NIATx –SI Business Practices for the Future – Fee For Service
MONTANA Regional Meeting Agenda
November 9-10, 2010

Red Lion Colonial Hotel
Helena, MT

Tuesday, November 9

1:00 Welcome and Introductions

1:15 Leadership Vision for this project

Update from the Insurance Commissioner's Office

Standing Laws/Policy for State and Federal Allocation

Why NIATx? Why Now?

Project Objective
To Improve the payer Mix

2:00 Changing Times exercise

2:30 Introduction to Marketing and Insurance Contracting

3:30 Break

3:45 Review Service and Market Priorities

4:30 What's unique about CD in Montana?

5:00 Close

Wednesday, November 10

8:00 Wait Watchers – Review of PI

9:00 Café Topics

10:00 Break

10:15 Financial Performance Improvement Worksheet

11:15 Project Charter

11:45 What's Next?

12:00 Good Bye

Market Segmentation – A Case Study

A small residential program in California appeared to have maximized their revenue potential and asked for analysis and help. Upon immediate examination, it was clear that they were missing opportunities to maximize revenues by making the most of what was already working. Unfortunately, they couldn't see what was or wasn't working as long as they couldn't see even the most basic data.

This client worked with their consultant to conduct a very basic cost estimate for their inpatient residential and outpatient aftercare programs. They worked with their consultant to review their existing third-party agreements and rates of reimbursement. Needless to say, armed with cost data, some of their agreements were causing them to lose money with every admission.

When they worked to discover their most profitable services, they also found they were their most successful services and those that were earning them a positive reputation. Lesser profitable services weren't engaging clients and weren't producing the kinds of accolades and revenue they hoped for.

When they looked closely at which markets were producing the highest returns in terms of revenue and profit per day, they thought through an approach that included expanding their service offering to include Partial, Medical Detox, and Intensive Outpatient Programming. Offering a more expansive continuum of care made their best payers happy, patients happy and kept most patients engaged in fruitful episodes of care over much longer spans of time. The additional services required additional staff and additional space. Staff were hired on temporary part-time basis until the model could be proven effective and the additional space consisted of leasing houses (at far reduced rates during the housing crisis) that served as Sober Living facilities while patients participated in the new Partial and IOP programming. They agreed to lease a van that could shuttle patients from house to house for clinical activities. Furniture was leased as well. They borrowed no money to make all of these changes.

This provider agreed to work with their consultants on a new brand image, new website, a new approach to marketing and sales and even a new staffing plan and organizational structure. Importantly, they agreed to implement a billing system that would enable electronic billing and improved cash flow.
As a result of their willingness to participate in this approach, targeting good business partners (payers), they are now operating three houses in addition to the original residential program and have doubled revenues from $2M to $4M in one year's time. They have also broadened their marketing reach and get referrals from places and people they hadn't planned for when they opened their doors. All of this unfolded between August of 2009 and August of 2010 – a time of extreme economic crisis.

In order to realize their vision and meet the demands of their mission, they also opened a larger residential facility in a more urban center where fundraising and profits are used to provide "scholarship" care to the indigent. Three profitable centers use their profits to support their non-profit division.

What can you learn and apply from this provider's experience?

NIATx™

Introduction to Marketing & Insurance Contracting

Optimizing Business Opportunities

Presented by
Patrick Gauthier

AHP Healthcare Solutions

Reduce Waiting Times & No-shows • Increase Admissions & Continuation

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*

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

Overview of Marketing

5 P's and 5 C's of Marketing

Product	Consumer Desire
Price	Cost
Place	Convenience
Promotion	Communication
People	Customer

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?*

Overview of Marketing

Marketing Fundamentals

Marketing is NOT Sales. It is…

- Market Segmentation
- Market Research
- A Marketing Plan
- A Customer Value Proposition

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

The Market *(2006 SAMHSA estimates)*

- 22.2 Million people suffer from a substance use disorder (SUD…the new SA)
- 3.9 Million (17% of SUD population) receive some form of treatment
- Barriers = cost, stigma, and inadequate insurance

The Market

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

Currently, all SUD treatment expenditures account for less than 1% of all health spending in US

The Market

Private funding was **50%** in **1986** and **was** expected to account for only **17%** by **2014**

Then & Now

The "Private Sector"

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)

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

Insurance and Managed Care
Under the Hood

Managed Care Functions…*Ideally*

1. 24-Hour Crisis Hotline, Customer Service and Care Navigators
2. Provider Network (qualified and verified)
3. Initial review of needs and referral based on location and anticipated need
4. Benefit authorization (prior or "pre")
5. Concurrent review
6. Case Mgmt
7. Retrospective review
8. Transitions and referrals across continuum/episode
9. Management of finite financial resources
10. Quality Assurance (credentialing, URAC, NCQA, HEDIS)
11. Quality of care, patient safety, outcomes and satisfaction measures and monitoring
12. Fiscal management (risk analysis, premiums, claims processing and cost controls)

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*

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

Establishing Rates of Reimbursement and Fee Schedules

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

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

Preparing for Managed Care

1. Business need to enter into agreements with MBHOs or other forms of managed care.
2. Requirements to participate in more rigorous professional credentialing.
3. Requirements to participate in utilization management (pre-certification or service and benefit authorization).
4. Increased use of diagnostic and screening tools to substantiate diagnoses.
5. Increased use of decision-support and treatment planning tools that help plan and track treatment across longer episodes of care.
6. Expanded communication and collaboration with other healthcare providers such as primary care physicians.
7. Requirements to demonstrate that care is consistent with evidence-based (scientifically-validated) best and promising practices.

Preparing for Managed Care

8. Incentives for new levels of services, new services for co-morbid or co-occurring disorders, expanded geography, and relationships with primary care.
9. Incentives to ensure timely, accurate, and efficient health information.
11. Increased need for expanded billing capacity and revenue generation, bearing in mind that ICD-9 is giving way to ICD-10 and that the commercial sector features tremendous complexity which will overwhelm manual workflows.
12. Increased need for data management that generates outcomes data and enables quality improvement and financial analysis.
13. Increased collaboration with utilization management (usually RN and Masters-level behavioral healthcare professionals) in treatment planning.
14. Expanded awareness that new funding will stimulate competition for new resources.

Preparing for Managed Care

- Conduct strategic planning and assess market conditions, existing network contracts, and resources required for compliance
- Assess credentials, certifications and accreditation requirements
- Convene meetings where possible with plans, payers and provider relations personnel
- 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

- Learn to negotiate Usual, Customary and Reasonable reimbursement
- 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 and clearinghouse outsource

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

Understanding the Demands of the New Business Environment

Addressing Policy Dimensions

- ❑ Situation Analysis – Developing a Vision and Understanding Markets
- ❑ Strategic Business Planning, Marketing and Sales Plans
- ❑ Dedicating Resources
- ❑ Market Research
- ❑ Revenue Mgmt., Unit Costing and Pricing and Contract Negotiations

Situation Analysis

- *What do MHPAEA and PPACA really mean for us?*
- *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?*

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

Assets Inventory

- Who are your key people?
- What are your key technology and system supports?
- What are your strongest tools?
- What is your most valuable information and what are you doing with it?
- What are your strongest marketing and promotion channels?
- What are your best prospects for partnership and alliance?
- How do you manage branding?

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

NIATx™

JOIN WAIT WATCHERS

Don C. Holloway, Ph.D.
NIATx Coach
Elizabeth Strauss, MSIE
NIATx Coach

Reduce Waiting Times & No-shows • Increase Admissions & Continuation

Objectives

To understand:

- The NIATx approach to Process Improvement, illustrated by joining Wait Watchers
- Using the NIATx Way to improve payer mix

What are members of Wait Watchers trying to accomplish?

Members join:

- To lose wait
- To be waitless

Are You Ambivalent About Losing Wait?

We will:

- Express Empathy
- Develop Discrepancies
- Roll with Resistance
- Support Self-Efficacy

How do Wait Watchers lose wait?

- Focus on the **customer**
- Focus on the **processes** that serve customers
- Use **simple tools** to identify process problems
- Use **rapid cycle testing** to see what changes really work

Focus on the Customers Who are they?

- External:
  - Patients and their family and friends
  - Referrers
  - Payers
  - Community
- Internal
  - Staff

Why Focus on the Process?

- Organizations exist to serve customers.
- Customers are served by people following processes.
- 85% of customer-related problems are due to poor processes, (not people).
- To serve customers better, improve processes.

THE Process

Watch the PROCESS (Not the People)

How will we know a change is an improvement?

Sample Chart

What changes can we make that will result in an improvement?

How Wait Watchers Learn

- Learn by Searching
- Learn by Watching
- Learn by Doing

Learn by Doing:

PDSA cycles
- **P**lan the change
- **D**o the plan
- **S**tudy the results
- **A**ct on the new knowledge (adapt, adopt or abandon)

Learn by Doing

SOURCE: Langley, Nolan, Nolan, Norman, & Provost. *The Improvement Guide,* San Francisco, Jossey-Bass Publishers, 1996

Learn by Watching

- Compare how airlines load passengers
- Compare use of commuter lanes
- Compare ATMs
- Compare hotels' checkout
- Compare rental car check in and out
- Compare grocery stores' checkout

Checkout Process: Pay Cash

Checkout Process: Write Check

Checkout Process: Credit Card

Checkout Process: Credit Card Target

Checkout Process: Credit Card Self Checkout

Which Loses the Most Wait?

- Cash?
- Check?
- Credit Card?
- Credit Card – Target's Variation?
- Self Checkout?

How can different changes be rapidly tested using Plan-Do-Study-Act?

Initial Steps in the NIATx Way

- Join NIATx
- Appoint an irresistibly influential change leader
- Appoint a highly motivated, representative change team
- Allocate sufficient resources
- Monitor progress
- Perform a Walk-through

The NIATx Way

- What's it like to be our customer?
- What are we trying to accomplish?
- How will we know a change is an improvement?
- What changes can we make that will result in an improvement?
- How can we pilot test the most promising change?
- How can we sustain the gains?

Closing Steps in the NIATx Way

- Tell your story
- Select the next project (*continuous* improvement)

Using the NIATx Way to Change the Payer Mix

Stories

Daybreak Youth Services

Spokane, WA

Changes:

- Managed government funded admissions to make more beds available to privately funded clients.
- Reduced assessment appointments from 2 hours to 1 hour by reducing paperwork and streamlining process, to align with private insurance allowances.
- Traded referrals with PTS, another NIATx agency whose mission was to serve only publicly funded clients.
- Tracked wait time for public vs. private pay clients.
- Publicized and marketed services on their website, with down-loadable intake/admission packet and information request form.

Daybreak Youth Services

Spokane, WA

- Visited probation offices throughout Washington
  - To explain what they do well, using inquiry and conversation
  - To find out what referrers liked (so they could do those things more)
  - To find out how they might assist the referrers and their clients further
- Send referrers a newsletter ***including success with NIATx aims***, thank you letters, and gifts (appt. books with the Daybreak logo).

Results

- Increased OP hours billed to private insurance by ~800 hours/year between 2002 and 2004
- Increased private bed days from just under 6 bed days/month to over 12 bed days/month between July and Nov. 2008

St. Christopher's Inn

Garrison, NY

Changes:

- Marketed to and contracted with Union Employee Assistance Professionals (EAP's)
- Became in-network providers for private insurance companies
- Created Targeted Marketing Brochures

Results:

- Increased revenue by $1,400,000
- Increased private insurance payer mix from 7% to 15% (in less than 2 years)

Prairie Ridge Addiction Treatment Services

Mason City, IA

Changes:

- Targeted admissions in the 40% of business that was fee-for service (to make up for 42% over-utilization of block grant funds 2000–2005, resulting in up to $462,000/year of un-reimbursed care).
- Accounts Supervisor put Change Teams together to increase collections of 3rd party, Medicaid, and client-fee receipts.
- Found extra capacity by improving processes, eliminating inefficiencies.

Results:

- Increased fee-for-service revenues (3rd party, Medicaid, and client-fee receipts) from $627,193 in Fiscal Year 2004 to $1,008,367 in Fiscal Year 2006.
- Outpatient direct service time increased from 40% to 53%, an effective increase of 3.12 new FTEs.

Using the NIATx Way for Contracting

- Some steps just need to be done. Try doing them and see what happens.
- See Contracting Flow Diagram.
- Treat each "sales call" with a payer, as a PDSA cycle.
- Increase referrals for this payer, using PDSA cycles.

What if you attract more clients from new payers?

Promising Practices

Increase Referred Clients (from "preferred" payer) who Get Admitted:

- Collaborate with Referrers to Streamline the Process
- Encourage Referrers to Make the First Appointment while the Client is Present
- Assign Each Referrer a Single Contact Person
- Guide Referrers to Make Appropriate Referrals
- Offer a Tour Guide
- Use Video Conferencing
- Orient Clients
- Use Motivational Incentives
- Map Out Continuing Care
- Include Family and Friends

Promising Practices

Increase Targeted Referrals:

- Become the Preferred Provider for Selected Referrers (i.e. contract with them)
- Tailor Brochures for Each Referral Source
- Offer New, Specialized Services
- Offer Intervention Services
- Publicize Your New and Improved Services
- Improve the Payer Mix

Selecting the Next Project

- You may discover that you need to:
  - Streamline the billing process (e.g. reduce the wait to submit bills)
  - Increase collections
- See Billing Flow and Measures Diagram

Promising Practices

Increase Collections:

- Increase Collection of Client Co-pays
- Increase Collections from Insurance Companies

Selecting the Next Project

Make sure that clients from the "preferred" payer:

- Can get into treatment quickly
  See: **Reduce Waiting Time** Promising Practices
- Show up
  See: **Reduce No-shows** Promising Practices
- Continue in treatment
  See: **Increase Continuation** Promising Practices

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- Use the promising practices as inspiration for change in your organization—**re-invent them, improve on them and be creative**—and let us know what happens so that we can continue to enrich and expand the library of change ideas available to the entire NIATx network.

http://www.niatx.net/content/contentpage.aspx?NID=68

www.NIATx.net

NIATx e-Learning Course:

Process Improvement 101

- A video training that provides an overview of the **NIATx Process Improvement Model** in less than 60 minutes
- http://www.niatx.net/Content/ContentPage.aspx?PNID=2&NID=15

Discussion Questions

1. Thinking about your ***best payer*** now (or a desired payer), what's working well?

1. Thinking about your ***most challenging payer*** now, what would you like to improve?

1. How can the Montana ***collaborative*** help you succeed? What tasks/efforts might be shared or done collectively?

Behavioral Health Direct Cost Calculators

Estimating Staff Time

Clinical Service:

Site	Activity (Step in Process)	Responsible Staff	Estimated Time (minutes) Required for Step in Process
Example: Group Room	Setting room up, aligning chairs and making coffee.	Jill	9
Office	Make copies of hand-outs for group	Bob	12
		Total Service Time (minutes)	21

Estimating time can be accomplished with Time Study, Workflow Analysis, and Observation

In the case of group activities, divide the total time by the average number of group participants to arrive at your cost per client per service

Behavioral Health Direct Cost Calculators

Total Staff Time

Clinical Service:

Total the estimated staff time for this specific service

Staff	Total Time (minutes)
Sandy	75

Behavioral Health Direct Cost Calculators

Staff Cost Per Minute

This and the following worksheets contains salary information and MUST be kept CONFIDENTIAL

Staff/Position	Hourly Rate (benefits and taxes included)	Minute Rate
Sandy	$32.00	$0.53
		$0.00
		$0.00
		$0.00
		$0.00
		$0.00
		$0.00
		$0.00
		$0.00
		$0.00
		$0.00
		$0.00
		$0.00
		$0.00
		$0.00
		$0.00
		$0.00
		$0.00
		$0.00
		$0.00
		$0.00
		$0.00
		$0.00

Behavioral Health Direct Cost Calculators

Service-Specific Cost Calculator

Clinical Service:

Staff	Total Time for this Service (minutes)	Cost per Minute	Total Cost per Client
Jill	12	$ 0.37	$ 4.44
Sandy	75	$ 0.53	$ 39.75
			$ -
			$ -
			$ -
			$ -
			$ -
			$ -
			$ -
			$ -
			$ -
			$ -
			$ -
			$ -
			$ -
			$ -
			$ -
		Total Cost	$ 44.19

Behavioral Health Direct Cost Calculators

Supply Cost Calculator

Clinical Service:

Supply Item	Unit Cost	Amount Used Per Client	Cost Per Client
Big Book	$ 7.00	1	$ 7.00
			$ -
			$ -
			$ -
			$ -
			$ -
			$ -
			$ -
			$ -
Total Supply Cost for this Service			$ 7.00

Behavioral Health Direct Cost Calculators

Supply Cost Calculator

Clinical Service:

Total Staff Time Cost	$ 39.50
Total Supply Cost	$ 11.25
Total Cost per Service per Client	$ 50.75

Behavioral Health Direct Cost Calculators

Service Inventory

Screening/Assessment
Social History
Physical/Medical Examination
UA/Labs
Outpatient Counsleing (50 minutes)
Group Counseling
Psychological Evaluation
Medication Management

Other Inpatient Service Factors

Meals
Vitals
Activities
Outing: 12-Step Meeting
Patient Education Session
Nutritional Counseling
Exercise

BILLING FLOW and MEASURES DIAGRAM

9/16/2010

STEPS (from NIATx Billing 3rd-Party Payer Guide)	**POSSIBLE INTERMEDIATE AIMS**	**POSSIBLE RAPID CYCLE MEASURES** (for specified period, e.g. 1	**TIER/STAGE of BILLING CONTINUUM**
START: Patient with insurance		# of clients with 3rd party insurance	
1 Verify coverage	Increase # of clients for whom coverage is	# of clients for whom 3rd party coverage was	**BILLING SYSTEM Design and Implementation**
2 Request prior authorization, if necessary			
3 Document authorization limits			
4 Provide services			
5 Record service provided and bill for appropriate amount	Increase # of 3rd party payers we're capable of billing.	# of 3rd party payers we're capable of billing	
	Reduce # of days between service and sending bill.	# of days between oldest date of service on bill and sending bill	
	Increase # and $ of bills sent to 3rd party payers.	#/$ of bills sent to 3rd party payers	
6 Document collections: Bill paid, denied, or no record of response?	Reduce # and $ of denials.	#/$ of bills paid; #/$ of denials by reason	**COLLECTION Process Improved**
7 Monitor receivables; Follow up process if bill not paid			
8 Make corrections and resubmit the bill			
9 Bill paid	**AIM: Increase $ collected from 3rd party payers and covered**	$ collected from 3rd party payers; $ copays collected	
10 Select next 3rd party to bill	Increase # of contracts with 3rd party payers. Increase # of clients with 3rd party insurance.	# of contracts with 3rd party payers	**Increase CONTRACTS with Payers**

CONTRACTING FLOW DIAGRAM

10/28/2010

STEPS (For detail, see NIATx Billing 3rd-Party Payer Guide, Seeking Contracts for your Services.)

1 Know state requirements for operating your business and providing treatment services.

↓

2 Conduct a service coverage analysis.

↓

3 Identify third party payers and consider:
Workforce requirements, e.g.education, experience, certification
Payment, e.g. case rates vs. treatment session
Level of care criteria

↓

4 Contact third party or managed care companies with whom you are considering contracting.
Treat each sales call as a PDSA cycle.

↓

5 Fill out payer's application form.
Include agency's strengths and outcome data.

↓

6 Prepare for site visit.

↓

7 Negotiate rates.
Consider cost analysis.

↓

GET CONTRACT
8 Make sure your agency is listed as a provider for this third party payer.

↓

9 Increase admissions by increasing referrals for this payer, using PDSA cycles.
See Promising Practices for Increase Admissions.

Dashboard

Clinic <Enter Clinic Name>
Year <Enter Year>

Financial Indicators

<Enter Year>	**Baseline Data**	**Target Goal**
Financial Indicators		
Denials as % of Total Billed	0.00%	0.00%
% of Collections of Net Revenue	0.00%	0.00%
% of Accounts Receivable Greater than 90 days	0.00%	0.00%
Days In AR	0.00	0.00
Current Ratio	0.00	0.00
Days Cash on Hand	0.00	0.00
Cost Per Unit of Service	$0.00	$0.00
Admin Exp as % of Total Exp	0.00%	0.00%

Definitions/Formulas

Total Number of Denied Claims/Total Number of Claims Submitted
Total Cash Collected/Total Net Revenue
Total Accounts Receivables over 90 days/ Total Accounts Receivables
(***Gross Accounts Receivables*** less allowance for doubtful accounts and contractuals)
((Revenue lest contractuals and bad debt)/365))
Current Ratio (current assets/current liabilities)
Days Cash on Hand (Cash and Cash equivalents)/((total expenses less depreciation)/365)
Cost Per Unit of Service (Total cost/total units of service)
Admin Exp as % of Total Exp (Admin expense/total expense)

NIATx™

IT – Aligning Optimal Patient Flow with Optimal IT

Reduce Waiting Times & No-shows • Increase Admissions & Continuation

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

The Revenue Cycle

Appointment Scheduling: Goals

What should be the goals those of the Clinical Department and Patient Services?

- Schedule the appointment within time desired by patient
- Informed patient of the sliding fee process
- Inform patient to bring insurance card and co-payment

Appointment Scheduling Process

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

Patient Registration: Goals

- Ensure Pre-authorization received
- Ensure verification of insurance and PCP validated
- Sliding fee application completely filled out
- For all appropriate patients, collect co-pay 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

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Patient Encounter: Goals

- Reasonable/timely access
- Complete clinical service
- Informative to patient
- Appropriate documentation for patient care and for 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 Process

- Clinician documents services
- Services coded by clinicians and/coders: CPT codes (procedures), ICD-9 (diagnosis)

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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

- Data Entry and coders enter data into Practice Management System
- Fee entered automatically or manually
- Claims Manager software scrubs entries for correctness
- Problems sent to department work file for processing
- Reconciliation performed to insure all entries received and entered into practice management system

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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 ensure 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 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

- Electronically or manually post remittances from payers and patients
  - Payments
  - Denials or rejections
  - Adjustments
- Refunds
- Reconciliation of charges, payments and adjustments

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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
- Clinical documentation required
- Correct coding /charge corrections
- Missing referral/pre-authorizations

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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

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…

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

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

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

Steps for the Board and Executive Management to Ensure the Health Center has a Maximizing Revenue Culture

- Establishing a culture of Revenue Maximization with Board, staff, patients, and community
- Setting the health center up for success – operationally
- Regular reports and monitoring
- Intervening when necessary

Patient Flow - Process Improvement

- Healthcare organizations must constantly balance the often-competing demands of maximizing the financials of the organization while maximizing the quality of care provided to the patient.
- It is important to improve processes effectively to allow staff to accurately forecast the impact of proposed operational changes on overall clinic performance.
- With process redesign efforts, organization should enable decision makers to identify opportunities for cost avoidance, improve the overall patient experience and maximize return on investments in proposed process changes.

Strategies for Better Patient Flow and Cycle Time

Charting Your Flow

- Before you can make meaningful changes, you must understand the patient care process in your practice well enough to identify bottlenecks and understand their root causes.
- Flow mapping and cycle-time measurement are two techniques that can help.
- Cycle-time measurement builds on flow mapping and involves measuring and charting the time associated with various parts of the patient visit.

Optimal Patient Flow through Systems

- Healthcare administrators face an enormous challenge in trying to manage the competing objectives of maximizing clinician's billable time with quality and administrative tasks
- Many IT systems have modules that provide powerful multi-dimensional 'what-if" capability for improving throughput and utilization.

Performance Metrics

- Performance measurement is an integral part of a process and a prerequisite to effective practice management.
- Systematic measurement becomes mission-critical with growth of behavioral practice complexity or outsourcing of the billing function.
- Traditional practice management and billing metrics are limited in scope and focus on scheduling, claim submission process, ignoring process imperfections on the insurance (payer) side.
- Modern computer technologies 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.
- Useful metrics must be comprehensive and simple.
- They must combine both complete end-to-end processes and their individual components.
- Metrics must be used consistently over time and compared to standards.

Data Management and Reporting

Sample Metrics – Type of Data Management Reporting

- Missed Appointments
- Collection Ratios
- Days in A/R (Accounts Receivable)
- First Pass & Denial Rates
- Patient Liability
- Percent of A/R Beyond 60/90/120 Days
- Unpaid Claims analysis
- Underpayment Reports
- Referral Source Analysis

But It's Not Just Technology

- ***Get Lean*** – commit to workflow/process and quality improvement. Eliminate waste and variation in your operations.
- Develop your own Report Card and share it
- Offer payers episode "case rates" that bundle wrap-around services
- Embrace pay-for-performance
- Take the lead in adopting best practices and let payers know
- Support efforts to standardize and normalize
- Develop people within your organizations
- Differentiate and innovate

IT Ideals

- Increase efficiency in all aspects – administrative, business and clinical – of operations.
- Provide clinicians with secure, real-time access to accurate, client-centric, clinical information that is communicable through interoperable behavioral and medical health systems using standards developed by Certification Commission for Healthcare Information Technology (CCHIT) and Health Level Seven (HL7).
- Provide secure, lawful access to patient records at points of care where – with explicit patient permission – quality, safety, and efficacy can be improved.

Name of Organization: ____

PROJECT CHARTER

1. **CHANGE PROJECT TITLE**	
2. What **AIM** will the Change Project address? Choose one aim and indicate baseline measure and target.	
3. **LOCATION**	
4. **START DATE** and expected completion date	
5. **LEVEL OF CARE**	
6. What **CLIENT POPULATION** are you trying to help, e.g. clients in a specific program?	
7. **EXECUTIVE SPONSOR**	
8. **CHANGE LEADER**	
9. **CHANGE TEAM MEMBERS**	
10. How will you **COLLECT DATA** to measure the impact of change?	
11. What is the expected **FINANCIAL IMPACT** of this change project? How will the Executive Sponsor know?	

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PDSA CYCLES

Rapid Cycle #	**Cycle Begin Date**	**Cycle End Date**	**Plan** *What is the idea/change to be tested?*	**Do** *What steps are you specifically making to test this idea/change? Who is responsible?*	**Study** *What were the results? How do they compare with baseline measure?*	***Act*** *What is your next step? Adopt? Adapt? Abandon?*

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EVALUATION AND SUSTAIN PLAN

Project Outcomes (only complete once the project is finished)	
1. What was the project **END DATE**, when you stopped making changes?	
2. What did you **LEARN** (e.g., what were some unexpected outcomes or lessons learned from your change efforts)?	
3. What was the **FINANCIAL IMPACT** of this change project? (e.g. Increased revenue? Reduced costs? Increased staff retention?)	

Sustainability Plan (only complete if you are sustaining the changes)	
A. Who is the **SUSTAIN LEADER**?	
B. What **CHANGES** do you want **TO SUSTAIN**?	
C. What **SUSTAIN STEPS** are being taken to ensure that the changes stay in place and that it is not possible to revert back to the old way of doing things?	
D. What is the **TARGET SUSTAIN MEASURE**, i.e. the point at which the Change Team would intervene to get the project back on track?	
E. What system is in place to effectively **MONITOR** the **SUSTAIN MEASURE**?	

Additional Notes:

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Overview

Topics to be addressed:

- Understanding and Documenting the Patient Flow
- Understanding and Documenting the Revenue Cycle
- Creating a Maximizing Reimbursement Environment

Slide 1

Patient Flow and the Patient Experience

Slide 2

Patient Flow

It all begins when the patient needs services from the Health Center

Slide 3

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

Slide 4

The Revenue Cycle

Slide 5

Appointment Scheduling: Goals

What should be the goals those of the Clinical Department and Patient Services?

- Schedule the appointment within time desired by patient
- Informed patient of the sliding fee process
- Inform patient to bring insurance card and co-payment

Slide 6

Appointment Scheduling Process

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

Slide 7

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 and verify demographic information

Slide 8

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

Slide 9

Patient Exam: Goals

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

Slide 10

Patient Exam

- Patient identifies concern/problem
- Procedures performed and/or treatment provided
- Physician documentation initially recorded

Slide 11

Documentation and Coding Process

Where it can go wrong!

- Physician documents services
- Services coded etc.

Slide 12

Documentation & Coding Process

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

Slide 13

Documentation & Coding: Goals

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

Slide 14

Ensuring Proper Coding – High-Level Overview

- Collect data on provider visits (E&M Codes)
  - By individual Provider
  - In the aggregate for the health center
- Prepare graphs to show frequency of codes used
  - Show increasing intensity of visit from left to right
- Overlay Health Center providers and aggregate data on national averages
  - Include payor-source specific graphs

Slide 15

Charge Processing

Data Entry and coders enter data into Practice Management System

- Fee entered automatically or manually
- Claims Manager software scrubs entries for correctness
- Problems sent to department work file for processing
- Reconciliation performed to insure all entries received and entered into practice management system

Slide 16

Charge Processing: Goals

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

Slide 17

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

Slide 18

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)

Slide 19

Payment Processing

ectronically or manually post remittances from payers and patients
  - Payments
  - Denials or rejections
  - Adjustments
- Refunds
- Reconciliation of charges, payments and adjustments

Slide 20

Payment Processing

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

Slide 21

Resubmission, Appeals, & Secondary Claims

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

Slide 22

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

Slide 23

A/R Follow-up

Follow-up on...

- Payment arrangements (budget plans)
- Red flag rules
- http://www.nachc.com/client/documents/FTC_Red_Flag_ITPP_IB_4_8_09%5b1%5d.pdf
- Improve claim edits as an outcome
- Bad debt transfer

Slide 24

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

Slide 25

Legal Collections

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

Slide 26

A successful Revenue Cycle depends on…

Slide 27

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

Slide 28

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

Slide 29

Billing and Revenue Strategies

Billing and revenue strategies are intended to improve the billing and collections process in the Health Center and encourage the effective use of staff who perform these functions.

Common goals and objectives achieved through billing and revenue strategies:

- Increased patient revenue.
- Improved collections rates.
- Reduced medical coding errors.
- Cost savings of doing it right the first time.

Slide 30

Steps for the Board and Executive Management to Ensure the Health Center ha a Maximizing Revenue Culture

- Establishing a culture of Revenue Maximization with Board, staff, patients, and community
- Setting the health center up for success – operationally
- Regular reports and monitoring
- Intervening when necessary

Slide 31