Business Practices for the Future – Fee for Service
Video Conference Meeting Agenda

Course #2 Red Team-Optimizing your Billing System to Improve Collections

AIM-Increase collections by xx%

Pre-work

1. Review the Billing Guide (complete page 7)-http://www.niatx.net/Action/promisingpractices.aspx
2. Complete page 7 of the Billing Guide and bring with you to the kickoff
3. Review the change project form and instructions-http://www.niatx.net/content/contentpage.aspx?NID=43
4. Come prepared to discuss your collections rate and primary reason for denials (this can come from the information you used to complete the survey monkey back in October)

Time	Title	Presenter
Before Distance learning session begins		
9:00-9:30 CT 30 minutes	Welcome Activity Suggestion: Simulation Exercise You are welcome to use the Telephone exercise we did in Madison. Providers will learn about change	Convener **Purpose of the exercise Is for the group in the room to feel comfortable working with each other, this may differ depending on who is there and how often the group meets together.** We have other ideas if needed, call us.
9:30-9:45 CT 15 minutes	Leadership Vision for this project Providers will learn about your vision for this project Be as clear and specific as you are able about your expectation for the collaborative outcomes	Convener- choose someone with a compelling vision to lead this Examples: County Director, Insurance Commissioner for the state, the head of County SU Dept **Purpose is to identify what billing options are there in their state or county.** **List out what the priority for this collaborative is for the convening org.**
9:45-9:55 CT 10 minutes	Video of Pam Hyde/Kathleen Sebelius Your providers will learn about national healthcare	Convener You may choose to show the video
	Prepare your 3 minute state Introduction See next agenda item for detail	
Begin Video Conference 10:00-11:15 CT Report out	Welcome and Introduction of participants – *test audio* Each Convener Group Chooses one spokesperson to do a 3 minute report out of the following:	NIATx

	• 2 or 3 fun facts about your state • 2 things your state is doing well on topic of healthcare reform • 2 things that are barriers in your state with healthcare reform	
11:15-11:30 CT	Overview of the project/NIATx Vision for outcomes	NIATx
11:30-12:00 CT Resource Allocation & Project Charter 30 minutes	*-Project Resource Allocation* *-Dedicated Staff* -Change Leader -Project Charters Providers will learn who in their organization does what and how to maximize that	Convener/Peer Mentor Report out from page 7 Change Project Form Identify the barrier and the Aim for the first change cycle
12:00-12:30 Lunch	Distance Learning goes off line	
12:30-1:00 CT 30 minutes 1:00-1:15 worksheet 15 minutes	Patient Flow -Breakdown of bottle necks and barriers -Hand offs -Is the right decision maker doing the right steps? Providers will learn how to do claims get denied?	NIATx
1:15-1:45 CT 30 minutes	Marketing Cocoa Puffs Simulation	NIATx Identify a third party payer and find out what they want or need?
1:45-2:30 CT 45 minutes	Managing Revenue and the Balance Sheet Reading a balance sheet Cash flow statements/Break even Accounts receivables which includes co-pay Ratios – what is good and what is bad? Identify a good system? How much of your income can be in receivables?	NIATx Benchmarking project from Jay.
2:30-3:00 CT 30 minutes	Design/Change Project Charter Providers will complete a change project form	All
3:00-3:30CT 30 minutes	Next Steps ICC webinar call schedules NIATx web resources page Each convener group will schedule their follow up calls as needed	NIATx/All

Welcome
Please be prepared to share:
2-3 fun facts about your state
2 things your state is doing well on the topic of healthcare reform
2 things that are barriers in your state with healthcare reform
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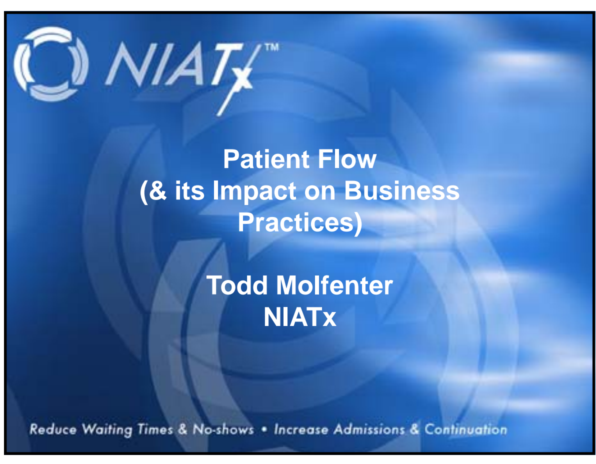
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Patient Flow
(& its Impact on Business Practices)
Todd Molfenter
NIATx
Reduce Waiting Times & No-shows • Increase Admissions & Continuation

Patient Flow
It all begins when the patient needs services
Presentation Adopted from Gervene Williams Of the NACHC NIATx/NACHC Integration Collaborative Talk
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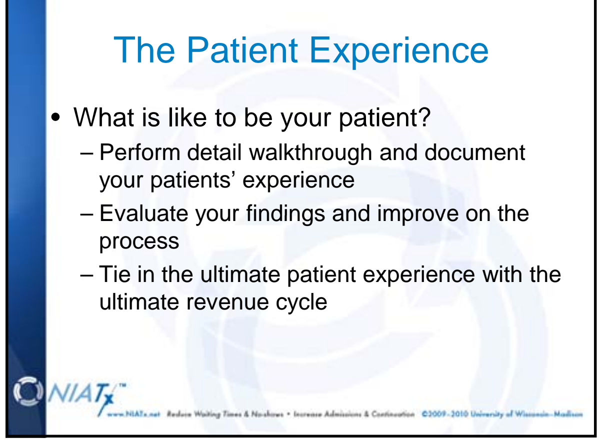
The Patient Experience
• What is like to be your patient?
– Perform detail walkthrough and document your patients' experience
– Evaluate your findings and improve on the process
– Tie in the ultimate patient experience with the ultimate revenue cycle
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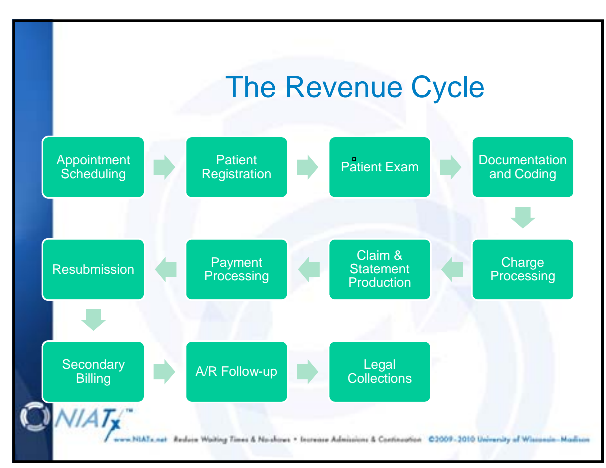
The Revenue Cycle
Appointment Scheduling
Patient Registration
Patient Exam
Documentation and Coding
Charge Processing
Claim & Statement Production
Payment Processing
Resubmission
Secondary Billing
A/R Follow-up
Legal Collections
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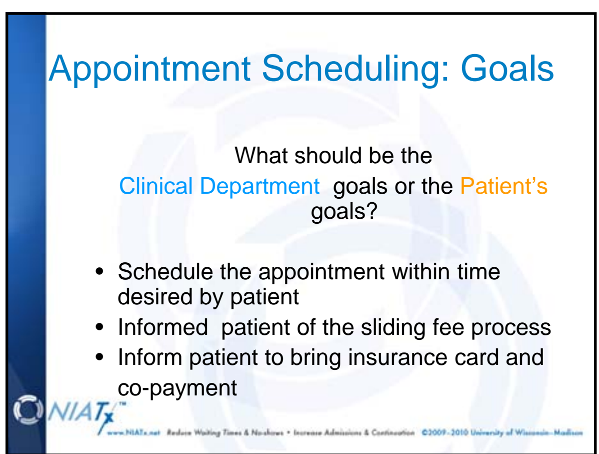
Appointment Scheduling: Goals
What should be the Clinical Department goals or the Patient's goals?
• Schedule the appointment within time desired by patient
• Informed patient of the sliding fee process
• Inform patient to bring insurance card and co-payment
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Appointment Scheduling Process

- Pre-registration
- Begin the revenue cycle
- Verification of insurance
- Authorization and certification of insurance
- Sliding fees policy

Patient Registration: Goals

- Insure Pre-authorization received
- Insure verification of insurance and PCP validated
- Sliding fee application completely filled out
- For all appropriate patients, collect co-pay or deductibles, and verify demographic information

Patient Registration Process

– **Revenue Cycle (For Appointments)**

- Verification of insurance
- Authorization and certifications
- Registration gathering demographics
- Initial review of financial requirements
- Co-pay collection for all appropriate patients

Patient Exam: Goals

- Reasonable/timely access
- Complete clinical service
- Informative to patient
- Appropriate documentation for patient care and for correct billing to third party

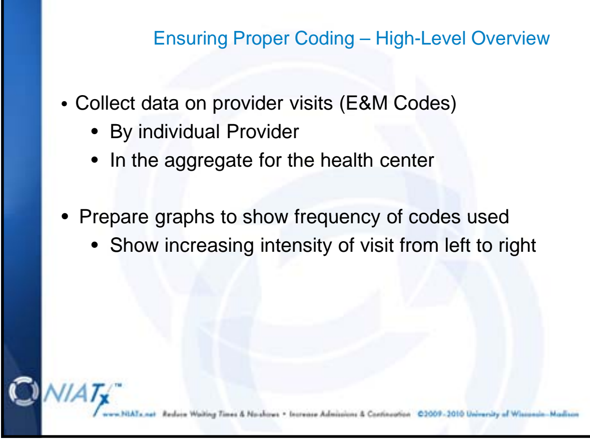
Documentation & Coding Process

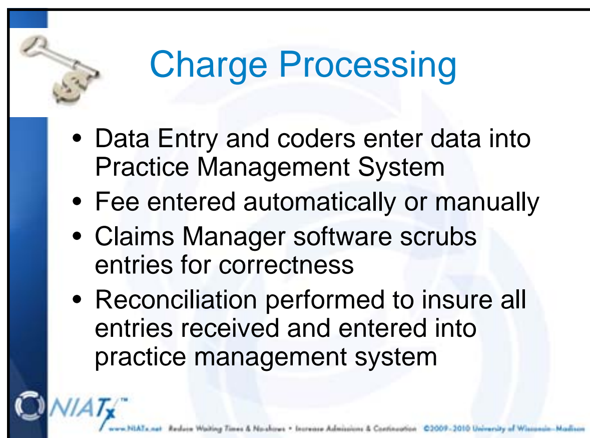
inician documents services

- Services coded by Physicians and/coders: CPT codes (procedures), ICD-9 (diagnosis)

Documentation & Coding: Goals

- Documentation complete and signed by provider
- Codes accurately reflect patient service(s)
- Coding reviewed to insure it reflects documentation





Charge Processing: Goals

- Accuracy of service and charge
- Appropriate edits to scrub data
- Charges entered timely for prompt payment

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Claim & Statement Production

- Claims edited to insure completeness and correctness
- Claims sent daily to carriers for processing
- Claims flow electronic and paper

- Billing statements sent to patients for self-pay balances

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Claim & Statement: Goals

- Get accurate claims out daily
- Increase % of electronic claims
- Keep average cost per claim low
- Get statements out to patients for self-pay balances every Monday within the current billing cycle (30 days)

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Payment Processing

- All payments and denials processed within 24 hours of receipt
- Process all refunds in a timely manner

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Resubmission, Appeals, & Secondary Claims

- Invalid registration
- Medical documentation required
- Correct coding /charge corrections
- Missing referral/pre-authorizations
- Secondary claims and patient statement produced

Resubmission & Appeals: Goals

- All invoices requiring an appeal processed are completed within one week of receiving rejection
- Process all responses from clinical departments within one day of receiving information
- All secondary claims submitted within a week of receiving primary payment

A/R Follow-up

Follow-up on...

- Payment arrangements (budget plans)
- Red flag rules
- Improve claim edits as an outcome
- Bad debt transfer

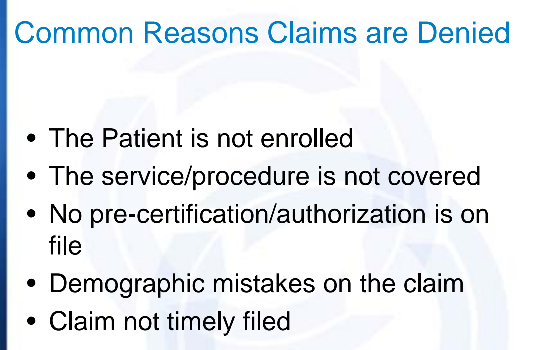
A/R Follow-up: Goals

- Process all denials requiring departmental involvement within one week of receipt of reject
- Follow-up on all outstanding requests with clinical departments within one week of initial request
- Follow-up on all “no response” invoices within 45 days of submission of claim

Legal Collections

- Actions if any to be determined by Executive Staff & Board

A successful Revenue Cycle depends on…


Common Reasons Claims are Denied
• The Patient is not enrolled
• The service/procedure is not covered
• No pre-certification/authorization is on file
• Demographic mistakes on the claim
• Claim not timely filed
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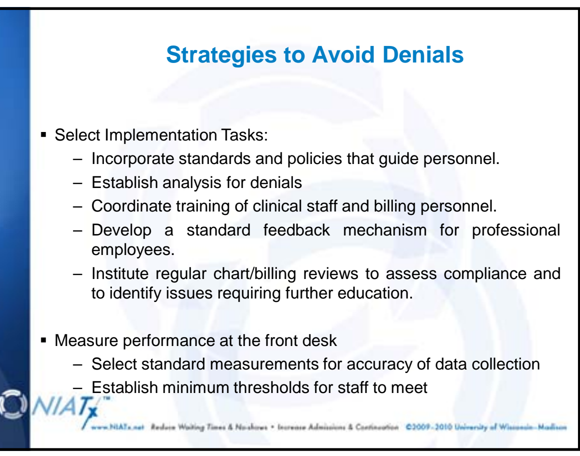
Strategies to Avoid Denials
▪ Select Implementation Tasks:
– Incorporate standards and policies that guide personnel.
– Establish analysis for denials
– Coordinate training of clinical staff and billing personnel.
– Develop a standard feedback mechanism for professional employees.
– Institute regular chart/billing reviews to assess compliance and to identify issues requiring further education.
▪ Measure performance at the front desk
– Select standard measurements for accuracy of data collection
– Establish minimum thresholds for staff to meet
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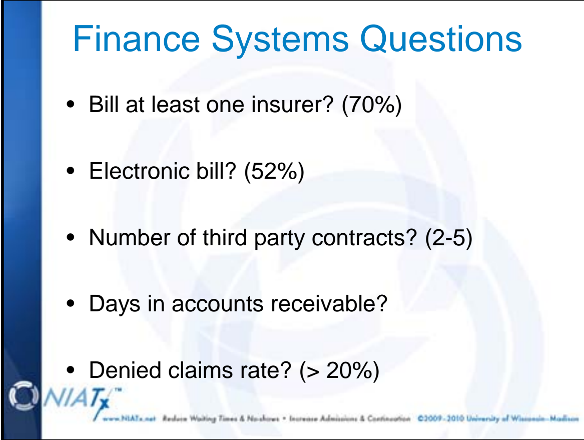
Finance Systems Questions
• Bill at least one insurer? (70%)
• Electronic bill? (52%)
• Number of third party contracts? (2-5)
• Days in accounts receivable?
• Denied claims rate? (> 20%)
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NIATx™
Introduction to Marketing & Insurance Contracting
Optimizing Business Opportunities
Presented by
Kim Johnson, MBA
Reduce Waiting Times & No-shows • Increase Admissions & Continuation

Let's Imagine you Work for General Mills
Cocoa Puffs
This is the product you need to sell
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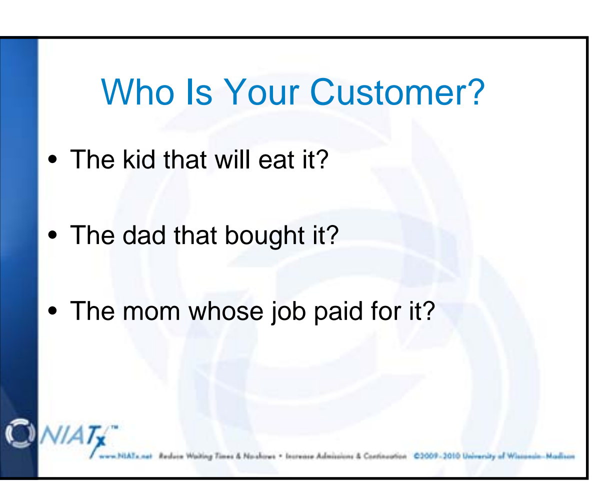
Who Is Your Customer?
• The kid that will eat it?
• The dad that bought it?
• The mom whose job paid for it?
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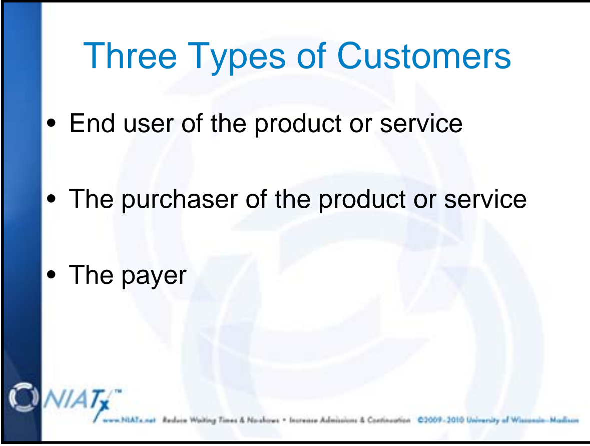
Three Types of Customers
• End user of the product or service
• The purchaser of the product or service
• The payer
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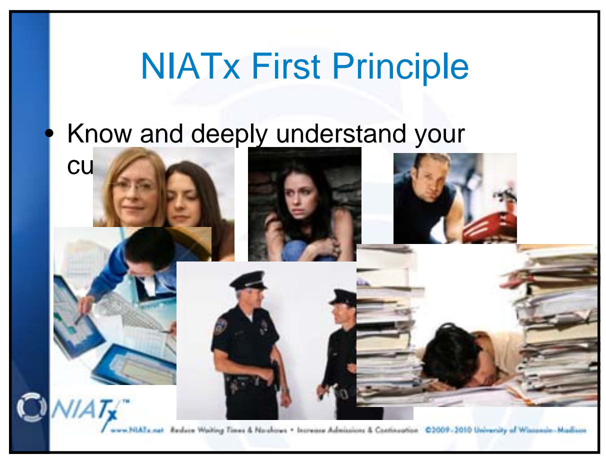
NIATx First Principle
• Know and deeply understand your cu
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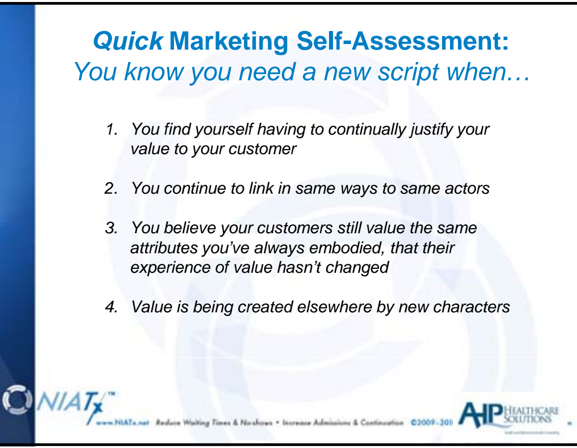
Quick Marketing Self-Assessment:
You know you need a new script when…
1. You find yourself having to continually justify your value to your customer
2. You continue to link in same ways to same actors
3. You believe your customers still value the same attributes you've always embodied, that their experience of value hasn't changed
4. Value is being created elsewhere by new characters
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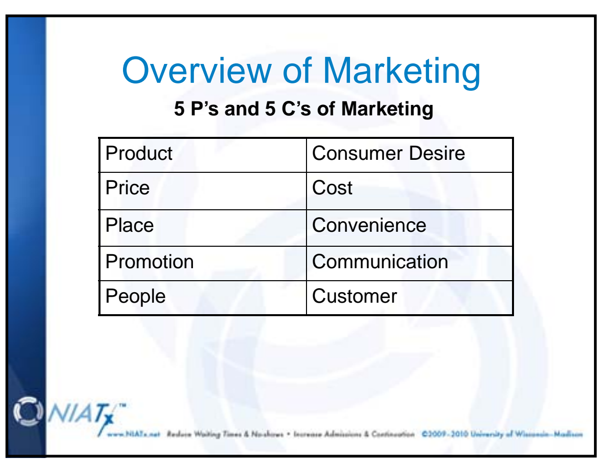
Overview of Marketing
5 P's and 5 C's of Marketing
Product | Consumer Desire
Price | Cost
Place | Convenience
Promotion | Communication
People | Customer
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Overview of Marketing
1. What are you selling?
2. To whom?
3. Why would they buy it?
4. What are the advantages and benefits and inherent value that differentiates you from your competitors?
5. How is your service priced? Why?
6. Where are your services found?
7. Is it convenient for your customers?
8. How will your customers become aware of you and develop a preference for you?
9. Who will deliver your services and how will they approach your customers?
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Overview of Marketing
Marketing Fundamentals
Marketing is NOT Sales. It is…
• Market Segmentation
• Market Research
• A Marketing Plan
• A Customer Value Proposition
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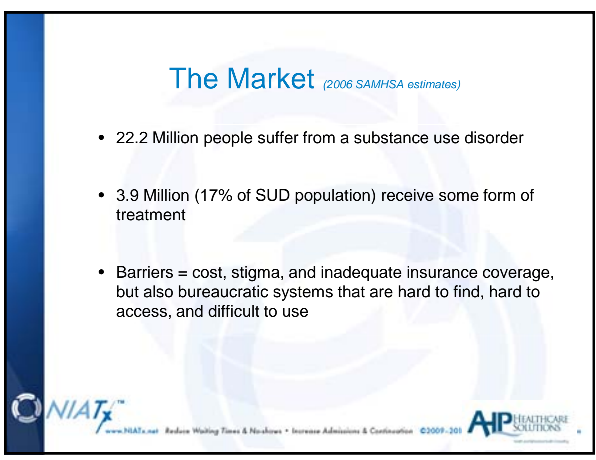
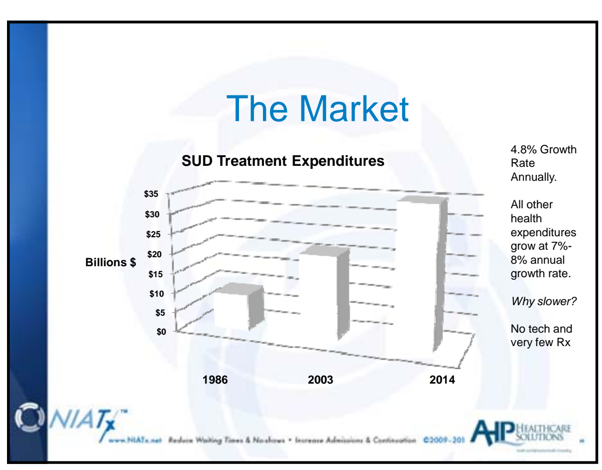
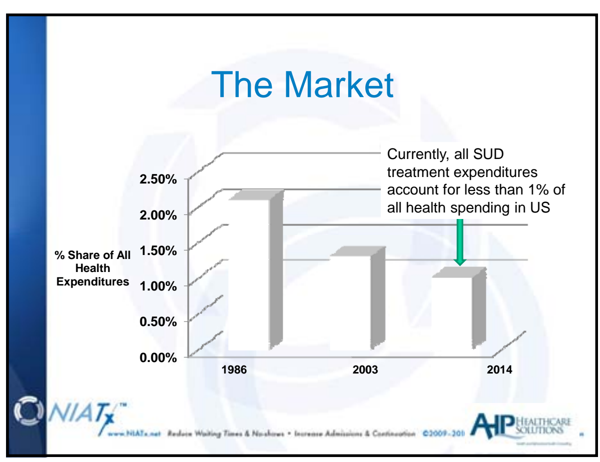
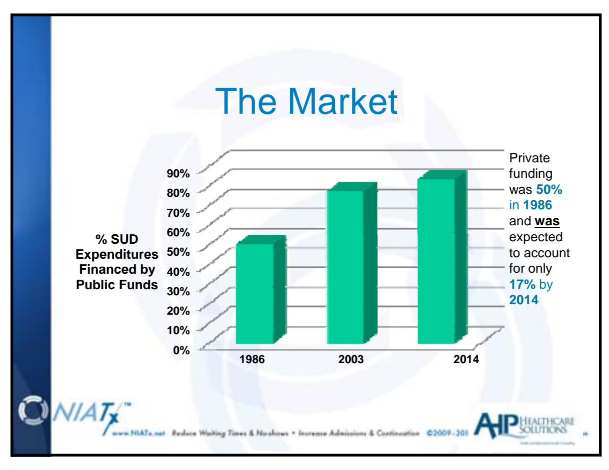
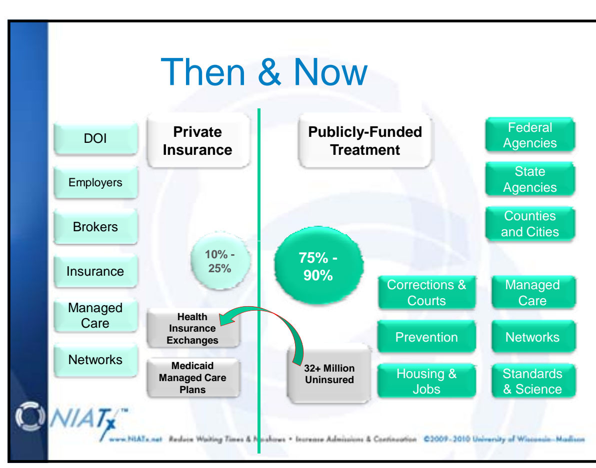
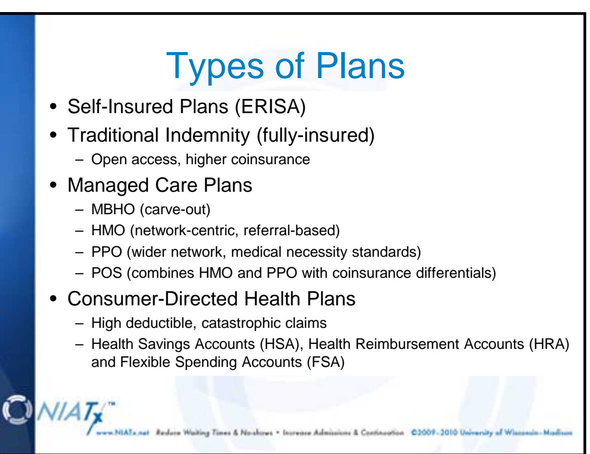

The Market (2006 SAMHSA estimates)
• 22.2 Million people suffer from a substance use disorder
• 3.9 Million (17% of SUD population) receive some form of treatment
• Barriers = cost, stigma, and inadequate insurance coverage, but also bureaucratic systems that are hard to find, hard to access, and difficult to use


The Market
SUD Treatment Expenditures
Billions $
$35
$30
$25
$20
$15
$10
$5
$0
1986
2003
2014
4.8% Growth Rate Annually.
All other health expenditures grow at 7%-8% annual growth rate.
Why slower?
No tech and very few Rx


The Market
% Share of All Health Expenditures
2.50%
2.00%
1.50%
1.00%
0.50%
0.00%
1986
2003
2014
Currently, all SUD treatment expenditures account for less than 1% of all health spending in US


The Market
% SUD Expenditures Financed by Public Funds
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
1986
2003
2014
Private funding was 50% in 1986 and was expected to account for only 17% by 2014


Then & Now
DOI
Employers
Brokers
Insurance
Managed Care
Networks
Private Insurance
Publicly-Funded Treatment
10% - 25%
75% - 90%
Health Insurance Exchanges
Medicaid Managed Care Plans
32+ Million Uninsured
Federal Agencies
State Agencies
Counties and Cities
Corrections & Courts
Managed Care
Prevention
Networks
Housing & Jobs
Standards & Science


Types of Plans
• Self-Insured Plans (ERISA)
• Traditional Indemnity (fully-insured)
– Open access, higher coinsurance
• Managed Care Plans
– MBHO (carve-out)
– HMO (network-centric, referral-based)
– PPO (wider network, medical necessity standards)
– POS (combines HMO and PPO with coinsurance differentials)
• Consumer-Directed Health Plans
– High deductible, catastrophic claims
– Health Savings Accounts (HSA), Health Reimbursement Accounts (HRA) and Flexible Spending Accounts (FSA)

Network Application

- Market Research (benefits, market share, reputation)
- Download Applications, Provider Manuals and Fee Schedules wherever available and study them
- Request Application
- Anticipate Credentialing – *primary source verification*
  - Education
  - Experience
  - Licensure
  - Liability Insurance (3 and 3)
- Site visit (possible)
- Reimbursement

Network Application

- Understand that your application can't be dealt with more stringently than an MD's (see MHPAEA)
- Complete paperwork thoroughly and honestly
- Fill a gap, satisfy a need
- Include letters of recommendation
- Explain issues
- Make copies, check mail
- Call and be "in relationship" – seek clarification and answers in writing

Tips

- Read Provider Manuals
- Read Level of Care/Medical Necessity Guidelines
- Read Provider Newsletters
- Read Practice Guidelines
- Verify eligibility, request authorization and submit claims and appeals *their way*

What's Attractive to an MCO?

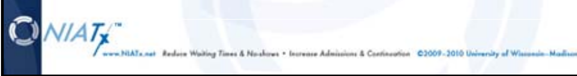
- Setting (clean, safe, secure)
- Access (emergency, urgent, routine)
- Prepared clinical interface and clinical documentation in Utilization Review/Mgmt
- Case Mgmt
- Information/Data Interchange (claims in particular)
- Performance and Outcomes Measures *(when you look good, they look good)*

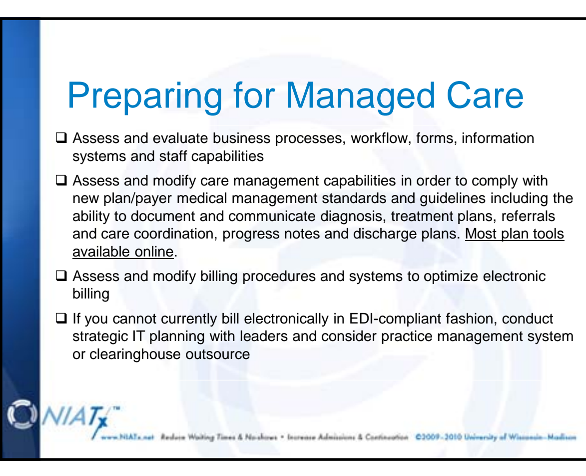
What's Attractive to a Patient?

- Insurance will cover it or it is affordable
- It's accessible
- It serves a patient perceived need
- It is welcoming
- It works

Preparing for Managed Care

- ❑ Assess market conditions, existing network contracts, and resources required for compliance
- ❑ Assess credentials, certifications and accreditation requirements
- ❑ Identify payers and provider relations personnel with organizations that you are interested in working with
- ❑ Review State insurance and managed care laws
- ❑ Position services relative to classification of benefits and scope of services with State definitions in full view
- ❑ Evaluate plan designs and plan requirements and apply for in-network status only where appropriate




Preparing for Managed Care
❑ Assess and evaluate business processes, workflow, forms, information systems and staff capabilities
❑ Assess and modify care management capabilities in order to comply with new plan/payer medical management standards and guidelines including the ability to document and communicate diagnosis, treatment plans, referrals and care coordination, progress notes and discharge plans. Most plan tools available online.
❑ Assess and modify billing procedures and systems to optimize electronic billing
❑ If you cannot currently bill electronically in EDI-compliant fashion, conduct strategic IT planning with leaders and consider practice management system or clearinghouse outsource
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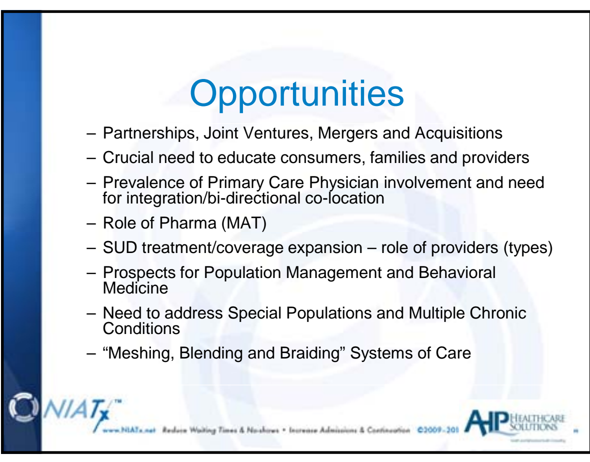
Opportunities
– Partnerships, Joint Ventures, Mergers and Acquisitions
– Crucial need to educate consumers, families and providers
– Prevalence of Primary Care Physician involvement and need for integration/bi-directional co-location
– Role of Pharma (MAT)
– SUD treatment/coverage expansion – role of providers (types)
– Prospects for Population Management and Behavioral Medicine
– Need to address Special Populations and Multiple Chronic Conditions
– "Meshing, Blending and Braiding" Systems of Care
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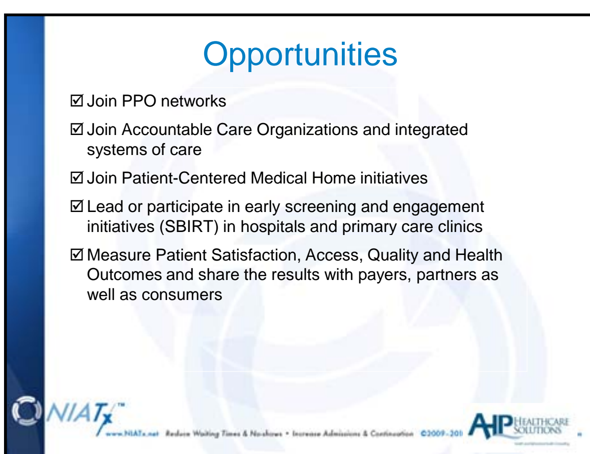
Opportunities
☑ Join PPO networks
☑ Join Accountable Care Organizations and integrated systems of care
☑ Join Patient-Centered Medical Home initiatives
☑ Lead or participate in early screening and engagement initiatives (SBIRT) in hospitals and primary care clinics
☑ Measure Patient Satisfaction, Access, Quality and Health Outcomes and share the results with payers, partners as well as consumers
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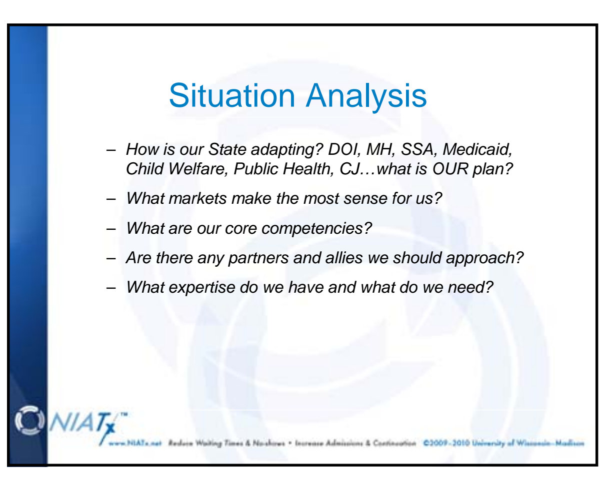
Situation Analysis
– How is our State adapting? DOI, MH, SSA, Medicaid, Child Welfare, Public Health, CJ…what is OUR plan?
– What markets make the most sense for us?
– What are our core competencies?
– Are there any partners and allies we should approach?
– What expertise do we have and what do we need?
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Readiness Assessment
• Knowledge of and experience with market and market forces (O's & T's)
• Honesty about competencies (S's & W's)
• Evaluation of current financial performance
• Assessment of leadership, vision and culture
• Willingness to adapt to changing business environments
• Openness to new relationships and conversations
• Allocation of resources
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Opportunities
☑ Conduct Local/Regional Market Research
❑ Health plans
❑ Managed care
❑ Employers
☑ Profile Your Market
❑ Benefit plan designs
❑ Provider network administrator(s)' willingness to meet and negotiate
❑ Medical network access standards and contracting requirements
❑ Features of their fee schedule in light of UCR
❑ Reputation for contracting, medical management and claims processing
❑ Mix of MH and SUD providers currently in-network
❑ Advantage of OON status
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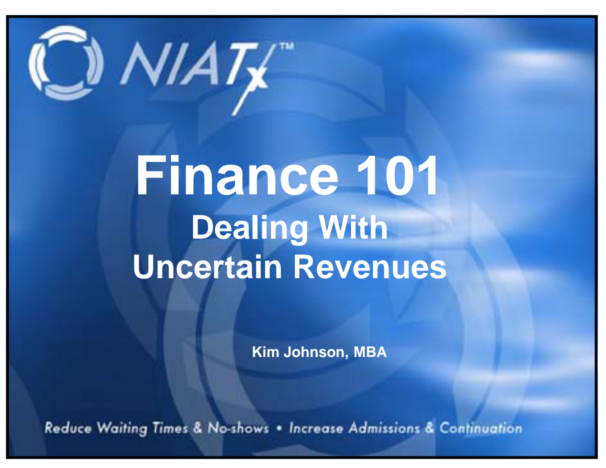
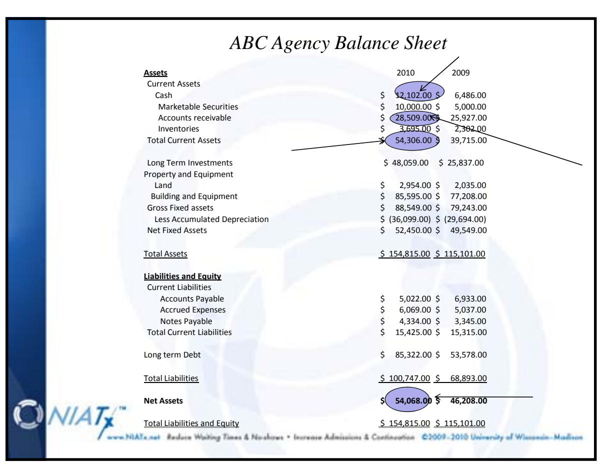
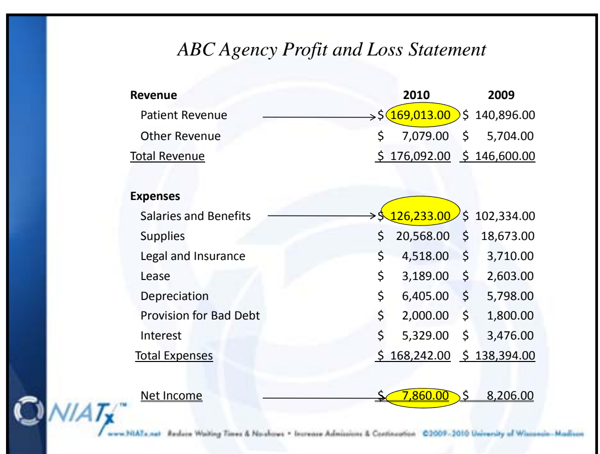




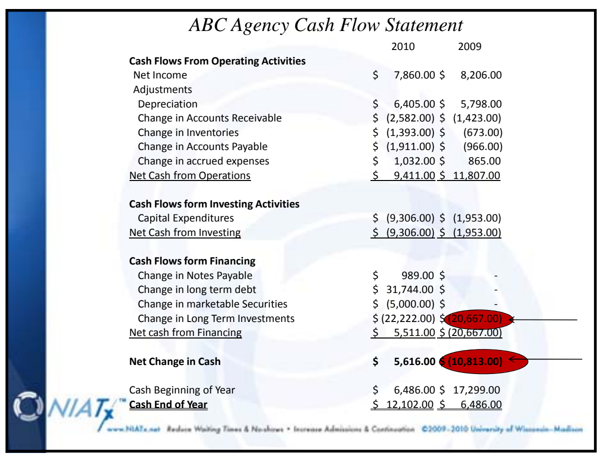
ABC Agency Balance Sheet

Assets	2010	2009
Current Assets		
Cash	$ 12,102.00	$ 6,486.00
Marketable Securities	$ 10,000.00	$ 5,000.00
Accounts receivable	$ 28,509.00	$ 25,927.00
Inventories	$ 3,695.00	$ 2,302.00
Total Current Assets	$ 54,306.00	$ 39,715.00
Long Term Investments	$ 48,059.00	$ 25,837.00
Property and Equipment		
Land	$ 2,954.00	$ 2,035.00
Building and Equipment	$ 85,595.00	$ 77,208.00
Gross Fixed assets	$ 88,549.00	$ 79,243.00
Less Accumulated Depreciation	$ (36,099.00)	$ (29,694.00)
Net Fixed Assets	$ 52,450.00	$ 49,549.00
Total Assets	$ 154,815.00	$ 115,101.00
Liabilities and Equity		
Current Liabilities		
Accounts Payable	$ 5,022.00	$ 6,933.00
Accrued Expenses	$ 6,069.00	$ 5,037.00
Notes Payable	$ 4,334.00	$ 3,345.00
Total Current Liabilities	$ 15,425.00	$ 15,315.00
Long term Debt	$ 85,322.00	$ 53,578.00
Total Liabilities	$ 100,747.00	$ 68,893.00
Net Assets	**$ 54,068.00**	**$ 46,208.00**
Total Liabilities and Equity	$ 154,815.00	$ 115,101.00



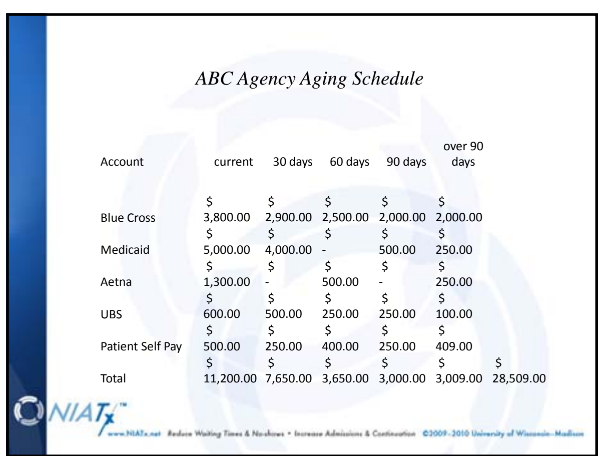
ABC Agency Profit and Loss Statement

Revenue	2010	2009
Patient Revenue	$ 169,013.00	$ 140,896.00
Other Revenue	$ 7,079.00	$ 5,704.00
Total Revenue	$ 176,092.00	$ 146,600.00
Expenses		
Salaries and Benefits	$ 126,233.00	$ 102,334.00
Supplies	$ 20,568.00	$ 18,673.00
Legal and Insurance	$ 4,518.00	$ 3,710.00
Lease	$ 3,189.00	$ 2,603.00
Depreciation	$ 6,405.00	$ 5,798.00
Provision for Bad Debt	$ 2,000.00	$ 1,800.00
Interest	$ 5,329.00	$ 3,476.00
Total Expenses	$ 168,242.00	$ 138,394.00
Net Income	$ 7,860.00	$ 8,206.00



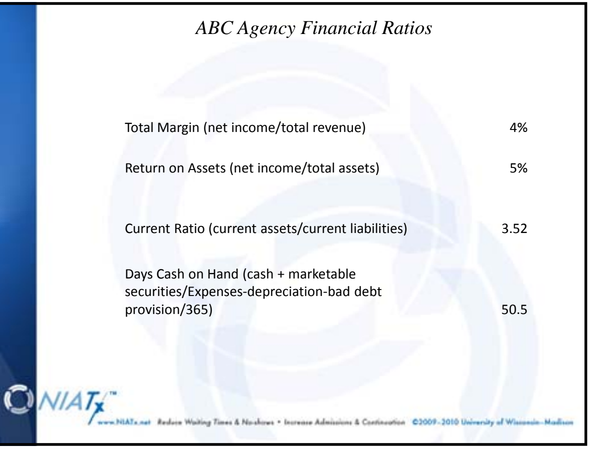
ABC Agency Cash Flow Statement

	2010	2009
Cash Flows From Operating Activities		
Net Income	$ 7,860.00	$ 8,206.00
Adjustments		
Depreciation	$ 6,405.00	$ 5,798.00
Change in Accounts Receivable	$ (2,582.00)	$ (1,423.00)
Change in Inventories	$ (1,393.00)	$ (673.00)
Change in Accounts Payable	$ (1,911.00)	$ (966.00)
Change in accrued expenses	$ 1,032.00	$ 865.00
Net Cash from Operations	$ 9,411.00	$ 11,807.00
Cash Flows form Investing Activities		
Capital Expenditures	$ (9,306.00)	$ (1,953.00)
Net Cash from Investing	$ (9,306.00)	$ (1,953.00)
Cash Flows form Financing		
Change in Notes Payable	$ 989.00	$ -
Change in long term debt	$ 31,744.00	$ -
Change in marketable Securities	$ (5,000.00)	$ -
Change in Long Term Investments	$ (22,222.00)	$ (20,667.00)
Net cash from Financing	$ 5,511.00	$ (20,667.00)
Net Change in Cash	**$ 5,616.00**	**$ (10,813.00)**
Cash Beginning of Year	$ 6,486.00	$ 17,299.00
Cash End of Year	**$ 12,102.00**	**$ 6,486.00**



ABC Agency Aging Schedule

Account	current	30 days	60 days	90 days	over 90 days	
Blue Cross	$ 3,800.00	$ 2,900.00	$ 2,500.00	$ 2,000.00	$ 2,000.00	
Medicaid	$ 5,000.00	$ 4,000.00	$ -	$ 500.00	$ 250.00	
Aetna	$ 1,300.00	$ -	$ 500.00	$ -	$ 250.00	
UBS	$ 600.00	$ 500.00	$ 250.00	$ 250.00	$ 100.00	
Patient Self Pay	$ 500.00	$ 250.00	$ 400.00	$ 250.00	$ 409.00	
Total	$ 11,200.00	$ 7,650.00	$ 3,650.00	$ 3,000.00	$ 3,009.00	$ 28,509.00



ABC Agency Financial Ratios

Total Margin (net income/total revenue)	4%
Return on Assets (net income/total assets)	5%
Current Ratio (current assets/current liabilities)	3.52
Days Cash on Hand (cash + marketable securities/Expenses-depreciation-bad debt provision/365)	50.5