Next Generation Revenue Cycle Management for Value-Based Healthcare
Given the pace of change in the contemporary healthcare marketplace, ensuring that you’re keeping a tight rein on your spending, claims, and collections is more important than ever. The good news is that revenue cycle management (RCM) innovations in technology and in process are keeping pace with industry changes to become more efficient and effective than ever before.

While high quality care and positive patient outcomes have always been the most important goal for providers, new reimbursement and payment models mean that delivering quality is imperative. New RCM tools and practices are helping providers ensure they’re collecting appropriately, allowing them to thrive in complex payer arrangements.

Effective RCM must be built on a strong technology platform, one which addresses both claims and performance—and electronic health records (EHRs) must effectively link claims, clinical, and business data to meet the challenges of today’s value-based healthcare environment.

Technology is only as effective as the people using it, which means practices also need to have a skilled, informed staff who fully understand the importance of working with patients to obtain key data. While this may seem like one more complex system to manage, when done effectively and efficiently, the rewards are well worth it. This white paper offers key insights on the factors and challenges that play into RCM to help make your RCM work for you.

The evolution of RCM

The egregious rise of cost and spending in the U.S. healthcare market is forcing policymakers and payers to action. The advent and early success of alternative and value-based payment models are making strides towards reaching the goals of the triple aim—reducing costs, improving quality, and enhancing patient satisfaction.
Turning these policies to practice, however, creates significant challenges for RCM, including the following:

- The increasing complexity of medical care itself
- Each payer’s development of its own set of payment rules and standards, calling for each clinical practice to acquire large, multi-layered and highly complex data sets
- Growing patient self-payment or high deductible plans—a significant change in reimbursement patterns
- Revenues based increasingly on performance measures, again varying by payer

These factors create a highly complex revenue cycle for physician practices. Consider the enormous variety of reimbursement models alone: fee-for-service, capitation, bundled payments, pay-for-performance, and shared savings. Add the challenge of different rules and guidelines for each of a long list of payers, including many different payment models, reimbursement, and incentives, and it’s enough to make any provider exasperated.

This all means that billing really begins not at submission of the claim, but far earlier at the point of patient contact with the provider—sometimes even before patient registration. Who is the patient’s insurer? What is the patient’s eligibility, correct billing address, previous denials? Once the patient has been seen, what is the correct coding? What treatment was actually delivered? How much has the patient paid to date? What are the particular requirements and standards of the patient’s insurer? All of these questions demand an effective solution in order to be answered.

**Technology platform plays a key role in RCM**

Automation is essential to an effective RCM system – one designed to respond to the challenges of value-based health care and increasing patient responsibility. Robust technology permits a high percentage of automatically generated clean claims. It reduces the manual work, freeing staff to focus their expertise on the most complex balance problems.

To create a clean claim—one that will be accepted and paid—a next generation RCM platform must contain complete data about each payer’s requirements and apply complex algorithms that access every piece of that data. Technology can perform many of the tasks, such as checking whether a claim has been paid, to further relieve staff from tedious manual work.
Consider the following advantages of a next generation RCM platform:

- **Claims accuracy:** An automated system can scan for errors before claim submission (e.g., incorrect member ID numbers) and significantly improve clean claims rates, decreasing denials and rejections.

- **Tracking claim status:** Checking on the status of a claim can be handled automatically, which is an advantage given the time and cost of manual tracking. Some systems include an algorithm that analyzes past payment information to predict future payment range and then automatically send a claims status inquiry if the remit is considered “late.”

- **Improved workflow:** Automated RCM processes offer reminders, by largest balance of revenue or age of claim, for example, allowing management to direct work to the most appropriate resource.

- **Tracking patient eligibility:** With automation, an effective RCM system can identify essential information about patient eligibility, co-payments, and deductibles. Staff can verify coverage and request the patient portion while the patient is still in the office.2

Two new RCM challenges

RCM is undergoing two additional changes that, despite a changing administration, will continue: patients are responsible for a growing percentage of payment for services, and value-based reimbursement calls for a degree of reporting with its own complexities.

**Increasing patient responsibility for payment**

Employers increasingly are choosing health plans with lower premiums and higher patient responsibility. For the ten-year period from 2000 to 2009, for example, individual coverage deductibles rose 289%.3 As a result, physician practices must adapt to a whole new set of data requirements, and staff must understand how to work with patients to obtain reimbursement from this new source.

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2Automated Revenue Cycle Management: Improving financial performance in uncertain times GE Healthcare

3“Mercer’s National Survey of Employer-Sponsored Health Plans” ©2009 In 2014 alone, the increase in patient payments is upwards of 23%

Increasing numbers of practices are allocating resources to the process of patient payment, according to Health Leaders Magazine. In addition to the use of information technology, providers must be prepared to offer front-end counseling and education for patients to understand their payment obligations. Improving collections goes back to patient outreach. As one provider said, “First and foremost, we are trying to connect with existing patients around education on the different coverage options that are available to them because people might not know the types of coverage that are in their local market.”

Providers need to understand each patient’s financial obligation. For example, what information do providers need about the patient and the patient’s plan, and how much should they collect from patients prior to service? Furthermore, what treatment was actually provided, what coverage is available, and has the patient met the deductible? The capacity of next generation RCM to marry all this data – essential for any healthy revenue cycle management system – is critical to any provider organization.

**Value-Based Reimbursement**

Although percentages differ slightly, many stakeholders expect value-based purchasing (VBP) models to represent nearly 70 percent of provider reimbursement by 2019. Both payers and providers agree that traditional Fee-for-Service (FFS) reimbursements will decline over the next five years, to be gradually supplanted by value-based payments. In fact, providers face penalties simply for not reporting value-based performance, regardless of the degree to which standards are met.

The consequence for providers? Reporting quality performance will be as essential to RCM as clean claims, accurate coding, and patient coverage information. What are the patient’s presenting conditions and severity of illness? What is the full spectrum of care provided? Population health information “is more important than ever to maximizing reimbursement under value-based payment models. Precise clinical records will both accurately represent the quality of care and increasingly contribute to reimbursement.”

If one of the metrics required in a value-based contract calls for a particular office exam...
or test and the claim is not coded correctly before submission to the payer, then the final results won’t show that the provider met that metric.

The tools and platforms for quality data collection and reporting are becoming available or are under development, and are essential—as are electronic medical records where much of the reporting is based. In fact, quality data reporting assumes a system for collecting and reporting population health, i.e. the use of preventive treatments for the key patient cohorts. The alternative to automated quality reporting is a manual collection, patient by patient, of treatment data.

With an advanced platform and meaningfully-structured electronic health records in place, quality data can be integrated into a practice’s management without significant delay.

In addition to an effective reporting system, collaboration between finance and other departments is crucial. “Coordination between the quality department and managed care contracting is vital in understanding both the current contracts that are tied to quality outcomes, as well as the potential to link future contract terms to quality outcomes.”8

RCM challenges faced by hospital-owned practices

Hospitals which own physician practices are equally concerned with how to manage those revenue cycles. A 2014 survey by MDeverywhere.com revealed that more than half of hospital respondents were buying practices, and 85 percent believed that high rates of denials meant significant revenues being left uncollected, especially in the form of denied claims. Hospital owners discover outdated—and multiple—systems, many of which don’t even know their denial rates, and frequently are unable to effectively “track billing statistics/trends for their physicians.”9

While physician providers remain, as always, committed to the highest quality of care for their patients, there is little doubt that they must also meet the significant financial challenges presented by the complexities of performance-based reimbursement and growing changes in patient responsibility for cost of care.

Integrated RCM and EHR technology is a valuable tool in this transformation, but staff understanding of payer requirements and standards is also critical. Value-based healthcare is here to stay, and those practices that understand how to adopt technology and methodologies to meet these new challenges will thrive.

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8 Reprinted from the February 2014 issue of Revenue Cycle Strategist. Copyright 2014 by Healthcare Financial Management Association
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