



**US Healthcare:
Transition to a Value-Based Care Model**
A BPO Perspective



Table of Content

1	Value Based Healthcare in US.....	3
1.1	Introduction.....	3
1.1.1	The Shift from Fee-for-Service to Value-Based Care Model in the US.....	3
1.1.2	Government Initiatives and Regulations	3
1.2	Value-Based Care - What Does it Aim to Achieve?	5
1.3	Emerging Value-based Payment Models.....	5
2	Transitioning to Value-Based Models: What and How?.....	7
2.1	What does the Transition to Value-Based Models Mean for Providers?	7
3	Intelenet - A Healthcare BPO Partner of Choice.....	8
3.1	About Intelenet	8
3.2	Our Healthcare Offerings	8
3.2.1	Services Overview	8
3.2.2	Key Clients	9
3.2.3	Supporting Providers across their Revenue Cycle Landscape.....	10
3.3	Case Studies	10
3.3.1	Case Study: A Leading Home Healthcare Company (Services: Billing & Collections, Customer Service)	10
3.3.2	Case Study: A Provider of Hospital-based Clinical Outsourcing (Services: Billing & Collections, Medical Coding).....	11
3.4	How Can Intelenet Help You?	12

1 Value Based Healthcare in US

1.1 Introduction

1.1.1 The Shift from Fee-for-Service to Value-Based Care Model in the US

The latest National Health Expenditures projections from the Centers for Medicare & Medicaid Services (CMS) forecast the annual US healthcare spending to grow at an average of 5.8% from 2014 to 2024. This represents c.1/5 (20%) of the total US GDP. The existing cost and payment models adopted by healthcare payers are deemed to be unsustainable and often result in gaps in care and variations in the quality of care delivered.

Current fee-for-service model of reimbursing providers, physicians and organizations incentivizes volumes. This means the more patients they see, tests they order, or procedures they do, higher the reimbursements. This often leads to huge variations in rates of procedures and tests such as screening and imaging across geographies/states. As per the Dartmouth Atlas of Health Care, there is a 2.5- fold variation in Medicare spending nationally, even post adjusting for differences in local prices, race, age and underlying health of the population.



The challenges faced by the healthcare delivery system thus necessitated large scale industry transition from the traditional fee-for-service model to value-based reimbursement models. The government thus introduced the **ObamaCare** Act, officially known as the **Patient Protection and Affordable Care Act** (PPACA), in 2010. The act, through its provisions, requires payers to improve outcomes, lower cost and increase access to care.

The emerging value-based care models are driving a shift from volume-based payments, to reimbursements for the value of care that providers deliver. The new reimbursement models will reward quality and outcomes such as quicker recoveries, fewer readmissions, lower infection rates, fewer medical errors, etc., while lowering overall care costs.

The adoption of these models has been bolstered by stringent government regulations under the PPACA. Private insurers and government payers alike are adopting these models, requiring providers to align their operational objectives with the greater objectives of better care, better population health and lower costs.

1.1.2 Government Initiatives and Regulations

As part of the government's health reforms, The **Affordable Care Act** (ACA) introduced various provisions which aim to resolve the underlying problems in healthcare delivery and payments in the US. These provisions focus on three primary areas:

1.1.2.1 Testing New Delivery Models and Promoting Successful Ones

- **Accountable Care Organizations:** In 2012, the ACA launched the **Medicare Shared Savings Program** to further the development of Accountable Care Organizations (ACOs) in the US. An ACO

is an entity formed when health care providers (primary care physicians, specialists, hospitals, etc.) agree to collectively take responsibility for the quality and total costs of care for a population of patients. As part of the program, if participating ACOs meet quality benchmarks and keep their spending under budget, they are entitled to half of the resultant savings. The other half goes to CMS. ACOs may keep a greater share (up to 60%) of the savings if they participate in a “two-sided risk” model, whereby they are required to repay a share of losses if healthcare spending for attributed patients exceeds the budget target.

- In 2015, there were over 400 Shared Savings ACOs serving close to 7.2 million beneficiaries, or 14% of the Medicare population

Transformation of Primary Care through Implementation of Medical Homes: Numerous ACA reforms seek to transform primary care through the medical home model, by means of programs and initiatives involving private physician practices, community health centers, and home-based care providers. The ACA is also assisting health systems and states in experimenting with ways to improve the quality of primary care, promote promising models, and integrate primary care seamlessly with other healthcare services, such as long-term care and behavioral health services.

Two key initiatives for Primary Care transformation include the '**Comprehensive Primary Care Initiative**', and '**Multi-Payer Advanced Primary Care Practice Demonstration**'.

1.1.2.2 Driving the Shift Toward Value-Based Payments: To support the development and spread of innovative payment methods, the ACA has laid down various payment reform provisions. These provisions, pertaining to provider reimbursement, have slowed growth in fee-for-service payment levels. Additionally, it sent a signal to providers that they need to adapt to a new incentive system that rewards high-quality care and good patient outcomes. Few of these reforms include:

- The ACA lowered annual increases in Medicare payment rates for hospitals and other facilities; It has also reduced overpayments to private plans administering Medicare benefits through the Medicare Advantage program, and linked plan payments to performance ratings, and, made the results public
 - The law also imposes financial penalties on hospitals which have high rates of hospital-acquired conditions and readmissions
 - For hospitals, the new value-based purchasing (VBP) program was introduced. The program fosters greater accountability for performance by giving out bonuses and penalties linked to publicly reported quality measures
 - Key payment reform provisions under the ACA include **Hospital VBP Program, Hospital Readmissions Reduction Program, Medical Shared Services Program, and Hospital-Acquired Condition (HAC) Reduction program**, among others

Did You Know?

- 758 hospitals were penalized in 2015 for higher rate of safety incidents
 - These hospitals will see their Medicare payments reduced by 1% for ranking in the bottom quartile nationally

1.1.2.3 Building Resources for System-Wide Improvement: The ACA created numerous resources to establish foundations, organizations and agencies that are contributing to greater public- and private-sector innovation in health care delivery. Some of these institutes/agencies include Center for Medicare and Medicaid Innovation (CMMI), Patient-Centered Outcomes Research Institute (PCORI), Medicare–Medicaid Coordination Office, and National Strategy for Quality Improvement in Health Care (NQS)

1.2 Value-Based Care - What Does it Aim to Achieve?

As the US healthcare system undergoes massive transformation and shifts to the much talked about 'Value-Based' model, it becomes important for all stakeholders in the system to understand the end objectives of this transformation.

Here is how shifting to value-based care is likely to benefit the overall US Healthcare system:



1.3 Emerging Value-based Payment Models

As a result of various reforms under the ACA, following are the key payment models that reward value instead of volume, that are emerging:

- **Pay for Performance**

Under the P4P model, physicians are compensated on measured clinical and cost-saving outcomes instead of reimbursing them for services and procedures. Their financial incentives or penalties are tied to measured performance. The model may also include performance thresholds, relative performance cut-offs or improvement thresholds. The provider receives performance based adjustments to its FFS rates. The measures for P4P could include the Physician Quality Reporting System (PQRS) and the Value-Based Payment Modifier offered by the CMS.

P4P

- Requires less integration and information technology (IT) infrastructure than other more advanced models
- Popular among smaller, or newer provider organizations

- **Bundled Payments/Episode of Care**

The bundled payment/episode of care model provides a fixed negotiated payment for all services for a specified procedure or condition, such as pregnancy and birth, knee and hip replacement surgery, and certain cardiac procedures. Under this model, two providers who would otherwise have different incentives are put under the same budget for risk purposes. Provider payments under this model are based on the costs of adhering to clinical standards of care, risk stratification, and complication allowances. Bundled payment models are based on the premise that coordinating care among different providers with a set budget will discourage unnecessary care and promote coordination, improving outcomes.

Bundled Payments

- Providers benefit from the savings they generate by improving efficiencies and by preventing unnecessary episodes of care
- Payers know up front how much money they will be spending

- **Shared Savings**

Under this model, a group of physicians (and other medical professionals), come together to form an accountable care organization (ACO). ACOs contract with payers to provide care for a patient population. They have a set of quality and cost benchmarks to meet for that population over a particular period of time.

If the ACO is able to provide care at a lower cost than the predetermined threshold, it shares the savings with the payer. However, it absorbs the difference in case the care costs exceed the threshold. The end objective is to foster greater accountability and offer a financial incentive to the participants for improving patient outcomes and lowering the cost of care.

Shared Savings

- This model expects that providers will provide care that's actually needed versus care that isn't, help manage chronic conditions, reduce administration, improve access and focus on the patient

- **Capitation**

This model involves prepayments to physicians or medical groups for a set of pre-defined services. The compensation is usually calculated based on the range of services provided, the number of patients involved, and the period of time that the services are provided for.

Capitation rates may vary from region to region, owing to local cost differences. Typically, many capitation plans establish a risk pool and collect money in the pool is collected throughout the year. If the plan does well financially, the money is paid to the physician. If it does not, the money is retained to pay the deficit expenses.

Capitation

- Capitation reduces the risk of patients being over-treated since physicians, committed to the aim of reducing costs, are expected to only prescribe necessary treatments

Services under capitation agreements usually include preventive, diagnostic and treatment services, injections, immunizations, and medications administered in the office, outpatient lab work, health education and counseling services performed in the office, and routine vision and hearing screening.

- **Hybrid Models**

A hybrid model incorporates two or more of the other models with fee-for-service. Hybrid models usually remove costly steps, such as payers rejecting claims and providers re-submitting claims. It often lowers the operational and administrative costs of claims processing.

2 Transitioning to Value-Based Models: What and How?

2.1 What does the Transition to Value-Based Models Mean for Providers?

In the wake of recent regulatory reforms, government organizations are fast driving the adoption of value-based models across the healthcare system. The CMS has detailed specific targets for transitioning to value-based payments and private payers are also linking reimbursements to improvements in safety indicators, patient outcomes and costs of care. Healthcare providers are thus increasingly focusing on meeting the Centers for Medicare & Medicaid Services' (CMS) Value-based Purchasing requirements, and the targets of their arrangements with private payers.

It is thus vital for providers to take a closer look at their capabilities and operations, to find ways to better manage the transition. The advent of value-based care has necessitated providers to focus on achieving the broader objectives of better care at lower costs, in a sustainable manner.

Providers thus need to align their operational objectives with the objectives of the value based care model they are participating in, and need to concentrate on improving the quality of patient care. They have to optimize their operations and improve effectiveness of their processes, starting from when a patient walks in till the bills and claims are settled, in order to deliver quality care amid stringent regulations, growing costs and ICD-10 transitions.

An increasing number of care providers are now partnering with experienced BPO players to support them in their transition journey. An experienced BPO partner, with the required knowledge of regulatory implications, a skilled workforce and access to and experience of latest technology in the industry, can prove to be an asset in times of massive regulatory changes.

The right partner will ensure achieve process improvements and operational efficiencies to manage costs, so that the clients can focus on improving patient care.

- An experienced BPO partner to support providers through their transition from fee-for-service to value-based payment models is the need of the hour
- BPO support offers the required expertise to deliver efficiencies across processes, improve process effectiveness, enabling providers to better manage costs and have a greater focus on delivering patient care

3 Intelenet - A Healthcare BPO Partner of Choice

3.1 About Intelenet

Intelenet Global Services is a leading provider of business process management services across industries, including Healthcare, Travel & Hospitality, Finance & Accounting, Telecom, Banking & Insurance and Retail.

With more than 50,000 people spread across 66 global delivery centers, Intelenet supports over a hundred clients in 50 languages. Our service capabilities are customized to cater to unique industry requirements, different customer bases, process mandates, and resource needs.

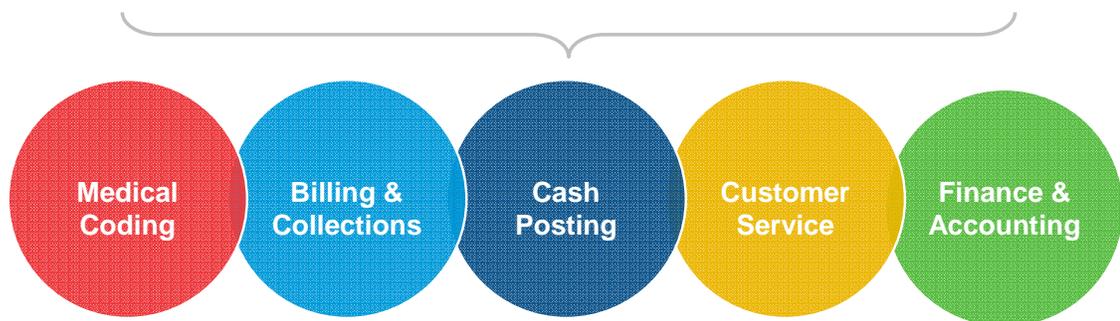
3.2 Our Healthcare Offerings

3.2.1 Services Overview

With over 9 years of experience with Healthcare clients, Intelenet currently employs over 1,800 FTEs delivering “Top-Notch” service to clients across the Healthcare spectrum. We offer a range of BPO services and solutions for healthcare clients and have capabilities to meet the needs of all players across the healthcare value chain, including payers, providers and suppliers.

We offer a range of industry-specific as well as cross-industry/horizontal services to our healthcare clients, with expertise in supporting providers in the United States.

Our Capabilities include:



- **Medical Coding:** As the industry transitions from ICD-9 to ICD-10 standards, the number of codes has gone up drastically, from 18,000 to 1,40,000, creating a need for well trained, ICD-10 certified coders and driving labor costs up. Intelenet offers a 100% ICD-10 certified team of coders to support you transition completely to ICD-10, with high accuracy levels.

Our trained team of coders works on the entire process of medical coding including reading patients' medical reports, assessing the medical treatment provided, converting the medical treatment into codes, and sending claims for approval/denial

- **Billing & Collection:** We deliver a range of services to streamline and optimize billing & collections for our clients. Our experienced billing professionals ensure claims are sent to payers faster, with fewer errors and at lower costs.

Our teams provide comprehensive medical billing and collections services including processing paper claims, charge posting, claims transmission, accounts receivables follow-up, and patient statements & follow-ups

- **Cash Posting:** In addition to the billing and collections services we offer, we offer payment posting services which include cash posting at invoice level, reconciliation, recoups and refunds, denial management, etc.
- **Customer Service:** We support our clients with a range of customer service and contact center services including order taking, order processing, query handling, insurance eligibility & coverage checking, and escalation handling and management
- **Finance & Accounting (F&A):** We have strong F&A capabilities across industries and deliver a range of F&A services to our healthcare clients, including Accounts Payable, General Accounting, Accounting, Closing & reporting (ACR), etc.

Tools & Technology

- Intelenet's trained workforce is supported by a range of internally developed process and capability specific tools that can be customized as per client requirements; these are successfully deployed across clients and processes
 - CodeSmart, a Clinical Documentation Improvement application: This tool sends out real time notifications to physicians to request for additional information/documentation, thus reducing TAT for sourcing information from physicians; this has resulted in improved coding accuracy, leading to reducing lost/delayed revenue
 - A Ps-10 IDX Simulator for ICD-9 to ICD-10 transition: This application that simulates the IDX revenue cycle management application which is used to input ICD-10 codes, thus providing hands-on practice before the go-live deadline of this transition revenue cycle

3.2.2 Key Clients

Our list of clients features prominent names in healthcare in the US as well as UK. These include:

- One of America's largest providers of hospital-based clinical outsourcing services that works collaboratively with hospitals and physician groups to deliver efficient, safe and patient centered care
- A leading US provider of home infusion therapies and services to over 20,000 patients every month

- One of the largest home healthcare company in America providing supplemental oxygen, ventilators, nebulizers, and sleep monitoring equipment and medication to patients; in addition, it also delivers home medical equipment such as walkers and hospital beds
- A UK based Client specializing in Private Medical Insurance, which is a joint venture between Prudential of the United Kingdom and Discovery Holdings of South Africa

3.2.3 Supporting Providers across their Revenue Cycle Landscape

With an in-depth understanding of providers' businesses, supported by a team of professionals with strong healthcare experience coupled with multiple proprietary tools, Intelenet has been delivering reliable back-office support across revenue-cycle functions.



Intelenet has extensive experience in Coding & Billing, Claim Submission, Payment Processing, Denial Management, Accounts Receivables, Patient Statements and Collections.

3.3 Case Studies

3.3.1 Case Study: A Leading Home Healthcare Company (Services: Billing & Collections, Customer Service)

Business Problem

One of the largest home healthcare company in America was looking for an outsourcing partner to better manage its billing & collections and customer support functions. The client was looking to outsource order processing, care support desk, AR management, and denial management functions.

What did we do?

- Supported the client's customer helpdesk through a single window support module for customer queries with reference to self-pay, from off-shore locations based out of Mumbai and Gurgaon

- Provided a partner site to the client for calling their patients (dialer + manual) for payment collection on the past due invoices
- Transitioned client's order processing and associated teams to Intelenet
 - Process Handled included Fax Intake, Revenue Confirmation, Suspended Billing, Electronic Payer Rejections, Patient Collections, Denial Management, etc.

What was the outcome?

- Improved inbound collections: Collected \$6 Mn in Patient Collections Inbound, an improvement of \$2 Mn from the Captive Centre's performance, and close to 50% improvement in Cash Flow from Patient Pay / Self Pay
- Greater outbound collections: Collected \$750,000 in Patient Collections Outbound, an improvement of \$150,000 from the Captive Centre's performance for the same period
- Reduced patient complaints by almost 75%
- Quicker customer issue resolution: Improved customer issue resolution TAT, following the implemented of a complaint tracker
- Adherence to COPC standards resulted in better operational efficiency

3.3.2 Case Study: A Provider of Hospital-based Clinical Outsourcing (Services: Billing & Collections, Medical Coding)

Business Problem

A leading provider of hospital-based clinical outsourcing services in the US wanted to gain market share within the U.S Emergency Room (ER) market, which was growing nationally because of reduced coverage & increased incidents. The client wanted to leverage global delivery and shared services models, allowing efficient service expansion and patient acquisition, while reducing costs and improving efficiencies.

What did we do?

- Hired and trained an off-shore medical coding team, as an extension of the client's billing operations
- Built a solution for consolidation, process transition, process standardization and exception based processing
- Provided ICD-9 CM Coding for Clinical Services across payer mix of Medicare; Medicaid; Commercial payers and the Blues
- Supported the entire ICD-9 to ICD-10 transition process; built an in-house simulator, which provides hands-on practice before the go-live deadline of this transition

What was the outcome?

- Process migration to the off-shore delivery center was completed in less than two months; coding processes & procedures were created in record time to ensure seamless delivery on client's Practice Management Systems
- The offshore team working as a multi-shift operation resulted in a reduction in TAT
- Improved accuracy and cycle times, minimizing revenue leakages

3.4 How Can Intelenet Help You?

As your trusted BPO partner, Intelenet will handle your back-office and support functions with greater efficiencies, reducing operational costs and streamlining processes through continuous improvements and technology adoption. We can assist you in managing your costs, delivering superior customer experience to overcome business challenges amid regulatory reforms, growing costs, and ICD-10 transition. You can rely on us for managing your back-office functions, so that you can increasingly focus on patient care to meet your long-term care quality goals.

Take the next step, Ask us how we can help

Contact us

Puneet Goyal , Practice Lead USHealthcare

USnumbers –

Puneet.goyal@intelenetglobal.com