The Transformation and Future of Healthcare

An Interview with Emad Rizk, M.D.,
President and Chief Executive Officer, Accretive Health

Emad Rizk

EDITORS' NOTE *Emad Rizk joined Accretive Health in July 2014 as President and Chief Executive Officer and a member of the Board of Directors. He was previously at McKesson Health Solutions where he served as President. Before joining McKesson in 2003, Rizk was Senior Partner and Global Director, Medical Management/Pharmacy for Deloitte Consulting. He is currently a board member of the National Association for Hispanic Health, Accuray, Inc., Intarcia Therapeutics, Inc., and the Managed Care Magazine editorial board. He also holds advisory roles with multiple academic universities. He is the author of* The New Era of Healthcare: Practical Strategies for Providers and Payers. Modern Physician *named him one of the "50 Most Influential Physician Executives in the United States" in 2013, the fifth time he has been recognized by this publication.* Modern Healthcare *has listed him among the "Top 100 Most Powerful People in Healthcare" while* Managed Healthcare Executive *named him to its "Top 25 Leaders in Disease Management." He is a lecturer at Wharton, Harvard, MIT, Columbia, and the Kellogg School of Management.*

COMPANY BRIEF *Accretive Health (accretivehealth.com) aligns with provider organizations to help them navigate the rapidly changing healthcare industry landscape. The company supports the mission and business objectives of hospitals, health systems and their affiliated ambulatory clinics and physician practices by effectively managing their revenue processes and strengthening their financial stability. The company has touched more than 59 million lives and manages more than $17 billion in net patient revenue. Its clients include three of the top 10 nonprofit health systems in the U.S., including the largest.*

What's the key to success in the move from volume to value in which payment will be based increasingly on quality outcomes versus the traditional fee-for-service model?

The transition is complex, so there are numerous challenges and enablers. If all payers were flipping the switch at once, every provider would be rushing to the new model. But this is not realistic – the industry is evolving at different speeds based on region, health system size, and payer contracts. The federal government is leading the way, but all payers are experimenting. As a result, today's healthcare providers must simultaneously manage multiple and evolving payment models while maximizing their returns in the prevailing fee-for-service environment. This is occurring along with other significant distractions, including M&A activity, the employment of more physicians by hospitals, increased consumerism as patients take on more financial responsibility, and increased health IT implementation costs.

It's a challenge for all providers, large and small, but it's the right thing to do. I think the keys to success are threefold: provider/payer collaboration, patient engagement, and in-depth analytics.

The incentives of providers and payers will be better aligned under a value-based model automatically. But these two entities will need to become more aligned to drive change, achieve the necessary efficiency, and improve the quality of patient outcomes. They will need to work together, ensuring contract terms are transparent and align to financial incentives that will drive change in provider behavior. Speaking of change management, patients will also have to start thinking like consumers. We've always focused on this transition in revenue cycle management in terms of pre-service financial transparency and registration quality. The difference now is that providers also have to focus on engaging patients in order to keep them in the network and affect behavior change in patients with chronic conditions and comorbidities. While analytics is last on this particular list, it's clearly a high priority. Without data that is complete and actionable, providers will have a much harder time succeeding under these new models.

Under fee-for-service, our analytics focused on financial metrics such as A/R, denials, collection rates, and P&L. In a value-based environment, financial and clinical data become interdependent, adding utilization, care gaps, value-based collection rates, and KPI performance to the mix. When assessing analytics, certain capabilities are a must: quality measure assurance, HCC and RAF assurance, population analytics, and contract modeling. But providers will also have to develop the operational infrastructure to analyze and take action based on these new data sets. We're finding that providers are looking for help, and there's a new appetite to outsource some of this to partners with expertise, scale, and a collaborative approach. It's an exciting transition, and Accretive Health is playing an important role in making it happen.

I'd also like to take a moment to emphasize the integration and standardization of process, software, analytics, and accountability – and by accountability, I mean roles and responsibilities. All of these components need to be well documented in a standardized and integrated methodology. Metrics should not only be outcomes-based but in process metrics also need to be actionable. This approach has been adapted by many industries, and healthcare needs to move in this direction.

Why is collaboration between payer and provider so important?

The most obvious reason is that collaboration will result in true alignment – not just an empty commitment without true action. By working together, payers and providers can create a benefit design that builds on an organizational infrastructure to support communications and cultural change management. True collaboration will enable payer/providers to align physician compensation with the payer reimbursement model. This is a move that will most certainly engage physicians in improved outcomes.

This kind of alignment is not just a pipe dream, by the way. I have worked on both the payer and the provider side. When I was at McKesson Health Solutions, I wrote a book with actionable strategies for finding mutual understanding in clinical, administrative, and economic areas – all designed to benefit the patient. The essential criteria are transparency and data sharing.

Payers must offer contracts with clearly defined performance requirements, and the payment bundles must include tactical details on scope and volume of services. On the other hand, providers must have the financial and operational infrastructure to analyze and detect gaps, navigate the problems and prioritize exceptions, capture updates,

and finally to validate and reconcile. This is new for most providers, so it's important to assess capabilities and make smart choices about developing those skills in-house or outsourcing.

Payers have been working on retrospective patient data stratification of high-risk patients for some time. Now they will have to share that data proactively with providers. With shared data, providers can better integrate clinical and financial analysis to resolve gaps and coordinate care.

Although patient engagement sounds simple, it has proven problematic for most providers. How are you helping your customers achieve that elusive objective?

It's not simple, but high-deductible plans are forcing patients to pay for more of their care out-of-pocket, and we find that's forcing patients to become more involved in their care management decisions. The question is whether providers are prepared to turn that financial angst into productive engagement and eventual behavior change. Like all aspects of the current transformation, that will be an evolution – not a revolution.

In our push for price transparency, Accretive Health has developed the technology to determine and communicate an accurate, educated estimate of what procedures will cost before they're done. This will only get more complex with new reimbursement models.

In the U.S. today, there are approximately 1,900 different plans – only 192 by name, but hundreds more when you consider the different third-party administrator (TPA) configurations. Now imagine the different reimbursement options ahead. It could be a fee-for service, an episode payment, bundled, or capitated. Pharmacy and imaging may or may not be part of the network. The options are numerous and the pricing complex, but patients deserve to know the cost of the services they're purchasing before they purchase. And when they do, they will become more engaged in the ensuing lifestyle choices that have a very real and direct impact on their pocket books.

Accretive Health is building out some new tools that we're pretty excited about. These are tools that bring information to the patient, with apps no different than those one uses on their iPhone. When one combines those tools with the operational infrastructure that we use to talk to patients in the post-service phase of care, we know we can help providers. Think about it: post-service communications shouldn't be entirely focused on billing. It can and should include follow-up on filling the prescription, inquiries about the need for home care, and returning for a check-up. Any and all of these communications will improve care compliance, recovery, and health maintenance.

This kind of patient engagement will be particularly important for providers who are joining accountable care organizations (ACOs) or other integrated delivery networks (IDNs). When the provider takes on risk, it's absolutely critical to keep patients in the network. Right now, a patient is not incentivized to stay within a particular network, especially before the deductible is met, and that could completely disrupt the financial equilibrium of risk. Medicare just released the 2014 results for 353 ACOs, and three out of four did not slow health spending enough to earn bonuses. In addition to experience, it is not exactly clear what makes some ACOs more successful than others, but I believe patient engagement has to be part of the reason.

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How ready are America's providers for population health?

Everyone is considering it, but most providers are years away from successfully assuming risk for a population. A Health Leaders survey of providers at the beginning of the year confirmed what we know anecdotally – scale is critical. Larger organizations are typically able to draw from larger populations, and they have the resources to develop the needed infrastructure. So it wasn't surprising that health systems led the pack with 80 percent reporting pilots currently underway, compared to 56 percent of physician groups, and 47 percent of hospitals. I don't talk to any provider who denies the inevitability of population health, but few have decided on a single care management model or reimbursement methodology.

What are the steps to making the transition to value reimbursement?

I see it as a four-step process. In the first, providers must develop the basic infrastructure – things like an EMR, achieving the first stage of Meaningful Use and patient-centered care. In the second phase, they have to incentivize specific activities, which could include engaging in the Physician Quality Reporting System (PQRS), Core Measures, and any variety of ways to bridge gaps in care, like the National Quality Forum's care coordination gaps. In phase three, they have to move from activities to outcomes, which is no small feat. Most of the market is somewhere between phase two and three right now. They're working on Stage II of Meaningful Use and they're experimenting with the value modifier.

In phase four, they'll have to take on risk and the total cost of care models. I'm not sure when the market as a whole will make that significant step, but some think the mandatory bundling of joint replacement next year will jump-start that move. There's no doubt that's the intent. With the Comprehensive Care for Joint Replacement Model, CMS is proposing mandatory bundling of hip and knee replacement in 75 geographic areas, impacting nearly 800 hospitals. The model would hold hospitals financially accountable for the quality and cost of the surgery and care for 90 days following discharge, so it will clearly require coordination of the post-acute care continuum. It's obvious CMS is serious about moving into value-based models sooner rather than later.

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How will the transition from volume to value impact revenue cycle management?

We'll have to evolve, and our evolution will obviously have to precede that of our customers. Fortunately, we're already there in the development of our capabilities. The biggest shift that we have been making over the past 18 months is moving our focus from back-end payer reimbursement-focused activities to front-end patient and provider-focused processes and intelligence. Earlier I discussed our current focus on talking to patients during pre-service about insurance eligibility and co-pays. In the new paradigm, we will proactively engage them about wellness visits and resolution of care gaps as well. Our coding focus will shift from medical necessity and CPT and E/M levels to comprehensive health conditions, risk scores, and quality measures. As a result, the basic downstream accounts/receivables that are the life blood of fee-for-service analytics will no longer be our highest priority. It will be upstream patient engagement, utilization, care gaps, value-based collection rates, and KPI performance.

In the conventional revenue cycle management model, there are silos that prevent an integrated, holistic view of the revenue cycle. In its simplest form, the revenue cycle is divided into the front end (insurance eligibility and financial counseling), the middle (coding), and the back end (billing). These operational silos restrict feedback across the cycle so that efforts to correct defects are typically reactive. Unfortunately when there are problems, the root cause analysis rarely contributes to change management in the manner everyone wants it to.

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Isn't that quite a jump for most providers?

Yes and no. Providers theoretically understand that this needs to happen. However, the operational infrastructure and change management can be daunting. With shrinking margins, providers are seeking support to streamline their operational processes and maximize their IT investments. If we are going to bring down the cost of healthcare and improve the quality, providers need to make every cent count.

Let me provide some context. Right now, more than 90 percent of reimbursement still falls in the fee-for-service model. Even the most conservative projections drop that penetration to 75 percent within two years. But here's the key facet of that shift. Collection rates for value-based reimbursement are still significantly lower than fee-for-service because providers lack the capabilities to identify, resolve, and reconcile defects that impact this new type of reimbursement. It's 98 percent in fee-for-service, 80 percent in acute value-based, and 30 percent in ambulatory value-based. The combined acute and ambulatory care collection rate in value-based reimbursement hovers around a perilous rate of 55 to 65 percent.

We've done analysis across multiple health systems in multiple geographies and have found that the primary area for financial leakage occurs in support operations that haven't transformed to the new paradigm. Most providers have made appropriate investments in health IT and clinical decision support and they're getting their quality teams running well. But the support operations aren't where they need to be.

We like to refer to such challenges as opportunities, so let's express it this way. The largest opportunity, fully half, is in patient outreach: effectively contacting and managing patient care requirements between service encounters. This includes encouraging wellness visits and preventative services, making sure that transitions between care settings are seamless, and paying special attention to patients with chronic conditions and comorbidities. Obviously those efforts will improve the HEDIS and PQRS scores that are so important to value-based reimbursement.

The next area of opportunity is coding. Everyone who works in healthcare understands the challenge of coding, but few outside of finance understand its impact. It's absolutely imperative that healthcare systems use specialized documentation and coding to remain compliant and financially viable within Medicare – especially as it relates to risk adjustment.

For those who are not that familiar with coding, keep in mind that CMS has adjusted Medicare payments based on a risk profile for quite some time, but the Affordable Care Act ramped up risk adjustment oversight to prevent risk selection by insurers. In the big picture, risk adjustment transfers funds from plans with lower-risk enrollees to plans with higher-risk enrollees, with a goal of discouraging Medicare Advantage insurers from just trying to attract healthy enrollees. Put simply, provider coding is the administrative function of accurately documenting the population's risk adjustment scores to ensure accurate reimbursement when their patients' health improves over time.

As a general rule, providers know what's needed in these support services – they simply need help getting there. The Accretive Health methodology is built on more than a decade of business intelligence experience and a collaborative business model in which we act as an extension of our customer organizations.

How is the industry progressing in the shift from a myopic focus on hospital-based care to patient-centered, coordinated care across the broad continuum?

Hospital systems are making great strides in the shift to ambulatory care. They're placing services in convenient locations and expanding the hours of availability. They're also fleshing out the continuum by employing primary care physicians for preventative and post-acute care, palliative specialists to address pain that isn't end-of-life and hospice that is. The percentage of hospital-employed primary care physicians doubled from 10 to 20 percent in two years (2012 to 2014) according to the annual survey by healthcare staffing company Jackson Healthcare. Joint ventures, mergers, and ACOs are furthering care coordination where physician employment leaves off.

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But common ownership and standardized protocols don't guarantee care coordination. It requires an organizational commitment to knowing the patient's needs and preferences, then meeting those needs through specific initiatives built on communications, accountability, and measurement. In most organizations with hospital-centric origins, that requires significant culture change. Fortunately that's happening, but I would say it's still in the early stages. What is generally acknowledged is the need for the silos to come down, for providers along the continuum to offer seamless transitions between care settings, and to communicate effectively.

Accretive Health helps facilitate change in provider organizations through three key capabilities: business intelligence that helps providers identify and prioritize their goals and associated approach; technology that enables operational and process integration; and support operations that reduce the administrative burden of change. What's especially unique about our approach is that our services become directly entrenched in the providers' administrative operations and our tools are EMR-agnostic, integrating with our customers via data exchange, work flows, and point-of-service alerts and prompts.

People at Accretive Health like to say that our product is operational excellence, and the formula is human capital and proprietary technology that allows true integration with our clients. We're not offering advice from afar – we're at their elbow, with our sleeves rolled up just like theirs.

Do you consider Accretive Health a technology company?

We are, and have always been, a services and technology company. Technology is clearly part of our offering but we also realize that operational comanagement and support are necessary to maximize the ROI of technology investment. Here's what our technology does – tt aggregates multiple data sources and integrates across multiple technology platforms, which is critical in organizing care across a continuum. It offers upstream defect detection, prioritization, and work flow management; it reconciles operational activities and financials; and it offers analytics and reporting. This is a significant offering, but it's the people we embed with clients that make the technology hum.

We have highly experienced staff and management across all areas of the revenue cycle. Specific to value-based reimbursement, we also have risk-based coders, auditors and educators, contract modelers and managers, data analysts, process coaches, and patient engagement specialists.

How does your technology differ from health IT and how have you achieved the ability to integrate across technology platforms when that is so problematic with EMRs?

Our technology is focused on operational and financial information, not clinical. Those operational and financial standards were developed some time ago, while standards for the exchange of clinical information are still only loosely defined.

Health IT is an absolutely essential element of healthcare transformation. Our focus at McKesson was integrated care management that enabled payers, providers, and patients to come together to transform care. Our efforts were surrounded by the influence of health IT and the associated frustration with barriers to interoperability. But let's not lose sight of the progress that's been made. With the exception of post-acute, which was generally ignored by the EHR incentives programs for meaningful use, the vast majority of providers have some sort of functioning electronic medical record today. Most providers within a single organization are getting comfortable with using it, exchanging information with the care team, and starting, albeit very slowly, to engage patients with patient portals. This is a significant change.

Of course, the roadblock to the full transformation of care is the general inability of providers to exchange clinical information across organizations and different IT vendors, making it even harder to consider integrating clinical and financial information from across the organization. But there's real progress there too – consider the following initiatives dedicated to health information exchange.

The Sequoia Project was formed as a public/private effort to promote hub-to-hub exchange, building on the federally led Nationwide Health Information Network Exchange formed in 2006. They also launched a separate initiative called Carequality to allow connectivity between networks. The CommonWell Health Alliance is focused on building a national infrastructure for pull-based exchange, and the Direct Project initiated by ONC is focused on push-based exchange.

On the standards side of the issue, the Argonaut Project founded in 2014 is defining the standards for the exchange of "discrete" data as opposed to the current approach of full documents. There is very real, very beneficial progress being made.

In closing, what's the impact of expanding Medicaid populations under the Affordable Care Act and the expanding Medicare population as the country ages?

Medicaid expansion is covering millions of Americans who had no coverage before the Affordable Care Act. While Medicaid doesn't cover all provider costs, it is certainly the best alternative when no other coverage is available. So that's good news for providers. Just as importantly, Medicaid means access to regular care, preventative services, wellness exams, and screenings. The goal of that coverage is to help Americans with lower incomes manage their health by bringing them into the system, rather than keeping them outside until they're so desperate that the emergency room seems like the only option.

Our aging population and the growing ranks of Medicare offer equally unique challenges, but I think we're ready to tackle them. Providers will have to work efficiently, they'll have to focus on the population segments that drive the majority of cost, and they absolutely must engage patients in their care. We're here to help. ●

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