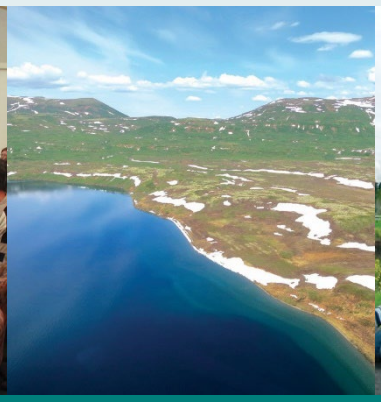
Community Behavioral Health Medicaid Service Provision: A Toolkit for New Providers

Technical Assistance funded by the Alaska Mental Health Trust Authority

July 2024

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Disclaimer: This is not an official State of Alaska guidance document. Organizations using this toolkit should complete their own due diligence and research to ensure their developing programs meet all applicable requirements.

Key Considerations

Eligible Services

Once you have determined your vision for service delivery, Alaska Medicaid has specific service descriptions both in regulations and in supplemental provider manuals that help to map the vision to Medicaid billable services. The Division of Behavioral Health maintains a webpage of these resources: https://health.alaska.gov/dbh/Pages/Resources/Medicaidrelated.aspx. Review the descriptions of Medicaid billable services to determine the best fit and communicate with the Medicaid Provider Assistance Services team with any questions.

Your organization may choose to provide services that are not described in Medicaid regulations and are therefore not eligible for compensation via billable revenue. Defining your organization's uncompensated services informs advocacy efforts to add new billable services and identifies areas where grants and other sources of funding are needed.

Eligible Providers

Staff Hiring and Credentialing

Regulation identifies the provider types eligible to render services. Community Behavioral Health Services (CBHS) providers can employ the widest range of individuals to provide services, including unlicensed master's level clinicians and providers with less than a master's degree. Under the CBHS model, the role of peer support specialists is limited. However, if a CBHS organization enrolls to provide 1115 Waiver services, an even more extensive list of provider types, including peer support specialists, becomes available. Services have different requirements for staff credentials and oversight, so it is important to consult regulation and program manuals to determine the appropriate staffing for each service you plan to provide.

The 1115 Waiver has a focus on workforce development and as such, important resources include matrices published by The Alaska Commission for Behavioral Health Certification for Peer Support Specialists, Chemical Dependency Counselors and Behavioral Health Counselors. These matrices and credentialling requirements will help your organization understand what is needed at time of hire and what supervision and education can be provided later.

Accrediting bodies also provide guidance on training and credentialling. Upon selection of an accrediting body, ensure that staffing requirements are aligned with that of the accrediting body and make adjustments as needed.

Background Checks

All staff will need to pass a State of Alaska background check. If they are unable, your organization may support the individual to pursue a variance. More information about the State of Alaska Background Check Program and variances are available on the state website: https://health.alaska.gov/dhcs/Pages/cl/bgcheck/default.aspx.

Background checks and waivers may slow your hiring processes and potential employees may not have the flexibility to wait for delayed offers. Your organization should define an approach for incorporating background checks and variances into the hiring process.

Staff Development and Retention

Employers have an important role to play in supporting the professional growth and job satisfaction of their staff. The following questions provide a starting point for considering your organization's role in supporting staff development:

- What credentials do your staff already have?
- What credentials are they interested in pursuing?
- How can your organization support staff in pursuing new or additional credentials?
- What is the supervision structure in your organization and how does that align with oversight requirements of the services you want to provide?
- Do you have clear professional advancement pathways for the staff you hire?

These questions do not have to be answered before service delivery begins but should be incorporated as part of your organization's strategic planning process.

Compensation

Billing for services is a specific type of funding. It is more reliable than other forms but has different requirements. Like any funding source, your organization must determine whether the requirements of this funding align with your mission. Billing will involve multiple external partners, including Medicaid, Medicare, and private insurance. Each of these payers will have their own requirements and, while Medicaid and Medicare are regulated at the state and federal levels, your partnership with commercial insurances will require additional negotiation.

- What services that you provide will not be compensated?
- Are there services that you will bill directly to clients if they are not covered by Medicaid or private insurance?
- Will the compensation you receive from your mix of payers be self-sustaining or will the program require additional support?

Documentation

Medicaid documentation requirements for behavioral health services are regulated based on how your organization enrolls with the state. This table shows which Alaska Administrative Codes apply to the documentation of different enrollments:

Table 1: Documentation Regulations

Enrollment	Regulations	Notes

CBHC	7 AAC 105.230 7 AAC 135.130	Section 135 contains additional service descriptions and service-specific documentation requirements
CBHC with 1115 Waiver Services	7 AAC 105.230 7 AAC 135.130 7 AAC 138 (1115 SUD Waiver) 7 AAC 139 (1115 BH Waiver)	Sections 135, 138 and 139 contain additional service descriptions and service-specific documentation requirements
MHPC	7 AAC 105.230 7 AAC 135.130	Section 135 contains additional service descriptions and service-specific documentation requirements
FQHC and RHCs	7 AAC 105.230 7 AAC 140.200-229	

- 7 AAC 105.230 describes the basic information needed to bill a service:
  - Recipient information
  - Financial information
  - Clinical record
  - 7 AAC 105.230(d)(7) includes the requirement that "documentation is complete no later than 14 days after the service ends."
- 7 AAC 135.130 requires:
  - Services must be **recommended** in an appropriate assessment to establish medical necessity
  - Services must be **ordered** in a client-driven treatment plan
  - Progress notes are no longer required by this regulation. For progress notes requirement, see 7 AAC 105.230 and applicable guidance by your accrediting body.

These regulations require interpretation to ensure that your agency's documentation standards comply with Medicaid requirements. Staff will also need support to ensure their documentaiton meets agency standards. See the section below on organizational infrastructure for more information on how agencies ensure quality.

Record Keeping and Reporting

Record keeping for healthcare providers is governed by both federal law and state regulation. Failing to comply with federal laws is a crime, so it is important that agencies have clear policies, training, and ongoing monitoring to ensure client privacy and the security of client information. See the organizational infrastructure section below for more details.

Some providers chose to maintain paper records. There are also many options for Electronic Health Records (EHR), which can be accessed remotely and can be used to collect and retrieve data to ensure quality care and help inform performance improvement.

The state of Alaska provides a free EHR system for Medicaid providers. This resource is called Alaska's Automated Information Management System (AKAIMS). Agencies who chose to use a different EHR system[1] or who maintain paper records are required to submit a minimal data set to the state-operated system. See the Department of Health's AKAIMS page for the most up-to-date guidance. The minimal data set that allows the state to comply with federal reporting requirements and informs decisions about behavioral healthcare resources throughout the state.

[1] For help in selecting and implementing and EHR, visit the Health IT Playbook: https://www.healthit.gov/playbook/electronic-health-records/#Plan-Selection-summary

In addition, you may have to collect and report data to comply with a range of other requirements. To ensure cost transparency, the state requires agencies to update publicly available rates sheets for services. The state also requires agencies to conduct self-audits of billing records to identify over-payments. Finally, the state conducts annual client satisfaction surveys and will require a list of names and addresses of all clients served.

Additional reporting obligations will depend on your agency's partners. Other funders may have reporting requirements, often included in grant agreements. Your community partners may agree to information exchanges to improve systems. Your accrediting body will require you to track some performance indicators and may require data reporting as part of the review process. Your Board of Directors may make one-time or recurring data requests. You will also want to report data internally to inform decisions.

Department Approval and Enrollment

To begin the enrollment process, contact the Division of Behavioral Health. Department approval is a multi-step process during which the provider works with state support to build appropriate policies and procedures. This is an iterative process without a set timeline. Providers should contact the division for guidance as soon as they decide to explore billing as an option. When this phase is completed, the division will send the provider a letter of certification informing them what services they are approved to provide. It is common that initial certification will not include all services the provider has proposed, and additional services can be added to the certification with more collaboration with the state. Upon receipt of the certification, the provider must then enroll with the appropriate state partners. See the Enrollment section below.

Accreditation

All providers must be accredited. Per 7 AAC 70.030(d), the department can issue provisional approval while a provider is seeking accreditation. The state acknowledges three accrediting bodies and providers should chose the option that best fits their business model. Regulation 7 AAC 70.160 also allows for alternative accreditation if other qualified accrediting bodies are available.

The three main accrediting bodies for behavioral health services are the Joint Commission, Commission on Accreditation of Rehabilitation Facilities (CARF), and the Council on Accreditation (COA). All three organizations assess fees based on surveys or site visits. Online resources and consultation are available between surveys. Below is an outline of the three accrediting bodies.

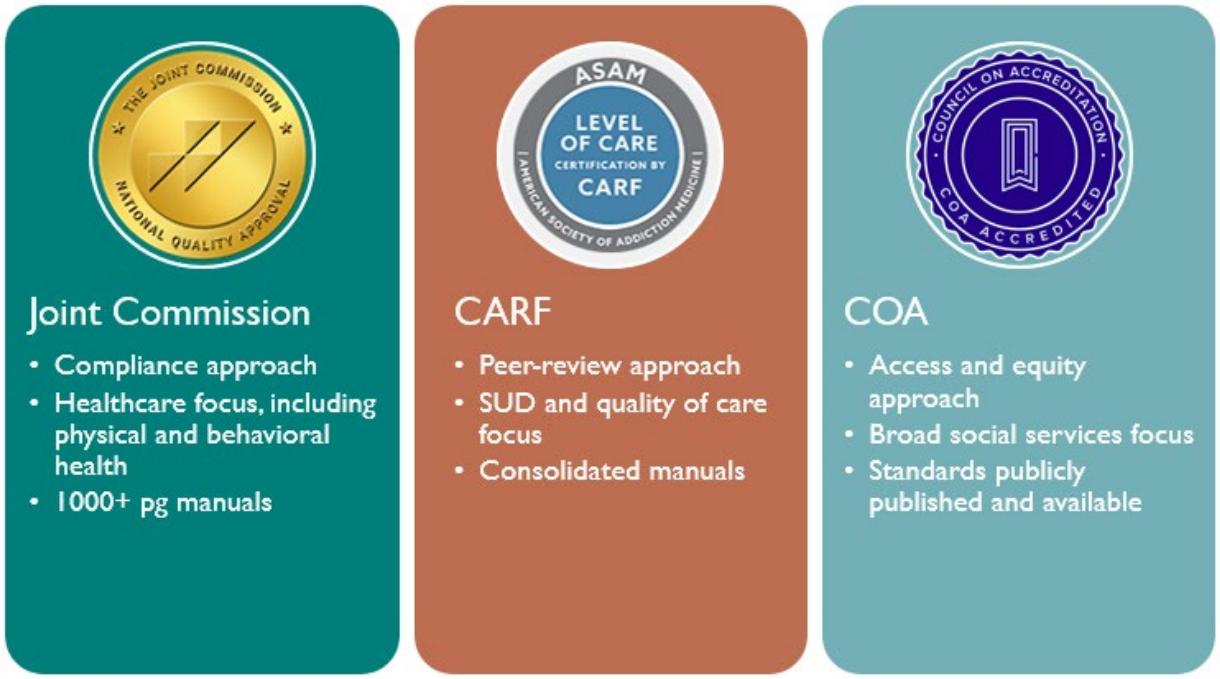

Figure 1: Accrediting Bodies for Behavioral Health Providers

Joint Commission

- Scope includes medical and social services
- Also provides a range of certifications and compliance services
- Most explicit/quantitative standards
- "Our survey time together includes both an objective evaluation of standards compliance along with strategies and structures for improvement."
- Survey every three years
- Self-assessment tools and potential quarterly reporting

Commission on Accreditation of Rehabilitation Facilities (CARF)

- Scope includes a broad range of rehabilitation services: aging services, behavioral health, child and youth services, employment and community services, medical and vision rehabilitation
- Also provides certifications for ASAM levels of care
- Standards are more qualitative
- Review conducted as coaching for service improvement: "Our surveyors are industry peers who follow a consultative (rather than inspective) approach."
- Self-review every year
- Site visit usually every three years, although some circumstances cause surveys to be more frequent
- Quality Improvement Plan expected after all site visits
- Surveys are conducted by other behavioral health professionals and CARF may offer contracts to staff members to conduct future surveys

Council on Accreditation

- Scope includes a range of social services and philanthropy

- Also provides certification for Certified Community Behavioral Health Clinics, a national designation with emphasis on addressing health disparities
- Standards are brief and broad and published publicly
- All accreditations include Service standards, Administration and Management standards, and Service Delivery Administration standards
- Nonprofit accreditations are estimated to take between 18 and 48 months.

Other Considerations

Before billing for behavioral health services, there are additional considerations that may affect your program design.

Under-resourced and Medicaid-ineligible clients

Medicaid does not cover services for everyone who needs care. To bill Medicaid, behavioral health providers must develop policies to capture available funds as well as make financial resources available to support the care of all clients, regardless of ability to pay. Some populations who can fall into this category include: those who are not eligible for Medicaid; those who are eligible but not enrolled; those who have private insurance but are unable to pay co-pays; those who are unable to provide meaningful consent at the time of service, such as minors or those experiencing a crisis; those who are unable to provide sufficient personal information to satisfy documentation requirements. To remain sustainable, behavioral health providers must budget for these uncompensated services and develop pathways for those served who can become billable Medicaid clients.

Service Locations

In a real physical sense, services must occur in a location and different locations can present additional considerations. Always confirm with regulations that the service you are providing is billable at the location. Even in an office setting, technology, data security, and privacy must be considered. If staff are meeting clients out in the community, they will have additional training, technology, transportation, and safety needs. Services provided remotely must use a HIPAA-compliant online service, although some services can be billed if provided over the phone. When providing remote services, both the provider and the client must have appropriate local settings.

Community Need and Partnership

Providers should understand community need and the gaps in currently available services to avoid service duplication. In many cases, community partners can improve communications and develop referral pathways to better serve community need. In some cases, a community partner is better positioned to expand services. In other cases, community partners may report needs that your agency is well positioned to fill.

Workforce Development

Workforce is a limited resource throughout Alaska and many communities struggle to recruit qualified staff who can relocate. If your agency does not currently have the staff to provide behavioral health services, consider your recruitment strategies. Have you struggled to retain or replace staff in the recent past? Alaska participates in the federal SHARP program.

One solution to workforce shortages is to adopt a "grow your own experts" approach in which local community members and persons served are supported in professional development to achieve the credentials required for compensation in providing the services their home community needs. Agencies can

work with the Alaska Commission for Behavioral Health Certification to ensure staff have meaningful access to the resources needed to advance through the Peer, Chemical Dependency Counselor or Behavioral Health Counselor matrices. Staff who wish to pursue an appropriate master's degree can be supported through online, part-time programs, including the MSW program offered by the University of Alaska system.

Enrollment

Enrollment Options

Alaska provides many enrollment options for the provision of Medicaid reimbursed behavioral health services. This toolkit is specific to providers who wish to enroll as Community Behavioral Health Clinic (CBHS) and CBHS with 1115 Waiver. CBHS offers the most service options and allows for billing by the most types of provider credentials. As an example, an unlicensed master's level clinician cannot bill for services under other models. Both the Qualified Addictions Professional (QAP) and Peer Support Specialist (PSS) credentials are specific to 1115 services. Peer Support Services are also eligible for reimbursement for CBHSs under the integrated state plan.

Once a provider has decided on a billing model, they must complete the enrollment process. Community Behavioral Health Clinics (CBHS), Mental Health Physician Clinics (MPHCs) and Professional Services provided by independent provider or provider groups are all under the purview of the Division of Behavioral Health (DBH) for the State of Alaska. For more information on provider who can bill Medicaid for behavioral health services, see 7 AAC 105.200. For more information on how providers enroll, see 7 AAC 105.210. For more information about the broad category of provider types who can provide services in the state and which are eligible for funding from the Department of Health, see 7 AAC 70.

Enrollment Process

The first step for a behavioral health provider to enroll to bill Medicaid is contacting the Division of Behavioral Health. Applications and other relevant materials can be found on the division's resources page, including the application and additional forms needed for the certification process. Division staff will assist agencies in reviewing their application materials and completing the application process. The most time-intensive task in the application process is developing compliance policies and procedures. The department will directly review some policies and procedures and will require the agency to attest to others. At the completion of the application phase, the division will issue a letter certifying the agency to provide specific services. This application and approval process can be ongoing. Some agencies will receive approval to provide some services initially, with the understanding that they can continue to work with the division and achieve approval for additional services. Provision of 1115 Waiver services requires additional enrollment paperwork.

Upon receiving the certification letter from the state, the agency has three additional processes to complete: enrollment, staff credentialling, and accreditation. Enrollment is a much simpler process than certification. Enrollment involves registering your business for the appropriate system to receive payment. For Alaska, this is the Alaska Medicaid Health Enterprise. The Enterprise website serves all Alaska Medicaid billing providers, not just behavioral health providers. Their website includes additional resources, including billing manuals, trainings for billing staff, and fee schedules for Medicaid reimbursed services. Staff credentialling should

correspond with the hiring schedule described below. Accreditation will need to be completed within two years of certification.

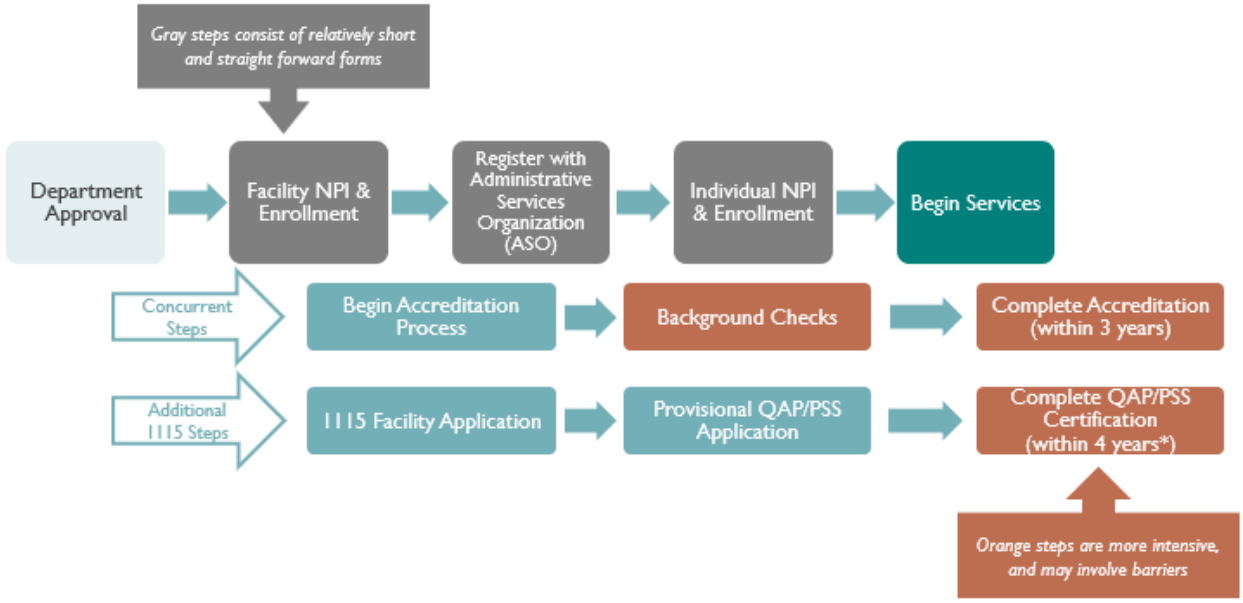

Figure 2: Timeline to Medicaid Billing

*Regarding QAP/PSS certification: The Provider Standards and Administration Manual for SUD Providers effective 2/2024 states that both QAPs and PSSs have 4 years to complete their certification. The BH Manual makes no mention of provisional certifications. The 1115 Waiver Provisional Provider Application effective 10/2020 states 3 years.

Organizational Infrastructure

Every agency needs the staff who perform the services, an executive team, clinical expertise, and a board of directors. Agencies who bill Medicaid also need a compliance infrastructure. There are many ways to define the roles within a compliance program, but agencies will need to complete tasks which can be broken down into those required for each service as those required as an agency overall. In the following figure, we demonstrate a sample of how these tasks can be grouped. For more guidance on building a compliance program, see the US office of Health and Human Service's General Compliance Program Guidance.[2]

[2] https://oig.hhs.gov/compliance/general-compliance-program-guidance/

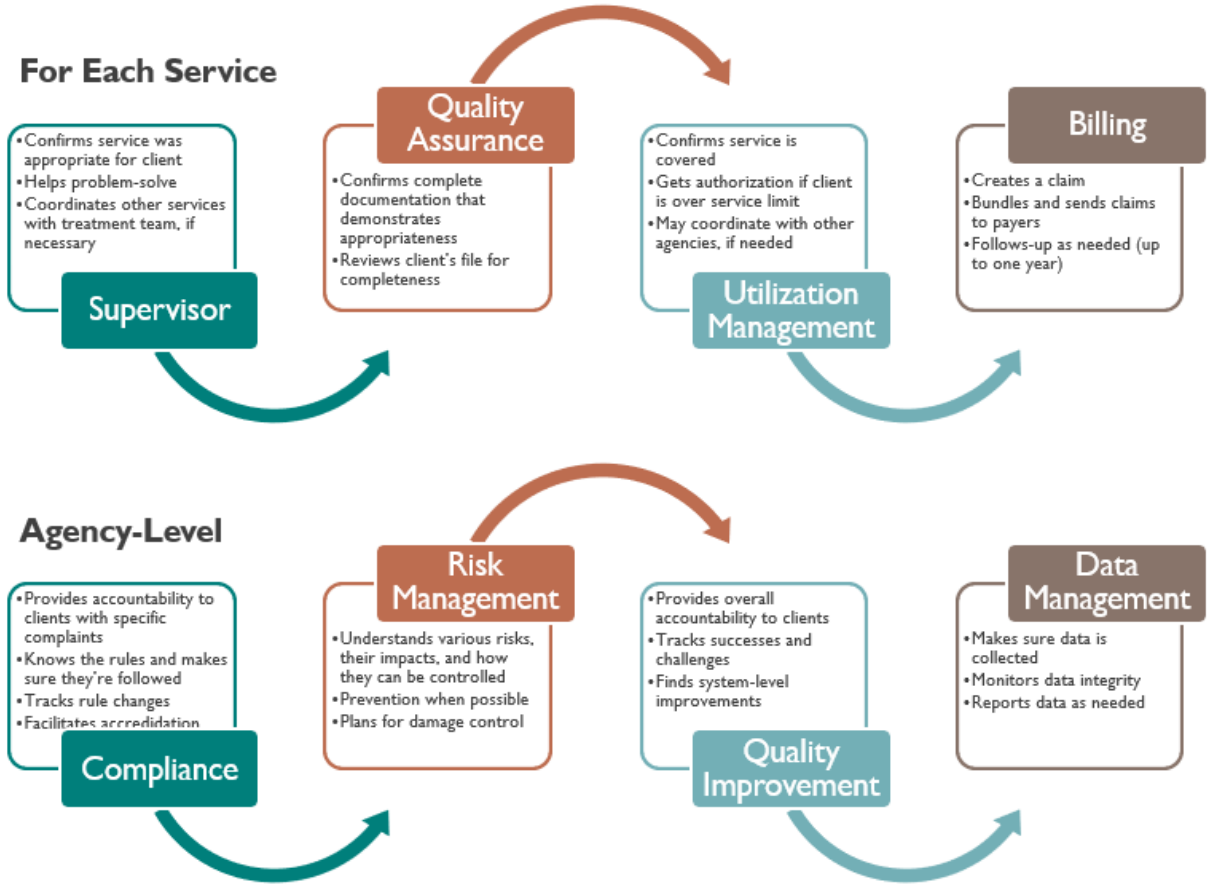

Figure 3: Compliance-related Tasks for Medicaid Billing

For Each Service

To bill Medicaid for services, an organization must complete administrative tasks beyond the direct provision of the service. This report breaks clusters those tasks into themed buckets both in Figure 3: Compliance-related Tasks for Medicaid Billing and in the descriptions below. Each organization will determine its own workflows and role clarity to ensure the most efficient and effective completion of these tasks.

All services require that the rendering staff receive **supervision**. A supervisor can assist staff in confirming that the service was both medically necessary and provided in a way that was appropriate for the client. The supervisor help support the staff with additional clinical judgment for complex decisions about appropriate care and ensure due diligence with reference to policies and consultation with the compliance program if the staff is concerned about ethical ambiguities. Organizations may also choose to route care collaboration workflows through supervisors.

Quality Assurance is distinct from clinical supervision. Quality assurance maintains specific non-clinical standards for the agency and reviews service documents to confirm those standards are being met. Quality assurance occurs both before and after a service claim goes to billing. These workflows can involve direct review of all documentation, establishing an audit system for established staff whose documentation is consistently compliance, and a regular review system. Quality assurance applies both to progress notes that are specific to each service as well as reviews of the entire client file to ensure completeness.

Utilization Management ensures that clients are eligible for Medicaid billable services and have not exceeded any service limits. This is an ongoing process that may include additional steps such as service authorizations or coordinating with other agencies who serve the same client to ensure services billed were not provided by the other agency.

On a service-by-service level, **billing** has several tasks that ensure payment for appropriate services rendered. Whether in-house or contracting with a third-party biller, agencies must ensure that all billing work is allocated to a specific responsible party. Billing includes creating a claim, maintaining accurate financial and payer information for each client, and submitting those claims to the appropriate payer. Many claims may need to be submitted to multiple payers or may need to be corrected, which means that the billing program may need to track an individual service claim for up to a year after the service is provided.

At the Agency Level

In addition to the administrative tasks required for each service, Medciaid-billing providers require administrative support at the agency level. As in Figure 3: Compliance-related Tasks for Medicaid Billing and the task description above, these agency-level tasks are clustered into themed buckets. Depending on the size of the agency, many of these buckets can be consolidated into a single position or can be distributed to ensure wide-spread buy-in. A robust **compliance** program has many components and requires agency-wide participation. However an agency chooses to distribute these tasks, it is essential that no one position be responsible for auditing its own work or the work of a position in their supervisory structure. The only exception is that the lead of the compliance team may review the work of the executive team if they will then report those findings directly to the board of directors.

The role of compliance is to **alert agency leadership of changes** in the laws, regulations, and requirements of external partners. These changes may look like new regulations, changes in how the courts interpret laws, changes to accreditation standards, or recent audit findings for similar agencies. Updating policies and procedures to adjust to these changes and training staff on any new requirements is then implemented by the appropriate leadership in an agency. In some cases, the agency will need to seek legal counsel to ensure steps taken are appropriate. See the section below on External Partners for more information.

The person who tracks changes in accreditation standards is usually also the person who **facilitates accreditation and facility licensing.** In years when the agency is under accreditation or licensing review, someone must collect documentation, coordinate site visits, and prepare the appropriate response to any review findings. In years between site visits, there may be quality improvement plans to implement, regular reporting requirements, or self-reviews.

Another crucial source of feedback is **client complaints**. The agency needs a staff member who can guarantee anonymity, provide objective review of all client complaints and report the results directly to whoever supervises the parties involved. In incidents where an investigation is required, such as instances where a client came to harm, the objectivity of this role must be clear to outside stakeholders, including law enforcement, accreditation reviewers, or affected community members.

Risk Management has both proactive and reactive components. Proactive risk management involves emergency planning, safety training, and risk assessment. All business requires some degree of risk tolerance, but risk assessment means analyzing the likelihood and potential impact of different risks as well as what is and is not within control of the agency to determine which require appropriate prevention steps. The reactive component of risk management means mitigating the impact of an event. This may involve implementing and

coordinating an emergency plan, development of postventions, or the distribution of information. It may also involve actions by public relations or human resources staff.

Quality Improvement is an ongoing process that should be part of any organization regardless of size or history. Quality improvement gathers performance data, determines key performance indicators (KPIs), and tracks performance against agency goals and mission. Quality improvement processes include strategic planning, case reviews to determine successes and challenges, and communication of those success and challenges to support the agency's overall performance.

Quality data is required for both data-driven decision making and to comply with reporting requirements. **Data management** is the set of tasks that ensure the quality and accessibility of data. Data management involves designing data collection that fits into reasonable workflows, monitoring data integrity to ensure data is collected accurately, and reporting the appropriate data to decision makers in clear and understandable ways.

Closely related to data management is **software system administration**. These tasks include making adjustments to software to facilitate agency needs and workflows, ensuring interoperability (making sure different software can share information when needed), managing contract relationships with software vendors, training new staff in how to use software, updating account access for new and departing staff, and resetting passwords as needed. Many software systems include these services as part of their contract while others have preferred subcontractors. Depending on an agency's data needs, unique workflows, or staff capacities, these functions can be completed in-house, through a single contract, or through multiple supporting contract relationships.

In addition to the billing tasks that must be completed for each service claim, there are agency-wide system-level tasks to ensure the revenue cycle doesn't get interrupted. **Revenue cycle management** involves contract negotiations with private payers to ensure appropriate compensation, establishing a sliding scale, following-up on claims that were denied in error, ensuring payments are deposited properly, reviewing intake procedures to ensure necessary information is collected, and making sure that services are codes are applied properly by both staff and software. Some agencies also create payment assistance programs for under-resourced clients to ensure they continue to have access to necessary care. Such programs require documentation, standards, confidentiality, and client education.

Sample Organizational Structure

Each agency will determine how best to distribute compliance-related responsibilities. To function properly, a compliance program must be separate from both clinical and billing infrastructure. This is because the three functions need to audit one another's work. A common saying amongst compliance professionals is "compliance is everyone's job." For example, program and clinical supervisors should never be supervised by anyone on the compliance team, but they should be accountable to the compliance team to ensure that agency policies and procedures are understood and followed across the agency. Data and IT tasks can be located in several different parts of an organizational structure depending on the skills and priorities required for various roles.

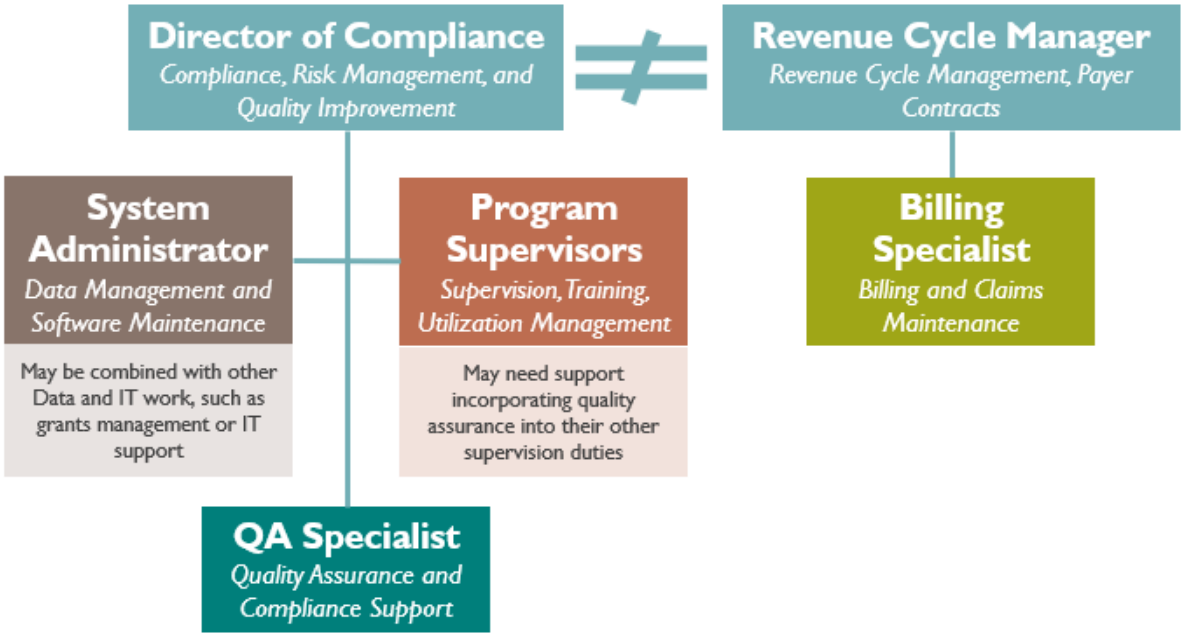

Figure 4: Sample Organizational Structure

External Partners

Most providers strive to fulfill requirements and provide the best quality service to their clients. Billing Medicaid significantly expands the partners who share these priorities and can support an organization to maintain compliance and quality assurance.

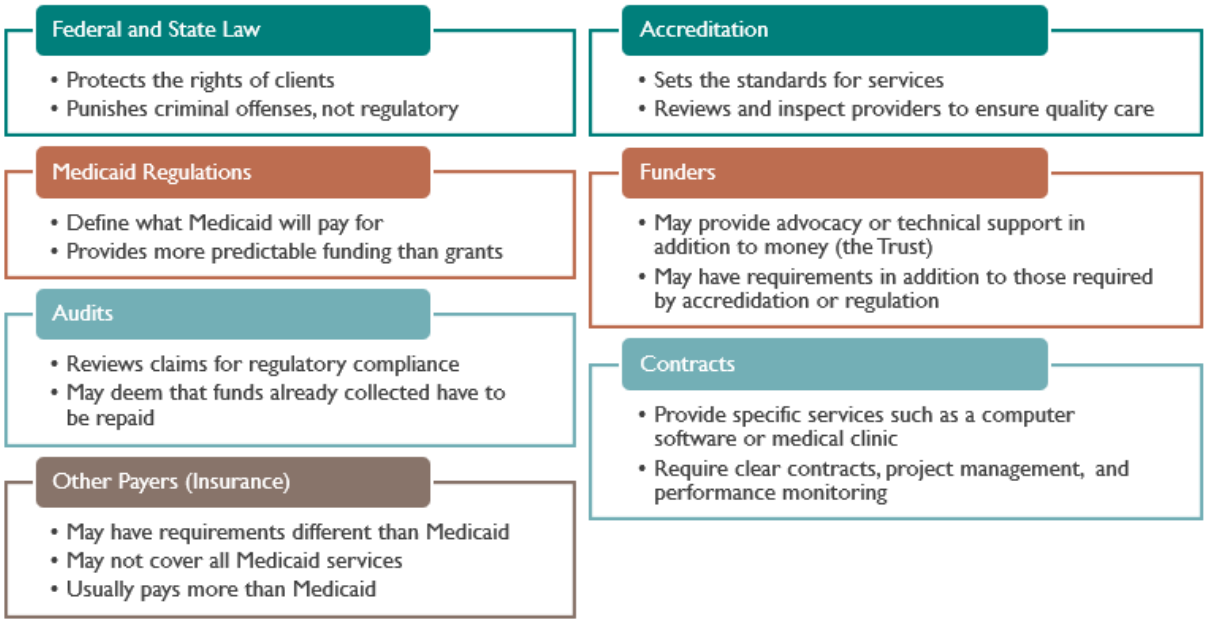

Figure 5: External Partners

The role of **federal and state law** is to protect the rights of those receiving services and other vulnerable populations. Laws include those that affect privacy, consent to treatment, services for minors, and appropriate distribution of controlled substances. Violating a law is a criminal offense and can be punished with fines, prohibitions, or even imprisonment.

Regulations are not the same as laws. Laws apply to everyone. Regulations are the conditions of participation in a program, such as Medicaid and therefore only apply to program participants. Medicaid regulations define appropriate uses for public funds. Regulations help agencies by providing a reliable source of funding in the form of standards for billable services. If your services do not meet regulatory standards, it essentially means that you are not entitled to program funds. If those funds have already been distributed, that means you must pay them back. Breaking regulations can also constitute waste, fraud, or abuse.[3] Waste is characterized by careless mismanagement of public funds. Abuse is the misuse of funds or one's position. Fraud is an intentional deception or misinterpretation for financial gain. All three can result in being excluded from Medicaid programs. Waste and abuse can have serious financial consequences. Fraud can also result in criminal charges.

One important tool to avoiding waste, abuse, and fraud is an **audit**. Periodic and unannounced audits help providers identify and correct errors that may have resulted in inappropriate payments. In Alaska, providers are required to conduct self-audits, and the state can audit providers directly. In an audit, a selection of a provider's claims will be reviewed to ensure they are compliant with regulation. If the state finds a claim for a service that is not compliant, they are authorized to assume that all similar services will have the same noncompliance rate as the sample. They can therefore require the provider to payback whole categories of services. The results of a self-audit must be reported to the state and may involve repayment. However, the state has some flexibility to work alongside providers to resolve the audit findings and ensure those errors are not repeated.

[3] https://oig.hhs.gov/reports-and-publications/featured-topics/ihs/training/fraud-waste-and-abuse-for-health-care-providers/content/#/

Medicaid is not the only payer who covers behavioral health services. Providers can establish billing relationships with **commercial insurance, other public insurance programs, and third-party payment systems** such as workers' compensation. Provider relationships with non-governmental payers are negotiated contracts that can vary in terms of rates, requirements, and services covered. Rehab services are less likely to be covered by payers other than Medicaid. Medicare pays comparable rates to Medicaid while most other payers pay higher rates.

In addition to payers, most providers receive additional resources, including **funding from grants and private donations**. These funds often come with requirements such as reporting data, serving specific populations, and providing services without charging a payer. Funders may provide advocacy, in-kind donations, or technical support in addition to direct funds.

Medicaid requires appropriate accreditation for billing. **Accreditation** means that a provider continues to meet the standards of an independent accrediting body, usually the Council on Accreditation (COA), the Commission on Accreditation of Rehabilitation Facilities (CARF), or the Joint Commission. The standards of each organization can vary significantly. Yet each organization creates metrics by which a provider can ensure that they are providing quality care, maintaining best practice, and implementing reasonable quality improvement processes. In addition to publishing standards, these agencies conduct site visits and reviews of both P&P and clinical records. Unlike an audit, a finding on one of these visits carries no financial penalty. Instead, the accrediting body will produce a report that helps providers identify areas of improvement. Specific follow-up steps on these reports also vary, but the overall process is that providers are permitted to respond with either evidence that the finding was an error or plans for improvement. Providers typically can maintain accreditation so long as they demonstrate willingness to meet standards and improve on identified areas between site visits. Payers entrust accrediting bodies to affirm quality of care. By separating the accreditation process from the payer contract, accrediting bodies can ensure that standards are fair and fairly enforced.

Many of the above tasks can be contracted out to external experts or consultants. **Contract management** involves reviewing agreements to ensure that all tasks are completed and that only agreed upon tasks are billed. All contracts should have a consistent point of contact, clear feedback mechanisms, and a regular review to ensure the contract continues to meet the agency's needs.

Accountability

Errors in operations are a reality of any business model. The repercussions of errors can vary significantly. Figure 6: Levels of Accountability for Medicaid Billing outlines levels at which errors can occur and the typical corresponding repercussions. Repercussions will reflect the gravity of the error and may escalate significantly depending on the specifics of each instance as well as the frequency of errors. Creating a strong organizational infrastructure and working closely with external partners helps to prevent errors and creates systems for catching and responding to errors when they do occur.

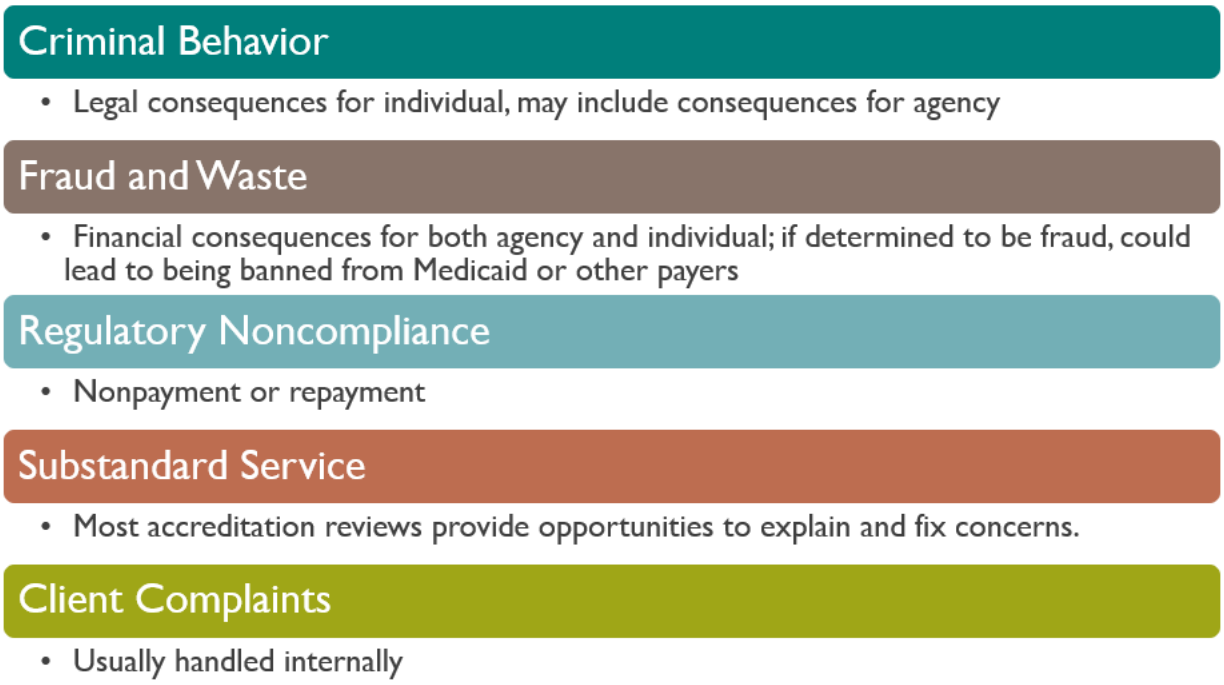

Figure 6: Levels of Accountability for Medicaid Billing