



# From Pay-for-Volume to Pay-for-Value: From Fee-for Service to Bundled and Capitated Rates

**Presented by:**

Michael Flora, MBA, M.A.Ed.

Senior operations and Management Consultant

MTM Services

E-mail: [michael.flora@mtmservices.org](mailto:michael.flora@mtmservices.org)

Web Site: [mtmservices.org](http://mtmservices.org)



## Learning Objectives

- Define proven strategies in back office readiness to meet payer demands
- Recall how to improve work flows for efficiency in billing operations
- Identify top billing challenges by reason code, percentage and dollar amount
- Review sample performance indicator reports for clinical and non-clinical staff



## Overview

- As states and their managed care companies tip toe into “value based” payment, mental health and addiction organizations need to shift their clinical, back office and front office operations to meet payer expectations. Organizations must define an episode of care including authorization, and re-authorization practices; develop collection and co-pay processes; and develop systems that generate reports that illustrate value through measurement of outcomes and attainment of goals. Critical to success are strategies for staff recruitment, retention, performance, and leadership development.



## Overview

- More provider contracts move away from strictly fee-for-service agreements with single fee schedules and towards contracts based in pay-for-performance, case rates, and upside/downside risk, behavioral health organizations are finding themselves wanting for more sophisticated back office management functionality.
- What level staffing is necessary to capture revenue under these new arrangements and monitor corporate compliance?
- What new workflows need to be put in place?

# Revenue Cycle Management



**PRE-SERVICE**  
Admission Eligibility  
Pre-Service Audit  
Authorization  
Verification  
Open to Schedule



**POINT OF SERVICE**  
Co-Pay Collections  
Treatment  
Post Session Scheduling  
Post Service Audit



**POST SERVICE**  
Billing  
Denial Management  
Account Receivable  
Management  
Cash Posting  
Consumer Follow-Up

**Key Performance Indicators**



## Challenges to the Revenue Cycle with complex contracts

- Effective, Efficient Operations Will Help to Minimize the Impacts of Value Based and Bundled Rate contracts
  - Increased compliance,
  - reduced rates,
  - outcomes focused,
  - Integration,
  - Denials, Failed Claims and complicated MCO, Medicare and Medicaid rules.

# How do Bundled Payments work? And what does it mean for my organization?

- **Bundled payment**, also known as **episode-based payment**, **episode payment**, **episode-of-care payment**, **case rate**, **evidence-based case rate**, **global bundled payment**, **global payment**, **package pricing**, or **packaged pricing**, is defined as the reimbursement of provider "on the basis of expected costs for clinically-defined episodes of care"
- It has been described as "a middle ground" between fee for service and capitation
- Bundled payments have been proposed in the healthcare reform as a strategy for reducing costs
- Commercial payers have shown interest in bundled payments in order to reduce costs.
- In 2012, it was estimated that approximately one-third of the United States healthcare reimbursement used bundled methodology.

Source: adapted from [https://en.wikipedia.org/wiki/Bundled\\_payment](https://en.wikipedia.org/wiki/Bundled_payment)



- According to a 2016 study by McKesson and ORC International, health plans predict bundled payments will grow 6% over the next five years, making them the fastest-growing of all payment models within health plans. Both payers and hospitals expect that bundled payments will account for 17% of medical payments in five years. But, only half of payers and 40% of providers report a readiness to implement bundles.

Source: <https://www.forbes.com/sites/realspin/2017/03/30/bundled-payments-and-episodes-of-care-whats-next/#4e18751be468>





- In a study this year in *JAMA Internal Medicine*, found that from 2008 to 2015 at San Antonio's Baptist Health System, which participated in Medicare's bundled payment initiatives, average Medicare episode expenditures declined 20.8% for episodes of lower-extremity joint replacement surgery without complications, and 13.8% for episodes with complications. Episodes with prolonged lengths of stay decreased 67%. Rates of readmissions and emergency room visits did not change significantly, and severity of patient illness remained stable. Average post-acute care spending declined 27% per case, but only when the bundles included financial responsibility for post-acute care. A research brief on the study concludes, "Hospitals can generate savings without compromising on quality."

Source: <https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2594805>



## Strategies to Prepare for the future....

- Identify your costs
- Identify the services provided within a defined episode of care
- Understand how the episode of care will be reimbursed
- Develop care coordination and service utilization management
- Create efficiencies to reduce waste, eliminate redundancy, and improve provider documentation
- Review your current service data to look at LOC by diagnosis and service gestalts



## Processes that Impact the Revenue Cycle

- Referral
- Authorization Process
- Scheduling
- Encounter/Documentation
- Charge Capture
- Billing
- Denials
- Failed Claims
- Follow-up Functions
- Cash Posting





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**Key Performance Indicators**



## Contract and Enrollment Management

- Develop internal protocols for all Support team members regarding Contract and Enrollment Management
- Anchor KPIs and Protocols in Job Descriptions

## Patient Scheduling

- Assure that all consumers have the appropriate authorizations, updated treatment plans and that services scheduled are ordered on the Treatment Plan PRIOR to services being scheduled.
- If not Ordered, Assessed, Authorized or Medically Necessary---

**DO NOT SCHEDULE**

## Eligibility/Benefits Management

- Develop Protocols for Client Eligibility and Benefits management
- Review Third Party Administration to assist with this back office function

## Registration

- Develop Protocols and KPIs for Client Registration into the state or appropriate payer portals.
- Example: All new consumer will be registered same day of service 100% of the time



# Pre-Service Audit



Program Reviewed:  MH/A  MH(C&F)  Medical Services  Site A  Site B  
 Date of Review: \_\_\_\_\_  Opened  Site C  Site D  
 \_\_\_\_\_  \_\_\_\_\_  \_\_\_\_\_  Other  
 Client Name: \_\_\_\_\_ Client ID: \_\_\_\_\_  
 CCC / Provider for Scheduled Service: \_\_\_\_\_ / \_\_\_\_\_  
 Medicaid  Medicare  Insurance  Uninsured  Other  
 Is spend Down met  Yes  No Is service covered  Yes  No

Date Opened: \_\_\_\_\_ TX Plan Date: \_\_\_\_\_ Date Closed: \_\_\_\_\_

IDENTIFYING AND BASIC INFORMATION	Location/Screen	Yes	No	Post Service Follow up/ resolution
1. Name				
2. Date of Birth				
3. Address and Telephone Number				
4. Next of Kin or Legal Guardian				
5. Signed Informed Consent/Client Rights				
6. Primary Language/Method of Communication				
<b>FINANCIAL INFORMATION</b>				
1. Signed Financial Fee Agreement				
2. Proof income verified ( at least annually)/ Dependents FS-2				
3. Medicaid Identification Number/Policy Numbers/ Ins Verification on file				
4. Co-Pay amounts/Balance Due				
5. Ins Authorizations are current for service scheduled				
<b>Point of Service</b>				
1. Assessment is current within 12 months /Annual				
2. ROIs are current ( PCP, Schools, Parents Etc.)				
3. Tx Plan Current and Signed				
4. Disclosure Statement in Chart				
5. Hosp Discharge / Requested Medical Records on File				
6. Treatment Agreement				
7. Consent to treatment are current				

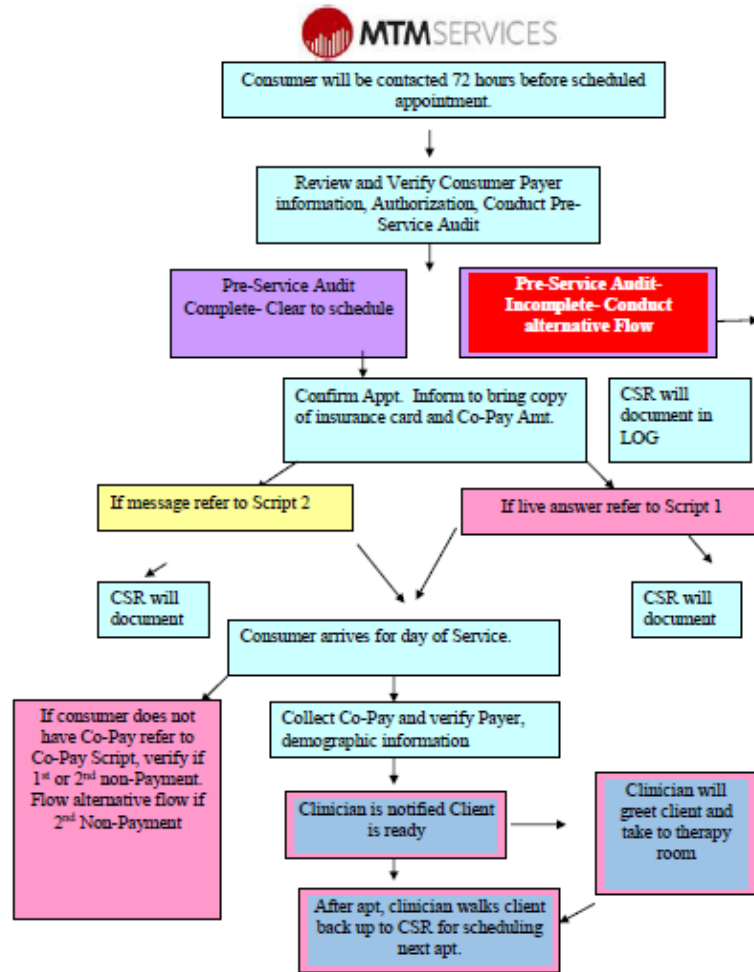
- Develop Protocols to review all services at least 72 hours prior to services being rendered
- For Open Access to care-develop protocols for Same day review of eligibility and consumer fee determination

## Back Office Management

- There is a growing concern across all providers as payers move to managed care, episode of care and value based purchasing requiring more sophisticated work flows and monitoring on the revenue cycle.



Sample Consumer Pre-Service and Point of Service Check-In Work Flow



# Pre and Point of Service Work flow

# Non-Clinical Performance indicators

front desk	Business/Billing office	call center	schedulers
85% of all appointments that are canceled within 48 hours will be backfilled	Denial rate of insurance payment will be less than 1%	100% of all calls will be answered live during normal operating hours	85% of all appointments that are canceled within 48 hours will be backfilled
99% of copays will be collected at the time of service	Third party fees will be billed 100% of the time within the timely filing deadline.	Unanswered or dropped calls shall not exceed 1%	100% of all calls will be answered live during normal operating hours
Intake paperwork will be processed same day of service		All eligible clients initial appointments will be offered an initial appt. same day next day 100% of the time	100% of all confirmation calls will be completed prior to 48 hours of service
Will have less than 2% dropped call rate	100% of financials will be updated in E.H.R. within 24 hours of receipt	Will have less than 2% dropped call rate & All calls are answered by 3rd ring	All calls are answered by 3rd ring
All calls are answered by 3rd ring	Will have 99% accuracy in EHR on entering information	Will have 99% accuracy in EHR on entering information	Will have less than 2% dropped call rate
Will have 99% accuracy in E.H.R. on entering information		No more than 5% of day logged out as unavailable	Will have 99% accuracy in E.H.R. on entering information
100% of required trainings will be completed within specified time frames.	100% of required trainings will be completed within specified time frames.	100% of required trainings will be completed within specified time frames.	100% of required trainings will be completed within specified time frames.
all client financial and demographic information will be refreshed at each visit		all client financial and demographic information will be refreshed at each visit	
100% of all confirmation calls will be completed prior to 48 hours of service			

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## Point of Service

1. Collection of Co-Pays
2. Clinical Care Documentation
3. Charge capture
4. Coding
5. Utilization Management



## Clinical Care Documentation

- Clinical Documentation must support the services provided for the day
- Services provided must be on the Treatment Plan and Assessment of need
- Documentation must be completed and accurately submitted within 24 hours after service is rendered.





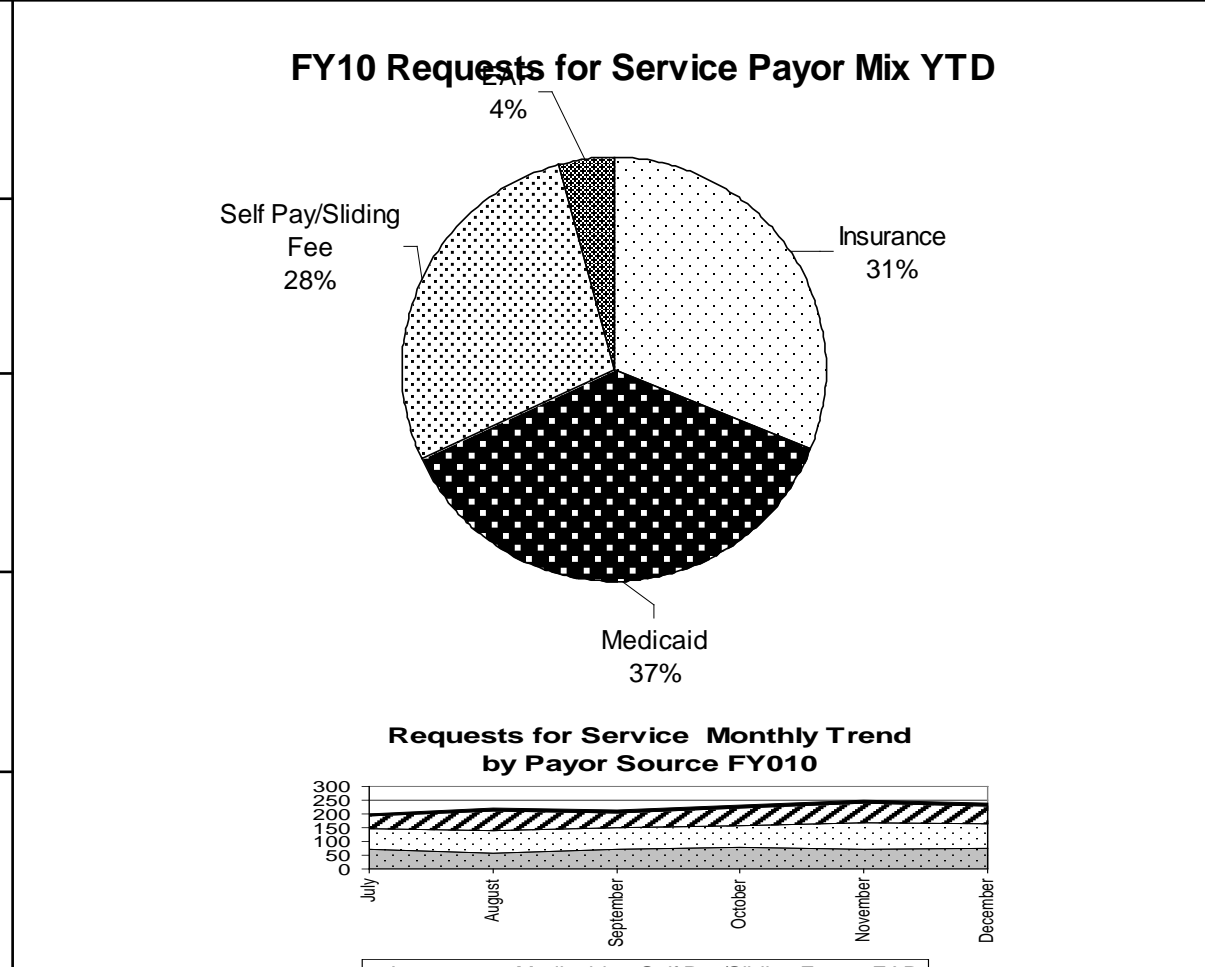
## Revenue Cycle – Payer Awareness

- Who are your payers now?
- Who will be your payers moving forward?
- What will the payer requirements be?
- Billing
- Timely Filing
- Modifiers
- Codes etc.
- Documentation standards
- Any other issues that may have an impact?

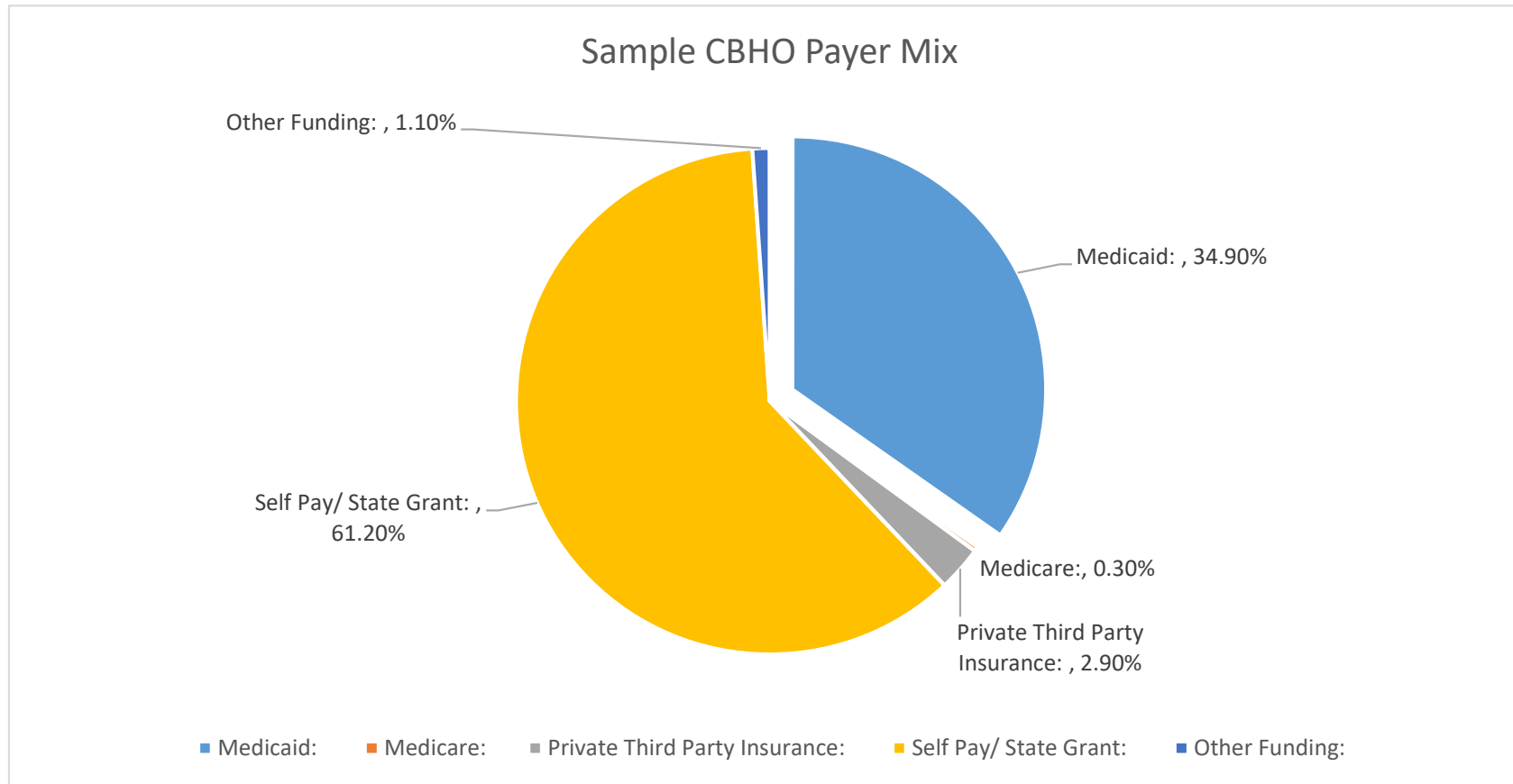


# Payer Mix Dashboard

Objective	Increase service delivery /market share to Third Party payers
Measure Type	Financial
Goal	Third Party revenues will increase over previous fiscal year
Result	Third party referrals are at 31%.
Comments	Given the economic conditions market share remains consistent

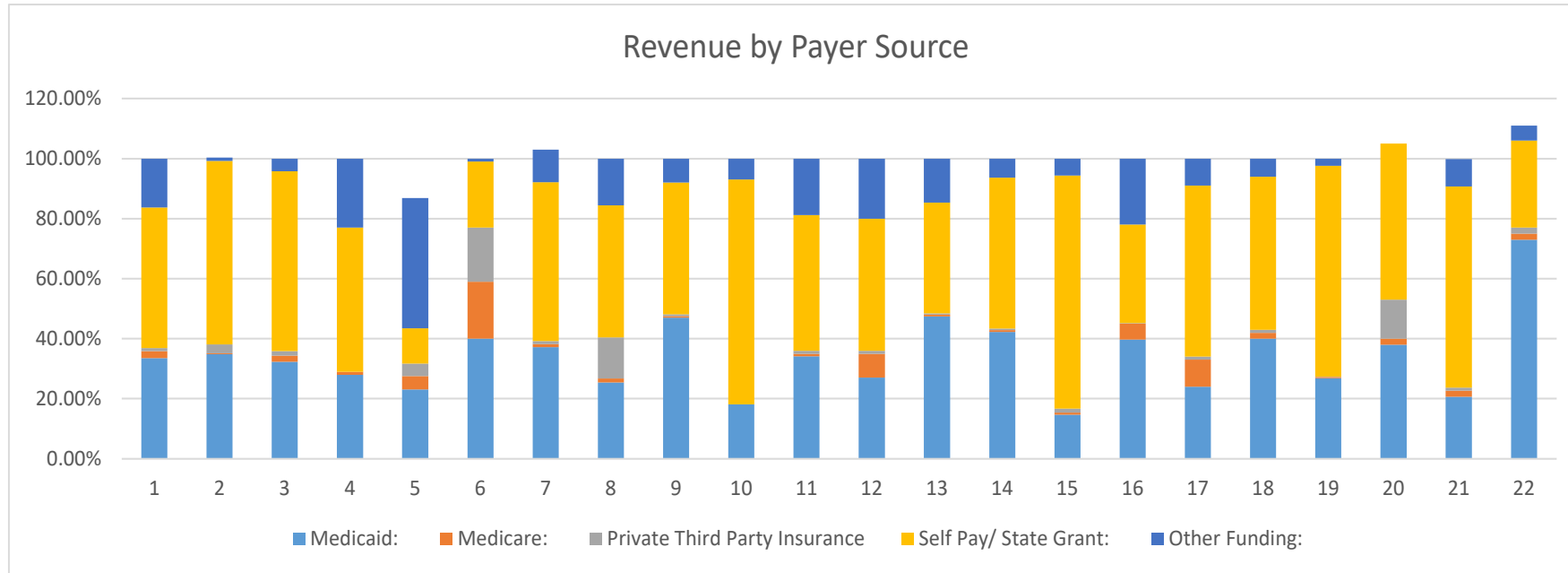


# Sample payer Mix



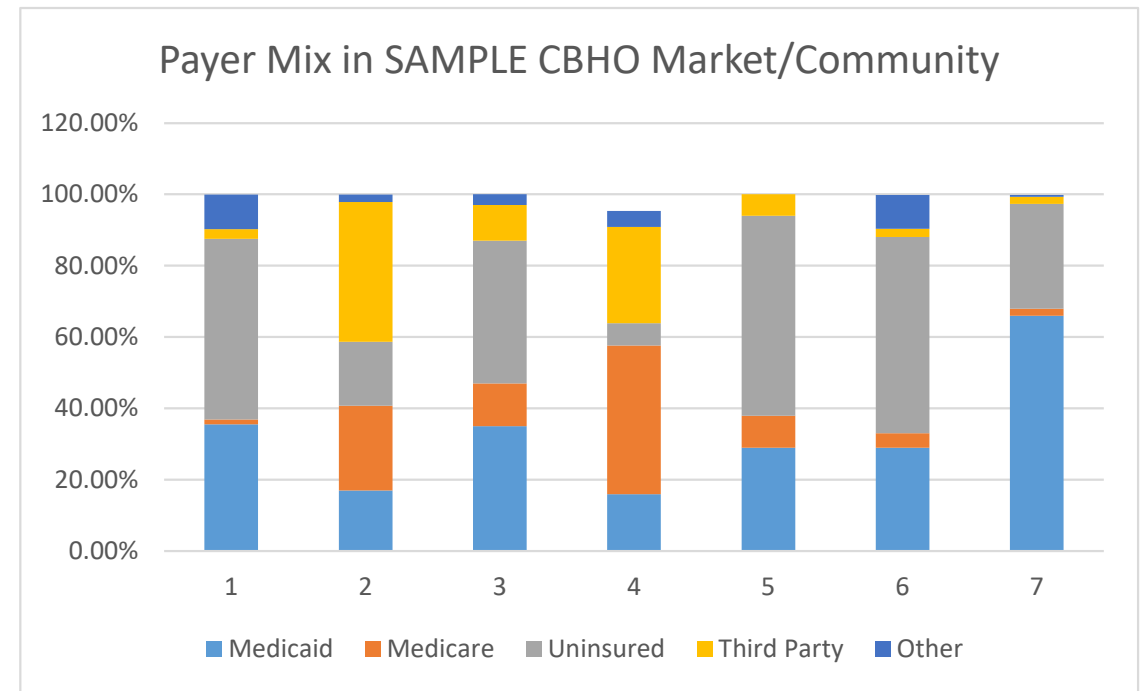


The graph below illustrates the percentage of revenue by source. The majority of CBHO funding is Self-Pay/State Grant. Very few CBHOs have a large third party or Medicare revenue source.



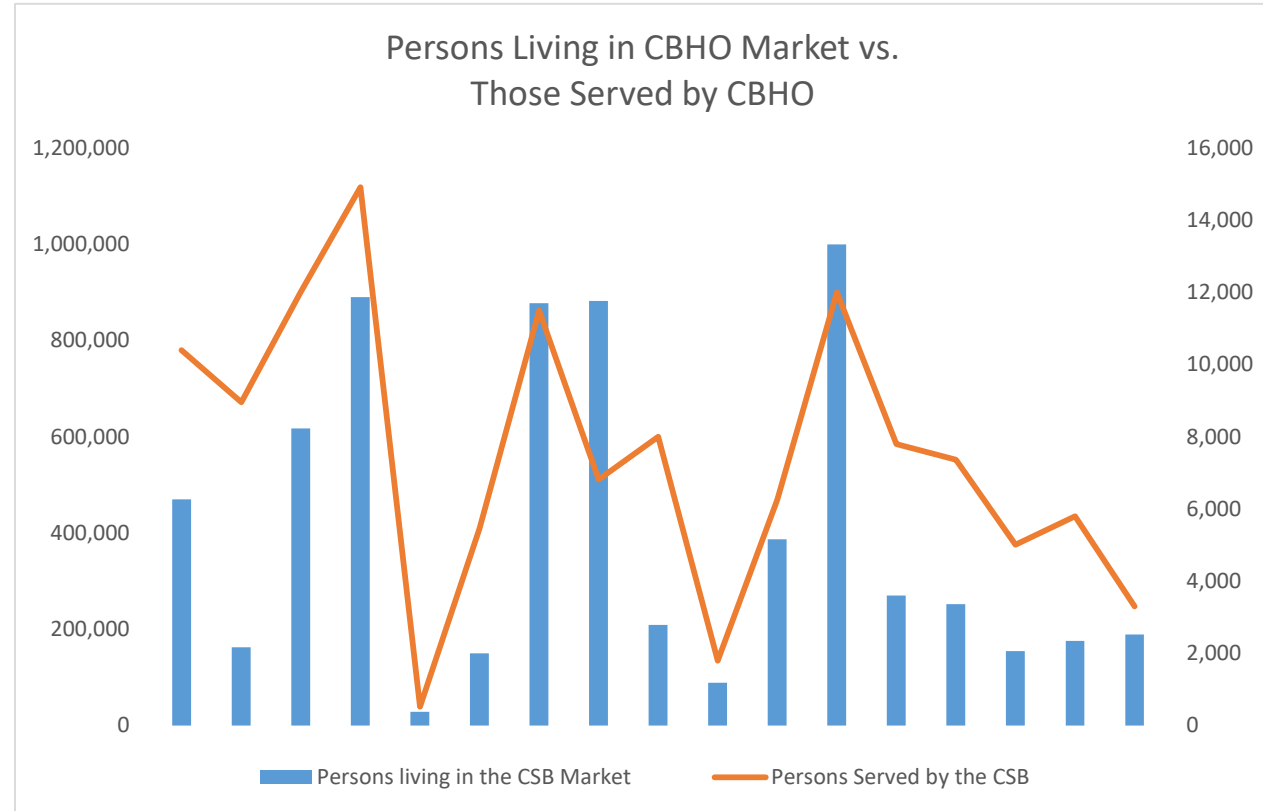
*Does the CBHO know the payer mix percentage of the general population within the CSB's service area for behavioral health service payers?*

**Six CBHOs (27.2%) responded Yes. Sixteen CBHOs (72.2%) responded No.**



*Does the CBHO know the service area population vs. the active number of consumers in their market?*

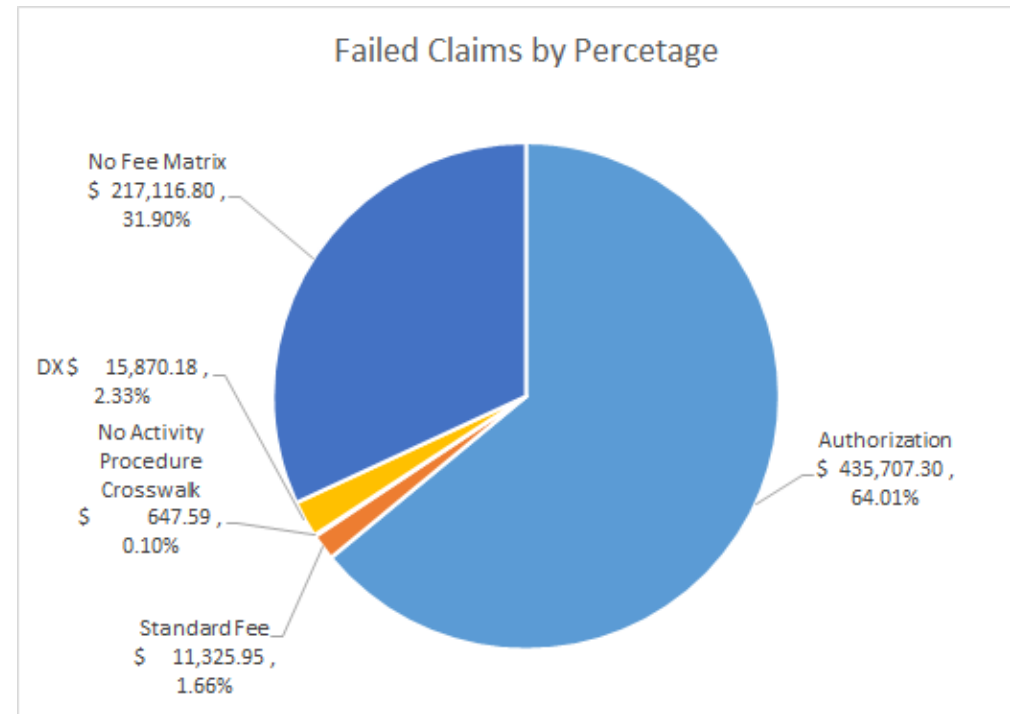
**Fifteen CBHOs (68.1%) responded Yes. Seven CBHOs (31.8%) responded No.**



The graph illustrates the number of persons living in the CBHO market on the right hand axis and the number of persons served on the left hand axis.

## In addition...

- This sample agency has \$680,070.23 in Failed and denied claims in the first 6 months of the fiscal year



## “Value-Based Purchasing” Model

1. Payment Reform is moving from *“paying for volume to paying for value/quality”*
2. VBP requires integration of our clinical, quality and financial information and the ability to track and analyze costs by consumer, provider, team, program, and payor and can operate effectively under fee for service, case rate, and sub-capitation payment models in order to succeed under a variety of Pay for Performance (P4) bonus arrangements.
3. Ability of all staff to develop a dynamic tension between “quality” and “cost” as if they are on a pendulum



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**Key Performance Indicators** 



## Post Service

1. Billing
2. Collections Management
3. Denial Management
4. Data Warehouse Analytics

## Accelerating Cash Collection

- What are your days of sales outstanding?
- After services are delivered behavioral healthcare organizations revenue cycle needs to assess and maximize revenue capture and streamline the billing and collection process.
  - electronic claim processing,
  - direct entry of Medicare/Medicaid claims,
  - automatic secondary/Waterfall billing,
  - remittance posting,
  - contract and denial management,



# Improving Access Management

- Assess the workflow processes and eliminate redundancies in collection and rework.
- Provider Organizations will need to accurately:
  - Obtain authorization for services,
  - Determine, validate coverage for payment,
  - Assess payment risk
  - Schedule resources prior to the consumer's arrival.



# Roles of Support Staff In Managed Care and Commercial Billing

1. Centralized Scheduling is needed to ensure referral is made to clinician on the appropriate insurance panel or is enrolled with Medicaid/Medicare
  - 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/Medicare cards prior to service
  - Obtain and validate at each visit the demographic information from consumers. Make this a KPI.



# Revenue Enhancement Work Sheet

3rd Party Revenue Evaluation Form						
Payor	Credentialing Requirements <i>(i.e., Rule 12 for Organization or Individual Providers)</i>	Licensure/Experience Requirements	Check all that apply: <i>(Click on box with your cursor to check)</i>	Rate Structure	Status/Notes:	Recommend Pursuing?
			<input checked="" type="checkbox"/> Pre-Certification Required <input type="checkbox"/> Authorization/Re Authorization Required <input checked="" type="checkbox"/> Custom Clinical Forms Required <input type="checkbox"/> Provider Panel is Open If not open, when will it open again: ___ / ___ / ___			
			<input type="checkbox"/> Pre-Certification Required <input type="checkbox"/> Authorization/Re Authorization Required <input checked="" type="checkbox"/> Custom Clinical Forms Required <input type="checkbox"/> Provider Panel is Open If not open, when will it open again: ___ / ___ / ___			
			<input checked="" type="checkbox"/> Pre-Certification Required <input type="checkbox"/> Authorization/Re Authorization Required <input checked="" type="checkbox"/> Custom Clinical Forms Required <input type="checkbox"/> Provider Panel is Open If not open, when will it open again: ___ / ___ / ___			
			<input checked="" type="checkbox"/> Pre-Certification Required <input type="checkbox"/> Authorization/Re Authorization Required <input checked="" type="checkbox"/> Custom Clinical Forms Required <input type="checkbox"/> Provider Panel is Open If not open, when will it open again: ___ / ___ / ___			

## Revenue Cycle Solutions- Referrals

### Solutions:

- Analyze staffing levels and capabilities now to determine their ability to complete tasks not only with an increase in referrals but as it stands today
- Organizations with numerous satellites may want to consider consolidating these functions to one centralized function
- Develop new policies and procedures
- Train staff on new processes
- Education of consumers will be critical at this point



## Revenue Cycle Solutions- Authorizations

- Providers should expect that authorizations will be for shorter periods of time
- Re-authorizations will be more difficult to obtain
- Medical necessity will be questioned
- Retro-active authorizations will become less common

# Revenue Cycle Solutions- Authorizations

## Solutions

- Analyze staffing capabilities today
- Plan and train
- Staff handling the authorization process will need to clearly communicate consumer needs and medical necessity.
- Staff will need to understand individual payer expectations and timelines for authorizations and re-authorizations
- Organizations with numerous satellites may want to consider consolidating these functions to one centralized function

## Revenue Cycle Solutions- Scheduling

- An increase in consumers results in a greater demand for staff time
- Schedulers will need access to the most up to-date technology in order get consumers scheduled
- Technology will need to effectively match the consumer insurance plan to the available authorized clinical staff for that plan

# Questions and Feedback

- Questions?
- Feedback?
- Next Steps?



Presented by: MTM Services



# A Roadmap for Impactful Change!



*Operationalizing Health Reform* was written by the entire MTM Services Team to be an up to date view of what we have learned working to help hundreds of organizations across the country and abroad make the changes necessary to be successful in today's ever changing environment of health reform. Each of the book's 14 chapters deal with a specific change focus required to help vision based leaders improve their organization's quality of care, efficiency, and the compliance of their service delivery system!

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## Resources

- <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf> Chapter 12, Section 150 – Clinical Social Workers; Chapter 12, Section 160 – Clinical Psychologists
- CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15, Section 60.1.  
<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf>
- <http://www.medicare.gov/Publications/Pubs/pdf/10184.pdf> Medicare and Your Mental Health Benefits
- [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Mental Health Services ICN903195.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Mental_Health_Services_ICN903195.pdf) CMS-Mental Health Services  
<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html?redirect=/PQR>  
<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html?redirect=/pqri/>  
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## References

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- HRSA QM Manual
- NY State Office of Mental Health CQI Plan Template
- GOA Performance Measurement and Evaluation
- A. Kilbourne, D. Keyser, H.Pincus: (2010) Challenges and Opportunities in Measuring the Quality of Mental Health Care. Can J Psychiatry. Author manuscript; available in PMC 2011 Sep 1. Published in final edited form as: Can J Psychiatry. 2010 Sep; 55(9): 549–557.

