Foundations in Essential Medicaid Managed Care Business and Operations Practices

CTAC Training Session for OCFS Voluntary Agencies

Health Management Associates

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Goals and Structure of Training

• Introductions
• Goals of today’s training
• Preparation for State Readiness Grant Funding
• Structure of training:
  – Interactive - exercises and case studies
  – Training materials - in your binders and online
  – Questions and Answers
Your Pre-Screening Responses

Responses to Pre-training survey (1=strongly agree, 4=strongly disagree)

- Plans to Contract with MCOs: 1.80
- Compliance with MCO contracts: 2.20
- QA systems: 2.40
- Exec New Partnerships: 2.60
- Basic MC Theories: 2.80
- Board New Partnerships: 3.00
- Revenue Cycle: 3.20
- Outcomes Capture: 3.00
- Strategic Plan and MA-MC: 2.80
- True Cost of Care: 2.80
- Value Proposition: 3.00
Agenda/Schedule for the Day

1. The big picture: Context
2. Foundational Elements of Managed Care
   – Managed Care priorities, Utilization Management, communication
3. Operations and Infrastructure
   – Finance and billing, revenue cycle management, quality improvement, IT, value proposition

Lunch

4. Planning for Change
   – Options for infrastructure development, strategic planning, developing an action plan, change management and the role of leadership

5. Questions
The Triple Aim

Quality

Cost

Experience
What Impacts Health Outcomes?

- Behavioral Patterns: 40%
- Social Circumstances: 15%
- Health Care: 10%
- Environmental Exposure: 5%
- Genetic Predisposition: 30%
Social Determinants of Health

- Financial Stability
- Health Care Access
- Neighborhood and Environment
- Community Context
- Education

The Social Determinants of Health
Within Ten years, Four Public Programs Will Cover Almost 200 Million or 56% of All Americans

- Millions of Beneficiaries
  - 134 Million (42% of Americans)
  - 172 Million (52% of Americans)
  - 191 Million (56% of Americans)

- Years:
  - 2014: 72
  - 2019: 91
  - 2024: 93

- Programs:
  - CHIP
  - Medicare
  - Medicaid
  - Exchange

134 Million (42% of Americans)
172 Million (52% of Americans)
191 Million (56% of Americans)
Care Management for All

• 95% of the Medicaid population will be enrolled in Managed Care by 2018 (Currently about 80%) including children
  – Exceptions include:
    • “Dual eligibles” under 18
    • Hospice only recipients
    • Family planning only recipients
    • Emergency only recipients
    • Native Americans
    • Partial duals

• 4% or less of Medicaid spending will remain fee for service (FFS)
Other Relevant Major Reform Initiatives

• State Innovation Model (SIM)
• Delivery System Reform Incentive Payments (DSRIP)
• Health Homes including Health Homes for Children and Families
• Balancing Incentive Payments (BIP)
• Fully Integrated Dual Advantage (FIDA) Capitated Demonstration
• Money Follows the Person (MFP)
Proposed 2017 Children’s Medicaid Managed Care Model

For all children 0-21 years old

Mainstream Medicaid Managed Care Organization: Benefit Package*

- All Health & Pharmacy Expanded Benefits
- Behavioral Health State Plan Services and New State Plan Services
- Aligned HCBS Services for children meeting LON and LOC criteria (transition of existing children’s 1915c Waivers - OMH, B2H & CAH I/II)

Care Management for All

Care Management will be provided by a range of models that are consistent with a child’s needs (e.g., Managed Care Plans, Patient Centered Medical Homes and Health Homes). Most children’s care and services will be coordinated through Health Homes.

*MCOS may opt to contract with other entities (e.g., BHOS) to manage behavioral health benefits
Fiscal Implications for Providers

- Managed Care Plans will be given a list of designated OMH, OCFS, DOH and OASAS HCBS providers with which to contract for 24 months in order to meet the network adequacy standards.
- Plans will be required to pay designated providers fee for service rates for 24 months.
- Non-risk arrangement for the new HCBS Services and new SPA benefits for 24 months (funding for these services will be outside the Plan premium), but these services will be paid through the Mainstream MMC Plans.
- Voluntary foster care agencies will receive a residual Medicaid per diem for some existing services, yet to be developed.
Revised Timeline – Other Transitions

• Six new Medicaid State Plan services will be implemented as soon as possible pending approval from the Centers for Medicare and Medicaid Services (CMS)
• In 2017, currently carved out Medicaid behavioral health services will move into Managed Care.
• Also, Children in Voluntary Agency foster care placements will be transitioned into Managed Care.
• The existing Home and Community Based Services (HCBS) that are in the six 1915c children’s Waivers (OMH SED, DOH CAH I/II, OCFS B2H) will be aligned to one array of HCBS benefits, pending CMS approval, and will be moved to Managed Care. As a result of this transition, the 1915c Waivers will be discontinued as separate programs once the transition is complete.
Target and Eligibility Criteria

• Children from birth to age 21 who have:
  – A Psychiatric Diagnosis from the DSM V
  – Alcohol or Drug Disorders (291.xx.292.xx.303.xx.305.xx.) or
  – Developmental Disorders (299.xx.315.xx.319.xx.) or
  – Organic Brain Syndrome (290.xx.293.xx.294xx);
  OR
  – Are Medically Fragile;
  OR
  – Have been impacted by Physical, Emotional, or Sexual Abuse, Neglect, or Maltreatment;
  AND
  – Have Extended Impairment in Functioning
  – Eligibility will be driven by Medical Necessity
  – Eligibility will also be driven by Level of Need/Level of Care criteria via the CANS-NY
Medical Necessity

New York State Department of Health currently requires the following definition of Medically Necessary:

Medically necessary means health care and services that are necessary to prevent, diagnose, manage or treat conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person’s capacity for normal activity, or threaten some significant handicap.
Medical Necessity

CMS also has the following criteria:

• Appropriate and consistent with the diagnosis of the treating Provider

• The omission of which could adversely affect the eligible Member’s medical Condition

• Compatible with the standards of acceptable medical practice in the community

• Provided in a safe, appropriate, and cost-effective setting given the nature of the diagnosis and the severity of the symptoms;

• Not provided solely for the convenience of the Member or the convenience of the Health Care Provider or hospital
Proposed New Medicaid State Plan Services

- Crisis Intervention
- Community Psychiatric Supports and Treatment (CPST)
- Other Licensed Practitioner
- Psychosocial Rehabilitation Services
- Family Peer Support Services
- Youth Peer Advocacy and Training
Proposed HCBS Array (available to children on Medicaid who meet population and functional criteria)

• Care coordination (for those ineligible for, or who opt out of, Health Home)
• Skill Building
• Family/Caregiver Support Services
• Crisis and Planned Respite
• Prevocational Services
• Supported Employment Services

• Community Advocacy and Support
• Non-Medical Transportation
• Day Habilitation
• Adaptive and Assistive Equipment
• Accessibility Modifications
• Palliative Care
New Approach to Eligibility for Children’s HCBS Benefits

- **Level of Care**—criteria met and determined by assessment that would indicate a child is eligible for, or at risk of, medical institutional placement in a facility licensed by NYS OMH, Intermediate Care Facility for the Mentally Retarded or Skilled Nursing Facility/Hospital

- **Level of Need**—criteria met and determined by assessment that would indicate a child has needs that cannot be met only by a non-medical institutional State Plan Service, but who does not qualify for Level of Care

- Eligibility determined by the **CANS-NY** (Child and Adolescent Needs and Strengths) assessment tool
**Timeline***

- **Jun-15**: NYC: First HARP Enrollment Letters Distributed
- **Jul-15**: NYC: HCBS begin for HARP population
- **1-Oct-15**: NYC: Mainstream Plans and HARPs implement non-HCBS behavioral health services for enrolled members
- **Oct-15**: ROS: RFQ Distributed
- **1-Jul-16**: ROS: Mainstream Plan Behavioral Health Management and Phased HARP Enrollment Begins
- **1-Jul-17**: ROS Children transition to Medicaid Managed Care
- **1-Jan-17**: NYC and LI Children transition to Medicaid Managed Care

*Subject to Change at Any Time*
Foundational Elements of Managed Care
Foundational Elements of Managed Care

• Managed Care Terminology
• Utilization Review and Utilization Management
• Authorization Process
• MCO Priorities (includes direct input from MCOs)
• Enrollment
• Payment Constructs and Value-Based Payments

• Capitation (full and partial)
• Contracting
• QI vs. QA (Quality Improvement vs. Quality Assurance)
• Analytics
• National Provider Identifier (NPI)
• Credentialing
What is the Difference Between Utilization Management and Utilization Review?

• Utilization Management is a function performed by MCOs as payer.

• Utilization Review is a regulatory requirement that requires utilization review of open cases. Therefore providers will need to complete the Utilization Review regulatory requirements as well as Utilization Management requirements.
Why do MCOs Conduct Utilization Management?

• Managed Care is an integrated system that manages health services for an enrolled population rather than simply providing or paying for the services (outcomes, service quality and service expenditures).
• Generally MCOs are paid for health benefits administration on a capitated basis (a fixed amount for each member each month/Per Member Per Month - PMPM).
• The MCO’s role is to make sure the individual receives the least restrictive care.
• Involves a determination of whether the service is medically necessary and appropriate for the patient’s symptoms, diagnosis, and treatment and recovery. Also reviews for the appropriate length of care.
• UM applies chiefly to diagnostic and evaluative services, hospital services, and certain specialty services including HCBS; primary care services are not typically subject to prior authorization or concurrent review.
• The core function of the UM program is to ensure that the MCO pays for only those services that are “medically necessary.”
Types of Reviews?

UM will occur at different points in the healthcare delivery cycle:

- **Prior authorization**: provider must request permission from the MCO before delivering a service in order to receive payment

- **Concurrent review**: occurs during an ongoing course of treatment (such as inpatient hospital admission) to ensure that such treatment remains appropriate

- **Discharge Review**: For inpatient, this review occurs prior to discharge to assure that plans are in place for a safe and supported re-entry into the community

- **Retrospective review**: review that takes place, on an individual or aggregate basis, after the service is provided
Typical Utilization Management Process

1. Prior to calling the MCO
   – Review Level of Care (LOC) criteria for the service being requested/discussed
   – Review the specific information regarding the individual (presenting problem, current symptoms, medications, recent treatment) and formulate a rationale for the requested LOC and anticipated service units

2. Contact the MCO representative
   – Provide patient name, Date of Birth (DOB), Medicaid number (CIN) and your name, facility name and contact number
   – Identify the start date for treatment being requested
   – Request the services and number of service units (days, visits, etc.) necessary to deliver these services
   – Present rationale for request
3. Discuss planned treatment changes (if any) and anticipated service units.

4. Always include overview of the long term treatment/support plan (including discharge planning steps if the individual is in an inpatient setting)
   - Communication with treatment providers (new, existing)
   - Family meetings
   - Medications (new, existing, changes)
   - Patient involvement (person centered approach)
   - If inpatient, discharge plans: to home, HWH, transfer to another facility, etc..

5. Obtain decision from MCO, document and schedule next review if necessary
   - If adverse decision:
     i. request rationale
     ii. consider MD to MD review
     iii. appeal
Authorization

- Individual is eligible
- Must be a part of the approved service plan
- Must be within the established service caps
- Must be the most appropriate (most integrated/least intensive) level of care
- Authorization must be provided within timeliness standards
- Meets medically necessary criteria
- In-line with best practice guidelines
Role of Health Home Care Management Providers

- Assessment
- Integrated Care Plan
- Coordinate Care
- Work with Managed Care plans, providers and families to integrate input
- NYS, working with IPRO, has commissioned the New York Care Coordination Program to provide a series of Health Home trainings to assist Voluntary Foster Care Agencies in fulfilling their role as a downstream Health Home care managers for children in Foster Care
Role of Voluntary Foster Care Agencies as Downstream Care Management Providers

- VFCAs provide Health Home care management for children in Foster Care
- VFCAs may also provide Health Home care management for children not enrolled in Foster care or that transition out of Foster Care
- LDSS provides consent to refer and enroll Foster Care children in Health Homes
- LDSS assigns child to VFCA for purpose of providing Health Home care management; VFCA chooses and assigns to Health Home
- Health Homes required to contract with VFCAs
MCO priorities

- Adequate Network
- Manage Care
  - Improved health outcomes for members
  - Timely access to high quality services for members
- Manage Costs
  - PMPM
  - Administrative
- Quality monitoring and reporting
- Authorization
- Utilization Management
- Customer Service
  - Members
  - Their funders/ regulators (State, CMS)
  - Providers
MCO Contracting

• Subject to NYS Regs & Guidelines
• Key Terms
  – Parties and Definitions
  – Scope of Services
  – Payment Adjustments
  – Administrative Requirements
  – Indemnification
  – Compliance

  – Term and Termination
  – Representations and Warranties
  – Assignment
  – Amendment
  – Notices
  – Dispute resolution or litigation
  – Audits, monitoring and oversight
Managed Care Financing Models

- Fee for Service
- Medical Home
- Pay for Performance
- Bundled Payment Rate
- Shared Savings (up/down)
- Partial Capitation
- Full Capitation
  - Global Payment with performance risk
  - Global Payment with financial risk
Communicating with Plans
Provider-Plan Communication

- Plans are part of the patient-centered planning team
- Knowing **who** to contact and **when** is key to smooth collaboration and getting issues resolved
- Some of the plan communication processes and protocols are set by the state; others vary by plan
- Designate a **liaison** responsible for developing relationships with plan contacts
Liaison Role

• Know the policies for communicating with and reporting to plans surrounding member verification, service authorization, etc.

• Become familiar with plan resources and materials:
  – **Provider manual** – Includes all relevant information on BH services, BH-specific provider requirements
  – **Plan websites** – Contain resources and information

• Keep a record of important plan phone numbers and contacts
  – A telephone tracking log is a good idea also

• Track plan reporting and information submission requirements (e.g., for performance reporting) and ensure they are being met
Behavioral Health Service Centers

• On the plan side, plans must have BH service centers with capabilities such as:
  – Provider relations and contracting
  – Utilization Management
  – BH care management
  – 7-day capacity to provide information and referral on BH benefits, crisis referral, prior authorization, etc.

• Become acquainted with the service center and know how it can help you, your agency and your clients
Your plan communications toolkit

Designated plan **liaison** within your organization

A record or database of **important plan phone numbers and contacts**

Plan **provider manual** (each plan will have one)
NYS DOH Complaint Line

1-800-206-8125

or

managedcarecomplaint@health.ny.gov

And DFS prompt pay complaint process at www.DFS.ny.gov
**Exercise: First Steps**

- ABC, Inc. is a 501(c)(3) medium-sized Voluntary Foster Care Agency that provides a range of services to children in foster care including special education, treatment to children in foster care, adoption services and health as well as preventive services. They also provide early childhood education services. Their mission is to advocate for children and families in need of care and to promote safe and stable environments. They serve children up to twenty-one years of age.
**Proposed HCBS Array (available to children on Medicaid who meet population and functional criteria)**

- Care coordination (for those ineligible for, or who opt out of, Health Home)
- Skill Building
- Family/Caregiver Support Services
- Crisis and Planned Respite
- Prevocational Services
- Supported Employment Services

- Community Advocacy and Support
- Non-Medical Transportation
- Day Habilitation
- Adaptive and Assistive Equipment
- Accessibility Modifications
- Palliative Care
Finance and Billing: Revenue Cycle Management
Poll

How many of you have a revenue cycle management process in place?
The Paradigm Shift

One or more grants/contracts for whole programs

Lots of small payments for individual services
The Paradigm Shift

One or more grants/contracts for whole programs

Lots of small payments for individual services
The Spokes that Make the Wheel Go Around: QI and IT
Executive Team Responsibility

• This process starts and ends with you
• You are responsible for hiring, training, supervising, measuring, managing and controlling this process
• You need to know:
  – How long your billing process is
  – What your denial percentage is
  – What your rate of billing errors is
• You need to establish the revenue cycle KPIs (Key Performance Indicators)
• You need to enable the communication that will make this all possible

Step 1 and 14: Performance management
Scheduling

• Make sure you have capacity
  – The right type of service provider
  – The right type of location
  – A sufficient length of time

• Your front desk/intake staff will need to be retrained
Eligibility Verification

- There is a contract in place with the client’s MCO
- The service you’re providing is on the Plan of Care
- Your agency is approved to provide the service
- The consumer has remaining eligibility
Insurance Validation

- The client’s insurance is currently active
- Prior authorization is not required
- The provider is qualified to provide the service
- The location is allowable
- The length of service is sufficient

Don’t provide the service until you have completed this step!
Service Provision and Documentation

• Contemporaneous documentation
  – Consumer’s name
  – Service type
  – Service date
  – Service location
  – Service duration (start and end times)
  – Relationship to PoC
  – Outcome/progress
  – Follow up/next steps (back to Step 2)
  – Name, qualification, signature, date
  – Get it right the first time
Coding

- Translate the service you provided into the billable code
- Use 837i claim form
- Also include the Medicaid FFS rate code – at least for now
- Procedure code(s)
- Procedure code modifiers (if needed)
- Units of service
Charge Capture

- Translate the code into a fee
- The right level of collaboration between your direct service and finance staff can lead to same-day charge capture
  - The documentation is the key
Claim Generation and Submission

- Meticulous quality assurance at this point will save you a lot of suffering down the line
Payer Follow-Up

• Make sure you know who hasn’t paid you yet
  – 30-day receivables
  – 60-day receivables
  – 90-day receivables
• Know who your late paying MCOs are
• Be proactive
Denial Management and Appeals

• If it was denied, make sure you know why
• Use denials to identify breakdowns in your processes
  – Intake staff who aren’t verifying and validating correctly
  – Direct services providers who aren’t documenting correctly
  – Incorrect coding
  – Incorrect charge-capture
  – Incorrect claim generation
• You may need to go back to Step 7
• DO NOT GO BACK TO STEP 6
Payment Posting

- Make sure you apply the payment to the correct service
  - Incorrect matching will throw your records into chaos
Executive Team Responsibility

• Yes, we’re back here again
• We told you this process starts and ends with you
• You are responsible for hiring, training, supervising, measuring, managing and controlling this process
• You need to know:
  – How long your billing process is
  – What your denial percentage is
  – What your rate of billing errors is
• You need to establish the revenue cycle Key Performance Indicators (KPIs)
• You need to enable the communication that will make this all possible
Exercise: Information Handoffs

• Using the form in your workbook, indicate the key pieces of information that need to be communicated between the different parts of your organization in order to ensure that the revenue cycle is managed effectively.
Quality Management
Importance of Quality Management (QM)

- Capability to track, monitor, report, and improve outcomes for clients is a fundamental component of health care reform
- Cornerstone of participation in incentive opportunities including value-based payment models
- Demonstrate the effectiveness of services to the agency, external stakeholders (e.g. MCOs, state), clients, and the community
- Drive identification of and action around areas that need improvement
- Work hand-in-hand with organizational risk management strategy
Poll

How many of you have a Quality Improvement or Quality Assurance Plan?
Key Elements of a QM Program

- Quality Improvement and/or Quality Assurance Plan
  - NYS OMH has a template plan available: [http://www.omh.ny.gov/omhweb/cqi/plan_template.html](http://www.omh.ny.gov/omhweb/cqi/plan_template.html)
- Quality Management Committee, Board of Directors, and Key Staff
- Goals, measures, and reporting
- Data capture and reporting mechanisms
- Developing, implementing, and evaluating strategies to achieve goals
Anticipated Performance Measures Children’s HCBS Services

• Child and Adolescent Major Depressive Disorder, Suicide Risk Assessment: the percentage of patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder and assessed for suicide risk.
• Early Childhood Screening: the percentage of children ages one, two and three years who had a social-emotional screening performed.
• Psychotropic medication measures from PSYCKES. Look at data for each of the five classes of psychotropic medication (i.e., Stimulants, Anti-depressants, Antipsychotics, Mood stabilizers and Antianxiety agents)
  – Youth younger than six years old on psychotropic medications
  – Youth on higher than recommended dose of psychotropic medication or
  – Psychotropic polypharmacy in youth (three or more psychotropic medications)
# Some Sources for Measures

<table>
<thead>
<tr>
<th>Name</th>
<th>Link</th>
<th>Measure type</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CAHPS</strong> &lt;br&gt; Consumer Assessment of Healthcare Providers and Systems</td>
<td><a href="https://cahps.ahrq.gov/">https://cahps.ahrq.gov/</a></td>
<td>Patient experience, operational measures</td>
</tr>
<tr>
<td><strong>Healthy People 2020</strong></td>
<td><a href="http://www.healthypeople.gov/2020/topicsobjectives2020/default">www.healthypeople.gov/2020/topicsobjectives2020/default</a></td>
<td>Outcomes measures, goals and national benchmarks for Mental Health, Substance Abuse, and Social Determinants of Health</td>
</tr>
</tbody>
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## QARR Measures Related to Children

<table>
<thead>
<tr>
<th>Category</th>
<th>Measures</th>
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<tbody>
<tr>
<td>Preventive Care</td>
<td>Adolescent Preventive Care (assessment or counseling for sexual activity, depression, tobacco and alcohol/drug use), Childhood immunization, Adolescent immunization, Lead screening, Weight Assessment and Counseling for Nutrition and Physical Activity</td>
</tr>
<tr>
<td>Caring for Illness</td>
<td>Appropriate Treatment for URI, Appropriate Testing for Pharyngitis, Asthma medication management and medication ratio</td>
</tr>
<tr>
<td>Women's Health</td>
<td>Non-recommended cervical cancer screening for teens, Chlamydia Testing, HPV Vaccination for Adolescent Females</td>
</tr>
<tr>
<td>Use of Services and Access to Care</td>
<td>Children’s Access to PCPs, Annual Dental Visits, Well care visits for 15 month olds, 3-6 year olds and Adolescents</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>Follow Up Care for Children Prescribed ADHD Medication, Follow Up After Hospitalization for Mental Illness</td>
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</tbody>
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Designing and Evaluating QI Initiatives

• Data results should drive design of improvement initiatives

• Examine processes that affect the data results. Good candidates for improvement include:
  – High **volume** (affecting a large number of clients), high **frequency**, high **risk** (placing clients at risk for poor outcomes)
  – Longstanding
  – Multiple unsuccessful attempts to resolve in the past
  – Strong and differing opinions on cause or resolution of the problem

• Evaluate results through staff and client feedback and ongoing data monitoring to demonstrate improvement
Information Technology Systems
Poll

How many of you have an electronic system for:

• Billing/Invoicing?
• Client scheduling?
• Client data (demographics, registry, etc.)?

“Nobody move! Everything’s working!”
IT System Requirements: What do you need it to do?

• Centralized scheduling
• Capture of clinical data
• Electronic submission of claims
• Financial accounting and revenue cycle management tools
• Reporting capabilities for financial reporting metrics, quality and risk management measures, and other internal operational management metrics
• Health Information Exchange (HIE)—Exchange of information with other providers through connectivity to a Regional Health Information Organization (RHIO)
IT System Requirements:
Security and Backup

• Ensure that it stores, manages, and transmits information in a manner compliant with requirements, regulations, and/or expectations (e.g. HIPAA)

• Ensure that there is adequate back up and redundancy in the system in order to protect data should the system go down (business continuity planning)
IT Systems: Challenges

• Budgeting up front and ongoing costs
  – Recommended 7-10% of total operating budget for safety net providers; however typically 3% or less for social services driven providers

• Ability to customize product

• Use of specific functions including:
  – Registries to track consumers over time
  – Reporting quality measures
  – Providing consumers with visit summaries
  – Exchanging key clinical information
IT Systems and Managed Care Readiness: Make Your System Work for You

• Determine what you want for:
  – New administrative processes
  – New service workflows
  – Financial, clinical, and operational priorities or needs
  – Reporting or regulatory requirements
  – Partners with whom you need to be connected

• Evaluate your current system and/or explore options
IT System: Key Considerations

• Test drive your specific needs with the vendor’s product
• Define implementation support and ongoing product support
• Understand vendor's stability and/or market presence in region
• Determine ability to integrate with other products (e.g., clinical data, practice management software, billing systems, and public health interfaces) and any associated costs
• Determine Health Information Exchange capabilities, barriers, and any associated costs
IT System: Key Considerations

• Ensure that you are optimizing use and function of system

• Ensure ongoing ability to customize product
  – Network with colleagues on same system to approach vendors and/or share costs for development of new features, templates, etc.

• Develop a robust user support function
  – Consider different models—In house, outsource, combination
Demonstrating Impact/Value

Customer Experience

Results

What you are the best at
Demonstrating your Value Proposition in Four Basic Steps:

1. Define the problem
2. Evaluate
   a) Unique?
   b) Compelling?
   c) Innovative?
3. Measure
   a) Cost/benefit of services to customers
4. Build
Define the Problem/Need

“A problem well stated is a problem half solved.”
– Charles Kettering, Inventor

• Is the problem Unworkable?
• Is fixing the problem Unavoidable?
• Is the problem Urgent?
• Is the problem Underserved?
## Analytics: Evaluating Impact

### Types of Measures:

<table>
<thead>
<tr>
<th>Measure Type</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Process Measures</td>
<td>Retention in services at 3 months</td>
</tr>
<tr>
<td>• Productivity</td>
<td>Billable hours/Week</td>
</tr>
<tr>
<td>• Outcomes</td>
<td>Reduction in # of days an individual used substances in last 30</td>
</tr>
<tr>
<td>• Efficiency:</td>
<td>Total # of individuals placed in housing/total cost of program</td>
</tr>
<tr>
<td>• Cost Effectiveness</td>
<td>Prevented hospitalization/dollar spent on diversion</td>
</tr>
</tbody>
</table>
Understanding your Total Cost of Care

• Direct Service Staff Salary
• Fringe Benefits
• Other Than Personal Services (supplies, space, furniture, equipment, insurance, training)
• Indirect Costs (a portion of central infrastructure i.e. % of CEO salary)
Sample Value Proposition

• Low prices for a high selection of books ordered through an anytime, anywhere extremely convenient mechanism.

• Low Costs:
  – Unique organizational system relying on an entirely automated order management system, tightly linked to their suppliers and payment networks, allowing them to minimize human intervention, therefore reducing costs.
  – Special deals with partners (suppliers) allow them to maintain very little physical inventory.

• Unique Customer Experience: Create a sense of community among book readers, who collaborate to serve as reviewers or salespersons

• Efficient Customer experience: Technology is used both in the back-office as well as in the interaction with the customer
Exercise: Value Proposition

• Using the form in your workbook, draft a brief value proposition statement for your agency.
Options for Infrastructure
Infrastructure Needs

- Accounting
- Accounts receivable
- Benefits administration
- Compliance
- Consumer affairs
- Contracting
- Credentialing
- Data analytics
- Development
- Executive leadership
- Facility management
- Grant management
- Grant writing
- Informatics
- Information technology
- Insurance administration
- Internal audit
- Legal
- Marketing
- Medical records
- Payroll
- Prospective financial modeling
- Public relations
- Purchasing
- Quality Improvement
- Recruitment
- Research
- Risk management
- Strategic planning
- Training
Timeline for Infrastructure Development

By January 1, 2017

• NPI & Medicaid ID
• At least one contract with an MCO
• Projected Budget with HCBS revenue
• Accounts receivable
• Compliance
• Credentialing
• Information technology
• Risk management

By January 1, 2019

• Data analytics
• Signed MCO contracts for all services
• Revenue Cycle Management
• An electronic record system including billing software
• Brand recognition and value proposition
• Internal audit
• Quality Improvement
• Training
## Infrastructure budget

<table>
<thead>
<tr>
<th>Personal services</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Billing Manager</td>
<td></td>
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<tr>
<td>Contracting/Crediting Manager</td>
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<tr>
<td>Database Administrator</td>
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<tr>
<td>Data Analyst</td>
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<tr>
<td>Quality Improvement Director</td>
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<tr>
<td>Financial Analyst</td>
<td></td>
</tr>
<tr>
<td>Compliance Officer</td>
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</tbody>
</table>

| Fringe                                 |       |

| Other than Personal Services          |       |
| Billing System                        |       |
| EHR                                   |       |
| Space/Equipment                        |       |

| TOTAL                                 |       |
| Billing needed to support (@15%)      |       |
Options for Infrastructure Development

• Build vs. Buy considerations
  – Control
  – Economies of scale/marginal cost
  – Specialization
  – Long-term financial viability

• Outsourcing
  – What are you going to outsource?
  – To whom?
  – How are you going to oversee the contract?
Options for Building Infrastructure

- Back-office collaboration
- Establish a new collaborative entity
- Strategic partnership
- Merger
Collaboration Models

• Independent Practice Association (IPA)
  – Network of independent physicians or practices integrated clinically and/or financially

• Provider Sponsored Organization (PSO)
  – Cooperative venture of a group of providers

• Physician Practice Management Company (PPMC)
  – Purchases the tangible assets of the provider and provides all of the personnel and assets necessary to operate the agency in exchange for a management fee

• Group Practice Without Walls (GPWW)
  – Created when a number of small organizations come together under a single tax ID
Management Services Organization (MSO)

- Provides Non-clinical Services for Individual Providers
- Economies of Scale and Cost Efficiencies

Range of Non-Healthcare Functions

- Administrative/ operational
- Financial
  - coding
  - billing
  - collections
- Personnel
- Education/training
- Data collection and management
- Quality management
- Utilization management
- Facilities management
- Equipment
- IT
- Marketing
- Compliance
- Credentialing
- Purchasing
- MCO negotiation and contracting
- Strategic planning assistance
Key Collaborative Considerations

- How do you provide the best possible service to your consumers?
- Time
- Money
- Control/Individual Organizational Identity
- Legal Complexities
- Start-Up Capital
- Governance
- Critical Mass to Achieve Economies of Scale
Merger considerations

- Values
- Culture
- Cost
- Synergies
- Integration
- Workforce
- Risk
- Ego

- Control
- Antitrust
- Timeline
- Cost
- Identity
- Horizontal v vertical integration
- Governance
- Excellence
Developing a Strategic Plan
Your Pre-Screening Responses

Responses to Pre-training survey (1=strongly agree, 4=strongly disagree)

- Plans to Contract with MCOs
- Compliance with MCO contracts
- QA systems
- Exec New Partnerships
- Basic MC Theories
- Board New Partnerships
- Revenue Cycle
- Outcomes Capture
- Strategic Plan and MA-MC
- True Cost of Care
- Value Proposition
Start With the People You Serve

• No matter how the financing structure, service environment, regulatory environment, program names, billing systems change...

...the people you serve will still need services

• The question is how?
Key Planning Steps

• Identify your key stakeholders and their needs
• Identify your organizational strengths and weaknesses
• Identify your top priorities
• Find your partners and allies
• Do the math
• Get out in front
Exercise: Conversation with the Board Chair

- Using everything you know about ABC, including the SWOT analysis in your workbook, present the relevant changes to ABC’s Board Chairperson. Discuss the strategic considerations and potential changes to the organization that will be necessary to adapt to the changes resulting from the carve-in of behavioral health services to Managed Care.
Action & Readiness Plan Development
Managing Change and Sustaining Gains
It is not the strongest of species that survives, nor the most intelligent that survives. It is the one that is the most adaptable to change.

Charles Darwin
Importance of Staff Engagement

• Common mistake made by leaders: thinking because leadership is ready to take action, action initiatives can be imposed on employees that are not prepared

....Imposed change is opposed change
Success Factors for Change Management

• Provide direct and visible leadership
• Deploy teams to make changes
• Test changes
• Coach to support change
• Make the new way unavoidable
• Allocate actual resources
• Monitor what you want to sustain and spread
• Create a culture of improvement

Factors Contributing to Sustaining and Spreading Learning Collaborative Improvements. PCDC. Dec 2007
Direct and Visible Leadership

• Leaders promote sustainability by regularly:
  – Providing clear direction, support, and guidance to teams
  – Discussing ongoing improvement efforts at meetings
  – Monitoring performance results
  – Providing consistent feedback to improvement teams
  – Responding to staff requests for resources
  – Directly and visibly supporting and working with teams

Factors Contributing to Sustaining and Spreading Learning Collaborative Improvements. PCDC. Dec 2007
Deploy Teams to Make Changes

• The use of teams promotes change by:
  – Producing positive experiences for team members
  – Promoting the acquisition and use of new skills
  – Breaking the routine way of operating
  – Fostering creativity
  – Creating opportunities for members to act in new roles
  – Allowing members to work across departments and sites
  – Enabling new teams to test changes before they spread them

Factors Contributing to Sustaining and Spreading Learning Collaborative Improvements. PCDC. Dec 2007
Test Changes

• Significant changes in workflow should be planned and tested in advance whenever possible

• Use a model that:
  – Enables participants to obtain quick, real-time results to determine if a change was effective
  – Is outcome-driven
  – Is widely applicable and useful across settings and interventions

Factors Contributing to Sustaining and Spreading Learning Collaborative Improvements. PCDC. Dec 2007
Coach to Support Change

• A facilitator or coach is an internal or external person designated to support the team in the design and implementation of change

• Use of facilitators or coaches support change by:
  – Providing expertise
  – Assisting with challenges
  – Guiding sites to use the PDSA process
  – Keeping the improvement teams on track
  – Providing constant and consistent coaching and communication

Factors Contributing to Sustaining and Spreading Learning Collaborative Improvements. PCDC. Dec 2007
Make the New Way Unavoidable

• Embed/institutionalize the change, including in:
  – Client care processes and forms
  – Policies and procedures
  – Staff education, training, orientation, and professional development
  – Job descriptions and performance evaluations
  – New departments and other infrastructures
  – Existing and new committees and departments
  – Orientations and staff development
  – Strategic plans, including vision, mission, and strategic direction
  – Measurements and reports

Factors Contributing to Sustaining and Spreading Learning Collaborative Improvements. PCDC. Dec 2007
Allocate Actual Resources

• Resources that contribute to success are:
  – Protected time, specifically time set aside for the improvement team to:
    • Meet
    • Review data
    • Plan tests of change
    • Discuss the logistics of the new processes
  – Financial support
    • Budgeted annually
  – Staffing, staffing support, and training

Factors Contributing to Sustaining and Spreading Learning Collaborative Improvements. PCDC. Dec 2007
Tools and Resources
Future Managed Care Readiness Trainings for OCFS Voluntary Agencies

• Readiness domain-specific training beginning January 2016 including:
  – contracting
  – revenue cycle management
  – business practices and change management
  – utilization management
  – Outcomes & data driven decision making

• Training will be tailored to specifically reflect unique needs of foster care agencies

• In-person and on-line formats will be utilized with supplemental office hours offered
Managed Care Tools Available Now

• Interactive on-line glossary of frequently used terms, acronyms, and language around Managed Care, available at http://glossary.mctac.org/

• Frequently asked questions (FAQs) on the transition to managed care and specific areas of readiness
  – Kick-off forum FAQs
  – Readiness domain specific FAQs

• Matrix of combined information about plans (contact info, counties served, pre-authorization requirements, etc.)
General Managed Care Resources Available

• Recordings of past in-person events, including:
  – Smart Managed Care Contracting and Negotiation Basics, featuring Adam Falcone, JD, MPH.
  – Statewide Kick-Off Series

• Presentation slides and recordings of webinars, including:
  – Change Management Leadership for Managed Care
  – NPI Number Webinar
  – Managed Care Contracting: the Provider Perspective
  – Managed Care Contracting: the Plan Perspective
  – Managed Care 101
OCFS Technical Assistance Online

http://www.ctacny.com/ocfs-technical-assistance
Email: OCFSta.info@nyu.edu

- NYS DOH’s official announcement of technical assistance offerings and opportunities for grant allocation for participating OCFS Voluntary agencies.

- Resources from CTAC's Managed Care Kickoff for OCFS Voluntary Agencies and leadership forum webinars are now available including slides, webinar recordings, and FAQs.
EVALUATION

- Outstanding
- Very Good
- Satisfactory
- Marginal
- Unsatisfactory