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Presented by



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



**encore**  
HEALTH RESOURCES

The logo for Encore Health Resources features the word "encore" in a lowercase, sans-serif font. The letter "o" is stylized with a blue circular arrow icon. Below "encore", the words "HEALTH RESOURCES" are written in a smaller, uppercase, sans-serif font. The logo is set against a white circular background that is part of a larger light blue arrow graphic pointing to the right.

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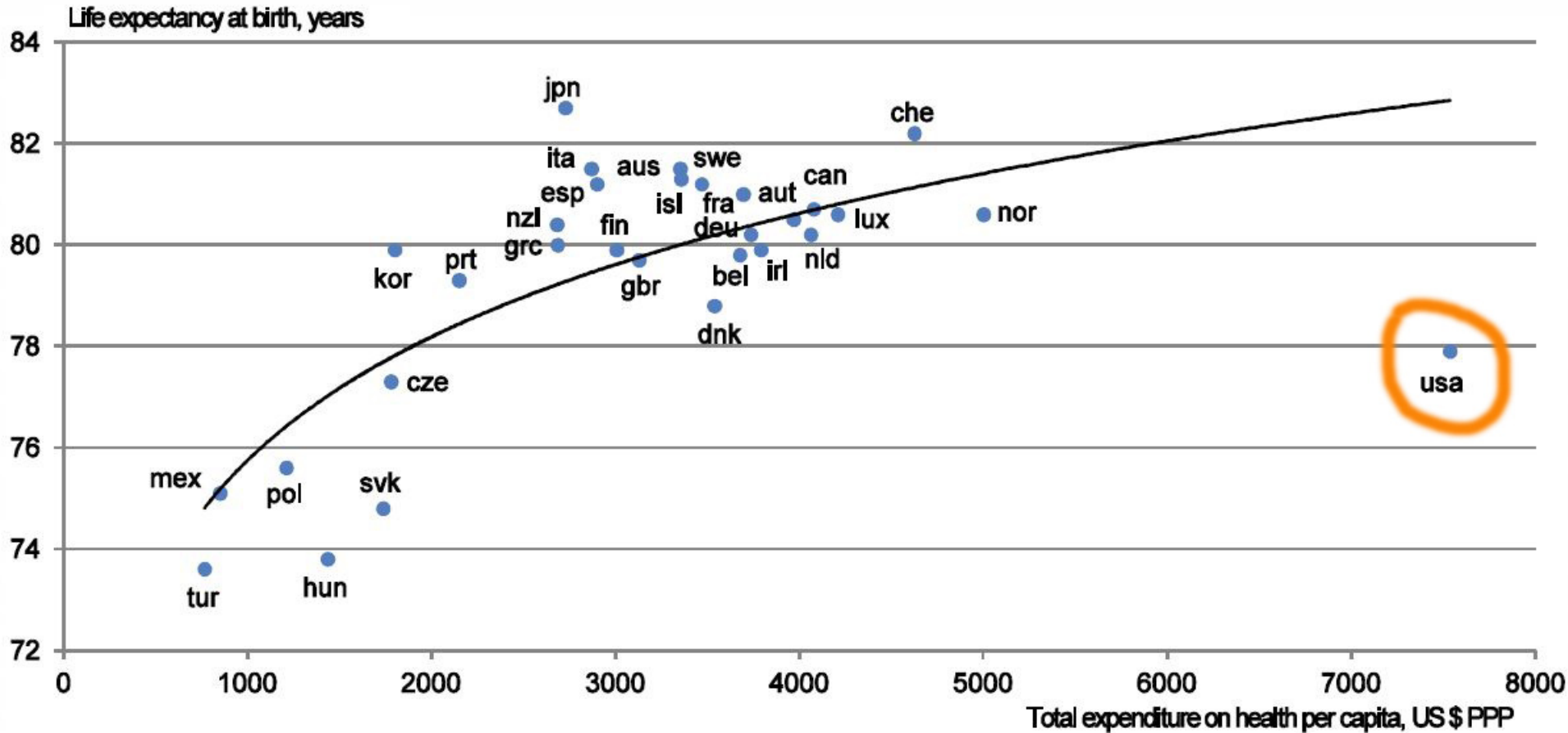
# Discussion Topics

- The Problem/ Solution**      What is broken and the approach to correct it
- Accountable Care**      Accountable Care (value-driven) and its components
- Revenue Cycle Management Systems**      Changing or staying the same?
- Revenue Cycle Management Leaders**      What to focus on
- Lions, Tigers, and Bears**      What to worry about

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# This Has to Change



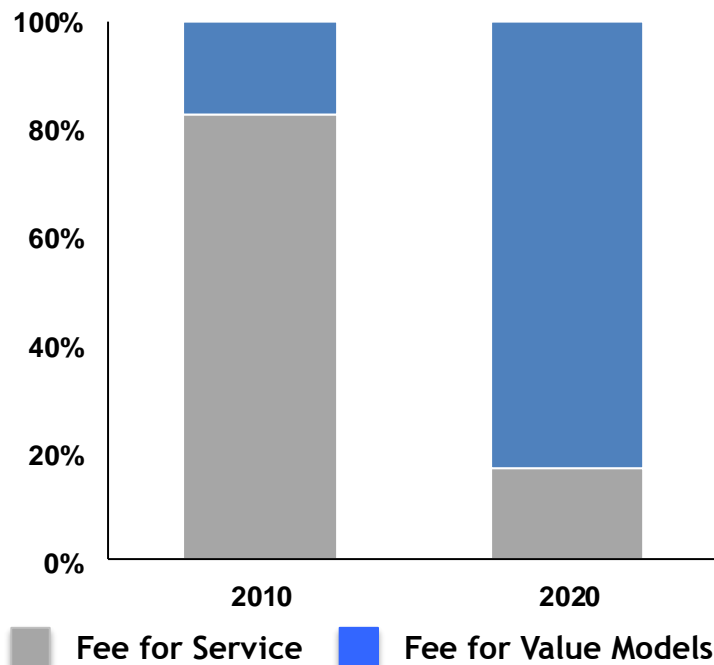
Source: OECD Health Data 2010

<http://fyi.uwex.edu/healthreform/2012/04/13/reforms-in-healthcare-system-needed/>

# Solution: The Movement towards Accountable Care and Supportive Payment Models

## Projected Acute Provider Model Evolution

*% of systems with Fee for Value components in operating model\**



- 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**

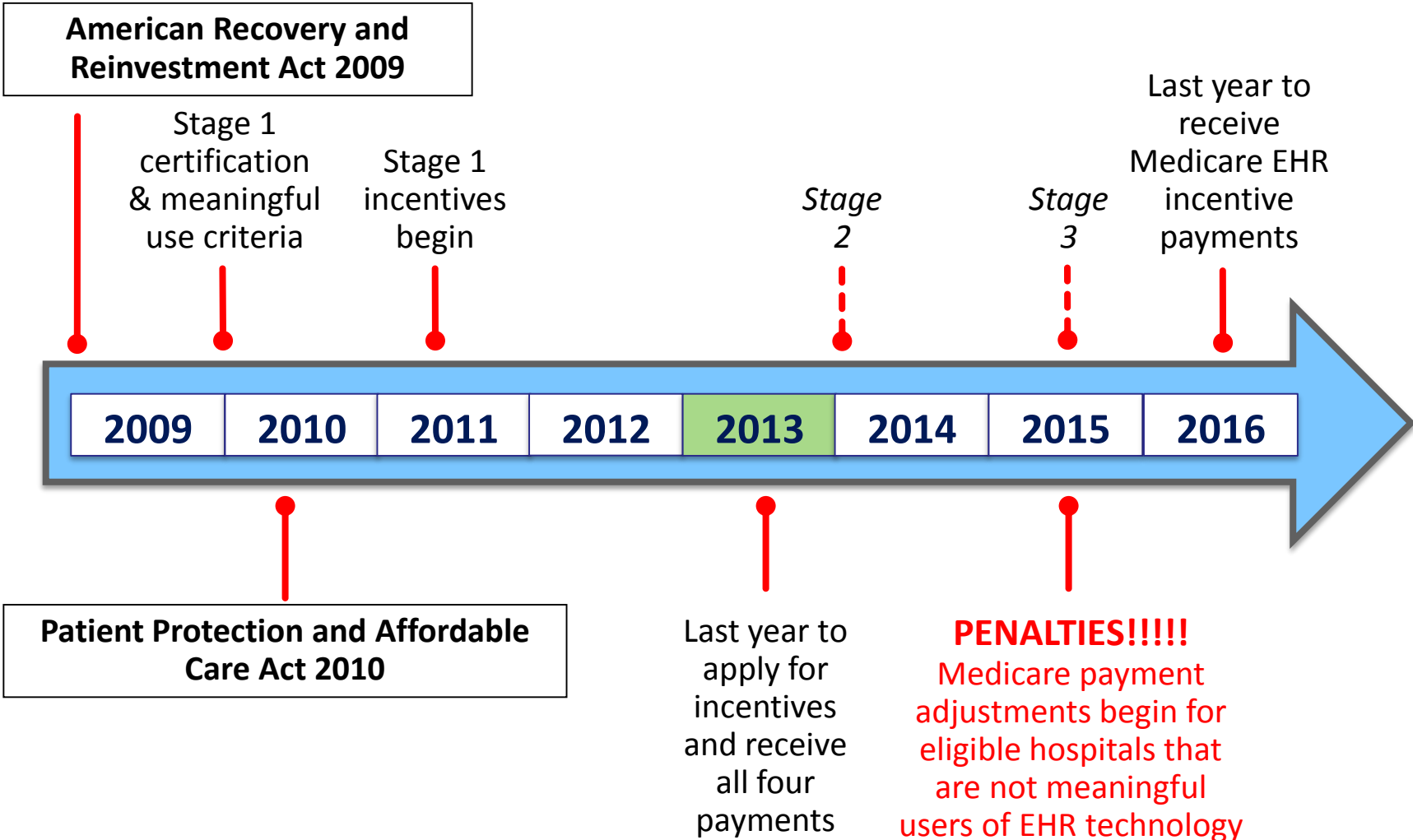
# The DRIVE for Data in order to Improve

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



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# Value Based: Care Delivery Models

## Clinically Integrated Networks

- Providers who contract with provider networks that in turn enter into payer agreements.
- May not have been able to do this on their own.
- Stronger contracts, better rates
- Regulated by strict FTC guidelines
- Follow agreed-upon clinical protocols and practice standards and measure them
- Providers who do not adhere to contract expelled

## Accountable Care Organizations (ACO)

- Have to start as clinically integrated but more focused on management of chronic disease in patient populations
- Payment is tied to achieving quality goals/targets and outcomes

## Patient Centered Medical Homes (PCMH)

- Primary Care focused.
- Team approach to care allowing for a personal approach to communication, coordinated with orientation focused on the whole patient
- High likelihood of enhanced access, reduction in variation of practice and increased patient satisfaction

# Value-Driven: Payment Model Definitions and Applications

## 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

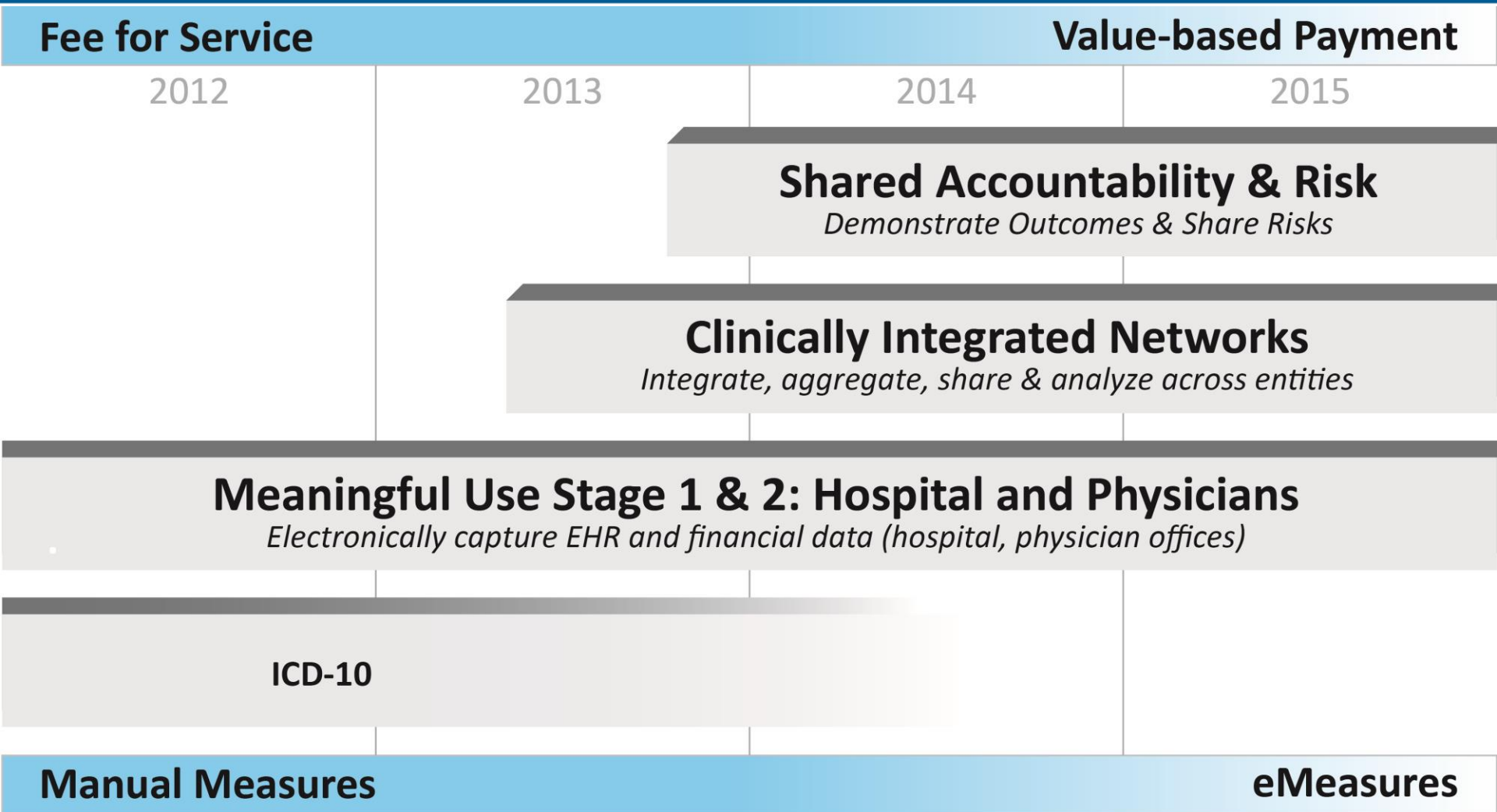
# Value-Driven: Payment Model Benefits and Concerns

Model	Benefits	Concerns
Fee for Service	<ul style="list-style-type: none"> <li>• Easy to manage from a business operations standpoint</li> <li>• Encourages delivery of care by maximizing patient visits</li> <li>• Supports accountability although limited to each specialty</li> </ul>	<ul style="list-style-type: none"> <li>• No incentive to delivery efficient care</li> <li>• Does not encourage coordination of care</li> <li>• Limited to face-to-face visits and certain services</li> <li>• Difficult for patients to understand the EOB</li> </ul>
Episodic/ Bundled Care	<ul style="list-style-type: none"> <li>• Potential to improve coordination of care among providers</li> <li>• Ensures a more efficiently managed episode of care</li> <li>• Provides for billing simplicity</li> </ul>	<ul style="list-style-type: none"> <li>• Difficult to define episode boundaries</li> <li>• Increases barriers to patients' choice of providers</li> <li>• Potential to avoid high-risk patients whose care exceeds the average episode payment</li> </ul>
Pay for Performance	<ul style="list-style-type: none"> <li>• Great potential to improve quality of care delivered</li> <li>• Encourages improvement by measuring outcomes</li> </ul>	<ul style="list-style-type: none"> <li>• Focuses on single condition (i.e. AMI, Stroke)</li> <li>• 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</li> <li>• Added overhead costs due to the collection, analysis and reporting of data for measurements</li> </ul>

# Value-Driven: Payment Model Benefits and Concerns (continued)

Model	Benefits	Concerns
Pay for Coordination	<ul style="list-style-type: none"> <li>• Enhances the physician-patient relationship and communication between providers</li> <li>• Increases family involvement</li> <li>• Reduces unnecessary care</li> <li>• Supports and rewards care between visits (i.e., phone, email, groups)</li> </ul>	<ul style="list-style-type: none"> <li>• Difficult to nail down specifics (scope) of care offered within the coordinated team</li> <li>• Many assumptions made about what will be covered in monthly amount</li> <li>• Patients may be expected to contribute part of that payment out of pocket</li> </ul>
Comprehensive/ Total Cost of Care	<ul style="list-style-type: none"> <li>• Great potential for providing innovative care and flexibility for providers</li> <li>• Improved incentives for providers who serve a particular population to collaborate</li> </ul>	<ul style="list-style-type: none"> <li>• Since payment is very risk-based, requires sophisticated IS and analytics</li> <li>• May overemphasize population health at the expense of individual health</li> <li>• Possible decrease in provider of choice by patients</li> </ul>

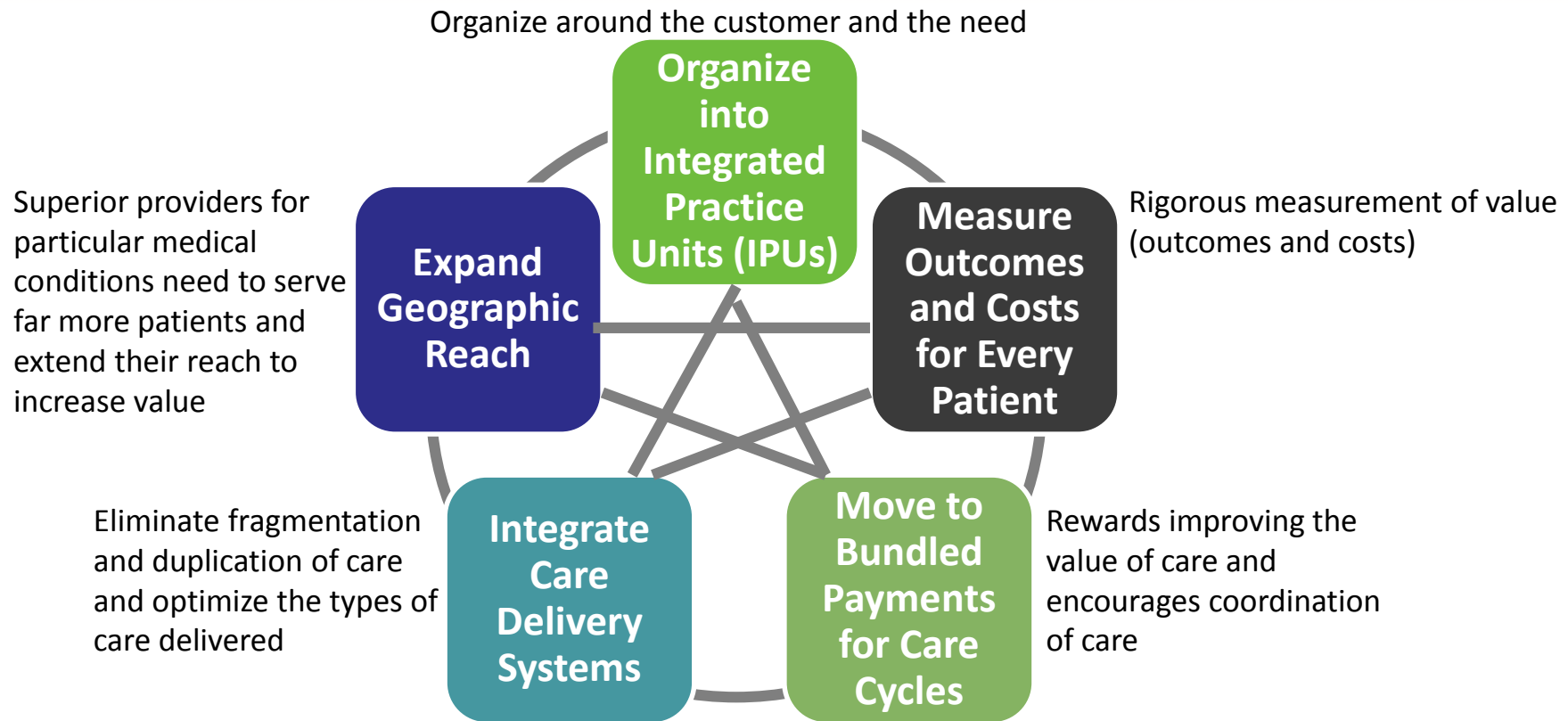
# The Shift in Reimbursement & Regulation Requires New Information Models



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# Successful Organizations that Focus on Value...



## Build an Enabling Information Technology Platform which:

- is centered on patients
- uses common data definitions
- encompasses all types of patient data
- makes medical records accessible to all parties involved
- leverages condition-specific templates
- enables easy information extract

# Revenue Cycle Management Systems

(Yesterday and Today)

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

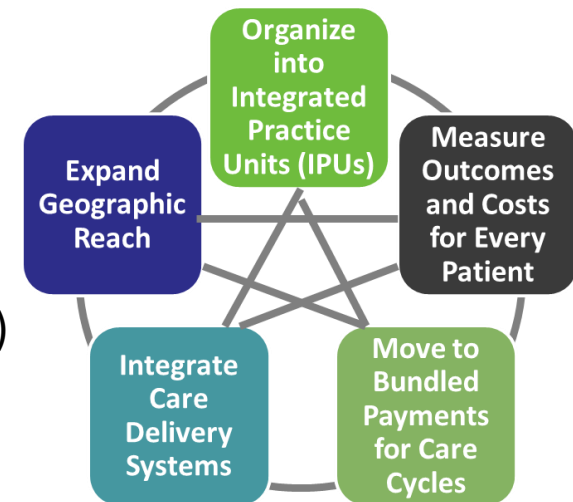
# Revenue Cycle Management Systems

(today and tomorrow)

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?*

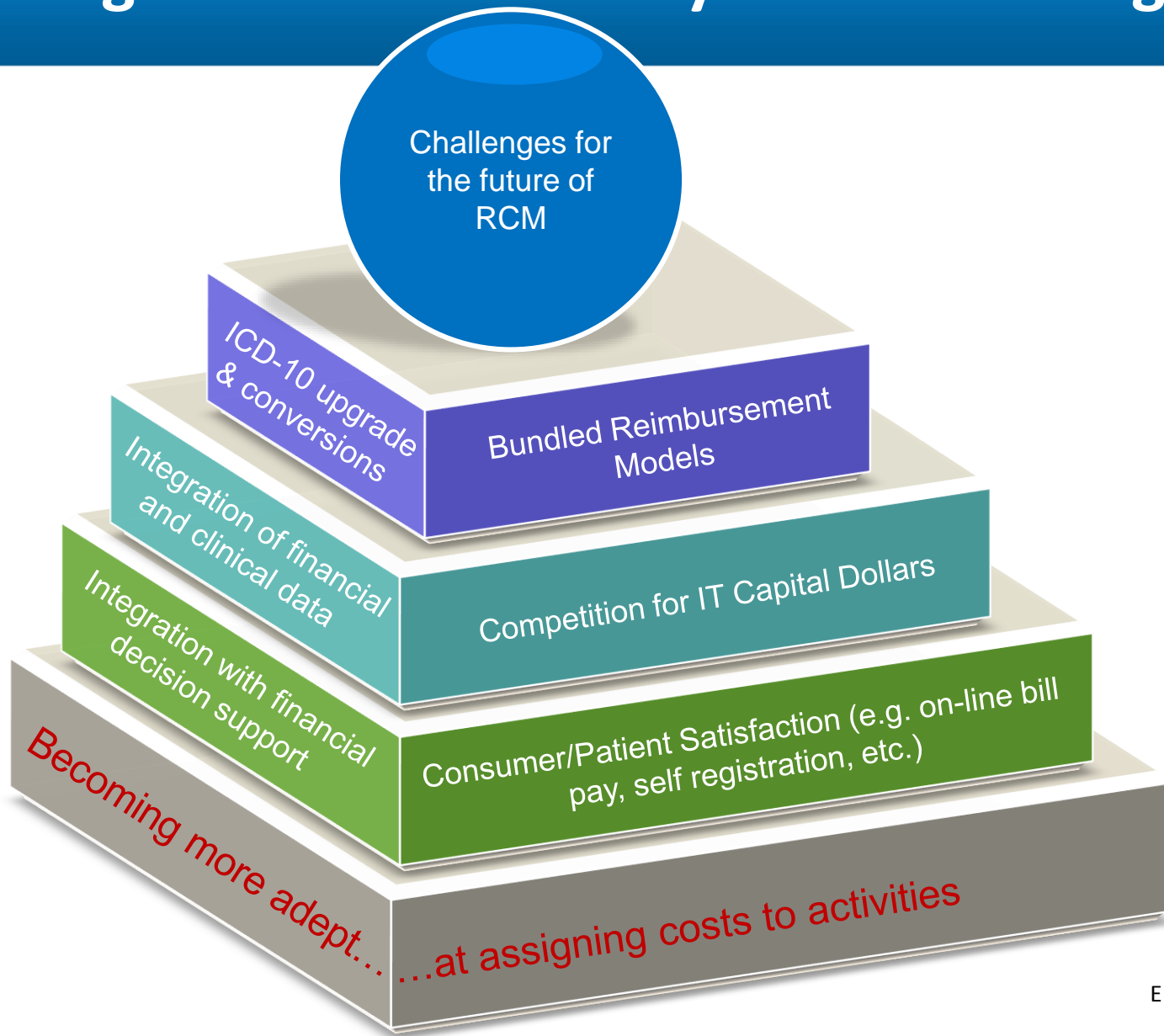
- YES** • Identifying and managing patient demographic information
- YES** • Collecting evidence for all services rendered (coding) and summarizing the charges for these services
- YES** • Producing a claim as efficiently as possible
- YES** • Remediating any barriers to payment
- YES** • Pursuing performance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



**Build an Enabling Information Technology Platform**

From : Harvard Business Review, October 2013, "The Strategy That Will Fix Health Care" Michael E. Porter, Thomas H. Lee

# Staying the Course while Incorporating Strategies for New RCM Systems Challenges



# For Example...

## Next Generation Solutions

Enhancements to legacy system or incorporated into full replacement systems

### Consumer focus

Web services to facilitate on-line pre-registration, self-scheduling, and bill payment to enhance patient service efficiency and convenience

### Eligibility verification

Supports real-time insurance eligibility verification transactions

### Claims processing

Bypass third party clearinghouse; direct receipt of remittances from payers

### Rules capability

- For billing and payment processing
- Multiple capabilities to improve accuracy and efficiency

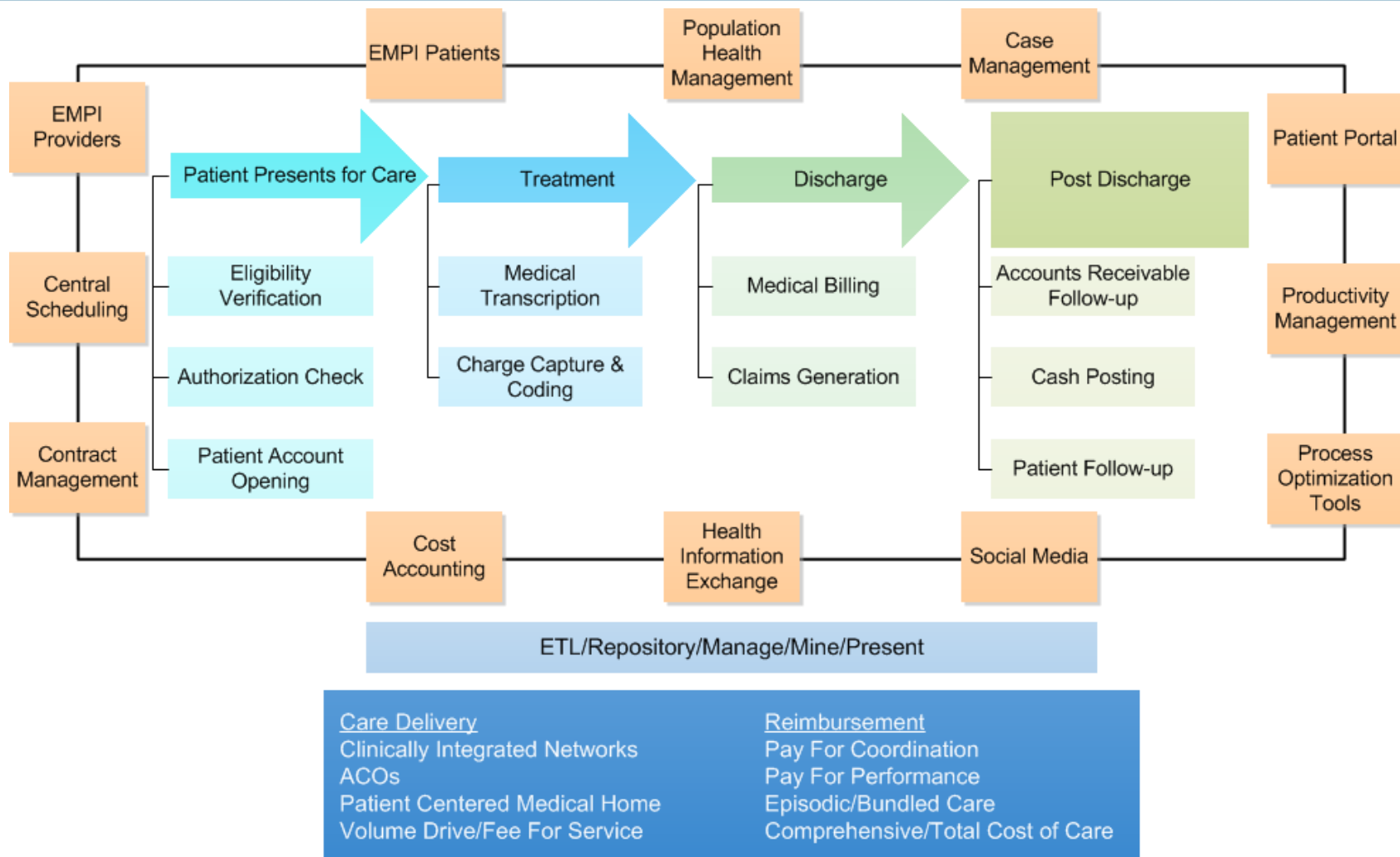
### Electronic fund transfers (EFT)

From third-party payers directly to the provider organization's bank accounts

# What Are the Leading HIT Vendors Saying about RCM Systems Changing with the Onset of Accountable Care?

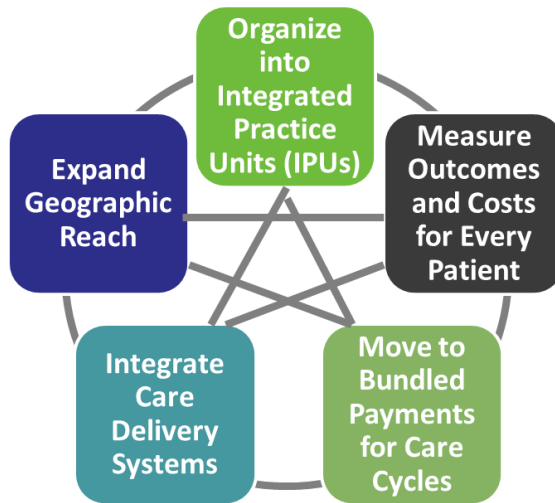
.....they will wait to see which of these Value-Based (VB) payment models will dominate, based on the pace of the movement toward VB care and reimbursement, before launching any major re-tooling effort.

# If not RCM Systems Directly, What Are the Tools that Should Get Some Attention?



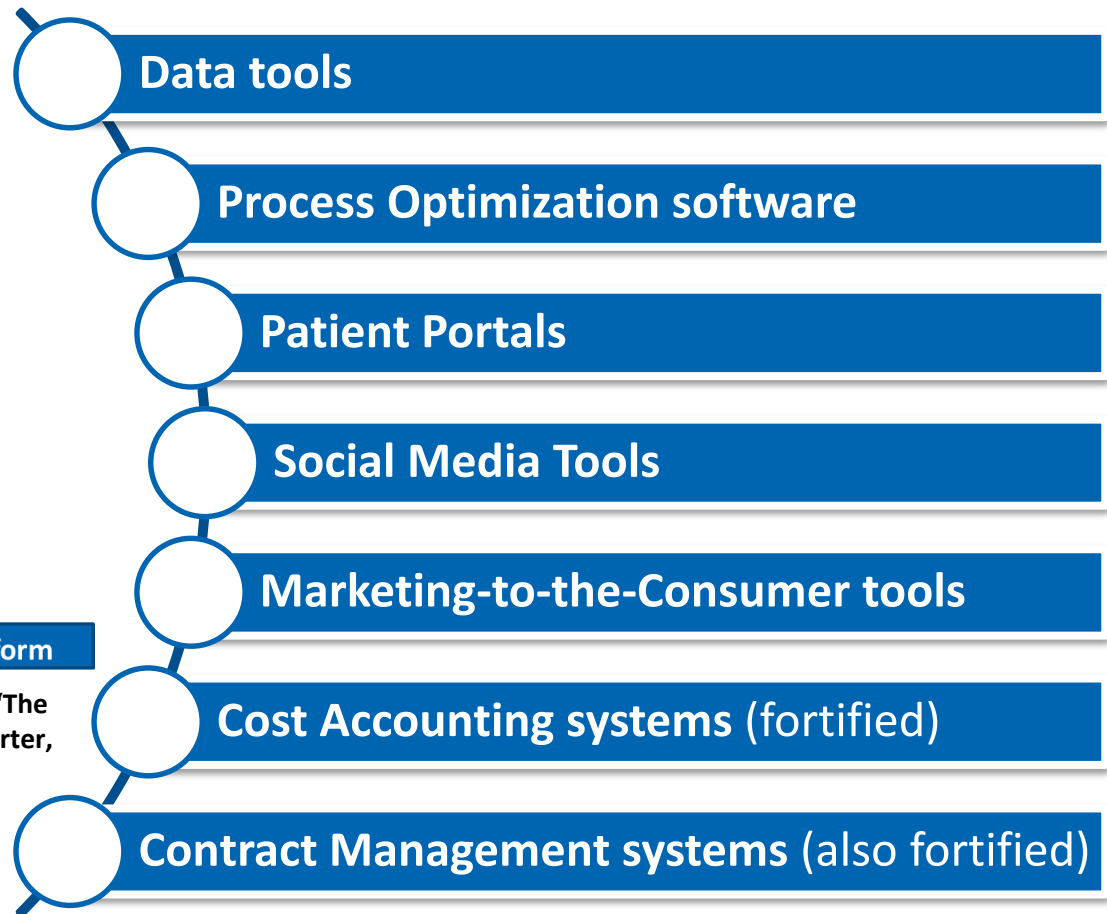
Measure PERFORMANCE/REVENUE/COST and Adjust  
(then do it all over again, and again, and again)

# If not RCM Systems Directly, What Are the Tools that Should Get Some Attention?



Build an Enabling Information Technology Platform

From : Harvard Business Review, October 2013, "The Strategy That Will Fix Health Care" Michael E. Porter, Thomas H. Lee



# 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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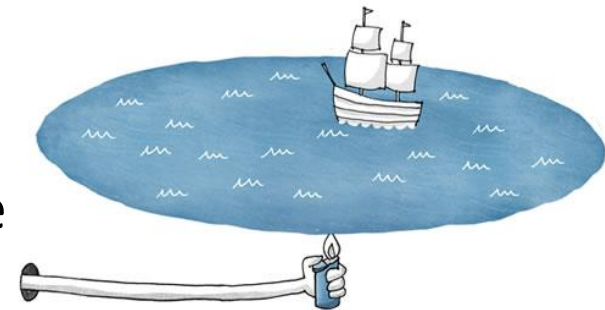
# Acknowledge that DATA Is Your Organization's Most Important Asset

- 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.



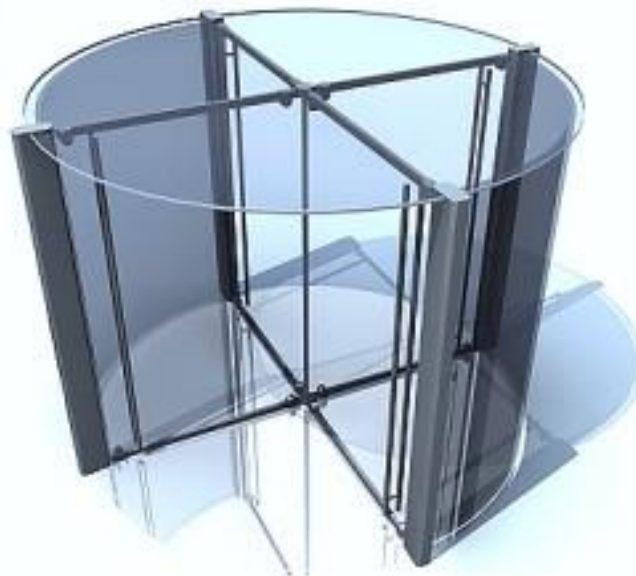
# Get Involved with the Data Management Strategy

- 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



# 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.”

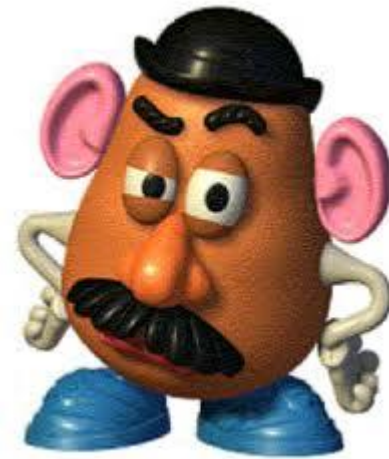
Benjamin Franklin

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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



# Keeping Patients from Going Outside the Organization

- 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

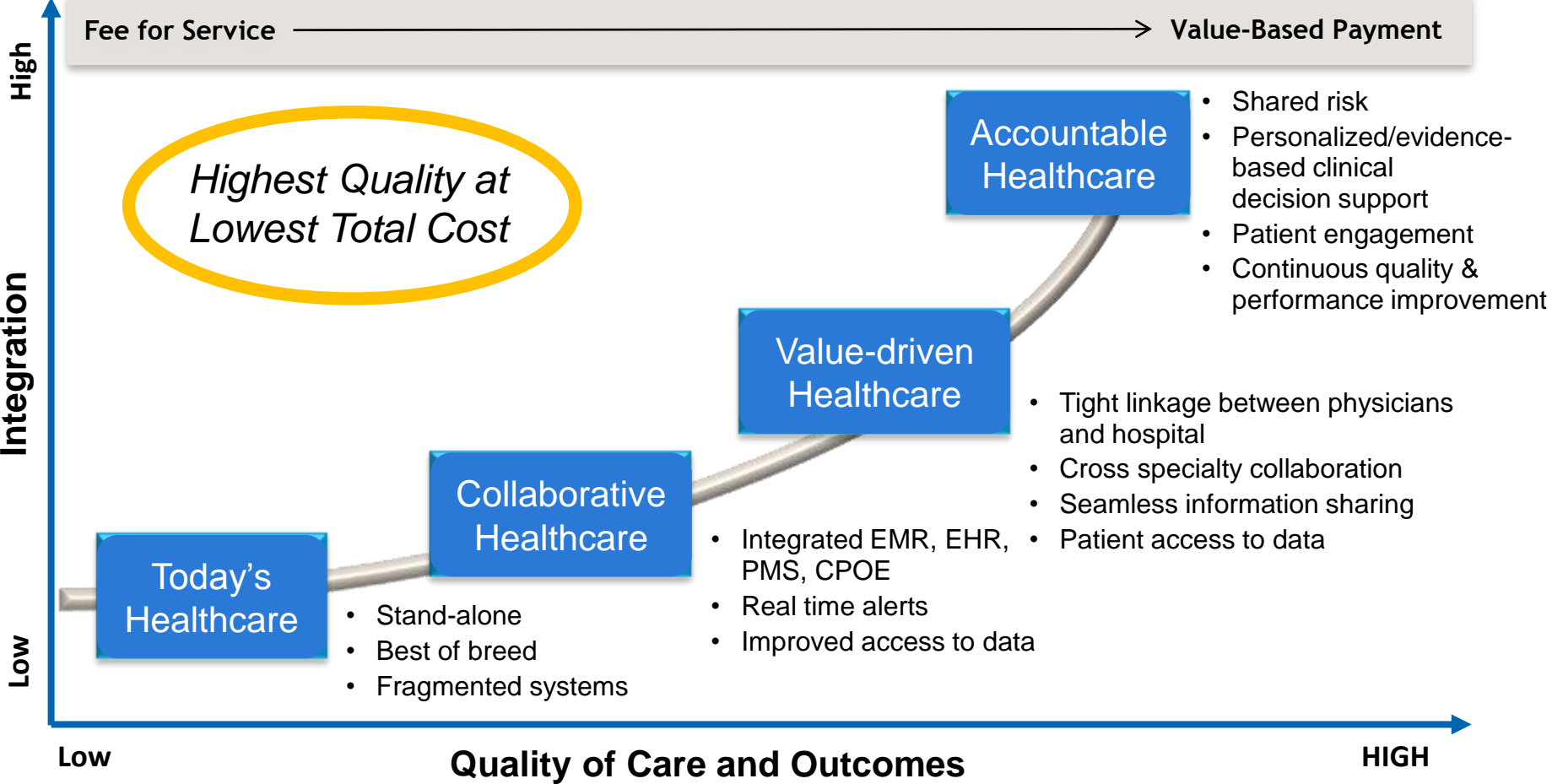
# ICD-10

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



# THANK YOU



## Questions?