Looking Behind the Curtain: Value-Driven Care’s Impact on the Revenue Cycle

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Client Services Executive
Revenue Cycle/ICD-10
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## Discussion Topics

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This Has to Change

Source: OECD Health Data 2010
http://fyi.uwex.edu/healthreform/2012/04/13/reforms-in-healthcare-system-needed/
Solution: The Movement towards Accountable Care and Supportive Payment Models

- Control costs by re-engineering care delivery – **cost control with the care of the patient instead of cost control with departmental charges**
- Provide financial rewards for increasing quality and value
- Holding providers of health care services accountable for both **cost** and **quality**

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* Oliver Wyman: A View from Healthcare’s Front Lines FFS to FFV, 2012
The DRIVE for Data in order to Improve

You can’t improve what you don’t measure.

You can’t measure what you don’t understand.

You can’t understand what you don’t collect.
Enter Meaningful Use

**American Recovery and Reinvestment Act 2009**
- **Stage 1** certification & meaningful use criteria
- Stage 1 incentives begin
- Last year to receive Medicare EHR incentive payments

**Patient Protection and Affordable Care Act 2010**
- Last year to apply for incentives and receive all four payments
- **PENALTIES!!!!** Medicare payment adjustments begin for eligible hospitals that are not meaningful users of EHR technology
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Polling Question #1

Is your organization actively planning for a full shift to Fee-For-Value?

– Yes
– No
## Value Based: Care Delivery Models

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<th>Accountable Care Organizations (ACO)</th>
<th>Patient Centered Medical Homes (PCMH)</th>
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<td>• Providers who contract with provider networks that in turn enter into payer agreements.</td>
<td>• Have to start as clinically integrated but more focused on management of chronic disease in patient populations</td>
<td>• Primary Care focused.</td>
</tr>
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<td>• May not have been able to do this on their own.</td>
<td>• Payment is tied to achieving quality goals/targets and outcomes</td>
<td>• Team approach to care allowing for a personal approach to communication, coordinated with orientation focused on the whole patient</td>
</tr>
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<td>• Stronger contracts, better rates</td>
<td></td>
<td>• High likelihood of enhanced access, reduction in variation of practice and increased patient satisfaction</td>
</tr>
<tr>
<td>• Regulated by strict FTC guidelines</td>
<td></td>
<td></td>
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<tr>
<td>• Follow agreed-upon clinical protocols and practice standards and measure them</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Providers who do not adhere to contract expelled</td>
<td></td>
<td></td>
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## Value-Driven: Payment Model Definitions and Applications

| Payment Model                        | Description                                                                                                                                                                                                 |
|--------------------------------------|-------------------------------------------------------------------------------------------------------------------------------- Adam ate a zebra. |
| Fee for Service                      | A service is provided, billed and paid. The “fee” is the result of a negotiation, not consumer driven. Well suited for emergent / trauma care, electives not covered by insurance or services that are difficult to categorize into a bundle. |
| Episodic/Bundled Care                | Single payment for a group of services related to a treatment or condition that involves multiple providers /settings. Well suited for obstetrical and maternity services, and surgical services covering transplant, coronary bypass, bariatric, knee or hip replacement. |
| Pay for Performance                  | A financial incentive (bonus) for achieving defined and measurable goals related to care processes, outcomes, patient experience. Well suited for services where metrics already exist and performance improvement is embedded in care delivery. |
| Pay for Coordination                 | Payment for care coordination services that are not otherwise provided and reimbursed (i.e. Patient Centered Medical Home). Well suited for Primary Care/Fam Med and patients with or at risk of developing chronic conditions. |
| Comprehensive/Total Cost of Care     | A single, risk-adjusted payment for a full range of healthcare services needed by a specific group of patients for a fixed period of time. Well suited for Primary Care and a population of patients within an integrated care network. |
## Value-Driven: Payment Model Benefits and Concerns

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<th>Model</th>
<th>Benefits</th>
<th>Concerns</th>
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<tr>
<td>Fee for Service</td>
<td>Easy to manage from a business operations standpoint</td>
<td>No incentive to delivery efficient care</td>
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<td></td>
<td>Encourages delivery of care by maximizing patient visits</td>
<td>Does not encourage coordination of care</td>
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<tr>
<td></td>
<td>Supports accountability although limited to each specialty</td>
<td>Limited to face-to-face visits and certain services</td>
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<tr>
<td></td>
<td></td>
<td>Difficult for patients to understand the EOB</td>
</tr>
<tr>
<td>Episodic/Bundled Care</td>
<td>Potential to improve coordination of care among providers</td>
<td>Difficult to define episode boundaries</td>
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<tr>
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<td>Ensures a more efficiently managed episode of care</td>
<td>Increases barriers to patients’ choice of providers</td>
</tr>
<tr>
<td></td>
<td>Provides for billing simplicity</td>
<td>Potential to avoid high-risk patients whose care exceeds the average episode payment</td>
</tr>
<tr>
<td>Pay for Performance</td>
<td>Great potential to improve quality of care delivered</td>
<td>Focuses on single condition (i.e. AMI, Stroke)</td>
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<td>Encourages improvement by measuring outcomes</td>
<td>Rigid measures and standards could create incentives for providers to avoid high-risk patients in these focused categories since they can negatively impact outcome measures</td>
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<td></td>
<td>Added overhead costs due to the collection, analysis and reporting of data for measurements</td>
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## Value-Driven: **Payment Model**
**Benefits and Concerns (continued)**

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| Pay for Coordination         | - Enhances the physician-patient relationship and communication between providers  
                              | - Increases family involvement                                                      | - Difficult to nail down specifics (scope) of care offered within the coordinated team  
                              | - Reduces unnecessary care                                                          | - Many assumptions made about what will be covered in monthly amount  
                              | - Supports and rewards care between visits (i.e., phone, email, groups)           | - Patients may be expected to contribute part of that payment out of pocket |
| Comprehensive/Total Cost of Care | - Great potential for providing innovative care and flexibility for providers  
                                    | - Improved incentives for providers who serve a particular population to collaborate      | - Since payment is very risk-based, requires sophisticated IS and analytics  
                                    |                                                                            | - May overemphasize population health at the expense of individual health  
                                    |                                                                            | - Possible decrease in provider of choice by patients                           |
### The Shift in Reimbursement & Regulation Requires New Information Models

<table>
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<th>Fee for Service</th>
<th>Value-based Payment</th>
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<td>2012</td>
<td>2013</td>
</tr>
<tr>
<td>2014</td>
<td>2015</td>
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- **Shared Accountability & Risk**
  - Demonstrate Outcomes & Share Risks

- **Clinically Integrated Networks**
  - Integrate, aggregate, share & analyze across entities

- **Meaningful Use Stage 1 & 2: Hospital and Physicians**
  - Electronically capture EHR and financial data (hospital, physician offices)

- **ICD-10**

- **Manual Measures**

- **eMeasures**

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Successful Organizations that Focus on Value...

Organize around the customer and the need

Expand Geographic Reach

Superior providers for particular medical conditions need to serve far more patients and extend their reach to increase value

Integrate Care Delivery Systems

Eliminate fragmentation and duplication of care and optimize the types of care delivered

Move to Bundled Payments for Care Cycles

Rewards improving the value of care and encourages coordination of care

Organize into Integrated Practice Units (IPUs)

Rigorous measurement of value (outcomes and costs)

Measure Outcomes and Costs for Every Patient

Build an Enabling Information Technology Platform which:

- is centered on patients
- uses common data definitions
- leverages condition-specific templates
- enables easy information extract

The RCM systems and operational processes that we have in place today are predominantly designed for Fee-For-Service and are geared toward:

- Identifying and managing patient demographic information
- Collecting evidence for all services rendered (coding) and summarizing the charges for these services
- Producing a claim as efficiently as possible
- Remediating any barriers to payment
- Pursuing performance metrics such as A/R days and denials
The RCM systems and operational processes that are expected to support accountable care and payment currently still work off of a Fee-For-Service chassis. They serve as a mechanism for:

Still valid in an accountable care world?

YES Identifying and managing patient demographic information
YES Collecting evidence for all services rendered (coding) and summarizing the charges for these services
YES Producing a claim as efficiently as possible
YES Remediating any barriers to payment
YES Pursuing performance metrics

Staying the Course while Incorporating Strategies for New RCM Systems Challenges

Challenges for the future of RCM

- ICD-10 upgrade & conversions
- Bundled Reimbursement Models
- Integration of financial and clinical data
- Competition for IT Capital Dollars
- Integration with financial decision support
- Consumer/Patient Satisfaction (e.g., on-line bill pay, self registration, etc.)

Becoming more adept... at assigning costs to activities
Polling Question #2

Have you had any dialog with your current Revenue Cycle system vendor in regard to any plans for application adjustments in response to value-based payment models?

– Yes
– No
## Next Generation Solutions

Enhancements to legacy system or incorporated into full replacement systems

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<th>Consumer focus</th>
<th>Web services to facilitate on-line pre-registration, self-scheduling, and bill payment to enhance patient service efficiency and convenience</th>
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<td>Eligibility verification</td>
<td>Supports real-time insurance eligibility verification transactions</td>
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<tr>
<td>Claims processing</td>
<td>Bypass third party clearinghouse; direct receipt of remittances from payers</td>
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| Rules capability                         | • For billing and payment processing  
• Multiple capabilities to improve accuracy and efficiency                                                                            |
| Electronic fund transfers (EFT)          | From third-party payers directly to the provider organization’s bank accounts                                                      |

*source: The Next-Generation Revenue Cycle Management Index from HIMMS-Analytics*
...they will wait to see which of these Value-Based (VB) payment models will dominate, based on the pace of the movement toward VB care and reimbursement, before launching any major re-tooling effort.
If not RCM Systems Directly, What Are the Tools that Should Get Some Attention?

EMPI Patients
- EMPI Providers
  - Eligibility Verification
  - Authorization Check
  - Patient Account Opening
- Central Scheduling
  - Contract Management
- Cost Accounting

Treatment
- Medical Transcription
- Charge Capture & Coding

Discharge
- Medical Billing
- Claims Generation

Post Discharge
- Accounts Receivable Follow-up
- Cash Posting
- Patient Follow-up

Patient Portal
- Productivity Management

Process Optimization Tools

ETL/Repository/Manage/Mine/Present

Care Delivery
- Clinically Integrated Networks
- ACOs
- Patient Centered Medical Home
- Volume Drive/Fee For Service

Reimbursement
- Pay For Coordination
- Pay For Performance
- Episodic/Bundled Care
- Comprehensive/Total Cost of Care

Measure PERFORMANCE/REVENUE/COST and Adjust
(then do it all over again, and again, and again)
If not RCM Systems Directly, What Are the Tools that Should Get Some Attention?

Data tools
- Process Optimization software
- Patient Portals
- Social Media Tools
- Marketing-to-the-Consumer tools
- Cost Accounting systems (fortified)
- Contract Management systems (also fortified)

Although, if the RCM System Is Being Replaced...

Adoption of new or replacement solutions should be based on business needs, strategies and competitive environment. Solutions should still focus on:

- improving collection rate
- business office workflows
- productivity and efficiency of the RCM process
- improving patient satisfaction and convenience
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Acknowledge that DATA Is Your Organization’s Most Important Asset

• Understand how all patient data is being managed
• Understand what data you have and how much of it you have
  – Financial
  – Clinical
  – Everything else
• Assess the tools that are being used to manage the data
• Question if patient “centeredness” is the goal for managing data in a holistic fashion.
Get Involved with the Data Management Strategy

- Question if the data that is required to manage the accountable care incentive programs (i.e. shared savings and shared risk contracts) is being captured consistently and reported correctly
- Help to direct data management strategies so that boiling ocean does not become the end goal
- Make certain the focus of the data management strategy is on the data that is needed to support the new contracts and incentive programs
Polling Question #3

Are you actively participating in your organizations’ data management / data governance program?

- Yes
- No
Have an Active Role in Identifying a Population

These are patients with chronic disease that, in a Fee-For-Service world, are in and out of the physicians’ offices, emergency departments, and hospitals on a frequent basis.
Strategize on Reducing and Controlling the COST of Delivering Care...

...and not cost based on charges

• Especially for expensive patient populations

• Matching cost to revenue establishes the basis for taming costs and eventually gaining the control needed in an accountable care world
  – Track costs across the entire continuum of care, constantly analyzing performance and applying adjustments
  – Focus first on clinical processes, not on supply chain management or resource utilization per clinical
  – Focus on how to control patient volume, not enhance it
Rethink Having More than One RCM System for an IDN

- Adds complexity for:
  - Care delivery
  - Providers
  - The business
  - The accountable care mission
  - The patient

- Serves as a barrier to the future under the new paradigm of accountable care delivery and reimbursement

*Life is really simple, but we insist on making it complicated.*

--Confucius
COMMUNICATE and Educate...

...regarding accountable care and the volume to value revolution

“An investment in knowledge pays the best interest.”

Benjamin Franklin
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Organizational Accountable Care Readiness

- The leaders of Finance, Quality, Contracting, Care Management, IT and the Revenue Cycle need to be more closely aligned.
- Realize that accountable care leadership and execution will be a “hot potato” who has many owners yet no implicit accountability.
- New roles within the revenue cycle, (i.e. revenue informatics experts) are also on the rise.
- Move toward total-cost-of-care revenue analytics activities are geared to uncover risks and gaps in care delivery.
• Pay very close attention to the front end:
  – Focus on identity management that leads to being predictive and proactive
  – Ensure well-coordinated scheduling across the continuum of care is also crucial
  – Market/communicate outside of the care setting
Much more detail in ICD-10 codes

Better correlation of diagnosis, treatments and costs

Ability to analyze costs and expected revenue for all kinds of variables
Journey to Value-Driven Care

Fee for Service → Value-Based Payment

**Highest Quality at Lowest Total Cost**

- **Today's Healthcare**
  - Integrated EMR, EHR, PMS, CPOE
  - Real time alerts
  - Improved access to data

- **Collaborative Healthcare**
  - Stand-alone
  - Best of breed
  - Fragmented systems

- **Value-driven Healthcare**
  - Tight linkage between physicians and hospital
  - Cross specialty collaboration
  - Seamless information sharing
  - Patient access to data

- **Accountable Healthcare**
  - Shared risk
  - Personalized/evidence-based clinical decision support
  - Patient engagement
  - Continuous quality & performance improvement
THANK YOU

Questions?