Fee for Service Provider Training
June 13 & 14, 2006

Illinois Fee for Service

Provider Training
June 13 & 14, 2006

Agenda—TA Themes

- Productivity measurement and reporting
- Measuring and closing the billing gap
- Restructuring to maximize billing
- Cost structure re-alignment
- Available management information
Fee for Service Provider Training
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Agenda—TA Themes

- Clinical side of productivity
- Intake functions for fee for service
- Assessment and treatment planning
- Residential issues
- Child serving agency issues

TA Project

- Targeted TA project January – May
  - 63 providers selected
    - Based on billing levels in ROCS, amount of billing gap and FY06 midyear reallocations
    - 7 providers declined TA
  - Phone assistance to 56
  - Site visits for 13 (23%)
TA Project

- Range of providers participating
  - Size/location
    - Large ($15+ million), with diversified revenues
    - Small (<$1,000,000) reliant on DMH contract
    - Locations—23 (41%) in Regions 3 - 5
  - Services
    - Full range, all ages
    - Child/adolescent services only
    - Primarily 1 or 2 services, residential, consumer operated
    - Specialties—languages, immigrants

- Results
  - Of participating providers (56), 41% have improved billing to over 70% of their total contract
Measuring and Reporting Productivity

- **Productivity**
  - Hours of billable time per day or week
  - Rate = billable time/available time

- **Available time**
  - Paid time less vacation, holiday and sick
    - No other subtractions
  - 2,080 paid hrs (40 hr/wk) less 7 weeks paid time off = 1,800
    - 15 days vacation, 10 holidays, 10 sick days
  - If 37.5 hrs/week, available = 1,670
Measuring and Reporting Productivity

- Available time
  - Calculate for "average" employee
    - Newer employees will have less time off/more available
    - Experienced staff will have more time off/less available
  - Compute for part-time staff—.8 FTE = 80% of available time for FT staff
  - Supervisors—compute based on percentage of full caseload
- Billable time—only what can be billed and reported to DMH or other payers
  - No credit for meetings, training, travel time or anything else

Measuring and Reporting Productivity

- Standards—in hours/week, month or a rate
  - 25 hrs/week or 67% of a 37.5 hour week (no time off)
  - May adjust up or down slightly for office based compared to community based (+/- 3 hours)
  - 30 hours for full time physicians
- Schedule at needed hours for productivity target plus no show rate
  - Schedule 6 hours to get 5 per day
Measuring and Reporting Productivity

- Groups
  - Calculated at a factor times actual staff time
    - Account for additional paperwork
    - Incentive to reduce no show
    - Compare group to individual rate to establish factor and minimum group size
  - Do not use number of consumers X amount of time
  - Use 1.33 to 1.5 times actual staff time if minimum group size (at least 3)
  - Example: 1 hour group with 5 clients = 1.5 hours productivity credit

Measuring and Reporting Productivity

- Decision—Calculate by “average” employee or actual time off by employee
  - Actual time off is very labor intensive, but may be clearer to staff on a day to day basis
    - Available time is reduced based on actual paid time off in a given payroll period
    - Requires gathering actual payroll data each reporting period and entering into productivity reporting
      - Payroll not typically integrated into billing/productivity
    - Maintain if already using this method and productivity is being reported regularly
Measuring and Reporting Productivity

- Average employee evens out over time—Best method for most agencies
  - Hours/rate will appear low during periods with concentrated time off, but will catch up over the time
  - Divide actual billable hours by average available time
  - 65% of available time = 1,086 hrs (65% of 1670 available for 37.5 hour week) per year or 90.5 out of 139 available per month

Measuring and Reporting Productivity

- Average employee example—
  - May and June each have 22 work days, took 6 days off in May for vacation/holiday
  - May—if bill 5 hours for 16 days = 80 hrs/139 or 57.5%
  - June—if bill 5 hrs per day = 110/139 = 79% productivity
  - Combined 190 billed/278 available or 68%
Measuring and Reporting Productivity

- **Reporting Do's and Don'ts**
  - Simpler is best
  - Report regularly, at least monthly
  - Report hours or percentage, not billed charges
  - Do not report percentage of target
    - If target is 100 hours, 90 hours not equal to 90%, actually 65% of available!
  - User friendly, summarized, graphical
  - Summarize by supervisor to improve accountability

- **Sample reports**
  - Team with one team lead (Ann) and one PT person (Fran)
  - Target is 90.5 hours per month or 65% of 139 available (37.5 hr week)
    - 25 per week
Monthly and YTD Actual

Productivity Sample--Actual to Target

<table>
<thead>
<tr>
<th></th>
<th>May</th>
<th>Target</th>
<th>%</th>
<th>YTD</th>
<th>YTD Target</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ann (tm ld)</td>
<td>68</td>
<td>67.9</td>
<td>65.2%</td>
<td>715</td>
<td>747</td>
<td>62.4%</td>
</tr>
<tr>
<td>Bob</td>
<td>67</td>
<td>90.5</td>
<td>48.2%</td>
<td>733</td>
<td>996</td>
<td>47.9%</td>
</tr>
<tr>
<td>Cee</td>
<td>58</td>
<td>90.5</td>
<td>41.7%</td>
<td>825</td>
<td>996</td>
<td>54.0%</td>
</tr>
<tr>
<td>Dan</td>
<td>108</td>
<td>90.5</td>
<td>77.7%</td>
<td>1,050</td>
<td>996</td>
<td>68.7%</td>
</tr>
<tr>
<td>Ed</td>
<td>80</td>
<td>90.5</td>
<td>57.6%</td>
<td>784</td>
<td>996</td>
<td>51.3%</td>
</tr>
<tr>
<td>Fran (PT)</td>
<td>85</td>
<td>72.4</td>
<td>76.4%</td>
<td>866</td>
<td>796</td>
<td>70.8%</td>
</tr>
<tr>
<td>Total</td>
<td>466</td>
<td>502.3</td>
<td>60.4%</td>
<td>4,973</td>
<td>5,525</td>
<td>58.5%</td>
</tr>
</tbody>
</table>

Monthly Target to Actual

May Productivity Blue Team
YTD Actual to Target

YTD Productivity Blue Team

Actual vs. Target for each individual from Ann to Fran.

YTD Trend

Productivity Trends YTD Blue Team

Trend graph showing productivity from July to May for Ann, Bob, Cee, Dan, Ed, and Fran.
YTD Actual to Target Trend

Average Productivity  Blue Team

Measuring and Closing the ‘Billing Gap’
Measuring/Closing Billing Gap

- Billing gap—difference between actual MCD/NMCD billing levels and DMH contract amounts
- Possible causes
  - Productivity shortfall
  - Insufficient direct service staff
    - Vacancies or improper staff allocations
  - Insufficient rates
  - Service mix
  - Combination

Measuring/Closing Billing Gap

- Quantify billing impact of productivity shortfall
  - Target less actual productive hours x DMH payor mix % x weighted average DMH rate
    - Annualized difference between target and actual productivity hours for all staff
    - DMH payor mix = DMH revenues/total revenues
      - Include only revenues where the same staff provide services under both contracts (Medicare, SASS, DMH, commercial)
    - Weighted average DMH rate = total DMH billings/total DMH units
Example Shortfall Calculation

### Billing Impact of Productivity Shortfall

<table>
<thead>
<tr>
<th></th>
<th>Actual</th>
<th>Target</th>
<th>Difference</th>
</tr>
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<tbody>
<tr>
<td>Ann (tm Id)</td>
<td>780</td>
<td>815</td>
<td>35</td>
</tr>
<tr>
<td>Bob</td>
<td>800</td>
<td>1,086</td>
<td>286</td>
</tr>
<tr>
<td>Cee</td>
<td>900</td>
<td>1,086</td>
<td>186</td>
</tr>
<tr>
<td>Dan</td>
<td>1,145</td>
<td>1,086</td>
<td>(59)</td>
</tr>
<tr>
<td>Ed</td>
<td>855</td>
<td>1,086</td>
<td>231</td>
</tr>
<tr>
<td>Fran (PT)</td>
<td>945</td>
<td>869</td>
<td>(76)</td>
</tr>
<tr>
<td>Total</td>
<td>5,425</td>
<td>6,027</td>
<td>602</td>
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<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>DMH payor mix</td>
<td>75%</td>
</tr>
<tr>
<td>Weighted avg hourly rate</td>
<td>56</td>
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<tr>
<td>Productivity billing shortfall</td>
<td>25,293</td>
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Sample Using FFS Tool

<table>
<thead>
<tr>
<th>Sample Provider</th>
<th>Actual Productivity</th>
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</thead>
<tbody>
<tr>
<td>DMH Contract Reconciliation</td>
<td>MCD</td>
</tr>
<tr>
<td>FFS Revenue</td>
<td>965,966</td>
</tr>
<tr>
<td>Capacity Grant</td>
<td></td>
</tr>
<tr>
<td>DMH Contract Allocation</td>
<td>1,423,955</td>
</tr>
<tr>
<td>Over/(Under) Allocation</td>
<td>(457,969)</td>
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</table>
Sample Using FFS Tool

<table>
<thead>
<tr>
<th>Sample Provider</th>
<th>Productivity at Standards</th>
</tr>
</thead>
<tbody>
<tr>
<td>DMH Contract Reconciliation</td>
<td>MCD</td>
</tr>
<tr>
<td>FFS Revenue</td>
<td>1,261,878</td>
</tr>
<tr>
<td>Capacity Grant</td>
<td></td>
</tr>
<tr>
<td>DMH Contract Allocation</td>
<td>1,423,955</td>
</tr>
<tr>
<td>Over/(Under) Allocation</td>
<td>(162,077)</td>
</tr>
</tbody>
</table>

Sample Using FFS Tool

- Billing shortfall attributable to failing to meet productivity standards
  - $773,000 – $350,000 = $423,000
- Remaining billing shortfall = $350,000
  - Look at remaining causes
  - Staffing allocations next
Sample Analysis of Direct Service Allocation

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
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<tbody>
<tr>
<td>Total DMH contract</td>
<td>2,700,000</td>
</tr>
<tr>
<td>Direct service staff (FTEs) (75%)</td>
<td>23</td>
</tr>
<tr>
<td>G&amp;A staffing (25%)</td>
<td>8</td>
</tr>
<tr>
<td>Total estimated staff</td>
<td>31</td>
</tr>
<tr>
<td>Estimated personnel costs from DMH contract</td>
<td>1,890,000</td>
</tr>
<tr>
<td>Avg salary/benefits per staff person</td>
<td>61,630</td>
</tr>
</tbody>
</table>

Measuring/Closing Billing Gap

- Direct service allocation parameters
  - Ratio of direct service to total staff = 70 – 75%
  - Personnel costs out of total budget = 70%
- Causes for improper direct service allocations
  - Common in grant funded systems
  - More common in agencies with non-MH services
    - Grants used to support total agency overhead associated with other, unrelated activities
    - Too few staff with productivity targets
Measuring/Closing Billing Gap

- Rates
- Service Mix
  - Examine mix of services being provided in total and by program
  - Change underlying services and amounts of certain service to increase effective rate
  - More groups (attendance), PSR, etc.

Restructuring to Maximize Billing

- Increase groups where appropriate
- Review non-billable staff time
  - Capture existing billable time not recorded
  - Adjust to be billable
  - Reduce non-billable activities--meetings, documentation efficiencies, standard clinical supervision time
Restructuring to Maximize Billing

- Non-Medicaid clients and services
  - Many providers billing more MCD than NMCD
    - Staff not capturing based on old information, avoid paperwork
  - FY07 contracts based on total MCD+NMCD billing
  - Look at:
    - Vocational services
    - Coordination for clients in state hospital/other inpatient
    - All other target/eligible clients not eligible for Medicaid
      - DMH funds can’t support

Clinical Strategies to Support Productivity
Productivity is a Clinical Issue

- Goes to the heart of clinical practice patterns
- Outlines clinical priorities and philosophy by determining what is important enough to count
- Gives supervisors a tool to assist staff in setting priorities and aligning with agency (and payor) philosophy

Structure BEFORE Work is Done

- Only so much can be accomplished through blaming, nagging, shaming, and complaining.
- Direct work before it is done – not after it is too late to change.
- Use data and reports to monitor effectiveness of direction.
First Step: Review Schedules

- On Thursdays, all staff turn in schedules for next week indicating clients to be seen, what will be done with them, and amount of time estimated to be spent.
- On Fridays, supervisors review schedules to ensure enough hours are included. If not, meet with staff and add time/clients/interventions.

Schedule for “No Shows”

- Compute the no-show (or failed appointment) rate for each staff member.
- Schedule enough visits and activities to compensate for no-shows.
Step Two: Right Clients?

Once staff are consistently scheduling enough hours, enhance review of schedules to make sure that:

- All consumers are being seen
- Minimum contacts are built into schedules
- Consumers with most intense needs are being seen more than those with less intense needs

Step Three: Right Amounts?

Build schedules from Service plans to ensure that frequency and intensity of services from Service plans are incorporated into schedules.
Productivity ‘Biggies’

- Service Plans
- Scheduling
- Travel
- Documentation
- Turnover
- Billing

Biggie: Service Planning

- Current
- Congruent with client needs and preferences
- Services prescribed appropriately
- Clarity of desired outcomes/activities
- Clarity and accuracy of prescribed intensity of service
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**June 13 & 14, 2006**

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### Biggie: Schedule & Calendars: Planning Work

- Review all cases (ISP) for recommended times/week, and activities
- Transfer to calendar template to see how to fit work into time (use post-its)
- Block other billable activities (ISP development & writing, linking with other agencies, etc.)
- Prepare a monthly/weekly schedule based on consumer needs from ISP

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### Biggie: Travel

- Assign case loads by zip code
- Organize daily and weekly calendar geographically
- Take advantage of other scheduled events (PSR, Med checks, etc)
- Do not always require going to office first
- Schedule and confirm appointments
- Make ‘no show/not at home’ a service and treatment planning issue
Biggie: Documentation

- Document with the consumer
  - Reference goal at start of contact
  - Summarize accomplishments and plans at end of session
  - Write the note while with the consumer
  - Consumer can review if desired
- Consider structured templates with ‘as evidenced by’ section for routine encounters
- Don’t get behind!

Biggie: Turnover

- Inevitable so plan for it
- Rehab services should functionally always be a ‘team’
  - More than one person should know consumer
  - ‘Attach’ consumer to agency as well as worker
- Require current documentation
- Have a consumer-focused, structured protocol that can be initiated when turnover occurs
Biggie: Billing

- Bill for the right things
- Capture all of the good work you do
- Timely documentation—a billing doesn’t count until the note is done
- Turn in your billing (SALs, charge ticket)
- Have internal controls to reconcile schedules to actual turned in billing

Intake Functions in Fee-for-Service
Fee-for-Service Access and Intake Scope

“To provide information, referral, eligibility screening, assessment, admission case management, resource verification, admitting, financial counseling, & utilization management services to exceed the expectations of all customers desiring access to the array of public mental health services & supports.”

Goals for FFS Access System Service Responsibilities

- Easy access to services by customers
- Determine client need & match to level of care
- Establish & document medical necessity
- Meet the clinical data information needs of all customers in a timely manner
- Eliminate repetitive assessments
Goals for FFS Access System Service Responsibilities

- Expedite the treatment process
- Initiate UM/CQI process
- Educate, assist, & advocate with client regarding resource benefits, rights, responsibilities

FFS Access & Intake Modifications

- Many ways to get there but above the clinical, fiscal, and administrative functions MUST work in concert
- Volume of intakes may dictate model
- Most agencies need to do a review of their intake process flow
Assessments and Service Planning

Assessments

- Are essential to establish medical necessity
- Are the foundation of the service plan
  - Should be direct link between assessed needs with items on the service plan
- Must minimally meet Rule 132 requirements
Assessments in Practice

Were often found to be:
- Very outdated (in some cases several years old)
- Not functionally oriented
- Not linked to service plans

Recommendations for Assessments

- Should incorporate functional assessment or level of care tools
- Should be updated at least annually
  - Does not require full assessment—just update
- Should be internally reviewed for consistency with service plans
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Service Plans

- Should directly tie to client needs as documented in the assessment
- Should be useful to direct treatment
- ‘Prescribe’ the medically necessary services
- ‘Prescribe’ the intensity of service
- Serve as a measure of progress and ‘rehabilitation’
- Congruent with and reflect client agreed upon goals and services

Service Plans in Practice

- Not always current
  - Lapsed
  - Not lapsed but materially not reflective of client’s circumstances
- Not supported by documented assessed needs
- Minimally useful to direct treatment
- Minimally useful to measure progress
- Minimally reflective of client input
  - > 70% of consumers felt they had little or not input in service plans
Recommendations for Service Planning

- Internal controls to monitor for lapsed plans
- Update plans as needed, not just at 90/180 days
- Tie to assessed needs
- Re-institute frequency/duration on service plans
- Integrate plans into management/supervision
- Train/support consumers and staff for greater input in service planning

Residential Issues
Residential Issues

- Lack of clarity of service definitions
- Lack of program/certification standards
- Wide variation in clients served, program models, staffing, credentials
- Complex inter-Departmental issues

Residential Recommendations – Short Term Options

- Work towards greater use of supported housing when available and appropriate
  - Deliver prescribed community based services at the right intensity
- Work towards using 24 hr supervised congregate settings for higher need clients
- Increase structure of daily programs/services
- Capture all appropriate billing
Children’s Issues

- A significant number of predominantly child serving agencies were reviewed
- Remarkable in that the core issues were NOT that different
- Most prevalent issues were
  - Clinical philosophy issues
  - Family involvement issues
Come Attractions

Future Training Topics

- Cost structures
- MIS/Key indicators
- Primary case management/community support models
- Clinical record review tools
- New services
Cost Structure Re-Alignment

Cost Structures

- FFS adjustments
  - Cost restructuring typically required for conversion from grants
  - Move from managing total budget with predictable revenues to managing components
    - Variable revenues
    - Largely fixed personnel costs
  - Increase emphasis on direct service staff
Cost Structures

- Accurate cost center analysis
  - Different from DMH program structures
  - Logical tracking for tracking revenues/expenses--by site or types of services (OP)
  - Used to refine analysis of operational issues
    - Negative margin areas targeted for improvement, reduction, elimination
    - Positive margin areas targeted for increase
    - IF allocations are reasonably accurate (not perfect)

Cost Structures

- Residential cost center example
  - DMH reduced residential grants
  - Revenues associated with residential staff in case mgt or other cost centers
  - Mismatch between location of residential costs/revenues, resulting large residential losses
  - Impossible to assess extent of residential losses without accurate cost center reporting
Cost Structures

- Expense allocations
  - Direct salary costs
  - Service related costs allocated by salary costs
  - G&A allocated by subtotal of direct/program costs

- Revenues
  - FFS matches staff costs
  - Grants based on purpose (DMH, federal) or to support high cost /low reimbursement “firehouse “services (United Way)

- Allocations reasonable, subject to judgment
  - May have different financials for fund raising

Cost Structures

- Unit cost analysis
  - Unit costs decrease as productivity increases—variable
  - Rates are benchmark for unit cost analysis
## Unit Cost Example

### Unit Cost Analysis

**Case Management**

<table>
<thead>
<tr>
<th></th>
<th>Actual</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total costs</td>
<td>615,000</td>
<td>615,000</td>
</tr>
<tr>
<td>Total hours</td>
<td>7,343</td>
<td>10,114</td>
</tr>
<tr>
<td>Cost/hour</td>
<td>83.75</td>
<td>60.81</td>
</tr>
<tr>
<td>Case mgt rate</td>
<td>RSA</td>
<td>63.98</td>
</tr>
<tr>
<td></td>
<td>MHP</td>
<td>76.92</td>
</tr>
</tbody>
</table>

## Management Information
Management Information and Key Indicators

- Management information must be available
  - Agencies must have provider information system
    - MIS Resource Tool available during July
  - Productivity
  - Cost center performance analysis
  - No show rates
  - Scheduling
- Manage by data and analysis, not anecdote

Management Information and Key Indicators

- Key indicators—monitor monthly or quarterly to assure achieving targets/standards
  - Productivity and no show rates
  - Time from service to submission of billing/documentation
  - Time scheduled for intakes, MD evaluations and medication monitoring
  - Intakes—length of time for routine appts, new intakes per week, no show rates
  - Caseloads, clients with no services last 90 – 180 days
  - DMH payor mix, MCD/NMCD penetration rates
  - Number FTEs, vacancies
  - Weighted average billing rate