Prepare Your IT Systems to Embrace Future Shifts in Revenue Cycle Management

White Paper

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Abstract: As the healthcare industry continues to shift from fee-for-service to fee-for-value, it is critical to examine the use of technology and the processes and procedures for revenue cycle management (RCM). Many organizations with currently stable information technology (IT) solutions and RCM processes will find these solutions and processes out-of-date in the context of MACRA/MIPS and bundled payments. Will your RCM and IT backbone be ready and able to administer these matters to ensure good data, sound billing, and accurate and timely follow-up? Now is the time to review your baseline and your IT system's capability for both traditional and global reimbursement models.

Readers will:

- Learn how the fee-for-value shifts are affecting healthcare IT systems and the RCM process.
- Understand the connection between technology and revenue in the context of a fee-for-value marketplace.
- Identify the steps needed to position their healthcare organizations for success in the future landscape of healthcare.

Key Words: Fee-for-value, Technology, Information Technology (IT), Revenue Cycle, Revenue Cycle Management (RCM), MACRA, MIPS, Bundled Payments, Financially-Driven Clinical Systems, Data Mining, Predictive Intelligence, Advanced Analytics, Electronic Patient Communications

INTRODUCTION

Today's technology for medical practices and hospitals focuses on the fee-for-service world. These systems mostly are disparate components that function autonomously. Think of it as one system performing without input and data from other systems.

While many healthcare organizations struggle with their revenue cycle management (RCM) processes and procedures, the continuing shift in how physicians will receive reimbursements will further complicate the instability of RCM. Many leaders believe their approach to RCM is fundamentally and financially sound will find that MACRA/MIPS and bundled payment methodologies will render their technology solutions as outdated in the context of fee-for-value and bundled payment reimbursements.

Most healthcare organizations live in an era of generic charge capture and claims processing without any inquiry and tracking of quality or performance. That is, a level three recheck is performed, it is billed out, the electronic fund transfer (EFT) returns, and the payment is posted to the patient's account. That scenario is predictable if everything goes along smoothly, i.e., no denials, no rejections, etc.

While the need for innovation remains, the push will continue to move away from volume (e.g., more patients) toward value. Reimbursements will be based on the quality of care, repeatable outcomes, and value delivered by providers rather than on how many level three rechecks a facility can manage during a clinic on a given day. To function under that new paradigm, information technology (IT) systems (inclusive and exclusive of RCM) and processes will need to evolve and adapt to these new payment models. This white paper addresses the increasing need for technology in healthcare and contemplates the future of healthcare technology.

For too long clinics and health systems have viewed IT as a necessary evil or additional expense instead of capturing and using the wealth of data available at their fingertips. Soon, it will be essential to use all IT avenues to manage aggressively and proactively both the revenue and the expense sides of the equation.

RCM and IT Redesign

While much remains unknown about how the reimbursement system will look on "the other side" of adjustments to the Affordable Care Act (ACA), especially with the changes in leadership (president and Congress) in Washington, D.C., it appears that pieces of the ACA will survive in one form or another. Bundled payment methodology will be a survivor of ACA adjustments.

One of the first steps in preparing for the future of RCM and technology is understanding how current IT systems and RCM processes and operations are situated. Once a thoughtful analysis is performed, and a baseline is established, it is useful to understand how the same matters will be affected by the new payment models. We have seen this in other industries, such as banking, where the Internet has had a tremendous influence. Today few people write paper checks to pay their bills. Instead, clients use electronic funds transfers (EFTs) or scan checks for deposit via their mobile devices. Quickly, the banking industry had to make significant investments in their technology and operations to respond to market changes or risk losing customers to more automated competitors. Similarly, physicians and hospitals who ignore modernizing their electronic patient communications risk losing patients to those who do. Worse, failure to adapt and adopt may have dire financial consequences.

Revenue cycle systems will need to change to manage the charging and collecting piece of their revenue, in the near term, via a "normal" RCM and be able to handle and parse out bundled payments.

For instance, Figure 1 shows the current status of the fee-for-service revenue cycle.

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Figure 1

Old RCM*	Charged	Adjustment	Allowed	Paid	AR
99213	$ 225	$ (75)	$ 150	$ 100	$ 50
99214	$ 275	$ (90)	$ 185	$ 100	$ 85
99215	$ 300	$ (100)	$ 200	$ 100	$ 100
Totals:	$ 800	$ (265)	$ 535	$ 300	$ 235

If you are billing a fair number of E&M codes, and the process is working smoothly, you will know precisely how much revenue is outstanding. We suggest, though, that a majority of practices and hospital systems struggle to manage their AR, even under the current model. However, let's look into a crystal ball and ponder a bundled payment in addition to our current RCM (see Figure 1). Suppose that the practice manages, exclusive of internal medicine physicians (e.g., all cardiologists), a patient population with congestive heart failure (ChF). This bundle excludes a hospital system, so the practice is on the hook for the management of care *and* the RCM. (Note: This white paper does not consider how to manage the delivery of care so as to save money and increase margins on the bundled payment.)

In Figure 2, we have a ChF bundle. We know that we are slated to receive $1,000 for all treatment related to that disease state. Given our current RCM, how will we track and manage that reimbursement? How will our electronic medical record (EMR) tie to our practice management (PM) system to ensure proper alignment?

Figure 2

Bundled Payment - ChF	Units	Reimbursement
Acute presentation	1	
Office visit 1	1	
Office visit 2	1	
In office RN protocol	1	
Readmission	1	
Global Reimbursement:		$ 1,000

In this case, we know that, for ChF, we should receive $1,000. But did we receive that money? And in the current fragmented era of our IT systems, could you track this reimbursement? For instance, let's say the "office visits" consisted of a level four new patient visit and a level three recheck. Will you bill those independently yet need to tie them back to the bundle and care regimen?

Next, in Figure 3, we contemplate a Medicare Model Four Bundled Payments for Care Improvement (BPCI) imitative. Let's assume that this is for orthopedic surgery X. You can see that the BPCI bundle includes a pre-op visit, procedure 1 (in surgery), procedure 2 (in surgery), post-op, and durable medical equipment (DME).

Figure 3

CMS Model 4 Bundled Payments for Care Improvement (BPCI)		
Care Group (w/System) - Ortho Surg X	Units	
Pre-Op	1	
Procedure 1	1	
Procedure 2	1	
Post-op	1	
DME 1	1	
Global Reimbursement:		$ 10,000

This BPCI involves multiple parties: The hospital where the surgery will be performed; the physicians' surgery procedures; and DME for our post-op patient. The prospective value of this bundle is $10,000. (If the procedures cost more than $10,000 to perform, the parties are in the red.) Leaving aside the practice's need to manage its costs to ensure that its piece of the $10,000 provides profit, the hospital is the "Awardee," in this instance. That is, the bundle goes to the Awardee. That said, how will you ensure that the practice receives appropriate remuneration for its portion of the bundled payment? Additionally, how do you set that "allowable" in your PM system?

Here, the tricky component is in understanding your bundles, how to manage both the fee-for-service aspects and the bundled component, and how those will affect the practice's finances. Enhanced data analysis and reporting will be mandatory. Will you intuit the components of what the practice is "liable" for under these new schemes and understand the status of the revenues and the RCM completely?

In short, these shifts will be more gradual than immediate. Regardless of how the ACA is adjusted and/or amended, some of these pieces will inevitably (and necessarily) remain intact. There will be fee-for-service, but you will now need to manage those components in a "classical" way and under the new models of global payments. Will your RCM and IT backbone be ready and able to administer these matters to ensure good data, sound billing, and accurate and timely follow-up? Now is the time to review your baseline and your IT system's capability.

Financially-Driven Clinical Systems

Today, PM and EMR systems are combined, but they are not always fully integrated in meaningful ways. The traditional approaches to managing the revenue cycle will need to evolve as the lines between financial and clinical goals blur. Information related to cost measures and treatment effectiveness will need to move closer to the point of care so providers can make decisions proactively and ensure all health and wellness requirements are current. Allowing the patient to leave the office to return for a subsequent or multiple subsequent visits will no longer be considered profitable and may not be reimbursable. Providers will have incentives to manage patients out of the office or hospital as the Centers for Medicare and Medicaid Services (CMS)

begins comparing treatment costs. As we shift to value-based reimbursement models, CMS will start linking payments for medical care to clinical outcomes. In 2014, CMS announced that 20% of all payments were linked to the value-based model; CMS has a goal to have 50% of its total payments, about $600 billion, linked to outcomes by 2018.[1] Because of this, the IT PM system and the clinical system will both become part of the RCM process and workflow. EMRs will no longer be just for documentation, and PM systems will no longer simply process claims and make appointments. These two systems will need to be fully integrated and aligned with care coordination and electronic patient communications.

Advanced Analytics

Powerful analytics will become imperative and be the only way to remain financially viable. Thus, it is paramount that the various IT components (data mining, PM, EMR) work in tandem *before* engaging in fee-for-value models. Advanced analytics will provide data on historical information, and it will also leverage the information for predictive intelligence based on evidence-based medicine.

Electronic Patient Communications

The final leg on leveraging IT for RCM will be the need to automate electronic patient communications. Today, fewer people have home phones. Those who do can now screen the caller and avoid answering the phone. Most people prefer to get a notification on their smartphone, like how they interact with social media sites such as Facebook. These electronic notifications allow people to respond in ways that are more convenient and suitable to their lifestyles. It also allows for improved tracking and documentation, which will be critical for the healthcare provider to identify those patients who are non-compliant. Additionally, the ability for patients to pay on-line, request appointments, and upload their health information will support the future payment models.

Conclusion

The changes noted in this paper will not happen overnight. Rather, the continually moving parts and multivariate inputs will bend and adjust as bundle model demonstration projects and payments evolve. Groups should use this relative lull to take stock of their IT structures. The review should encompass the data gathering and analytics packages and their PM and EMR systems to ensure that they will have significant flexibility and scalability to ramp up to new payment models, track the revenue cycle, and ensure that practices receive all allowable payments due.

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[1] Better Care. Smarter Sending. Healthier People: Paying Providers for Value, Not Volume, published Jan. 26, 2015, https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-01-26-3.html, Accessed Feb. 16, 2017