

# Baseline Readiness for Medicaid Rehabilitation Option Implementation

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DMHAS MH Providers  
March 14-15, 2006

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## Purpose

- Describe provider operational competencies for success in a changing environment
  - Providers can implement many of these processes prior to conversion to FFS
- Understand the process for and content of the Baseline Readiness Self-Assessment Tool
- Describe typical processes and patterns associated with changing to Medicaid reimbursement and fee-for-service

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## What to Expect As Payer Requirements Change

*While each state has unique circumstances, changing payer requirements do have trends that transcend state boundaries*

- Transition is a process not an event
- Transition is not linear
- Transition is a 3-5 year process to achieve restabilization
- Transition will require more 'supports' than expected
  - Supports = \$\$ and technical assistance
    - Variety of funding for supports, including special appropriations, grants, absorb from within existing budgets
    - Provider Associations and provider budgets

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## Provider Response to Change

- Accustomed to responding to specific payer requirements
- Less familiar with proactive development of competencies
  - Identification of good clinical, administrative and business practices
  - Adjust as needed based on new payer requirements

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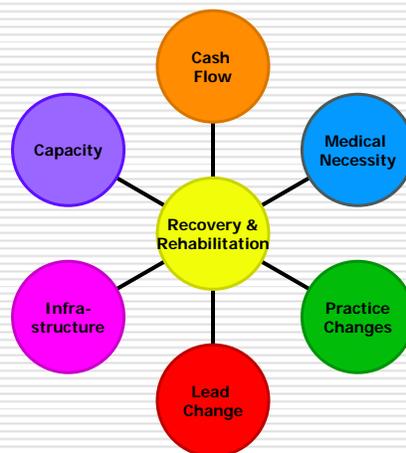


## CT Medicaid Funding Changes

- ❑ Any Willing (and Qualified Provider)
- ❑ Consumer Choice of Providers
- ❑ Catchment areas
- ❑ Two funding streams for ACT and Community Support: Medicaid and DMHAS grants
- ❑ Change from “slots” to capacity
- ❑ Change from fixed and predictable revenue to revenue based on billing levels
- ❑ Pre-payment to post payment
- ❑ DMHAS moving from funding programs to purchasing services

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## Core Competencies



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## Recovery & Rehabilitation

- Express Commitment to Recovery
  - Vision/Mission
  - Policies & procedures
- Training of Staff in Recovery Principles & Practices
- Meaningful Involvement of Clients in Policy, Operations, and Practice
- Meaningful Involvement of Clients and Families in Their Own Care

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## Lead Change: The Board

- Board actively drives the expectation of change, sets goals and outcomes for the change process, and monitors progress of the change process.
- The Board includes business, consumer, and service-oriented members
- Board educated to policy implications of changes
- Board serves as a buoyant force, rather than a drag
- Board anticipates future directions and needs

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## Lead Change: Management

- View selves as Change agents who actively plan, lead, and facilitate change as opposed to resisting or turfing
- Promote and model accountability at all levels of organization
- Promote problem solving not blaming
- Active decision makers
- Tolerance for ambiguity: act and adjust
- Build integrated approach: financial, administrative & service
- Demand and use data to quantify, prioritize and focus issues
- Ask hard and strategic questions: Buy? Build? Partner? Reorganize? Do at all?

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## Lead Change: Communicate

- No Surprises
- Honesty, honesty, honesty
- Clear & multiple communication plans and vehicles
- Identify all key stakeholders and communicate with each:
  - Board, Staff, Clients, Community, others
- Process not event
- Multiple repetitions

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## Manage Cash Flow

- Key to survival in fee-for-service (FFS)
- Cash Reserves: Days-of-Cash a Key indicator.
  - Ideal: 60-90 days
  - For CT: 60-90 days of the proportion that is converting to FFS
- Manage costs and revenue, rather than just expenses

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## Manage Cash Flow: Benefits

- Eligibility verification upon intake and monthly thereafter
- Sliding Fee Scales
- Manage spend downs
- Coordination of Benefits (not huge issue for ACT or Community Support)

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## Manage Cash Flow: Billing

- Submit Claims to EDS at least twice/month
- Electronic claims submission for faster receipt
- Ongoing, timely monitoring of performance
  - Timely billing of FFS provides better data and cash flow
  - Earning grant dollars
  - Achieving budget/productivity levels with periodic adjustments as needed
- Accounts Receivable Management
  - Reconciliation of amounts billed to receipts
  - Use results to adjust procedures, feedback loops
- Diversify revenue and funding

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## Manage Cash Flow: Billing Flows

- Controls to capture all services
- Monitored timelines for submission/data entry of service data
- Prompt and frequent (2x/month) billing
- Two key measures/indicators:
  - Service to date entered
  - Date entered to date billed
- Monitor those indicators by service, supervisor, staff person

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## Manage Cash Flow

- Integrated service note and charge ticket
  - Allows for easier billing audits: assures presence of note and all required elements before billing
  - Ensures consistency of data on billing and service forms
  - Billing audits (presence/absence) can be completed by support staff

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## Capacity

- Grant funding provides a certain amount of money to care for a certain number of clients
- FFS requires organizations to titrate staff resources in response to both the number of clients and their service needs
- Capacity management means ensuring ability to serve all the clients you have (or want)

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● Capacity & Cash Flow:  
● Productivity Management

- Scheduling for Achieving Productivity and Internal Controls
- Schedule for required productivity plus no-shows
- Clinical supervisor's role is critical
- Used as Internal control to ensure capturing all service tickets and service notes

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● Capacity & Cash Flow:  
● Productivity Management

- Schedules: First Step
  - Thursdays: collect schedules for next week
  - Fridays: Supervisor reviews and assists to fill
- Second Step: Match to treatment plans and service priorities
- Third Step: Build staff and client schedules together for treatment plan period

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 Capacity & Cash Flow:  
 Productivity Management

Scheduling Issues

- Use as Internal control to ensure receipt of all billing tickets
- Can be manual or electronic
- Move to centralized as soon as feasible
- Check length of time slots, geography, frequency
- Supervisors handle office-based needs such as crises to allow direct staff to maintain schedules

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 Capacity & Cash Flow:  
 Productivity Management

"Billable" time divided by available time

- Mix of FFS and grant-funded activities need to have defined billable/productive activities
- Available time = paid hours less paid time off, approximately 1,700 – 1,800 hours per year per FTE
- Meeting, travel, supervision, documentation time not included
- Translate requirements into hours per day and week.

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## Capacity & Cash Flow: Productivity Management

- Productivity Standards
  - 50-65% for community based services
  - 60-70% for office-based services
  - 75-85% for physician/nursing services
  - Non-billable activities are considered in formula
- Standards must reflect levels needed to maintain costs that can be supported by fees and funding
  - Will productivity standards cause costs to be less than or equal to rates?
  - Total program costs divided by total units – what productivity standard is required to attain needed units?
- Must have enough staff to produce revenue

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## Capacity & Cash Flow: Productivity Management

- Productivity Reporting
  - User friendly: graphs, simple reports
  - Regular and timely
  - Express as a percentage of available time NOT of target
  - Best to come directly from billing data
  - Hours or Units not dollars in mixed funding environments
- Clinical/Service Issue as well as financial one
  - Sets priorities for clinical practice

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- Capacity & Cash Flow:
- Productivity Management
- Supervision Critical
- Focus on providing structure and direction
- Focus on clinical/service priorities
- Remove non-revenue producing tasks

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- Capacity & Cash Flow:
- Productivity Management
- Productivity barriers
  - Lack of management support
  - Poor data or data integrity questions
    - No "side" systems
  - Unfriendly or untimely productivity reports
  - Poor or inconsistent supervision
  - Documentation
  - Inflated caseloads

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## Capacity: Access & Intake

### Key Goals:

- Clients (and potential clients) are quickly seen, assessed, and moved into services.
- Clients, potential clients, and referral sources see responsive system.
- All information necessary for billing is collected and verified.

### Track:

- Time from contact to entry into services

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## Capacity: Access & Intake

- 24-Hour rule
- Reduce Steps
- Initial Treatment Plans
- Collect Information ONCE and ACCURATELY
- Reduce redundancy

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## Capacity: Access & Intake

- Timely/responsive telephone triage, information, referral
  - rapidly and competently determines what clients need and matches them to the most appropriate service
  - Remember: clients have choices
- Timely, competent and balanced financial resource/eligibility screening and verification
  - Determines/facilitates client eligibility and funding resources
- Timely access to face to face assessments
  - new clients seen for assessment within five business days
- Availability of urgent/emergent assessment and intervention services
  - same day face-to-face assessments and same day psychiatrist appointments, especially for ACT
- Integration of authorization process with intake and access (if applicable)

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## Capacity: Access & Intake

- Coordination between clinical and specialty providers
- Communication of key information
- Speed and ease of coordination: key for client access and choice

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## Medical Necessity

- All Medicaid-reimbursed services must meet medical necessity criteria
- Must be consistent with service definitions
- Individualized: must be directly related to mental illness of each client
- Requires blend of clinical, rehabilitation, and recovery knowledge and expertise

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## Medical Necessity

- Direct links from diagnostic assessment to treatment plan to rehabilitation intervention to documentation
- Requires access to diagnostic and clinical approaches that may not have been present in past
- Supervision and systems essential to ensure

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## Medical Necessity: Compliance

### Goals:

- Internal processes and structures to ensure that all payor requirements – including medical necessity – are met
- Allows for “clean” billing
- Minimizes risk of paybacks
- Enhances payor satisfaction

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## Medical Necessity: Compliance How Tos

- Structured, effective, and ongoing monitoring systems in the following areas:
  - Medical Necessity: ensures clients have the level of medical necessity as required by payers
  - Benefits: types, duration, and exhaustion of benefits
  - Eligibility for benefits from various payers
  - Community-based productivity creep: ensures service duration or frequency is not overstated by clinicians in billing documents
  - Documenting supervision: ensures there is documentation of a supervision plan and that clinical supervision is occurring
  - Service Definitions: monitors that actual services being delivered are consistent with services as defined by payers
  - Documentation: monitors the accuracy, completeness, timeliness, and presence of supportive clinical documentation for all billed charges. Includes tracking of treatment plans dates/content and notes.
- Regularly communicates results of compliance monitoring efforts to senior management and the Board of Directors.

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## Practice Changes: Goals

- All staff can implement the services in alignment with the treatment plan AND with fidelity to service definitions AND aligned with billing rules
- Systems are in place to ensure medical necessity for services
- Philosophy is integrated into service
- Staff are able to be successful at meeting client needs AND meeting productivity targets

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## Practice Changes

- Treatment plan must be the roadmap for delivery of services
- Supervision is more than a signature on treatment plan – must direct practice
- Key data elements to track:
  - Treatment plan dates
  - Authorization (if necessary) or service unit use
  - Time from service delivery to documentation (Best practice = same day)

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## Practice Changes

- Training re: new services/rules is process not event
  - Complex skill set requiring complex skills training
- Training about recovery and impact on service delivery and process is essential
  - Must include how to operationalize concepts
- Linear relationship between functional assessment, diagnosis, service plan, services, interventions, notes
  - Supervise to this
- Enhanced role of consumer/family in service planning, interventions, and services with use of natural supports
- Majority of service units delivered in natural environment
- Productivity (billed time/available time)
- Supervision structure changes emphasis to treatment plan

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## Practice Changes: Documentation

- Medicaid will require a stronger base of documentation than may now exist
- Training on service-specific requirements will occur closer to implementation
- In general, will likely need to incorporate:
  - Individual notes reflecting an intervention and the client's response to it
  - Regular assessment of progress toward treatment plan goals and objectives
  - Date, time, place and duration of each individual intervention

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## Infrastructure: Organizational Relationships

- ❑ DMHAS goal is to maintain a mix of comprehensive and specialty providers
- ❑ Specialty providers will need formal affiliations with a variety of comprehensive providers to coordinate assessment, treatment planning and access to a variety of other services
- ❑ Certification requirements for providers of MRO ACT and Community Support services will detail how these relationships are structured.

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## Infrastructure: Information Systems

- ❑ Providers must have basic internal MIS capabilities
  - Good MIS decreases administrative costs in managing operations
  - Needs minimum billing and client tracking components
  - Clinical module can be next/last phase
- ❑ Staff access
  - Access to workstations and e-mail
  - Reports

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## Infrastructure: Information Systems

- Track key indicators
  - Service plan expiration
  - Absence/presence of notes
  - Productivity
  - No shows
- Facilitate timely processes, e.g. scheduling
- Reporting—timely and user friendly
  - Graphs, comparative, small number of fields/numbers

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## Recommended Approach to Survey

- Use paper version (downloadable from DMHAS website) for first cut of survey, then enter on-line when final
- Multi-disciplinary, line staff/supervisors, consumers
- Some agencies have each area self-assess, then combine into an organizational assessment – used for training, increasing awareness
- Use the results to inform internal development processes and plans

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## Instructions

- Indicate what actually happens most frequently NOT policies/procedures or management desires
- Be careful of multiple answers: all parts must be YES to answer YES
- If not applicable, answer NO
- We expect that many competencies are not yet present because they have not been necessary.
- This is not an audit!

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## Key Information

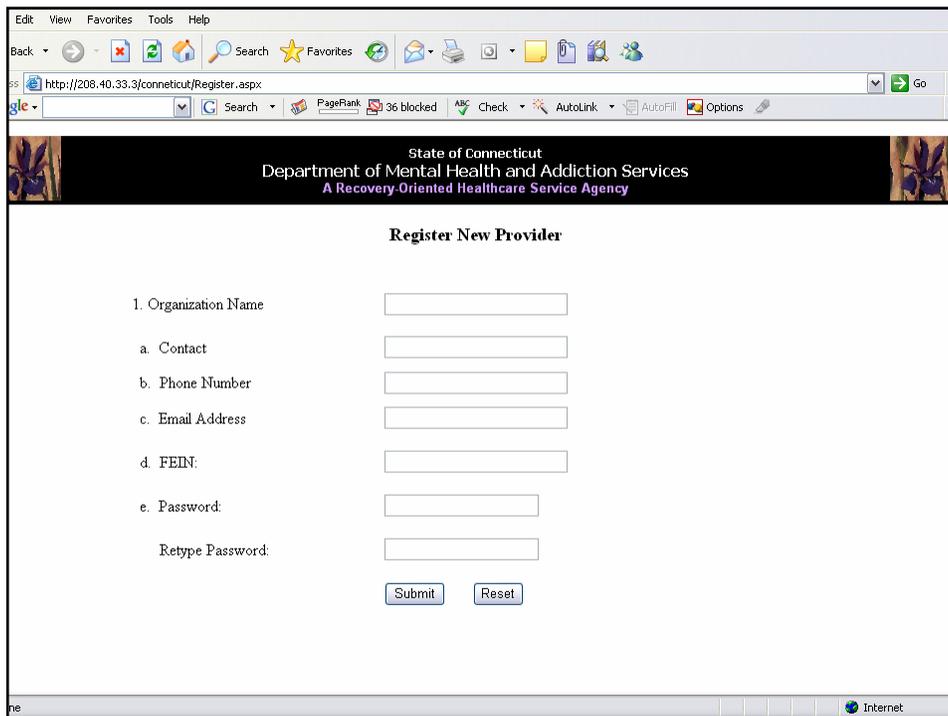
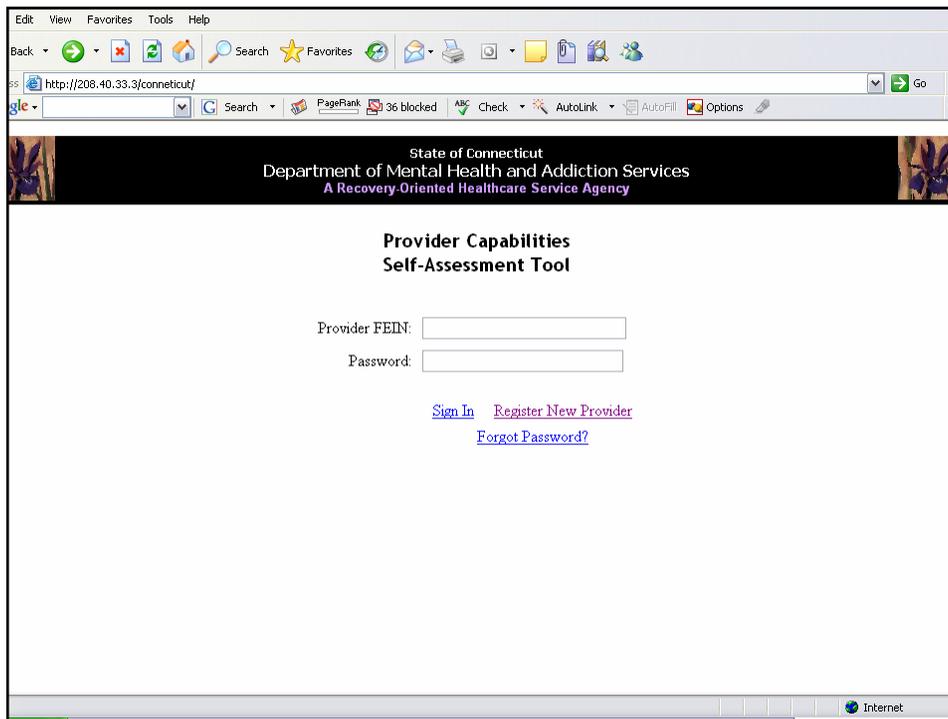
- Must be completed and returned by COB, ***March 31, 2006***
- Forms and data entry available at <http://www.dmhas.state.ct.us/medicaidrehab.htm>
  - Slides
  - Paper version of survey
  - Link to on-line survey
- [LASlayton@aol.com](mailto:LASlayton@aol.com)
- [Susan.graham@po.state.ct.us](mailto:Susan.graham@po.state.ct.us)

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Internet Explorer browser window showing the DMHAS website (http://www.dnhas.state.ct.us/). The page features a navigation menu on the left with categories like AGENCY DIRECTORIES, INFORMATION, and RELATED LINKS. The main content area is titled "WHAT'S NEW" and lists recent updates, including a message about Tobacco Cessation on March 9, 2006, and a report on Governor Reil Cites Connecticut's Mental Health System for Top Rating in National Survey on March 2, 2006. A "FEATURED ITEMS" section lists links for Medicare Part D, Medicaid Rehab Option, Consumer Survey, Request for Proposals (RFPs), and Request for Qualifications (RFQs). The right sidebar contains sections for DMHAS Presentations, Upcoming Events, In the News, Citizen Involvement, and Partnerships. At the bottom, there is a "CT.gov" logo, a visitor count of 286983, and a last edited date of 03/09/2006.

Internet Explorer browser window showing the "Medicaid Rehab Option: Overview and Linkages" page on the DMHAS website. The page header identifies the State of Connecticut Department of Mental Health and Addiction Services as a Recovery-Oriented Healthcare Service Agency. The main heading is "Medicaid Rehab Option: Overview and Linkages". Below this, there is a bulleted list of links: ACT (Assertive Community Treatment), Group Home, CSP (Community Support Program), Client Profile Workgroup, YAS LOCUS Spreadsheet (for use only with the YAS population) (XL file), Online Baseline Readiness Self-Assessment, FAQ, and Presentations. A section titled "OVERVIEW OF THE MEDICAID REHABILITATION OPTION AND THE DMHAS RECOVERY INITIATIVE" includes the question "What is the Medicaid Rehabilitation Option?" followed by a paragraph explaining that Medicaid is a federal-state health insurance program for persons with limited income and/or disabilities, and that it allows states to use federal dollars for defined services, including rehabilitative, community-based services for persons with psychiatric and co-occurring psychiatric-substance abuse diagnosis. It also notes that Medicaid pays for behavioral health services through the Clinic Option and through Targeted Case Management (TCM). A final paragraph states that MRO services have the advantages of being reimbursed for delivery in clients' natural settings as well as in offices, and that they focus specifically on assisting clients with gaining skills and resources that allow them to live and function as independently as possible.



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## Online Provider Forms

### 2006 Self Assessment Form

**Demographic and General Information**  
*The purpose of this section is to collect provider identifying information, establish baseline demographic data (such as budget size, consumers served, payer mix) to allow stratification of the results, and to identify information/billing system platforms.*

Ownership Structure: <i>(If the agency is part of a larger agency, report the ownership structure of the parent organization.)</i>	<input type="radio"/> For Profit <input type="radio"/> Non Profit <input checked="" type="radio"/> Government <input type="radio"/> Other <input type="text"/>
Budget Size: <i>(If the agency is part of a larger agency, report the total budget of the larger agency or system.)</i>	<input type="radio"/> Under \$250,000 <input type="radio"/> \$250,000-999,999 <input type="radio"/> \$1,000,000-4,999,999 <input type="radio"/> Over \$5,000,000
Percentage of current annual budget from the following payers combined: DMHAS contracts, SAGA, and Medicaid, (Use total organization, CT only)	<input type="radio"/> More than 90% <input type="radio"/> 76-90% <input type="radio"/> 50-75% <input type="radio"/> Less than 50%

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In general, is the agency able to post and fill vacant positions in less than 60 days?	<input type="radio"/> Yes <input type="radio"/> No
In general, is the agency able to post and fill vacant positions in less than 90 days?	<input type="radio"/> Yes <input type="radio"/> No
In general, is the agency able to post and fill vacant positions in less than 120 days?	<input type="radio"/> Yes <input type="radio"/> No
What is the work week for fulltime staff who provide either ACT, case management, or supportive housing services? <i>(Check all that apply)</i> <input type="checkbox"/> 40 hours <input type="checkbox"/> 37.5 hours <input type="checkbox"/> 35 hours	
Does your agency have an internal staff credentialing process?	<input type="radio"/> Yes <input type="radio"/> No
Does the agency have an orientation program that trains new staff (both administrative and direct service) in the specific services and payer requirements of the jobs they do?	<input type="radio"/> Yes <input type="radio"/> No
Does the agency have a training program to assist staff in learning new requirements or refreshing skills when external requirements change?	<input type="radio"/> Yes <input type="radio"/> No

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