

Redesigning Provider Organizations and Designing Provider Sponsored Networks

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Introduction

Behavioral health organizations are confronted with an environment where prices are being pushed down, financial risk is being shifted to providers, and expectations regarding access and quality are increasing. Many nonprofit organizations are simply not capable of surviving these pressures. Two strategies for addressing these challenges are substantive organizational redesign and the development of provider-sponsored networks.

Organizations that attempt redesign or network development frequently lack a full understanding of how much they will have to change. They are often uncertain about how to begin, and may focus only on issues of cost, FTE count or organization chart adjustments.

Through consultations with numerous behavioral health organizations and networks the authors have learned that the steps for designing a new provider sponsored network and redesigning an existing organization are essentially the same. This chapter is a roadmap to help organizations pursue one or both of these strategies.

The (Re)Design Process

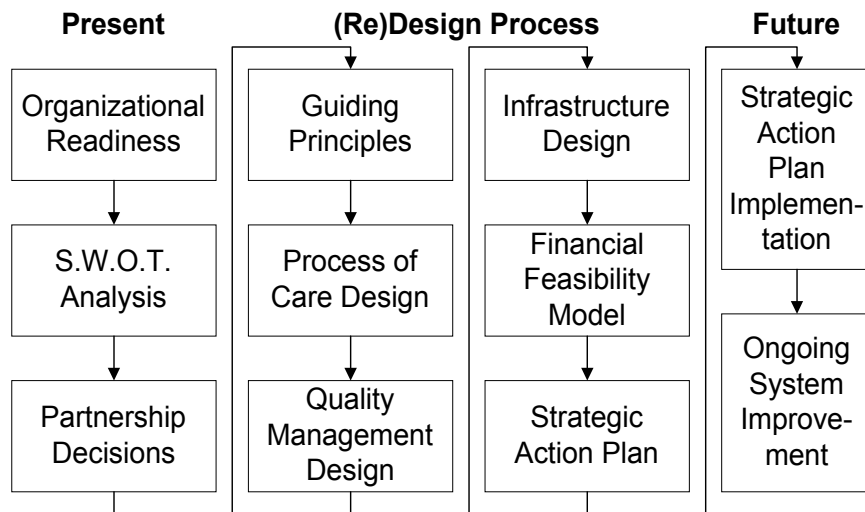


Figure 1: A (Re)Design Workplan

Organizational Readiness

Key activities at this step

- Need & Timetable for Change
- Team Formation
- Initial Training
- Organizational & Leadership Engagement
- Stakeholder Involvement
- Communication Plan

The first thing that an organization must do in preparation for a (re)design is fully understand how financial risk operates in a managed care environment. The (re)design needs to consciously consider the financial environment in which the organization or network will be operating and what level of risk they expect to be managing. This will affect a number of choices they make during the design process.

The other side of financial risk is reward, but to obtain reward, an organization or network has to be prepared to actively manage the risk. There are multiple levels of financial risk, which build up from the population to be covered.

- **Cost:** Services cost more per unit than payment rates per unit.
- **Utilization (Individual):** Individuals, on average, use more units of service than estimated.
- **Utilization (Case Mix):** The mix of patients is weighted toward higher severity or complexity than estimated.
- **Penetration:** More individuals from the covered population use services than estimated.
- **Population:** The population requiring coverage grows faster than originally estimated.

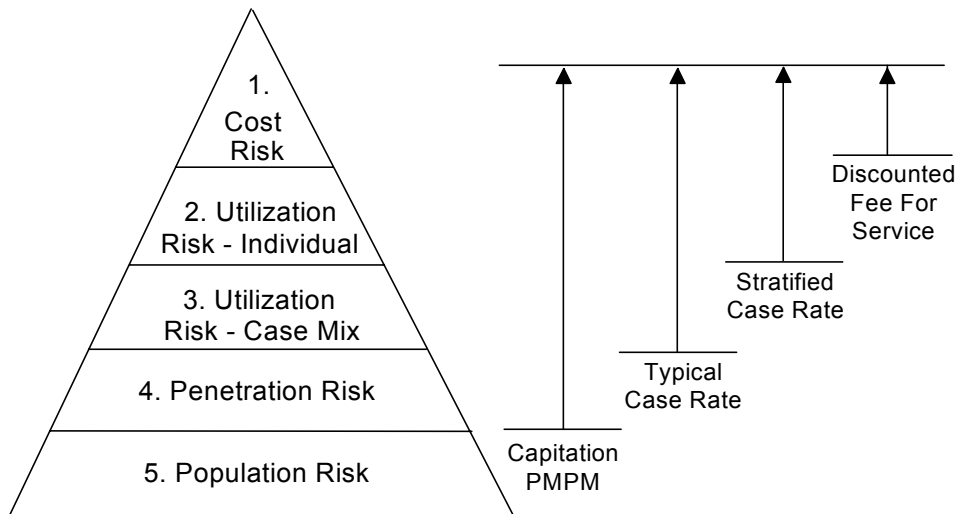


Figure 2: Types of Risk In the Risk Triangle

The payment mechanism is the method by which risk is transferred from payer to provider.

- **Discounted Fee for Service:** Payment for all authorized services from a defined fee schedule, minus a per visit co-payment.
- **Stratified Case Rate:** Payment of a flat fee per patient for a predefined episode at a specific level of care, regardless of how much time and money is spent.
- **Typical Case Rate:** Payment of a single flat fee per patient for a predefined episode regardless of how much time and money is spent.
- **Capitation:** Payment of a fixed fee per enrollee (per member per month) to provide all medically necessary services to the covered population.

Note that each payment type transfers a specific risk as well as all of those above it (e.g., accepting capitation means the provider holds all of the types of risk from penetration on up through cost).

These payment mechanisms carry varying incentives for both payer and provider. In order to address the incentives inherently in play, quality and utilization management processes and structures must align with the type of risk that is to be managed.

Starting the process of change begins with leadership acknowledgement and preparation. Top leadership (executive, clinical, and financial) must set and maintain the climate for change and assure consistent support of the (re)design process. This includes managing the local politics surrounding the change, so the (re)design effort can focus on the content and taking the time to understand the detailed implications during the design process in order to effectively lead the transition.

Leadership also needs to focus on and maintain role clarity, especially in the design of a provider sponsored network, where multiple roles exist. This includes knowing when one is operating in the role of:

- risk bearing entity vs. provider organization;
- governance vs. administration; or

- network owner vs. network provider.

Assuring team formation and stakeholder involvement is yet another leadership activity. Cross-functional teams include people from all parts of the organization, executive through staff, as well as advocates and consumer representatives. Including people from all parts of the system improves the likelihood that new or redesigned processes will be effective when implemented.

Before beginning the (re)design process, establish an ongoing process for informing and engaging others; identify and educate key stakeholders (internal and external) and decide on the methods for gathering stakeholder and consumer input.

SWOT Analysis

Key activities at this step

- | | |
|----------------------------|------------------------------------|
| • Baseline Data Collection | • Internal Performance Assessment |
| • External Market Analysis | • Alternative Scenario Development |

To set the stage for (re)design, a classic strategic planning tool helps participants organize and understand the issues: a strengths, weaknesses, opportunities, threats (SWOT) analysis.

The key functional areas to review in an internal performance assessment¹ include:

- Leadership and Vision
- Human Resources
- Service Delivery
- Quality Improvement
- Service Utilization
- Financial Planning and Management
- Consumer and Financial Accounting
- Management Information
- Marketing and Public Relations

Another aspect of internal performance assessment is to gather baseline performance data on quality, access, utilization and cost, and then benchmark against other organizations or published performance measures.

External market analysis requires gathering information regarding the local environment, such as:

- What is the population in your service area?
- What percent is insured for healthcare?
- What is the distribution among private/employer paid and public paid?
- What percent are in managed care plans?
- Are significant changes occurring in the population?
- Who are the major payors, what do they want, and how are they structuring contracts?

- How are covered lives distributed among payors and delivery systems?

An organization planning for the future should create alternate scenarios regarding what might come to pass regarding the local market: How will risk be structured, with what incentives for providers and payors? What are the implications for payor mix, risk type/payment mechanism, and covered lives volumes and mix? Which strategic goals will give you leverage in most or all of the possible scenarios?

Partnership Decisions and Timing

Key activities at this step

- Payor Negotiation/RFP Process
- Mergers & Acquisitions
- Network Formation
- Management or Administrative Services Organizations (MSO/ASO)

For network formation and design this step ideally takes place early, before clinical design, so the network partners can participate in the clinical and infrastructure design process.

For organizational redesign, this step generally takes place following infrastructure design because the partnership focus is on assistance with infrastructure requirements, and the design process serves to develop some of the criteria for selection of a partner

To set criteria, consider your organization's strengths and weaknesses (that SWOT analysis serves more than one purpose!) and those of potential partners, and identify capacities that are most important to achieve strategic goals. Prepare a partner selection document that describes in detail the expectations of the potential partner and the selection process and timetable.

In order to move forward on a partnership decision, you must know your organization's rules and processes for selecting a partner. You must keep your governing body at a high level of understanding and involvement throughout the process and be clear about the legal structure you envision. Partnership decisions obviously have legal implications: organizations should use expert assistance for negotiation, due diligence, and organizational/governance structuring and legal counsel for review of antitrust issues and development of legal documents.

Guiding Principles

Key activities at this step

- Mission/Vision/Values
- Customer Requirements/Outcomes/Measures
- Strategic Goals
- Business Requirements/Outcomes/Measures

Guiding principles should be specific enough to support decisions in the future. This includes **Mission** (What is your purpose? Who do you serve? What services do you provide or, what business are you in?); **Vision** (What are you trying to create?); and, **Values** (How will you act on the way to achieving your mission and vision?).

Strategic goals are developed by using information from the SWOT analysis and development of alternative scenarios to answer key questions:

- What service area(s), over what time frame?
- What size of delivery system, over what time frame?
- What patient mix, payor mix, over what time frame?
- What expansions, in types of services, over what time frame?
- What key accomplishments, over what time frame?

Customer or business requirements and outcome standards/indicators establish design criteria for both clinical and infrastructure designs and should be articulated in advance of the design process. For example:

- Appointment for face-to-face assessment will be offered within 5 days of initial contact, for those seeking routine care (as measured by time elapsed between date of call and date of offered appointment).
- All clean claims must be paid in 30 days (as measured by time elapsed from stamped date of receipt until date check is cut or electronic transfer).

Process of Care Design

Key activities at this step

- Service Delivery Workflows
- Clinical Tools for Assessment & Measurement
- Best Practice Clinical Processes
- Utilization Benchmarks

Population-based service delivery planning ensures that equitable policy choices are made in advance by developing standard service delivery workflows, standard tools for assessment and authorization to care, best practice clinical tools and utilization benchmarks.

Service delivery workflows describe how you will serve the population (and assure that individuals are served appropriately) by providing a “map” and service specifications for the delivery system. Workflows are structured to meet the needs of “most of the people most of the time”; will vary for children, adults, older adults, and special populations; provide the functional basis for reorganizing the form of the organization; and, provide the basis for identifying the array of services that should be available. The process uses information about the populations to be served and their needs and results in consistent process steps and best practice guidelines. These free the provider to focus on the unique variations appropriate to each consumer, assuring individualized service planning through consideration of individual strengths, personal support systems, community resources, and the patient’s goals and commitment to care.

The process of care (re)design begins with a high level workflow and then describes the detailed steps that occur under each step of the high level flow. Teams may find it easiest to do this by imagining they are creating a new organization, where there are fewer temptations to get stuck on “how we have always done it”.

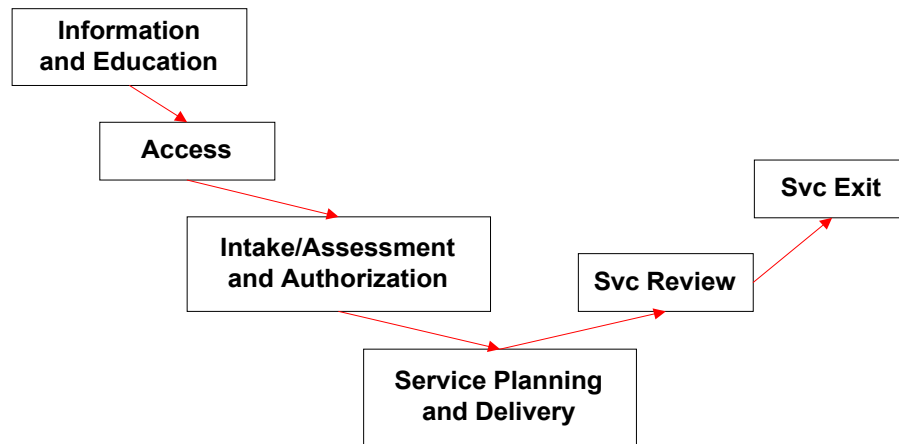


Figure 3. High Level Work Flow for Behavioral Health

As the a team develops the detail below the high level flow, they should draw a picture (the flow) and capture the specifics (specifications) at each step. Specifications focus on:

- How the step is performed;
- How the consumer (ideally) experiences the process;
- The staff skills required;
- The resources or tools required;
- The Utilization Management/Utilization Review process;
- The Quality Assurance/Quality Improvement process; and
- The network management process (if applicable).

Specifications become the basis for job descriptions, policies, and procedures, as well as the development of performance standards/indicators and their measurement.

Standardized clinical tools those used for the clinical assessment process (and pre/post scoring), level of care criteria, and a standardized patient data set. National professional organizations are rapidly developing and disseminating best practice guidelines based on research and using evidence based medicine techniques. When it comes to selecting assessment tools and best practice guidelines, organizations and provider networks are urged to adopt nationally validated tools rather than creating local variation. It becomes very difficult to benchmark performance against others if you are measuring with something that is not in use elsewhere.

Level of Care criteria are used to authorize to a level of care for the benefit period (outpatient intensity and duration, residential, partial, inpatient). They are the same as “medical necessity” criteria except the services accessed include wrap around and community support services. Especially as used for authorization to outpatient services,

the intent is to realistically authorize the right amount of services (no more and no less) from the beginning of the care period. This empowers the care provider to focus on individualized care planning over the course of treatment, using the pool of resources that have been authorized. This contrasts with authorization methods that require frequent justifications, reviews, and reauthorizations in order to deliver an intensive, longer duration plan of care.

Level of Care (LOC) criteria generally consider a DSM - IV diagnosis (but are not diagnosis specific); level of functioning (from assessment tool); domains of interest (e.g. the LOCUS created by the American Association of Community Psychiatrists includes dangerousness, functional status, medical and psychiatric co-morbidity, recovery environment/stress, recovery environment/support, treatment and recovery history, attitude and engagement); duration and intensity of care required; and, expected outcomes.

As standard clinical tools are developed, the design team should identify the data fields to track and report, to support clinicians in managing as well as to support utilization and quality analysis. At a minimum, these should include an MIS patient record with diagnosis; level of functioning (per assessment tool); assigned Level of Care; demographic data; and payment source.

Best practice clinical processes are generally diagnosis specific practice guidelines or clinical pathways that reflect research and expert consensus. In Managing Managed Care, released by the Institute of Medicine, it was observed that “development of clinical practice guidelines should be linked to outcomes research, performance standards, and accreditation...research should examine successful implementation models...and, practitioners and consumers should be included in the development of practice guidelines.”ⁱⁱ This means that organizations need to carefully assess guidelines prior to selection and implementation and establish a method for evaluating their impact.

Utilization benchmarks, or service packages, are not practice guidelines or clinical pathways; they are established for levels of care for each age group, measured by standardized service hours as the unit of measure, and based on the average service hours by modality expected for each level of care. As benchmarks used to inform individualized treatment planning, they are a first step to making a process of care more consistent and should be assessed for accomplishment of outcomes and revised over time.

As part of a design effort, service packages are an integral part of clinical/financial modeling because they provide a method for quantifying the amount of care that the population might require in a benefit year. The clinical/financial modeling step allows an organization to test the financial feasibility of the clinical design prior to finalizing and implementing it. The service package table is key to projection of total demand for services, it also enables projection by modality (and by type of clinician), thus enabling the organization to determine whether it has sufficient or appropriately distributed capacity.

Input Screen: Service Package Make-Up by Modality								
Modality	Hrs / Std Hr	Package 1	Package 2	Package 3	Package 4	Package 5	Package 6	Package 7
Individual/Family Therapy	1	3	-	12	-	-	-	-
Group Therapy	6	12	-	72	-	-	-	-
Medication Clinic	1	-	3	-	3	3	3	3
Adult Day Treatment	6	-	-	-	-	408	-	318
Medical Evaluation	1	1	2	3	3	4	4	4
Clubhouse	12	-	12	-	144	-	-	-
Clinical Case Mgmt 1:100	1	-	-	-	9	-	-	-
Clinical Case Mgmt 1:40	1	-	-	-	-	30	-	-
Clinical Case Mgmt 1:10	1	-	-	-	-	-	98	144
Total Hours (Non-Standardized)		16	17	87	159	445	105	469
Total Hours (Standardized)		6	6	27	27	105	105	204

Figure 4. Service Package Table

One of the methods in the service package table that supports the translation of population based demand to organizational capacity is the “standardization” column. This column allows an organization to translate client hours into standardized capacity (or staff) hours. For example, if group services are ordinarily provided with a group size of six with one clinician, six hours of client services are the equivalent of one hour of capacity or staff time. The method of standardization can be applied to any modality; the treatment package table can include all the modalities required by the population. The example above uses a short list and simple conversion factors to illustrate different packages for populations with different needs and the conversion from client hours to standard hours for the purposes of demand forecasting (see Package 1 and Package 2 above).

Quality Management Design

Key activities at this step

- Risk Management
- Utilization Management/Review
- Performance Contracting
- Quality Assurance/Improvement
- Credentialing/Recredentialing

The first imperative of Quality Management is to assure stable clinical processes. Without stable processes of care, outcome data is meaningless; you cannot know whether clinical processes have achieved the outcomes, or how to improve on or replicate those processes! Service delivery workflows, level of care and practice guidelines, policies and

procedures that assure processes operate as planned, and performance standards/indicators and measures all are elements for assuring stable clinical processes.

Track outcome data by computerizing the standard patient data set and connecting it to utilization data. Baseline assessment data is collected at intake, intervals, and/or at termination. Consumer satisfaction data is collected using a standard tool, and chart reviews are conducted for QA / UR purposes. Outcomes (e.g., improvements in symptoms and functioning, level of satisfaction) are then analyzed and understood in the context of the performance of the process(es).

Document the intent to gather and evaluate this data in the quality work plan, assign accountabilities through the quality program description, and evaluate annually, asking the following questions:

- Is the clinical process of care/service delivery process stable and predictable?
- Are customers satisfied?
- What are the outcomes over time?
- How do we compare to benchmarks for performance measures?

Start with a limited focus and then improve on it, including methods of data collection. As data is collected and design improvements made, evaluate the impact of process improvements; evaluate the QM process itself and revise the work plan and program description.

Infrastructure Design

Key activities at this step

- Legal & Governance Structure
- Reimbursement Model
- Member Services
- Administrative Structures
- Provider Relations
- Clinical/Financial Information Systems

When a network or provider organization begins contracting to serve a population on a risk-basis for mental health services there are several design decisions that must be made regarding the business rules and infrastructure:

- Will the network be set up as a limited liability company, a for-profit corporation, a nonprofit organization or a partnership? What type of contractual relationship will a provider organization have with entities it contracts with for services?
- If more than one organization is involved in providing service under a risk-bearing contract how will they be paid for services rendered? Will the entity holding the risk of a capitated contract subcapitate or case rate providers? Will some services be funded with capitation dollars on a capacity basis (such as crisis services)?

These and other important decisions must be decided prior to implementation. The details of how money flows embody a critical set of decisions that must be integrated into the design.

If a network is formed to service a contract business rules must be created to address provider recruitment, contracting, credentialing, training and profiling.

Policies, workflows, forms, and information systems will need to be created to address client information requests, complaints, compliments, and grievances. These processes will need to be integrated with internal and external performance measures for quality and responsiveness.

The weak link in most in most system designs is the information system. The specifications of the (re)design become the business requirements for the information system. The information system required to manage a network or provider organization responsible for managing risk-bearing contracts is part insurance company system, part clinical system, part medical billing system, and part financial accounting system.

To meet these needs most organizations begin by searching for integrated behavioral health information systems that will meet all of their requirements. To date there are very few organizations that are satisfied with such solutions. Because both technology and the rules for how to manage care has been changing so rapidly, information system vendors have been unable to keep up with the needs of their clients.

Financial Feasibility Modeling

Key activities at this step

- Demand/Capacity Planning
- Revenue/Expense Projections
- Make or Buy Decisions
- Alternative Scenarios

Once the first draft of the system (re)design is complete it needs to be tested for financial feasibility. This involves two balancing processes. Is demand in balance with capacity? Are revenues in balance with expenses? These questions are answered through the development of an electronic spreadsheet-based management flight simulator using the following process.

Historical data is combined with the results of the (re)design process to estimate projected inpatient days, inpatient alternative units of service (days and/or service hours), and outpatient service hours. Using the Service Package Table illustrated in Figure 4, estimates are made of how many clients will be serviced in each package. This then becomes the basis for the number of outpatient hours that will be projected in the flight

Service Package	# to be Served	Average Svc Hrs	Hours Calc
Level 1	600	5.00	3,000
Level 2	300	28.00	8,400
Level 3	100	62.00	6,200
Level 4	150	118.00	17,700
Level 5	50	260.00	13,000
Total	1,200		48,300

simulator.

Figure 5. Outpatient Utilization Calculation

The flight simulator will be used to quantify the number of full time equivalents by discipline (e.g. MD, PhD, MSW), the productivity standard, and the resulting service capacity. This is often presents in the form of service hours available to meet the clinical demand.

	MD	RN	PhD	MA	BA	Total
Current FTE's	2.70	4.50	2.25	22.05	13.50	45.00
Work Hours per Year	1,840	1,840	1,840	1,840	1,840	
Productivity Standard	70%	70%	60%	60%	60%	
Productive Hours per FTE	1,288	1,288	1,104	1,104	1,104	
Direct Svc Hrs Capacity	3,478	5,796	2,484	24,343	14,904	51,005

Figure 6. Capacity Calculation

A crosswalk of the types of services demanded by the covered population with available capacity will help the network or organization determine which services should be provided by staff of the entity and which services should be “bought” from the marketplace. Additional criteria for the make or buy decision include cost, quality, and geographic availability. Purchased services are then input into the flight simulator as units purchased times unit price.

At this point the flight simulator will display the relationship between capacity and demand. In the above example the capacity of 51,005 hours exceeds the demand of 48,300 by 2,705 hours. Key questions to be answered at this point include: How realistic are the projections? Can the productivity standard be met? Are there other populations that can be served with any excess capacity? Does the organization need to consider downsizing the clinical staff?

If demand exceeds capacity examination of the service delivery design, the productivity standards, and the need to hire additional staff or purchase services on a contract basis would need to be examined.

The flight simulator should accommodate capitation revenue, case rate revenue, fee for service revenue, and grant funding. Using the results of the demand projections, revenue will be calculated based on the volumes for each payment method times the projected rates.

Enrolled Lives	15,000
Per Member Per Month Rate	\$ 28.00
Months per Year	12
Annual Capitation Revenue	\$ 5,040,000
Active Cases	500
Annual Case Rate	\$ 2,400.00
Annual Case Rate Revenue	\$ 1,200,000
Total Revenue	\$ 6,240,000

Figure 7. Projected Revenue Calculation

When an organization takes on financial risk it will need to set aside a risk reserve that balances the amount of risk being assumed with the degree of comfort the organization requires. Because a higher comfort level means shifting a greater amount of funds from

service delivery to risk reserve, the organization must be careful to not be overly conservative and set too high of risk reserve. Using probability software may be the most effective way to develop a risk reserve and many flight simulators use packages such as *@Risk™* and *Crystal Ball™* to determine the appropriate reserve.

Using a typical budgeting process, the flight simulator will project the cost of service delivery staff, support staff, other direct service costs and administrative expenses.

At this point the organization will have its first look at whether the clinical design is financially feasible. If the answer is yes, the organization can move on to the next step. If a budget deficit is projected the design team will use the flight simulator to test a variety of changes to the clinical design in an attempt to balance the budget without sacrificing the quality embedded in the design. Because a well designed flight simulator can run dozens of changes in a short time, the design team can work to find the right balance between the “ideal” design and what is affordable.

The last step of the modeling process involves thinking about what might occur if things don’t go as planned in the balanced flight simulator. What will be the effect of increased or decreased enrollment, a different case mix of clients, a lower payment rate or higher write-off percentage than expected? The organization can use the flight simulator to develop a range of scenarios from pessimistic to optimistic. The probability modeling software can then be configured to test the likelihood of the various scenarios so that a final flight simulator scenario can be selected.

Strategic Action Plan

Key activities at this step

- Clinical Delivery System Plan
- Quality Management Plan
- Marketing Plan
- Business Plan
- Information Systems Plan
- Training Plan

Once the design is complete and tested for financial feasibility it is important to compile the work into a plan that can be used as the roadmap for implementation. This includes the following sections.

The **Introduction and Overview** describes the environment in which the organization is operating, the need for change and an overview of the process that is being used to bring about the (re)design. Brief, but clear, this section provides staff, consumers and other key stakeholders with a conceptual framework for understand the strategic action plan.

The next section lists the **Mission, Vision, Values, and Strategic Goals** that have been adopted by the organization. These become the anchors against which all major decisions are tested. “Are we on course?” “Is a given decision consistent with what we want to become?”

The **Action Plan** section lists the activities that must take place to bring about a successful (re)design. This section often includes governance, clinical design, business planning, and infrastructure development action steps. The action plan should include a narrative description of each action step including detailed tasks, resources required to complete the step and comments about each task. All of the steps should then be

combined into a GAANT chart that describes the overall workplan in a graphically-oriented manner.

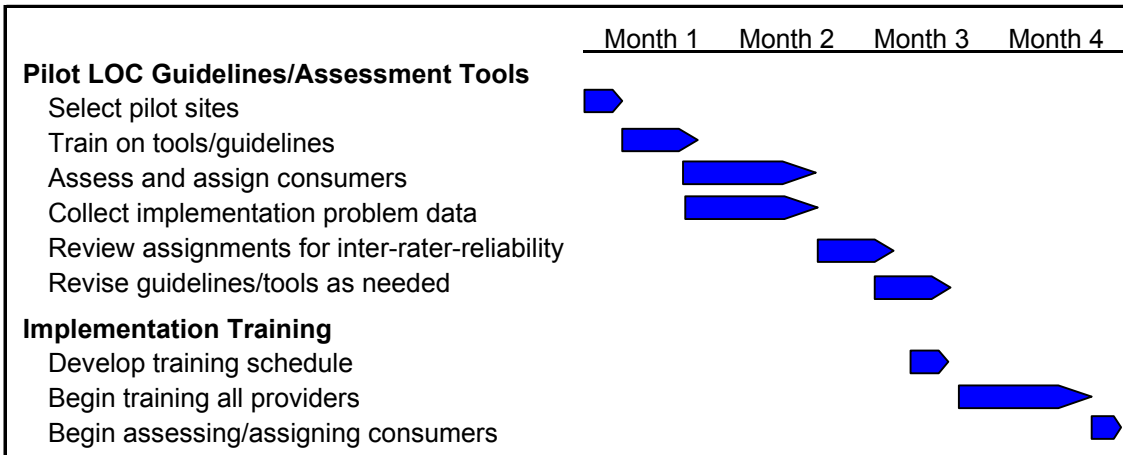


Figure 8. Sample GAANT Chart

Conclusion

Successful change requires solid grounding in understanding the structure of financial risk followed by an in-depth and honest assessment of the internal and external environment leading to a (re)design plan that is appropriate for the community in which an organization is operating. Organizations that succeed are ones that are willing and able to spend the time and resources necessary to create structures that are based on customer requirements, best practice, quality improvement, and the commitment to test all major decisions for financial feasibility.

ⁱ Mauer, B. et. al. How to Respond to Managed Behavioral Healthcare: A Workbook Guide to Your Organization's Success. Tiburon Calif.: CentraLink Publishers Inc., 1995.

ⁱⁱ Edmunds, M. et. al., Editors. Institute of Medicine. Managing Managed Care: Quality Improvement in Behavioral Health. Washington, D.C.: National Academy Press, 1997.