ECG MANAGEMENT CONSULTANTS

A Siemens Healthineers Company

Rethinking Payer Contracting and Revenue Cycle in a Value-Based World

In no industry anywhere in the world is the pricing of goods and services, as well as the process of securing payment, as complex as it is in the US healthcare system.

Consider what a typical hospital with an employed network of physicians must manage: a charge master with pricing for approximately 760 inpatient DRGs,[1] 790 APC groupers for hospital outpatient services,[2] 25,000 HCPCS/CPT codes for physician services, and more than 72,000 ICD-10 diagnosis codes that describe why a service was provided.

The hospital likely contracts with a dozen or more payers, each of which has several insurance products. Based on those factors alone, the possible combinations of items and prices that the organization must manage would be virtually limitless.

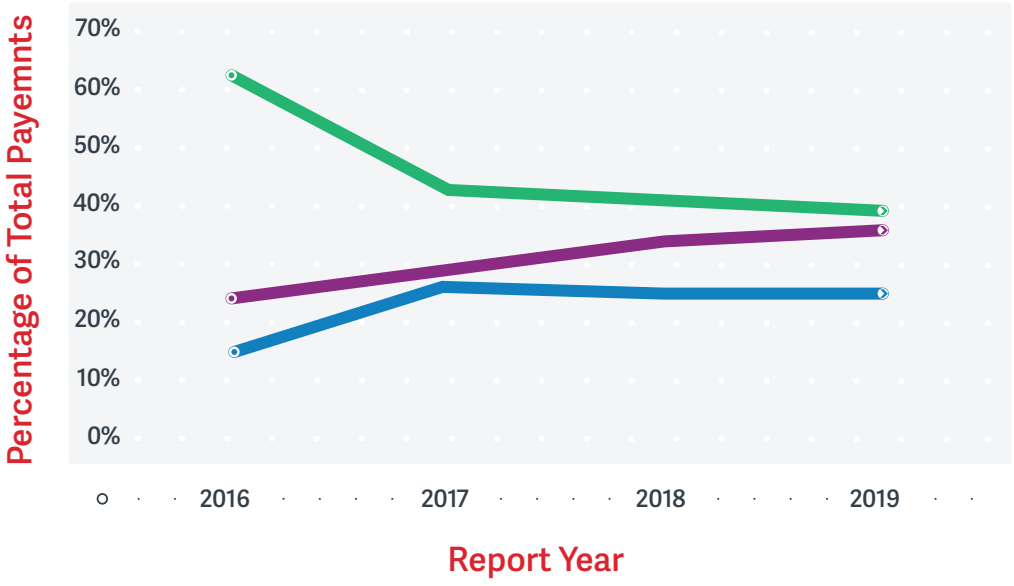
Alas, if only it were that simple.

The payers are also likely to have different (and constantly changing) payment methodologies, bundling rules, claims adjudication rules, and authorization and eligibility requirements.

And then there are rules for incident-to billing, supervision of residents, APP billing, and so forth. It's no wonder that healthcare providers spend a whopping 3.4% to 4.6% of their entire net revenue just on the process of getting paid.[3]

As if that weren't enough, the industry is shifting away from a fee-for-service (FFS) model to a proliferation of value-based reimbursement methodologies that tie payment to factors other than simply providing services. Payment is increasingly determined by factors such as patient satisfaction scores, quality measures, readmission rates, and total cost of care. Figure 1 shows this trend over the past few years, and payers have given every indication that this will continue indefinitely.

FIGURE 1: FFS VERSUS VALUE-BASED PAYMENT DISTRIBUTION



1 Margaret Foley, PhD, "IPPS Final Rule Changes for Fiscal Year 2020," *Journal of AHIMA* (January 1, 2020), https://journal.ahima.org/ipps-final-rule-changes-for-fiscal-year-2020.
2 AAPC, https://www.aapc.com/codes/apc-codes-range.
3 Joey Moss, *Uncovering Your True Cost to Collect for Data-Driven Performance* (Parallon), https://parallon.com/insights/uncovering-your-true-cost-collect-data-driven-performance.

This shift to value-based models creates another layer of complexity for healthcare professionals whose job is to make sure their organization is paid appropriately. It is no longer enough to negotiate good rates, document the billable services provided, and then collect what the organization is owed. The process of maximizing revenue increasingly involves the redesign of clinical processes, capture and management of a much broader array of performance metrics, and greater communication of economic incentives across provider organizations to drive operational change.

This requires a more extensive skill set, and many organizations may find they are not currently set up for success in the future-state environment. The implications of this are real. Imagine an environment in which performance under value-based reimbursement could legitimately drive a 10% swing (positive or negative) in revenues. That's not a far-fetched scenario, and it presents a make-or-break proposition to providers, given the slim margins under which most operate. Failure to succeed in that environment could easily result in an organization's demise.

CURRENT STATE AND FUTURE CHALLENGES

To gain a better understanding of how provider organizations are addressing the challenge of ever-increasing payer complexity, ECG interviewed a number of our clients and reflected upon our nationwide consulting experience.

Most organizations have recognized that payment models are getting more complicated, requiring greater collaboration across the contracting and revenue cycle functions. This is playing out through greater attention to practices such as:

- Cross-divisional meetings.
- Joint meetings with payers.
- Development of payer scorecards.
- Joint participation in payer contract negotiations.

However, because the vast majority of markets are still dominated by FFS reimbursement, most organizations continue to work within their traditional structures, which are characterized by a clear delineation of managed care and revenue cycle.

But as value-based reimbursement continues to gain prominence and becomes a permanent, indispensable part of a provider's revenue, these structures will prove inadequate.

Our clients agreed that the coordination of managed care and revenue cycle functions is an evolving process and that more integration will be required in the future.

GROWING PAINS

We've already seen instances in which organizations moving to future-state payment methodologies have outgrown their traditional structures. One noteworthy example was an academic institution consisting of a main teaching hospital, several affiliated hospitals, and a faculty practice plan. The organization participated in multiple value-based payment arrangements for both professional and facility fees ranging for its Medicaid, Medicare, and commercial populations, as well as its own employee health plan.

Although the organization embraced value-based payment as the future of healthcare, it lacked an overarching, unifying reimbursement strategy to include a coordinated means of managing performance.

As a result, the proliferation of value-based payment models spawned multiple committees and work groups that were loosely connected at best. Revenue cycle and contracting leaders were involved but mostly within their traditionally defined roles. Because performance management spanned the clinical, operational, and financial arenas, accountability was diffuse, and as a result, performance across models varied widely. Simply put, nobody owned it, and it showed.

Moving the needle on any value-based reimbursement model—let alone multiple models—requires a tremendous amount of time, energy, expertise, and organizational clout. The person or persons in charge of this need to be sophisticated analysts, strategic thinkers, knowledgeable operators, cheerleaders, and politicians. These activities require a much broader skill set than is usually expected of traditional revenue cycle and contracting leaders.

And it is unlikely that good results will come from making this a part-time focus for many different individuals. There comes a point at which this needs to be someone's primary focus.

AN EXECUTIVE FOCUS

As payment models become more complex, with ever-greater dollars at stake for a variety of performance measures, it becomes more important to maintain continuity from the time of negotiating a contract all the way through to performance management.

In a highly developed managed care environment, it's imperative for the person negotiating these arrangements to understand what they're signing the organization up for and what it takes to succeed.

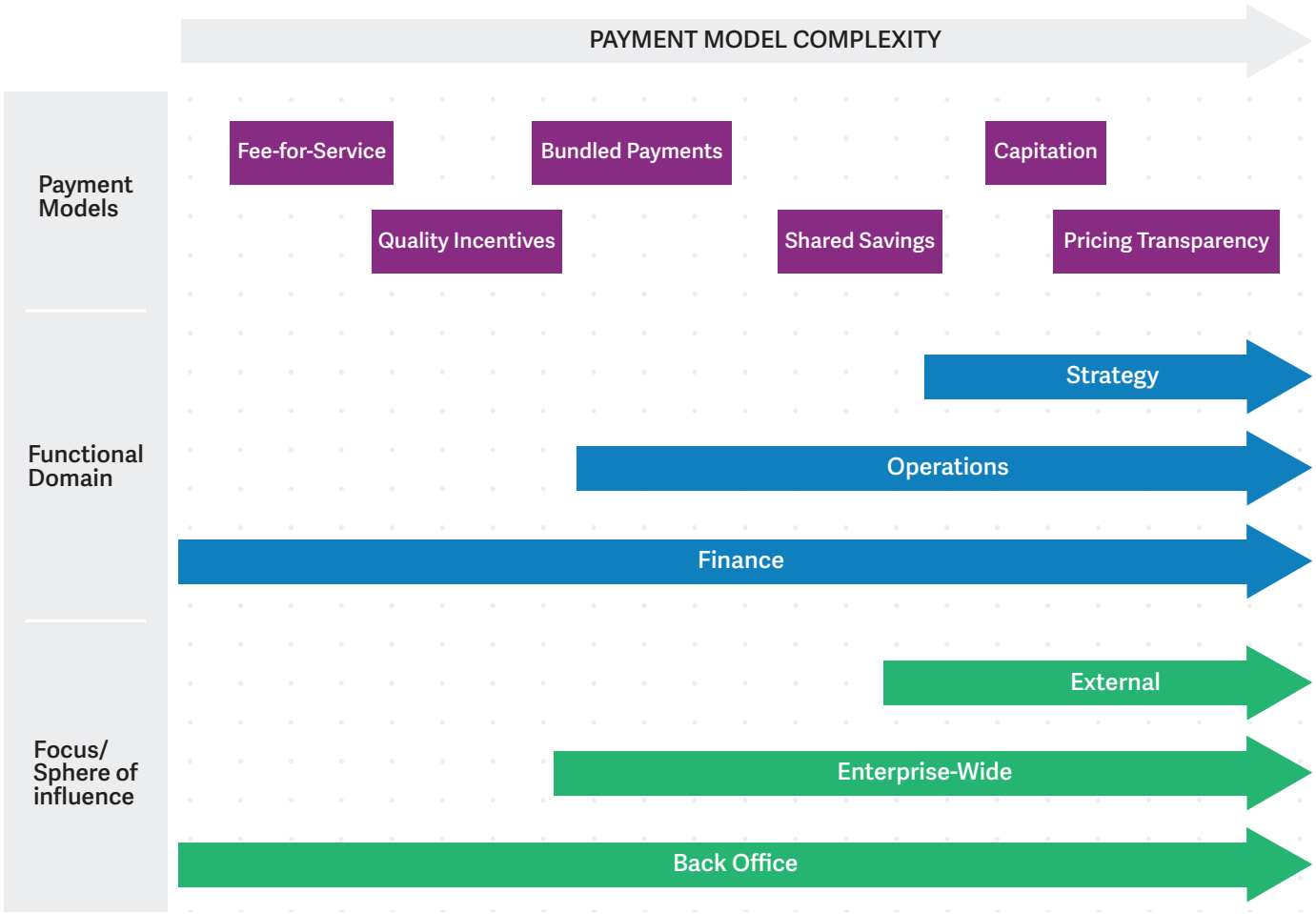
That person must not only know how to negotiate with payers, but also needs to be well versed in the clinical and operational processes needed in order to deliver results; how to effect change throughout the organization and how much change is possible; and what that translates to in terms of financial results under the proposed agreement.

Certainly this involves input from leaders throughout the organization, but committees cannot lead the charge. Someone needs to be on point, and the person who pulls all of these elements together is going to have a very high-visibility executive role in the organization.

Figure 2 highlights the increasing complexity of reimbursement models and the expanded functional domains and organizational spheres of influence associated with managing them.

That said, we recognize that value-based reimbursement is not critically important to all organizations today, so it is necessary to think of a migration strategy. The next section lays out several potential structures that could provide that kind of migration.

FIGURE 2: REIMBURSEMENT MODEL LANDSCAPE



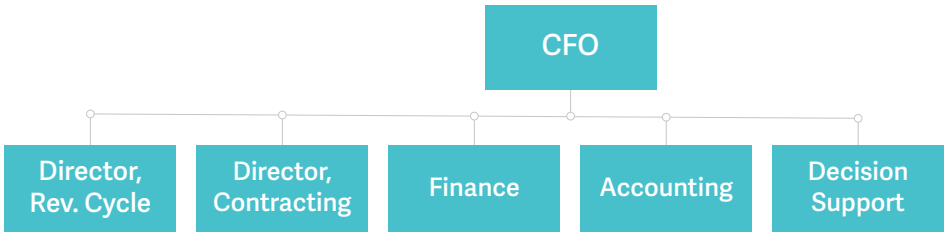
ORGANIZATIONAL STRUCTURES

The three models presented below move from separate revenue cycle and managed care departments to full operational integration and strategic leadership of value-based reimbursement performance under a single owner. As these functional areas become more integrated, the ability to succeed within more complex reimbursement models also increases. That said, this integration is likely to involve additional infrastructure and management layers, so organizations should evaluate their strategies at every level before determining their desired level of integration.

TRADITIONAL MODEL

For smaller organizations or those that are still in a predominantly FFS environment, major changes to the typical structure may not be necessary or feasible. Figure 3 presents a traditional organizational structure with separate revenue cycle and contracting departments that report up to the CFO.

FIGURE 3: TRADITIONAL ORGANIZATIONAL STRUCTURE



Continued coordination and collaboration across both functions will be necessary because even FFS payment is getting more complex and harder to manage. Enhancements and best practices include the following:

- Establishment of payer key performance indicators
- Documentation of payer performance against these measures and key operational issues on regularly updated scorecards
- Routine internal meetings to review payer performance and resolve denials
- Regular meetings with payers to address outstanding issues, develop strategies to resolve them, and hold parties accountable for making progress on issues
- Inclusion of revenue cycle feedback during contract negotiations to resolve operational issues and improve contract provisions related to billing requirements or denials
- A defined process for revenue cycle staff to escalate unresolved payer issues to managed care; this escalation path should be prospectively defined and metric driven
- Development of an organizational culture in which members of revenue cycle and managed care are encouraged to collaborate with one another

ECG's blog post on collaboration between revenue cycle and managed care functions includes a more detailed overview of each of these best practices and can be applied more broadly than the denials-reduction scope outlined in the blog.[4] Implementing these improvements enhances financial performance through more efficient resolution of denials and operational issues tied to managed care contract provisions.

The functional domains and spheres of influence under this model are narrower than those in the models below. Although revenue cycle and managed care leaders may be visible elsewhere in the organization, most of what they oversee is regarded as "back office" functions (as evidenced by the fact that their staffs are often located off site).

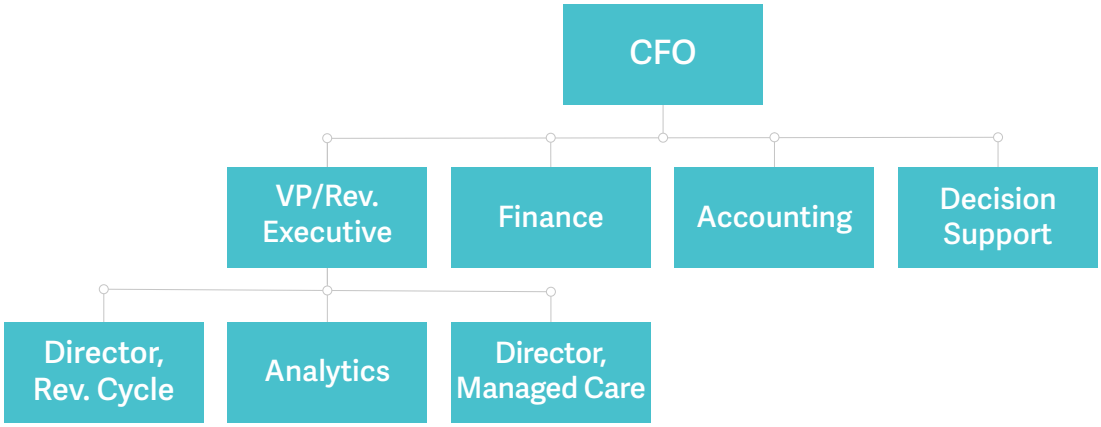
INTEGRATED REVENUE CYCLE AND MANAGED CARE FUNCTIONS

For larger organizations, and for those taking on more value-based reimbursement, it may make sense to consolidate the revenue cycle and contracting functions under a leader whose primary focus is on revenue maximization.

The primary benefit for the creation of this role is to ensure maximum collaboration and coordination across these two arenas.

The reporting leader's sphere of influence would include the organization as a whole, since a significant portion of revenue is based on value. Note, this cross-departmental partnership requires a significant executive presence and influence throughout the organization, which the CFO may not have the bandwidth to provide. Figure 4 represents the revenue cycle and managed care partnership.

FIGURE 4: REVENUE CYCLE AND MANAGED CARE PARTNERSHIP ORGANIZATIONAL STRUCTURE



4 https://www.ecgmc.com/thought-leadership/blog/collaboration-is-key-addressing-the-increasing-volume-of-payer-denials

This partnership would be well suited in a large organization with multiple locations that manages both facility and professional fees. Characteristics that would differentiate it from the previous model include:

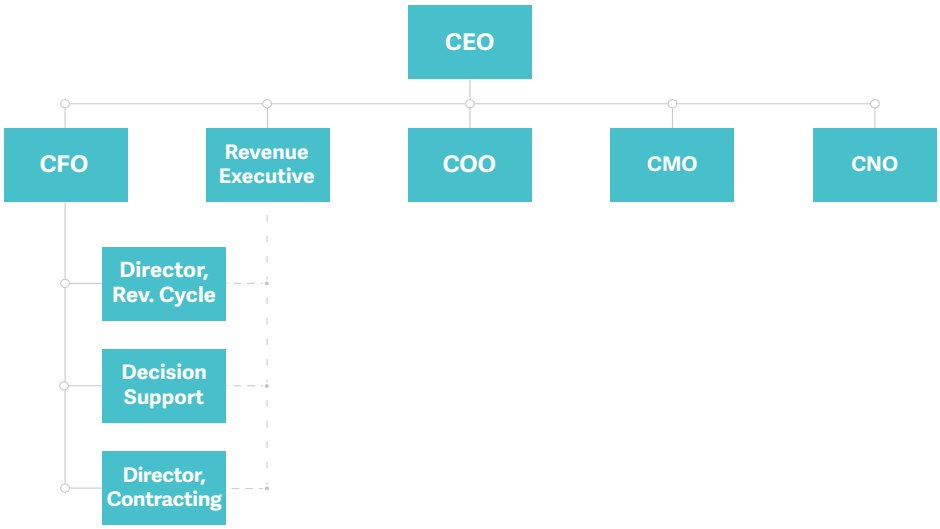
- Consolidation of managed care and revenue cycle functions under a single leader who is dedicated to revenue maximization.
- Development of sophisticated analytics to assess contracts prospectively, during the negotiation process, and on an ongoing basis through the use of leading and trailing indicators.
- Enhanced ability to elevate the visibility of performance under value-based arrangements and to effect improvement throughout the organization.

DEDICATED REVENUE EXECUTIVE

Although this is not a role that we are currently observing, we envision that organizations will create a senior-level executive position focused exclusively on performance in a heavily value-based reimbursement environment. This executive would be well versed not only in managed care and revenue cycle, but also in the operational, clinical, and organizational dynamics needed to effect change across the enterprise and potentially beyond. Because of the multidisciplinary nature of this person's role, managed care and revenue cycle may continue to report to the CFO directly but would indirectly report to the revenue executive.

This allows for the traditional organizational structure to maintain authority over daily operations while the revenue executive focuses on strategic development, coordination, and execution within these departments and across the operational and clinical enterprise. This position would also be responsible for coordinating and implementing all revenue improvement strategies across multiple departments within the organization. Figure 5 illustrates this model.

FIGURE 5: PROPOSED ORGANIZATIONAL STRUCTURE WITH REVENUE EXECUTIVE



The principal distinction between this model and the previous one is that this leader plays a fundamentally different role in the organization. While the previous model focuses primarily on unifying the leadership of managed care and revenue cycle functions, these efforts are likely to stop short of full strategic revenue improvement development and implementation based on the limited availability of a VP to manage daily operations and priorities in addition to leading the charge on cross-functional collaboration efforts. Having a dedicated leader to perform this function would extend the interdepartmental coordination into more strategic analytics and revenue maximization partnerships.

The revenue executive role would be highly matrixed and likely have indirect reporting relationships to a number of operational and clinical leaders, in addition to finance, in order to:

- Develop and prioritize a comprehensive payer strategy.
- Direct collaboration across operational and clinical departments (particularly including other legal entities) to implement revenue enhancement strategies.
- Facilitate organizational change and performance monitoring across the financial, operational, and clinical domains.

As indicated previously, these functions require a highly developed and robust skill set that is outside the realm of most managed care and revenue cycle leaders today. Consequently, this position represents a new career path that might be pursued either by traditional revenue cycle or managed care leaders who wish to expand their scope, or by leaders from other backgrounds who are able to develop the necessary reimbursement expertise.

NO TURNING BACK

The level of complexity in healthcare is steadily increasing, with no end in sight. As a result, provider organizations must develop ever-increasing levels of sophistication in virtually everything they do, particularly in the realm of reimbursement.

This requires gaining new capabilities, knowledge, and skills that typical organizational structures today can accommodate with only limited effectiveness.

For that reason, we believe these structures will need to evolve.

Undoubtedly, most readers will have noticed that two of the three models presented here involve the addition of new management positions. Understandably, organizations will be hesitant to add management layers; however, this may become an inevitability, particularly when one considers the reimbursement dollars that will eventually be at stake.

Our hope is that this paper will alert readers to the need to develop a thoughtful and rational transition to the future state.

ABOUT ECG

With knowledge and expertise built over the course of nearly 50 years, ECG is a national consulting firm that is leading healthcare forward. ECG offers a broad range of strategic, financial, operational, and technology-related consulting services to providers, building multidisciplinary teams to meet each client's unique needs—from discrete operational issues to enterprise-wide strategic and financial challenges. ECG is an industry leader, offering specialized expertise to hospitals, health systems, medical groups, academic medical centers, children's hospitals, ambulatory surgery centers, and healthcare payers. Part of Siemens Healthineers' global enterprise services practice, ECG's subject matter experts deliver smart counsel and pragmatic solutions.

For more insights from ECG, visit www.ecgmc.com/thought-leadership.

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