Payments on the Fast

By Eric Foust and Parag Shah

For years, the healthcare provider revenue cycle exhibited a degree of financial predictability amid constant industry change. While there have been major challenges, including the rise of Meaningful Use, the shift to the International Classification of Diseases (ICD)-10, and increasing scrutiny by payers regarding medical necessity, an organization's fundamental revenue cycle marching orders have remained consistent: improve the amount and speed of collections while identifying and minimizing payer denials.

Value-based care is transforming these foundations and, in doing so, creating major new

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Track

Rooting out the top payment challenges in the value-based care era

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financial winners and losers in its wake. Organizations that outperform under new models can expect to see payments increase, while those that fall behind could suffer a major blow to their bottom lines. Moreover, physician practices that participate in advanced alternative payment models (APMs) that include downside risk could be obligated to reimburse the Centers for Medicare & Medicaid Services (CMS) for costs exceeding a target level.

Since the launch of the final Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) rule in 2016, revenue cycle uncertainty has been falling disproportionately on specialty practices, which are generally newer than primary care practices to the core mandate of value-based payment—assuming holistic accountability for patients throughout an episode of care and across all settings. More recently, payment reform programs expanded into new areas,

including Emergency Medical Services (EMS) agencies, as evidenced by the February 2019 announcement of the Emergency Triage, Treat and Transport (ET3) Model.[1]

To optimize operations for emerging payment models while minimizing or avoiding risks, healthcare organizations must be ready to transform both core clinical and financial processes that served them during the fee-for-service era. They must implement best practices and invest in new skill sets and tools that are needed to maximize revenue. Below we dive into the payment challenges facing EMS and physician practice organizations in the era of value-based care, as well as key steps many are taking to close potential revenue gaps and accelerate cash flows.

Payment Challenges

With the rise of value-based care, payers have increasingly required specialists to take on financial accountability for patients with some of our healthcare system's most complex—and costly—diseases, from diabetes and congestive heart failure to cancer. This has precipitated a significant shift in what many healthcare stakeholders considered specialists' traditional responsibilities and has infused a high amount of risk into the revenue cycle.

First, value-based care presents new challenges that are intrinsically clinical in nature. Specifically, to avoid claim denials, organizations are now expected to analyze episodes for issues such as deviations from care pathways or errors in outcomes documentation. Furthermore, under MACRA, Medicare fee-for-service (FFS) reimbursement is adjusted based on the Merit-based Incentive Payment System (MIPS) composite score, which is calculated from data in the practice's electronic health record (EHR), among other sources. Gathering this data can be problematic for many practices with legacy EHRs. Revenue cycle management (RCM) teams are then required to close the loop with clinical leadership to flag issues requiring immediate attention, such as gaps in care or in documentation.

Additionally, physician practices are now being measured against cost-efficiency targets—CMS' predicted total cost of care per episode. While practices that exceed defined cost-efficiency targets are also able to partake in a share of savings, those that fall short may see reimbursement rates decline. Should practices select to assume upside and downside risk, they may also be liable for excess costs and increased risk, including bundled payments and two-sided risk payment models.

As with FFS RCM, accurately determining how much revenue will result from value-based sources requires anticipating that some percentage of revenue will not come in because of either internal errors or inaccurate reimbursement from payers. Because value-based contracts are relatively new, both providers and payers have a lot of details to work out around compliance, measurement, reporting, and payment expectations (see "Quality Is Key").

Challenges Facing EMS Agencies

For the EMS industry, collecting payments is most often hindered by either missing insurance details or a patient not understanding their financial responsibility, which has become increasingly problematic with the growing number of high-deductible plans. At dispatch, validating patient information—including insurance coverage, payer requirements, deductibles, and copays—is often difficult to obtain, especially in emergency situations when treating the patient takes center stage. Moreover, as the patient moves through the medical system from transport to arrival at the hospital and treatment, critical patient data can be "trapped" within each vendor-specific silo. Without a fully integrated solution, incomplete and unblended records can hinder agencies' EMS/Fire ability to accurately code and submit clean claims.

Post-treatment, patients are often left managing multiple bills that correspond with their emergency care, from ambulance trips to emergency room charges and more. Unfortunately, paper statements rarely offer detailed explanation of benefits (EOBs) and provide limited recourse for correcting insurance information or other patient details to ensure accuracy. When patients are financially unprepared to pay, or do not understand the amount they are being asked to pay, emergency transport bills are ultimately written off.

As we look to the future, EMS agencies will soon face a new hurdle. Current reimbursement rates reflect the cost of patient transport, but often discount the costs associated with

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Quality Is Key

Value-based contract challenges are complicated by the fact that they are affected far more by the quality of clinical encounters across multidisciplinary provider teams in every care setting, rather than simple codes indicating services rendered in the office.

delivering holistic patient care to the patient during transport. While Medicare add-ons provide some relief, they are temporary and therefore not sustainable. In response, the Bipartisan Budget Act of 2018[2] brings with it a new requirement for collecting cost and other financial data from ambulance service suppliers and providers. Under the cost data collection initiative, financial data—including revenue, utilization, and expense (cost) data—will be collected via surveys, pulling from a subset of large and small ambulance services each year. This aggregate cost data will be used to develop a national benchmark against which all agencies will be measured moving forward.

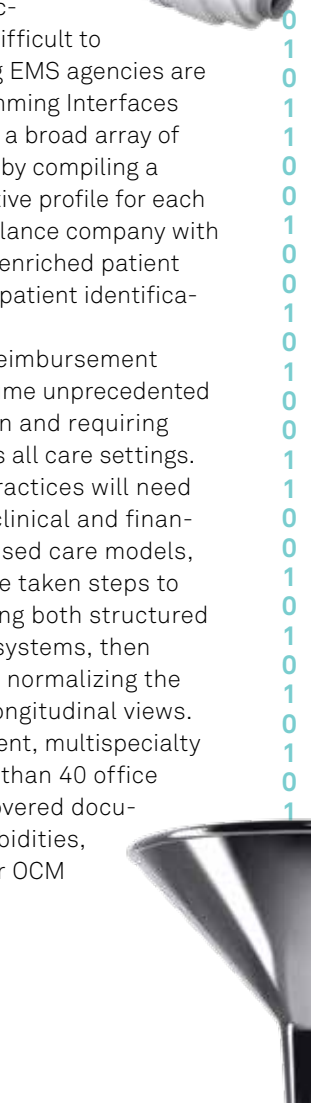
While the objective is to create an ambulance fee schedule that reflects the true costs of providing ambulance services, under the cost data collection program, municipal agencies will be compared to for-profit agencies, which often have more efficient operations and higher economies of scale than their not-for-profit counterparts. Without access to comprehensive cost data, small agencies will be disadvantaged and ultimately see their payment decline. Additionally, ground ambulance services and suppliers that fail to provide the required data will be subject to a 10% reduction in their Medicare payments, resulting in long-lasting, negative impacts on agencies' financial success.

TOP THREE ACTIONS TO ACCELERATE PAYMENTS

1 Enrich Patient Data

For EMS agencies, especially in the case of high-deductible health plans, verifying patient financial responsibility upfront empowers the dispatcher to proactively address billing issues that may be difficult to mitigate late in the revenue cycle. Leading EMS agencies are beginning to leverage Application Programming Interfaces (APIs) to establish direct connections into a broad array of data sources to enrich patient data, thereby compiling a holistic clinical, financial, and administrative profile for each patient at the time of dispatch. One ambulance company with operations in the Southeast is leveraging enriched patient data to flag missing information, validate patient identification, and confirm insurance coverage.

For physician practices, value-based reimbursement models are compelling specialists to assume unprecedented accountability for their patient population and requiring them to manage total costs of care across all care settings. To have a clear picture of each patient, practices will need to create and maintain a unified view of clinical and financial data. Top performers under value-based care models, like the Oncology Care Model (OCM),[3] have taken steps to integrate their disparate data by extracting both structured and unstructured data from a variety of systems, then syntactically scrubbing and semantically normalizing the data to create holistic, patient-centric, longitudinal views. By employing this approach, one preeminent, multispecialty OCM practice—serving patients at more than 40 office locations throughout the Midwest—uncovered documentation gaps related to patient comorbidities, revealing an opportunity to increase their OCM Target Price by as much as 50%.



2 Integrate Business Intelligence Tools

It is important to project revenue upsides and downsides. While retrospective, financial analytics used to be enough—enabling visibility into past business performance and informing new process improvements—to succeed under value-based care, healthcare providers are compelled to adopt business intelligence solutions that can predict revenue risk factors and identify improvement opportunities. In parallel, they must also maintain visibility into the top key performance metrics that indicate the financial health of a practice, from cash flow to denial rates and days in accounts receivable (AR) to ensure overall financial performance and sustainability.

Leading organizations leverage business intelligence to identify missed billing opportunities by:

- Personalizing queries at the patient level
- Driving targeted payer negotiations by establishing a high-value performance benchmark
- Demonstrating continuous quality improvement
- Aligning quality and cost performance
- And more

By introducing real-time analytics, one ambulance company based in the Southwest significantly boosted efficiency, reducing days sales outstanding by two-thirds and denial rates to 5% in just the first six months.

3 Establish a Governance Model

Your practice must manage overall revenue-cycle performance, including performance against new value-based care objectives. Revenue-cycle performance has inherently depended on the operational excellence of the front- and back-office teams, with clinician engagement narrowly scoped to ensure efficient and complete in-office documentation. In the new era of value-based care, healthcare providers are expected to take on a much more active role to ensure patient engagement and documentation compliance with quality measure reporting requirements. For many, these changes require a shift in organization culture.

To drive the necessary cross-team engagement, highest performers are introducing varying degrees of financial incentives to encourage behavioral changes, and some are incorporating these metrics into monthly performance reviews. One prominent OCM practice in the Southeast focused on top-down communications and a robust education program, including webinars and related resources, to gain physician buy-in.

The Road Ahead

Value-based care is here to stay. To ensure long-term financial stability, healthcare provider organizations must proactively identify potential operational gaps, from insufficient data and workflow challenges to whether existing staff have the appropriate skills, training, or incentives to effectuate a value-based program. For organizations already participating in value-based reimbursement models, their next step is to determine their appetite for taking on two-sided risk, evaluate what new tactics they could take on—such as investments in new technology-enabled solutions—then estimate the impact of these efforts on their projected cash flows. GPJ

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