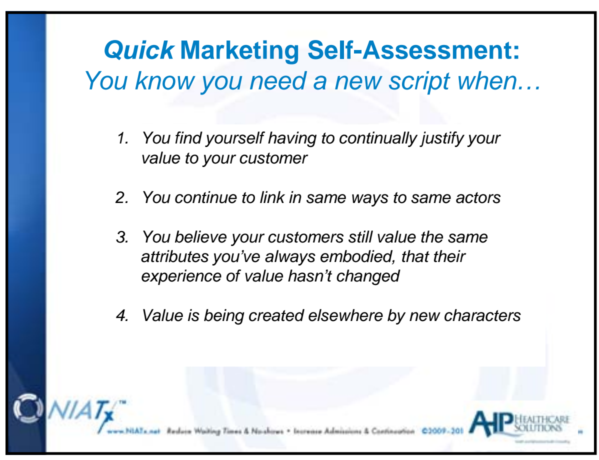
November 17, 2010 agenda
Location: 1211 Vine St., Suite 2230, West Des Moines

8:15	Registration	Julie Shepard
	SETTING THE STAGE Welcome and Introductions Leadership vision State laws/policy (Medicaid, Medicare, State Benefits Mandates)	 Janet Zwick Kathy Stone Kathy Stone
	MARKETING **Pre work assignment.** Review of AHP Business Modeling tool	Patrick Gauthier
10:30	Break	
	Pre work assignment. Discuss walk through regarding contract information Small group discussion	Jay Ford & Janet Zwick
	Selling your service Role play exercise	Jay Ford & Janet Zwick
12:00	Lunch	
12:30	FINANCE Review and discussion of best practices for collection of co-pay Financial Performance Improvement Discussion regarding cost analysis	Patrick Gauthier Jay Ford & Jay Hansen Patrick Gauthier Jay Ford & Patrick Gauthier
2:30	Break	
	Align optimal patient flow with optimal IT	Patrick Gauthier
	Design change project in small program groups	All
	Next steps	Janet Zwick
4:30	Adjourn	



Overview of Marketing

- **What is Marketing?**
  - Marketing is a series of inter-related processes and activities designed to develop customer interest in a company's goods and services
  - It's a strategy that leads to communications and sales and strong customer relationships
  - It's used to identify, satisfy and keep the customer
  - Marketing heralds a business shift away from mass production (50's), product quality (60's), and sales (70's) toward identifying customer needs and definitions of value and then…meeting them

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CONTEXT:

The New Business Environment

- MHPAEA - designed to end discriminatory benefits and business practices
- MH/SUD benefits will finally enjoy the same financial requirements and limitations as med/surg benefits.
- Health plans, Managed Care Plans, Self-Insured Employers, Medicaid Managed Care Plans and S-CHIP are all subject to MHPAEA.
- Parity alone impacts 130+million Americans
- Healthcare Reform expected to expand Medicaid enrollment by 16 million beginning in 2014
- Reform establishes Health Insurance Exchanges that will enroll another 16 million in small group and individual plans
- Parity + Reform = Shifting funding streams, melding of the public and private systems

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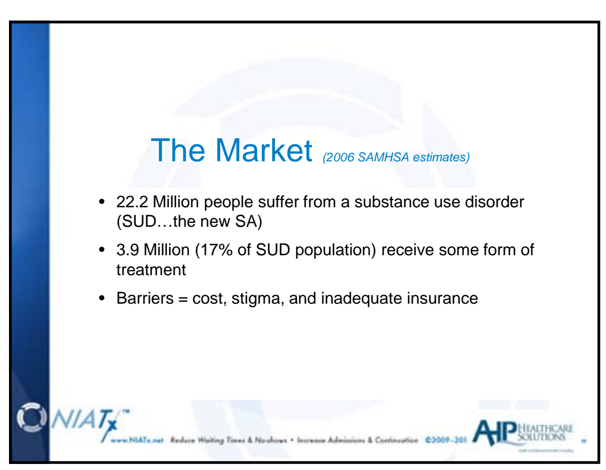

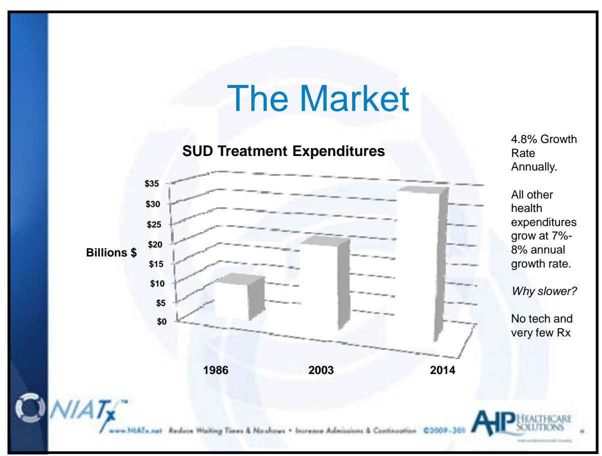

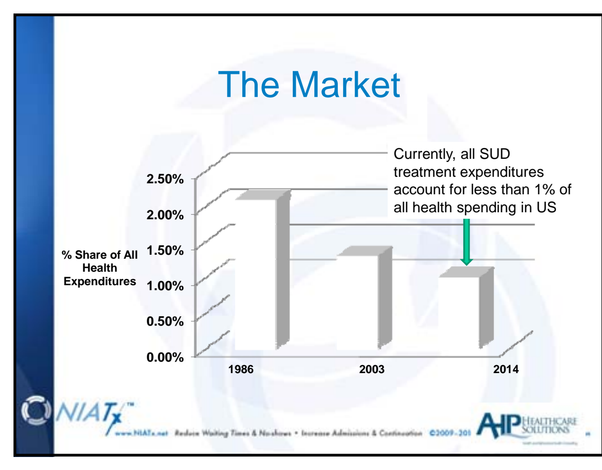

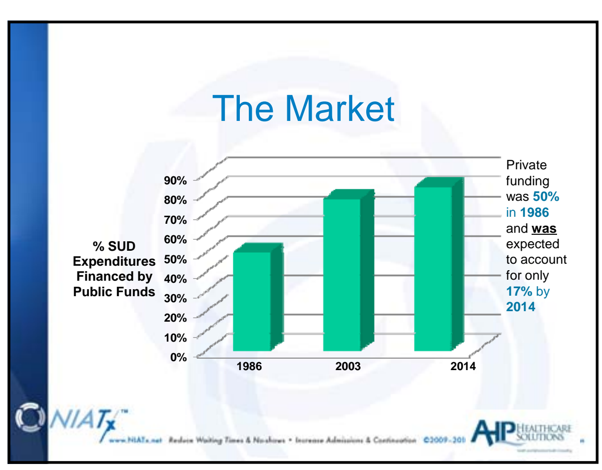

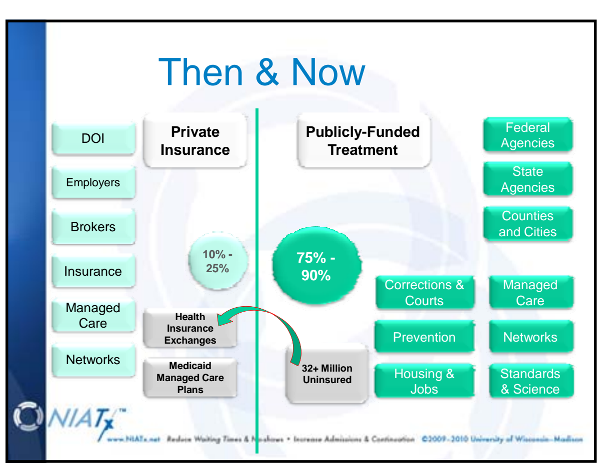

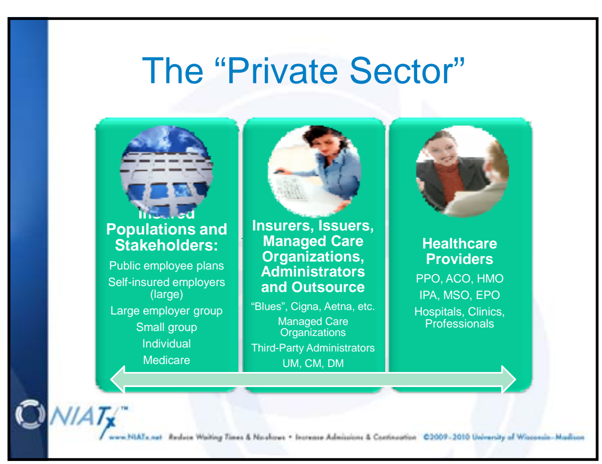
The "Private Sector"
Populations and Stakeholders:
Public employee plans
Self-insured employers (large)
Large employer group
Small group
Individual
Medicare
Insurers, Issuers, Managed Care Organizations, Administrators and Outsource
"Blues", Cigna, Aetna, etc.
Managed Care Organizations
Third-Party Administrators
UM, CM, DM
Healthcare Providers
PPO, ACO, HMO
IPA, MSO, EPO
Hospitals, Clinics, Professionals
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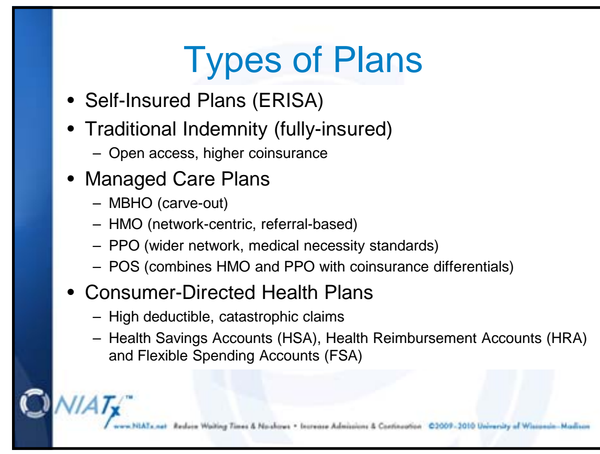
Types of Plans
• Self-Insured Plans (ERISA)
• Traditional Indemnity (fully-insured)
– Open access, higher coinsurance
• Managed Care Plans
– MBHO (carve-out)
– HMO (network-centric, referral-based)
– PPO (wider network, medical necessity standards)
– POS (combines HMO and PPO with coinsurance differentials)
• Consumer-Directed Health Plans
– High deductible, catastrophic claims
– Health Savings Accounts (HSA), Health Reimbursement Accounts (HRA) and Flexible Spending Accounts (FSA)
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Innovations in Health Insurance
• Personal Spending Accounts (debit cards)
• Hospital and Provider Quality Comparisons online
• Hospital and Provider Cost Comparisons online
• Personal Health Records (PHR)
• Coverage Advisors
• Treatment Advisors
• Treatment Cost Advisors
• Nurse Line
• Health Risk Assessments and Health Risk Management Programs with Incentives ($)
• Disease Management Programs
• Choice of Networks
• Prevention Benefits and Services
• Patient-Centered Medical Homes and Accountable Care Organizations
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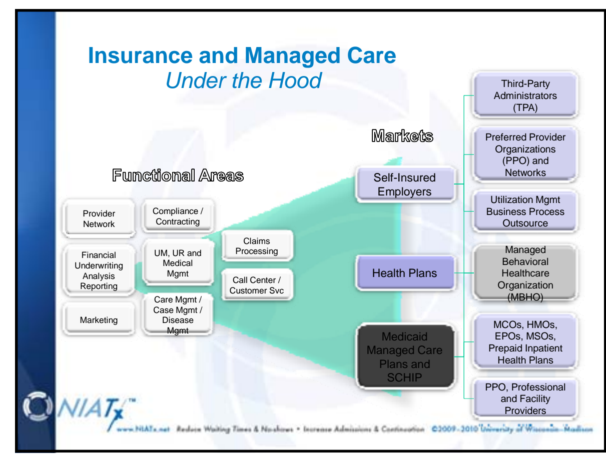
Insurance and Managed Care
Under the Hood
Markets
Functional Areas
Provider Network
Compliance / Contracting
Claims Processing
Financial Underwriting Analysis Reporting
UM, UR and Medical Mgmt
Call Center / Customer Svc
Care Mgmt / Case Mgmt / Disease Mgmt
Marketing
Self-Insured Employers
Health Plans
Medicaid Managed Care Plans and SCHIP
Third-Party Administrators (TPA)
Preferred Provider Organizations (PPO) and Networks
Utilization Mgmt Business Process Outsource
Managed Behavioral Healthcare Organization (MBHO)
MCOs, HMOs, EPOs, MSOs, Prepaid Inpatient Health Plans
PPO, Professional and Facility Providers
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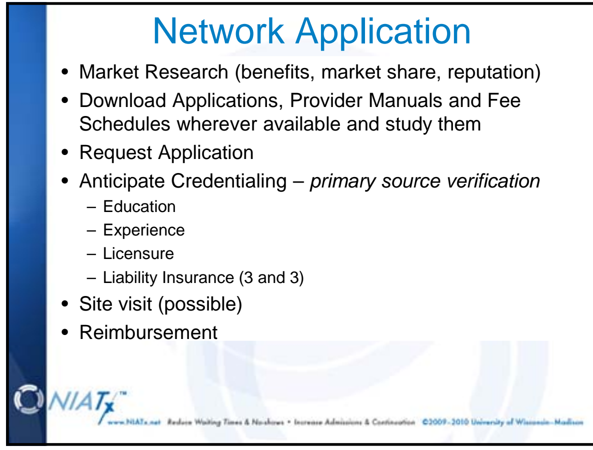
Network Application
• Market Research (benefits, market share, reputation)
• Download Applications, Provider Manuals and Fee Schedules wherever available and study them
• Request Application
• Anticipate Credentialing – primary source verification
– Education
– Experience
– Licensure
– Liability Insurance (3 and 3)
• Site visit (possible)
• Reimbursement
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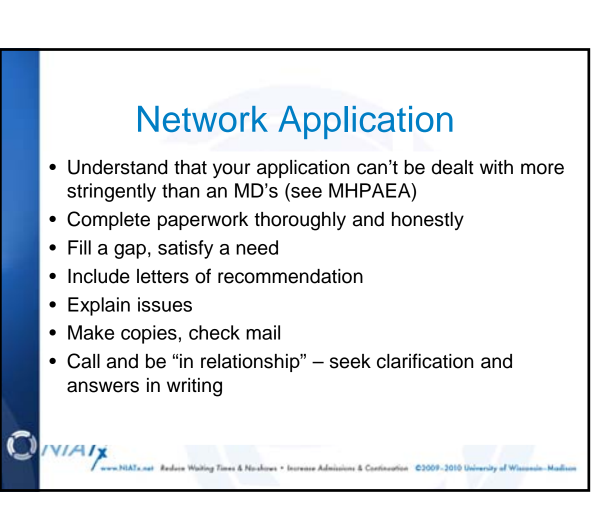
Network Application
• Understand that your application can't be dealt with more stringently than an MD's (see MHPAEA)
• Complete paperwork thoroughly and honestly
• Fill a gap, satisfy a need
• Include letters of recommendation
• Explain issues
• Make copies, check mail
• Call and be "in relationship" – seek clarification and answers in writing
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Tips

- Read Provider Manuals
- Read Level of Care/Medical Necessity Guidelines
- Read Provider Newsletters
- Read Practice Guidelines

Re-Credentialing

- Credentials (licensure and insurance up-to-date, legal or disciplinary actions)
- Patient satisfaction ratings
- Complaints
- Outcomes
- Administrative performance
- Access
- Peer review and appeals decisions

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 Provider?

- Network admission
- Profitable rates of reimbursement
- Easy access to information like eligibility (portal)
- Customer service
- Benefit authorization (approved and timely)
- Case Management
- Claims turn-around (cash flow)
- Easy on the paperwork
- Easy on the appeals

Preparations

1. Incentives for: new services, addressing co-morbid and/or co-occurring disorders, expanded geography, and integration with primary care.
2. Incentives to ensure timely, accurate, and efficient health information.
3. Electronic billing (electronic data interchange or EDI) and "clean claims".
4. Systems that generate outcomes data, enabling quality improvement and financial analysis.
5. Increased collaboration with utilization management (usually RN and Masters-level behavioral healthcare professionals) in treatment planning.
6. Expanded awareness that new funding will stimulate competition for new resources.

Strategic Preparations

1. Conduct strategic planning and renew your mission – *what business are you in? What services do you provide to whom and why?*
2. Review State insurance and managed care laws
3. Assess credentials and accreditation requirements
4. Conduct market research including competitor analysis
5. Position services in context of coverage and benefits
6. Gather intelligence: *Who's who? Directors? Board?*
7. Ask for the meeting – aim is everything. See #6 above
8. Come prepared - marketing/brand, data and dress the part
9. Evaluate plan requirements and apply for in-network status only where appropriate

Reimbursement Methods

Variety of Approaches and Methodologies

- Usual, Customary and Reasonable (UCR)
- Diagnosis Related Grouping (DRG)
- Resource-Based Relative Value Scale (RBRVS)
- Innovations including:
  - Sub-capitation
  - Bundled case rates and episode rates
  - Administrative fees for additional services like Case Management
  - Bonuses for performance
  - Shared savings

Preparing for Negotiations

- What's important to them as a payer? What's their reputation?
- Key linkages and networks? Relationships to leverage? Endorsements?
- Number members in your area?
- Number providers serving those members? Any gaps in services?
- Why your organization? Why you? What problem do you solve for them?
- What's in it for them?
- What innovation can you deliver? What value can you deliver?
- What financial offer are you prepared to make? What "skin" might you put in the game?
- What partners do you bring to the table?

Preparing for Negotiations

- Know what your services cost before you meet or discuss reimbursement
- Know what rate you need (cost + ?)
- Know where you need to start the bidding so you give yourself plenty of room to come down
  - Cost = $250 per residential day
  - Need = $350
  - Start = $500

Negotiations

1. We understand you have a need/pain
2. We are already seeing X # of your members and plan on seeing many more real soon. They love us! (letters from real members?)
3. We can fix your problem - Here's how
4. Nobody else can do it like we can
5. Between Parity and Reform, we expect our market to grow substantially. We'd like to grow with you.
6. It'll produce (quantify) value for you (be prepared with scenarios and data)
7. We have a lot of friends in this community who'd like to see us succeed in in crafting an agreement with you (letters of endorsement)
8. What would you pay for services like ours? (they must go first. Don't react.)

Negotiations

- These are our operating costs ($525). You've seen our service offering so you can understand why our costs are what they are.
- We're asking for a rate of reimbursement closer to $500. We think we can make it at that rate if we have enough volume and claims turn-around is good.
- Understanding your coverage, if we target your primary care providers and members with our marketing and treat them on an Out-of-Network basis, this is what will happen (be prepared with real numbers)
- However, if we can strike an agreement, on an In-Network basis, here's what it looks like for us both (real numbers). Can you agree to $500?

Negotiations

- Be prepared to deal with the objections and have a strategy for each:
  - "We have providers like you in our network already"
  - "We have much better rates with them and nobody is complaining"
  - "We've never heard of you"
  - "Your costs are too high. We can't pay you that much."
  - "We need to see your facilities and some outcomes data"

Negotiations

- So you're saying you can't do $500. What can you do?
- If we agree to $450, we can agree to a multi-year contract at that rate.
- If you can agree to the $450, we'll knock 20% off the Partial rate and another 20% off our IOP.
- If you want to go any lower, we'll have to start talking about real traffic through our doors. Can you do something exclusive with us? Do you have that authority? Can you capitate us? Sub-cap?
- I just cannot go any lower than $400 without having to adversely affect quality and staffing. I'll have to do business with your members on an out-of-network basis.
- Let's start at $400 and if the traffic is really good and we hit our numbers, I'll come back with a deeper discount. Let's try $400 for a year and see how it suits us both

A Vision for the Future

1. The "New Business Environment"
2. Accountable Care Organizations (ACO)
3. Patient-Centered Medical Home Model (PCMH) – Primary Care Integration
4. Value-Based Insurance Design (VBID) and EBPs
5. Comparative Effectiveness
6. Behavioral Medicine
7. Pay-for-Recovery Outcomes, Quality, Value
8. Prevention
9. Mergers and Acquisitions
10. Competition

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

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

More Market Research

☑ 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

The Patient Experience

- What is like to be your patient?
  - Perform detail walkthrough and document your patients' experience
  - Evaluate and prioritize your findings
  - Tie in the ultimate patient experience with the ultimate revenue cycle

Revenue Cycle

Appointment Scheduling → Patient Registration → Patient Exam → Documentation and Coding

Documentation and Coding → Charge Processing

Charge Processing → Claim & Statement Production → Payment Processing → Resubmission

Resubmission → Secondary Billing

Secondary Billing → A/R Follow-up → Legal Collections

Appointment Scheduling Goals

- Schedule the appointment within time desired by patient
- Inform patient to bring insurance card and co-payment
- Obtain as much demographic and eligibility information ahead of appointment as possible

Patient Registration Goals

- Verify insurance
- Ensure Pre-authorization received
- For all appropriate patients, collect co-pay and verify demographic information

Patient Encounter Goals
• Reasonable/timely access
• Complete, effective clinical service
• Appropriate documentation for patient care and correct billing to third party
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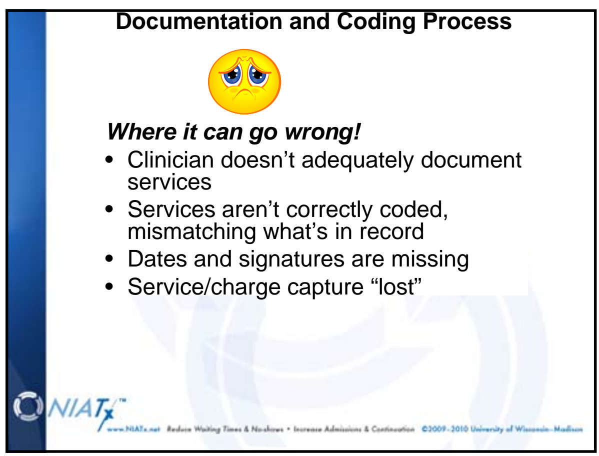

Documentation and Coding Process
Where it can go wrong!
• Clinician doesn't adequately document services
• Services aren't correctly coded, mismatching what's in record
• Dates and signatures are missing
• Service/charge capture "lost"
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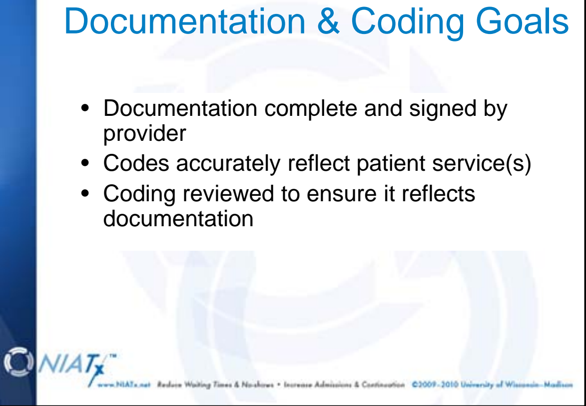

Documentation & Coding Goals
• Documentation complete and signed by provider
• Codes accurately reflect patient service(s)
• Coding reviewed to ensure it reflects documentation
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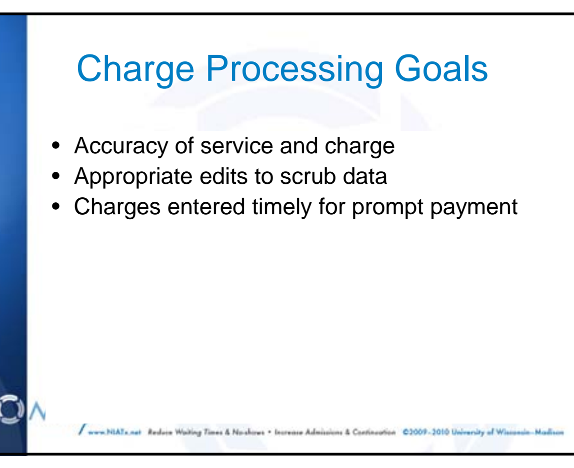
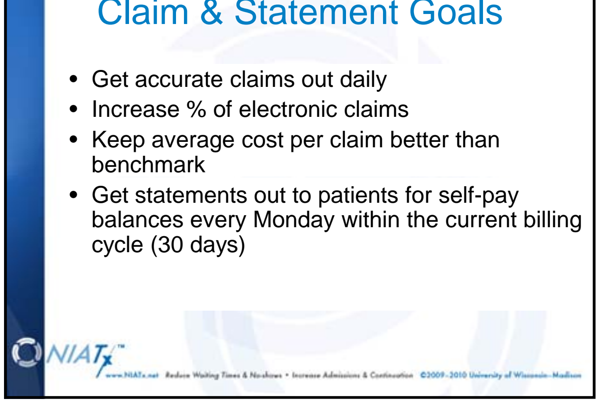


Charge Processing Goals
• Accuracy of service and charge
• Appropriate edits to scrub data
• Charges entered timely for prompt payment



Claim & Statement Goals
• Get accurate claims out daily
• Increase % of electronic claims
• Keep average cost per claim better than benchmark
• Get statements out to patients for self-pay balances every Monday within the current billing cycle (30 days)
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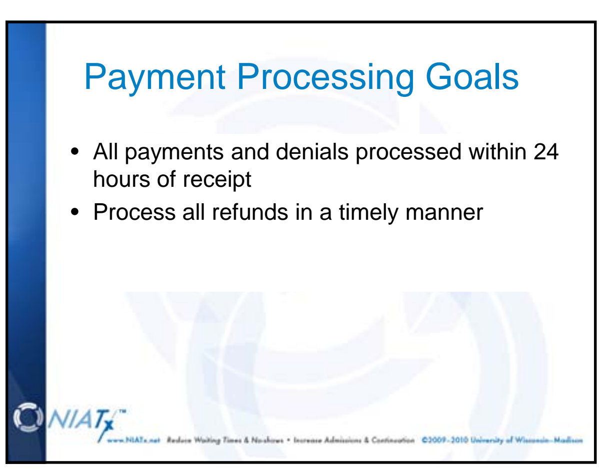

Payment Processing Goals
• All payments and denials processed within 24 hours of receipt
• Process all refunds in a timely manner
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Resubmission & Appeals Goals

- 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 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

A Successful Revenue Cycle Depends on…

- Documented workflow
- Documented business rules
- Optimized business process (waste reduced to a minimum)
- Alignment between workflow, processes, and information system like practice management/billing systems
- Monitoring and Response

Common Reasons Claims are Denied

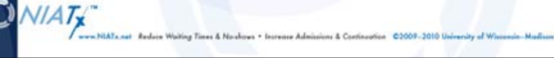
- The Patient is not enrolled/eligible
- The service/procedure is not covered – know the benefits!
- No pre-certification/authorization
- Demographic mistakes on the claim
- Claim not filed within time frames

Getting Paid!

1. Make reimbursement part of your mission, goals and objectives and report performance regularly.
2. Develop standards and policies for service/charge capture and billing.
3. Conduct training for clinical and billing personnel.
4. Make sure patients and services are eligible.
5. Get services authorized prior to delivering them.
6. Master coding (DSM/ICD diagnosis, CPT services, NPI, authorization number, etc.)
7. Select standard measurements, measure and enforce them.
8. Institute regular chart/billing reviews to assess compliance and to identify issues requiring further training.
9. Develop a standard feedback mechanism for clinicians.
10. Perform denials analysis regularly and re-submit claims in a timely fashion.

Revenue Management Culture

- **Values.** Establish a culture of Revenue Management with Board, management, administrative staff and clinicians. The same is true for patients.
- **Beliefs.** Make commitments to necessary resources such as training, systems, consultants, staff, etc.
- **Behaviors.** Monitor data and report frequently (weekly)
- **Norms and Expectations.** Intervene when necessary



Patient Flow - Process Improvement

- **Challenge:** balance the competing demands of maximizing the financials while maximizing the quality of care.
- Process improvement enables forecasting impact of proposed operational changes on overall performance.
- Process redesign CAN:
  - help cost-avoidance through efficiency gains;
  - improve the overall patient experience;
  - and lead to new levels of financial performance.

Strategies for Better Patient Flow and Cycle Time

- **Visualizing with Workflow:** Before you can make meaningful changes, you must understand processes well enough to identify bottlenecks, quality concerns, and understand their root causes.
- Workflow and Process mapping as well as cycle-time measures or time studies are extraordinarily helpful tactics.
- Process and time studies are fundamental to costing services

Performance Metrics

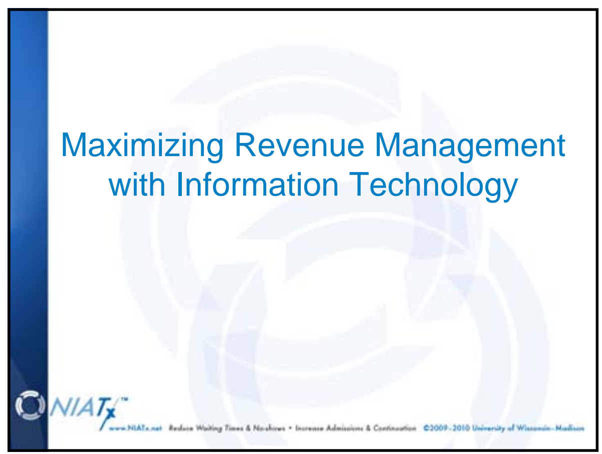
- Performance measurement is integral to process improvement and a prerequisite for effective practice management.
- Systematic measurement becomes mission-critical when business conditions become more complex.
- Traditional practice management and billing metrics are limited in scope and focus on scheduling, claim submission process, ignoring such variables as process imperfections on the insurance (payer) side.
- Modern software allow both productive measurement and effective action to improve patient flow and payment processes.

Optimal Patient Flow through Performance Metrics

- Using appropriate metrics helps improve policies and procedures, shorten revenue cycle, reduce patient complaints, improve financial performance and compliance, increase cash flow, reduce bad debt, identify areas of potential growth, improve employee morale, increase productivity, and reduce costs.
- They must focus on the “right” processes and their individual components. Measure what matters.
- Metrics must be used consistently over time and compared to standards and benchmarks.

Sample Metrics – Types of Data Management Reporting

- Missed Appointments
- Days in A/R (Accounts Receivable)
- Denial Rates
- Cash Collections
- Percent of A/R Beyond 60/90/120 Days
- Unpaid Claims Analysis
- Underpayment Reports
- Referral Source Analysis



IT Ideals

- Increase efficiency in all aspects – administrative, business and clinical – of operations.
- Automate the billing process
- Provide clinicians with secure, real-time access to accurate, client-centric, clinical information that is communicable through interoperable behavioral and medical health systems.
- Provide secure, lawful access to patient records at points of care where – with explicit patient permission – quality, safety, and efficacy can be improved.

Practice Management Systems

- Contact Tracking
- Patient Registration
- Eligibility Verification/Management
- Scheduling and Case-Load Mgmt
- Service Capture
- Billing (AR)

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Practice Management Systems

- Providers can buy PMS software or can “buy” PMS access online – software-as-a-service (ASP)
- PMS often needs to interface with the outside world. There are a number of standards that are used:
  - HL7 used to communicate with EMR systems
  - ANSI X12 EDI transactions

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EDI: Electronic Data Interchange

- EDI supports:
  - 837 Health Care Claims
  - 835 Payment Advice
  - 270/271 Health Care Benefit Inquiry and Response
  - 276/277 Claim Status Request and Response
  - 278 Health Care Services Request for Review
- Two basic methods are available to generate EDI claims transactions:
  - Direct Submission by Provider
  - Submission by Clearinghouse or Billing Service

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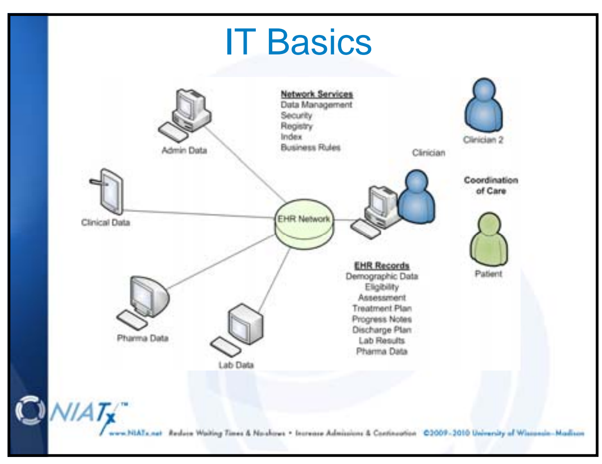
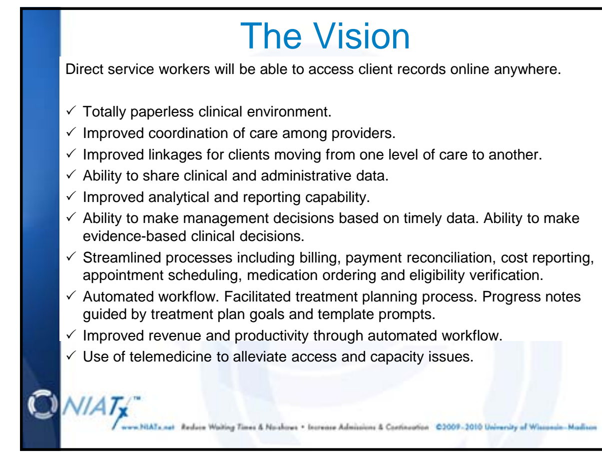
IT Basics – what is an EHR?

- The **Electronic Health Record (EHR)** is a longitudinal electronic record of patient health information generated by one or more encounters in any care delivery setting. Included in this information are:
  - Patient demographics
  - Progress notes
  - Problems
  - Medications
  - Vital signs
  - Past medical history
  - Immunizations
  - Laboratory data
  - Radiology reports.

  The EHR **automates and streamlines** the clinician's workflow. The EHR has the ability to generate a complete record of a clinical patient encounter, as well as supporting other care-related activities directly or indirectly via interface—including evidence-based decision support, quality management, and outcomes reporting.





The Objective Reality

- EHR selection and implementation can be a long, protracted process. Most implementations fail for lack of planning and commitment.
- Careful implementation planning is critical to successful EHR adoption. Unless mitigation strategies are developed, organizations can experience a serious reduction in revenue and slowdown in service delivery during implementation.
- HIPAA security and confidentiality (42 CFR) confuse providers.
- Since the market is still evolving, vendor stability and product viability should be validated during the selection process.
- Vendor contract and maintenance agreements must define level of support.
- Business processes should be re-engineered preferably BEFORE buying software
- Training is critical as is ongoing support
- Job descriptions may have to be revised to reflect new procedures and duties.

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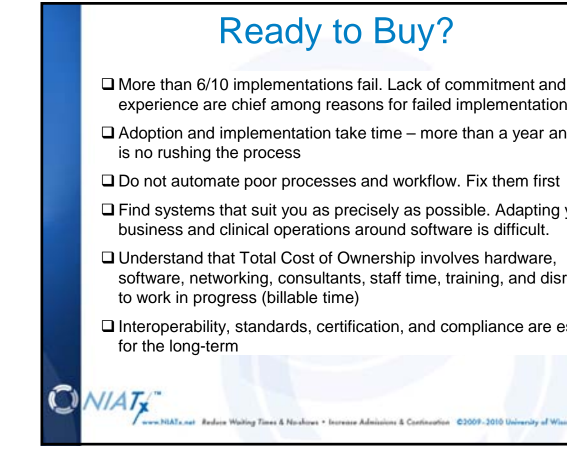
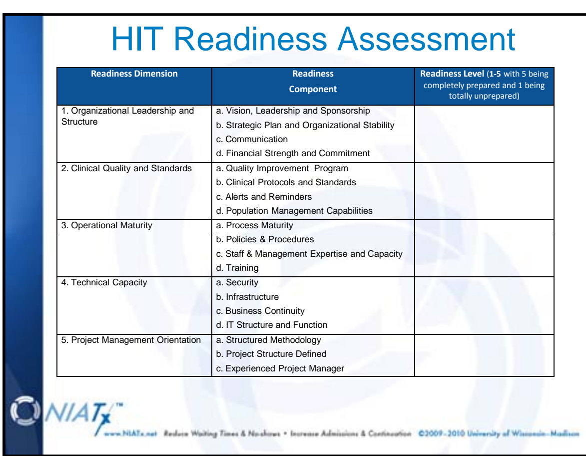
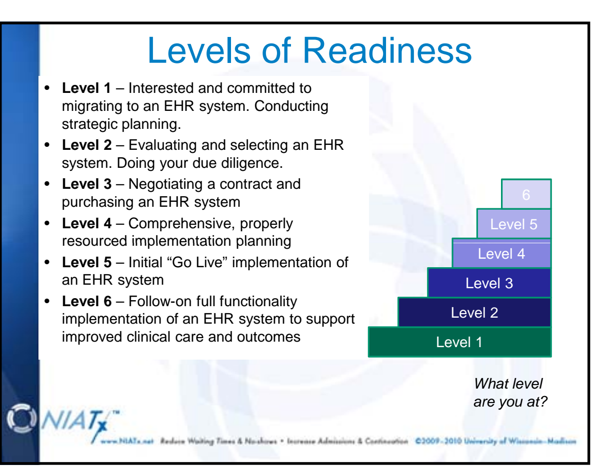


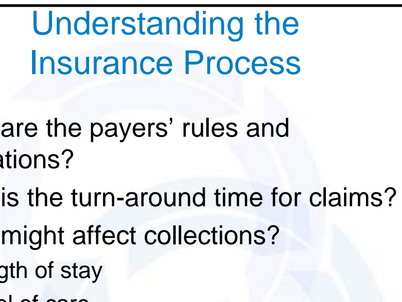


HIT Readiness Assessment

Readiness Dimension	Readiness Component	Readiness Level (1-5 with 5 being completely prepared and 1 being totally unprepared)
1. Organizational Leadership and Structure	a. Vision, Leadership and Sponsorship	
	b. Strategic Plan and Organizational Stability	
	c. Communication	
	d. Financial Strength and Commitment	
2. Clinical Quality and Standards	a. Quality Improvement Program	
	b. Clinical Protocols and Standards	
	c. Alerts and Reminders	
	d. Population Management Capabilities	
3. Operational Maturity	a. Process Maturity	
	b. Policies & Procedures	
	c. Staff & Management Expertise and Capacity	
	d. Training	
4. Technical Capacity	a. Security	
	b. Infrastructure	
	c. Business Continuity	
	d. IT Structure and Function	
5. Project Management Orientation	a. Structured Methodology	
	b. Project Structure Defined	
	c. Experienced Project Manager	



Understanding the Insurance Process



- What are the payers' rules and regulations?
- What is the turn-around time for claims?
- What might affect collections?
  - Length of stay
  - Level of care
  - Patient Volume
  - Patient Acuity
  - Billing Volume

Quick Definition

- Days in Accounts Receivable indicates the average time in days, that receivables are outstanding (DSO)

(Gross Receivables)/(Annual Net Revenues/365)

Billing Process

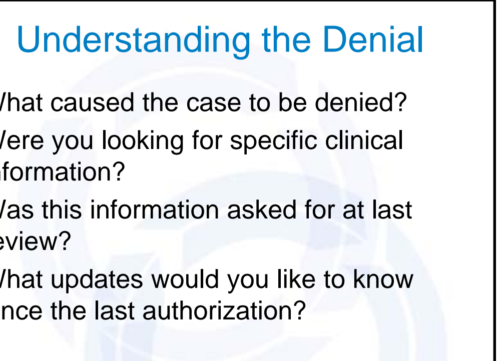
- What is your process for billing?
- When do you bill?
- Who is responsible?
- How long does each step take?
- Is the information from the authorization on the bill?

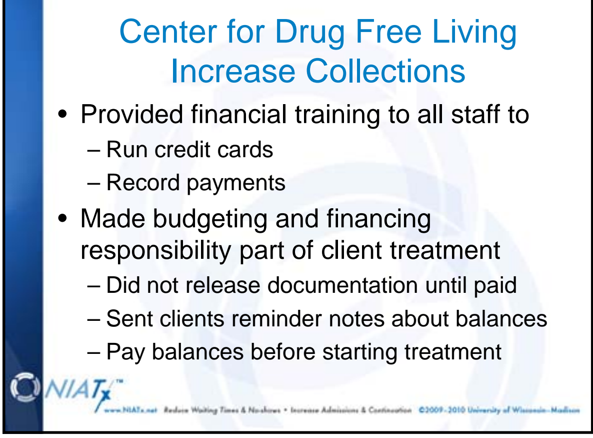
Authorization for Services

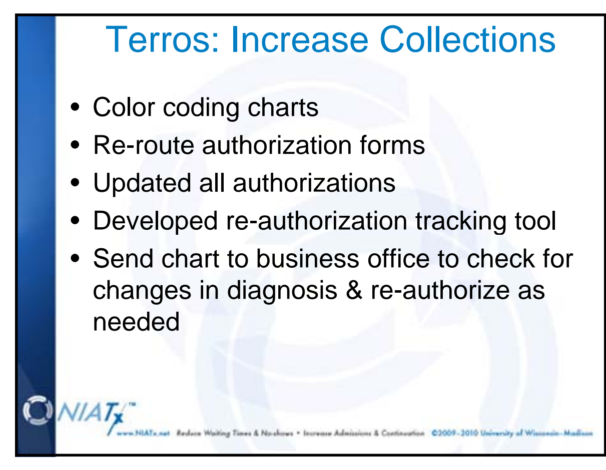
- Authorization
  - What is your process?
  - When is authorization sought?
- Information
  - What information is captured?
  - Who is the owner of the information?
  - How is the information disseminated?

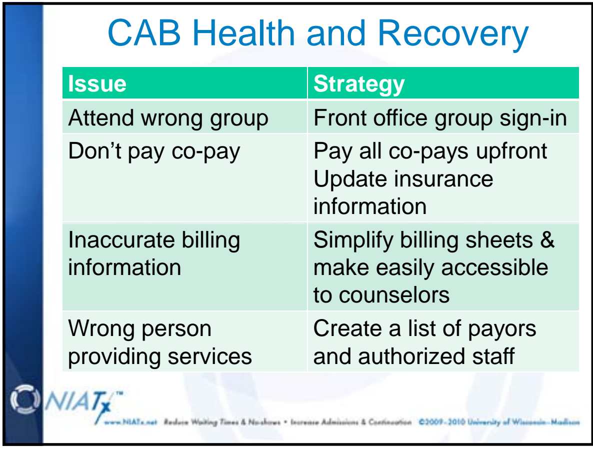
Collection Process

- What does the accounting process look like?
- What is your system for tracking paid versus outstanding bills?
- What percent of claims are denied?
- What is the most frequent denial reason?
- What is your re-authorization process?

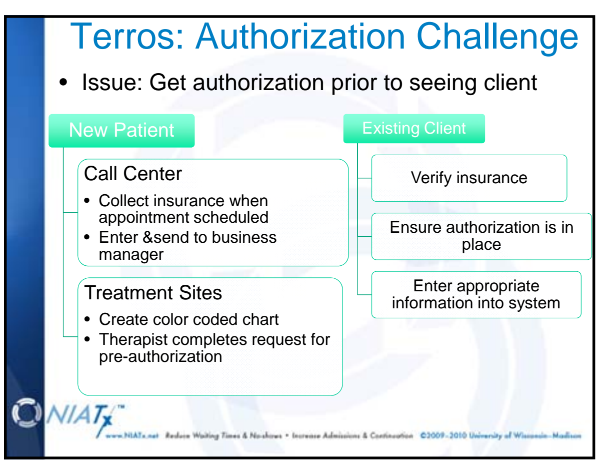


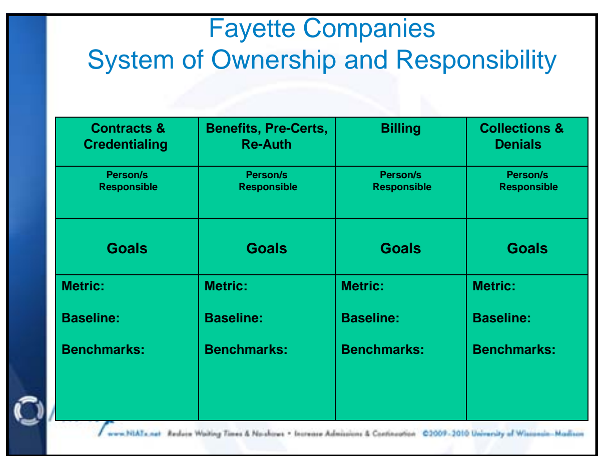





CAB Health and Recovery

Issue	Strategy
Attend wrong group	Front office group sign-in
Don't pay co-pay	Pay all co-pays upfront Update insurance information
Inaccurate billing information	Simplify billing sheets & make easily accessible to counselors
Wrong person providing services	Create a list of payors and authorized staff



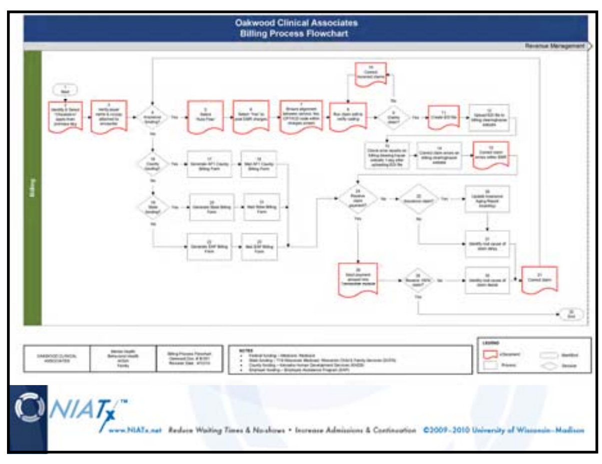


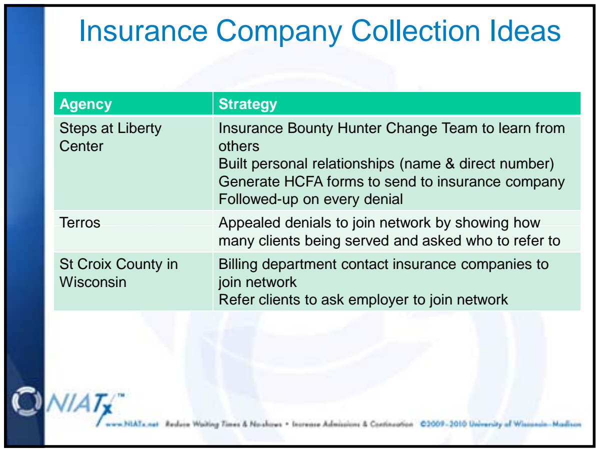
Fayette Companies
System of Ownership and Responsibility

Contracts & Credentialing	Benefits, Pre-Certs, Re-Auth	Billing	Collections & Denials
Person/s Responsible	Person/s Responsible	Person/s Responsible	Person/s Responsible
Goals	Goals	Goals	Goals
Metric: Baseline: Benchmarks:	Metric: Baseline: Benchmarks:	Metric: Baseline: Benchmarks:	Metric: Baseline: Benchmarks:

Other Client Collection Ideas

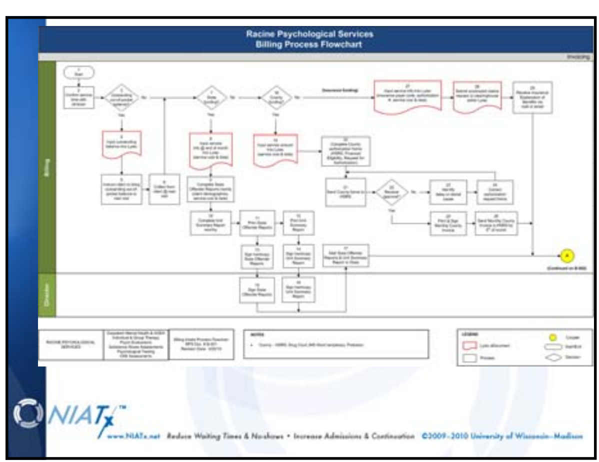
Agency	Strategy
Fayette	Admission fee ($20-30) vs. Sliding Fee for Treatment
Genesis Behavioral Health	Co-pay tracking form for counselors Collect co-pays before session
Mid-Columbia Center for Living	Include session cost on appointment card Review costs at orientation Offer stay and pay later option (DUI)
Steps at Liberty Center	Train staff on financial working of agency Ask clients about payment in private Inform client about expected payment
Solutions Behavioral Health	Work with specialist at intake Require payment when treatment received Use sliding fee scales as necessary
Racine Psychological	Use Quick Books not credit card machine
Oakwood Clinical Associates	Reminder call about co-pay Address budgeting as part of treatment

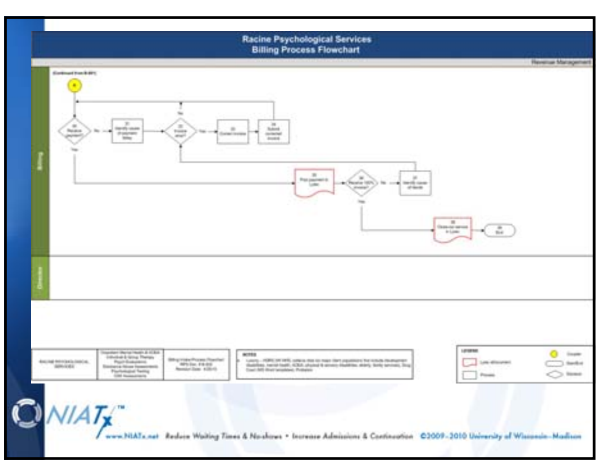




Insurance Company Collection Ideas

Agency	Strategy
Steps at Liberty Center	Insurance Bounty Hunter Change Team to learn from others Built personal relationships (name & direct number) Generate HCFA forms to send to insurance company Followed-up on every denial
Terros	Appealed denials to join network by showing how many clients being served and asked who to refer to
St Croix County in Wisconsin	Billing department contact insurance companies to join network Refer clients to ask employer to join network




Racine Psychological Services
Billing Process Flowchart
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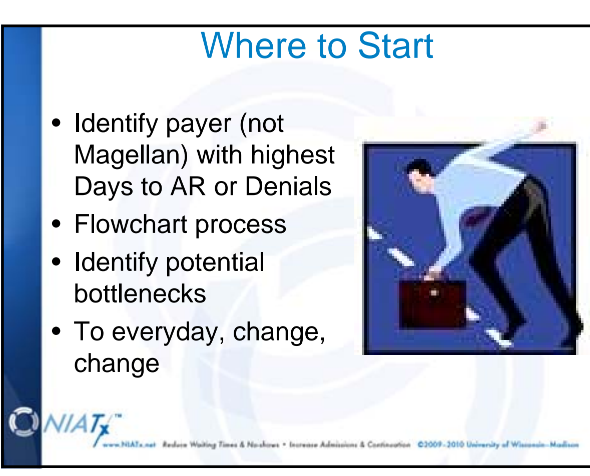
Where to Start
• Identify payer (not Magellan) with highest Days to AR or Denials
• Flowchart process
• Identify potential bottlenecks
• To everyday, change, change
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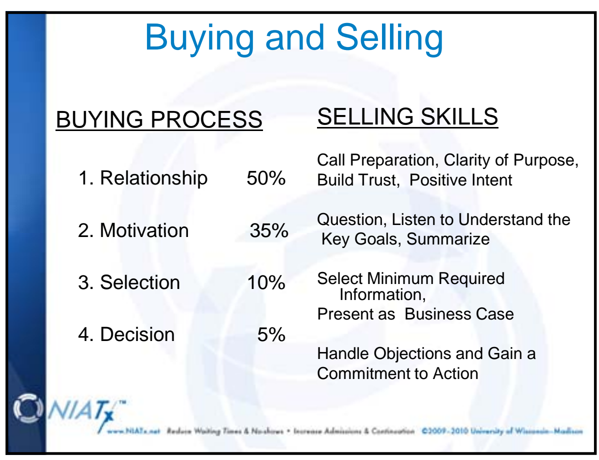
NIATx
Selling Your Services
Janet Zwick
Special Thank You
Chuck West University of Wisconsin
Reduce Waiting Times & No-shows • Increase Admissions & Continuation


Buying and Selling
BUYING PROCESS
1. Relationship 50%
2. Motivation 35%
3. Selection 10%
4. Decision 5%
SELLING SKILLS
Call Preparation, Clarity of Purpose, Build Trust, Positive Intent
Question, Listen to Understand the Key Goals, Summarize
Select Minimum Required Information,
Present as Business Case
Handle Objections and Gain a Commitment to Action
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Remember
Funders are
Customers
too

Building a Relationship
Prepare for call
learn about organization
be clear on purpose
Does the organization fit with your vision and purpose?
Build trust
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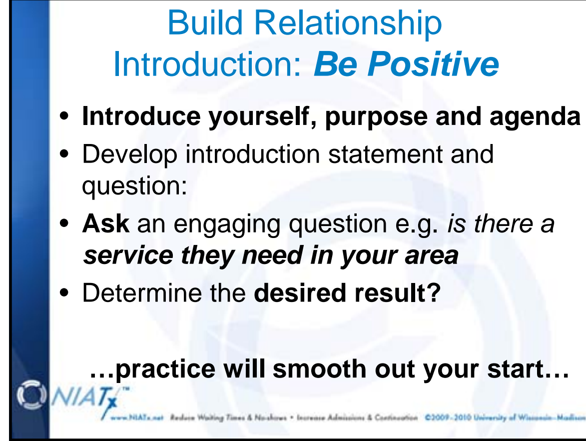
Build Relationship
Introduction: Be Positive
• Introduce yourself, purpose and agenda
• Develop introduction statement and question:
• Ask an engaging question e.g. is there a service they need in your area
• Determine the desired result?
…practice will smooth out your start…
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Motivation
Question
Listen
Summarize
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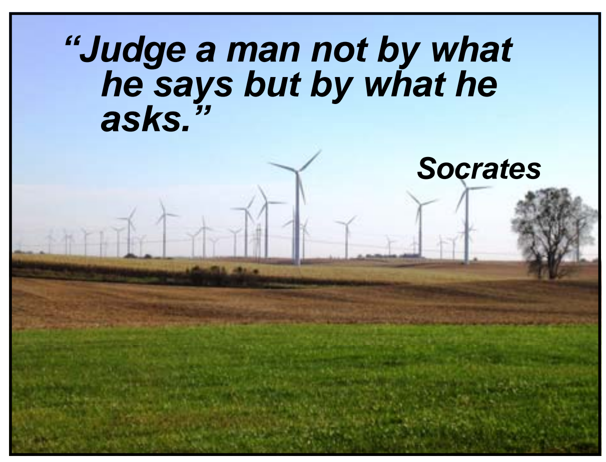
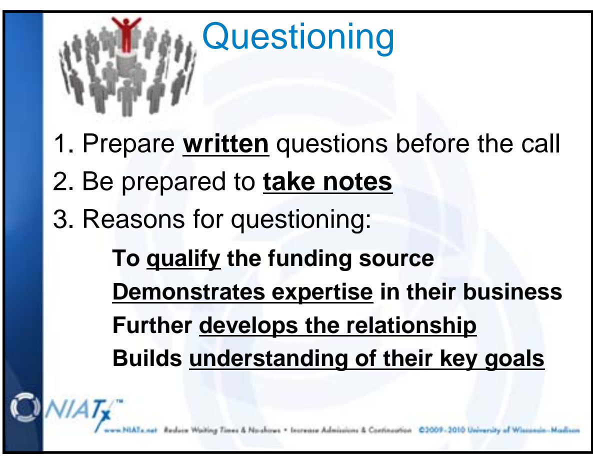
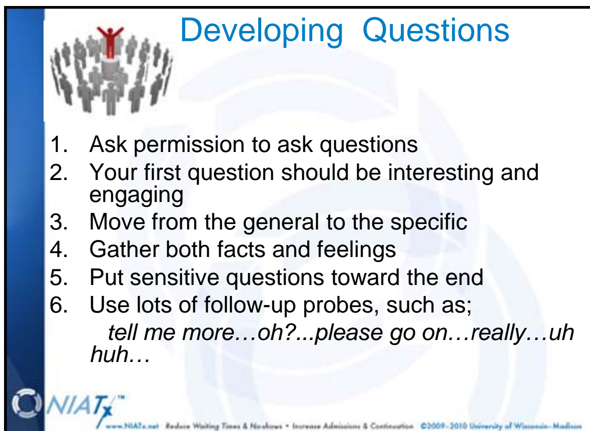

"Judge a man not by what he says but by what he asks."
Socrates


Questioning
1. Prepare written questions before the call
2. Be prepared to take notes
3. Reasons for questioning:
To qualify the funding source
Demonstrates expertise in their business
Further develops the relationship
Builds understanding of their key goals
NIATx


Developing Questions
1. Ask permission to ask questions
2. Your first question should be interesting and engaging
3. Move from the general to the specific
4. Gather both facts and feelings
5. Put sensitive questions toward the end
6. Use lots of follow-up probes, such as;
tell me more…oh?...please go on…really…uh huh…
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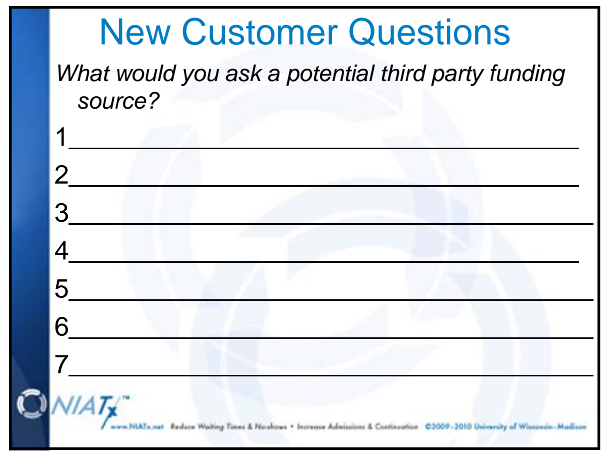
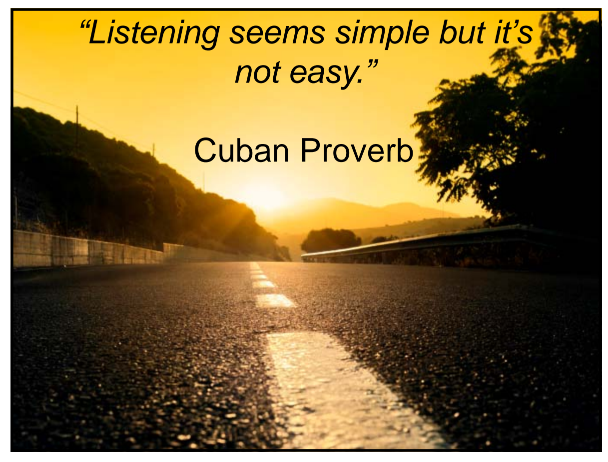
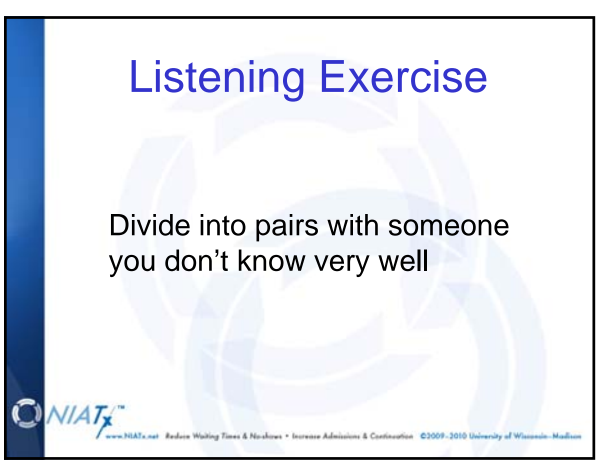

New Customer Questions
What would you ask a potential third party funding source?
1
2
3
4
5
6
7
NIATx


"Listening seems simple but it's not easy."
Cuban Proverb


Listening Exercise
Divide into pairs with someone you don't know very well
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A Listening Exercise
How did you feel?
How did you feel about your partner?
What did you want to do?
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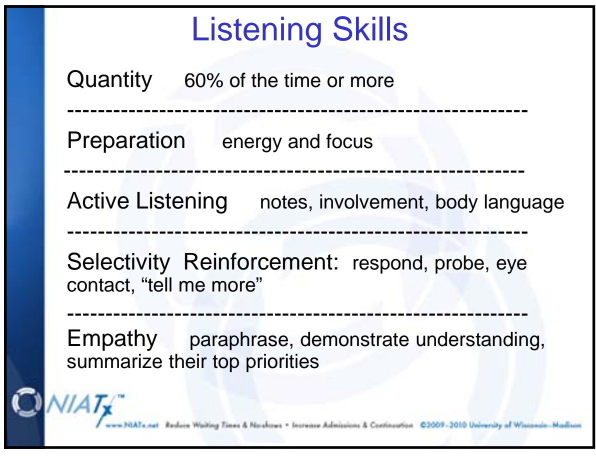
Listening Skills
Quantity 60% of the time or more
Preparation energy and focus
Active Listening notes, involvement, body language
Selectivity Reinforcement: respond, probe, eye contact, "tell me more"
Empathy paraphrase, demonstrate understanding, summarize their top priorities
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Questioning and Listening
Does it Sound Familiar?

Motivational Interviewing
Behavioral Health field trained in MI …use those same skills when marketing and selling!
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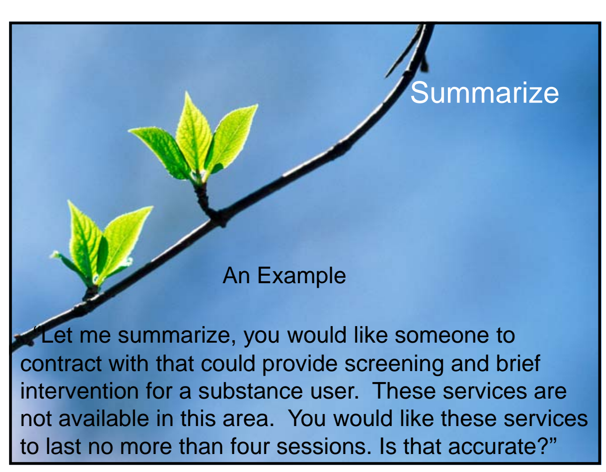
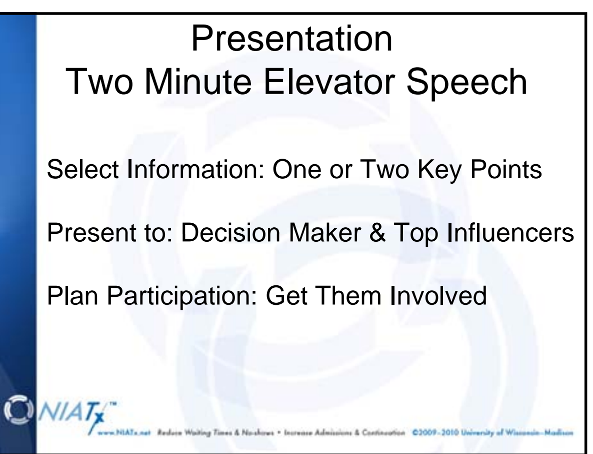

Summarize
An Example
"Let me summarize, you would like someone to contract with that could provide screening and brief intervention for a substance user. These services are not available in this area. You would like these services to last no more than four sessions. Is that accurate?"


Presentation
Two Minute Elevator Speech
Select Information: One or Two Key Points
Present to: Decision Maker & Top Influencers
Plan Participation: Get Them Involved
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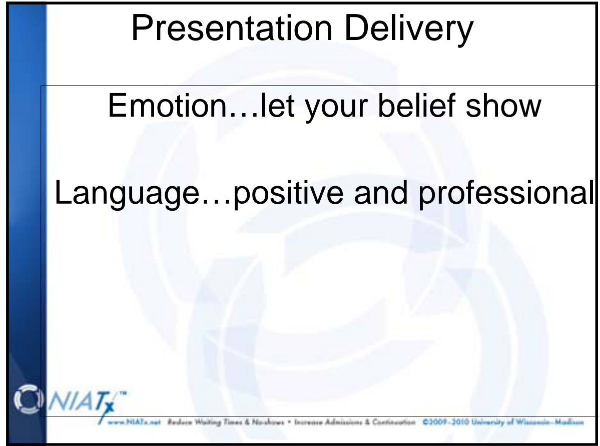
Presentation Delivery
Emotion…let your belief show
Language…positive and professional
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Exercise
Prepare your elevator speech
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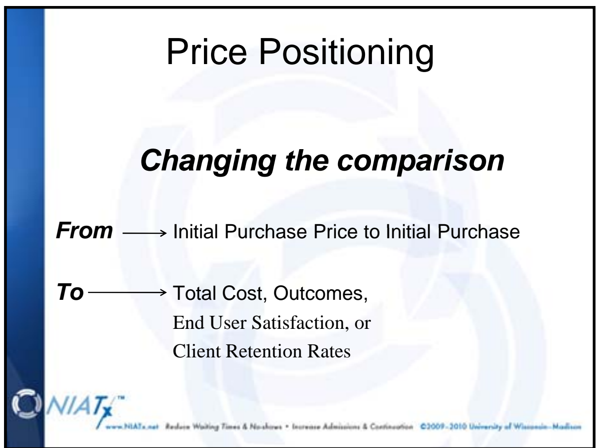
Price Positioning
Changing the comparison
From Initial Purchase Price to Initial Purchase
To Total Cost, Outcomes,
End User Satisfaction, or
Client Retention Rates
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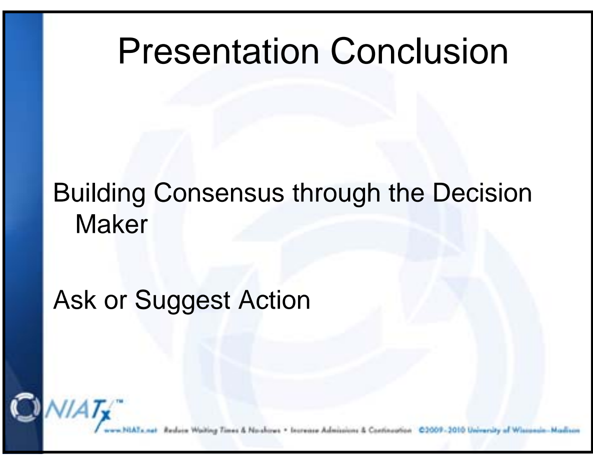
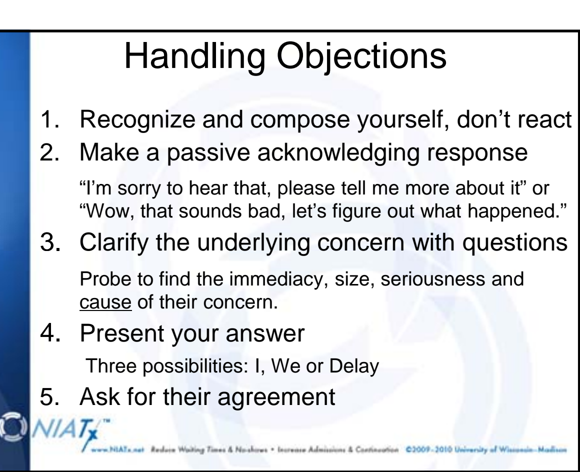

Presentation Conclusion
Building Consensus through the Decision Maker
Ask or Suggest Action
NIATx

Decision
• Objections
• Price Objections
• Commitment
NIATx


Handling Objections
1. Recognize and compose yourself, don't react
2. Make a passive acknowledging response
"I'm sorry to hear that, please tell me more about it" or "Wow, that sounds bad, let's figure out what happened."
3. Clarify the underlying concern with questions
Probe to find the immediacy, size, seriousness and cause of their concern.
4. Present your answer
Three possibilities: I, We or Delay
5. Ask for their agreement
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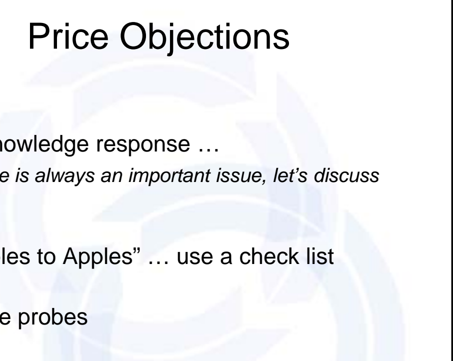
Price Objections



1. Acknowledge response …
   "Price is always an important issue, let's discuss it."
2. "Apples to Apples" … use a check list
3. Value probes

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Value Probes

1. What do you think your customers will be looking for in behavioral health treatment?
2. What patient outcomes are you providing incentives for?
3. Do you have any other concerns about going with us as a provider?

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Pricing Justifications

- Increased productivity or outcomes
- Education with $ comparison

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Enhanced Productivity or Outcomes

Find an outcome that is important to a funder and show that your outcomes produce better results

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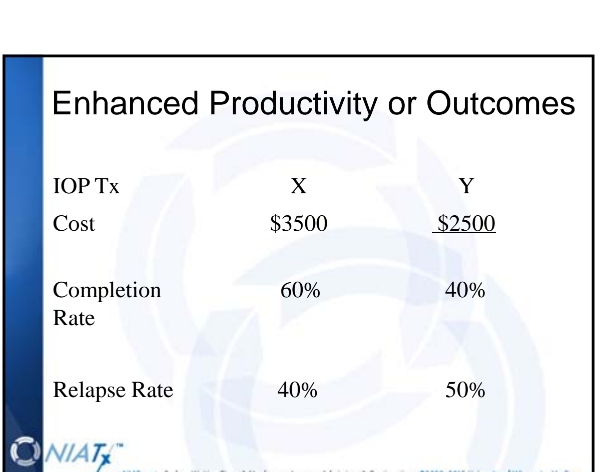
Enhanced Productivity or Outcomes



IOP Tx	X	Y
Cost	$3500	$2500
Completion Rate	60%	40%
Relapse Rate	40%	50%

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Education with $ Comparison

You can pay $ 2,500 to buy behavioral health services or you can pay $ 3,500.

If you invest $ 3,500, more clients complete treatment and have learned to recognize the symptoms of relapse. In the long run you will spend less for behavioral health treatment because clients who receive our services have been trained to recognize relapse symptoms and come back into treatment prior to having multiple health issues.

Now, let's discuss how our treatment is different and better than other alternatives.

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Asking for the Contract

1. Ask for their agreement with your proposal, or
2. Suggest the next action steps

Conclusions 2010

- You are a service business
- Funding sources will be changing
- You will be selling your service to new funding entities and customers
- To survive you must continue to provide quality service and make quality marketing and sales calls

Business Modeling:

How to Position Your Strongest Services in the Most Attractive Market Segments

Products and Services

We believe that it is important to grow from your organization's Core Competencies and most promising lines of business. Please score your organization's services in each of the five criteria below on a scale of 1 through 5 where a score of 1 is *"least, worst, poorest"* and a score of 5 is *"strongest, greatest, or most"*.

Top-Selling Services Your Organization Currently Delivers		Share of Revenue	Share of Profits	Competency, Expertise, and Quality	Mission Driven	Reputation	**Total Score**
Service 1							
Service 2							
Service 3							

Our most promising core competency and service is: ____.

Markets and Market Segmentation

We also believe that it is important to grow in those existing markets and new markets that hold the greatest promise. Please score your organization's identified market segments in each of the five criteria below on a scale of 1 through 5 where a score of 1 is *"least, worst, poorest"* and a score of 5 is *"strongest, greatest, or most"*

Top-Performing Markets Your Organization Currently Operates in		Share of Revenue	Share of Profits	Market Maturity and Visibility	Mission Aligned	Reputation and References	**Total Score**
Market Segment 1							
Market Segment 2							
Market Segment 3							

Our most promising market or market segment is: ____.

Therefore, we would be wise to prioritize branding, positioning, promoting and selling ______________________________ (service) in the

_______________________________ (market segment).

Plan Profile Tool

Plan Name	
Plan Type	
Coverage Area (city, county, region, state)	
Total Membership in this Plan	

Behavioral Health Plan Designs in Policy (co-pay, coinsurance, deductible, in-network and out-of-network coverage, special limitations, etc)					
MH IP	MH OP	SUD IP	SUD OP	SUD Other	Other

Covered Conditions/Diagnoses	
Covered Services	
Covered Providers	

Exclusions and Limitations

MBHO Carve-Out Vendor Name	
Coverage Area (city, county, region, state)	
Total Membership in this Plan	

Key Contacts			
Department	**Contact Information (email, telephone, mailing address)**		
Provider Relations			
Provider Contracting			
Medical Management			
Behavioral Health			
Claims Processing			
Case Management			

Network Application	
Application online or paper? Paste links	
Network Admission Process	
Credentialing and Accreditation Requirements *(education, experience, licensure, liability insurance, etc.)*	

Provider Tools Indicate whether available online (paste link) or available upon request (telephone number or mailing address	
Provider Manual	
Practice Guidelines	
Level of Care/Medical Necessity Guidelines	

Payer Reputation Turn-around time, accuracy, quality, customer service, etc.	
Network Access and Credentialing	
Utilization Review	
Claims Processing	

Current Provider Network Intelligence Number, types, locations, etc.

Reimbursement Methodology Usual, Customary and Reasonable (UCR), Diagnosis Related Grouping (DRG), Relative Value Scale (RVS), Case Rates, Episode Rate, etc.

Claims Submissions Process, rules, special policies or procedures, forms

Project Charter
Business Practices Fee for Service

<table>
<tr><td>Project Name</td><td colspan="2"></td></tr>
<tr><td>Executive Sponsor</td><td colspan="2"></td></tr>
<tr><td>Project Manager</td><td colspan="2"></td></tr>
<tr><td>Primary Stakeholder(s)
Board, Leadership, Finance, Agency Directors</td><td colspan="2"></td></tr>
<tr><td colspan="3">Project Description / Statement of Work</td></tr>
<tr><td colspan="3"></td></tr>
<tr><td colspan="3">Business Case / Statement of Need (Why is this project important and why is it important now?)</td></tr>
<tr><td colspan="3"></td></tr>
<tr><td colspan="2">Customers (Direct users/Those impacted by the project)</td><td>Customer Needs / Requirements</td></tr>
<tr><td colspan="2"></td><td></td></tr>
<tr><td colspan="2"></td><td></td></tr>
<tr><td colspan="2"></td><td></td></tr>
<tr><td colspan="2"></td><td></td></tr>
<tr><td colspan="2"></td><td></td></tr>
<tr><td colspan="3">Design</td></tr>
<tr><td>Project Goals</td><td colspan="2"></td></tr>
<tr><td>Project Deliverables</td><td colspan="2">How will you know that the change is an improvement?</td></tr>
<tr><td>Project Measures and Outcomes</td><td colspan="2">What tools will be used to measure the impact on:
The organization
The patient/customer
The value to the community?</td></tr>
</table>

Project Risks *(Actions, events, and situations outside the project plan that may positively or negatively impact the project)*
Implementation Plan / Milestones) *(Due dates and durations)*
Use separate worksheets to outline and track progress
Project Budget / Resources *(Money, people, services, materials, etc.)*
Communication Plan *(What needs to be communicated? When is communication needed? To who? How?)*
When will you meet? Weekly, monthly? When will both teams meet? Weekly, monthly? Who will take meeting minutes? How will minutes be distributed?
Change Management / Issue Management *(How decisions will be made? How changes will be made?)*

Project Team Roles and Responsibilities *(who do you want on your team to help with this project?)*		
Team members	**Roles**	**Responsibilities**
(your name here)		
Data?		
Administrative?		
Finance?		
Etc.		

Stakeholder Roles and Responsibilities	
Stakeholders	**Roles and Responsibilities**

Sign-off

Sponsor

____ **Date:** ____________

(Name, Role)

PROVIDER MARKET PROFILE TOOL

Plan Name	Total Membership	Types of Plans Offered	MH/SUD Carve-Out Partner
Health Plans			
Blue Plan	*125,000*	*PPO and POS*	*Acme Behavioral Health*
Managed Care Plans			
Managed Medicine	*75,000*	*HMO*	*Superior Network*
Self-Insured Employers			
Jack's Stores	*10,000*	*PPO and CDHP*	*Orion BHN*