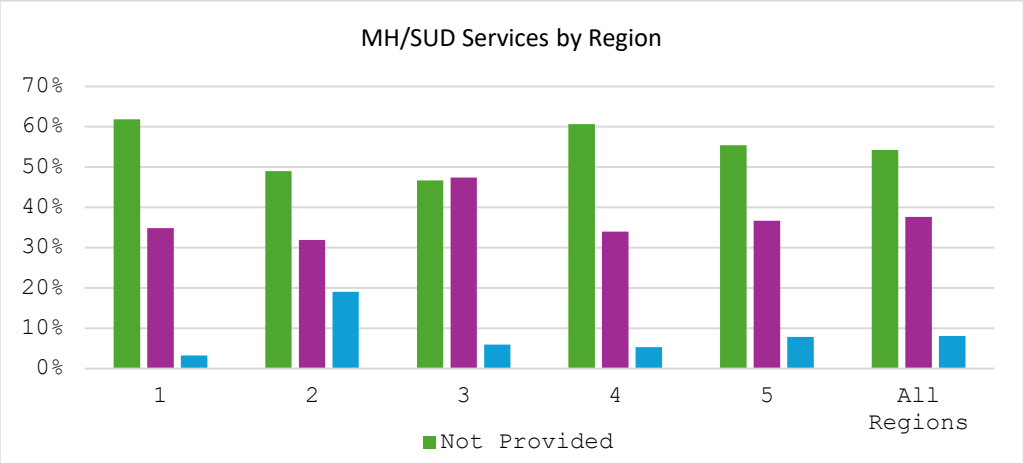
Figure 4.



Please note that each service listed in the survey has a distinct rate according to the fee schedule. For instance, drug urine screening is a one-time, low-cost service, whereas targeted case

management is a monthly, high-cost service. CSBs should ensure that all high-volume and high-reimbursement services are accessible to the Medicaid population. Mental Health/Substance Abuse account for the highest volume of services listed on the survey that are not provided (54 percent). Figure 5 shows Mental Health/Substance Use Disorder services by region, indicating whether services are provided, not provided, or provided but not billed to MCOs/DMAS.

Figure 5.



Region 1 (9 CSBs) does not provide 62 percent of the MH/SUD services provided in the survey followed by region 4 (7 CSBs) with 61 percent. Table 4 outlines the list of services most commonly not provided by CSBs. It is important to note that Part C/Early Intervention Services have a "lead agency" in each part of the state, therefore, if the CSB is not the area's lead agency, they would not be expected to provide these services.

Table 4.

MH/SUD	**I/DD**	**Part C/ Early Intervention**
Electroconvulsive Therapy	Community Guide	Speech/Language Therapy
MH Partial Hospitalization	Therapeutic Consultation	Physical Therapy
Applied Behavioral Analysis	Skilled Nursing Services	Team Treatment Activities
IOP-MH w. Occupational Therapy	Supported Employment	Occupational Therapy
MH Partial Hospitalization	Community Coaching	Assessments
Therapeutic Group Home	In-Home Residential Support	Developmental Services-Individual
Neurobehavioral, Neuropsychological	Day Support	Targeted Case Management
Annual Wellness-Primary Care	Congregate Residential Support	
ASAM Level 4.0	Community Engagement	
SUD Partial Hospitalization (ASAM 2.5)	Group Day Support (All tiers)	
IOP-MH	ID Support Coordination	
MST	Environmental Modifications	
Developmental Testing	Assistive Technology	
Annual Physical-Primary Care	DD Waiver Screening	

Table 5 outlines the list of services most commonly provided but not billed to MCOs/DMAS.

Table 5.

MH/SUD	I/DD	Part C/ Early Intervention
MH Peer Recovery Support Services	DD Waiver Screening	Physical Therapy
SUD/MAT Peer Recovery Services	Group Day Support	Speech/Language Therapy
Alcohol Breathalyzer	Congregate Residential Support	Occupational Therapy
Nursing Visit	Day Support	
Substance Screening & Intervention		
Drug/Urine Screening		
Smoking & Tobacco Counseling		
Mediation Administration		
Crisis Stabilization		

CSBs Interviews –Medicaid Data Analysis

A data request was submitted to three CSBs varying in size and location as part of the interview process. The following FY 2024 data was requested to better understand industry benchmarks and key performance indicators (KPIs) for each CSB:

- Collection Rates: Billed vs. paid claims
- Revenue: Trended monthly
- Unbilled/Held Claims
- Accounts Receivable Aging Reports (as of 6/30/24): Breakdown of outstanding claims by age.
- Claim Rejection Rate: The percentage of claims that are rejected upon initial submission due to errors or missing information.
- Claim Denial Rate: The percentage of submitted claims that are denied by insurers.
- Days in Accounts Receivable (A/R): The average number of days it takes to collect payments from the time a claim is submitted.
- Write-off Reports: Reasons for write-offs and amounts written off.

Metrics missing or unpopulated in the graphs/charts below were either unavailable or not provided by the CSB during this review. Of the CSBs interviewed, CSB #1 was able to provide the requested data with minimal effort and the quickest turnover, indicating a strong understanding of their EHR and reporting capabilities. Table 6 shows the CSB KPI summary for Medicaid claims. Table 7 shows CSB A/R aging of Medicaid claims.

Table 6.

CSB	FY24 Annual Medicaid Revenue	Collection Percentages	Unbilled Claims	Rejection Rate	Denial Rate	Days in A/R	Annual Bad Debt Write Offs	% of Total Revenue
CSB #1	$26,720,851	97.4%	#N/A	3%	#N/A	48-61 Days	$1,362,320	5.1%
CSB #2	$3,590,000	98.0%	#N/A	1%	5%	27 Days	$59,113	0.2%
CSB #3	$17,823,954	*92.19%	**$19,130	#N/A	#N/A	#N/A	$160,613	0.6%
Industry Benchmark	**#N/A**	**>98%**	**#N/A**	**<10%**	**<5%**	**45- 60 Days**	**#N/A**	<2%

**CSB #3 top 7 service programs account of 64 percent of total billing volume and has a collection rate of 98 percent.*
*** $19K in unbilled claims is due to waiting on approval for Medicaid Crisis credentialing. This has been resolved since the interview and claims have been billed.*

Table 7.

CSB	0-30 Days	31-60 Days	61-90 Days	91-120 Days	120+	Total	A/R > 90 Days
CSB #1	$2,425,643	$514,657	$186,815	$139,852	$796,115	$4,063,081	23%
CSB #2	$0	$367	$70,102	$67,144	$97,174	$234,787	70%
CSB #3	$1,067,213	$114,888	$97,937	$101,380	$237,006	$1,618,425	21%

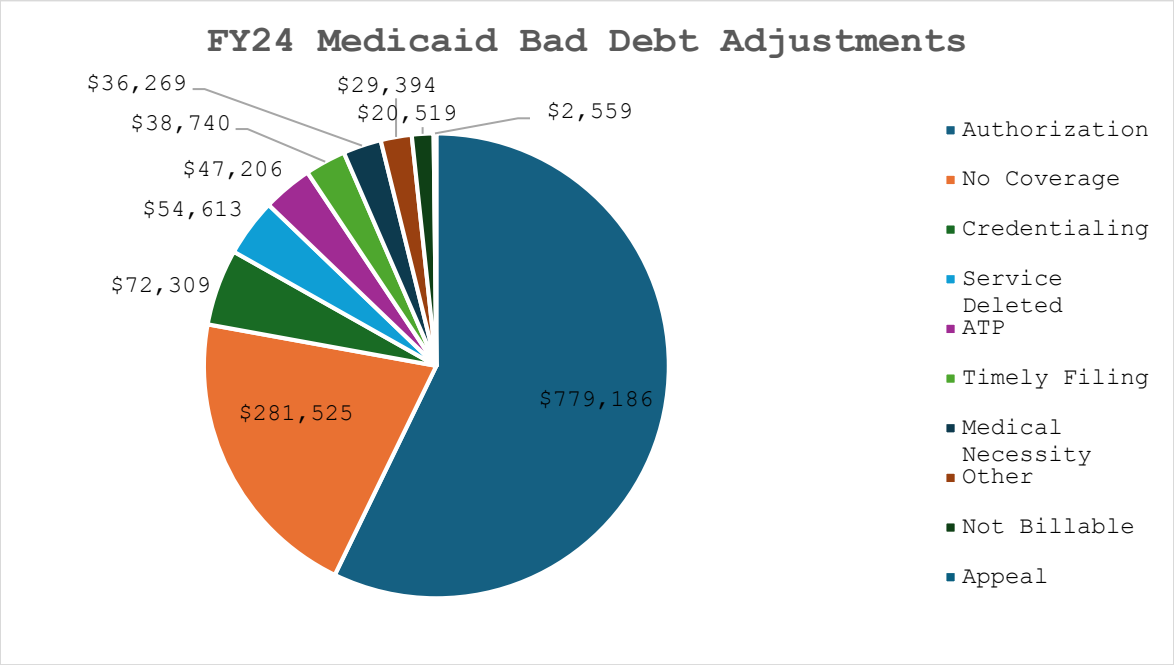
**Industry best practice is for the A/R aged over 90 days to be less than 15 percent of the total A/R.*

Medicaid Bad Debt Summary – CSB #1

CSB #1 adheres to industry best practices by entering bad debt write-off codes into the Electronic Health Record (EHR) system, enabling monthly trend analysis of adjustments. Bad debt write-offs are recorded when all collection efforts have been exhausted and the remaining balance is deemed uncollectible. It is essential to compare bad debt write-offs to revenue to assess their financial impact on the CSB.

In FY 2024, CSB #1 adjusted approximately $1.3 million, representing 5.1 percent of the annual revenue, which is higher than the industry benchmark. The graph below outlines the reasons for bad debt adjustments, highlighting the most significant opportunities for improvement. Bad debt due to authorizations accounts for 58 percent ($779,196) of all adjustments. The varying authorization processes with the Medicaid Managed Care Organizations (MCOs) were a consistent theme during interviews with CSBs. Establishing consistent authorization requirements and submission processes across all MCOs could present an opportunity to reduce bad debt across all CSBs and potentially lead to an increase in payments. Figure 6 shows these adjustments.

Figure 6.



Stakeholder Interviews and Documentation

Interviews were conducted with key stakeholders from three CSBs. The participants included Executive Directors, Chief Financial Officers, Reimbursement Managers, Supervisors, and Quality/Compliance personnel.

Billing processes and frequencies differ among the CSBs. To reduce billing denials due to coverage changes, monthly benefits are reverified. Pre-bill edits are analyzed in the Electronic Health Record (EHR) to ensure timely billing. Some staff perform manual utilization reviews before billing for specific services. The responsibilities of reimbursement staff for billing and claims follow-up also vary by CSB. There are no monthly Key Performance Indicators (KPIs) in place to track the overall success of billing and collections. It is important to also note that financial processes and funding differ between those CSBs considered Administrative Policy CSBs and those that are Operating CSBs. Administrative Policy CSBs receive local funding and must follow local government processes.

Several challenges were identified, including issues with credentialing with payors and vague billing denials from Medicaid Managed Care Organizations (MCOs) that necessitate phone calls to payors. From the perspectives of the CSBs interviewed, the payor representatives often provide conflicting and inconsistent responses regarding claim denials. Inconsistent Medicaid MCO authorization submission requirements and eligibility verification requests managed outside the EHR present additional risks per the CSB reports. Coordination of benefits and eligibility issues also pose challenges for the CSBs. In certain scenarios, Medicaid MCO claim

adjudication errors lead to payment delays and extra claims follow-up. An example discussed during the interviews was a system error with a dedicated payor resulted in $1.1 million in incorrect denials and three to four month delays in proper payment/adjudication.

From these interviews, it is likely important to establish a single source of truth for all Medicaid data to ensure consistency and accuracy in reporting, beyond claims data (which is used for the public facing DMAS behavioral health dashboard). If such data were available across CSBs, this centralized data source could be utilized for Key Performance Indicator (KPI) reporting and benchmarking, enabling better decision-making and performance evaluation.

Overall, implementing a standardized billing and claims follow up - process would ensure timely submission of claims and proper adjudication for payment. These practices and benchmarks will help CSBs enhance their financial performance and service delivery.

Summary

CSBs bill Medicaid for the vast majority of Medicaid billable services.

Behavioral health specifically may be disproportionately impacted by the transition to managed care and five health plans because of the qualitative nature of behavioral health work and related documentation, in the context of the behavioral health workforce shortage which is nationwide. Beyond behavioral health providers, CSBs may be disproportionately burdened by paperwork because Medicaid is one of many payers and they often have 20 or more grant funded projects/lines of funding with requirements from DBHDS.

Medicaid revenue accounts for 30 percent of CSB revenue across the state. CSBs have responsibilities to a range of other payers, including state general funded programs managed by DBHDS, which have their own paperwork and service requirements. Thus, although the administrative burden associated with Medicaid services would be similar across CSBs and private providers, CSBs have additional requirements for other payers which private providers who focus on the provision of Medicaid services would not have. This report has yielded five recommendations for consideration, some of which are actionable and others of which would require General Assembly funding or authority.

Recommendations

Follow Up with Technical Assistance for Any Unbilled Services
Overall, CSBs are billing the majority of Medicaid covered services to Medicaid. Services most commonly provided but not billed to Medicaid included peer recovery services, ancillary ARTS services, and some crisis stabilization services.

Although overall a small minority of services, CSBs, MCOs, and DMAS should work together to understand any barriers to billing and adjust policies and practices accordingly. For example, there may be policy clarifications regarding supervision requirements for some services which could be clarified through technical assistance. DMAS and MCOs will pursue this in partnership

with VACSB to identify any areas where clarifications could enhance billing, however, it is important to emphasize that CSBs are billing for the majority of Medicaid covered services. MCOs will be included in these conversations to explore any opportunities for alternative payment arrangements and additional training and support opportunities and collaborations between health plans and CSBs.

Implement KPIs for Billing and Claims at State or CSB Level

The results of this report are limited by a lack of standard data, health records, and KPIs for billing. The implementation of KPIs within CSBs or across the state could provide more formal feedback and actionable insights for the General Assembly as well as DBHDS, DMAS, and MCOs.

CSB Data Solution

To enhance data analytics for all CSBs and provide actionable data for improved visibility in billing and collection processes, a comprehensive data solution and architecture is recommended. This solution aims to streamline overall reporting by storing and integrating CSB data, automating data import processes, and optimizing the reporting structure to support data analysis while adhering to data governance principles. Key components of this architecture include the creation of a unified environment for managing metadata, defining organizational hierarchies, and setting business logic parameters.

Automated processes will be employed, where feasible, to import data from source systems into a centralized data warehouse. Effective metadata management will maintain references and business logic, ensuring robust data governance processes that facilitate security and long-term maintenance of the environment. Additionally, data policies will be established to regulate how data is gathered, stored, processed, and disposed of.

The optimized reporting structures will enhance data access and analysis, supported by data discovery and information delivery tools designed for executives, data analysts, and other analytic data consumers. Furthermore, business logic will be integrated into reporting and dashboard applications to support key performance indicators, ensuring that actionable data is readily available for informed decision-making.

Whether or not a CSB data solution is used at the state level, standardized KPIs could be pursued through standard reporting. Three key KPIs that should be considered for state level reporting for all CSBs would be:

- A/R Aged Over 90 Days: Benchmark <15 percent of the total A/R
- Net Collection Rate: Benchmark 98 percent or higher
- Bad Debt Percentages: Benchmark 1.5 percent - 2.0 percent of total revenue (by payor and reason type, if possible)

The combination of these three metrics will provide meaningful insights into the billing operations. Additionally, the data points required to track these metrics should be easily accessible, regardless of the Electronic Health Record (EHR) system in use.

Offer CSBs Technical Assistance on Revenue Management and Billing
Whether based on implementation of #2 (standard KPIs) or not, CSBs could self-select for technical assistance and centralized support functions if these were made available by the state through General Assembly funding or optional "buy in" arrangements for CSBs. Requiring a single, standardized billing solution is not recommended at this time as no feasible structure or concept emerged during the course of this study.

A/R Analysis
To enhance potential collections, focus on targetingCSBs with the highest accounts receivable (A/R) aged over 90 days. To achieve this objective, this would require the obtainment of monthly A/R Aging files from all CSBs, organized by payor. Conduct a root cause analysis to identify delays in cash collections, such as authorization, eligibility, timely filing, and payor setup issues. Determine whether these delays are related to CSB billing practices or payor adjudication issues. Provide education on relevant technology and processes to streamline future billing efforts. Additionally, ensure that Medicaid Managed Care payers are held accountable for timely adjudication of properly submitted claims and adherence to Medicaid authorization guidelines. Track incoming payments specifically related to accounts aged over 90 days to demonstrate the financial impact of targeted education efforts.

In addition to A/R Aging, request that FY 2024 bad debt adjustments be organized by payor and reason type from all CSBs. This analysis will identify the reasons claims are deemed uncollectible and for which payors. This presents an opportunity to implement process changes that reduce the root causes of bad debt moving forward, providing a quantifiable return on investment for the CSBs. Preventable bad debt can lead to enhanced cash collection and streamlined operations.

Effective cash collections are crucial for the overall financial health and operational efficiency of a CSB. Timely collection of accounts receivable (A/R) ensures that the CSB maintains a healthy cash flow, which is essential for meeting its financial obligations, such as payroll, supplier payments, and other operational costs. Delays in cash collections can lead to liquidity issues, increased borrowing costs, and a reduced ability to invest in growth opportunities. Additionally, efficient cash collections help minimize bad debts and improve the accuracy of financial forecasting and budgeting. By addressing the root causes of delays and implementing streamlined billing processes, a CSB can enhance its financial stability and overall performance.

Staffing Structure Evaluation – Centralized Billing Office
Implementing a centralized model in the near future is highly challenging due to the diversity of Electronic Health Records (EHRs), clearinghouses, staffing models, and services provided. The EHR systems currently in use based on the CSBs interviewed include Credible (Qualifacts), Welligent, Netsmart, and ConCENTRIX Profiler. The clearinghouses utilized are TriZetto, Change Healthcare, Inovalon, Availity, and the Medicaid Portal. Revenue reporting methods vary by CSB, with some employing a cash basis and others an accrual basis. Additionally, the responsibilities of reimbursement staff differ among CSBs, and their close connection to field staff and other CSB personnel presents a risk for a centralized model.

Transitioning to a new EHR system is a complex, multi-phased process requiring meticulous planning and execution. The general timeline for an EHR transition includes several phases:

The Pre-Implementation Phase (three to six months) involves evaluating the current system, identifying needs, and setting clear objectives for the new EHR system. This phase includes researching and selecting an appropriate EHR vendor, establishing a budget for the transition, and assembling a project team comprising IT staff, healthcare providers, administrative staff, and other key stakeholders. During the Implementation Phase (six to twelve months), the EHR system is customized to meet the organization's specific needs, existing patient data is migrated, comprehensive training sessions are conducted, and thorough testing is performed to resolve any issues before going live. The Go-Live Phase (one to two months) focuses on final preparations, officially switching to the new EHR system with a potentially reduced patient load and providing on-site support to ensure a smooth transition. In the Post-Implementation Phase (three to six months), ongoing support and optimization are provided, the overall success of the EHR transition is assessed, and continuous improvements are made to enhance the system's functionality and efficiency.

Overall, the process of transitioning to a new EHR system can take between twelve to twenty-four months, depending on the size and complexity of the CSB and the specific requirements of the new system. Each phase requires careful planning, execution, and support to ensure a successful transition. Given the cost, which would be in the millions and overall complexity, it is not recommended that CSBs consolidate to a single EHR, which would be necessary for a centralized billing model.

Comparative Analysis of Billing Practices & Best Practice Processes
Revenue Cycle Best Practices: Efficient CSBs should implement streamlined processes for intake, assessments, initial and on-going verification, authorization (if applicable), utilization review, pre-bill edits, and weekly & monthly billing. Claims should be submitted through a clearinghouse to increase visibility of rejections and denials, ensuring all claims are on file with the payor. Monthly reverification of benefits before billing is crucial to ensure accuracy.

Eligibility: The electronic 270 Transaction should be used to inquire about eligibility benefit status, and the 271 Transaction should be used for responses on a monthly basis.

Claims Submission: Submitting all claims through a clearinghouse not only increases visibility of rejections and denials but also ensures all claims are on file with the payor. This process enhances the efficiency and accuracy of claim submissions.

Month-End Close Process: Reconciliation with bank statements and posted payments should be completed within three business days. Accounting should be provided with reports to book General Ledger transactions, and all revenue should be reported on an accrual basis to reflect services performed accurately within the month. Monitoring bad debt reserves against A/R aging reports ensures appropriate funds are allocated for potential bad debt write-offs.

Benchmarking Against Federally Qualified Health Center (FQHCs)
Federally Qualified Health Centers (FQHCs) play a critical role in providing comprehensive health services to underserved populations. Their billing practices are essential for maintaining financial stability and ensuring the sustainability of services. Efficient billing practices help FQHCs maximize revenue, reduce claim denials, and improve cash flow. By adhering to best practices and benchmarks, FQHCs can ensure timely reimbursement for services rendered, which is crucial for continuing to meet the healthcare needs of their communities. Implementing

these standardized billing and claims follow-up processes will help Community Service Boards (CSBs) enhance their financial performance and service delivery.

Below are the billing industry benchmarks to analyze against CSB metrics:

- Claim Submission Rate: Aim for a clean claim submission rate of 90 percent to 98 percent.
- Claim Denial Rate: Maintain a claim denial rate of 5 percent or lower.
- Days in Accounts Receivable (A/R): Target 30 to 45 days for accounts receivable for traditional Medicaid. MCO target is 45-60 days due to varying adjudication timeline by the payors.
- Net Collection Rate: Aim for a net collection rate of 98 percent or higher.
- Claim Resubmission Rate: Keep the claim resubmission rate below 10 percent.
- Patient Eligibility Verification Rate: Strive for a 100 percent verification rate before services are rendered.
- Days to Payment: Aim for less than 30 days from claim submission to the first payment received.

Additional Best Practice Benchmarks:

- A/R Aged Over 90 Days: Less than 15 percent of total A/R.
- Bad Debt Percentages: Less than 1.5 percent - 2 percent of total revenue.

Appendix

1.1 CSB by Region (table has formatting that is slightly off)

Region 1	Region 2	Region 3	Region 4	Region 5
Alleghany Highlands Harrisonburg Horizon BH Northwestern Rappahannock Rappahannock-Rapidan Region 10 Rockbridge Valley	Alexandria Arlington Fairfax Loudoun County Prince William	Blue Ridge Cumberland Mtn Danville Dickenson Highlands Mt Rogers New River Valley Piedmont Planning District One Southside	Chesterfield Crossroads District 19 Goochland Hanover Henrico Richmond BH	Chesapeake Integrated BH Colonial Community Eastern Shore Hampton Newport Middle Peninsula Norfolk Portsmouth Virginia Beach CSB #1

1.2 CSB Survey

Service List	Does Not Provide		Provides and Bills DMAS		Provides But Does Not Bill DMAS	Reason for Not Billing	Additional Comments
****Includes DMAS reimbursable services only (whether primary or secondary). Services reimbursed only by non-DMAS entities and services with no reimbursement options are not included in this review.**							
Assessment							
IAACT Assessments							
Therapeutic Day Treatment Assessment							
Intensive In-Home Assessment							
Psychosocial Rehabilitation Assessment							
Mental Health Skill Building Assessment							
Substance Screening & Brief Intervention (All ages/durations)							
E&M (Includes new/established all coding levels, telehealth, and PCP E&M, MAT)							

Psychiatric Diagnostic Evaluation								
Psychiatric Diagnostic Evaluation with medical services								
Developmental Testing & Interpretation (All credentials and timeframes)								
Psychological Testing & Interpretation (All credentials, platforms, and timeframes)								
Neurobehavioral, Neuropsychological								
Nursing Visit								
Telehealth Originating Site Fee								
Smoking & Tobacco Cessation Counseling (All timeframes)								
Pharmacologic Management								
Electroconvulsive Therapy								
Annual Physical-Primary Care								
Annual Wellness-Primary Care								
Medical Testing (EKG, COVID, Pregnancy, TB, HIV, HEP)								
Venous Puncture								

Drug/Urine Screening							
Alcohol Breathalyzer							
Mediation Administration (Including MAT)							
MAT Induction							
Substance Use Care Coordination (Preferred OBAT/OTP)							
ASAM Level 4.0							
ASAM Level 3.7							
ASAM Level 3.5							
ASAM Level 3.0							
P-ACT Programming							
ACT Programming (Includes all sizes and fidelity)							
IOP-SUD (ASAM 2.1)							
SUD Partial Hospitalization (ASAM 2.5)							
IOP-MH							
IOP-MH with Occupational Therapy							
MH Partial Hospitalization (Hospital POS)							
MH Partial Hospitalization (Out of Hospital POS)							
Therapy (Including: Short, Med, Long; Individual, Family with and without consumer, Group, SUD/MAT/ASAM 1.0)							
Interactive Complexity Add-On							
Outpatient Crisis Therapy (All durations)							

Applied Behavioral Analysis (Includes all formats & modalities)								
23 Hour Observation								
Crisis Stabilization (Includes all credential configurations)								
Mobile Crisis Intervention (Includes pre-screenings and all credential configurations)								
Residential Crisis Stabilization								
SUD/MAT Case Management								
MH Case Management								
Treatment Foster Care Case Management								
SUD/MAT Peer Recovery Support Services								
MH Peer Recovery Support Services								
Transportation (Taxi & Wheelchair)								
Psychosocial Rehabilitation								
Mental Health Skills Building								
Supported Employment								

Therapeutic Day Treatment (Includes school, summer, & afterschool)								
Intensive In-Home								
FFT (New, established and all credentials)								
MST (New, established and all credentials)								
Therapeutic Group Home (All levels)								
Psychiatric Residential Treatment Facility (Including all related services, supports, assessments, and treatments)								
I/DD SERVICES								
DD Waiver Screening								
DD Case Management								
ID Support Coordination								
Group Day Support (All tiers)								
Community Engagement (All tiers)								
Day Support								
Community Coaching								
Community Guide								
In-Home Residential Support (All sizes)								
Congregate Residential Support (All tiers)								
Skilled Nursing Services (RN & LPN)								

Therapeutic Consultation Positive Behavior Supports Environmental Modifications Assistive Technology Supported Employment PART-C/EARLY INTERVENTION Assessments (Category 1 & 2 Providers) Targeted Case Management-Early Intervention Team Treatment Activities (Category 1 & 2 Providers) Developmental Services-Individual (All credentials) Speech/Language Therapy-Individual (Includes feeding, sound production, swallowing) Physical Therapy Occupational Therapy							