OPEN MINDS

Value Based Care for Behavioral Health
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Managed Care Competency Domains:

12 Organizational Systems Providers Need To Have To Deliver Services Under Health Plan Contracts

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Agenda

I. Twelve Competency Domains For Managed Care Success

II. Questions & Discussion

I. Twelve Competency Domains For Managed Care Success

Domains For Managed Care Success

Success Domain	Domain Goal	Area Of Focus
Clinical Operations	Standardize clinical protocols to ensure compliance with MCO administrative requirements and ensure consistent consumer quality outcomes.	• Managed Care Clinical Operations • Quality Management • Compliance Management
Customer Focus	Implement processes that facilitate consumer engagement and satisfaction.	• Customer Centric Intake & Admissions
Network Management and Marketing	Develop relationships with payers that strengthen opportunities to partner around consumer needs.	• Managed Care Marketing
Technology and Data Management	Build the data and technology infrastructure necessary to create a data-driven organization and achieve service outcomes.	• Information Technology Systems • Metrics Management
Financial and Revenue Cycle Management	Create a system of processes and technology to ensure that the maximum amount of revenue is generated, and the maximum amount of cash is collected to ensure provider profitability.	• Revenue Cycle Management Admissions • Revenue Cycle Management Billing • Revenue Cycle Management Collections • Margin Management
Leadership and Strategy	Establish a performance-focused culture with clinical and operating targets that staff are incentivized to achieve.	• Leadership & Human Resources

Clinical Operations

- Managed Care Clinical Operations
- Quality Management
- Compliance Management

Clinical operations should ensure consistent treatment protocols, quality initiatives to improve consumer outcomes, and a comprehensive compliance plan.

Managed Care Clinical Operations

1. **Care Management Role** – A care management role should be established to provide an interface between health plan care managers and coordination of care for members assigned to the organization.
2. **Stay Reviews** – A structured process for clinical stay reviews will ensure clinical information is captured to justify medical necessity requirements for the length of time needed for effective treatment.
3. **Relapse Prevention** – Effective client intervention and education during treatment to achieve service outcomes and reduce the need for report services.
4. **Referral Linkage Protocols** – Effective discharge from services involves not just referring to social and community support services but should include active linkage to those services.

Quality Management

1. **Quality Measurement** - To succeed in a managed care environment, providers need to track a number of critical outcome and process measures, and then quickly address any variance using quality management and improvement tools.
2. **Timely Documentation** - In a managed care environment, it is critical that clinical documentation is timely, complete, and accurate so that service payments are not delayed or denied.
3. **Documentation Standards** - Payers may have different requirements for documentation, so clinical managers need to review staff documentation on a regular basis and implement corrective action plans when documentation does not meet standards.
4. **HEDIS Measures** - Payers are measured based on their performance around HEDIS measures – unnecessary hospitalizations or hospital readmissions, so the quality program needs identify how these measures can be addressed through service design.
5. **Appeals Process** – Knowing the utilization requirements of each payer, identifying the root cause for issues, and taking corrective will improve the appeals process for MCO service or payment denials.

Compliance Management

1. **Regulatory Knowledge** - Success with managed care requires a complete knowledge of federal, state, and local regulations, along with contractual requirements.
2. **Compliance Plan** – A comprehensive compliance plan should be created and updated annually to ensure compliance with all sources of authority.
3. **Compliance Officer** – A compliance officer is necessary to interpret compliance requirements, update the compliance plan, and train staff. The compliance officer should have direct access to the board of directors.
4. **Comprehensive Compliance Training** – Comprehensive compliance training should focus not only are regulations and requirements, but also ethics and integrity.

Customer Focus

The goal of customer-centric intake and admissions is to identify needs and engage the consumer in a positive, supportive manner from the very first contact.

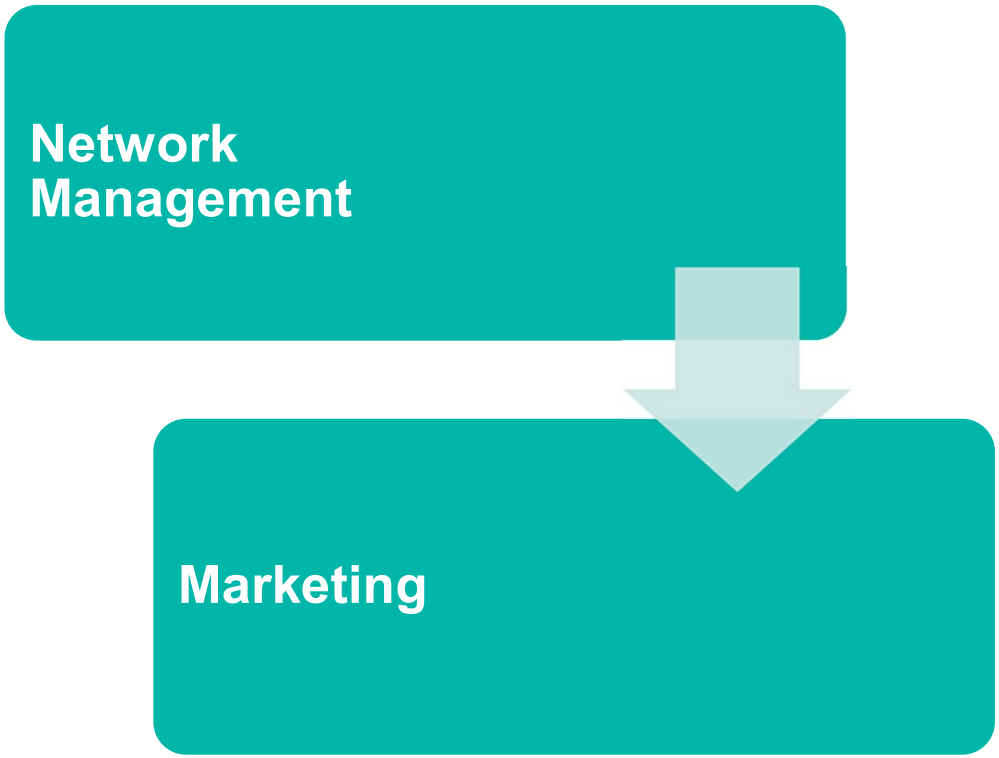
Customer-Centric Intake

1. **Intake Customer Training** - Trained intake and admission staff who are customer-focused and motivated to "screen in" new clients will reduce barriers to accessing treatment.
2. **Centralized Intake** - Centralized intake utilizes properly trained staff to engage new clients, handle high call volumes, and reduce long wait times on hold and lost calls. Metrics should be put in place to track each of these goals.
3. **Standardized Intake Protocols** - Intake staff should have consistent scripts and protocols for engaging consumers and include steps for referring consumers who are calling in because of a crisis.
4. **Intake Data Tracking** - Implementation of tracking and reporting systems to document and analyze intake calls by admission rates and referral source will provide insights for marketing and business development staff.

Admissions

1. **Maximize Consumer Choice** - Consumer choice in the selection of a treatment provider is an important competitive aspect of managed care.
2. **Consumer Engagement Data** - Organizations should track and measure admission and no-show rates to drive better admission conversion rates related to good customer service and effective client engagement. Consumer consistency in keeping the first few service contacts is data to be tracked. It identify issues with the admission process, staff, or clinicians.

Network Management & Marketing



Network management and marketing are focused on health plan contracting opportunities and developing referral sources.

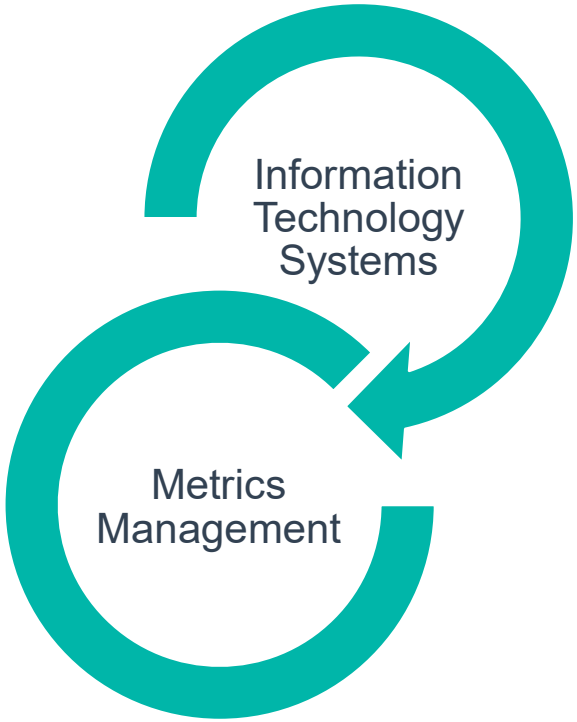
Network Management

1. **Payer Relationship Building** - Routine contact with key health plan and referral source contacts is vital to maintaining strong business relationships and ensuring customer satisfaction with provider services.
2. **Dedicated Account Manager** - A provider account manager can be the main contact between the health plan and provider staff to resolve member service issues and can be a resource to consumers and family members to resolve concerns. Health plan contacts include provider relations, contract managers, network managers, and crisis or call center supervisors.
3. **Network Opportunity Planning** - Health plan and managed care network management requires analysis of outreach functions to ensure targeted contract and referral development. Payer network development includes strategic planning, market positioning, and competitive analysis, to identify payer needs and create new contracting opportunities.

Marketing

1. **Competitive Advantage** - Marketing is focused on creating competitive advantage by building credibility and relationships with health plans and referral sources.
2. **Build Referral Sources** - Building relationships with referral sources - hospital discharge planners, hospital ED social workers, payer crisis or call center supervisor, school counselors, and local medical groups should be part of a marketing plan to increase business opportunities.
3. **Educate Referral Sources** – Educating referral sources through marketing materials and relationships can reduce the number of inappropriate referrals that intake and admissions staff might receive.

Technology & Data Management



Information technology creates efficiency and competitive advantage for providers contracting with managed care organizations, and the data from systems should be used to drive better client outcomes and a financial margin.

Information Technology Systems

1. **Success with managed care requires technology to support multiple systems** – for instance, call center intake, customer referrals and management, care coordination, client documentation, data management, and billing.
2. **Integrated Systems** – Technology systems that are integrated or data warehouses that receive data from multiple systems will create better data to drive consumer outcomes and contractual requirements.
3. **Technology For Competitive Advantage** - Electronic health records and other technology originally used for billing, compliance, and documentation purposes are now being used to create competitive advantage.

Metrics Management

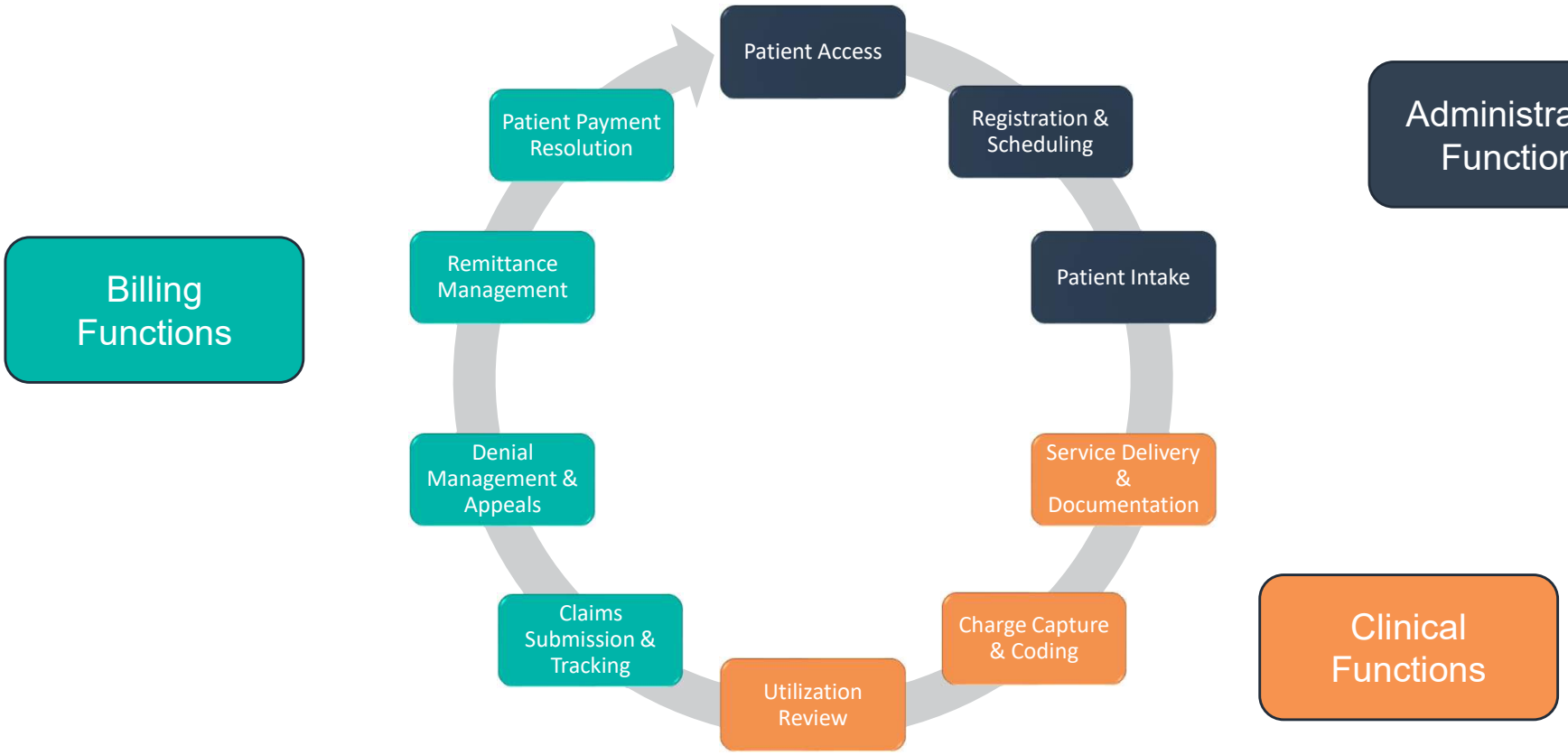
1. **Key Performance Indicators (KPIs)** - KPIs link strategy to operating results. They educate staff on what is important and what they need to do to impact service quality and organizational sustainability needed for managed care success.
2. **Clinical Impact Data** - Providers must be able to demonstrate the clinical impact of services delivered, rather than relying on vague claims about longevity, commitment to quality, or other claims not supported by data.
3. **Process Measures** - In a managed care environment it is critical that providers demonstrate proof of performance, i.e., that you are tracking measures that are important to the payer: access, length of stay, and outcomes. This is important both for current contracts and to build the support for new services and contracts.

Financial & Revenue Cycle Management

- Revenue Cycle Management - Admissions
- Revenue Cycle Management - Billing
- Revenue Cycle Management – Collections
- Margin Management

Financial and revenue cycle management ensure that processes are in place across multiple staff and departments to capture service data and effectively convert it to cash to create a financially sustainable organization.

Comprehensive Revenue Cycle Management



Revenue Cycle Management - Admissions

1. **Admissions Policy** - A comprehensive admissions policy will ensure that all information needed to for the client registration process and admission to services is captured.
2. **Payer Requirements** - Data required to comply with health plan payers should include:
   - Active insurance verification
   - Eligibility of coverage
   - Benefits coverage and explanation to consumer
   - Identification of necessary health plan authorizations
   - Tracking and consumer assignment based on clinician credentials
   - Coordination of benefits
   - Self-pay fee schedule

Revenue Cycle Management - Billing

1. **Billing Policy** - Comprehensive policies and procedures ensure that all critical tasks are identified and assigned to staff members. For billing policies and procedures to be effective, staff must be trained, documentation must be accessible, compliance must be monitored, and there should be a continuous process for review and updates.
2. **Efficient EHR** - Configurability and scalability are two key features to consider with an EHR. Configurability will create efficiency to adapt the technology to the most efficient workflows and facilitate payer changes. Scalability will enable your organization to add and bill more new services with a minimum of additional workforce.
3. **Cash Conversion** - Speed and accuracy are important for billing. The longer the lag time between service provision and billing, the greater the negative impact on cash flow and greater potential impact on compliance

Revenue Cycle Management - Collections

1. **Claims Analysis** - Effective collections is based on analyzing unpaid claims to identify issues with missing intake or admissions data, clinician documentation issues, billing system errors, or payer policy or system problems.
2. **Payables Metrics** - Metrics play a key role in managing the collections process. Some important metrics include:
   - Aged accounts receivable by current, 30 days past due, 60 days past due and over 90 days past due
   - Collection performance, for instance the percentage of claims billed that are paid
   - Number of days that a billed service is in accounts receivable, with a target of 30 to 45 days

Margin Management

1. **Unit Costs** – Knowing your units costs in a managed care environment is important for three reasons:
   - Managers can track services and costs and ensure that they line up with operating targets
   - For engineering your costs to fit the needs and rates of payers
   - For negotiating contracts and new value-based reimbursement opportunities
2. Managers need frequent access to this information so that they can manage unit costs and ensure that costs are not exceeding established targets.
3. Staff and program managers need to know productivity targets and have access to data so they can monitor results and achieve the targeted clinical outcomes and financial results.

Leadership & Human Resources

Leadership

Human Resources

Leadership

1. **Market Understanding –** Senior management needs to understand the market dynamics of managed care – seeing both the health plan payer and consumer as customers, marketing to and engaging those customers, designing services that are effective at meeting current needs, and creating an effective, profitable business infrastructure.
2. **Performance Culture** – Managed care requires a culture shift where clinical and operational managers understand their responsibility extends beyond clinical services to also driving quality and financial profitability.
3. **Performance Targets** – Identifying performance targets that align with operational objectives and contractual requirements are necessary

Human Resources

1. **Performance Assessment** – Educating staff on performance requirements and tying those requirements to performance assessments and supervision.
2. **Incentivizing Performance** – Creating financial and non-financial incentives that align with staff KPIs, quality client outcomes, and financial profitability.

Questions & Discussion

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