Proactive Approaches to Utilization Management
Chuck Ingoglia
National Council for Community Behavioral Healthcare

Today’s Topics
- Budget Shortfalls & Payment Structures of the Future
- Behind Medical Necessity
- Integrated Healthcare and Parity Values
- Utilization Management and a Refocus on Treatment
- External Authorizations and Third Party Management

Budget Shortfalls Are Putting Pressure on Medicaid & MH/SUD Programs
- States have over $4 billion from mental health agency budgets over the course of the recession
- Proposed Medicaid cost-saving measures in Florida for FY2013:
  - Reduce provider payments
  - Limit benefits
  - Enhanced program integrity efforts

Payment Systems of the Future
- New payment structures that incentivize care management will become the norm
  - Shared savings
  - Bundled payments
  - Healthcare Homes
  - Accountable Care Organizations
  - And more
- Placing providers who cannot successfully manage care for these populations at risk for decreased payments or inability to succeed in the new healthcare ecosystem
Increasing Access to Behavioral Healthcare: Managed Care Options and Requirements

Provides answers to questions such as:

• Should you carve in with managed care organizations or carve out with managed BH organizations?
• What type of services are MCOs and MBHOs looking to contract for, and what makes your organization appealing as a contractor?
• What type of quality/cost outcomes are managed care entities seeking?
• What do managed care contractual obligations and plan offerings look like?

An Unsustainable Crisis

Healthcare costs continue to rise

• Exceed workers’ earnings by 3-4x
• $2.6T in annual healthcare costs, which is > 3x the $714B spent in 1990
• An estimated 1/3 is duplicate or waste

Inappropriate utilization of hospitalizations

• Patients suffer a 6% complication rate for every day of hospitalization
• 98,000 people die prematurely in hospitals every year
• 20% readmission rate, which results in more costly care and complications, including a higher risk of hospital acquired conditions & infections
• In 2000, $14,000 treatment complications cost $19B

Variation in care

• Recommended care is being delivered 55% of the time
• Case-mix adjusted hospital death rates vary 400%
• Dartmouth Center for Evaluative Clinical Sciences estimates that 30% of Medicare spending is wasted

Gaps in Quality Care: Recommended vs. Actual Care Delivered

Adherence to Quality Indicators

<table>
<thead>
<tr>
<th>Service</th>
<th>Expected</th>
<th>Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Cancer</td>
<td>80.7%</td>
<td>55.5%</td>
</tr>
<tr>
<td>Preventive Care</td>
<td>75.5%</td>
<td>50.3%</td>
</tr>
<tr>
<td>Cancer Care</td>
<td>98.5%</td>
<td>81.7%</td>
</tr>
<tr>
<td>Coronary Artery Disease</td>
<td>98.5%</td>
<td>81.7%</td>
</tr>
<tr>
<td>Hypertension</td>
<td>94.7%</td>
<td>71.8%</td>
</tr>
<tr>
<td>Congestive Heart Failure</td>
<td>92.4%</td>
<td>70.4%</td>
</tr>
<tr>
<td>Depression</td>
<td>97%</td>
<td>82%</td>
</tr>
<tr>
<td>Chronic Conditions</td>
<td>97%</td>
<td>82%</td>
</tr>
<tr>
<td>Colorectal Cancer</td>
<td>98.8%</td>
<td>82.5%</td>
</tr>
<tr>
<td>Anemia</td>
<td>97%</td>
<td>82%</td>
</tr>
<tr>
<td>Renal Failure</td>
<td>88.6%</td>
<td>69.4%</td>
</tr>
<tr>
<td>Hypothyroid</td>
<td>46.4%</td>
<td>25.5%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>46.4%</td>
<td>25.5%</td>
</tr>
<tr>
<td>Diabetes Mellitus</td>
<td>46.4%</td>
<td>25.5%</td>
</tr>
<tr>
<td>Venous Thromboembolic Disorders</td>
<td>46.4%</td>
<td>25.5%</td>
</tr>
<tr>
<td>Ulcers</td>
<td>39.1%</td>
<td>23.3%</td>
</tr>
<tr>
<td>Hip Fracture</td>
<td>39.1%</td>
<td>23.3%</td>
</tr>
</tbody>
</table>

Tools to Improve Quality and Cost Outcomes

Criteria for Determining Medical Necessity

Rigorous and consistent clinical management of:

• Scientific Evidence
  • Standards will be based on credible published scientific evidence, supported by controlled clinical trials or observational studies
• Clinical Appropriateness
  • Services must be clinically appropriate for individual members in terms of type, frequency, extent and duration
• Cost Effectiveness
  • Services must not be more costly than an alternative service that is at least as likely to produce equivalent diagnostic or therapeutic results

Behind Medical Necessity
Medical Necessity: Hierarchy of Evidence

- Statistically robust, well-designed randomized controlled trials
- Statistically robust, well-designed cohort studies
- Large, multi-site observational studies
- Single-site observational studies
- Expert opinion using Cochrane grading
- In the absence of incontrovertible scientific evidence, medical policies may be based upon national consensus statements by recognized authorities

Example: UnitedHealthcare’s Medical Necessity Hierarchy

- The following stratification describes the hierarchy of use of medical policies and clinical guidelines within UnitedHealthcare:
  - National guidelines and consensus statements, e.g., USPSTF recommendations
  - NIH clinical statements
  - AHRQ clinical statements
  - Evidence-based nationally recognized guidelines
  - CMS NCDs
  - Clinical position papers of professional specialty societies, e.g., ACP, ACC, ACCP, when their statements are based upon referenced clinical evidence
  - Particularly for new or emerging medical technologies, no health service will be deemed unproven solely on the basis of a lack of randomized controlled trials.
  - Similarly, UnitedHealthcare will develop no medical policies solely on expert opinion.

Example: UnitedHealthcare’s Benefit Coverage Review Hierarchy

- While evidence-based science forms the basis of our adjudication of coverage, a hierarchy of review takes precedence over clinical policy:
  - Eligibility: the enrollee must be eligible for coverage of the service at the time it is requested.
  - Federal and state mandates, including:
    - Medicare NCDs apply to all Medicare beneficiaries
    - Medicare LCDs apply to Medicare beneficiaries in the regions in which they are written
    - Medicaid mandates, written state by state
    - State-specific mandates (commercial enrollees)
  - Benefit document: services that are explicitly included or excluded from benefit coverage take precedence over an evidence-based medical policy.

Pre-Service Review as a Tool: Guidelines for Application

- Diagnostic or therapeutic service is included as an insured benefit.
- Utilization of service reflects high variation in quality.
- Utilization of service reflects high variation in costs.
- Independent and credible guidelines define appropriate use of services.
- Management of services reflects significant impact potential to improve quality, patient safety, and/or costs.
- Complies with regulatory and accreditation standards, including use of highly trained nurses, pharmacists, and physicians.

Pre-Service Review: Managing Unwarranted Variation

<table>
<thead>
<tr>
<th>Diagnostic/Treatment Service</th>
<th>Rationale</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advanced Medical Imaging</td>
<td>Reduce risk of radiation exposure</td>
<td>9.9% inappropriate utilization</td>
</tr>
<tr>
<td>Spine Surgery</td>
<td>Prevent end-stage disease</td>
<td>6.4% inappropriate utilization</td>
</tr>
<tr>
<td>Elective Surgery (Eligible for GapFill)</td>
<td>Prevent evidence-based treatment</td>
<td>3.8% inappropriate utilization</td>
</tr>
<tr>
<td>Plastic Reconstructive Surgery</td>
<td>Decrease cost outcomes for consumer</td>
<td>3.7% inappropriate utilization</td>
</tr>
<tr>
<td>Joint Replacement</td>
<td>Increase benefit coverage for consumer</td>
<td>3.7% inappropriate utilization</td>
</tr>
<tr>
<td>Urology Procedures</td>
<td>Reduce inappropriate endoscopy</td>
<td>3.0% inappropriate utilization</td>
</tr>
<tr>
<td>Breast Reconstruction – Invasive</td>
<td>Increase benefit coverage for consumer</td>
<td>1.2% inappropriate utilization</td>
</tr>
<tr>
<td>Genetic Testing – BRCA</td>
<td>Reduce unnecessary genetic testing</td>
<td>1.2% inappropriate utilization</td>
</tr>
</tbody>
</table>

Post-Service Review as a Tool – Guidelines for Application

- Similar to pre-service review.
- Review warranted where billed codes fall outside of established standards for specific services.
  - Claim submission accurately represents service performed.
  - Often includes medical record review to verify claims details.
- Billing and coding standards are reviewed and updated on a regular basis to ensure they reflect current industry standards & practices.
Integrated Healthcare and Parity Values:

What values will shape the approach to health system redesign/reform?

Under an Accountable Care Organization Model the Value of Behavioral Health Services will depend upon our ability to:
1. Be Accessible (Fast Access to all Needed Services)
2. Be Efficient (Provide high Quality Services at Lowest Possible Cost)
3. Electronic Health Record capacity to connect with other providers
4. Focus on Episodic Care Needs/Bundled Payments
5. Produce Outcomes!
   • Engaged Clients and Natural Support Network
   • Help Clients Self Manage Their Wellness and Recovery
   • Greatly Reduce Need for Disruptive/ High Cost Services

“Making the Business Case” Support
1. Incorporate as much objective data as possible to support awareness of service delivery capacity being delivered by association members
2. Provide demographic, diagnostic and population groups served information
3. Provide service locations/clinics by county/region with a companion service array table to support awareness of services/programs available
4. Identify qualitative outcomes that provide a shift from "providing services" to focus on value/quality
5. Identify "unique factors" that association members can provide (i.e., historical community based case management/coordination of care experience, etc.)

Total Count of Persons Served Trend

Persons Served by County or Region

Age Groups Served Statewide

<table>
<thead>
<tr>
<th>Statewide Totals</th>
<th>Clients</th>
<th>%</th>
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<tbody>
<tr>
<td>0-5</td>
<td>788</td>
<td>1.94%</td>
</tr>
<tr>
<td>06-11</td>
<td>3,905</td>
<td>5.62%</td>
</tr>
<tr>
<td>12-17</td>
<td>6,147</td>
<td>15.14%</td>
</tr>
<tr>
<td>18-59</td>
<td>26,696</td>
<td>64.28%</td>
</tr>
<tr>
<td>60+</td>
<td>3,600</td>
<td>8.97%</td>
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</table>
Service Mix Provided Statewide

<table>
<thead>
<tr>
<th>State Service</th>
<th>Clients</th>
<th>%</th>
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</thead>
<tbody>
<tr>
<td>Assessment</td>
<td>8,555</td>
<td>9.75%</td>
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<tr>
<td>Case Management</td>
<td>21,564</td>
<td>24.54%</td>
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<tr>
<td>Day Treatment</td>
<td>422</td>
<td>0.48%</td>
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<tr>
<td>Emergency/Case</td>
<td>3,661</td>
<td>4.1%</td>
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<tr>
<td>Family Therapy</td>
<td>3,987</td>
<td>4.54%</td>
</tr>
<tr>
<td>Group Therapy</td>
<td>5,465</td>
<td>6.22%</td>
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<tr>
<td>Individual Therapy</td>
<td>18,067</td>
<td>20.7%</td>
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<tr>
<td>Mail Management</td>
<td>19,764</td>
<td>22.51%</td>
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<tr>
<td>Other Service</td>
<td>3,983</td>
<td>4.54%</td>
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<tr>
<td>Psychiatric Evaluation</td>
<td>2,364</td>
<td>2.83%</td>
</tr>
<tr>
<td>Psychological Testing</td>
<td>65</td>
<td>0.06%</td>
</tr>
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</table>

Total Persons Served: 397,270
% of Total Persons: 100%

Notes:
1. Person Counts may be duplicated due to change in benefits during CY2009
2. Counts represent persons with at least one event paid by indicated payer or self-pay

Utilization Management and a Refocus on Treatment

Utilization Review Vs. Utilization Management

> Utilization Review is primarily focused on retrospective review of what has or has not happened in services
> Utilization Management is focused on retrospective, concurrent and prospective management of service delivery capacity from intake to discharge and every thing in between

Key Qualitative Based Utilization Management Focus Area to Support UM Plan

> Are we treating the illness we have professionally diagnosed that each client has?

OR

> Are we carrying inactive active caseload members?... (i.e., Clinical Protocols that require Therapist to Carry Chart for Physicians)

Sample Definition of Treatment

Define a definition of "treatment" and therefore what is not treatment:
Sample Definition:
"Behavioral health therapeutic interventions provided by licensed or trained/certified staff either face to face or by payer recognized telephonic/Telepsychiatry processes that address assessed needs in the areas of symptoms, behaviors, functional deficits, and other deficits/ barriers directly related to or resulting from the diagnosed behavioral health disorder."
What Treatment is Not... A Major UM Concern

Carrying cases in order to:
> Provide treatment planning and other documentation support to “medication only” clients
> Providing pseudo services to unengaged clients to support maintenance of benefits or legal conditions
> Avoid closing cases

Refocusing on Treatment

> Develop internal level of care expectations based on assessed needs and client choice (benefit packages)
> Review caseloads to determine if beneficial treatment levels are being provided
> Employ person centered/driven engagement strategies to engage/re-engage individuals with legitimate needs
> Address caseloads accordingly to ensure that your resources are maximized to provide treatment!

Integrated Quality Improvement/ Organizational Structure

Clinical and Support/Administrative staff assigned based on size of organization and active caseload

Focus Areas for UM Plan

Front End (i.e., Screening/Triage, Eligibility, Emergency Services, Referrals, etc.)
Concurrent (i.e., Urgent/Routine Transfer/Discharge Criteria/Planning, Services for high risk consumers, qualitative review of clinical documentation and treatment planning, etc.)
Retrospective (i.e., Qualitative/ Quantitative Review of Charts and Outcomes/Satisfaction Measures, etc.)
Overview of Utilization Management

The Utilization Management Program’s mission is to provide a decision support system for clinicians and managers. The Utilization Management Program will provide feedback on service utilization to clinicians and managers on behalf of clients. The Utilization Management Program will monitor and report on system wide service utilization patterns. The UM Program will also provide concurrent utilization review of individual client service needs.

UM Plan Summary

Assumptions
1. Management of service utilization is necessary to assure optimal use of MH resources on behalf of clients.
2. Utilization Management can provide a decision support system for managing service utilization.
3. Programs and service modalities have discrete functions linked to client outcome.
4. Medical/clinical necessity criteria, levels of care, and practice standards are valid and reliable mechanisms for systems management.
5. If a client is receiving the appropriate level of care and service modalities the result will be improved client outcomes.

Objectives
1. Facilitate access to and availability of needed services.
2. Facilitate service coordination and continuity of care.
3. Implement a set of review criteria, protocols, and clinical policy guidelines.
4. Provide timely review of service utilization.
5. Monitor utilization trends and recommend changes in practice patterns/resource deployment.
6. Contribute to performance improvement/quality assurance.

Chart Review Sampling Requirements/Procedures Authorized:
1. Level I Review: 100% reviews shall be conducted on all admissions, continuing stays, and discharges, as outlined in Administrative Policies.
2. Level II Review:
   - Substance Abuse Services:
     - A service data report is generated to identify all admissions, continuing stays, and discharges within each quarter.
     - The UM Chairperson receives the list and calculates the number of files to be reviewed as outlined in Administrative Policies.
     - A minimum sample of 10% of all Medicaid files must be weighed for each quarter. 30% of all cases for review each quarter.
   - Mental Health:
     - A service data report is generated to identify all admissions, continuing stays, and discharges within each quarter.
     - The Support Team Manager receives the list and calculates the number of files to be reviewed as outlined in Administrative Policies.
     - A minimum sample of 10% of all Medicaid files will be reviewed quarterly. The cases for review will be selected on a random basis.

UM Plan Summary

Goal
To ensure highest quality mental health services to all persons served by MHS at the most appropriate level of care, in the most appropriate setting, in the least restrictive environment, by the most appropriate provider and in the most cost effective manner possible.

Accountability Loop:

SANCTIONS:
Staff are expected to maintain clinical records in accordance with all applicable laws, rules, regulations, and policies. When clinical records are found to be in non-compliance, Management will work with staff to develop corrective plans of action to address deficiencies. Management will monitor the progress toward completing corrective plans of action and will continue to review files to make sure that the problem has been corrected within the time frames agreed upon in the corrective plan. Staff who fail to follow-through with the corrective plan of action will be subject to disciplinary action, up to, and including, termination. Failure to follow through with recommendations made at any review level will result in disciplinary action, up to, and including, termination.
Clinical (Medical) Necessity Criteria
(Services recommended in the treatment plan must meet all of the following criteria)
1. Treatment must be no more and no less than the client requires based on diagnosis/symptoms/behaviors/skills/abilities/functioning.
2. Treatment is safe and effective according to national standards.
3. Treatment is in the least restrictive setting.
4. Treatment is cost effective.

Source: UM Plan for DuPage County Mental Health

Levels of Care/Benefit Design:
- Level of care guidelines will be used to determine the kind and intensity of services necessary to achieve treatment benefits. Level of care guidelines provide a framework for determining who is eligible for which services at what level of intensity and for how long.
- Utilization Management will provide clinicians with a decision support tool to assist them in assigning clients to the appropriate level of care.
- The same decision support tool will be incorporated into treatment planning and used for all utilization review.
- If possible, the decision support tool will be used for both program evaluation (client outcomes) and utilization management.
- Utilization Management will investigate whether these outcome measures are useful for level of care assignment and make recommendations.

Internal Benefit Design/Levels of Care Provide the Required Framework for UM Plans and to Create Capacity for New Clients to Receive Treatment
1. Development of internal levels of care/benefit package designs to support appropriate utilization levels for all consumers.
2. Core Elements of Benefit Design/LOC Model:
   - Admission Criteria (as objective as possible using Diagnostic Profiles, DLA-20/LOCUS scores, etc.)
   - Continue Stay Criteria
   - Transition/Discharge Criteria
   - Service Array and Frequency to be Provided
   - Projected Service Duration within each level.

Engagement Based Same Day Access/Treatment Plan Model Using Benefit Design/Level of Care Criteria
Purpose is to establish Group Practice Clinical Guidelines to Facilitate Integration of all services into one service plan. Provide an awareness to consumers at entry to services the types of services and duration of services the practice has found most helpful to meet their treatment needs so that the consumer will know and the staff will know what services are needed to complete that level of care. Moves consumers to a more recovery/resiliency based service planning and service delivery approach. Facilitates being able to use centralized scheduling using the actual service plan of each consumer.

Standards of Care/Best Practices:
- How will the MHC ensure that Units/Programs and staff attain service delivery consistent with "Standards of Care" for each level of care?
- Also, how will MHC ensure that services within each level of care are consistent with best practice protocols (i.e., Practice standards for many MH services are listed in the DHS Program Book).

Other Samples of Level of Care Guidelines
1. Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS) Adult Version 2000 developed by the American Association of Community Psychiatrists
2. Child and Adolescent Level of Care Utilization System (CALOCUS) Version 1.5 developed by the American Academy of Child and Adolescent Psychiatry and American Association of Community Psychiatrists
3. Vermont Clinical Guidelines developed by the Behavioral Health Network of Vermont and available through the National Council of Community Behavioral Healthcare in Rockville, MD
4. Other appropriate Level of Care or Clinical Practice Guidelines can be used to provide clinical tools for staff to help ensure that appropriate utilization, intensity, frequency and duration of services is provided within Medical Necessity criteria.
UM Plan Clinical Tools Needed

Utilization Management Procedures:
* "The provider shall have a written utilization review (UR) plan and ongoing activities to assess:
1. The appropriateness of Medicaid community mental health services
2. Intensity/level of services, and
3. Continued services for the client.
4. Such services may be subject to utilization management parameters established by the public payer.

UM Plan Clinical Tools Needed

Utilization Management Procedures (Cont’d):
* > Describe in the written Plan the methods and procedures for performing and recording individual case reviews by persons not involved in providing services to the clients whose records are reviewed
> Need to define the authority and functions of the individual case review designated unit, which may be:
  1. A representative committee, chaired by a QMHP, and including QMHPs, MHPs, and RSAs; or
  2. A QMHP

UM Plan Clinical Tools Needed

Utilization Management Procedures (Cont’d):
* > How will the MHC ensure that appropriate utilization reviews are provided by UM Program?
> Will the reviews be retrospective or concurrent and how will result affect each six-month treatment plan review/revision?
> Need procedures in Plan describing the method for selecting cases for quarterly case review and the procedures for reviewing 10 per cent of the clients served under annually
> Need procedures in Plan to ensure that the review includes and summarizes the client's progress over the previous 90 days

UM Plan Clinical Tools Needed

Monitoring Client Care
* > What treatment milestones that will be used to monitor consumers' care and progress (i.e., Treatment Plan Reviews or Annual Updates)?
> Who will monitor consumer services delivered and progress attained?
> What procedures will be used for utilization review of individual client's use of available funds, medication expenditures or other community based resources.

UM Plan Clinical Tools Needed

UM Information Sources and Documentation Requirements
* > What data elements/fields or information will be used to monitor/measure outlier management process?
> What forms/written process will be used to document utilization reviews and inform staff and clinical managers of findings?
> How will information regarding findings be conveyed to appropriate staff?
> Need procedures in Plan for following up on case review recommendations.
External Authorizations and Third Party Management

UM Plan Clinical Tools Needed

Review Levels and Appeal Process:
> Need procedures in Plan for appeal by clients and staff affected by the UM decisions with which they disagree

Level One Appeal of Review Findings: (Sample of typical Level One Appeal protocol)
> The first level of appeal occurs only when the provider and/or consumer are not satisfied with the result of utilization review process regarding Medical Necessity determination for appropriateness for continued service intensity, frequency and/or duration. The first level of appeal is processed in a manner to ensure independent review of the relevant issues of the appeal by a UM Review Panel. Requests for first appeals can be made either concurrently or retrospectively but not both. Concurrent first level of appeal can be made verbally followed by a written notification by fax or writing. All retrospective first level of appeal must be made in writing.

Level Two Appeal: (Sample of typical Level Two Appeal protocol)
> A second appeal is available to the client and/or clinician in the appeals process. It occurs only when the provider and/or consumer are not satisfied with the result of the first level of appeal. Second level of appeals is processed in a manner to ensure independent review of the relevant issues of the appeal.
> Requests for second appeals can be made either concurrently or retrospectively but not both. Concurrent second level of appeal can be made verbally followed by a written notification by fax or writing. All retrospective second level of appeal must be made in writing.

Third Party/Managed Care Utilization Management Plan Components:

Internal utilization management processes and support staff to help ensure:
- Pre-Certification, authorizations and re-authorizations are obtained
- Referrals are made to only clinicians credentialed on the appropriate third party panels
- Appropriate front desk co-pay collections
- Timely/Accurate claim submission to support payment for services provided

Source: DuPage County Mental Health, Wheaton, Illinois
UR/UM Plan Clinical Tools Needed

Entry Into Care
1. What are the Access to Care standards for consumers per level of acuity that are required by the third party payers (Emergent = within one hour, Urgent = within 24 hours and Routine = within 7 to 10 days)?
2. Who will:
   • Determine the type of Third Party Insurance a client has
   • Obtain initial authorization prior to service delivery and
   • Refer the client to a clinician that is credentialed on the right insurance company panel?
   • Confirm if an additional authorization is needed to continue services after the initial intake/assessment
3. What clinical tool(s)/Reports will they use to make the assignment (i.e., Access data base of all third party payers and the clinicians credentialed on each panel, etc.)?

Re-Authorizations During Service
1. Who will:
   • Confirm the number of sessions that have been delivered against the current authorization from payer
   • Obtain re-authorization prior to the end of the current authorization if additional services are clinically needed, and
   • Engage in appeals process with payer if re-authorization is denied?
2. What clinical tool(s)/Reports will they need/use to monitor current authorization levels and confirm need for re-authorizations (i.e., Number of remaining session in current authorization are recorded in centralized scheduler, etc.)?

Roles of Support Staff In Third Party Billing
1. Centralized Scheduling is needed to ensure referral is made to clinician on the appropriate insurance panel
   • Ability to know at all times the availability of clinical staff that are credential on third party panels will be critical to timely acceptance of new referrals
2. Re-think Front Desk functions/needs
   • Collection of Co-Pays prior to Service
   • Confirmation of Insurance via copy of Insurance cards prior to service

Roles of Clinical and Financial Staff In Third Party Billing
1. Completion and submission of all required clinical documentation by direct care staff will be needed to support authorizations after Intake (if required) and re-authorizations
2. Filing timely and accurate claims will be critical
3. Monitoring level of unreimbursed third party care – determine reasons for non payment and correct issues

Questions and Feedback
> Questions?
> Feedback?
> Next Steps?
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