

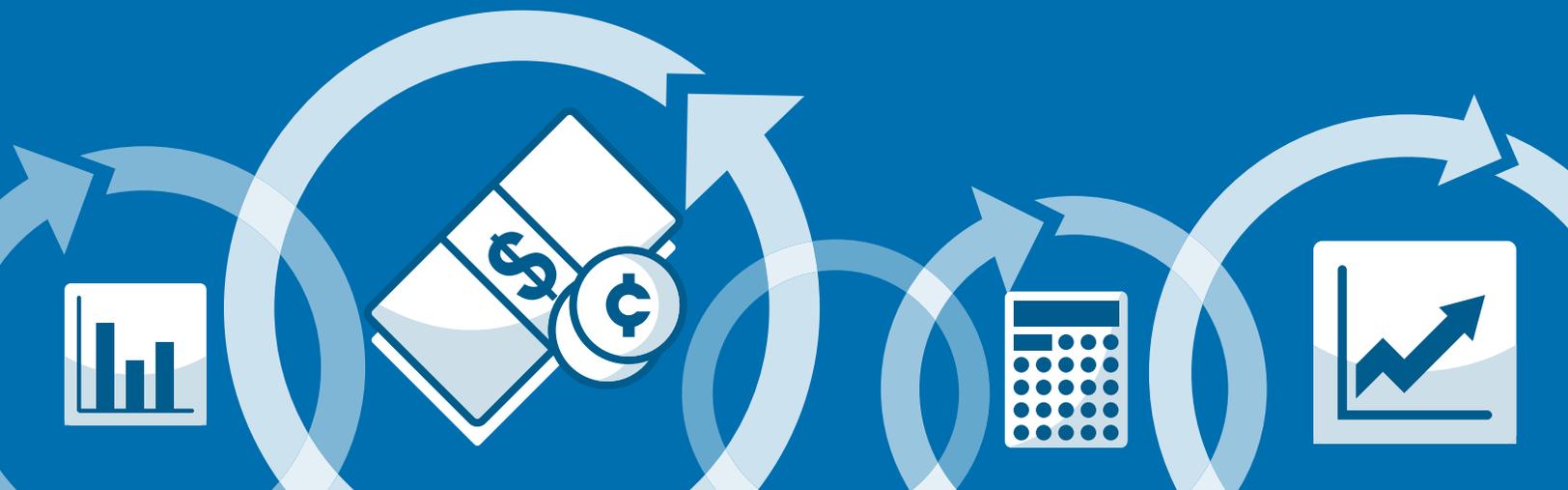
FROM SILOS TO SERVICES FOR VALUE-BASED CARE

A bundled payment program built by hand 25 years ago is still delivering lessons for HIT today



By Amy Larsson

RN, BSN, MBA, Vice President, Clinical
Claims Management



The evolution of healthcare IT systems seen by industry visionaries sounds great. Siloed clinical and insurance systems get connected and can work as one. Information-rich processes flow smoothly and securely over connected services that span care settings, providers, and payers.

We gain leaps in efficiency, quality, and accuracy of care coordination, delivery, and payment systems. And as healthcare evolves in its journey to value, we snap clinical and payment services together like the related pieces of the healthcare puzzle that they are, to keep up with changes and speed innovation.

Sign me up for healthcare interoperability! At a practical level, though, healthcare professionals are asking what does “interoperability” really mean? What barriers remain? How close are we today to that vision of tomorrow? When can we realistically expect to get there?

Good questions all. Our industry has made astonishing gains digitizing information, automating processes, and innovating payment models. And we are fast approaching a time when nearly all payment incorporates measures of value, with [payers now 58% and hospitals now 50% along the continuum to full value-based reimbursement \(VBR\)](#)¹.

These new payment models require providers and payers to collaborate as never before to achieve higher quality outcomes at lower cost. But that means our IT systems must be able to collaborate as never before, too. Despite other advances, the clinical and financial systems we need to make the best decisions and fully automate complex reimbursement models remain siloed, for the most part.

To make VBR work, we must achieve interoperability at scale—and that means across payer, provider, and vendor lines. We must unlock these silos and shift to true healthcare interoperability if we are ever to realize the long-sought-after goals of higher quality care delivery; and better outcomes for patients in an efficient, cost-effective healthcare system.

¹ Journey to Value: The State of Value-Based Reimbursement in 2016, a national study of 465 payers and hospitals conducted by ORC International and commissioned by McKesson.

A BUNDLE OF INSIGHTS

That's a tall order for an industry that hasn't always had the technical standards to define how systems should work together, the competitive market dynamics (i.e., the transition to value, competing vendor systems) or, perhaps most important, the evidence showing how connected systems can unleash profound benefits for administrative and medical cost reduction, and improved outcomes.

I was fortunate enough to see and experience the impact of interoperability early in my career in a small way, at a single institution—and long before “interoperability” was a buzzword. That experience taught me that clinical and financial interoperability was the missing link for bending the healthcare cost curve and improving care quality.

In 1991, I joined a transplant team at an academic medical center in a newly defined role: “transplant insurance coordinator.” Today that position would be referred to as a “nurse navigator.”

In those days our team faced a fundamental challenge common to healthcare professionals everywhere. Once our physicians decided on a particular care path, our transplant patients needed to be treated quickly. But securing authorizations from insurance providers was time-consuming. We also often encountered unexpected variations in coverage that created more delays and required us to make different decisions.

As the new insurance coordinator, my job was to help facilitate that process by clarifying benefits; determining financial parameters; coordinating referrals; and explaining the financial implications to the care team, patients, and their families. We quickly discovered that we needed a way to align insurance information with clinical information in order to process approvals more efficiently, and free our physicians and nurses to focus more on the clinical aspects of care instead of administration and paperwork.

Our solution was to build a database that integrated benefits, coverage limits, and referral information. Through this, we began to see patterns in referrals, utilization, approval patterns, and the administration of benefits that gave us the ability to drive process improvements and reduce costs.

For example, insights into referral patterns helped us establish a network of physicians with the expertise, qualifications, and capabilities to work with transplant patients. This, in turn, helped us negotiate “case rate” contracts with insurers, and then refer our patients to physicians who were in our network and willing to work under the terms and conditions of a predetermined rate.

The network information was also shared with the care team and patients. This helped ensure their care was coordinated and could be more cost-effective because they stayed in the program. Lastly, outcome data was shared with payers to tie the clinical quality of the care with the program.

Sound familiar? Twenty-five years later, that type of contract for an episode of care would be called a bundled payment arrangement. By unlocking silos, bringing information together, and aligning the processes, we revealed clinical and financial insights that helped improve the quality, cost-effectiveness, and administrative efficiency of the care we provided our patients.

STILL SILOED AFTER ALL THESE YEARS

As we started to build our database, one thing quickly became clear: *This was how clinical care should work for every patient in every subset of medical need.* The problem? A quarter-century ago, most of the data entry and analysis had to be done manually across our network of care settings and physicians. When we needed data from another system, it had to be requested, extracted, and then re-entered into the database manually or through an import function.

That challenge was compounded by a larger problem. Every system and function we worked with was a stand-alone silo that couldn't be connected to anything else. For instance, while we were able to extract, load, and then combine payer and referral data in our transplant work, that information wasn't connected to our revenue cycle system.

Likewise, our clinical research group used multiple worksheets to track patient information and manually enter data into a separate research database—but they weren't connected to the system nurses used to record data in the hospital record. We had to manually combine the research and outcome data with the financial data to reveal patterns of complications rates and long-term survival trends with cost data. This let us adjust our case-rate-per-treatment protocol based on patient outcomes.

Fast-forward 25 years. Much of the information payers and providers work with today is digital. Much of the workflow and processing is automated. It's not perfect nor is it complete end to end—we still see a lot of paper forms, faxing, and phone calls when dealing with authorizations, for example—but we've come a long way on the digital automation front.

We can digitally share information about the patient's obligation and responsibility, clear patients, authorize approvals, direct patients to the right clinicians in a network, automatically edit and adjudicate claims, and more. But here's the rub: We have digitized massive amounts of information and automated complex processes that *remain largely locked in traditional silos.*

We still can't move, apply business rules to, or transact information along a unified workflow that crosses silos autonomously—and that means payer, provider, and vendor boundaries. This is the

barrier impeding healthcare's progress in our journey to value-based care, and reduces our ability to drive to better outcomes.

THE INTEROPERABILITY IMPERATIVE

To see how interoperability facilitates value-based care and reimbursement, consider the rapidly rising use of bundled payment models today and the challenges payers and providers alike face in designing, contracting, implementing, scaling, and analyzing them.

A June study of 465 payers and hospitals conducted by ORC International and commissioned by McKesson found bundled payment will account for 17% of medical spend by 2021.² Underscoring that projection, in July the CMS³ introduced a plan to mandate bundled payment around three new care episodes: treatment for acute myocardial infarction, coronary artery bypass grafts, and hip or femoral fractures.

But according to ORC's research, just half of payers and only 40% of providers said they're ready to implement bundles, and only a quarter of respondents said they had the tools in place to automate these complex models—not to mention connect the requisite legacy and contemporary systems so as to make them interoperable.

Sadly, these challenges have changed little since my days as a transplant insurance coordinator. What has changed, though, is our ability to solve them through HIT automation and, increasingly, interoperable solutions. But it's a chicken and egg situation. While the technology is available, payers and providers must commit to modernizing their HIT, because the increasing complexity of alternative payment can't be addressed with siloed automation alone.

McKesson anticipated the rise in bundled payment and has been investing in development of technologies to simplify, automate, connect, and scale these programs since 2010. That sounds like boastful marketing speak, but the truth is we were too far ahead of the curve. We piloted our first bundled payment platform in 2011. The program worked, we developed know-how and experience, and we created a product. But the market wasn't ready.

It's ready now. And that's why, more recently, McKesson revealed our \$15 million investment to build the McKesson Intelligence Hub™, our enabling platform for interoperability between our

applications, as well as between our customers' systems. It's all about unlocking silos to unleash value for an industry moving to value. As a result, we're now well positioned to have the interoperability infrastructure in place to simplify, automate, and connect episode management.

² Journey to Value: The State of Value-Based Reimbursement in 2016, a new national study of 465 payers and hospitals conducted by ORC International and commissioned by McKesson.

³ [Notice of proposed rulemaking for bundled payment models for high-quality, coordinated cardiac and hip fracture care](#)

VALUE-BASED CONNECTIONS IN ACTION

Using bundled payment as an example, here's what unlocking silos to unleash value could look like. Let's say a physician determines that a patient needs a knee replacement. That diagnosis and order would be introduced into the hospital's EMR system and would automatically generate all the medical necessity information.

That information would be instantly transmitted to the payer and run through their authorization process, automated using an exception-based UM (utilization management) model where the majority of authorizations would be untouched by human hands. If it meets authorization, that approval information would bounce back to the clinician. This would happen in minutes if not seconds. In this vision, there's no separate process or tools, no paperwork, no faxing, no phone calls.

The clinician or care team can then inform the patient which centers do knee replacements as part of the bundled payment arrangement, to help minimize or eliminate the patient's out-of-pocket expense. The patient would also learn about other services, such as care coordination and physical therapy, through specific service providers that are included in the bundle. The provider information would be automated, accurate, and available on demand, because the requisite systems would be connected to a central repository—a single point of truth on the payer's provider networks.

Meanwhile, the payer would have automatically received a "trigger" (notice) that one of its members is going to get a knee replacement. As the claims start arriving, they would be automatically parsed, processed, and paid as part of the bundled payment arrangement. Example: when the patient goes to lab services for pre-admission testing. The payer would automatically know it's not paying for that using fee-for-service; rather, it's part of the bundle their integrated systems knew was coming.

Likewise for other services (surgeon's bill, anesthesiologist, hospital, outpatient radiology, physical therapy, lab work, and so on). In the end, one bill would be automatically compiled and move through the system. Using McKesson's solutions as an illustration, this would happen because the payment side was automated and connected through authorizations, network management, contracting,

and payment. That's how the payer would know who's part of the program, who's not part of the program, what's in the contract, what's the reimbursement, and how to automate the payment accurately.

Moreover, it's possible the payer would have configured the episode using our HealthQx® bundled payment solution and then sat shoulder-to-shoulder with providers to devise the program in the first place using Contract Modeling, which would then automatically generate the contract and rate schedules via McKesson Contract Manager™ and McKesson Reimbursement Manager™.

This is how medical policy, payment policy, value-based reimbursement models, provider management, and contract management can be automated today and could be connected tomorrow, through the Intelligence Hub, to help unlock immense value now trapped in information and automation silos.

Interactive dashboards would allow clinicians to see episodes as they are happening, so they could intervene, connected to the clinical and financial information. The clinical data would be aggregated with financial trends to determine the effectiveness of value-based programs, allowing setting of KPIs, to assess outcomes. With this type of feedback mechanism, the care paths could be enhanced in a continuous process that gets reflected in the financial trends.

ON THE CUSP OF THE NEXT BIG ADVANCE

The degree of automation and streamlining that results from today's McKesson portfolio is very powerful, and can help decrease manual effort, administrative expense, and delays that are baked into the payment system—as well as help enable claims payment accuracy. Each claim has to meet clinical guidelines that determine how the claim is paid, comply with contract terms, and conform to the relationships payers have with providers.

As a result, payments can be faster, more accurate, and more aligned to clinical guidelines. Providers can reduce or avoid costly audits, retrospective looks, and the delays that contribute to bad debt. Physicians can focus more on clinical care rather than payment processing or coverage options. Patients can be less burdened by the need to coordinate with payers and providers to make corrections to their bills or determine where they should get care to maximize their benefits, and can pay what they actually owe.

The time has come to tear down the silos. It is crucial that our HIT systems be capable of collaborating digitally just as payers and providers collaborate in the real world. The time has come to start unlocking and integrating the clinical and financial data and processes we need to make the best decisions and help automate reimbursement models end to end.

In our push toward value-based care, we've come a tremendous way since the early days of separate manual databases and case rate contracts. Winning the hearts and minds of payers, providers, and technology vendors; innovating, piloting, incentivizing, and even mandating new payment models—these are all important steps in the journey to value. But they only get us so far. Interoperability is the next essential step on our journey to value.

<http://www.McKesson.com>
<http://www.McKessonHealthSolutions.com>

Copyright © 2016 by McKesson Corporation and/or one of its subsidiaries. All rights reserved.

McKesson Health Solutions

McKesson Corporation

275 Grove Street
Newton, MA 02466
1.800.782.1334

<http://www.mckesson.com>
<http://www.mckessonhs.com>
<http://www.contactmhs.com>
<http://www.mhsdialogue.com>