

California Institute of Mental Health
California Behavioral Systems Coalition
Phase II Report

Prepared by:

Dale Jarvis, CPA

MCPP Healthcare Consulting Inc.

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Chapter 1: The Phase II Transition and Process

Phase I Results

Multi-county collaborative software search identified four top ranking vendors

In January 2004 the California Institute of Mental Health (CIMH) California Behavioral Systems (CBS) Coalition released its Phase I report, describing the process 27 California counties used to evaluate Behavioral Health Information System vendors and the findings from their research.

Finding: The Field has been Narrowed. The coalition came to the conclusion that there was no “perfect” vendor for the California counties, nor was there a vendor that was universally preferred by all Coalition members. Within this context, the “top 3” vendors for every county came out of a pool of four vendors: *Anasazi*, *CMHC Systems*, *Creative Socio-Medics*, and *Raintree*.

Finding: Further Research is Needed. Various strengths and weaknesses were identified among the vendors as the coalition researched the clinical, billing, administrative, managed care, reporting, technology and security, and corporate capacity capabilities of the vendors. The group concluded that further investigation of specific vendor issues was necessary prior to selecting and pursuing contract negotiations with a vendor; this work should be completed collaboratively among coalition members through a Phase II project.

Phase II Startup

Twenty of the twenty-seven counties participating in Phase I made the transition to Phase II. Solano County, which was not part of the Phase I process, joined the Coalition for Phase II.

20 of the 27 counties participated in a Phase II process

Individual County Members	Small County Group	
Alameda	Amador	Madera
Butte	Colusa	Modoc
Contra Costa	Del Norte	Mono
Kern	El Dorado	Nevada
San Mateo	Glenn	Calaveras
Santa Barbara	Inyo	San Benito
Solano	Lassen	
Stanislaus		

Table 1: Phase II CBS Coalition Counties

The first task of the coalition was to decide which vendors would be evaluated in Phase II: the top four or all eight Phase I finalists. Due to the strong showing of four vendors in Phase I and the need to focus limited time and resources, all coalition members agreed to focus the coalition's resources on evaluating only *Anasazi*, *CMHC Systems*, *Creative Socio-Medics* and *Raintree*. Counties that continued to be interested in other vendors or felt they needed to continue to evaluate all eight as part of their local procurement rules would be free to continue evaluating the other vendors on their own.

Phase II Goals

Five Phase I goals served as the foundation for Phase II activities

Phase II carried forward the original goals from Phase I.

Goal 1: The coalition will work together to find systems that meet common needs. Since it was estimated that perhaps as much as 80% of county behavioral health system needs were shared, the coalition will pursue these common needs together.

Goal 2: Each county will make its own decision regarding the system and vendor that best meet local needs. While focusing on shared system requirements, the coalition has also maintained a consistent commitment to individual county decision-making autonomy.

Goal 3: Counties will share their local expertise with all members of the coalition. All counties need not send representatives to each and every activity. All evaluations by county participants will be shared amongst coalition members.

Goal 4: Travel expenses will be kept at an absolute minimum. To reduce such costs, web based meetings will be used whenever possible.

Goal 5: Counties that select the same vendor may continue to cooperate to achieve advantageous pricing and to continue collaborative efforts to achieve cost efficiencies. It is expected that several counties will select the same vendor for their next generation of information systems.

CBS Coalition Process

A multi-part workplan was used to gather additional vendor information

Phase II research efforts included the following activities:

- 40+ reference calls to current customers and subsequent write-ups
- "Mission Critical" workflow development including additional specification of key California requirements
- Collecting county-specific price quotes for each county interested in a given vendor

The Phase II report has been designed to add qualitative information to the Phase I report

- Vendor contract analysis
- Development of a model contract that could be used by one or more county with any of the vendors
- Completion of a risk assessment for each vendor
- Two-day face-to-face gap analysis meetings with each vendor to walk through the workflows, address county-specific questions, and review other outstanding issues
- Half-day conference calls with each vendor to discuss outstanding corporate capacity questions
- Local compilation and analysis of the Phase II data
- Coalition member negotiations to compare findings and begin building vendor-specific contract negotiating workgroups

The Phase II analysis activities occurred primarily at the local county level. Unlike Phase I, specific county results were not compiled, summarized and presented as a final product. The purposes of Phase II was to assist each county in making a local decision, using other colleagues as resources, and to identify where common ground existed among counties. Accordingly, the Phase II report is more qualitatively oriented, containing descriptions of how vendors address key issues, rather than presenting a set of numeric scores.

Chapter 2: Phase II Results and Findings

Overview

Chapter 2 examines several areas that distinguish the vendors from one another

Several coalition members concluded they could successfully implement any of the four software packages and meet the behavioral health information system needs of their county.

During Phase II, each county has refined its set of local decision-making criteria and developed a scoring matrix that gives a weight to each criteria and a score to each vendor. In some cases counties have used the “Green Book” decision making tool described in the Phase I report; in other instances, counties developed a new matrix.

Chapter 2 examines several of these variables, describing what the counties have learned about each vendor. Other variables such as corporate capacity, system interfaces, technology compatibility, security, etc., have not been included in Chapter 2, either because of the complexity of the topic or because it was adequately covered in Phase I and not a focus of Phase II.

Level of Customization – California Billing and Reporting

The coalition identified 35 key California-specific functional requirements

Attachment A contains 35 key California-specific functional requirements that are required by each county, sorted into four areas. These functional requirements are a subset of the larger list identified in the original Request for Proposal and analyzed in Phase I.

- California Eligibility Loading and Checking
- California Client Intake, Registration and Related State Reporting
- California Billing and Collections
- California Data Reporting Interfaces

Both *Anasazi* and *Raintree*, which do not have installations in California counties, will need to design and develop each of these pieces of functionality. Estimates for this work range from six to twelve months. *Anasazi* has proposed to complete this work “on their nickel”, recouping the investment through the sale of its software. *Raintree* has submitted preliminary estimates for the cost of developing this functionality and has proposed to complete a small number of components as part of a “proof of concept” demonstration.

CMHC Systems and *Creative Socio-Medics* have California county customers and have stated they have all the functionality for which the State of California has provided specifications. As the state rolls out new

functional specifications, such as the Automated Real-Time Eligibility Checking of State MEDS Point of Service Database, the two vendors will modify their systems under the maintenance contracts with their California customers. *CMHC Systems* continues to use character-based billing screens, deployed through its browser user interface, which several counties consider a product shortcoming.

Some coalition members have determined that *CMHC Systems* and *Creative Socio-Medics* have designed certain components that do not meet their needs and would require changes prior to implementation, if they were to purchase the product. An example is the compliance requirement that necessitates the blocking of billing day treatment and therapeutic behavioral services, including those provided by the county, if there isn't an open, active authorization; currently *Creative Socio-Medics* does not have this functionality. It is our understanding that any statewide requirements identified as gaps during the pre-contracting process would be completed by these two vendors with no additional charge to the counties.

Each county will also have local customization needs to address during the contracting process. Because the coalition did not examine these local requirements, we are not able to describe the extent to which they are met by the different vendor products.

Clinical Functionality

The coalition identified three major clinical processes that lend themselves to automation

Although there is much similarity in the clinical work done by coalition members, there is variation in how that work is done. There is little standardization of clinical forms among counties; different counties have different workflows related to their assessment, treatment planning, service delivery and service review processes.

Coalition members have identified three major clinical processes that lend themselves to automation:

- Appointment Scheduling > Service Entry > Progress Notes
- Medication Management
- Assessment > Treatment Planning

Each of the four vendors has developed its system functionality somewhat differently to both meet these requirements and offer different options for county versus vendor tailoring of existing functionality to meet local needs.

The overall look and feel of the clinical modules varied from vendor to vendor. *Anasazi* utilizes a Clinician's Home Page that lists all of the clients on a clinician's caseload and provides a number of predefined flags and alerts for specific clients. The *CMHC Systems* Clinician Desktop shows the clinician's calendar as well as his/her caseload and to-do list. *Creative*

Socio-Medics is rolling out a new version of its software that is browser-based and also utilizes a clinician's home page metaphor. *Raintree* has no single clinical design and customizes its software to the needs of the customer; the version demonstrated in Phase II included a provider menu with Appointments, Case Load Listing, All Patients, Ticklers, Outstanding Documentation and a Cosign List.

All four vendors have appointment scheduling modules that interface with the service entry process and support the scheduling of clinician time and facilities, such as group rooms. The coalition members generally judged this functionality based on how close a vendor's solution is to the county's current and desired operating practices, perceived ease of use, and comments from reference calls.

All vendors provided different service entry views to support data entry of individual services, group services, residential-based services, etc. Again, most of the service entry approaches were available with each product and counties' personal preferences drove their opinions in this area.

Anasazi appeared to have the most tightly managed treatment plan/progress note system; progress notes need to be connected with goals selected from a drop down list from the client's treatment plan, in order to claim for services. Although some aspects of this functionality were available in the other three products, *Anasazi* has had this functionality as a core part of its clinical product for the longest period of time.

Creative Socio-Medics has purchased the InfoScriber Medication Management software and has worked to integrate it with its other modules. Several counties concluded that this was the most mature medication management system in the group, with the greatest functionality. Counties also noted that InfoScriber wasn't completely integrated with the *Creative Socio-Medics* practice management package and must be purchased separately. This product is the most widely used medication management system of the four.

Overall, counties generally concluded that, at this time:

- *Anasazi* has the most structured set of clinical functionality.
- *Creative Socio-Medics* has medication management capabilities that would most likely best meet the needs of prescribers.
- *CMHC Systems'* clinical module is a work in progress with much potential.
- *Raintree's* clinical module would be built to the county's specifications (and there wasn't a standard design).

These characteristics were valued and weighted differently by each county.

Vendors' managed care functionality has evolved over time

Managed Care Functionality

The managed care functionality of each vendor's product was built after the practice management module and has evolved over time.

The *Anasazi* and *Creative Socio-Medics* managed care products were designed as separate, standalone products. Both companies have described the need to create a tighter integration between managed care and practice management. *Anasazi* finished its first phase of integration in December 2003 and plans to complete its second phase in the fourth quarter of 2004. *Creative Socio-Medics'* new version allows the user to move more easily between the two modules. Counties that utilize authorization, assignment to level of care and utilization management practices with county staff providers have expressed concerns about the ability of these packages to meet all of their needs.

Unlike its billing module, which has most of what is needed by California counties, *CMHC Systems* has not yet put together a managed care module that addresses the standard California-specific managed care workflows. During the Phase I demonstrations and Phase II gap analysis counties were able to see various aspects of the *CMHC Systems'* managed care functionality, including claims processing, but concluded that significant design work would be needed to adapt the product to the needs of the coalition members.

Raintree's managed care functionality scored the highest in the Phase I demonstration process. The functionality has been developed within the practice management system over time, as opposed to being a separate module. During Phase II, counties also saw that there is not a standard set of data elements, forms, workflows and business rules for *Raintree's* managed care functionality and they would need to work with the vendor to create this functionality. This was seen as either positive or negative, depending on the county.

Standard and Ad Hoc Reporting

Each vendor has developed its own approach to reporting

Each vendor has developed their own approach to reporting, with two relying primarily on Crystal Reports and two that use their own report writer.

Anasazi depends primarily on their internal report writer. All *Anasazi* customers have the same core database structure that contains several thousand data elements common to all customers. When customers develop their own screens they draw from this database. If a data element is required that is not in the *Anasazi* database, *Anasazi* adds the data element and it becomes part of the next software release for all customers. *Anasazi* also supports the use of third party report writers, such as Crystal Reports, but

most customers rely on the internal report writer.

CMHC Systems has a number of internal report writers that come with the system and included Crystal Reports in its price quote. It also demonstrated a new data warehouse reporting tool, ACCEOS, during its last meeting with the coalition. Many of the standard reports that come with the system have been developed with the internal reporting tools. As the vendor transitions its customers to the MS-SQL Server data base there is some question about which report writers would accompany the transition. The coalition members have assumed that they would be using Crystal Reports as their primary report writer.

Creative Socio-Medics has embedded Crystal Reports into its product. Standard reports have been developed with Crystal and this is the tool that is recommended for user-developed reports. Customers can also use any SQL-compliant report writer as an alternative to Crystal Reports, but these products won't be as tightly integrated.

Raintree, like *Anasazi*, has its own internally-developed Report Engine and Report Generator that serve as primary reporting tools. Standard reports are developed by *Raintree* staff using the Report Engine that uses the *Raintree* Forms Scripting language. The Report Generator is a graphical front end to the Report Engine that was recently released. As *Raintree* users move to the MySQL database they will also be able to use SQL-compliant report writers.

System Pricing

Pricing includes the vendor price quote, hardware, networks, staffing and more

Pricing is a complicated issue that encompasses the vendor price quote, hardware, network and telecommunications costs, information technology staff including help desk personnel and trainers, etc. Counties are also aware that for a mission critical product like their behavioral health information system, the "cost" of purchasing a system that does not maximize revenue, creates compliance problems that result in payor recoupment, or negatively impacts the productivity of staff, can far outweigh a 20% or 30% difference in purchase price.

Phases I and II attempted to collect specific vendor pricing for counties and identify the differences in the other price areas. In Phase II, the four vendors provided a total of 82 price quotes to coalition members, including quotes for locally installed systems managed by the county; Application Service Provider (ASP) systems, where the servers and software are managed by the vendor; and ASP Plus systems where billing and report production services are added to the ASP services.

Specific price quotes are a work in progress for each county and are not included in the Phase II report.

County Decision-Making

The information in Chapter 2 is a subset of the Phase II data, which complements the large quantity of information gathered, analyzed, weighted and scored during Phase I. This information helps frame the work taking place as each county completes its decision-making process. The following examples further illustrate important differentiating issues.

Counties need to address several issues in their decision-making

- **Current System Obsolescence:** If a county needs to replace its current system no later than six to twelve months from now, the county would likely lean towards a vendor already doing business in the state – *CMHC Systems* or *Creative Socio-Medics*. As the required replacement date is pushed out this variable becomes less important.
- **Risk Tolerance:** If a county has a low threshold for the risk involved in a substantial development project, such as developing the 35 California-specific requirements identified by the coalition, the county would again lean towards one of the two vendors already doing business in the state. As the risk tolerance increases the importance of this variable decreases.
- **Billing and Compliance:** Counties have identified a number of differences in how the four products address core billing and compliance functionality. If a county believes there is a strong match with a specific vendor’s product in how it links billing with authorizations and treatment plans, the county might weight this more heavily than other criteria such as vendor technology or medication management capabilities. For example, one county might find the “tight” billing and compliance rules that are built into *Anasazi* a near perfect match, while another might prefer the approach used by *Creative Socio-Medics* or *CMHC Systems*.
- **Basic Clinical Workflow:** Similar to the above item, several counties have given high priority to a strong match in the basic clinical workflow, which includes appointment scheduling, client check-in, service entry and progress note recording. A number of counties plan to roll out this functionality in their first phase of clinical automation and ensuring a successful transition with staff who have limited computer skills is mission critical. Because each of the four systems addresses this workflow somewhat differently, each county has to evaluate its local needs and priorities against the vendors’ solutions.
- **Medication Management:** Different counties have given different levels of priority to implementing a full featured medication management module that includes the ability to easily review medication history, complete an online medication evaluation form, access a medication database that uses artificial intelligence to suggest medications and check for contra-indications, generate a pharmacy script and transmit that script to the pharmacy and then tie that activity back to

Several counties have placed a high priority on automating the basic clinical workflow

billing. For example, counties that are simply going to maintain a record of current and past client medications and complete the other activities outside their behavioral health information system (manually or with another software package), would give less weight to *Creative Socio-Medics'* InfoScriber than a county that wanted the additional functionality found in that package.

Different counties have different models of managed care

- **Managed Care:** Counties have differing needs for a managed care module. Some counties have call centers with the need to electronically track all calls, triage cases to a large network of internal and external providers, and maintain a community referral database; other counties can easily manage these tasks manually. Some counties have several hundred external providers to whom they issue authorizations and pay claims; others track their handful of external providers in an Excel spreadsheet. Some counties organize the work of county clinicians through the use of a level of care system that is managed via an authorization component, track upcoming expirations, and trigger reminders and therefore want the managed care functionality to link to the county billing functionality; others do not. The importance of specific managed care functionality will drive which packages fit their needs and what weight will be given to a managed care module. For example, if *Anasazi's* existing managed care model meets a county's needs it may not need or want to do the extra work required to design managed care functionality in *Raintree* or *CMHC Systems*; the opposite could also be true.

Counties split into two "camps" when it came to reporting

- **Reporting:** County opinions have generally grouped into two "camps". Counties without staff trained in report development appeared to prefer *Anasazi*, whose report writer appeared easier to learn. Counties with SQL programmers and report development specialists preferred the Crystal Report solutions and, in some cases, felt they could succeed with the *Raintree* Report Engine and Report Generator. All four systems have the ability to export data to external databases such as Microsoft Access or SQL Server.

Chapter 3: Next Steps

Counties are interested in using a four part, cooperative approach to vendor negotiation

The CBS Coalition has demonstrated the considerable strength that a large group of counties can bring to a task. Coalition members have been able to work together, while at the same time involving a large number of their staff in the evaluation of a future system. Significant cost savings have been achieved and many counties concluded that pooled resources created a more thorough evaluation process. Also, knowledge has been continuously exchanged between counties throughout this process. Such advantages are being leveraged as the counties move into the four-part contracting and pre-implementation activities described below.

The following methodology has been developed in cooperation with Richard Wyde, a partner at the law firm Davis Wright Tremaine LLP, whom CIMH has engaged to assist with the Phase II project. It describes a cooperative method of vendor negotiation that uses a county developed contract template, versus the vendor contract, and is structured to facilitate multiple counties working with a single vendor in a joint negotiation process that results in separate but consistent contracts among the counties.

Several counties have expressed an interest in adopting this methodology or a modified version to support their contracting process.

Part 1: Pre-Contracting Organization

Pre-contracting activities come first

Activity	Participants
1. Data Analysis: Complete Phase II evaluation activities including updating your county's decision-making matrix.	Each County Project Team
2. Contract Review: Carefully examine the model contract, identifying questions, recommended edits, and county-specific contract wording; forward to CBS consulting attorney.	Each County Project Lead, Contracting Staff, County Counsel.
3. Leadership Group Meeting: <ol style="list-style-type: none"> Gather additional vendor information from other counties including the vendors the other counties have selected; Initiate Vendor-Specific Workgroup by editing the Phase I Workplan and setting the next meeting time. 	County Project Leads and other staff as necessary
4. Initial Vendor Notification: Notify vendors of counties' preliminary decisions.	Each County Project Lead
5. Vendor Workgroup Meeting: Each workgroup holds WebEx or face-to-face meeting to: <ol style="list-style-type: none"> Organize the roles of the workgroup members Determine consulting resources to support the workgroup 	County Project Leads

- c. Develop desired schedule for Workgroup Meetings, Needs Assessment and Contract Negotiations
- 6. **Finalize Decision** about ‘Apparently Successful Vendor’ within the county and obtain approval to begin vendor negotiation in two phases:
 - a. Needs Assessment Contract to develop the Specifications and Deliverables documents for the new system contract.
 - b. New System Contract.

Note: It is assumed that the Needs Assessment will occur and be completed prior to the completion of the New System Contract.
- 7. **Notify Vendor of Intent to Pursue Contracting** via written communication.
- 8. **Complete Model Contracts:** Compile county feedback into a Model Contract for each vendor.

Each County Project Team and County Executive Leadership

Each County Representative

Rich Wyde, Davis Wright Tremaine

Part 2: Needs Assessment

Some counties may request a needs assessment

Activity	Participants
1. Needs Assessment Contract: Develop a purchase order or contract to purchase needs assessment services from the vendor, including scheduling the assessment, preparing the agenda, and identifying the deliverables from the Assessment. Coordinate these efforts with the other counties working with the same vendor.	County Team and Vendor
2. Internal Needs Identification: Determine the Phase I system functionality areas that may not have been addressed by the CBS Coalition by reviewing the CBS workflows, Key Requirements and other information. Prepare any additional materials for the Needs Assessment including local workflows, county forms and reports, reference material, etc. Compile into a binder to give to the vendor. Share this material with the other counties working with the same vendor.	County Team
3. Needs Assessment: Hold the needs assessment, following the agenda and walking through the materials prepared by the county. Provide adequate information so that they can prepare the Specifications Document.	County Team and Vendor
4. Specifications Document: Prepare the Specifications Document in sufficient detail to ensure proper understanding of the work that will need to be accomplished.	Vendor
5. County Review: Review the Specifications Document, making any corrections, as needed. Discuss and clarify with vendor.	County Team and Vendor
6. Vendor Proposal Update: Update the county proposal based on the needs assessment, updating the deliverables, statement of work, pricing, etc.	Vendor

- 7. **County Review and Finalize:** Review the proposal, making any corrections, as needed. Discuss and clarify with vendor. These materials will become Exhibits to the Contract. County Team and Vendor

Part 3: Negotiation Preparation

There's an "art" to preparing for negotiations

Activity	Participants
1. Contract Additions: Identify any county-specific language that needs to be in the Model Agreement and work with the attorney to integrate these edits.	Each County Team; Attorneys
2. Put Together Contracting Team: Assemble the multi-county contracting team that will work with the vendor.	Each County Team
3. Schedule Negotiations: Schedule Contract Negotiations with vendor based on Phase IV Activities	Multi-County Negotiation Team
4. Analyze Agreement: Prepare for negotiations by reading the Model Agreement carefully, arranging to get help from your attorneys and experts, and remembering 45% to 65% of projects fail, in part due to poorly written and negotiated agreements.	Each County Team
5. Vendor Research: Understand the goals and context of the chosen vendor, e.g., financial needs, where on the project the vendor plans to make its profit, recent project failures and successes, whether it is buying market share at the risk of losing money or has a dominant market position already.	Multi-County Negotiation Team
6. County Goals/Context: Understand your goals and context, e.g., time pressures from an obsolescing system, political pressures, or a very tight budget.	Each County Team
7. Leverage Analysis: Understand the extent of competitive leverage of each side.	Multi-County Negotiation Team
8. Decide County Parameters: Meet internally with your negotiating team (one county or all counties working together) to establish, to the extent possible, your dollar limits, time requirements, and bottom line positions on technical, business and legal issues.	Each County Team
9. Final Preparation: Communicate the results of all preparation activities with other counties and finalize the negotiation approach. Assume you will use cooperative negotiations (seeking common interests) but prepare to use competitive negotiations as needed.	Multi-County Negotiation Team

Part 4: Vendor Negotiation

	Activity	Participants
Negotiations should follow a predefined structure	1. Submit Model Agreement: Forward the Model Agreement to the vendor for review and analysis.	Multi-County Negotiation Team
	2. Vendor Feedback: Get all issues on the table at the beginning by requiring the vendor to provide all of its comments on the model agreement in writing in an issues list (preferred approach) or specific proposed revisions to the agreement.	Vendor
	3. County Response: Provide your responses in writing in the issues list (as a table) or revisions to the vendor’s proposed revisions to the agreement.	Multi-County Negotiation Team
	4. Vendor Response: Get the vendor’s responses to your revisions in writing.	Vendor
	5. First Meeting: Your team should meet with the vendor to understand its positions and why the vendor’s positions are more logical or more appropriate than your positions; avoid contentious negotiations at this stage.	Multi-County Negotiation Team and Vendor
	6. Internal Meeting: Meet internally with your staff, technical experts, and attorneys to discuss the vendor’s positions and prepare a compromise that satisfies your most important needs, that gives the vendor the rest of the issues, and that delineates the compromises in a chart.	Multi-County Negotiation Team
	7. Next Round of Feedback: Send the chart with proposed compromises to the vendor, tell the vendor this is a delicately balanced package deal which is designed to accelerate completion of negotiations and which will be completely “off the table” if the vendor proposes more than a few changes to it, give the vendor a few days to meet internally.	Multi-County Negotiation Team and Vendor
	8. Second Meeting: Meet with the vendor to negotiate a resolution to the issues that remain after it accepts most of the positions on the chart.	Multi-County Negotiation Team and Vendor
	9. Revisit County Parameters: Meet internally and prepare another chart with further compromises.	Multi-County Negotiation Team
	10. Third Meeting: Complete negotiations.	Multi-County Negotiation Team and Vendor
	11. Revise Agreement: Revise the agreement based on the negotiations and send the revised agreement to the vendor.	Multi-County Negotiation Team

12. **Finalize Agreement:** Negotiate final revisions to the agreement since there will always be open issues raised by the edits and prepare the final version of the agreement

Multi-County
Negotiation
Team and
Vendor

Non-CBS
Coalition
Counties can
join the
process

Non-CBS County Involvement

Members of the CBS Coalition have expressed an interest and willingness to include other California counties in the Next Steps process, should they be interested in joining a Vendor Workgroup.

Interested counties should contact Barbara Field at CIMH, (916) 556-3480 x106; bfield@cimh.org or Dale Jarvis, project consultant, at (206) 613-3339; dale@mcpphc.com.

Potential Phase III CBS Coalition Activities

Following the final selection and the contracting process, opportunities remain for multi-county collaboration. Counties may achieve additional cost savings with the following collaborative work:

Opportunities
exist for
counties to
continue
working
together after
contract
signing

Implementation Project Management

Assuming that multiple counties select a common vendor, it will be extremely important to develop a cross-county project management structure in addition to the internal county project management structure. This type of coordination can result in a single voice and a single master project plan that can significantly increase the probability of success.

Implementation Quality Assurance

After the contract is signed, the vendor and the county have put together teams to do the "heavy lifting" required for a successful implementation, it is often advisable for an independent third party to provide oversight and quality assurance. This would include monitoring the timelines, tracking deliverable completion, doing ongoing problem solving and providing conflict resolution services. There is a strong correlation between the creation of this role and on-time, on-budget results.

Shared Operations Costs

It is possible that Counties may want to set up one or more arrangements to share operations costs. This might include using a Host County (or a Host Vendor) with several other counties serving as "clients" of the host. This would involve developing the contractual relationships between and among participating counties and identifying specific responsibilities for Vendor/Host County and participating counties.

Attachment A: Key California Functional Requirements

I. Overview

In June and July 2004, CBS Coalition members met two days with each Phase II vendor to review key California functionality and identify potential gaps between those requirements and the vendors' bid products. An analysis of the CBS Coalition RFP and notes from the sessions has yielded a list of 35 Key California Requirements needed by each Coalition member. In addition to the Gap Analysis Meetings, all of these requirements have been discussed in detail in several forums including:

- CIMH – State of California Fiscal and Reporting Conference held June 24-25, 2003 in Folsom, California
- CIMH Request for Proposals # 07-03
- *CIMH - California Behavioral Health Fiscal and Reporting Requirements: A Resource Guide*, that can be found at:
<http://www.cimh.org/index.html?ptype=content&menuid=9&pid=209&session=306743500145f8096d712de6e88acdd2>

II. Key California Requirements

A. California Eligibility Loading and Checking

1. MEDS Eligibility loading of Medi-Cal and Healthy Families Data into BHIS Eligibility Table using California Proprietary Format.
2. MEDS Eligibility loading of Medi-Cal and Healthy Families Data into BHIS Eligibility Table using California's ASC X12N Format, when available.
3. Lookup and viewing of information in MEDS Eligibility Table in BHIS.
4. Automatic updating of Client/Guarantor Insurance Records with MEDS Data including all retroactive additions to Medi-Cal/Health Families; Report of Updated Records.
5. Support for identifying partial matches of potential clients with Medi-Cal or Healthy Families Eligibility and semi-automatic process to update Client/Guarantor Insurance Records.
6. Report of Clients Losing Medi-Cal/Healthy Families coverage after MEDS Update.
7. Method for mapping different Medi-Cal/Healthy Families Aid Codes to specific benefit packages.
8. Automated real-time eligibility checking of State MEDS Point of Service database.
9. Method for clearing Medi-Cal Share of cost at time of service.

B. California Client Intake, Registration and Related State Reporting

1. Supports admission and discharge of Mental Health clients including the collection of payor financial information and CSI Client and periodic data elements.
2. Supports admission and discharge of Alcohol and Drug Program clients including the collection of payor financial information and CADDs data elements.
3. Supports admission and discharge of Alcohol and Drug Program clients including the collection of payor financial information and CalOMS data elements when the latter is available.
4. Supports the data collection for the OSHPD Hospital Reporting System.
5. Supports the data collection and calculation of UMDAP annual family deductible information.
6. Supports the data collection and calculation of Alcohol and Drug Sliding Scale information.
7. Supports the coordination of client financial liability via the UMDAP and Sliding Scale systems when a client is receiving Mental Health and Alcohol & Drug services.
8. Supports the data collection of the California Adult and Children's Outcomes reporting requirements.

C. California Billing and Collections

1. Supports California data structure to capture mode, service function code and procedure code.
2. Addresses the requirement to capture direct service, transportation, and charting time and supports the related billing rules for Medi-Cal, Medicare, and private insurance.
3. Calculates California Medi-Cal Charges using the number in group, therapist, co-therapist, group minimum/maximum rules.
4. Supports the California Medi-Cal billing lockout rules for services provided on the same day.
5. Generates California Alcohol and Drug 837 claim file.
6. Generates California Mental Health proprietary claim file.
7. Generates California Mental Health 837 claim file.
8. Supports billing of Medi-Cal Claims based on retroactive Medi-Cal eligibility updates and corresponding corrections claims billed to other payors and client/guarantor.
9. Supports billing of match Dollars only for Medi-Cal clients who reside in other counties.
10. Generates client-responsibility invoices and statements based on California UMDAP rules.

11. Generates client-responsibility invoices and statements based on California Alcohol & Drug Program sliding scale rules.
12. Supports receipt, loading and record updating of California Proprietary Remittance Advice payment receipt.
13. Supports receipt, loading and record updating of California 835 Remittance Advice payment receipt.

D. California Data Reporting Interfaces

1. Compiles service units and charges into the Medi-Cal cost reporting categories, properly calculates retroactive billing activity, and produces reports to support the development of the annual cost reports.
2. Supports the collection, compilation, reporting and analysis of the California-mandated Performance Outcome System (POS) Client Outcome and Satisfaction Reports.
3. Supports the bi-directional exchange of data with the California CSI system including transmission of client, periodic and service data, receipt of error reports, and processing and submission of corrections and updates.
4. Supports the electronic submission of CADDs Participant Record Forms for Alcohol and Drug facility admissions and discharges.
5. Supports the electronic submission of CalOMS Data when the system goes live.