REVENUE CYCLE OPERATIONAL EXCELLENCE: A FOUNDATION FOR VALUE-BASED PAYMENTS

HMA

Date: 9/21/23
9:00-10:30 AM ET

Presented By:
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The source of funding for this grant award is District appropriated funds earned based on the American Rescue Plan Act (ARPA) of 2021.The obligated amount funded by Grantor shall not exceed $999,000 in the first year per year, and one option year of up to $500,000 unless changes in the obligated amount are executed in accordance with ARTICLE XV of this agreement.

DHCF
Department of Health Care Finance

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- The AAFP has reviewed Value-Based Payment Virtual Learning Collaborative and deemed it acceptable for up to 4.00 Live AAFP Elective credits. Term of Approval is from 09/21/2023 to 09/21/2023. Physicians should claim only the credit commensurate with the extent of their participation in the activity. **1.50 credits are available for this session**.
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  - Certificates of completion will be emailed within 10–12 business days of course completion.

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AGENDA

1. Provide an overview of ways to optimize revenue cycle management (RCM) within healthcare organizations transitioning to value-based payment (VBP) models.
2. Explore key financial performance indicators and best practices and how they are linked with value-based care principles.

Learning Objectives

1. Discuss the impact of Operational Excellence in Revenue Cycle Management and Technology Infrastructure

2. Demonstrate how to align you Payment Model with Quality Metrics

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SHARE YOUR KNOWLEDGE-VALUE BASED CARE

In value-based arrangements, if providers perform well on _____ they get enhanced reimbursement?

A) Quality

B) Costs

C) Patient and Provider Experience

D) Equity

E) All of the above

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BENEFITS OF VALUE-BASED CARE AND VALUE-BASED PAYMENTS

Value-based care is a delivery model in which providers, including hospitals and providers, are paid based on health outcomes.*

Value-based payments are intended to support the delivery of evidence-based, person-centered, efficient care that contributes to improved quality and positive health outcomes at an appropriate cost.**

Patients	Providers	Payers	Suppliers	Society
Lower costs and better outcomes	Higher patient satisfaction rates and more effective care	Stronger cost controls and reduced risks	Alignment of prices with patient outcomes	Reduced health care spending and better overall health

The future of health care will be determined by payers and patients looking for the best value and rewarding providers who can deliver better outcomes.

*NEJM Catalyst-Innovations in Health Care Delivery Jan 2017 "What is Value-Based Healthcare?" available at https://catalyst.nejm.org/doi/full/10.1056/CAT.17.0558
**OHA-CCO VBP Roadmap September 2019 available at: https://www.oregon.gov/oha/HPA/dsi-tc/Documents/OHA-CCO-VBP-Roadmap.pdf

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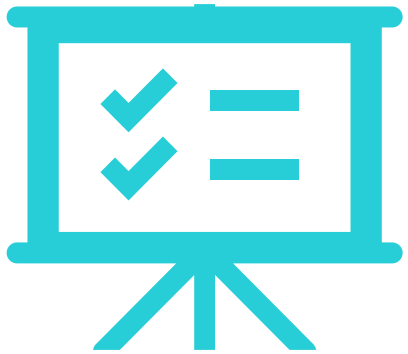
IMPORTANT CONSIDERATIONS FOR VBP & REVENUE CYCLE MANAGEMENT

Investments, infrastructure, & governance models

Long-term planning

Clinical transformation



Clear and consistent standards and benchmarks

Capacity to utilize/analyze data in real time

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OPTIMIZING REVENUE CYCLE IN A VALUE BASED MODEL

Contracting & Collaboration: understand the arrangements and revenue and others will be based upon built-in benchmarks that must be met before payment is made. Understanding the differences to predict and manage revenue.

Staffing Optimization: Optimize RCM, system and staffing workflows. Educate providers, clinical and non-clinical support teams on the impact on VBC reimbursement.

Data & Quality: RCM Transformation and success under VBC models/contracts prioritizes quality outcomes over quantity, paid based on the health outcomes of their patient panels and the quality of services rendered.

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CONTRACTING & COLLABORATION

SHARE YOUR KNOWLEDGE-VALUE BASED CARE

What payment model is **not** an example of value-based care?

1. Cost based reimbursement
2. Risk-based payment
3. Fee for service payment
4. Capitation

Could be more than one [What listed is NOT an example of VBC=Fee For Service Payment]

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CONTRACTING

Know the rules (know your contracts)

- **Who** is a covered member (or beneficiary)
- **What** healthcare delivery actions and outcomes are valued
- **How** the healthcare delivery actions and outcomes are valued
- **When** the healthcare delivery actions and outcomes are valued

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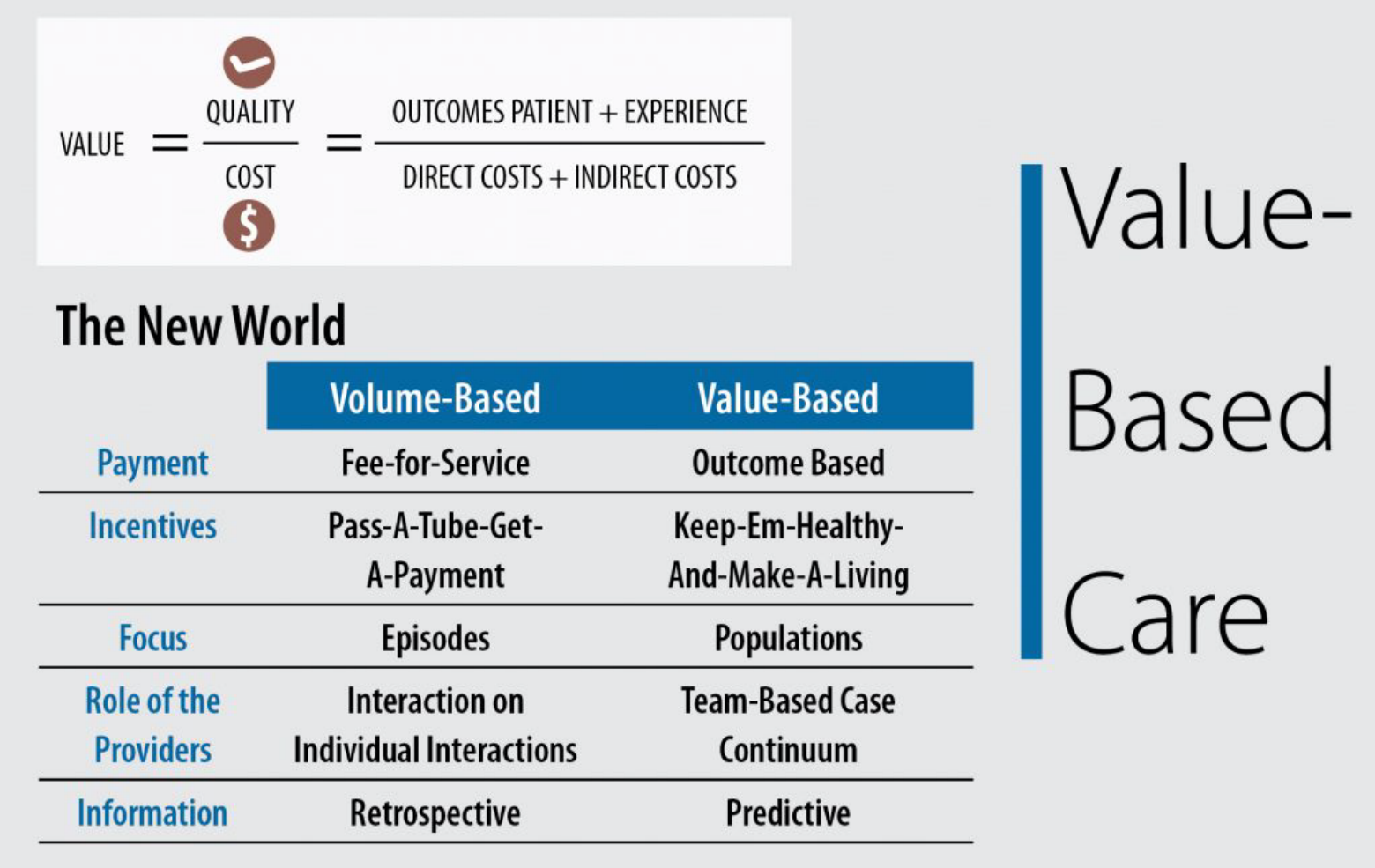
REVENUE CYCLE VALUE BASED CARE – HOW YOU GET REIMBURSED



Source: AAPC Knowledge Center 2023 Prepare for Value-Based Payment - AAPC Knowledge Center

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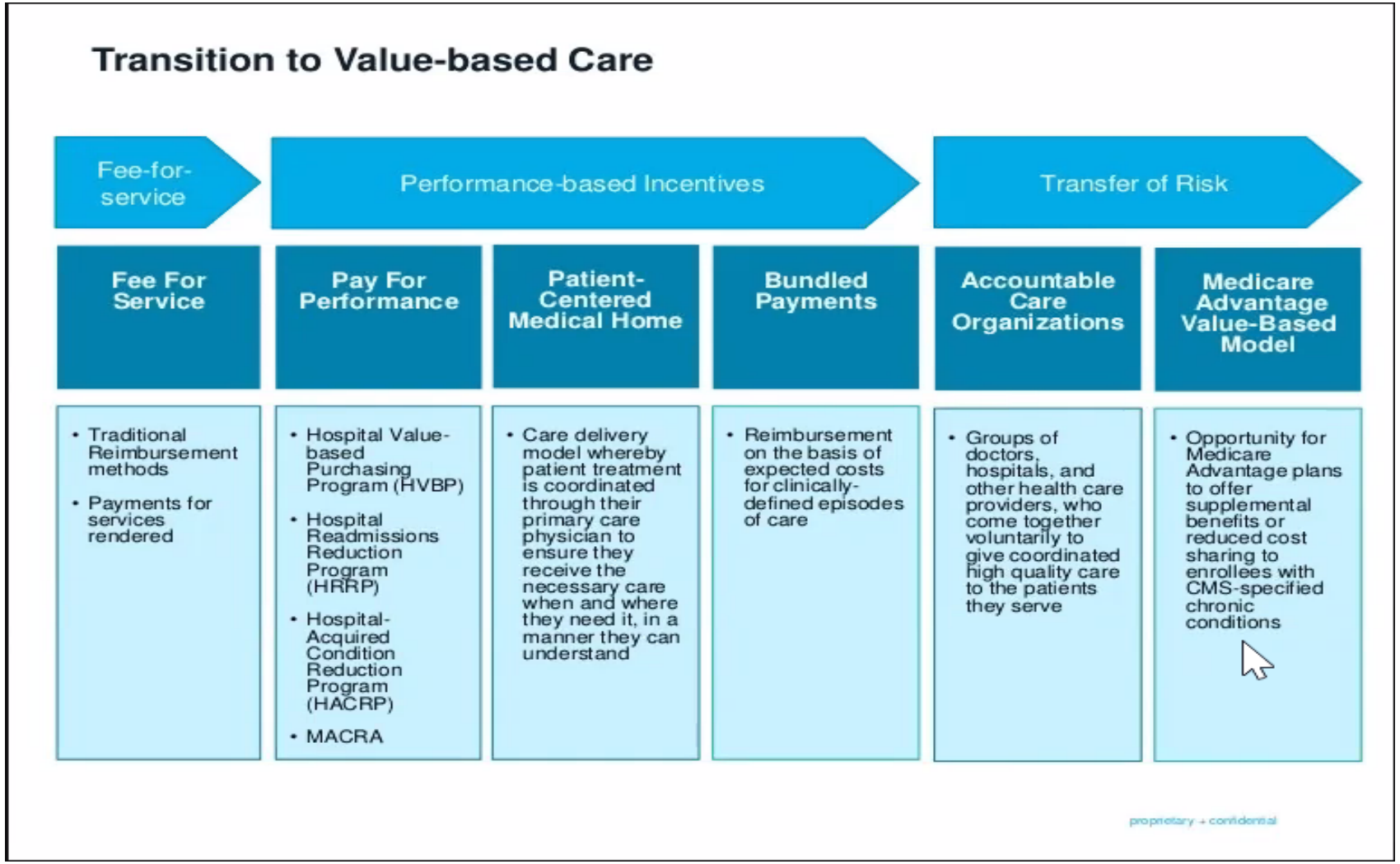
OPTIMIZING REVENUE HCC EXAMPLE



Source: Medical Group Management Association. https://www.mgma.com/

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CONTRACTING & COLLABORATION

- Collaborate with payers and other entities to build value **centered** on accurate and specific coding
- Align goals, expectations and incentives with payers/ partners
- Establish clear and mutually beneficial contracts, expectations, and metrics with outsourcing and partnering entities
- Monitor and manage performance and quality
- Daily, weekly, monthly

Source: AAPC Knowledge Center 2023

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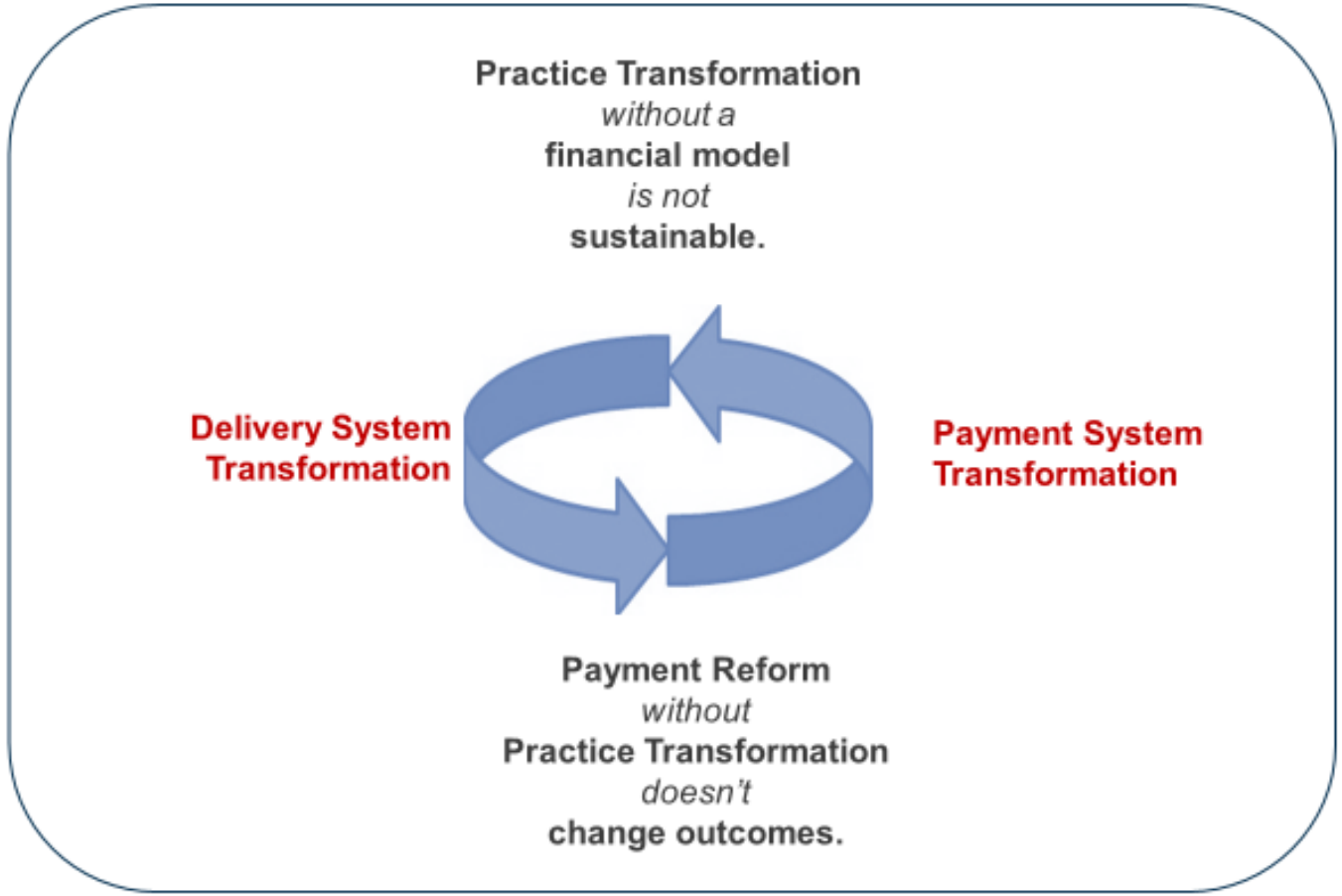
STAFFING OPTIMIZATION

VBP REQUIRES INTERDEPENDENCE OF PAYMENT REFORM AND PRACTICE REDESIGN



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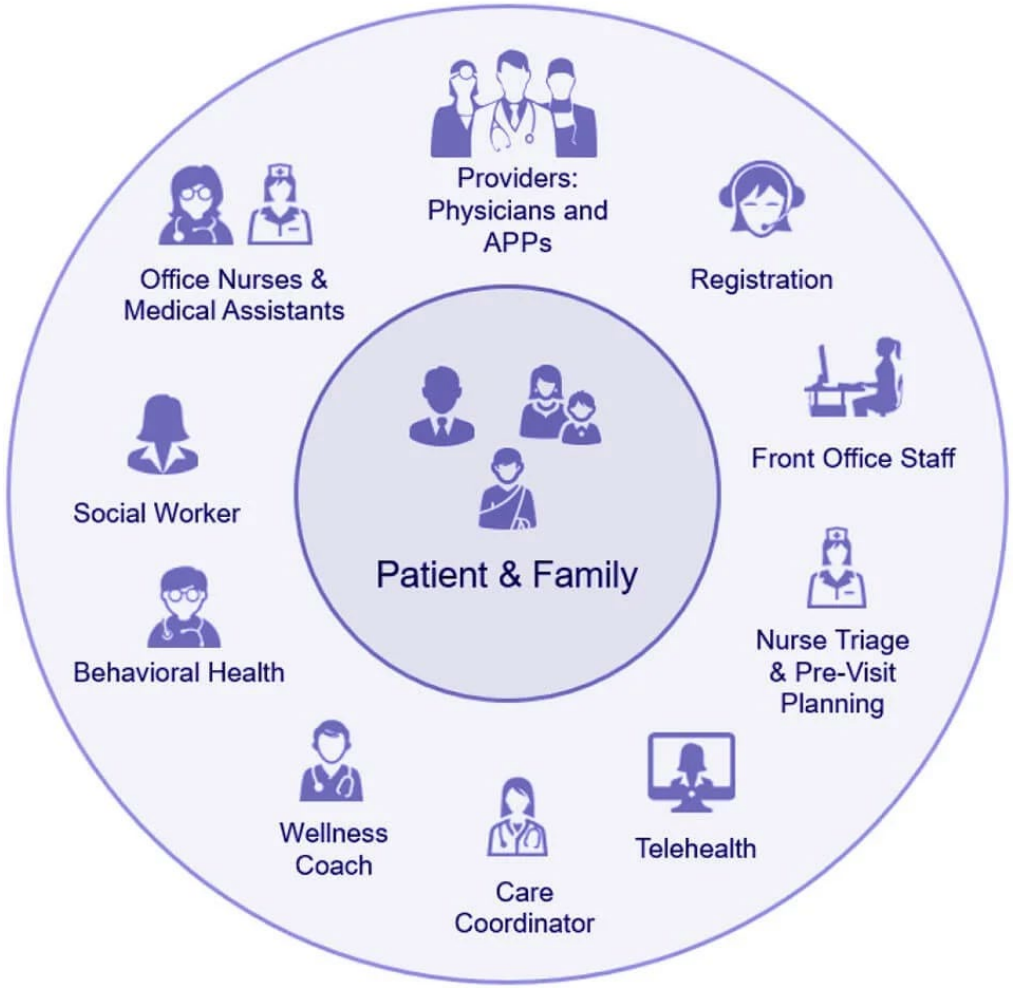
STAFFING: KEY ROLES AND THEIR IMPACT ON VBP

FIGURE 1. TEAM-BASED CARE ROLES



- Identifying critical roles in the organization and the impact on VBP
- Understanding the intersection between roles
- Using staff to top of scope

Source: Medical Group Management Association. https://www.mgma.com/

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TEAM MODEL DAILY HUDDLE CHECKLIST

- Provider and Care Teams
  - Am and Pm Huddles
- Discuss High Risk Patients of the Day
- Hospital, emergency department, and nursing follow up visits
- Results or referrals needed for the Day
- Patient specific issues
- Scheduling: Clinician and staff
- Scheduling: Patients (back-to-back lengthy visits, openings, etc.
- Potential bottlenecks (work slowdowns)
- Safety issues (sound-alike names, equipment issues, transportation needs, pharmacy alerts
- Patient risk levels

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OPERATIONAL DASHBOARD

Source: Medical Group Management Association. https://www.mgma.com/

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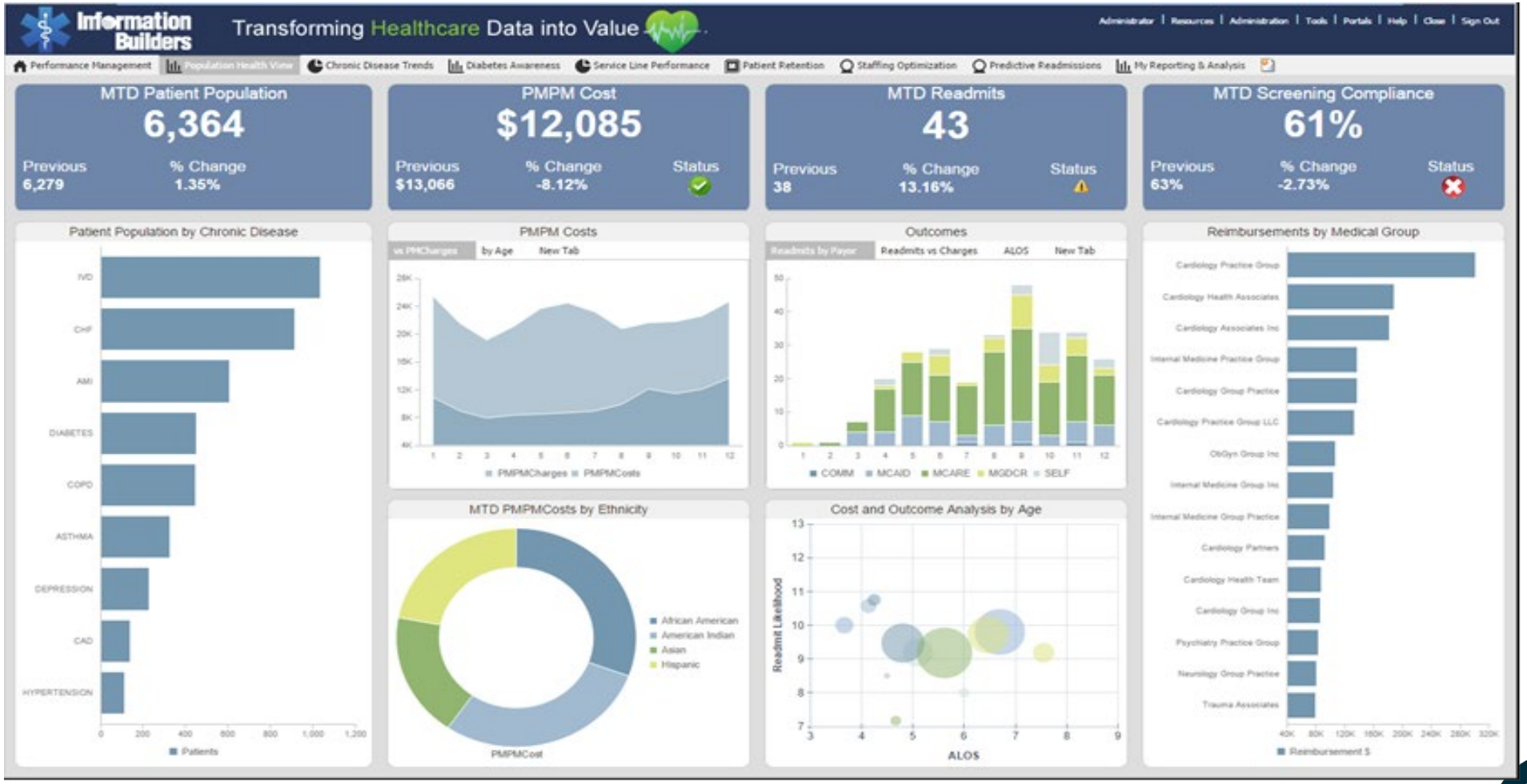
OPERATIONAL DASHBOARD



Source: Medical Group Management Association. https://www.mgma.com/

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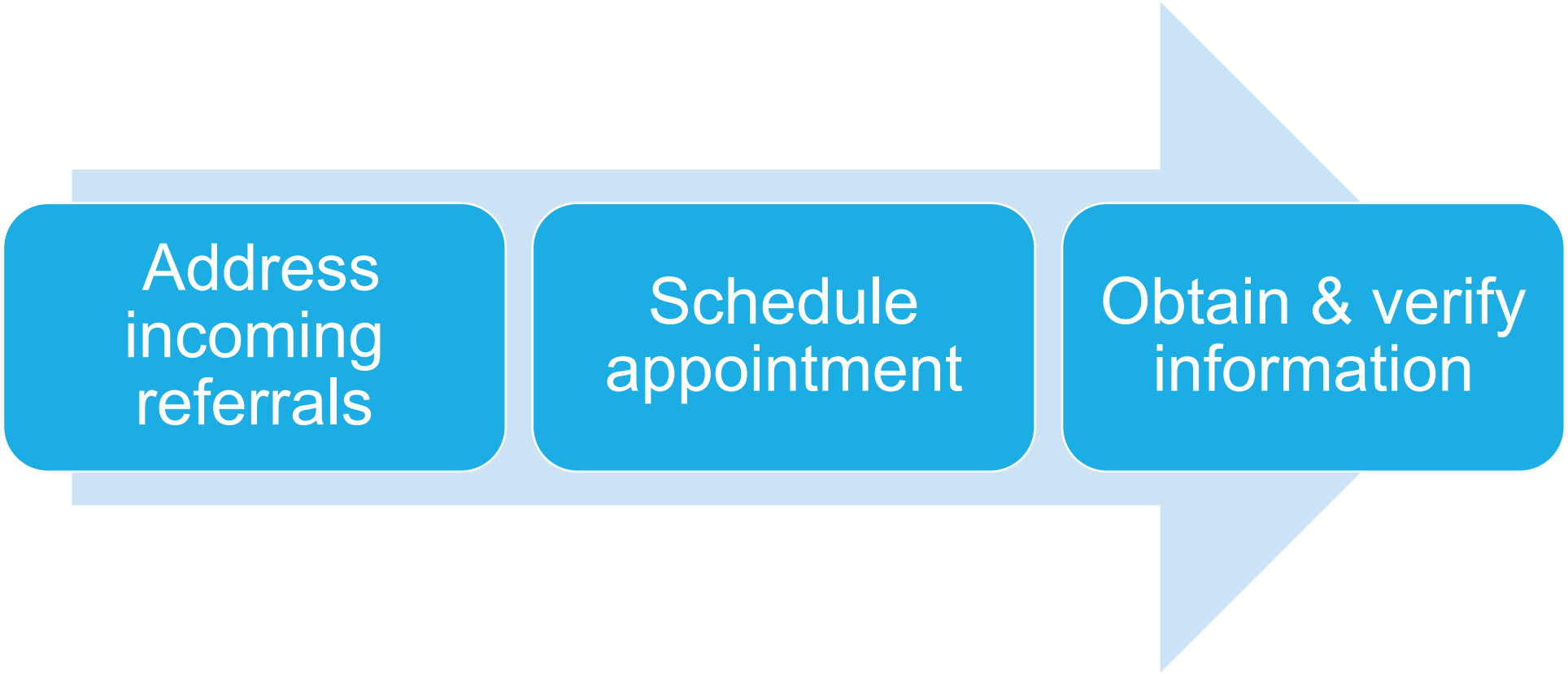
PATIENT ACCESS



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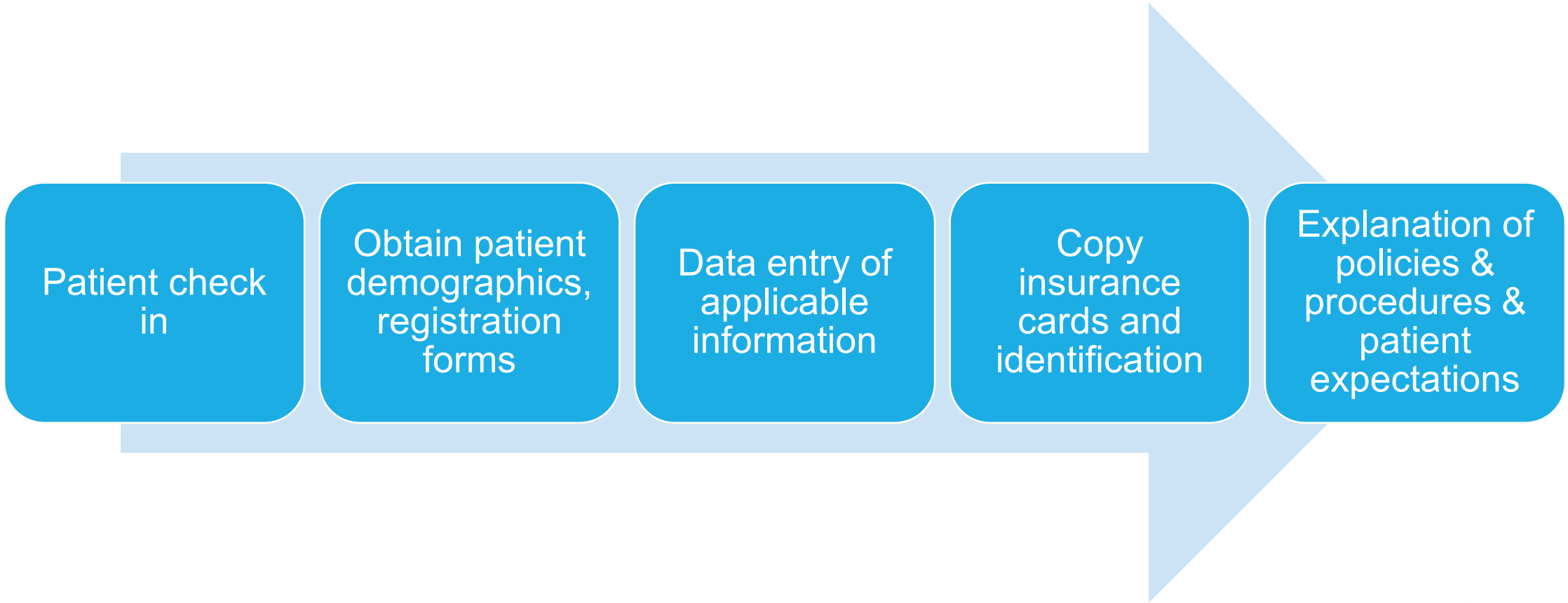
PATIENT REGISTRATION



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ROLE OF FRONT DOOR

The “Front Door” to the organization and the first step in the revenue cycle process for the majority of patients.

- Important functions and information gathered in during scheduling include:
- Centralized versus decentralized scheduling
- Wellness or sick visits, therapy services are typically managed in the department
- Identify the referring provider
- Obtain prior authorizations/certifications, physician orders and other required documents from the referring provider’s office
- Pre-registration when possible/gather patient demographics and insurance information

Photo Source: Unsplash

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PATIENT REGISTRATION KEY PERFORMANCE INDICATORS

- Daily Total Visit versus Expect Visit
- Total Monthly Visit Utilization
- Chart Check in advance of next appointment – 100%
- Call answer rate: answer calls within 3 rings or 30 seconds – 90%
- Comprehensive member assessment plans (CMAP) - 90%

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PATIENT ACCESS CONSIDERATIONS

2021 PATIENT PORTAL UTILIZATION	
Logged into patient portal	78%
Schedule appointments through patient portal	10%
Pay bills through patient portal	44%
Access test results through patient portal	57%
Communicate with providers and medical staff through patient portal	54%
Download or transmit medical records through patient portal	33%
Refill a prescription through patient portal	13%
Fill a new prescription through patient portal	62%

Source: *2022 MGMA DataDive Practice Operations*

PERCENT OF APPOINTMENTS RESCHEDULED WITHIN 30 DAYS	2019	2020	2021
Primary care specialties	49.0%	76.0%	16.5%
Nonsurgical specialties	52.0%	75.0%	75.0%
Surgical specialties	50.0%	79.5%	81.0%

Sources: *2022, 2021 and 2020 MGMA DataDive Practice Operations*

APPOINTMENT CANCELLATION RATE	2019	2020	2021
Primary care specialties	26.0%	8.3%	8.0%
Nonsurgical specialties	26.0%	8.3%	17.7%
Surgical specialties	26.0%	7.0%	8.4%

Sources: *2022, 2021 and 2020 MGMA DataDive Practice Operations*

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REVENUE CYCLE MANAGEMENT: STAFF TRAINING

Enhance staff training on the skills and knowledge required for VBC

Foster a culture of learning, collaboration, and innovation among staff, and provide them with feedback, recognition, and incentives

Potential Training Opportunities
Financial consequences of registration errors
Ways to discuss reimbursement matters with patients
Importance of disseminating policy, protocol, and contract changes timely
Denial prevention and management techniques
Basics of Revenue Cycle Management
Documentation impacts on reimbursement

IMPORTANCE OF DATA, REPORTING, OPERATIONAL COSTS

The data necessary for revenue cycle management & value-based models comes from a variety of sources:

- Demographic data
- Population health data
- Diagnosis and service codes
- Claims Data
- Quality Metrics

Additional operational data that could also be necessary under VBP:

- Cost and revenue data
- Operational Metrics
- Enhanced Demographic data

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METRICS & OUTCOMES

IMPORTANCE OF DATA, REPORTING, OPERATIONAL COSTS

Collaborate with IT Technology to develop data review and reporting.
Prepare every day and prior days for each patient visit

Table 2. Examples of data "cubes" for standardization and visualization

Appointments	Workflow	Finances/ Revenue Cycle	People	Volume/ Production	Clinical/Quality
Day of week	Timestamps • Check-in/ rooming • Chart completion • Task completion	Charges	Hired/Profiled FTE	wRVUs	CPT® codes
Times	Statuses • Timestamps for each status	Payments	Worked FTE	tRVUs	Diagnoses
Blocks/ Appointment type	Users/customers • Employees • Providers • Patients	Adjustment/Denials	Clinical FTE	Encounters	Chronic diseases
Slots vs. Appts.		Payers	Comp data	Tasks	Annual screening
Provider/ Resource		Providers/ Resources	Type of comp (salary, benefits)	Appointments	Wellness measures
Department		Expenses by class	Worker types (W2, contracted, owner)	CPT® codes	Quality measures
		Time/Date stamps (DOS/posting date)			
		Payment statuses			

Source: Medical Group Management Association. https://www.mgma.com/

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REVENUE CYCLE MANAGEMENT VBC KEY PERFORMANCE INDICATORS

Patient Access

- Schedule Utilization
- Average Patient wait times
- Obtaining Authorizations
- No-shows, Appointment Cancellations & Reschedules

Patient Registration

- Copay collection
- Registering 2.5-3 patients/hour
- Average Patient Call Time
- Demographic data: disability status, gender, age, & other factors

Revenue Cycle Management

- Clinical Data
- Claims Data
- CDPS RX
- Risk Adjustment Factor Scores
- Payments are provided by a complex formula/algorithm that is applied to Medicare RAF terms based on location

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REVENUE CYCLE FFS BENCHMARKS

Days in Accounts Receivable - **35 Days**

Collection Rate - **95%**

Clean Claim Rate - **98%**

Denial Rate - < **5% of Gross Charges**

Charge Lag - **2 Days**

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CODING

TABLE 1. HEALTHCARE DELIVERY VALUE CATEGORIES AND ASSOCIATED ACTIONS AND OUTCOMES

Value categories	Associated actions and outcomes
Healthcare delivery quality	• Preventive and wellness care • Vaccinations and screenings • Chronic care monitoring, tests and treatments • Medication adherence
Healthcare delivery effectiveness	• Pre-office visit preparations • Annual wellness visits • Managing transitions of care • Care management for chronic and complex conditions • Comprehensive and accurate HCC[A] coding • Assessing and addressing SDoH[B] • PCMH infrastructure • Positive patient experience
Healthcare delivery efficiency	• Total cost of care less than projections • Validating suspect conditions • Appropriate use of E.D., inpatient and ASC[C] locations • Limited unexpected inpatient readmissions • Limited use of high-cost specialty services • Prescription of generic and preferred drugs

(A) Hierarchical condition coding, (B) Social determinants of health, (C) Ambulatory surgery center

Source: MGMA | Insight Article | Essentials for transformative healthcare delivery success 9/2021

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CODING

TABLE 2. THE 3Rs OF THD INITIATIVES (INCLUDING APM, VBC AND OTHER REFORM INITIATIVES)

Foundational constructs	Elements and components
Rules	<u>Who is covered</u> • Attributed members (or beneficiaries) <u>What is valued</u> • Healthcare delivery quality • Healthcare delivery effectiveness • Healthcare delivery efficiency <u>How is it valued</u> • Discrete payments • Payments per attributed member • Payments via multivariate formulas with weights and thresholds <u>When is it valued</u> • Calendar plan year • Fiscal plan year • Annually, quarterly or monthly
Resources	• Health information portals • Analytics on healthcare delivery quality, effectiveness and efficiency
Representatives	• Rules translators • Resource educators • Transformation coaches

Source: MGMA | Insight Article | Essentials for transformative healthcare delivery success 9/2021

WRAP-UP/NEXT STEPS

KEY TAKEAWAYS

- Team centered approach
- Knowing your contracts
- Developing relationships with payers
- IT infrastructure is critical
- Staffing
- Everything and everyone matters!

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BRIEF EVALUATION

- Please Complete the Online Evaluation:

https://healthmanagement.qualtrics.com/jfe/form/SV_9zEbuA1AyGmE6IC

AFTERNOON SESSIONS

Session	Legal Track	Session	Financial Track
9 – 11 A.M. ET	Forming Community Partnerships to Participate in VBP Arrangements - Part 1	9 – 10:30 A.M. ET	Revenue Cycle Operational Excellence: A Foundation for Value-Based Payments
		9 – 10:30 A.M. ET	Evaluating Payment Models and Financial Modeling
1 – 3 P.M. ET	Forming Community Partnerships to Participate in VBP Arrangements - Part 2	1 – 3 P.M. ET	Clinical Documentation and CDPS+Rx Coding Guidelines for Value-Based Payment Optimization

Join us again from 1-3 pm ET!

https://www.integratedcaredc.com/event/value-based-payment-virtual-learning-collaborative/

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ADDITIONAL INFORMATION

Visit the Medicaid Business Transformation DC web page for more information and upcoming events:

www.integratedcaredc.com/medicaid-business-transformation-dc/

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https://www.integratedcaredc.com/newsletter/

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ADDITIONAL TOOLS & RESOURCES

- AAFP. (2022, August 10). *AAFP Guiding Principles for Value-Based Payment.* American Academy of Family Physicians. https://www.aafp.org/about/policies/all/value-basedpayment.html
- *Certificate of Need*. DC Health. (n.d.). https://dchealth.dc.gov/service/certificate-need
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APPENDIX

KEY TERMS

- **Hierarchical condition categories (HCC):** Groupings of clinically similar diagnoses in each risk-adjustment model. Conditions are categorized by hierarchy and the highest severity takes precedence over other conditions in a hierarchy. Each HCC is assigned a relative factor that is used to produce risk scores for Medicare beneficiaries, based on the data submitted in the data collection period
- **Medicare Advantage (MA) plan:** Sometimes called “Part C” or “MA plans,” offered by private companies approved by Medicare. If a Medicare Advantage plan is selected by the enrollee, the plan will provide all of Part A (hospital insurance) and Part B (medical insurance) coverage. Medicare Advantage plans may offer extra coverage, such as vision, hearing, dental, and/or health and wellness programs. Most include Medicare prescription drug coverage (Part D)
- **Risk-adjustment factor (RAF):** Risk score assigned to each beneficiary based on his or her disease burden, as well as demographic factors
- **Sweeps:** Submission deadline for risk adjustment data that occurs three times annually: January, March, and September. Generally, claims continue to be accepted for two weeks after the deadline
- **Net Promotor Score (NPS):** A metric that measures customer satisfaction and loyalty. How likely they are to recommend. NPS is calculated by subtracting the percentage of detractor score (t0-6) from the percentage of promoters score (9-10). Contract models will vary

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