

Building Infrastructure for Medicaid Rehabilitation Option

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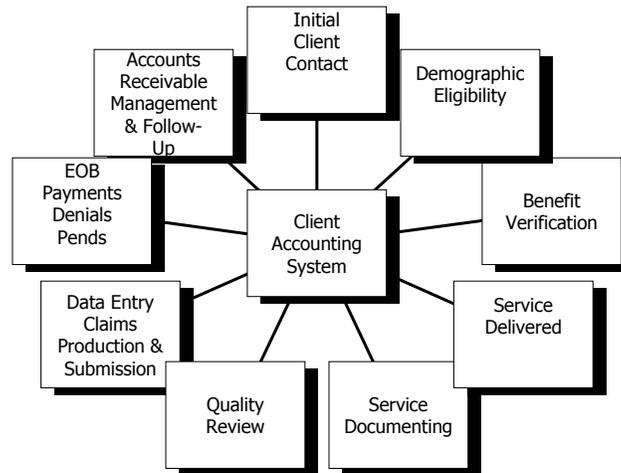
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Focus Areas

- Internal Systems to Support MRO
- Billing & Accounts Receivable Management for FFS
- Financial Management for FFS
- Staffing, Staff Functions, Internal Controls, Reporting, Internal Processes & Procedures, Information System

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Internal Systems Flow



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Internal Systems

- Understand why Internal Information Systems are a Requirement
- Explain Fee-for-Service (FFS) Versus Contract Billing
- Describe Key Components of Revenue Cycle
- Revenue based Internal Controls for Accurate, Timely, & Appropriate Claims
- Understand Billing FFS is a Process
- Understand Coding Basics, Service and Diagnostic

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Internal Systems

- Describe Payer rules (Medicaid)
- Billing Rules for the State of Connecticut System – Medicaid
- Explain the Importance of Coordination with Staff in Other Departments to Ensure Appropriate Billing

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Infrastructure: Key Functions

- Data Entry: Billing Function
- Clerical Support
- Quality Assurance
- Medical Records
- Information System Support
- Clinical Team Leaders

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Decision Support Tool

- Background of the Decision Support Tool
- Using the Tool for Your Organization
- Review How to Use the Tool

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Internal Information System

- Good Management Information System = Decreased Administrative Costs
- Information System Requirements:
 - FFS Financial Management Requires Detailed Billing and Service Information
 - Must be able to Track Key Indicators: Service Plan Expiration, Absence/Presence of Notes, Productivity, No Shows
 - Facilitates Critical Tasks: Scheduling, Billing, Reporting

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Grant Funding Versus FFS

- Contract Billing/Earning Usually Based on Cost Reimbursement or Encounter Data
- Contract uses Statistical Information
- Contract Amount Received on a Predictable Schedule (Predictable Cash Flow)
- DMHAS Changing from “Funder” of Services to “Purchaser” of Services

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Grant Funding Versus FFS

- FFS Billing is Revenue Based and Payments are Retrospective
- Very Detailed and Individual Activity Based
- Both Client and Provider Tracking must be Recorded in MIS
- Requires Individual Client Account Tracking System (Aged Receivable)
- FFS Billing and Revenue Based on Provider Productivity
- Well Defined & Prompt Billing Cycle (Service Delivery to Cash Collection/Follow-Up Process)

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Key Revenue Cycle Components

- Clinical & Administrative Functions must Work Together
- Requires Behavioral Healthcare Management Information Software
- Based on the Amount of Specific Individual Services Provided
- Demands a Defined Process before Revenue is Recognized
- Demands a Timeline for Activity Completion Prior to Billing
- Cycle Completed when Cash Received, or Legitimately Denied by Payer

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Financial Management

- Assessing Your Grant Dollars Based on MRO Service Definitions
- Assessing the Volume of Services Currently Being Delivered
- How will Current Service Levels Translate into Revenue?
- Will Current Volume Levels Financially Sustain your Organization?

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Financial Management: Tools

- Cash Flow Tracking in FFS: Review Example
- Assessing Program Viability
- Productivity Standards: Review Example
- Budgeting in a FFS Environment
- Calculating Cost of Service: Compare to Medicaid Rate Schedule (Not Yet Available): Review Example

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Internal Controls

- Electronic Tracking System for Consumer Enrollment to Services
- Electronic Tracking System for Service Plans
- Electronic Tracking System for Capturing all Services Provided
- Deadline for Service Activity to be Completed and Service Tickets or Service Data Available for Billing
- Appropriate Monitoring of Accuracy for Billable Activities (Quality Control/Review)
- Must be a Management Mandate

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Financial Intake

- Begins at the “Front Door”
- All Staff must Understand the Importance of the Financial Intake in Revenue Collection
- Clinical and Fiscal Staff must be Adequately Trained on the Financial Intake Process
- Software Functionality Helps
- Accurate Payer Data Collection is a MUST

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Billing FFS is a Process

- Eligibility: Medicaid or Grant
- Ongoing Benefit Verification
- Tracking Spend Down
- Tools to Monitor Timeliness and Accuracy of Data Prior to Billing (Information System)
- Consistent Billing Cycle/Schedule to Maximize Cash Turn Around Time
- Clinical Information, such as Diagnosis is Important to Claims Collection
- Denials, denials, denials

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Billing FFS is a Process

- Feedback Loop for Denials and Write-Offs
- Consistent monitoring & follow-up
 - Accurate and Detailed Aged-Receivable Reports
 - Denial Reports by: Payer, Client, Service Code
 - Calculate and Track Days in Receivable
 - Cash Collection Rates

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Sample Report: Days in AR by Fund Source

Description	Total Due	0 - 30 Days	Days in A/R
Self Pay	\$1,122,310.00	\$113,940.11	269.86
Medicare	\$354,617.32	\$96,345.45	100.84
Medicaid/Crossovers	\$46,530.53	\$7,071.51	180.27
Medicaid	\$228,610.00	\$136,077.53	46.02
Commercial Insurance	\$293,982.36	\$61,760.51	130.41
Other	\$121,137.00	\$13,370.53	248.22
Total	\$2,167,187.21	\$428,565.64	138.54
Total Accounts Receivable	\$3,006,000.00		

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Sample Report: Denials by Reason

Payment Denial Report

(Remittances Processed 12/1/04 to 12/31/04)

<u>Denial Reason Code</u>	<u>Code Description</u>	<u>Total Dollars Denied</u>
1	No Benefits	\$891.00
2	Non-Covered Service	\$0.00
3	No Authorization	\$260.00
4	Non-Credentialed Staff	\$280.00
5	Billing Error	\$0.00
6	Non-Collectable Self Pay	\$0.00
7	Other	\$0.00
Total Dollars	National Council Consulting Services	\$1,431.00

Payer Mix

- Focus will be Medicaid & DMHAS Grant
- Measure Payer Mix Based on Revenue/Dollar Value of Service Provided
- Identify split between Medicaid & Grant
- Payer Mix is Important in Developing Internal Systems
- Monitoring Alerts your Organization when System Changes are Required (i.e. Change in Medicaid rates)

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Billing FFS is a Process

- Consistent Monitoring & Follow-Up
 - Unbilled Services
 - Self Pay Charges (Sliding Fee Schedule)
 - Allowance for Doubtful Accounts

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Coding Basics (Service & Diagnostic)

- Know What Services your Agency Delivers:
Comprehensive Array of Services, Specialty Provider
- Know Which Staff can Deliver Which Services
- How do you Know you are Billing for the Service that was Delivered?
- Who is Responsible for Diagnostic Review for Appropriateness?

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Payer Rules

- Connecticut Medicaid MRO Rules: ACT & Community Support
- FFS Billing Rates: Fee Schedules, Maintenance
- What is a “Non-Covered” Service?
- Non-Medicaid Covered Clients

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Medicaid Rules in Connecticut

- Who is “Payer of Last Resort”?
- Self Pay and Sliding Fee Scales
- Medicaid Spend Down Tracking
- Collecting Self Pay Amounts, Monthly Statements
- Practice Management Software Capabilities

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Coordination with Clinical Service Delivery

- Billing Department's Defined Role & Responsibilities
- Service Providers' Defined Role & Responsibilities
- Proper Internal QA Process Prior to Billing
- Staff Training in Understanding of Requirements for a "Billable" Service
- Consistent Follow-Up, Monitoring and Training

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Accounts Receivable Management: FFS

- FFS Requires Individual Client Accounting System
- Client Accounting System Provides A/R to be Reflected on G/L
- Components of an Effective Month-End Close Process
- Procedures for Processing & Posting of Cash Receipts
- Procedures for Processing, Tracking & Reporting Claim Denials

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Accounts Receivable Management: FFS

- Procedure to Identify, Monitor, & Consistently Perform Write-Offs
- Clean Accounts Receivable = Higher Percentage of Cash Collection
- Process to Balance Client Accounts Receivable to G/L
- Process to Balance Client Cash Receipts to G/L
- Monitoring of Days in A/R: Monthly Calculation

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Getting Started

- Management Information Systems are Major Components of any Transitional Planning Process
- Assess Current Information Systems:
 - Manual Systems must be Replaced with Behavioral Healthcare software Applications
 - Current Electronic Information Systems must be Evaluated for Performing Required Functionality for FFS
 - Identify Benchmark Data & Process for Tracking

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Getting Stated

- Pursue the Purchase of Behavioral Healthcare System or Upgrade of Current System
- Utilize the Readiness Assessment Tool as a Guide
- Use your Organizational Data from the Assessment Tool to Review Information System Options Available

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Accounts Receivable Tool Kit

(Excerpts from “Realizing Your Viability – The Tenets of A Successful Organization”)

- Components of an Effective Month-End Close Process
- Procedure for Processing and Posting Cash Receipts
- Procedure for Processing, Tracking and Reporting Claim Denials
- Procedure to Identify, Monitor and consistently Perform Write-Offs
- Process to Balance Patient Accounts Receivable to the General Ledger
- Process to Balance Patient Cash Receipts to the General Ledger
- Calculation of Days in Account Receivable
- Example of Days in Accounts Receivable by Funding Stream

An Effective Month-End Close Process

Centralized Billing Office responsibility:

Private Pay Review

- Run final Service Ticket Control Log through the month end date.
- All Service Tickets must be accounted for before Month End procedures can continue.
- Run Audit Report for all services that were recorded in Self Pay for the month by client.
- Review each client to determine if these services, in fact, should be recorded to Self Pay. If not, make eligibility information changes and include in recalculation of fees process.

Recalculation Process

- Run audit report to check all other payers.
- Review for reasonableness number of services, dollar amounts, etc.
- Review any New Admissions to Ensure Accurate Eligibility information.
- Make any Eligibility information changes needed.
- Recalculate Fees.
- Run other audit reports to validate required data elements for billing, i.e. Diagnosis.

Balancing Cash

- To balance cash, Centralized Billing will make use of daily cash logs; the general ledger functions of your accounting software, journal entry information from accounting, and other accounts receivable reports/tools you have available. (**See Balancing Cash Instructions**)
- Daily Deposits can be tracked by a spreadsheet for Patient related deposits with a running monthly total to be use for balancing each day's cash as it is posted to client accounts. This total will be compared to the total of the general ledger cash account(s) in the Cash Receipts Journal.
- If these totals do not agree, then proceed to the detail of the general ledger cash account. Compare this detail to the detail of the journal entries and amounts noted on the daily cash logs.

Balancing Accounts Receivable (See Balancing Checklist):

- Centralized Billing will review a preliminary Summary Aged Receivable report.
- This review is to determine if any payers are appearing on the report with incorrect fees for the month and if there are any notable outliers that should be researched further before month-end close.

- Centralized Billing will perform any adjustments deemed necessary with the approval of the supervisor based on this preliminary review.
- Once cash receipts are balanced to the general ledger and the preliminary review of the Aged Receivable report is complete, Centralized Billing will perform any additional recalculation of fees that is necessary.
- Then the Aged Patient Accounts Receivable will be balanced to cash receipts on the General Ledger.
- If your Patient Account Receivable software has the ability, run an audit report to determine if any patient accounts are out of balance.
- Prepare a “Cash Collections Report” by payer and provide to the Supervisor for review and feedback.
- Prepare an “A/R Balance & General Ledger Allowance for Non-Collectable Report” and provide to the Supervisor for review and feedback.
- Prepare a “Write Offs/Adjustments to Accounts Receivable Report” and provide to the Supervisor for review and feedback.
- Prepare the “Days in Receivable by Payer” to the Supervisor for review and feedback. **(See Attached)**
- The Centralized Billing will perform all the above functions by the fifth working day of the month following close.

Receipt of Cash Logs

Centralized Billing responsibility:

- Centralized Billing will receive a copy of all cash logs and enter them into spreadsheet for daily and monthly tracking.
- Centralized Billing will document on spreadsheet when each individual day's cash is posted to client accounting.
- The cash spreadsheet will be sent to the Supervisor on a daily basis to keep them informed of the status of cash being posted. The cash spreadsheet will be sent to the Comptroller (or Finance Officer) on a weekly basis for cash management purposes.
- At month end after all client cash has been posted and balanced a copy of the spreadsheet with monthly totals will be forwarded to Finance Officer and Comptroller.

Processing Cash Receipts

Centralized Billing responsibility:

- After receiving all cash logs, Centralized Billing will post all Clients accounting cash. Cash receipts will be divided into two categories: Patient Receipts and Miscellaneous Receipts.
- Patient cash receipts are those cash receipts from clients or third party payers intended to reduce the balance of Patient Accounts Receivable. These will be entered through the cash application process of your Patient accounting software.
- Every batch of cash posted will be balanced to that days cash receipt log. The payer and amount of the amount posted will be included on the log.
- Miscellaneous cash receipts are those cash receipts that do not affect the Aged Receivable. These receipts will be entered through the journal entry function of your General Ledger software package.
- The journal entry number and amount will be noted on the cash log for which it is created.
- Once all data entry for a cash deposit dates is complete, this total will be compared to the spreadsheet for that day to ensure that all cash logged is entered in the computer.
- Centralized Billing and the Comptroller will determine all deadlines for the functions listed above jointly.

Processing & Tracking Denials

Centralized Billing responsibility:

- Denials will be processed as received. All denials received for a given month should be processed within the same time frame that cash is to be posted.
- Research should be done to determine if the claim can be corrected and resubmitted or if the fee should be written off.
- If the claim can be corrected and resubmitted, it should be done immediately.
- Centralized Billing will work with the various offices, program directors and providers during this research and correction.
- If the service must be written off, denial codes should be used. Centralized Billing and the Comptroller will determine denial codes jointly.
- Centralized Billing will provide a Denial Report monthly. The report will detail the number of services written off for specific reasons and the dollars associated with these write offs. This can be tracked in a spreadsheet to show monthly comparisons and YTD totals.

Centralized Billing Supervisor responsibility:

- The Supervisor will ensure all denials are submitted to Centralized Billing in a timely manner.
- The Supervisor will be able to use the Denial Report to monitor staff credentialing problems, authorization problems, data entry problems, etc.
- The Supervisor will report problem areas to management and provide any possible corrections to services using the Denial Report as a resource so Centralized Billing can resubmit charges for reimbursement.
- The Supervisor will offer feedback as to any services that may be written off in error that can be resubmitted for reimbursement.

Process for Accounts Receivable Write-Offs

Centralized Billing Supervisor Responsibility:

- On a weekly basis accounts will be identified needing dollar amounts written off the Accounts Receivable by the Centralized Billing Supervisor.
- As these accounts are identified they will be added to a Saved List.
- Weekly an Aged Accounts Receivable Report will be processed using the Saved List created and printed.
- Documentation will be provided on the Aged Receivable Report identifying the reason for the write-off.
- Once all documentation is noted on the Aged Receivable Report, the report will be forwarded to Controller (CFO can determine if other than Controller) for review and approval. No write-offs, other than normal contractual adjustments, will be written off without approval by the Controller.
- Controller (CFO can determine if other than Controller) will approve each account individually and his or her signature is required on the Aged Receivable Report beside the clients' name before the account is written down.
- When the review is complete and approval documented the report will be given back to Accounts Receivable staff to perform the actual write-off of the clients account on the Client account system.
- After completing the write-off, the dollar amount and reason for the write-off must be notated in a tracking system (ideally in a database). This is consistent with all other efforts to manage the Accounts Receivable and provides documentation in one place.
- A file is to be maintained for each calendar year providing documentation of all write-offs for the annual audit.

A/R BALANCING OUTLINE

1. Recalculate Fee's to ensure accuracy of Revenue and A/R by Payer.
2. Run any processes required for special fee calculation and billing. (I.e. bundling of total charges per day)
3. Run Preliminary Aged Receivable to see if there are any Payers being used incorrectly (check totals only).
4. After all clean up of A/R is complete, all cash for that month is entered and balanced, and all Service Tickets are entered; Reports can be run to create journals for recording Revenue and Cash Received.
5. Post all activity to the General Ledger.
6. Run General Ledger balances from the G/L software and compare to Patient Accounting activities for the month.
7. Research any discrepancies and make correcting journal entries and repost.
8. If available, run report from your client accounting software that checks if the client accounts balance reflecting all activity correctly.
9. Run a final Aged Receivable and a final General Ledger Listing and compare to balance.

CASH BALANCING PROCEDURE

- Make sure all daily cash logs are posted for the time period for which you wish to balance.
- Post all Cash Journal Entries for the time period you are balancing.
- Check the totals of your spreadsheet against the total amount posted in the Cash Account by displaying the Account Balance in your General Ledger software package. The total for the month you are balancing should equal the total on your spreadsheet.
- If your totals do not match you will need to individually check off each Daily Cash Log amount to the General Ledger Cash Account. Run a General Ledger Trial Balance Report for the detail of the Cash Account to compare to and find the error in posting.
- Check off each Journal Entry on the G/L Report to make sure it is posted to the correct cash account and for the correct dollar amount. Depending upon the error a General Ledger Journal Entry or Cash Journal Entry may have to be made to correct the problem.
- After all accounts are balanced to the spreadsheet make copies of the Account Balance/Trial Balance Report for each cash account and attach the spreadsheet for that account number to that page to keep for closing documentation.

Calculation of Days in Account Receivable

- Total Patient Aged Accounts Receivable Divided by the 0 – 30 Day Column Divided by .0365

Example: 3,000,000 divided by 640,000 = 4.68
 4.68 divided by .0365 = 128.21

□ 3 Month Net Revenue	3,203,019
# Days Last Three Months	92
Factor	34,815
Net A/R per General Ledger	2,597,888
Net Days in A/R	74.61

Job Description

Actual Job Description for Alabama Provider

Job Title: Business Office Manager

Job Summary: To ensure that all financial and business office functions are completed accurately and timely following generally accepted accounting principals. This includes performing monthly accounting general entries and producing monthly financial statements.

Competencies:

1. Thorough understanding of budgeting process.
2. Working knowledge of generally accepting accounting practices.
3. Knowledge of vouchering and contract compliance issues.
4. Ability to establish and maintain rapport with staff members, board members, business and civic communities.
5. Proficient skills in computer operation.
6. Proficient skills in use of calculator.
7. Proficient verbal and written communication skills.
8. Good supervisory and training skills.
9. Understanding of and ability to effectively utilize accounting, budgeting and other financial functions.
10. Understanding and ability to effectively utilize management information systems.

Duties and Responsibilities:

1. Ensure that all assigned duties are implemented according to Indian Rivers Mental Health Center policies and procedures.
2. Ensure that all assigned duties are implemented according to Department of Mental Health policies and standards.

Primary Functions:

1. Ensure all bank deposits, inter-fund transfers are completed.
2. Categorize all deposits by accounts and maintain cash receipts journal.
3. Monitor investments and transfer funds according to approved policy.
4. Prepare vouchers for funding for all contracts and grants.
5. Maintain documentation for all contracts and grants.
6. Ensure payroll operations are carried out in a timely manner and maximize efficiency.

7. Balance all Payroll Journal entries.
8. Ensure timely payroll tax deposits.
9. Ensure timely payment of payroll deductions.
10. Ensure timely 941 and W-2 preparation and filing.
11. Balance Payroll withholding accounts.
12. Balance all bank accounts.
13. Balance all Asset & Liability Accounts for monthly close.
14. Prepare monthly General Ledger Close Journal Entries as directed by Chief Financial Officer.
15. Prepare and assist in budget preparation.
16. Prepare monthly financial report for the Board of Directors and Division Directors Team.
17. Monitor insurance on property/vehicles and coordinate changes, additions and deletions to insurance program.
18. Ensure that client funds are audited and policies and procedures are followed.
19. Ensure that a property inventory system is maintained and followed to insure the protection of organization assets.
20. Ensure petty cash boxes are audited for accuracy and adherence to policies and procedures.
21. Assist in preparation of grant applications.
22. Ensure that the Fiscal Policies and Procedures Manual are revised annually.
23. Ensure that purchasing procedures and practices are in accord with state laws and streamlined for efficiency and cost effectiveness.
24. Supervision of investments to ensure maximum security and yield.
25. Ensure that the Center's financial records are audited by a certified public accountant that is approved by the Board and State Department of Mental Health.
26. Review fringe benefit programs annually in conjunction with Human Resources Director.
27. Provides supervision for Payroll functions, Accounts Receivable.

Understanding the Fees We Charge ***Representative Sample from Illinois Provider***

Our Center is a private, non-profit agency that provides behavioral health services in Illinois. We bill state and local government funding sources but these funds only cover a portion of the cost of services. For this reason all clients are asked to pay a Fee Share.

Your Fee Share is the amount you will be charged and expected to pay for services. What you actually pay for services may differ after insurance or government benefit payments are applied to your bill.

- Your fee share is determined using a sliding scale that considers public funding resources, residency in our service area and total family income.
- Total family income is income from all sources including wages, salary, child support, investments, employee pension and government benefits.
- We ask that all clients verify their income. Acceptable forms of income verification are:
 - a. copy of your latest tax return
and
 - b. 2 paycheck stubs or government benefit letter and card.
- Adjustments to our sliding scale fees are available when family size, economic hardship, or other factors make the fee share a barrier to needed services.
- We annually reassess fees to assure accuracy and fairness.
- More specific information about Insurance, Medicare, Medicaid and Kidcare coverage can be found on the back of this page.
- If you have questions or concerns about your fees or billing statements, always feel free to ask our staff to answer your questions. They may need time to check with our billing or insurance departments but they will get an answer for you or be able to direct you to the person who can answer your questions.

Thank you,

Indigence Determination Scale 11/17/05

Level	Household Income	Flat Fee Amount
1	\$0.00 to \$4,999	\$0.00
2	\$5,000 to \$9,999	\$5.00
3	\$10,000 to 19,999	\$10.00
4	\$20,000 to \$29,999	\$20.00
5	\$30,000 to \$39,999	\$30.00
6	\$40,000 and up	Full Fee

Household income is defined as follows:

- 1) The client is an individual living alone: count their income only.
- 2) The client is married living with their spouse: count combined income.
- 3) The client is an Adult child (18 or older) living with a parent: count client's income only.
- 4) The client is adult parent with an adult child living with them: count the parent's income only.
- 5) The client is living with any other person (not their spouse): count only the client's income.

CLINICAL PRACTICES POLICY
Representative Sample of Illinois Provider

SECTION: Client Care
CATEGORY: Continuum of Care
PRACTICE: Fee Setting
PAGE 1 OF 1
EFFECTIVE DATE: 6/7/05, REV 2/7/06 REV 4/5/06

PURPOSE: To ensure that fees are set uniformly.

PRACTICE: All clients will have fees for services set during the Screening appointment.

PROCEDURE: Fees for services will be set using the total income of the individual(s) requesting service and the Subsidized Fee Schedule.

There are certain circumstances when the process will be amended to better meet the needs of the clients. Those situations are:

1. Minors wanting 5 sessions without parental consent:
Income of individual requesting service, use of insurance waived.
2. Unmarried or Cohabiting couples:
Combined income when requesting couples treatment (even if one lives “out” of the service area)
If one of them has **MEDICAID:**
 - 1) Use the Fee Schedule and set a fee for the other person to cover the Assessment session(s). This also applies to the “out” person.
 - 2) If the “out” person wants other services (e.g., Individual Therapy, Case Management), they must pay FULL FEE.
 - 3) Bill as a Family Session (230) to the Medicaid client.

If one member of the couple requests an individual service and is “supported” in some fashion by the other i.e. has income, we use the income of the individual requesting and ADD \$15,000. This will apply to ALL couples married or not when the other party will not or can not help pay for services.

3. Separated or Divorcing Couple:
Income of individual requesting service (include any type of spousal/child support)
4. Adult Individuals (at least 18 years of age) :
 - A) SMI Adult living with parents or family members:
Use the income of the *individual* requesting service. When requested, family treatment is based upon the total family income unless it is needed to assess / treat the individual client.
 - B) Undomiciled individual:
Minimum fees with Scholarship available if no stated income.
 - C) Living w/ parents or family and not working:
Use \$15,000 as income.

- D) High school student living in the family home:
Total family income used unless clinically contraindicated.
- E) Reports being unemployed and no current income and living independently
(could be living off savings):
Use \$15,000 as income
- F) Fluctuating income due to seasonal work, sales (real estate e.g.) such that there
is no clear income and last year's income was either a hi or low year in terms of
income:
Use \$15,000 MINIMUM as income AND the fees will be re-evaluated quarterly..

Representative Sample from Georgia Provider
Aged Receivable as of 06/30/01

FS #	FS Name	Amount Due	Non-Appl.	0-30	31-60	61-90	>90
			Cash	Days	Days	Days	Days
1	PRIVATE PAY	\$238,163.08	-\$18,223.75	\$52,716.12	\$28,525.73	\$19,823.29	\$155,321.69
2	MATCH	\$992,886.60	\$0.00	\$961,902.52	\$14,396.62	\$5,633.46	\$10,954.00
3	EXCEL	\$143,110.00	\$0.00	\$143,110.00	\$0.00	\$0.00	\$0.00
6	ADVENTURE COBB DO	\$67.43	\$0.00	\$67.43	\$0.00	\$0.00	\$0.00
8	M.A.A.C.	\$46,970.03	\$0.00	\$37,267.96	\$0.00	\$0.00	\$9,702.07
9	AL CALHOUN CO DHR	\$9,389.10	\$0.00	\$9,389.10	\$0.00	\$0.00	\$0.00
11	JJ DISTRICT 1	\$5,127.70	\$0.00	\$0.00	\$1,998.00	\$0.00	\$3,129.70
12	JJ DISTRICT 2	\$60,730.20	\$0.00	\$60,730.20	\$0.00	\$0.00	\$0.00
13	JJ DISTRICT 3	\$15,648.50	\$0.00	\$0.00	\$0.00	\$0.00	\$15,648.50
14	JJ DISTRICT 4	\$18,392.47	\$0.00	\$13,385.10	\$0.00	\$0.00	\$5,007.37
15	JJ DISTRICT 5	\$9,389.10	\$0.00	\$9,389.10	\$0.00	\$0.00	\$0.00
16	JJ DISTRICT 6	\$11,892.86	\$0.00	\$9,702.07	\$2,190.79	\$0.00	\$0.00
20	STATE OF MICHIGAN	\$18,903.90	\$0.00	\$0.00	\$0.00	\$0.00	\$18,903.90
26	OTHER STATE	\$160,383.84	\$0.00	\$75,881.07	\$53,778.17	\$19,243.20	\$11,481.40
29	MEDICAID	\$13,774.29	\$0.00	\$7,349.79	\$1,759.50	\$880.00	\$3,785.00
30	OTHER INSURANCE	\$186,360.00	\$0.00	\$34,895.00	\$21,830.00	\$27,475.00	\$102,160.00
31	CHAMPUS TRICARE	\$133,937.50	\$0.00	\$42,187.50	\$33,725.00	\$15,605.00	\$42,420.00
32	BC FED	\$55,155.00	\$0.00	\$25,820.00	\$24,460.00	\$0.00	\$4,875.00
33	AETNA	\$1,150.00	\$0.00	\$575.00	\$100.00	\$125.00	\$350.00
34	CIGNA	\$149,495.00	\$0.00	\$16,225.00	\$12,470.00	\$10,815.00	\$109,985.00
36	GUARDIAN	\$5,250.00	\$0.00	\$0.00	\$0.00	\$0.00	\$5,250.00
39	CAMERON	\$24,140.00	\$0.00	\$7,140.00	\$8,500.00	\$8,500.00	\$0.00
40	BC AL	\$18,827.00	\$0.00	\$1,607.00	\$0.00	\$0.00	\$17,220.00
41	GA ST MERIT	\$57,325.00	\$0.00	\$14,160.00	\$13,275.00	\$7,980.00	\$21,910.00
43	BC/BS GA	\$11,280.00	\$0.00	\$300.00	\$425.00	\$325.00	\$10,230.00
50	CIGNA BEHAVIORAL	\$31,850.00	\$0.00	\$10,850.00	\$10,500.00	\$10,500.00	\$0.00
52	VALUE OPTIONS	\$114,027.50	\$0.00	\$27,475.00	\$15,650.00	\$9,100.00	\$61,802.50
53	MAGELLAN	\$127,151.00	\$0.00	\$35,870.00	\$34,525.00	\$830.00	\$55,926.00
54	UNITED BEHAVIORAL	\$116,211.00	-\$95.00	\$41,125.00	\$33,010.00	\$1,250.00	\$40,921.00
57	ANHEUSER BUSCH	\$7,800.00	\$0.00	\$0.00	\$2,400.00	\$5,400.00	\$0.00
58	PHCS	\$30,665.00	\$0.00	\$8,000.00	\$10,000.00	\$12,000.00	\$665.00
60	CHOICE BEHAVIORAL	\$38,160.00	\$0.00	\$29,880.00	\$8,280.00	\$0.00	\$0.00
99	SCHOLARSHIP	-\$1,500.00	-\$1,500.00	\$0.00	\$0.00	\$0.00	\$0.00
	Total	\$2,852,113.10	-\$19,818.75	\$1,676,999.96	\$331,798.81	\$155,484.95	\$707,648.13

DC MRO Staff Productivity/Revenue Projection:

	Service Provided	MHRS Code	Hrs per year	Less Time off Estimate Hrs *	Total Hrs Available	Minimum Productivity 50% or 20 Hrs/Wk	Billable Units	Unit Rate	Revenue Generated
FT Staff Providing Services:	CS - Individual	DMH05	2080	240	1840	920	3680	\$20.10	\$73,968.00
	CS - Group	DMH04	2080	240	1840	920	3680	\$8.67	\$31,905.60
	Med/Som - Ind.	DMH03	2080	240	1840	920	3680	\$32.47	\$119,489.60
	Med/Som - Group	DMH02	2080	240	1840	920	3680	\$19.33	\$71,134.40
	Counseling/On-Site	DMH12	2080	240	1840	920	3680	\$16.25	\$59,800.00
	Counseling/Off-Site	DMH13	2080	240	1840	920	3680	\$23.19	\$85,339.20
	Counseling/Group	DMH11	2080	240	1840	920	3680	\$10.45	\$38,456.00

* Liberal estimate of total time off for Sick, Vacation, Holidays, etc.

Instructions: For Fee For Service Revenue, put in # of Services Rate - Revenue, Allowances & Bad Debt will Calculate Automatically).
 For Non-Fee for Services Revenue such as contracts, type in the amount.
 For Expenses, Go to Staffing Spreadsheet & Type in Position, Houly Rate, % FTE (IE: 1.00/.80, Etc.) Salary will Calculate & Automatically be sent to P&L Sheet. Benefits & Some Other Expenses, Including Overhead will calculate Based on Salaries Review Expenses for Items such as Medical Specialist which do not calculate automatically
Staffing & Revenue are Inserted for Example Only, Those should be Changed to zero before beginning.

Performa for New Business
Representative Sample from Ohio Provider

<u>Budget A/C</u>	<u>Item</u>	<u>Amount</u>	<u># Services</u>	<u>Rate</u>
<u>Revenues</u>				
4101	Medicare Revenue	0		
4102	Medicaid Revenue	90,000	1,000	90
4105	Educational Service Revenue	0		
4107	Juvenile Court Revenue	0		
4108	Insurance Revenue	0		
4110	Client Pay Revenue	0		
4111	Local Grant	0		Insert Grant Amount
4112	Miscellaneous Revenue	0		Insert Misc. Amount
4113	Donations	0		Insert Donations Amount
5001	Medicare Allowances	0		
5002	Medicaid Allowances	-6,300		
5005	Montgomery Co. Educational Service Allowance	0		
5007	Juvenile Court Allowance	0		
5008	Insurance Allowance	0		
5010	Client Pay Allowance	0		
5013	Contractual Allowance for Bad Debt	-5,441		
	Total Revenue	<u>78,260</u>	<u>1,000</u>	
<u>Expenses</u>				
6000	Salaries & Wages	50,369		
6001	Accrued Vacation	0		
6100	Social Security	3,853		
6105	Alocated Fringe Benefits	6,917		
6160	Tuition Refunds	0		
6161	Employee Certification	0		
6175	Child Care	0		
6180	Employee Meetings & Refreshments	0		
6190	Employee Relations/Satisfaction	0		
6200	Audit Fees	0		
6211	Bank Service Charges	0		
6220	Medical Specialists	0		
6250	Accredation Fees	0		
6270	Taxes & Licenses	0		
6355	Patient Foods	10		
6360	Drugs	0		

Representative Sample from Ohio Provider

<u>Budgeted A/C</u>				
<u>Number</u>	<u>Item</u>	<u>Amount</u>	<u># Services</u>	<u>Rate</u>
6385	Occupational Therapy	0		
6450	Recreational Therapy	0		
6460	Housekeeping Supplies	35		
6462	Towels & Other Paper Products	65		
6463	Cleaning Supplies	15		
6470	Laboratory	0		
6490	Maintenance Supplies	0		
6491	Electrical Supplies	15		
6501	Microfilming	0		
6540	Office Supplies	0		
6541	Labels	201		
6543	Photocopying -IKON	0		
6550	Photocopying (IKON Lease Expense)	0		
6551	Special Printing	91		
6570	Contracted Printing/Relizon	96		
6573	PC Accessories & Software	212		
6590	Service Contracts	0		
6600	Software Maintenance	207		
6601	Repair & Maintenance - Buildings	0		
6610	Repair & Maintenance - Grounds	463		
6611	Repair & Maintenance - Furn. & Equipment	76		
6620	Contract Services - Non Physician	136		
6621	Repair & Maintenance - Auto	0		
6625	Electricity	0		
6630	Gas	504		
6640	Water & Sewage	393		
6650	Telephones	20		
6680	Cellular Telephones	428		
6681	Long Range Beepers	0		
6682	Local/Long Distance Calls	0		
6683	Telephone Installation	0		
6686	Telephone Equipment Lease/Installation	0		
6687	Dues	0		
6700	Travel - Direct Service Related	76		
6701	Travel - Meetings, Education - Staff.	353		
6702	Rental - Equipment	201		
6710	Rental - Property	0		
6711	Pest Control	0		
6730	Property Insurance	35		
6740	Liability Insurance	0		
6809	Training Material	408		
6811	Periodicals	0		
6812	Auto Expense - Oil & Gas	0		
6840	Depreciation	15		
6860	Gifts & Donations	1,526		

Representative Sample from Ohio Provider

<u>Budgeted A/C</u>					
<u>Number</u>	<u>Item</u>	<u>Amount</u>		<u># Services</u>	<u>Rate</u>
6870	Postage	0			
6890	Special Events	10			
6901	Community Relations	0			
6902	Telephone Yellow Page Listing	10			
6924	Classified Advertising	0			
6926	Small Equipment	0			
6940	Purchased Services	25			
6960	Purchased Labor - Non Clinical	126			
6963	Purchased Services - Labor	0			
6964	Waste Removal	0			
6965	Housekeeping Outside Services	35			
6966	Patient Transportation - Taxi-RTA	625			
6969	Freight Charges	0			
6970	Freight - Non Stock	0			
6971	Courier Services	0			
6972	Wearing Apparel	0			
6973	Security	0			
6974	Meals - Catered	0			
6999	Total Expenses	<u>0</u>			
		<u>67,551</u>			
9999	Overhead	<u>14,388</u>			
	Profit/Loss	<u>-3,680</u>			

Example from BMS Tool Kit
Representative Data from Georgia Provider

Revenue/Cost per Service Report

Name	Direct Expenses	Education	Pharmacy,Clinic Transportation,	Facility	Administration	Total Costs	Services	Direct Cost Per Unit	Overhead Per Unit	Cost Per Unit With Overhead	YTD Average Fee Per Unit
Residential Stabilization	\$12,641.87	\$439.88	\$2,743.42	\$1,838.46	\$1,983.29	\$19,646.92	58	\$304.55	\$34.19	\$338.74	\$405.56
Group Home #1	\$47,052.46	\$0.00	\$6,283.12	\$2,884.18	\$8,114.69	\$64,334.45	300	\$187.40	\$27.05	\$214.45	\$145.85
Group Home #2	\$16,880.44	\$0.00	\$1,939.89	\$1,034.72	\$2,910.08	\$22,765.13	29	\$684.66	\$100.35	\$785.00	\$1,102.55
Adult Program #1	\$163,551.82	\$20,621.71	\$18,104.42	\$25,365.65	\$25,631.18	\$253,274.78	866	\$262.87	\$29.60	\$292.47	\$324.04
Adult Program #2	\$93,714.17	\$28,472.00	\$25,337.81	\$35,500.19	\$14,709.98	\$197,734.15	1212	\$151.01	\$12.14	\$163.15	\$114.33
Adult Outpatient Services	\$34,079.02	\$0.00	\$0.00	\$0.00	\$5,274.02	\$39,353.04	409	\$83.32	\$12.89	\$96.22	\$88.58
Total	\$367,919.78	\$49,533.59	\$54,408.66	\$66,623.20	\$58,623.24	\$597,108.47	2874	\$187.36	\$20.40	\$207.76	\$232.00

Cash Flow Projection

28-Feb-05		852,977
Estimated March Cash Receipts		
Medicaid	107,936	
Medicare	57,356	
Insurance	3,917	
Grant/Misc.	984,573	
		1,153,781
Estimated March Expenses:		
Accounts Payable	544,322	
Payroll	475,814	
		1,020,136
Cash Balance March 31,2005		<u><u>986,622</u></u>
Estimated April Cash Receipts		
Medicaid	107,936	
Medicare	57,356	
Insurance	3,917	
Grant/Misc.	879,958	
		1,049,167
Estimated April Expenses:		
Accounts Payable	544,322	
Payroll	713,722	
		1,258,044
Cash Balance April 30,2005		<u><u>777,745</u></u>
Estimated May Cash Receipts		
Medicaid	107,936	
Medicare	57,356	
Insurance	3,917	
Grant/Misc	879,958	
		1,049,167
Estimated May Expenses:		
Accounts Payable	544,322	
Payroll	475,814	
		1,020,136
Cash Balance May 31,2005		<u><u>806,776</u></u>
Estimated June Cash Receipts		
Medicaid	107,936	
Medicare	57,356	
Insurance	3,917	
Grant/Misc	879,958	
		1,049,167
Estimated June Expenses:		
Accounts Payable	544,322	
Payroll	475,814	
		1,020,136
Cash Balance June 30, 2005		<u><u>835,807</u></u>
Estimated July Cash Receipts		
Medicaid	107,936	
Medicare	57,356	
Insurance	3,917	
Grant/Misc	879,958	
		1,049,167
Estimated July Expenses:		
Accounts Payable	544,322	
Payroll	475,814	
		1,020,136
Cash Balance July 31, 2005		<u><u>864,839</u></u>
Estimated August Cash Receipts		
Medicaid	107,936	
Medicare	57,356	
Insurance	3,917	
Grant/Misc	879,958	
		1,049,167
Estimated August Expenses:		
Accounts Payable	544,322	
Payroll	475,814	
		1,020,136
Cash Balance August 31, 2005		<u><u>893,870</u></u>
Estimated September Cash Receipts		
Medicaid	107,936	
Medicare	57,356	
Insurance	3,917	

Cash Flow Projection

Grant/Misc	879,958	
		1,049,167
Estimated September Expenses:		
Accounts Payable	544,322	
Payroll	713,722	
		1,258,044
Cash Balance September 30, 2005		684,993

Decision Support Tool for Grant-Funded Providers Moving to Medicaid Rehabilitation Option Services in Connecticut

This decision support tool was developed to assist a provider in estimating additional infrastructure costs related to moving from grant-funded case management to a Medicaid, fee-for service rehabilitation model of community support. The tool provides the provider with a breakdown of positions/functions required as part of the needed infrastructure.

The specific allocation between positions/functions can vary from one provider to another. Key functions required are:

- Data Entry/Billing Function for Fee For Service
- Clerical Support
- Quality Assurance
- Medical Records
- Information System Support
- Clinical Team Leaders

The tool also provides basic estimates for other related costs required for the MRO Business Model.

- Computer Equipment
- Software
- Internet Connection and other communication cost.

Using the Tool:

The tool is based on a Microsoft Excel spreadsheet.

- The provider is required to complete four key pieces of information and the tool will provide estimated costs based on this information. Enter information only into the yellow cells on the spreadsheet. The green cells are automatically generated.
 - Number of active clients receiving case management
 - Estimated total number of service hours provided for all case management clients per week;
 - Standard work week hours for case management staff;
 - Hourly Staff cost including benefits. (for positions that you do not currently have, estimate the hourly cost based on what you think it would take to recruit and retain that person. If you are planning on an existing staff member taking over a particular function, list that person's salary and benefits. For example, you may have a receptionist/clerk who can take over some data entry functions for billing.)
- The primary data factors used to perform key calculations are as follows:
 1. The number of clients being served (given 25% weight toward the calculation);

2. The volume of services provided (given 75% weight toward the calculation);
 3. Team Leader requirements are based on service volume only: 1 FTE for every 170 hours of services or 680 units.
- “Total other cost” is based on the number of FTE’s calculated from the top portion of the tool.

What the Results Mean:

- This tool assumes NO current infrastructure in the staffing areas listed. Therefore, if the organization already has some support in a given area, they can subtract that from the estimate to get what they would need to add.
- Example:** An organization has a half-time FTE working in Medical Records. The tool suggests that 0.75 FTEs are needed for this function. The organization would thus only need to add 0.25 FTE.
- This tool provides an estimate of required resources across a year, based on the consulting teams’ experience with providers in more than 40 states, It can be used as a starting point to identify key infrastructure needs. Estimates err on the generous side of the equation.
- Obviously there are other factors besides number of clients and volume of services that play a part. For example, an organization with multiple sites might require more computer or internet resources than one in a central location. Other factors include:
1. Current state of automation and electronic connectivity in an organization.
 2. Baseline experience of staff and sophistication of systems. For example, organizations where deadlines have not existed (or not been enforced) relative to turning in billing information may need more staff resources initially to change that practice.
 3. Full-time versus part-time staff. This tool calculates based on FTEs. Organizations with larger numbers of part-time staff may find that they need more infrastructure for tracking and processing than if the same number of FTEs were full-time.
 4. Prior experience: organizations with more experience in a given function (for example, billing, medical records, quality assurance, data entry) are usually better equipped to expand that function than are organizations that have to build the function from scratch.
 5. Building or changing any functions requires more resources during the building/changing process than are required for ongoing operations.

