Welcome

Fee-for-Service, Level II

January 2012

Project Funded by CSAT

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

Overview

What to expect in the next two days?

Housekeeping

Information to assist you with your comfort

Current State

The Change Process

Desired Future

1. Your Name/Organization/Role
2. If the bike represents your organization's current "change process", what part of the bike are you?

Health Care Reform

The Patient Protection & Affordable Care Act (HR 3590)

(Four Interlocking Strategies)

- Insurance Reform*
- Coverage Expansion**
- Payment Reform
- Delivery System Redesign

*The ACA includes BH services as an "essential benefit" for inclusion in Health Insurance Exchanges

**Parity legislation assures that the coverage of BH services must be the same as for physical health conditions

Leading Change: A Plan for **Substance Abuse and Mental Health Services Administration (SAMHSA)** Roles and Actions 2011 - 2014

Behavioral health is an essential part of health. Individuals and families cannot be healthy without positive mental health and freedom from addictions and abuse of substances. Behavioral health, prevention and treatment services are important parts of health service systems and community-wide strategies that work to improve health status

SAMHSA Strategic Initiatives

- Prevention of Substance Abuse and Mental Illness
- Trauma and Justice
- Military Families
- Recovery Support
- Health Reform
- Health Information Technology
- Data, Outcomes and Quality
- Public Awareness and Support

SAMHSA Definition of Behavioral Health

- State of mental/emotional being and or choices and actions that affect wellness
- Includes substance use, misuse, alcohol and drug addiction, serious psychological distress, suicide mental and substance use disorders
- Range of problems from unhealthy stress to diagnosable chronic disease treatment and recovery oriented
- Systems: promotion of emotional health, prevention of mental and substance use disorders, treatment and recovery support

Drivers of Health Care Reform

- Greater attention to preventing illness and promoting wellness
- Primary focus is on the prevention of **Chronic Illnesses**
- Increased access to care
- Increased focus on the coordination/integration of services between primary care and specialty services
- Increased focus on quality and outcomes
- Increased provider accountability
- Greater emphasis on home and community based services and less reliance on institutional care

(Adapted from SAMHSA, John O'Brien)

Major Strategic Components of the ACA

- Coverage expansion
- Delivery system and payment reform
- Insurance reform
- Emphasis on key levers to drive cost savings and quality improvements
    - HIT
    - Comparative effectiveness research
    - Prevention/health promotion

Aims of Health Care Reform

- Increase the number of individuals that have health insurance
- Increase accountability through the expansion of primary care, medical homes and Accountable care organizations and financing structures
- Increase access to preventive services to improve health outcomes

Aims of Health Care Reform (cont.)

- Expanded Populations
  - Newly Medicaid Eligible--133% of the Federal Poverty Level (FPL)
  - Health Insurance Exchange Participants--Individuals and Families at or below 400% of the FPL

Parity and Affordable Care Act

- Affordable Care Act includes Behavioral Health as an essential benefit
- Parity legislation requires coverage same as physical health coverage

Coverage Expansion

- Expansion of Medicaid
  - Expanded eligibility (up to 133% of FPL)

- Establishment of Health Benefit Exchanges
  - Two per state by January 2014
    - One for individuals and families
      - (American Health Benefit Exchange)
    - One for small businesses <100 employees
      - (Small Business Health Options Program)
  - Requirements for multi-state plans, non-profit consumer

Benefit Expansion

- Wellstone-Domenici Act of 2008
- ACA mandates all exchange plans offer all "essential benefits"
  - Essential benefits (10 major categories, including MH/SUD Rx)
- Expanded benefits
  - The "good and modern benefit"
    - Full range of services, from prevention through chronic care management
    - Caveat – HHS regulations released July 2011
    - IOM report October 2011

Delivery System & Payment Reform

- Investment in primary and integrated care
  - Patient-Centered Medical Home
- Investment in population health management
  - Accountable Care Organizations
- Movement towards paying for value, not volume
  - Away from FFS towards capitation and bundled payments

Implications of Health Care Reform

- 35 million additional insured
  - Older, poorer, less educated, & more racially diverse than current privately insured
  - 65% previously uninsured, therefore high unmet medical needs
  - 25% will need MH/SUD services in any given year
- Therefore, great increase in demand for MH/SUD Rx services
  - Workforce issues

Implications of Health Care Reform (cont.)

- ABSOLUTE requirement to be able to bill FFS
  - SUD Rx revenues will come from Medicaid and other forms of insurance
    - 100% paid for by Federal funds, decreasing to 90% by 2020
    - SAPT Black Grants will most likely be reduced and target "wrap-around" services

Implications of Health Care Reform (cont.)

- As “essential” benefit, full range of SUD services covered
  - Includes prevention, early recognition and intervention, acute RX, chronic care management
  - Need for expansion of services to cover “harmful use” population in primary care = SBIRT

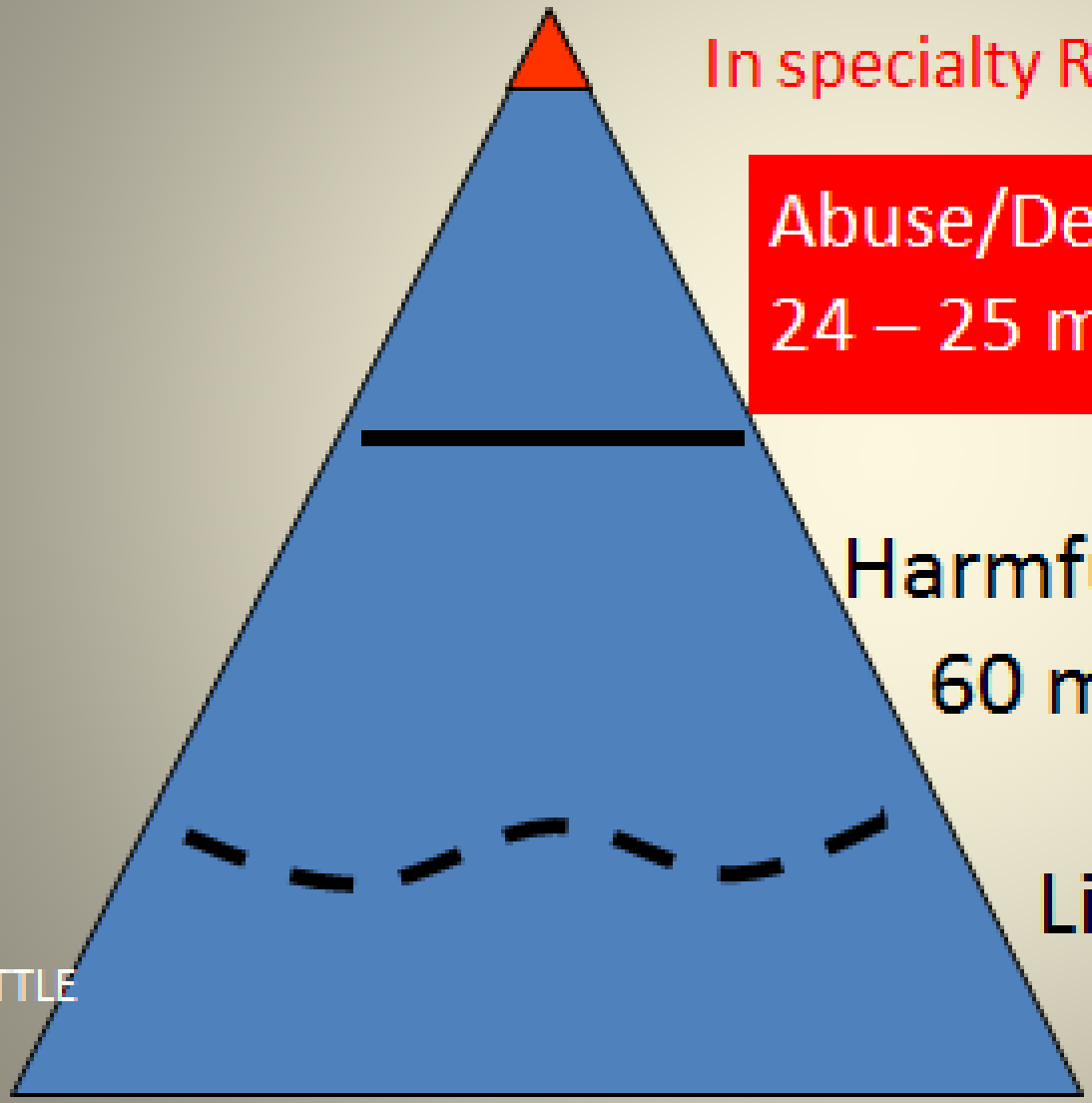
Implications of Health Care Reform (cont.)

- Buy what is good and modern
- Focus on coordination between primary care and specialty care:
  - Significant enhancements to primary care
    - Workforce enhancements
    - Increased funding for Federally Qualified Health Centers
  - Bi-directional
    - MH/SUD in primary care
    - Primary care in MH/SUD settings

Implications of Health Care Reform (cont.)

- More Incentives to identify MH/SUD
  - SBIRT—huge focus by SAMHSA and HRSA
  - Coverable service—enhanced Medicaid match
- More payment strategies
- Payment on successful episode of care

Population Prevalence



In specialty RX - 2.5 million 2,300,00

Abuse/Dependence –
24 – 25 million

Harmful use -0
60 million

Little or no use

LITTLE

Implications

- Movement to population health management is a "game-changer" for SUD RX
  - SUD and other behavioral problems contribute greatly to cost and poor outcomes for medical conditions
  - SUD interventions, including SBIRT, become PROFIT CENTERS rather than medical expenses
  - The "second" phase of SBIRT sustainability

How Does Behavioral Health Fit?

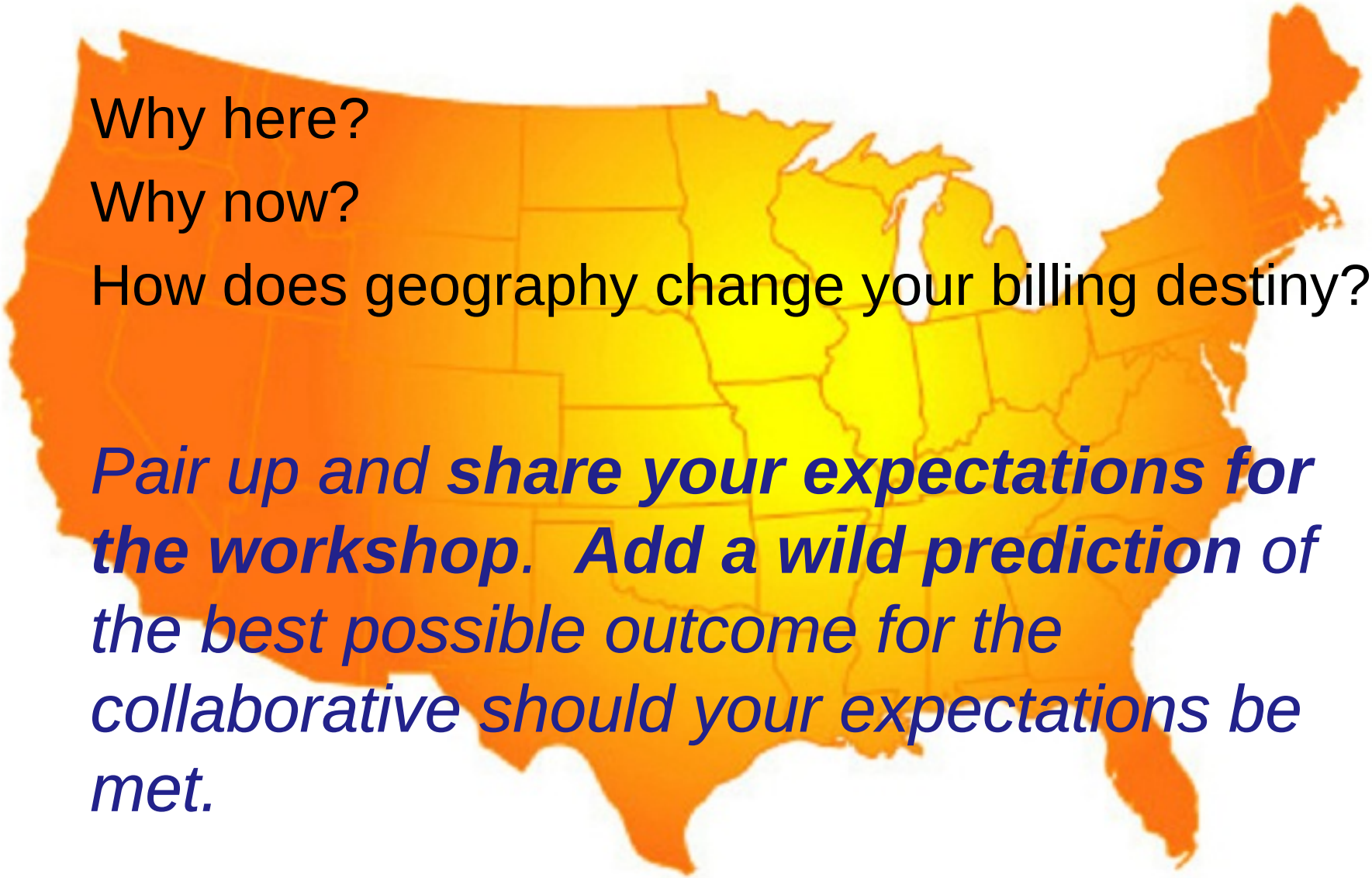
- Become valuable partners with primary care or become one themselves
- **Establish your niche**
- Demonstrate value to insurers, medical providers and others
- Rapid effective access!
- Super Easy to work with!

Opportunities

- Opportunity to broaden your financial base
- Opportunity to have good data to fine tune and improve care
- Opportunity to partner with primary medical care and improve overall health of your target groups
- Opportunity to form new alliances and establish community supports for what you do
- Opportunity to invest in prevention


So What Does Health Care
Look Like in ??

Geography is destiny……..



Why here?

Why now?

How does geography change your billing destiny?

*Pair up and **share your expectations for the workshop**. **Add a wild prediction** of the best possible outcome for the collaborative should your expectations be met.*

Geography is Destiny

Why Here? Why now?

Sonoma County	Source	FY 08-09	FY 11-12	Variance	%	FY 12-13?	Variance
Budget - AODS		$17,500,000	$13,000,000				
SAPT Block grant	Federal	$2,500,000	$2,500,000	$0			
Co General Fund (CGF)	Local	$6,900,000	$4,500,000	($2,400,000)	35%	$ 4,050,000	($450,000)
Drug Medi-Cal	Fed/State	$2,100,000	$2,200,000	$100,000			
DUI	Client Fees	$2,300,000	$2,300,000	$0			
SACPA - Prop 36	State	$1,770,000	$0	($1,770,000)			
Drug Court	State	$356,000	$356,000	$0			
SoWKS	State	$340,000	$300,000	($40,000)			
BASN	State	$206,000	$230,000	$24,000			
Peri NNA	State	$174,000	$174,000	$0			
Peri Grants	Combo	$254,000	$250,000	($4,000)			
MAA, Dribs & Drabs	Combo	$600,000	$190,000	($410,000)			
Total		$17,500,000	$13,000,000	($4,500,000)	26%		
County FTEs		81	32	(49)	60%		

Impact of Reductions

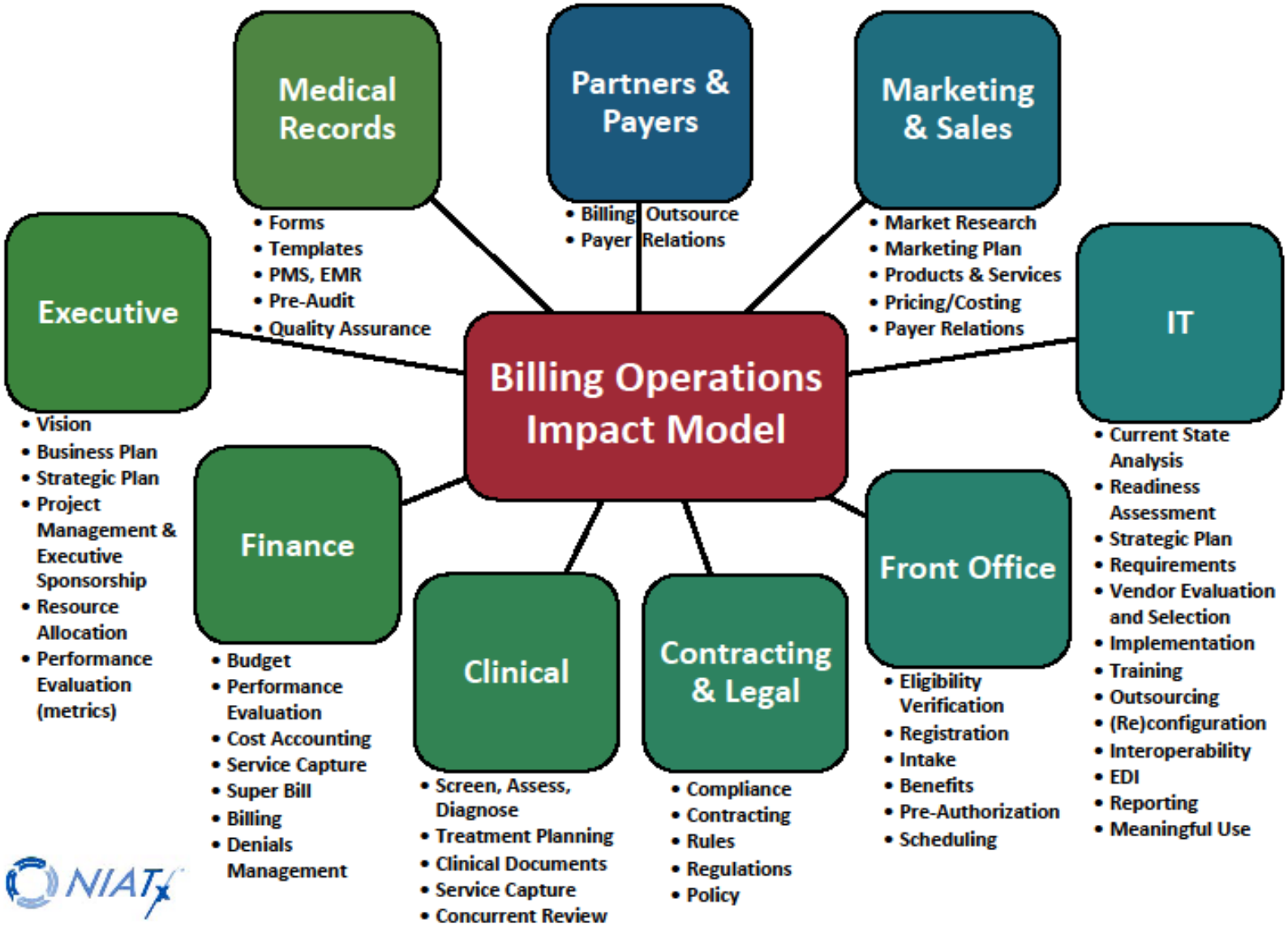
- All county residential beds to private non-profits
- All county outpatient services to private non-profits
- All county detox beds to private non-profits

Landscape

- AODS and MH services integrated on county level into behavioral health division
- State ADP and state MH reconfigured & integrated – still in progress
- NNA, drug court, & drug Medi-Cal – realigned to counties – VLF, sales tax dependent
- CGF – Local real estate; housing market dependent
- Health Care Reform 2014

Expectations

- Clinic based model of service delivery
- AOD, MH, public health integration
- Potential reduction in emphasis upon residential Tx, more upon outpatient
- MFT – LCSW emphasis in AOD service delivery
- **Increased reliance upon insurance driven reimbursement – 3rd Party Billing**


Billing Operations Impact Model
Medical Records
• Forms
• Templates
• PMS, EMR
• Pre-Audit
• Quality Assurance
Partners & Payers
• Billing Outsource
• Payer Relations
Marketing & Sales
• Market Research
• Marketing Plan
• Products & Services
• Pricing/Costing
• Payer Relations
Executive
• Vision
• Business Plan
• Strategic Plan
• Project Management & Executive Sponsorship
• Resource Allocation
• Performance Evaluation (metrics)
IT
• Current State Analysis
• Readiness Assessment
• Strategic Plan
• Requirements
• Vendor Evaluation and Selection
• Implementation
• Training
• Outsourcing
• (Re)configuration
• Interoperability
• EDI
• Reporting
• Meaningful Use
Finance
• Budget
• Performance Evaluation
• Cost Accounting
• Service Capture
• Super Bill
• Billing
• Denials Management
Clinical
• Screen, Assess, Diagnose
• Treatment Planning
• Clinical Documents
• Service Capture
• Concurrent Review
Contracting & Legal
• Compliance
• Contracting
• Rules
• Regulations
• Policy
Front Office
• Eligibility Verification
• Registration
• Intake
• Benefits
• Pre-Authorization
• Scheduling
NIATx

Fee-For-Service * Deeper Dive

We will cover the following:

Executive

Vision, Business Plan, Resource Allocation, Metrics

Financial

Budget, Performance Measures, Service Capture Level II Creating a Super Bill, Denial Management

Clinical

Screen, Assess, Diagnosis,Treatment Planning, Clinical Documents,Service Capture,

Contracting

Compliance, Rules and Regulations

Front Office

Eligibility Verification, Registration, Intake Benefits, Pre-authorization, Scheduling

Law of Supply and Demand

Unlike some business
models there are plenty
of customers and lots of demand

Thinking About Your Business

Where does the revenue come from?

Do you provide easy access to services?

What do you do better than your competition?

What do you need to improve?

Patient Flow

- Billing starts with your first interaction with the patient and ends when all possible payments have been posted and any balance has been written off.

- Everybody in the organization plays a role.

Gervean Williams, National Association of Community Health Centers

NIATx Key Principles

1. **Understand and involve the customer**
2. Focus on key problems that keep the CEO awake
3. Pick a powerful Change Leader
4. Get ideas from outside the organization or field
5. Use rapid-cycle testing

NIATx Four Project Aims

Reduce Waiting Times

Reduce No-Shows

Increase Admissions

Increase Continuation Rates

The Patient Experience

- What is it like to be your patient?
- Perform a detailed 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 NIATx Third Party Billing Guide

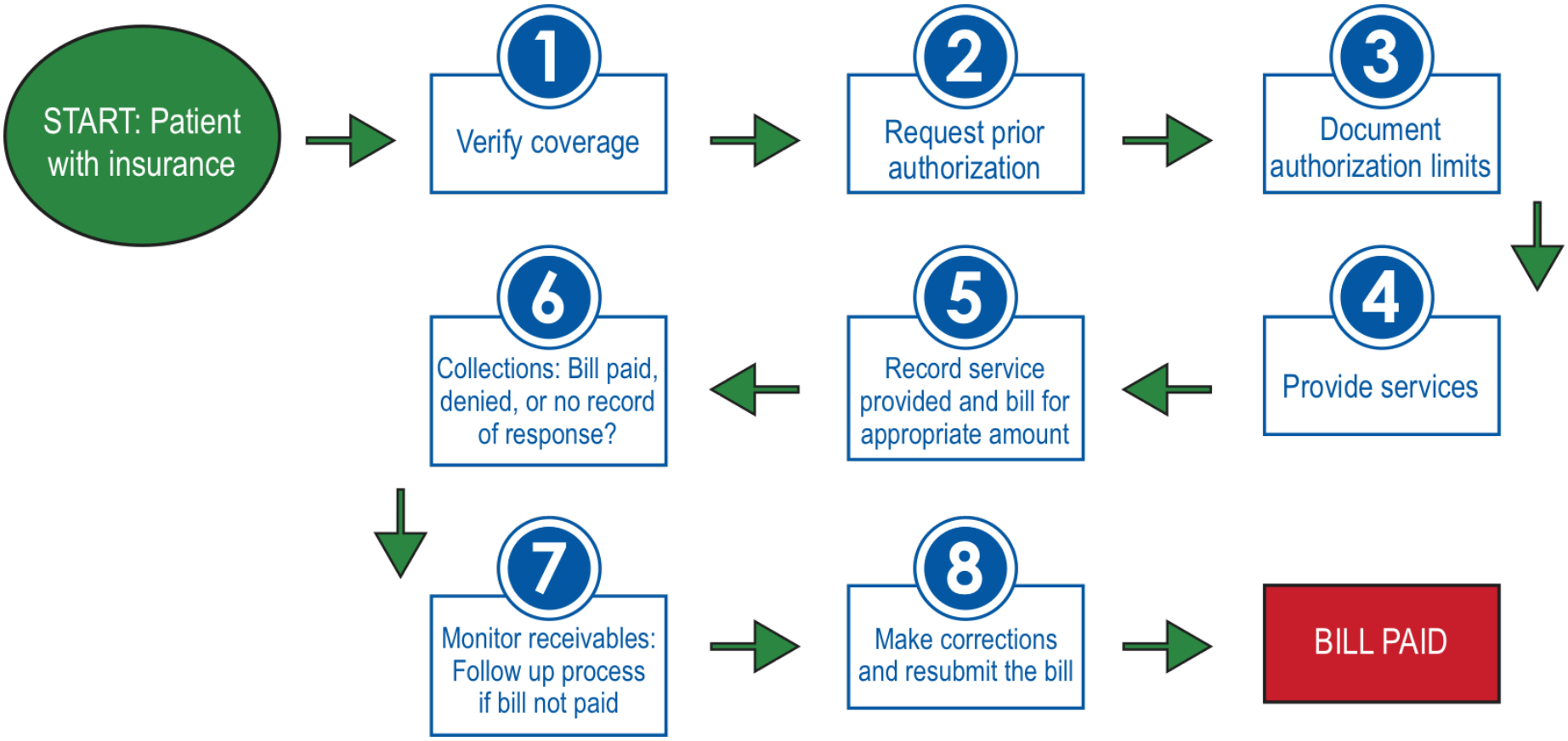
Reduce Waiting Times & No-shows • Increase Admissions & Continuation

Creating Your Billing System

NIATx Billing Guide Overview
Eric Haram, Director OPBH-MidCoast Hospital
David Moore – Director Fayette Companies and NIATx Coach

The Vast Unknown?

- Looking into your billing processes can be daunting.
- Where to start….



Billing Practices Organizational Level

"Who Does What"

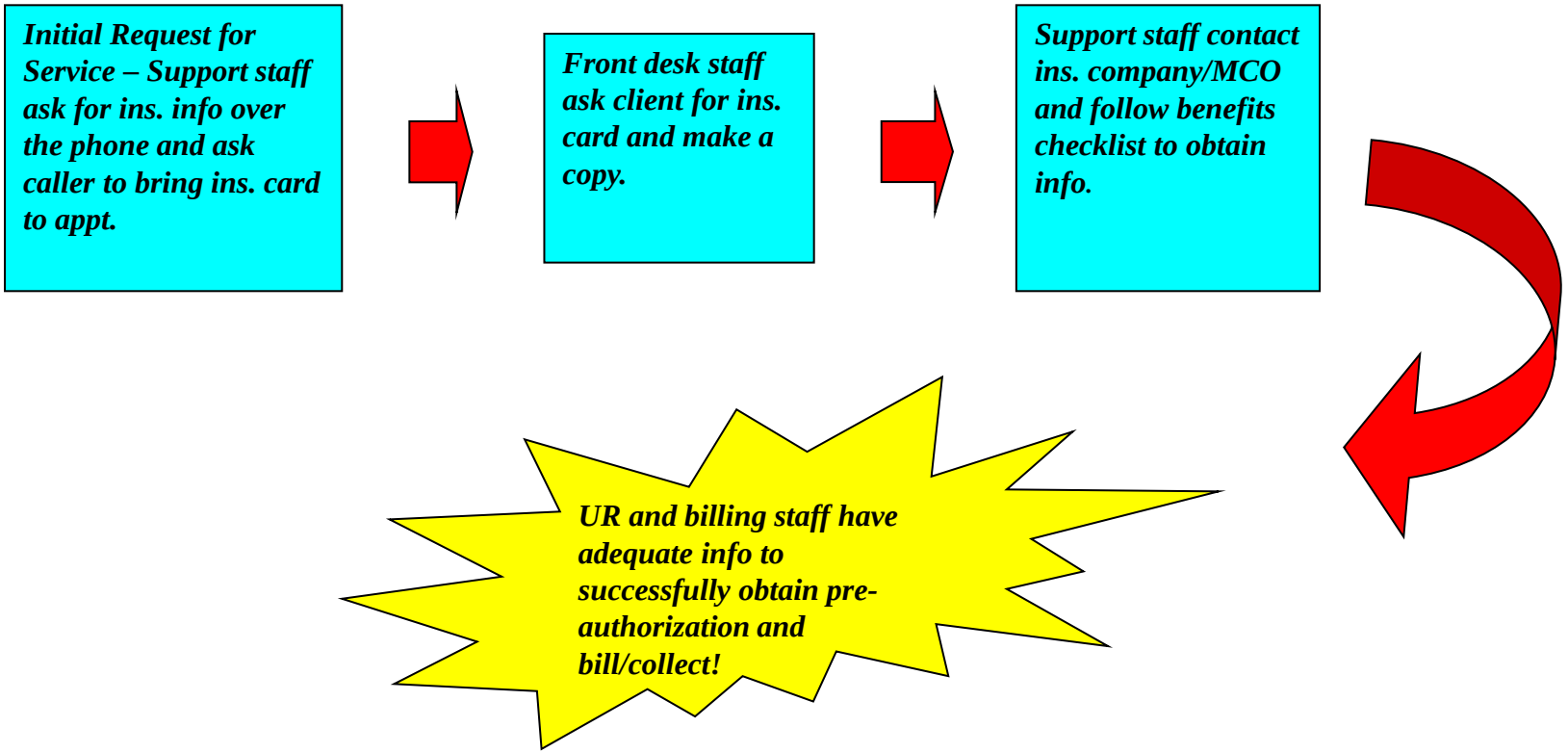
Workflow - Assessment

Step in the Process	Who is assigned?	When is this task done?	Who is it handed off to?	Who else needs this information?
Verify coverage				
Request prior authorization				
Document authorization limits				
Provide services				
Document service provided				
Bill for appropriate Amount				
Collections: bill paid or denied				
Monitor receivables				
Make corrections and resubmit				
Monitor cash flow				

Page 9 in the NIATx Billing Guide Workbook

Step in the Process	Who is assigned?	When is this task done?	Who is it handed off to?	Who else needs this information?
Verify coverage	Support Staff complete checklist	Completed prior to admission	Utilization Review	Billing Staff
Request prior authorization	Utilization Review	Prior to admission or w/in 24 of detox admit	Clinical Staff	Utilization Review
Document authorization limits	Utilization Review	Throughout tx process	Clinical Staff	Billing Staff
Provide services	Clinical Staff	Post Discharge	Other clinical staff	Clinical Team
Document service provided	Clinical Staff	Post Discharge	Other clinical staff	Clinical Team
Bill for appropriate Amount	This occurs electronically – service doc	At time of service	Billing – FOCIS	Clinical staff are
Collections: bill paid or denied	Billing Staff	When Bill is Collected on	Coordination between FOCIS and Billing	Process for monitoring the system and flow between support staff, clinical staff, UR staff and billing staff.
Monitor receivables	Accounts Receivable Staff	When revenue is recognized	Agency's Comptroller Reviews	Regular meetings between clinical, UR and billing to strategize
Make corrections and resubmit	Central Access Manager fills this role	Claims that have been in process for over 6 months due to appeals	Comptroller and VP of Quality are involved if contracts need to be changed	Feedback loop to clinical, UR and billing staff so that patterns of errors can be addressed
Monitor cash flow	Comptroller	Continuous	President, CEO	Executive Committee

Example of "Verify Coverage" Process Flow



Increasing Revenue Options by Billing Third Party Payers

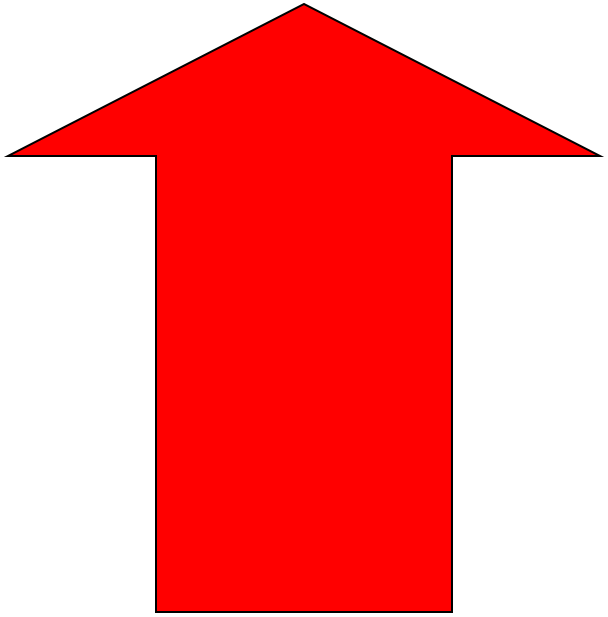
One Provider's Experience

David Moore, MPA

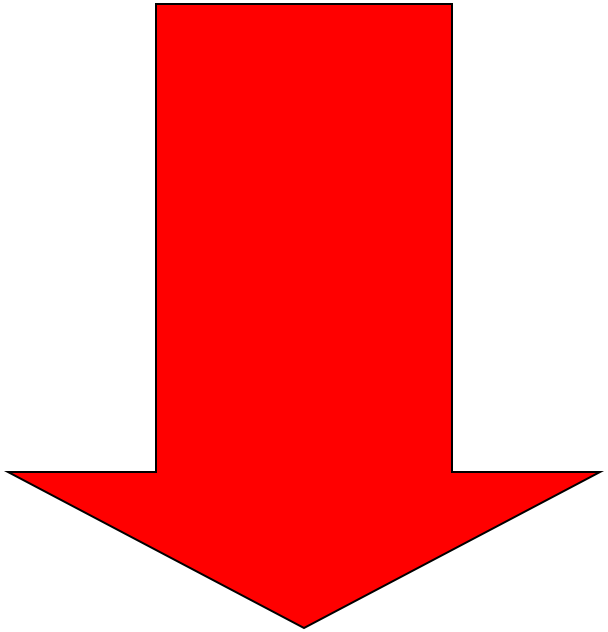
Background on Fayette

- Fayette Companies/Human Service Center is located in Peoria, IL.
- Majority of revenues come from state contracts.
- Have been contracting with third party private payers over 20 years.
- Have both outpatient (group contracting) as well as inpatient (facilities contracting) services.

Increase in Denials

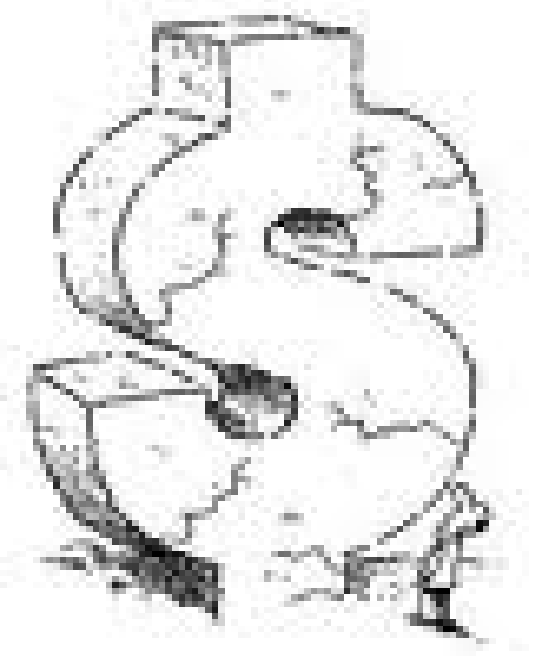


Decrease in Collections



What was Broken

- The way we addressed contracts & credentialing had become fragmented and decentralized.
- Front door process for checking benefits was hit or miss at best.
- Little to no communication existed between staff responsible for benefits checks/pre-authorizations and billing/collections.



System of Ownership and Responsibility

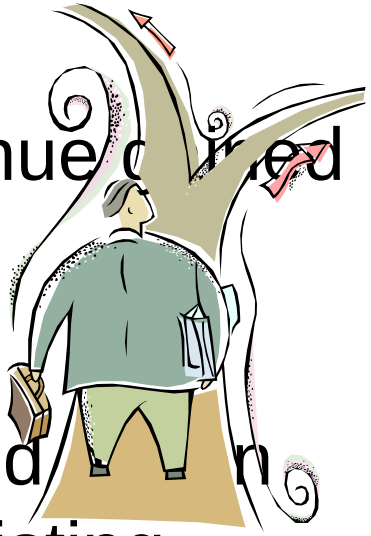
Contracts & Credentialing	Benefits, Pre-Certs, Re-Auth	Billing	Collections & Denials
Person/s Responsible	Person/s Responsible	Person/s Responsible	Person/s Responsible
Goals	**Goals**	**Goals**	**Goals**
Metric: **Baseline:** **Benchmarks:**	**Metric:** **Baseline:** **Benchmarks:**	**Metric:** **Baseline:**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

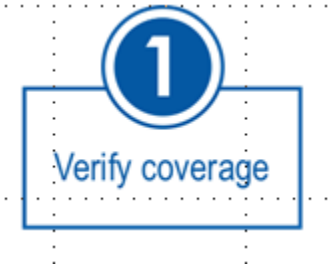
Thinking Differently

- Changing the way we view financial documentation at the front door.
- Recognizing Ins. Company/MCO/EAP as a part of the treatment team.
- Recognizing that establishing medical necessity is much easier if we do a more thorough job of reviewing the case.

Results and Next Steps

- Decrease in denials and increase in collections recognized.
- Have begun to recognize revenue d[illegible]ed from appealing denials.
- Have added MCO contracts and [illegible]n more staff credentialed with existing contracts.





Page 10-14
Checklist page 10

You will need to verify:

- Patient Co-Pay (PCP)
- Total benefits covered
- Calendar year and lifetime max status
- Deductible: amount met and how much overall
- Co-Pay: all levels of care
- Claims address
- Certification (Pre-Authorization) numbers and phone #
- Policy effective and termination dates
- Authorizations required and the name of the person who gave you the information.

Page 12-13
Template page 13

- Process of obtaining approval of coverage for a treatment deliverable. (before the treatment occurs!)
- Each payer may use a different term and has a different process.
- Prior Authorization may be obtained at the time of benefits verification. Requesting auth. for the upcoming assessment, eval., session.
- You may request to bill out-of-network if you do not have an in-network contract.

Operation Par in Florida hired a single staff person to obtain authorizations. This increased third party collections from $129,000-$436,000 within one year

- Record the authorized date and name of the person who granted the service.
- Record the authorization number. (if they tell you no prior auth. is needed, ask for an authorization number for administrative purposes).
- Record the number of authorized units, date range, and next review date.
- Include the contact name and direct phone number of the source for on-going reviews.

Level I

That is it for the first part of your pilot test. Did services get authorized?

Here is what one agency found in their pilot.

AIM

Increase Medicaid third party payments from 0 to 15 by March 31, 2011

Current Billing or *Baseline* = 0 or $0.00

Target = 15 clients with Medicaid

$1000.00 billed and received.

Muskingum
Behavioral Health
Zanesville, Ohio

Plan

- Having no experience with Third Party billing, work with change team and billing person on familiarizing ourselves with the NIATx billing Guide
- Start Documenting our process for third party billing information
- Ask each person who calls if they have any insurance
- Record results on a tally sheet

Muskingum Behavioral Health - Zanesville, Ohio

Results

- The first step was to establish a process and being to document each step.
  - Ask everyone who came in if they had insurance?
  - Copy the insurance card when they arrived
  - Document coverage using the NIATx pre-authorization template
  - **Work with one clinician for one month to begin to track each service and match authorization and billing codes for that treatment plan**

- Not everyone was willing to ask for insurance cards.
  - Needed to train staff, create a tally sheet,
  - Educate customers about insurance - understand if they had possible insurance coverage
  - Practice by role playing
  - and then documenting the process and the results. Not everyone verified insurance every time.

- Worked on establishing and improving process for 3 months. Kept working with the one clinician

- In April of 2011, we had 15 clients who were covered by Medcaid.
- In 5 months we collected $1,875 in Medicaid revenue. Though this may not be a large amount of money, it is for a small organization. That's $22,500 . per year more than we were getting before the project started!

- Clients with third party payers have gone from zero to 10 per month.

Muskingum Behavioral Health - Zanesville, Ohio

Next Steps

- Make the current billing processes more formalized
- Continue to foster relationships with third party payers.
- Establish protocols for addressing denials
- Increase marketing effort to people who have third party reimbursement.

Muskingum Behavioral Health - Zanesville, Ohio

- Provide the services that were authorized.
- Within the specified date range for approved units of service?
- Provided by appropriately credentialed staff member?
- Does the payer require specific deliverables? UDS, MAT, 12-Step, Family

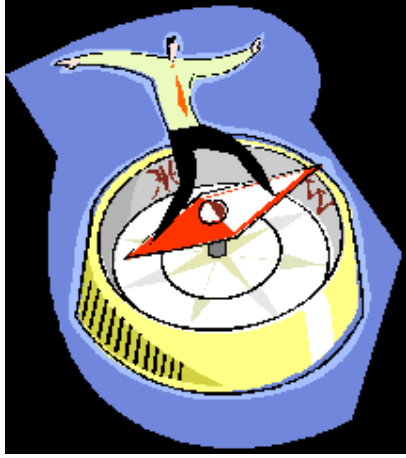
- Services documented in the clinical record?
- Dates of service match dates of charge?
- Correct demographic information?
- Correct billing form? UB-04 or the HCFA 1500

That’s it for the second part of your billing pilot. Did you get paid? Did you get a denial?

TAKE AIM

Reduce the number of claim rejections to 5% or less. The current baseline measure is 39 rejections within one quarter or 6.5% of all claims. Of those rejections 10 resulted from the client being scheduled with a non-independently licensed staff.

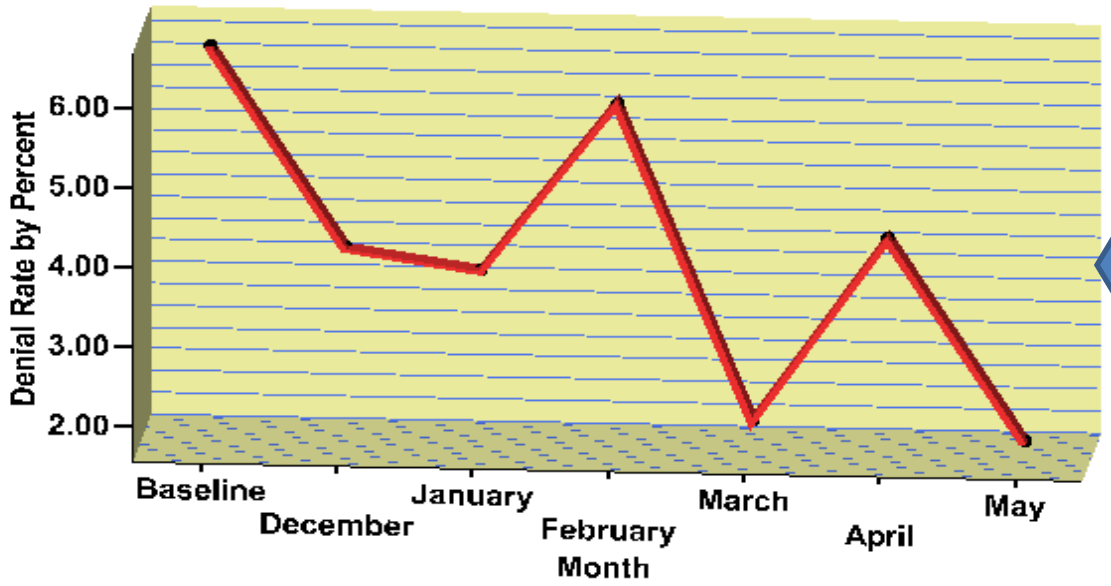
Time for a Change!



Incoming assessment clients who disclose insurance at the time of scheduling will be scheduled with independently licensed staff only for assessments.

- *Reception staff will be notified that clients with insurance will be scheduled in the diagnostic assessment slots of independently licensed staff only.*

- *The Intake Coordinator will continue to monitor insurance billing to assess if rejection rate is reduced. This monitoring will include analysis for the reason of rejection.*



Denial Rate

Value of Denied Claims

THE RESULTS

Month	# of Denials	Total # of Claims	Value of Denied Claims
Baseline	39	600	$1014.00
Dec	3	75	$298.05
Jan	9	240	$1381.84
Feb	9	153	$1185.42
Mar	4	207	$394.17
Apr	8	188	$796.86
May	3	172	$287.83

IMPACT AND LESSONS LEARNED

- Decreased insurance denial rate
- An increased sensitivity by all staff regarding the need to incorporate insurance as a viable source of funding which requires special accommodations.
- The finding that the current system within the organization is already efficient and provides for a relatively low denial rate but is flexible enough to allow for change projects that may enhance further.

- Accounting staff or managers will need to monitor receivables.
- Aging reports from your local accounting system are best for monitoring this activity.
- An aging report lists accounts receivable balances by customer, detailing the current status or delinquency of the balances owed or owing.
- Pay attention to accounts that are more than 69 to 90 days overdue. This will impact your cash-flow.

- Why is the claim not being paid?
- Billing error?
- Rejected claim?
- Define the rejected claims specifically

✓ Identify and document the reason, this will enable you to identify the processes you need to adjust and systems that you need to improve.

AIM

- Increase revenue collected from third party payers.
- Decrease insurance claims error rate.

Changes

- Register clinicians on CAQH.
- Create a list of insurance providers and the credentials needed to allow for reimbursement for services provided.
- Work with our insurance clearing house on
  - why we have claims errors
  - how to fix the errors
  - how to resubmit corrected claims
- Create a checklist with information needed to collect from insurance companies when calling to verify coverage.

Results

- Our claim error rate has decreased from baseline of 33% to 16%.

- Insurance reimbursements are increasing from 10% of total charges the beginning of the fiscal year to current 17%.

Next Steps

- Create a system for collecting co-pays once we have implemented our new E H R.
- Research how to bill IOP services in order to receive adequate reimbursement.
- Research how to direct insurance clients to properly credentialed clinicians when in group and IOP sessions. Can supervisors sign off?
- Track progress on insurance claims so we are aware when we need to recertify visits.
- Monitor V code diagnosis codes since insurance companies don't usually pay for these codes.
- Pursue inclusion on insurance panels.

Impact

- By tracking claim activity we were able to better analyze the responses and make necessary billing adjustments for future claims
- Able to make the necessary claims corrections so the claims could be sent on to the insurance companies.
- Understanding of contract stipulations allowed us to follow more efficient procedures in obtaining authorizations
- Realized the importance of having personnel dedicated to insurance.

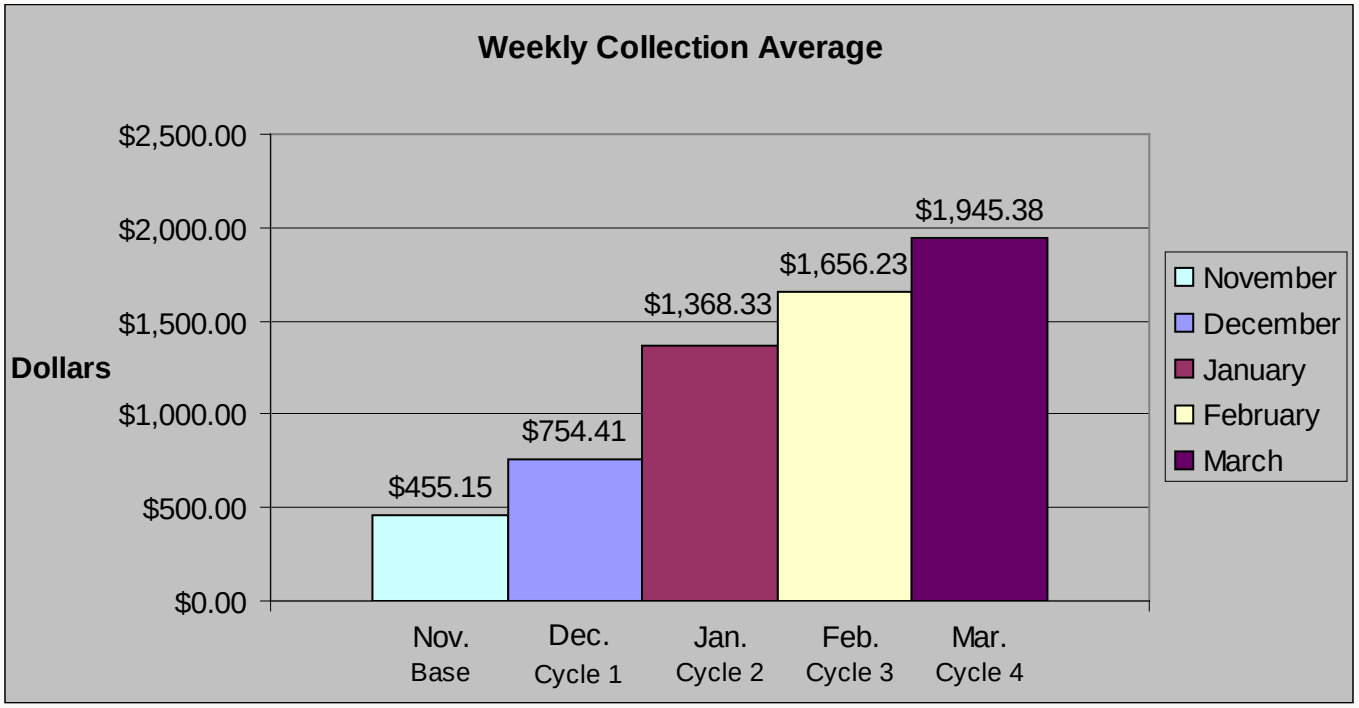
Next Steps

- Get together with key members of your team.
- Review your walk-through and share examples of the presentations you hear with them.
- Get familiar with the Billing Guide
- Pilot the 8 steps from the Billing Guide
- Allow your PDSA process to point you in the correct direction for maximizing your efforts on this work.

Co-Pay Action Team

Annualized: weekly collections have improved from $23,660 to $101,140/yr.

How: Signage, e-mail ticklers to counselors, batching opportunities.



Exploring New Business Models

Discussion at each table

What services do you provide that are most profitable?

Which third party payer do you work with and have the most denials? Why?

Which third party payer is easiest to work with? Why?

Do you provide the right services? Which services are actually billable?

Do you have staff dedicated to complete each step of the billing guide? If not why?

Keep At It

Nominal Group Technique

NGT

- Chalk Talk - Identified at least one problem or barrier

- Need to generate creative solutions

Benefits of using the NGT

- Makes it clear what decision is being made
- Allows everyone to participate
  - Prevents people with authority or with loud voices from dominating
- An easy, fast way to reach consensus around a decision

7 Steps to the NGT

Step 1

- Prepare the room:
    - Flip chart or wall to post ideas
    - Post-it notes
    - Two colors of sticky dots for voting

- Prepare the Question

  Write it at the top of your flip chart paper.

Step 2- up to 5 minutes

Silent idea generation

- Record each idea you have on a separate sticky note
- One sticky note, one idea and so on, keep all your notes in front of you

Step 3 – 5 minutes

Recording of ideas (round robin)

- Go around the table and ask each person to read one idea from their list; next person reads one idea--and so on
- Post each idea as it is read on the flip chart
- Refrain from discussion or clarification of ideas

Step 4 – 5 minutes

Idea discussion

- Group can ask questions of each other to clarify the meaning of each idea.

Step 5 – 2 minutes

Preliminary voting – "What ideas can we test first?"

- For this step, you will each have three votes to cast
- Each participant is allowed to cast votes for the idea or ideas they judge as most important

Step 6 – 3 minutes

Discussion of preliminary voting:

- Brief discussion to ensure that everyone has the information they need to cast a final vote.

Step 7 – 2 minutes

Final voting on ideas:

- Each participant casts one final vote
- Record all ideas for future reference and possible PDSA Cycles

- Video “Leadership Lessons from the Dancing Guy”

Here is the link http://sivers.s3.amazonaws.com/DancingGuy-ff.m4v

The final slides will have the power point embedded

Final Check-in

- How did we do?
- What can we do to improve (for tomorrow)?
- Tomorrow we will begin at _____