Encore Health Resources

Value-Based Care – What Revenue Cycle Impacts should you worry about?

A point of view on Revenue Cycle's usefulness in the transition to value-based care and reimbursement

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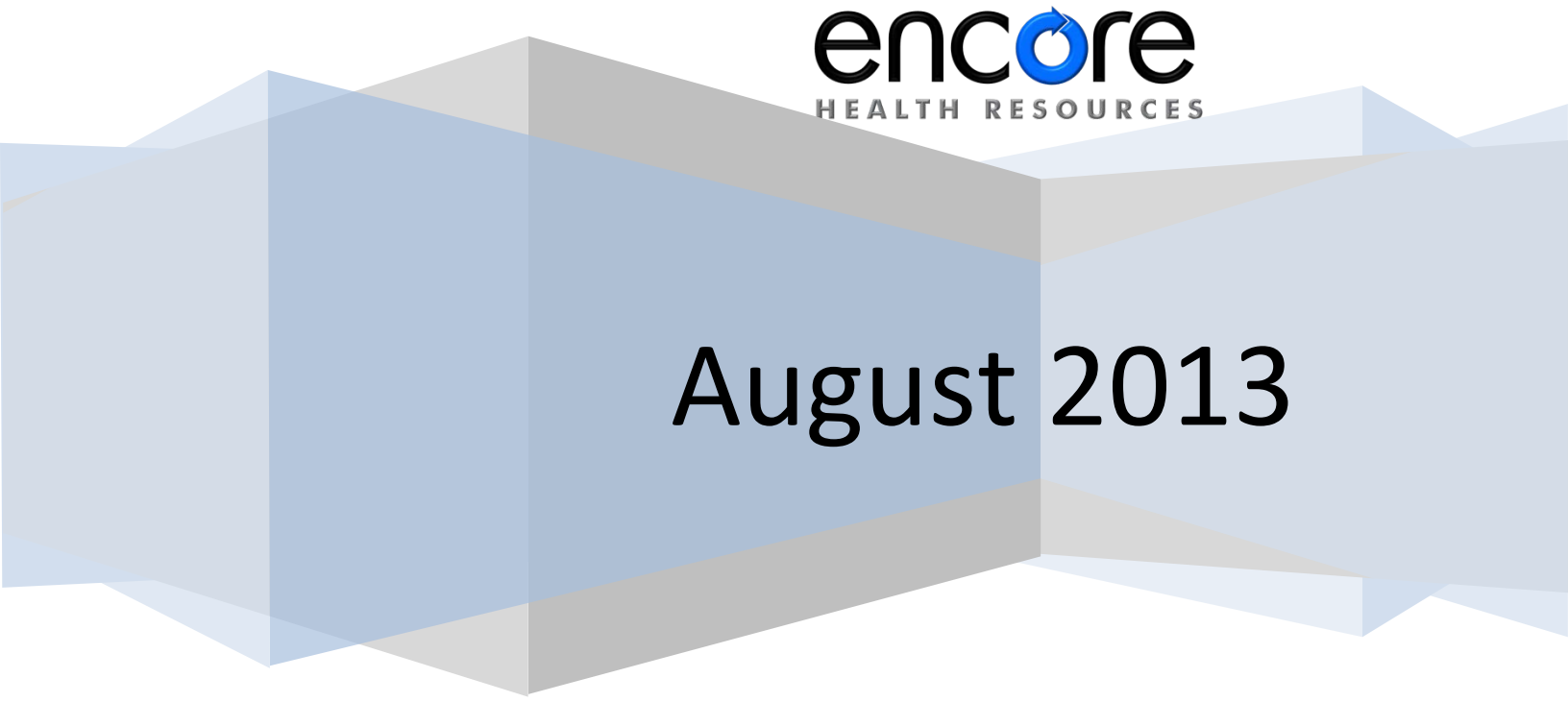

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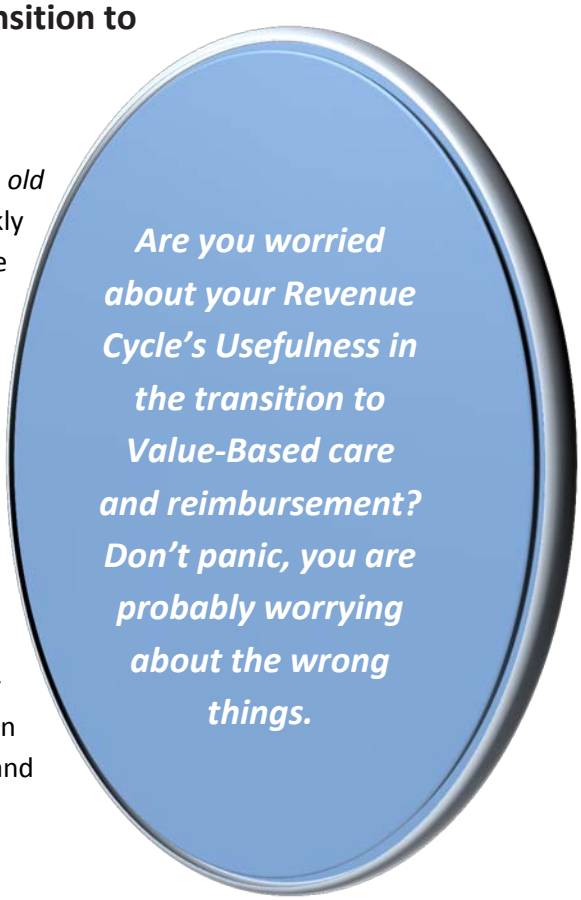

Remember the great Smith Barney slogan? *"We make money the old fashioned way – we earn it."*[1] Healthcare organizations are quickly finding the old fashioned way of making money, Fee-For-Service based on volume, is an earning mechanism starting to fade and fade quickly. With the advent of value-based (VB) care and reimbursement models, say good-bye to getting paid for just doing something and say hello to earning it the hard way – being held accountable for its value.

Many are asking the question of how this will affect the Revenue Cycle Management (RCM) systems and the operational processes that have been in place and supporting a Fee-For-Service structure for decades. The answer, from Encore's point of view, may be surprising.

This paper provides a basic understanding of Value-Based health care, or accountable care, and why the industry is moving toward it. It then provides insight into the impact of VB health care on RCM systems and operational processes.

Value-Based Care and Reimbursement (accountable care)

Simply put, **the United States health care system is broken, the business is failing.** Compared to the rest of the world, the United States spends the most money for health care. Yet overall health is not improving, especially within the most expensive-to-care-for patient populations; those patients with chronic disease such as diabetes and congestive heart failure.

The Federal government and most of the large commercial health insurance payers believe the fix is of equal parts.

1. Controlling costs by re-engineering care delivery.
2. Providing financial rewards for increasing quality and value.

This fix holds providers of health care services accountable for both cost **and** the quality of care; a very deliberate shift in the providers' risk associated with the cost of delivering care. It encompasses changes to how care is delivered and how it is paid for. This is value-based care and reimbursement.

Given all the frenzy around healthcare reform, the terms and definitions used to describe the components of VB care and reimbursement have become quite familiar. Patient Centered Medical Homes (PCMH), Integrated Clinical Networks (ICN) and Accountable Care Organizations (ACO) dominate the changing care delivery space; while Risk/Shared Savings, Global Payment, Incentive and Pay-for-Performance are all payment models that are getting new and, in some cases, renewed attention.

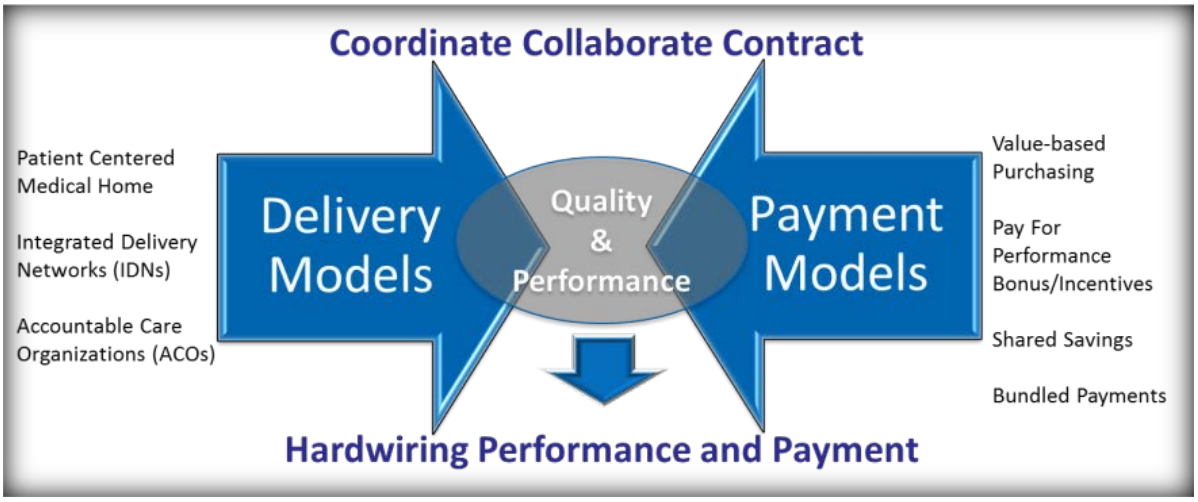

Figure 1. Hardwiring Performance and Payment

Without a doubt, new tools are needed to manage the components of these new strategies. Starting with the obvious – the RCM systems and operational processes in place today are predominantly designed for Fee-For-Service and are geared toward one thing:

- ***Serving as a mechanism for identifying patients,***
- ***Collecting the charges for services rendered,***
- ***Coding the diagnoses and procedures that support the charges, and***
- ***Summarizing those charges and producing a claim as efficiently as possible in order to receive payment.***

So will this mechanism really need to change so drastically with the transition to VB care and reimbursement?

Encore thinks not and here is why. The coded evidence of what transpires to deliver care, along with its associated price tag, will still be as essential as ever. Instead of thinking about dismantling and re-building the RCM components and its structure to make VB care and reimbursement work, think back to when the different payment models were introduced in the '90s. RCMs didn't have to change much then either.

Sometimes it's worth looking back

"Meet the new boss, same as the old boss"

(Lyric from the song "Won't Get Fooled Again," Pete Townshend, The Who, 1971)

Michael Dukakis on ACOs: "We tried that, folks. It didn't work."[2]

By Chelsea Conaboy; The Boston Globe, November 28, 2011.

The creation of accountable care organizations or a global payment structure won't fix the health care system in Massachusetts and make it more affordable, former governor Michael Dukakis told an audience at Harvard last week. Speaking during the Harvard School of Public Health Voices from the Field series, Dukakis said urging the health care market to fix itself is "a colossal waste of time." Here's an excerpt from the event:

> *"If we paid a little attention, it might be a good idea, to the experience of other countries around the world who are doing this and who, for some reason, seem to be able to provide rather good health care to their people at half the cost we do — whatever the siltstone, whether it's Australian Medicare or a multi-payer system in Germany or an essentially privatized system in Switzerland — every one of them regulates cost, without exception."*
>
> *"What do we do? Come up with this ACO, global payment thing… We've done it. ACOs and global payments. What did we used to call them? HMOs and capitation. We tried that, folks. It didn't work. Why are we doing it again?"*

To answer Mr. Dukakis' question, lessons were learned about the importance of ***value***. If trying this again today without adding in the accountability for value of the care delivered then Mr. Dukakis would be right.

In a VB world, it is all about the never-ending cycle of tracking cost, quality and the resultant value while constantly making adjustments for improvement. Everyone can agree this is very, very difficult to do in the health care industry, predominantly due to the historical lack of usable data and the inadequate alignment – the sheer disconnect – between payment and value.

Just ask any of the integrated delivery networks who have literally been running reconnaissance with the new delivery models. These "pioneer" colleagues, whether participating in a large ACO or in a small PCMH, have allowed others to play armchair quarterback watching and learning why some have done well and why others have failed to see any real increase in quality and a subsequent fiscal benefit.

The successful organizations have kept it simple by participating in only one or two of the VB care delivery models and piloting only one or two of the payment models. Before signing the shared savings or shared risk agreements, these organizations made certain they had the data necessary to assess a baseline and trend compliance. They agreed to standardized best-practice care delivery processes and they focused on improved referral management for transitions of care. They replaced volume targets with quality measures and aligned profit with value.

No doubt this is a completely different mindset and plan of attack than the 1990s experience Mr. Dukakis refers to in his comments above.

If the Revenue Cycle doesn't need to radically change, then what does?

By taking into account the experience of "pioneer" colleagues as well as paying attention to trends in the industry, the four focal points below summarize where the most significant changes are occurring, and what is important to not repeat from the past to maintain profitability in a VB world.

1. **Realize the most important asset is data**

   It will be imperative to know what is happening with patients **demographically, clinically and financially** in order to succeed in a VB world. Luckily, RCM systems have been hoarding demographic and financial data for years. Not so for the clinical data, but in the last decade, drivers like the Meaningful Use Incentive Programs have spawned widespread implementation necessitating the constant optimization of EHRs (in both the ambulatory and acute care settings). Add to that the tools needed to push/pull, house, integrate, aggregate, normalize, mine and present data, all with the goal of acquiring and maintaining as complete a footprint as possible on each patient. And if that isn't enough, keep in mind that with patient "centeredness" as a goal, the way in which data is managed at the patient level, in a holistic fashion, will also be crucial.

2. **Focus on the data required to manage incentive programs, shared savings and shared risk contracts**

   DO NOT boil the ocean when it comes to managing data. One of the most unfortunate misconceptions within the last five years is that all data is needed everywhere, about everything, available at **all** times and forever. A strategy that is expensive, extremely time and resource consuming, and definitely diverts attention away from the data really needed. Instead, why not focus on the data needed to support those new contracts and incentive programs geared toward achieving value. Rather than trying to boil the data ocean, focus first on the data required to support these key initiatives.

3. **Identify a population and focus on the most expensive patients**

   In a VB world, profit is achieved when spending slows against a target and slows enough against the target that real savings is realized and becomes sustainable. That savings in money not spent is then shared as a bonus or incentive and can be substantial if the focus is a population of patients that incur the greatest amount of expense. 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. Their utilization of resources is, frankly, way over the top. In a VB world, by implementing new care delivery models focused on patients who are at the highest risk of hospitalization, there is greater ability to achieve the savings necessary to maintain a positive financial bottom line while transitioning from Fee-For-Service (FFS) to Fee-For-Value (FFV).

4. **Reduce and control the COST of delivering care**

   The beast called COST must be tamed. There is no doubt that an improved understanding of what the "true" costs are for delivering care, especially for certain expensive populations, and then matching that to revenue will provide the basis for taming costs and eventually gaining the control needed to succeed in a VB world. This kind of cost control goes far beyond just focusing on supply chain management and/or an analysis of resource utilization per department, per shift. Traditional cost monitoring typically happens at the service line and department level; not at the episode of care level. Although direct, indirect, fixed, and ad hoc costs are certainly important and are included, VB cost control and reduction efforts must focus on the clinical processes, the whole package thereof, and that means volume control. This will require tracking the costs across the entire continuum of care, constantly analyzing performance and applying adjustments.

Interestingly, not one of these focal points includes or even hints at having to dismantle and replace current revenue cycle management systems.

Encore has spoken with a few of the dominant HIT vendors and, not surprisingly, the outlook from a module revision standpoint is virtually the same. There is little evidence of any targeted effort to re-architect the RCM modules. Rather, there is evidence of reintroducing functionality that was offered in the 1990's to support HMOs, capitation, etc., in order to support a fortified cost accounting effort.

With a VB payment model based on episodic and bundled care, for example, the nuances involved in payment receipt and distribution to multiple contributors will certainly require RCM module tweaking. But the HIT vendors we spoke to, for the most part, are choosing to wait patiently to see which of these VB payment models will dominate based on the pace of the movement toward VB care and reimbursement before launching any major re-tooling effort.

Now, keep in mind that the comments made above are squarely focused on whether or not RCM systems, by design, will change drastically in the near future based on changes brought about by value-based care and reimbursement (and ICD-10 changes aside).

What **will** take a hit is the continued justification of the virtues for having multiple RCM systems that separately support providers and their parent facility organizations. This approach to revenue management will simply become more and more difficult to maintain in an integrated care delivery scenario.

Having more than one RCM system supporting an integrated care delivery network equals complexity for care delivery, complexity for providers, complexity for the business, complexity for the value-based mission and, most importantly, complexity for the patient.

When a patient asks "how much will I have to pay?" there should be a firm answer which should not include the barrage of "facility verses provider portion" explanations. The way patients are currently charged and claims billed in a multi-RCM world will not be in anyone's best interest when it comes to the future under the new paradigm of VB care delivery and reimbursement.

If not the RCM systems, then what tools are getting the attention?

Certainly there are RCM functions and/or processes that could be enhanced and better aligned to help address the four focal points noted above. But the more notable change will be around adding new tools (or dusting off old ones) that fit comfortably AROUND the revenue cycle and will be necessary to achieve the goal of maintaining a profitable margin.

They include:

- **Data tools** – to pull (Extract, Transform, Load – ETL), house (repository), integrate–aggregate–normalize (manage), mine (analytics), present (reporting/dash-boarding) and push (Health Information Exchange – HIE) data.
- **Process Optimization software** – to enhance workflows.
- **Patient Portals** – to enhance communication with patients, better manage prevention, promote wellness and collect cash.
- **Social Media tools** – to manage patient, provider and business communication challenges now common for integrated care delivery networks.
- **Marketing-to-the-Consumer tools** – to market services based on price and quality.

- **Cost Accounting systems** (fortified) – to track costs across the continuum of care.
- **Contract Management systems** (also fortified) – to provide bilingual type management of traditional FFS based contracts as well as FFV based contracts.
- **Enterprise Master Person Index** (Patients) – to identify a population and tag patients who are "eligible" under alternative payment models.
- **Enterprise Master Provider Index** – to support centralized scheduling, referral management and overall patient care coordination.
- **Scheduling systems that incorporate Referral Management** – to manage patient care coordination.
- **Case Management systems** – to manage transitions of care.
- **Population Health Management systems** – to support care management of defined populations.
- **Productivity Management systems** – to manage the resource aspect of clinical processes.
- **Health Information Exchanges** – to capture and share patient data from multiple, disparate sites of care delivery.

This is certainly not an all-inclusive list but these are good examples of tools experiencing a growing popularity and, in some cases, a re-birth in the advent of VB care and reimbursement. Many of these tools may already be in place as integrated modules within the major EHRs or already added to the HIT platform to address a particular business need.

The point is to first assess the need then assess what already exists before going on a buying spree or, worse, develop unrealistic expectations of what a vendor is to provide.

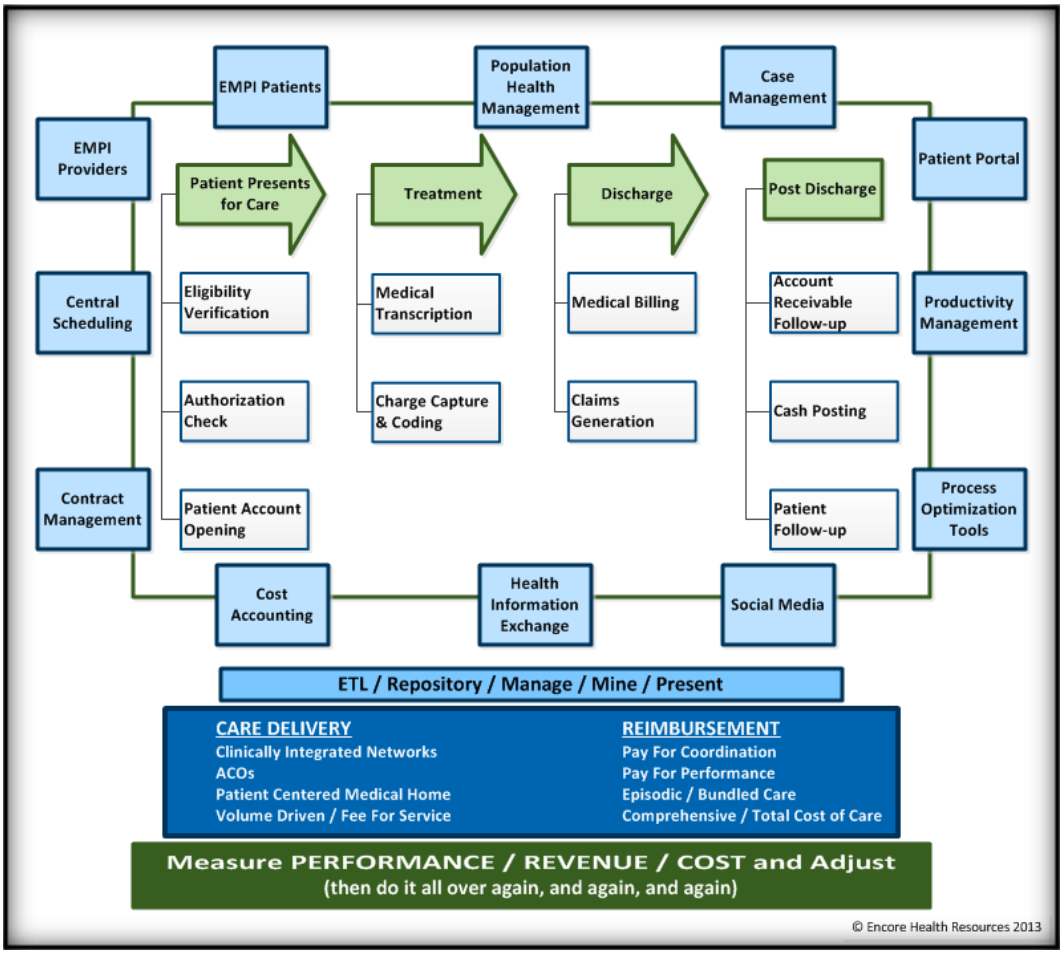

Figure 2. The Value-Based Revenue Cycle Impacts and Tools

What to really worry about…….

Now that it is understood changes to RCM requirements will be more evolutional than "revolutional," here are the things to really worry about.

First – Organizational value-based readiness and Revenue Cycle leadership

Asses the organization's VB readiness. Unfortunately, many organizations jumped headfirst into piloting shared savings, and shared risk agreements long before they were ready. There was a quick realization this effort required much more than just the ability to produce a report showing an improvement in a quality measure.

- Organizational management structures need to be carefully assessed so affected reporting relationships, especially with the leaders of Finance, Quality, Contracting, Care Management, IT **and the Revenue Cycle**, are more closely aligned.

- Just like the Meaningful Use programs, VB care and reimbursement management does not fit naturally into an existing health care systems' traditional structured department or division make-up. Many organizations play a game of "hot potato" with execution of the effort, only to end up with many owners, yet no accountability. Identify WHO will lead the development and execution of strategic and tactical plans regarding how information systems and operational adjustments will address the evolving revenue cycle management needs under VB care and reimbursement. Find the answer to who will be accountable for accountable care.

- With revenue and profit margins at such high risk, new roles within the revenue cycle, such as revenue informatics experts are also on the rise. It is vital to move on from traditional key performance indicators focused only on the billing cycle and move toward total-cost-of-care revenue analytics activities geared to uncover risks and gaps in care delivery.

Second – Know the patients and work to keep them from going "outside"

It will be especially important for organizations adopting population management care delivery models and the incentive and payment models that will support them to KNOW THEIR PATIENTS and know them well. For RCM, that means paying very close attention to the front-end and fortifying **patient identity, scheduling functions and patient** communication as much as possible.

- VB care and reimbursement is forcing a different way to think about front-end approaches. Currently, the patient initiates an interaction (i.e., they call for an appointment or show up in an ED). To successfully manage chronic disease through population management, the initiation will almost always be the other way around. To do this effectively, the heavy lifting must be happening long before patient care is initiated. By knowing as much about the patient as possible through **identity management** and the monitoring of health care activity, the ability to be predictive and proactive with delivering care becomes easier and easier. And being predictive and proactive is crucial when trying to reduce costs, increase quality and add value.

- Well-coordinated **scheduling** across the continuum of care is also crucial. The need to coordinate (right place at the right time) provider visits, diagnostic testing, rehabilitation visits, etc., within an integrated delivery network will also contribute to a streamlined and more efficient patient care delivery process, which will reduce costs and increase patient satisfaction.

  In most organizations today, scheduling is largely decentralized and highly fragmented for the purpose of protecting utilization of the provider, not coordination of the patient's care. A centralized scheduling approach puts the patient coordination first while allowing for provider or department specific "rules" to continue playing a part. A centralized scheduling effort also virtually ensures the patient will not go outside the care network since their future care interactions are being managed for them.

- Give patients the information before they ask for it. Patients are fast becoming wise consumers of their health care and are becoming more and more mindful that, just like any other commodity, a medical procedure can differ in price and quality based on where it is performed and who performs it.

  Integrated delivery networks will need an effective model for marketing their services; one that includes pricing for services and ratings for quality performance. From a marketing perspective, price and quality will ultimately drive demand for health services to those who provide the best quality at the lowest cost (the essence of VB care). This means hospitals and physicians will need to show their cost and quality are better than the competition.

Third – International Classification of Diseases, 10th Revision (ICD-10)

This paper would not be complete without some mention of ICD-10 and its impact on the Revenue Cycle as something to be worried about.

- As with VB care and reimbursement, an assessment of technical readiness, a plan for communication around the concepts and a plan for training are all essential to ICD-10 success.

Conclusion

RCM systems and their operational processes are simply not seen as being affected to any substantial degree with the advent of VB care and reimbursement. At least not right away. In a traditional sense, RCM systems as used today are still very relevant and necessary. Along with some degree of repurposing, yet still resting comfortably on a Fee-for-Service chassis, RCM systems will need to continue providing much of the foundation for establishing "who" the patient is (MPI), "what" happened with that patient (codes and charges), "where" the patient was seen (service locations), "when" the patient was seen (visit logs) and "how" the care was provided (codes and claims) in order to succeed in the transition period.

What will be changing and evolving is the general business strategy needed to transition the profiting from volume to profiting from value. Leaders involved in RCM can be instrumental in helping to fashion that strategy by focusing on the following.

#	Strategy
1	Learn from organizations that are ahead of the curve in transitioning to VB care and reimbursement.
2	Understand how clinical and financial data is housed, managed and reported.
3	Become familiar with payer contracts, especially those that have shared savings, shared risk components, or any incentive programs; and perform an analysis of where the supporting data lives for those key contract initiatives.
4	Be knowledgeable about the chronic disease populations served and what population is most expensive to care for.
5	Assess cost control mechanisms such as process and workflow optimization to reduce waste.
6	Assess tools living AROUND the revenue cycle that will be instrumental in managing a VB care and reimbursement environment. Pay close attention to social media products and their value with extended communication requirements.
7	Assess how closely aligned Finance, Quality, Contracting, Care Management, IT and RCM are in the leadership structure and if that structure will serve to support the transitional strategy.
8	Improve front-end processes by fortifying patient identity and scheduling functionality to enhance patient care coordination.
9	Rethink the justification for maintaining a "multi-RCM" environment with the advent of VB care and reimbursement.

And finally……

COMMUNICATE and educate whenever and wherever possible regarding the volume to value revolution.

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