Preparing for October: Revenue Cycle Management for 2015 ICD-10 Go-Live
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Introduction

How can you benefit from ICD-10 and use the transition to better position your organization for success?

In July 2014, the U.S. Department of Health and Human Services (HHS) issued a rule finalizing Oct. 1, 2015, as the new compliance date for healthcare providers, health plans, and healthcare clearinghouses to transition to ICD-10. This new deadline gives providers, insurance companies, and others in the healthcare industry time to ramp up their operations to ensure their systems and business processes are ready to go on Oct. 1, 2015.

“ICD-10 codes will provide better support for patient care, and improve disease management, quality measurement and analytics,” said Marilyn Tavenner, Administrator of the Centers for Medicare & Medicaid Services (CMS). “For patients under the care of multiple providers, ICD-10 can help promote care coordination.”

The transition to ICD-10 is required for everyone covered by the Health Insurance Portability Accountability Act (HIPAA). Ultimately, ICD-10 regulations require an overhaul of systems and software to meet these expectations and maximize revenue in the modern healthcare environment. Revenue cycle management is a critical operation area and one of the key areas of impact affected by ICD-10. The revenue cycle has changed—new payment models are creating a new healthcare revenue cycle.

With the recent transition delay to Oct. 1, 2015, practitioners have the opportunity to use the next 12 months to significantly reduce their exposure to disruptions and ease their conversion to ICD-10 by continuing and completing preparatory actions.
reduce their exposure to disruptions and ease their conversion to ICD-10 by continuing and completing these five preparatory actions:

**Plan thoroughly.** Practices that haven’t yet developed a strategy for a smooth transition to ICD-10 should start planning now. Identify all systems that are used to create, store and transmit ICD-10 codes, and work with their vendors to understand the timing of their support for ICD-10. Create a plan for training, testing, transitional activities and support during the period following the effective date.

**Educate and train.** The ICD-10 transition was extended, but that doesn’t mean training should slow. Front office staff should continue to learn as much as they can about ICD-10 so they can accurately and efficiently codify patient complaints. Billing staff should also take advantage of the delayed transition to become more familiar with the larger number of diagnosis codes. Up-front knowledge about the entire coding process will minimize practices’ exposure to major financial disruptions.

**Use ICD-10-ready technology.** Prior to the conversion, medical practices must have assurances that their practice management (PM) and electronic health record (EHR) systems are as ready for ICD-10 as they are. If they haven’t already, practices should contact their vendors to learn when the ICD-10-ready releases will be available. Vendors should be able to articulate an ICD-10 approach that clearly expresses their mapping or crosswalk strategy.

**Gain physician buy-in.** Failure for providers to quickly adapt to ICD-10 could result in operational and fiscal hardship for the healthcare practice. Office staff can ease the changeover by helping ensure
physicians are well prepared. They can identify the clinical documentation and patient encounter workflows that will change under the new coding rules and encourage practitioners to educate themselves on the new requirements. For their part, physicians should take it upon themselves to practice with real-life examples so they gain first-hand knowledge of how the new code set will impact their care delivery habits.

**Test.** To ensure users are as comfortable as possible with the new system, many practices completed or scheduled their upgrade well in advance of the prior 2014 deadline. Practices that haven’t done so yet should contact their vendor now, as far out from the deadline as possible. They must be prepared to conduct testing with payers early in the process, continuing until they are confident there are no gaps in the claims submission workflow. If there is one lesson the industry can take from the HIPAA 5010 conversion, it’s that many health plans and providers did not conduct enough large volume testing; only after they went live did a number of significant issues come to light. This is a preventable situation and continued testing can help.
Clearing the Air on the ICD-10 Transition: AHIMA’s Policy and Coding Leader Speaks Out
AHIMA’s Sue Bowman shares her perspectives on the current moment in the journey towards the ICD-10 transition
Mark Hagland

When the U.S. Congress inserted a year-long delay in the mandate for the transition from the ICD-9 coding system to the ICD-10 coding system from Oct. 1, 2014, to at least Oct. 1, 2015, as part of a broader bill creating a temporary “SGR fix” (a delay in Medicare physician payment cuts under the program’s sustainable growth formula), it threw ICD-10 planning into disarray across the U.S. healthcare system.

At the Chicago-based American Health Information Management Association (AHIMA), the national association of health information management (HIM) professionals, the reaction to Congress’s March 31 action was one of shock and dismay. After the U.S. Senate passed the SGR-fix bill on March 31, and just before President Obama signed it into law on April 1 (the provision on ICD-10 had been slipped quietly into the SGR-fix bill by lobbyists representing medical specialty societies), AHIMA issues a press release saying that “The American Health Information Management Association (AHIMA) expressed deep disappointment that the U.S. Senate voted today to approve H.R. 4302, Protecting Access to Medicare Act of 2014, which included language delaying implementation of the ICD-10 code set until at least October 1, 2015.”

The press release included a formal statement from AHIMA CEO Lynne Thomas Gordon.
stating that, “On behalf of our more than 72,000 members who have prepared for ICD-10 in good faith, AHIMA will seek immediate clarification on a number of technical issues such as the exact length of the delay.” The press release later went on to say that “It has been estimated that another one-year delay of ICD-10 would likely cost the industry an additional $1 billion to $6.6 billion on top of the already incurred costs from the previous one-year delay. This does not include the lost opportunity costs of failing to move to a more effective code set.” And it added that “The United States remains one of the only developed countries that has not made the transition to ICD-10 or a clinical modification, a more modern, robust and precise coding system that is essential to fully realize the benefits of the investments in electronic health records and maximize health information exchange.”

What’s more, the leaders at AHIMA have been very active in the Coalition for ICD-10, a group advocating for a speedy and comprehensive transition to ICD-10. That group includes a broad array of industry groups, including America’s Health Insurance Plans (AHIP), the BlueCross BlueShield Association, the Medical device Manufacturers Association (MDMA), the American Hospital Association (AHA), and American Medical Informatics Association (AMIA).

AHIMA strongly applauded the announcement on July 31 by the federal Centers for Medicare and Medicaid Services (CMS) that the new transition date would be Oct. 1, 2015 (the earliest day allowed by the congressional legislation), with the association saying in a statement on July 31 that “Now, everyone in the healthcare
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community has the necessary certainty to move forward with their implementation processes, including testing and training."

AHIMA’s leaders say they continue to do everything possible to help healthcare organizations prepare for the transition, while making it clear that they will oppose any further delays, and speaking out against what they see as myths propagated by the opponents of the ICD-10 coding system.

In that context, Sue Bowman, senior director, coding, policy, and compliance, at AHIMA, spoke recently with HCI Editor-in-Chief Mark Hagland regarding the current moment in the ICD-10 transition saga, and her perspectives on it. Below are excerpts from that interview.

In interviews I’ve done recently, I’ve heard some pushback about the usefulness of the ICD-10 system. Are you hearing any pushback right now?

Well, nothing new, really. In fact, as people become more familiar with ICD-10, their negative view is changing. And people are still saying there was no clinical input in the development of the coding system. But from the beginning, all of the content of it really came from the clinical community; and there’s actually something called the Coordination and Maintenance Committee, co-chaired by the National Center for Health Statistics, and CMS. They’re responsible for the maintenance of ICD-10 code sets in the U.S. NCHS maintains ICD-10-CM, which is a diagnosis system; and CMS maintains ICD-10-PCS, the new procedure coding system, for hospitals. So they’ve been guiding the development process.

So it’s a public process, where people can submit proposals for new and expanded codes. And so even from the development to how it’s being maintained now. On the one hand, you hear people complaining
about the detail and specificity of it; but it’s physician organizations that want more codes—which is kind of funny.

Is it correct that ICD-10 in this country will be different from the ICD-10 systems in other countries, with ten times the codes of other ICD-10 systems? That’s what a few people have told me.

No, that’s not entirely correct. The first few digits have to be kept standardized internationally; but beyond the first few digits, codes can be expanded for your specific country’s needs. Within the constructs of the code sets of the international system, you have to maintain stability in the first few characters. And a lot of the specificity we’ve added is not new diseases; it’s specific details about anatomy; but a significant percentage is around laterality—left or right side. If you can code broken left arm or broken right arm, that doubles the number of codes right there; but it doesn’t add to the complexity of the system; indeed, it provides clinical clarity that speaks to patient safety. And of course, hopefully, laterality is already being documented in the medical record.

Are those expressing dissatisfaction just a few isolated grumblers?

It’s like with anything else; the negative people tend to be louder. But the vast majority of people, including physicians, are in support of the ICD-10 transition, and realize we need to replace ICD-9 after 35 years of use. And you’d think, of any country, that we’d have more motivation than anyone else, to change systems, for all the reasons we use healthcare data. And if you think of how things were in the 1970s—it’s just a different environment today inpatient care.

Do you think everyone’s pretty much ready at this point?

Yes, and interestingly, I’ve heard from a number of physicians in practice who weren’t
happy with the delay, including my own personal physician. My physician said, ‘I’m the kind of guy who follows directions, and turns his homework on time. And now I’m going to have to keep my staff trained and systems up; and so the delay is going to cost more money for everyone except for those who did nothing—and why are we rewarding them?’ And that’s why the coalition put an infographic together. I think we’ve gotten so lost in arguments that some people have lost sight of why we’re doing this. We’re doing this to get better data, not just for the U.S., but to share globally around things like global health threats. And healthcare today is global, just like everything is global.

Should people be doing dual coding now, then?
Yes, a lot of organizations are doing dual coding, to keep their coders in ICD-10 practice, because a lot of people have already been trained, and otherwise, they’ll forget it. And also, people are using that dual-coding data, to assess reimbursement effects and payment mix. So instead of hypothesizing how ICD-10 might affect them, they can see it in real data.

What percentage of hospitals and medical groups are doing dual coding?
I’m not sure of the exact percentage. Probably not the smaller practices; it does take additional time to dual-code. So I would imagine it would be hospitals and larger practices.

Has anyone shared with you what they’ve done with this?
Yes, we had something on that in a report, a white paper that we produced after an ICD-10 summit. Obviously, this is giving people more practice in ICD-10, which means that on the transition date, hopefully, the impact will be considerably less, because they will have been coding in ICD-10 for some time at
least in some records; the other thing is that the training for ICD-10 has actually improved coding for ICD-9. And it’s also pointed out that the ICD-9 coding isn’t all that great. So when you talk about the impact of ICD-10 on coding accuracy, then you discover that actually, ICD-9 coding wasn’t optimal to begin with, so the training is helping to strengthen core coding principles and practices. And some people going through ICD-10 coding training, may never have had formal ICD-9 coding training. A lot of people coming to ICD-10 training just sort of picked up ICD-9 on the job.

What should CIOs know about all this?
I think they should know that this isn’t simply an “HIM thing.” Now, certainly, CIOs should know that this is an enterprise-wide transition. Codes, underneath the surface, are driving different initiatives, and when people begin doing their assessments, they have a lot of surprises about places where codes are used, not just in claims. I can send your our preparation checklist; but some things are disease management programs, where they use ICD-9 codes to identify patients; registration for medical necessity—when the patient registers, a lot of times, a code is put into the system to match data against any review policies, to make sure it will be a covered service by a payer, so, eligibility. I’ve even heard of things like OR scheduling systems, where the codes are used to identify patients.

CIOs should know that this is an enterprise-wide transition. Codes are driving different initiatives, and when people begin doing their assessments, they have a lot of surprises about places where codes are used, not just in claims.

Overall, how do you feel about what’s going on right now?
I feel pretty good. I know that with the delay, some momentum was lost; and now there’s some skepticism—some people think it could still be delayed again. But I’ve seen a lot of evidence that people are moving forward. I’m glad to see CMS come out with testing information, because that’s the stage people need to get to next. So there are
a lot of strong messages out there around what needs to be done. A year seems like a long time, but it really isn’t. Don’t wait ‘til the last minute.

And physicians shouldn’t be afraid?
No, they really shouldn’t. There’s been so much fear-mongering out there, but once physicians experience it, they say, oh, this isn’t so bad. And it turns out that many of the codes have been created by their own medical specialty societies. And they’re still only going to be using a small subset of codes that they typically use in their area. And you can still use a super-bill. You’ve still got your list of common conditions. All you have to do is translate the codes you use already into ICD-10 codes.

So there will be more codes, but it won’t be overwhelming for individual physicians?
Right. And in a lot of cases, they might find the terminology of the codes closer to how they document to begin with. An example I use is asthma. In ICD-9, it’s broken down into terms like “extrinsic” and “intrinsic,” terms that no physicians have used for years in documenting; instead, asthma under ICD-10—the vocabulary has been updated to terms physicians use today. And the physician community had a lot to do with modernizing that terminology.

A year seems like a long time, but it really isn’t. Don’t wait ‘til the last minute.
5 Ways to Capitalize on the ICD-10 Delay

Gabriel Perna

For many, the delay of the ICD-10 transition will require major revisions to their implementation plan. For others, the changes will be minor. Some won’t change a thing.

A recent webinar, hosted by the Weymouth, Mass.-based consulting firm, Beacon Partners, articulated this discrepancy while providing tips to providers that are undergoing ICD-10 implementation. In a survey conducted during the webinar, 43 percent of attendees said they anticipated minor revisions to their implementation timeline, 23 percent said they were staying the course, and 16 percent said they were going to undergo major revisions to the timeline.

While industry-wide opinions seem to be split on whether or not the delay was a good idea, Summer Humphreys, executive consultant at Beacon, said that most providers still have a lot of work to go on implementation, even with an extra year. Humphreys shared five tips with providers on how they can utilize the extra time.

**Tip 1: Dual Coding**
This can occur multiple ways, Humphreys said. It happens when one coder codes a record in ICD-10 and then performs crosswalk coding in ICD-9 when possible in a single session. It can also happen with two coders, one coding in ICD-10 and the other in ICD-9, or multiple coders coding in ICD-10. Dual coding she said can measure the impact ICD-10 will have on productivity while helping apply a standard measure of...
coding application. Those who wish to dual code should figure out what specific areas to focus on, she said, and also create a diagram workflow process.

Tip 2: Create a Clinical Documentation Improvement (CDI) Program
This kind of program can capture and monitor key performance indicators (KPIs) and measure them against benchmarks, Humphreys said. It also gives an organization a better idea of its coding workflows and helps it better understand where the problem areas might be. Of highest importance in this kind of program is to incorporate feedback from physician advisors and champions. In order to make a CDI program successful, she said organizations have to obtain physician participation and make them understand what’s in it for them. Also it’s critical to get buy-in from the hospital’s leadership team, she said.

Tip 3: Optimize Revenue Cycle Workflows
In a poll conducted by Beacon during the webinar, 81 percent of participants predicted that ICD-10 would have a significant impact on their revenue cycle. No matter what an organization thinks of the ICD-10 delay, Humphreys said she is fairly certain that there will be room for improvement in its revenue cycle management (RCM) when it comes to ICD-10. Some ways to optimize the process, she said, include meeting with frontline staff, using staff interviews to map out workflow diagrams and matching workflow to IT scripts/process flow, and rebuilding RCM workflows to fit employees. She also suggested analyzing which payers, providers, and coders have the highest denial rates to try and better understand those reasons for denials. This can help an organization evaluate how much time staff is spending on claim resubmission and denials.

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Tip 4: Evaluate Computer Assisted Coding (CAC) Readiness
Humphreys noted that as of last year, fewer than 10 percent of provider organizations have implemented CAC. She said that many organizations don’t have the expenses for CAC and there are no standards within the systems, so it creates a lot of variations. However CAC, she said, can increase productivity, coding consistency, create an audit trail, and it can be used in conjunction with the CDI program. To evaluate readiness for CAC, she said organizations should figure out how much electronic documentation they are doing and the costs and benefits of CAC within their specific organization. Even with the delay, if CAC doesn’t result in a 20 percent increase in productivity, it might not be worth it, she said.

Tip 5: Test, Test, and Re-Test
Testing was one of the big issues brought up by industry stakeholders BEFORE the delay was announced. Humphreys recommended organizations create an internal testing plan for each of the ICD-10 touch points, beginning with the most important systems first. She said organizations should test systems more than once using a varied data sample. Lastly, she said organizations should take the extra time to reach out to payers and external reporting agencies to test on that end.
As healthcare reform-related reimbursement pressures continue to intensify, the pressure on patient care organizations has mounted, making it critical for them to execute a thorough and efficient revenue cycle management (RCM) system.

Today, hospitals, medical groups, and integrated health systems are facing the twin burdens of Medicare and Medicaid payment changes stipulated by the Affordable Care Act (ACA)—estimated to trigger more than $150 billion in reductions over the next 10 years—in addition to the specter of additional cuts from the Budget Control Act of 2011. Most hospitals have long deployed automated systems to address core processes around RCM, but these legacy IT applications often have out-of-date technology platforms that lack the advanced functionality needed to address new models of care delivery and reimbursement. In addition, the complexity of medical billing and collections has created fragmented workflows across the patient accounts pathway, resulting in gaps and inefficiencies that lead to lost revenue, according to new research from consulting firm Frost & Sullivan.

That research has estimated that the RCM industry is expected to grow significantly in upcoming years; RCM applications and services in U.S. hospitals are predicted to increase in value from $1.9 billion in 2012 to $3.07 billion in 2017, representing more than a 61 percent increase over five years.
Denied billing claims—mostly due to patients being ineligible—accentuate the need for a sound RCM system. Patients who receive care, but end up not qualifying for coverage and cannot pay out of pocket, can cause hospitals and physician practices to lose money, which when added up, and can result in financial burdens to the organizations.

What’s more, managing denied claims can also rack up expenses. Having an up-to-date medical billing service is essential for staying on top of various ACA provisions as well as other laws that deal with healthcare.

The trick about revenue cycle is that it really is a-rip-and-replace solution, says George Hickman, executive vice president and CIO at Albany Medical Center, northeastern New York’s only academic health sciences center, which incorporates the 651-bed Albany Medical Center Hospital. “On day one when you flip the switch, everything has to work if you’re going to get bills out and keep everything working the way it’s supposed to. Here, we had to pull back, clean it out, and then roll it out again. To prepare for that, the team has to be highly integrated in terms of how it behaves to pull this off, and there has to be a lot of accounts receivable and cash collection work,” says Hickman, who is chairman of the board of the College of Healthcare Information Management Executives (CHIME).

The key to a successful RCM system is that it starts the moment a new patient asks for a consultation or his or her first visit with a healthcare provider, and ends when that person’s balance equals zero. But healthcare reform and the push for deficit reduction are forcing hospitals to address long-standing inefficiencies and shortfalls around the RCM process, driving the market for a host of next-generation RCM solutions.
Ellis Medicine, a Schenectady, N.Y.-based 438-bed community and teaching healthcare system, for example, was able to connect three hospitals, including about 25 physician groups, on a single-enterprise revenue cycle solution. “The idea behind the search for an enterprise-wide product was that we wanted a single-source product for all of our clinical information, financial information, as well as the implementation of a centralized business office,” says David Snyder, Ellis’ CIO. “As part of that implementation, it was key for us to have a single enterprise revenue management solution, so there is one call-in point for our customers. This allows them to get all of the data about any of the stays/services that were performed throughout the entity.” Ellis Medicine has been able to minimize disruption to its cash flow and has been able to keep the days that accounts stay in accounts receivable (AR) far lower than their pre-implementation baseline, says Snyder.

**Strategic Challenges**

A recent survey of 300 hospitals by the Healthcare Financial Management Association (HFMA) indicated declines in patient revenue and cash on hand. Healthcare organizations must implement strategies to increase cash, such as business office improvement, front-end collections, reduction in aged AR, denials management, and outsourcing to improve self-pay collections, say industry experts.

According to William Hasselbarth, executive vice president and CFO at Albany Medical Center, preparing strategically as well as operationally for health reform and the characteristics that they knew were part of health reform was a huge challenge and something that was crucial to their RCM success. “Strategically, we identified a number of corporate strategies that we would deploy around preparing for the new world (so to speak) of reform and what that
entails; but also on the operational side, we knew there were going to be revenue pressures, expense profile pressures, demand for efficiency, and accountability to justify our cost, so we undertook an operational review, identifying areas where we looked at performance improvement,” he says.

One of those areas was revenue cycle, and stemming from that, Albany Medical Center was able to identify plenty of recommendations on how it could implement best practices. “It goes all the way from making sure our clinical documentation is robust to capturing every last clinical indicator and making sure we’re capturing all of that from coding standpoint and revenue standpoint,” he says. “But it was also around denial management, revenue capture, identification and charge capture, AR management, how quickly it takes a bill to go out, how clean those bills are when they go out the door, and the cost to collect. We have a whole list, and we’re making sure we track and optimize our performance around all of those revenue cycle areas.”

One of the big things related to system change was the cultural shift in terms of how revenue cycle operations were conducted, adds Veronica Ziac, director of information technology at Ellis Medicine. “The system drove some of those changes—previously we had a lot of fixes going on at back end. For instance, the business office would adjust charges and would change things on a visit to produce clean bills, but a lot of those problems were caused by front end staff (registration error or charge error), and it all ended up back in the business office. It was a poor model, it was hard to manage, and it did not put the right work to the right person at the right time.” The way the system works now, Ziac continues, is that it pushes much of
the responsibility to the right place, so you can fix your own errors. “That’s been a huge shift for us, in thinking and in culture; and we have added staff up front to handle those workloads.”

Ziac admits that RCM becomes more challenging every single day. “More recently, one example is the increase in high deductible plans. That is something we have now started to understand the implications of, as we are seeing a downturn in some of our volumes for voluntary admissions and procedures. People are putting off care because they have to pay out of pocket. How do you mitigate that? Your volumes are down but these are people who need service. How do you work that in your business plan?”

Kara Marx, R.N., CIO at Methodist Hospital, a 460-bed facility in Arcadia, Calif. feels that the workflow to more tightly align clinical and financial processes is going to be the difference maker, but that’s something that can be challenging right now. “How do we continue to optimize the clinical side and the pieces that help drive that reimbursement?” she asks. “Is it from physician documenting, coding, or dropping off the bill and getting the AR? It just needs to be much more progressive in identifying the points in revenue cycle that create the delays and bottlenecks. Is it registration? Is it identifying a patient’s eligibility when he or she first comes and communicating what his or her responsibility is? To me, integrating and communicating and understanding the role that each of those stops along the revenue cycle path plays can be the difference maker. It’s not all about technology. In fact, technology can get in the way sometimes. It’s about workflow. You have to find partners who align with your goals and identify the whole picture.”
Next Steps
By Oct. 1, 2015, all U.S. healthcare organizations will have to transition to the 10th revision of the International Classification of Diseases (ICD-10). The standard diagnostic tool will not only improve the medical billing process as a whole but also help patients get appropriate coverage and doctors get paid. Revenue cycle teams will have to invest resources and time to master the new coding system, which will affect reimbursement trends and electronic health record (EHR) implementation.

“What would be nice is if there were vendors who said, ‘How can I help you position to code better?’” says Marx. “Instead of training physicians for ICD-10 (what it is and understanding it), why don’t we just incorporate it into their workflow today? I want to see vendors say that they are going to sell a physician documentation system that has already taken into consideration ICD-10 and will prompt the physician to document better so when the coders get it, it won’t take as much time.”

To this end, there is still an industry-wide feeling that people aren’t ready for ICD-10, and from the healthcare system side, that is an accurate sentiment, says Hamilton Shawn, executive director at The Advisory Board Company, a Washington, D.C.-based healthcare consulting firm. “Missing one thing can screw you up and make you fall behind if you and the vendor aren’t aligned. In reality, we’re probably six months behind from where we should be. The Office of the National Coordinator for Health Information Technology (ONC) has told us no more delays before, and now they’re doing it again. So there is a feeling that people have—‘Are we ever going to go through with this?’”
Shawn says that engaging patients and finding a better way to have a financial conversation is crucial for long-term RCM success as well, despite admitting that many patients might not yet be ready. “It hasn’t been a smooth approach so far. I know HFMA is working on that [with its new patient financial interaction guidelines], but it’s time to sit down with them and explaining what’s going on. This is something that is confusing to them, and it will become even more important as we see the road ahead in terms of healthcare reform.”

Looking down the line to what’s coming with us at reform, revenue cycle won’t be the same as we know it, agrees Albany’s Hickman. “We’re going to see a different type of tool suite emerge around how is it that we manage in the world of bundled payments, how is it that we recant our data into other forms so we can do business analytics that we need to better understand bundled payments and population health. ”

The Centers for Medicare & Medicaid Services (CMS) recently announced 106 new accountable care organization (ACO) program participant organizations, nearly doubling the national total. But numerous existing patient accounting systems are not currently built to process bundled payments, and most revenue cycle personnel are not trained for this method.

Nevertheless, that is where the industry is heading, says Ellis’ Snyder. “What we’re seeing on the horizon are ACOs directing many of our customers towards plans that they will carry, which will mostly be under a bundled payment model. At the federal and state level, that’s where the guidance is toward. It’s only logical when you look at the percent of the federal and state budget. Economically, when you look at the
consumption curve, it’s unsustainable going into the future. We have started a couple pilot tests asking the question, ‘If we are to bundle your customers into some type of collaborative, can we effectively manage care and reduce cost for both the customer and the insurer?’ We need to determine what we need to be proactive rather than reactive, and that’s where healthcare is going.”
Quality and Cost: Healthcare Leaders Learn How to Redefine Value

John DeGaspari

Is the healthcare industry at a tipping point, where the clinical and financial sides of the industry are beginning to come together to work toward the common goal of value-based care?

In a compelling keynote presentation at the Healthcare Financial Management Association’s 2014 ANI Conference in Las Vegas in June, Atul Gawande, M.D., a surgeon at Brigham and Women’s Hospital in Boston and professor of the Department of Health Policy and Management at the Harvard School of Public Health and the Department of Surgery at Harvard Medical School, said that the emerging lesson in healthcare today is that the system is broken. “We are not sure that we are seeing the value and quality you would expect from the money we are putting in,” he said.

Gawande, the noted author of several books, including The Checklist Manifesto: How to Get Things Right, told his audience that while it has long been known that 5 percent of the sickest patients account for 50 percent of the costs, many in the industry have miscalculated what it meant. The reason for that miscalculation, in his view, is that the financial professionals who know about the largest share of healthcare spending are different than the clinicians who care for the sickest patients who account for those costs—and the two groups historically have not talked to each other.
That is now changing: “We are just starting to discover what happens when you put the ‘you’ and ‘I’ together,” he told the audience of financial professionals. “When they do communicate, it’s a pretty stunning thing.”

He offered an example of changes in hospital practices that are resulting in dramatic improvements in patient care, along with major potential cost savings. His team at Ariadne Labs, a joint center for health systems innovation at Brigham and Women’s Hospital and Harvard School of Public Health, has worked with the World Health Organization (WHO) to develop a checklist that would be used for procedures in the OR to help prevent complications from surgery. “We know that major issues that affect quality and cost of care occur in the OR,” he said.

Where it was deployed in eight hospitals globally in 2009, every hospital saw a reduction in complications and deaths—an average 35 percent reduction in complications and 47 percent reduction in deaths. He also noted that the checklist was rolled out across 74 hospitals in the Veterans Administration hospital system, which has seen an 18 percent reduction in deaths. Commenting on that result, Gawande said, “every complication is an $80,000 increase in costs, and those costs were also eliminated.”

**Data and Transparency at Texas Health Resources**
Yet the task of implementing such cost-saving initiatives can be challenging. One major hospital system that has adopted the surgical checklist to its operating rooms is Arlington-based Texas Health Resources.
(THR). The results of its initiative were published in the Journal of the American Medical Association (JAMA) in April 2013.

Mark Lester, M.D., executive vice president and Southeast Zone clinical leader at THR, says the study grew out of a larger effort by the health system to improve quality and safety. “We had an opportunity to work with Dr. Gawande and a team of the School of Public Health at Harvard and members of the Boston Consulting Group, on work that would take a look at how we could take a surgical checklist, with it’s demonstrated ability to improve safety, combine it with collaborative team training, and how we could implement that in all of our active operating rooms,” he says.

Lester says the preparation for the project took an entire year of work that involved going into the ORs of the system’s wholly owned hospitals, and speaking with the doctors, nurses and anesthesiologists. “The idea was to customize the WHO checklist to their environment and to their workflows,” he says.

The team then stepped back, and gathered a baseline of 2010 data, the year that preceded the work of implementing the checklist. “The baseline was a look at the economics of its surgical patients and the complication rates,” Lester says. The complication rates were gathered from examining the health system’s coded data used for billing purposes. From that information it developed 10 categories of complications that followed surgery. “We saw in that year what our complication rates were, and that it was within the range of published complication rates,” he says, adding that the complication rates were correlated with economic data.
The study findings that were published in JAMA were eye-opening: hospital revenue was roughly 330 percent higher when patients who had private insurance coverage had at least one complication following surgery ($56,000) versus patients with no complications ($17,000). For patients with Medicare coverage, the difference was lower but still significant: a 190-percent up-charge for patients with at least one complication ($3,600) versus patients with no complications ($1,880).

Lester says that Texas Health has now implemented the checklist in the ORs of all of the system’s wholly owned hospitals. It plans to do a detailed analysis of the data it has obtained since the checklists and surgical teamwork training were put into effect.

He declined to comment on the data specifically at this point, before a rigorous analysis of the data is performed.

Nonetheless, on its website, Texas Health highlights its “safe surgery” program that embodies the checklist and surgical teamwork training that “aims to reduce surgical complications and drive down healthcare costs.” Adds Lester, “We take it as a given, and it has been demonstrated in the literature and in experience, that when you improve quality, costs come down. Reducing the risks to the patients will certainly lower the costs of care.”

In a separate initiative, launched in April, Texas Health took the idea of transparency a step further by announcing its Quality and Safety Report, which it says is an unbiased report of quality and safety at all of the health system’s wholly owned hospitals. The reports are being made available externally as well internally throughout the organization.
Ferdinand Velasco, M.D., Texas Health’s chief health information officer, says the report is aimed at delivering more value in care as it relates to quality. Historically the health system has made a distinction between the quality and safety of care and the cost of care, he says. “We are trying to be more inclusive in combining the two notions of the collective idea of value.”

Transparency is at the root of the initiative, he says. “At the external level we have made a decision to publish quality and safety metrics, because we believe that transparency is what is needed to drive accountability in the organization, and ultimately to improve it,” he says.

The initial reports will include 15 indicators made up of about 300 metrics. The report displays clinical results, including complication rates and the number of procedures performed at each wholly owned hospital. Velasco notes that the metrics are from third-party organizations, and not proprietary to Texas Health; they are based on transparent, publicly available methodology that can be replicated; and both positive and negative metrics are included. “What are on there are warts and all,” he says. “We show not only our performance, but where available, how we compare to state and national averages, so we can see how we compare to the industry.”

“Healthcare organizations that do a better job of providing excellent quality tend to be more cost effective, which leads to decreased costs associated with inefficiency and inappropriate care,” Velasco says. He adds that the transparency of the quality data in the reports puts Texas Health “in a favorable position to take advantage of pay-for-performance and value-based reimbursement programs.”
Velasco notes that although the majority of Texas Health’s reimbursement is still based on the fee-for-service model, “we know that is not going to remain the case, so we are being proactive before it is mandated.”

**Value-Based Reimbursement on a Steady Climb**

A report released in June by King of Prussia, Pa.-based McKesson Health Solutions is in line with Velasco’s assessment. The study, which was conducted by ORC International for McKesson, was based on a survey of 114 payer and 350 provider organizations across a range of sizes and regions.

Among the report’s main findings are:

Ninety percent of payers and 81 percent of providers use some mix of value-based reimbursement with fee-for-service. Yet the organizations using mixed models anticipate significant growth of value-based care, which will make up two-thirds of the market by 2020, up from one-third today. Providers using mixed models expect fee-for-service to decrease from 56 percent today to 34 percent five years from now.

“Collaborative” regions, where one or two payers and providers stand out, are more likely to be aligned with value-based reimbursement than “fragmented” regions, where there are no clear market leaders among payers or providers.

Forty-five percent of providers surveyed are part of an accountable care organization (ACO), and are significantly more likely to feel that transition to value-based reimbursement will have a positive financial impact on their organizations compared to those that are not in an ACO.
Although all of the existing value-based reimbursement models are expected to grow, payers and providers predict that the proportion of their total business that is aligned with pay-for-performance will experience the most growth, followed by the episode-of-care model. Nonetheless, 15 percent of payers and 22 percent of providers characterize pay-for-performance as difficult to implement.

The primary obstacles payers and providers say are urgently needed to address to enable value-based reimbursement are technology-related; and existing healthcare IT systems are not aligned with value-based reimbursement.

While technology to catalyze physician engagement is critical, lack of physician buy-in was the number one challenge cited by both payers and providers.

Dana Benini, vice president of ORC International, says the rapid pace at which in industry is moving towards value-based reimbursement is surprising. “The volume of reimbursement that would be associated with value-based reimbursement is quite significant, basically moving from one-third to two-thirds,” she says, adding that the fee-for-service model will continue to be around for a long time, but it will be eclipsed.

Larger organizations in a region that is defined by a grouping that is more collaborative with payers, and that also has some type of ACO model, are more likely to be aligned with value-based reimbursement, she says. Smaller institutions, as well as those that are not part of an ACO model, are less likely to be aligned. That’s partly a result of lack of resources, she surmises, but she adds that in fragmented regions, there is not enough alignment between providers and payers to allow value-based reimbursement to happen.

The kind of alignment that’s needed to move a market forward is to have different payers in the market move in the same direction, and then to have the providers collaborate with the payers moving in the same direction.
She notes that payers are not sharing clinical and financial with other payers to a large extent today; but “a significant proportion of them do expect that will be happening in the next several years.” She says there will be a demand for technology to allow that to happen.

Adds David Nace, M.D., vice president of clinical development at McKesson Health Solutions, “That’s the kind of alignment that’s needed to move a market forward—to have different payers in the market move in the same direction, and then to have the providers collaborate with the payers moving in the same direction. People recognize that the time is now, and the technology is available now and we can actually do this, so we are moving forward.”

Nace adds that physician buy-in is crucial to value-based reimbursement. “You have got to have the stakeholders understand this new model of care and understand how to use the technology in a value-based world.” He adds that education, buy-in and collaboration within the organization are critical.

Interestingly, about 60 percent of the payers surveyed by ORC think that the transition to value-based care will have a positive impact on their organizations, while only 50 percent of the providers think it will have a positive impact. According to Nace, although many providers may be skeptical of being evaluated on their performance, cost pressures are moving the industry toward value-based reimbursement. Payers have been concerned about their ability to survive in the model they have been using, while hospitals have been under extreme pressures as their margins are projected to decline, he says.
A Medical Group Implements Population Health

The Pioneer Medical Group, in Cerritos, Calif., has successfully implemented value-based care in its practice. (The group works with McKesson Health Solutions to help it collect and manage data.) Eighty-five percent of business is based on the coordinated-care model, according to the group’s president, Jerry Florio, M.D. The group consists of 52 physicians, including primary care doctors and sub-specialists, and five mid-level providers. It operates two after-hours clinics, offers radiology services at an outpatient center, and offers home-bound and nursing home services.

“Good quality is, at the end of the day, cost-effective care. I strongly believe that, and that is the fundamental axiom that we believe in our group,” Florio says. Yet aligning a group practice to value-based care has not been an easy undertaking, and requires an assumption of risk and a close eye on costs.

Pioneer operates three lines of business under the coordinated care model: Medicare Advantage, a commercial HMO and Medi-Cal HMO, which covers 33,000 patients, 3,000 of whom are in Medicare Advantage. “We get a fixed amount of money and we are responsible for all of the professional services; and we have to make sure we do the Triple Aim: highest quality at the lowest cost and making sure all of the patients are happy,” he says.

In the capitated model for California, the health plans take the administrative costs off the top and then give the medical group a fixed amount of money for professional services. It’s up to the medical group to set up relationships with its hospital partners;
identify the primary hospital to work out of; and set up the tertiary centers it is going to use. It has to be versed in the federal regulations and state regulations for managed care, Florio says.

It also assumes delegated functions, including claims, adjudication, and payment. This requires a system that takes care of all of the professional claims, both within the group and outside the group; handles credentialing of all the physicians within the group and outside the group; has a quality management program that monitors quality, monitors patient complaints, monitors patient satisfaction, and deals with the issues and has appropriate action plans; and shows improvement.

Pioneer Medical uses a shared risk model, where it gets a cap for professional services. The health plan sets aside a certain amount of money for institutional costs, and if there is money left over, it will share that profit with the medical group. That incentivizes the medical group to be more efficient in the use of the hospital system, he says.

When it is contracting with the health plan, Florio says the medical group has to know the patient data and whether it has a sicker population that needs more resources allocated for care, when negotiating with the health plan. “That requires good data. You have to adjudicate your claims and pay the bills correctly, based on the contracts you have. That’s very important, so you need a good claims shop; and you need a hospital that understands all these things and is willing to work with you,” he says.

Within Pioneer Medical, its employee-based physicians understand value-based care, Florio says, but he adds that there is a potential problem when it’s necessary to reach outside the group to a specialist, who
is being paid on the fee-for-service model. “Medicare is cutting their rates down in the Medi-Cal and indemnity plans are cutting their rates down,” he says. One result is that the outside specialist may hike its rates to make up his losses, which hurts the healthcare system, Florio says. He believes that the solution in the future will be to find a way for outside providers to share in the cost savings.

Florio says it’s necessary for physicians to know what their requirements are in terms of quality care. Even more important, he says, are what he calls oversight committees to make sure that the objectives are met. Pioneer Medical has three major committees, all of which are staffed by clinical representatives, that are charged with keeping an eye on costs and making sure appropriate care is given. These include a utilization management committee to determine if appropriate care is being given to the patient; a pharmacy and therapeutics committee to manage drug costs; and a quality group to monitor for potential abuses.

He notes that preventative services are absolutely essential to his medical group, which also offers case management services for patients who are not compliant with their medications or who do not understand their treatment well, as well as homebound services. Data, including ICD codes, patient demographic information, lab data, pharmacy data and access to hospital data are all important to these services, he says.

The most important thing, Florio says, is to convert the data into useable information. “We want the doctors to focus on taking care of patients,” he says, adding that the expertise of a technology partner is important to providers.
In the view of Atul Gawande, M.D., the transition to value-based care is an ongoing puzzle that is still being sorted out. “We are in the midst of a transition of a different way of practicing medicine, learning how to practice as teams, and that’s hard for us as clinicians,” he said in his keynote. The financial side and clinical side of healthcare are learning to talk to each other, he said. “The critical place where we can talk is using data, which tells us the value of what we are providing, the costs, and the results that we are getting.”
About Greenway Health

With an established marketplace presence dating back more than 30 years, Greenway Health continues to lead the way in health information technology by offering smarter solutions that help providers compete in an evolving value-based healthcare system.

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