

Infrastructure Essentials

Managing Managed Care: An Introduction to Managed Care for Massachusetts Substance Use Providers

Sponsored by the MA Department of Public Health, Bureau of Substance Abuse Services & AdCare Educational Institute, Inc.

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Welcome!

- **Introductions**
 - Technical Assistance Collaborative (www.tacinc.org)
 - Kelly English
 - Parker Dennison & Assoc. (www.parkerdennison.com)
 - Susan Parker
 - Rusty Dennison
- **Learning objectives**
 - Identify strategies for managing and monitoring staff productivity.
 - Specify changes to an organization's infrastructure necessary for success in a managed care/fee-for-service environment.
- **Logistics for the day**

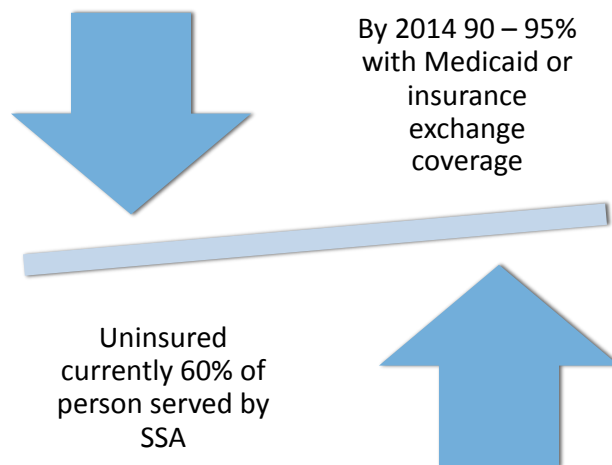
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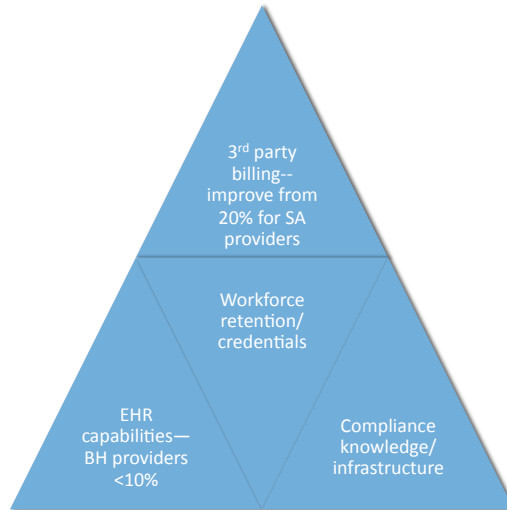
Agenda

- Why Now?
- Front Desk
- Scheduling Monitoring and Management
- MIS
- Productivity
- Billing Flows and Timelines
- Financial Management for Fee For Service (FFS) and Managed Care

Why now? SAMHSA says...



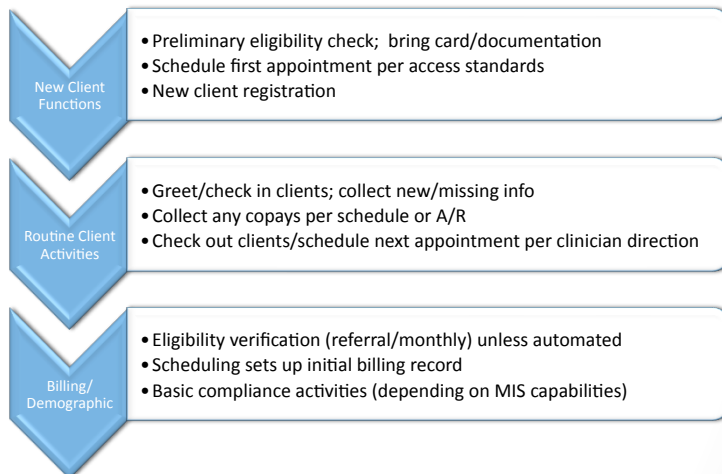
Provider “Plumbing” Improvements



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Front Desk Activities



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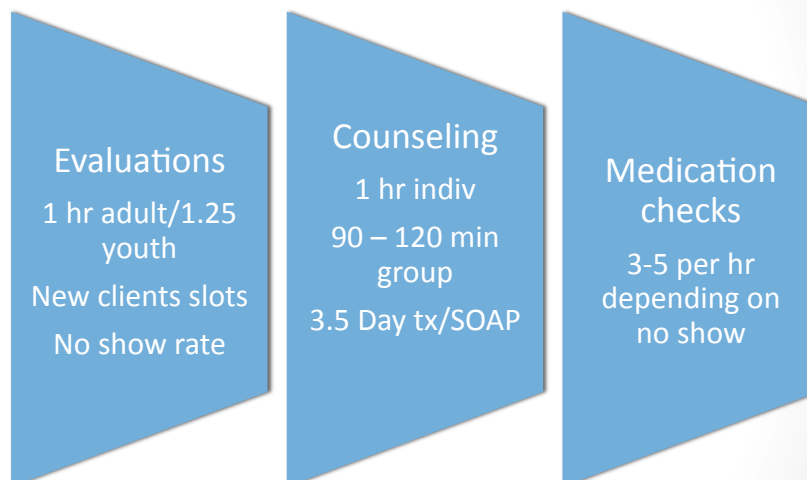
Scheduling Management

- Centralized (manual or automated)
- Establish clinical and management protocols
 - Front desk staff schedule according to protocols
 - Supervisor approval for override
- Specified time allocations for each activity
- Minimum time scheduled per day/week
- Scheduling template by type of staff
 - Eliminate person- specific time blocks
- Supervisory advance review weekly
- Evening/weekend availability to match client needs

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Scheduling Allocations



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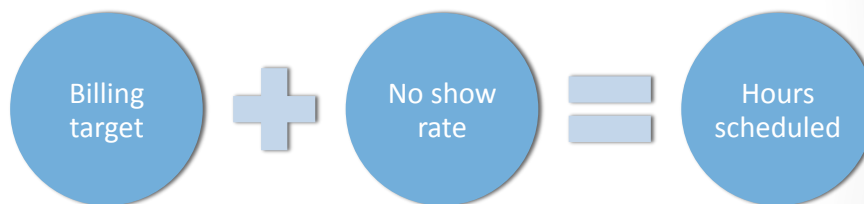
Scheduling Frequency Protocol

- Establish standard protocols by type of service
 - Subject to modification based on clinical needs
- Example—adjust by clinical policy/client need
 - Groups—daily/weekly according to nature of group
 - Individual—weekly or bimonthly for limited episode
 - Medication visits
 - Every 2 – 4 weeks at medication initiation/change
 - Every 90 – 120 days thereafter
 - Day treatment 3 – 5 days per week
 - Adjust through treatment/aftercare

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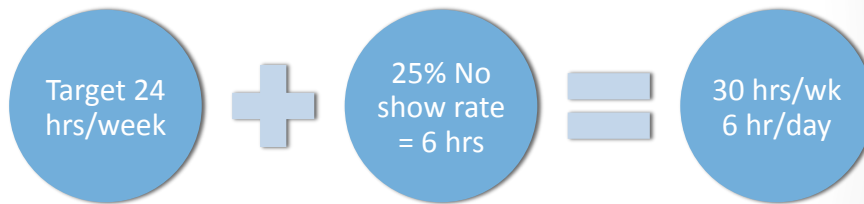
Daily/Weekly Scheduling Requirements



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Daily/Weekly Scheduling Requirements



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SOAP Daily/Weekly Scheduling Requirements



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Advance Review of Schedules

- Supervisors review weekly schedules weekly midweek of prior week
 - Schedule complete at review date/time (phase I)
 - Sufficient time scheduled to achieve productivity--target plus no show (phase II)
 - Schedule reflects caseload and client intensity (phase III)
 - Maintain running list of no-show filler activities
 - Outreach, documentation, calls, case mgt, etc.
 - Scheduling of community based services
 - List of clients each day, approximate times geographic efficiency

MIS Core Functions

- Standard claims formats (837 I/P)
- Scheduling
 - Load protocols
 - Initiate billing events
- Basic client demographic
- Eligibility
 - Payer rules/rates
 - Link to specific clients
- Tracking treatment plan dates
- Tracking authorizations

Core MIS for Decision Support

- Financial performance
 - Payer mix, service mix
 - Performance by program and payer
- Staff performance
 - Productivity, no show
 - Caseloads
 - Gaps in service, average service per client per week
- Claim performance
 - Time from service to billing
 - Rejected claims by reason code with resubmissions

Enhanced MIS Functions

- Automated eligibility checks (270/271)
- Matching clients to staff based on credentials/contracts
- Authorizations—submissions and enhanced tracking
- Remittance advice (835) to post payments
- Clinical record elements
 - Assessment, treatment plan, progress note
 - Enhances compliance based on presence of documentation, treatment plan dates
 - Staff training needs

MIS Costs

- ASP options most affordable for small providers
 - Implementation \$100,000
 - Annual \$50 – 60,000 for 30 to 40 users
- EHR incentives possible depending on:
 - Medicaid penetration rates and eligible providers (MDs and nurse practitioners)
 - HHS/CMS Overview of Incentives:
<http://www.cms.gov/EHRIncentivePrograms/>
 - Summary of Meaningful Use:
http://www.cms.gov/EHRIncentivePrograms/35_Meaningful_Use.asp

Manual Alternatives

- Substitutes staff costs for MIS costs to accomplish the same tasks
 - Or key gaps exist in procedures and systems
- Use daily schedules to track submission of progress notes
 - Deadlines 1 – 2 days after service, check off as received
- Staff complete eligibility checks via phone/internet
- Maintain spreadsheet to track treatment plan dates
- Use payer websites to enter/submit billing data
- Use payer websites for available billing reports
 - Aggregate/analyze with Excel
 - Productivity can be challenging if rendering provider is not tracked

Why Productivity?

- Replacing revenue
 - Budget cuts
 - Reduction in GRF/Medicaid conversion
- Achieving revenue targets
- Budgeting
- Keeps unit costs low and competitive
- Access and capacity management
- Focus on the “right” amount of direct service resources
- Very challenging to manage—need routine and timely reporting



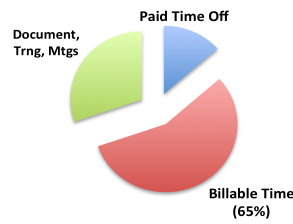
Measuring Productivity

- What is it?
 - Billable time per day, week, month or year
 - Productivity rate = billable time/paid or available time
 - Available time = paid hours – paid time off
 - Available time better for staff supervision
 - Paid time easier for financial modeling
 - Revenue results equal over long periods/a year
 - Rate higher for available time (5 – 10% higher than paid time)
- What counts?
 - Billable time only, no credit for
- Use billable time per day/week/month or % of paid/available
 - Not as percentage of target

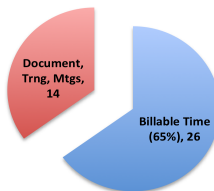
Time Distribution

Time Distribution	Annual	Monthly	Weekly (no PTO)
Paid hours		2,080	173
Vacation (3 weeks)	120		
Holidays (2 weeks)	80		
Sick time (2 weeks)	80		
Paid time off (7 weeks)		280	23
Available time		1,800	150
Billable time (65%)		1,170	98
Training, meetings, documentation		630	53

Annual Time Distribution



Weekly Time Distribution



Other Productivity Dimensions

- Caseloads and active caseload
 - Track avg amount of service by client
 - Track clients with gaps in service exceeding clinical standards
- Census for bed based services
 - Match to staffing levels
 - Manage gaps between discharge and admission
- Group enrollment and avg actual group size
 - Compare to staffing for day treatment/IOP programs

Productivity Calculations

- Convert outpatient billing codes into time
 - Service definition
 - Assessment and counseling are in 15 minute units
- Event codes converted based on activity/rate
 - Medication check (90862)—convert to 15 minutes of productivity for adults, 20 minutes for youth
- Day treatment
 - Monitor enrolled and actual census, match to staffing
 - Over-enrollment needed to cover avg no shows
 - Consider small amount of add'l direct service time to increase productivity/client access

Productivity Calculations

- Groups—NOT participants x group time!
- Group calculations
 - Compare rates—45 min individual = \$42, group = \$11
 - Requires 4 in group to match individual revenue
 - 20 – 30% additional productivity credit for group time or 54 - 58 minutes per 45 minute group
 - Encourages groups, acknowledges increased documentation time, reduces no show impact
 - If avg group is 8 people for 90 minute group
 - 90 min x 1.25 = 112 min productivity credit or 22 minutes of “extra” credit for group documentation time
 - Revenue = \$176 group vs \$84 individual (8x\$11x2)

Productivity Examples



Productivity Standards

- Standards established based service, cost of service compared to rates and revenue budget
- Outpatient services
 - 5 – 6 hours per day or 1125 – 1350 per year
 - 7 weeks PTO or 1800 available hours
 - 55 – 65% of paid time/62 – 75% of available time
 - Lower end for less experienced/lower paid staff and/or community based services
- Prescriber services
 - Minimum of 6.5 hours per day or 1462 per year
 - 7 weeks PTO or 1800 available hours
 - 70% paid time/81% available time

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Productivity Management

- Uniform management and clinical support
- Be prepared for data integrity issues
 - Resolve but don't get bogged down]
- Starts with scheduling at standard plus no show
- Enroll group/IOP at targeted capacity plus no show
- Management of no shows/cancellations
 - Clear procedures to back fill cancellations
 - Client specific management for chronic no shows
- Team leads/supervisors should have productivity targets
 - Reduce target by approximately 25% for every 4 staff

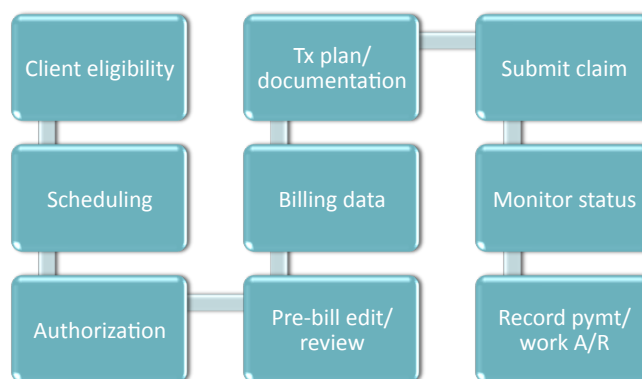
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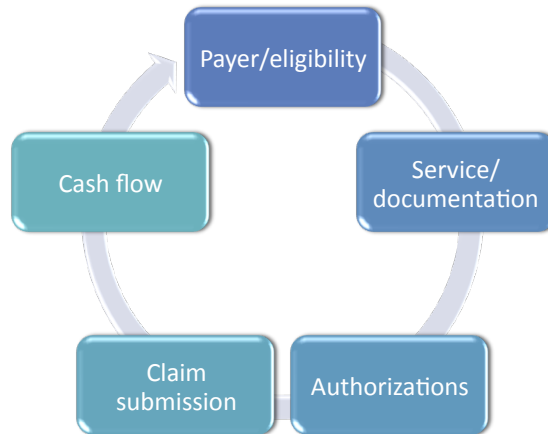
Productivity Management

- Monitor inflated caseloads
 - Client needs/active clients may not support expected billing levels
- Identify and reduce productivity barriers
 - Meetings, excessive supervision, work hours inconsistent with client needs, revise flows
- Requires consistent supervision to manage and improve

Billing Flow



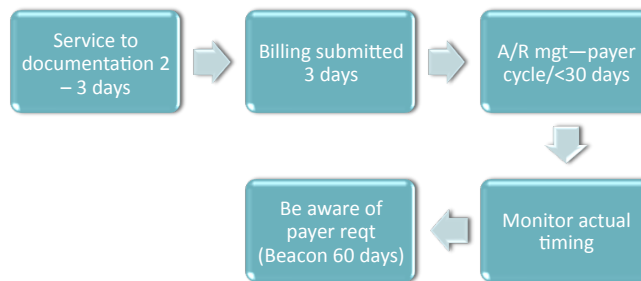
Billing as QA



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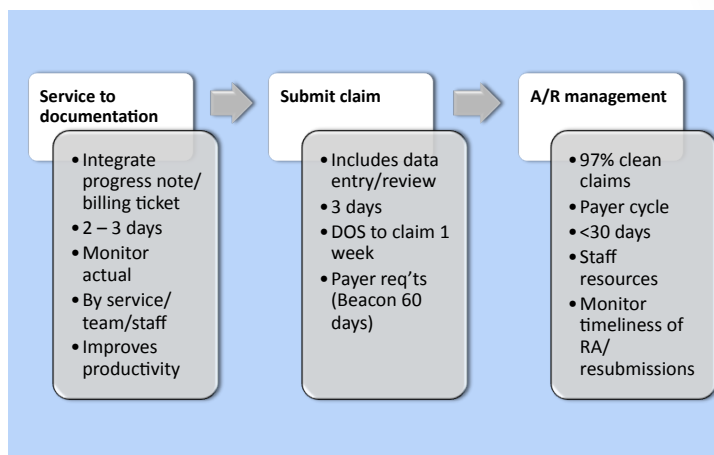
Billing Timelines



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Billing Timelines



Other Billing Issues

- Controls to capture all services
- Billing audits depending on MIS controls
- Front desk critical for effective billing
 - Consider reporting relationships for front desk staff
 - Functional either way, requires coordination
- Resources
 - Front desk—can re-assign existing resources
 - Billing and A/R mgt—needs dedicated person
- Coordination of benefits
 - GRF is payer of last resort, Medicaid second to last payer
 - Billing timeframes extended, start after receipt of primary EOB

Financial Management

- Budget development
 - Manage/track as separate line of business
- Revenue adjustments
 - New clients or replacement of existing clients
 - Revenue variability increases with FFS or managed care
 - Use direct service staff FTEs targeted for new business X productivity
 - Expected IOP attendance or bed census X rate
- Expenses
 - Adjustments in credentials
 - New resources for MIS, billing/AR mgt, authorizations

Budget Full Year Operations					Productivity and Billing				
FTE	Caseload	Salaries	Fringe/Taxes	Total	Available Time	Productivity (paid time)	Billable Time	Rate	Billing

	875 Clients		18%							
Personnel										
Clinical Director	1	10%	76,500	13,770	90,270	1800	50%	90	117.48	10,573
Crisis Intervention	1	10%	26,000	4,680	30,680	1800	50%	90	117.48	10,573
CPS/Court Liaison	0.5	50%	17,500	3,150	20,650	1800	50%	225	82.74	18,617
Team Leads (1:8)	4.1	50%	210,648	37,917	248,565	1800	50%	1,823	117.48	214,156
CADCs (1:27)	32.4	100%	1,134,259	204,167	1,338,426	1800	50%	29,167	82.74	2,413,250
LPN	1.0	100%	43,500	7,830	51,330	1800	50%	900	70.00	63,000
Medical Director	0.5	0.05%	176,800	-	176,800	1800	50%	0	309.66	70
Prescriber	0.8	100%	152,755	27,496	180,251	1800	65%	936	309.66	289,842
Subtotal	41.3		1,837,963	299,009	2,136,972					
								Billing		3,020,081
								Collection rate		95%
								Net Revenues		2,869,077

Cash Flow

- Cash flow typically minimum of 15 -30 days from date of service AND billing
- Impact depends on nature of new business
 - New business = incremental cash with up-front costs for staff, MIS
 - Significant cash flow impact if replacing grant-funded clients
 - Cash flow delays may reach 60 – 90 days depending on historical grant receipt date, provider billing cycle and payer processing cycle
- Plan for transition
 - Cash flow budget
 - Defer expenses/build reserves
 - Line of credit
 - State transition support

Financial Tracking/Analysis

- Segregate MCE/FFS line of business
- Actual to budget
 - Billing and receipts
 - Expenses
- Monitor/project cash flow
- Service and payer mix
- Compare cost per unit of service to rates
 - Reduce administrative/non-direct service costs
 - Increase productivity
 - Increase staff with direct service targets
- Timely and user-friendly reports for problem resolution

Review Unit Cost Model

Cost of Service Example		
LADAC II Annual Salary		38,000
Fringe/tax rate	24%	9,120
Direct personnel costs		47,120
Other direct costs	23%	10,838
G&A/Overhead	13%	6,126
Total cost		64,083
Available hours per year	1800	
Productivity rate	65%	
Billable hours		1170
Cost per hour		54.77
Cost per 15 min		13.69

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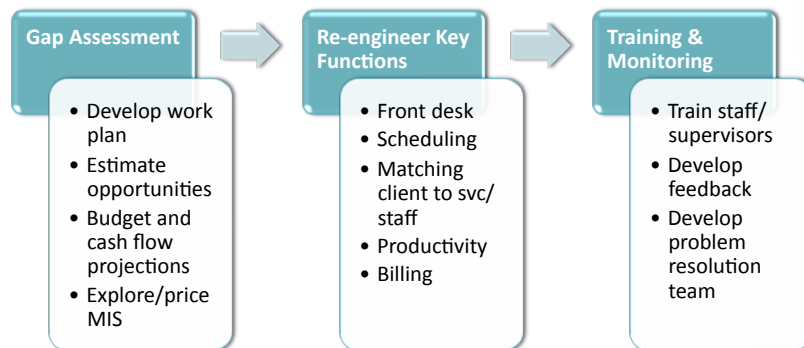
Key Indicators

- Scheduling compliance
- Productivity level/trends
- No show/cancel/reschedule
- Billing flow timing
 - DOS – Billing data complete – submit claim - receipt
 - Resubmissions
- Billing error rate
- Authorization denial rate
- Payment denials by reason code—eligibility, authorization, treatment plan expiration
- Revenues/services not billed by reason code

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Where to Start?



That's A Wrap

All Presentation Materials, Tools & Resources May Be Found

- <http://parkerdennison.com/library/project-documents/other>