MILLIMAN CASE STUDY

Process improvements lead to increased value-based care program revenue for physician practice

Laurie Lingefelt, RN, BSN

Client profile

A family physician practice consisting of more than 60 practitioners spread across 18 sites had recently been acquired by a private equity firm. The firm wanted to improve the financial performance of the practice with a strategic plan that would increase revenue and improve contractual terms with its payers.

Challenge

After preliminary investigation, it was evident the practice was not realizing the maximum payouts available from the value-based care programs in which it participated. The practice staff's lack of knowledge of payer contracts, numerous gaps in patient care, and low scores on most of its quality performance targets contributed to the shortfalls. Numerous workflow issues also impeded systematic capture and reporting of patient care activities.

Approach

To address these issues, we first gained an understanding of the current state of the practice. We performed a review of all commercial payer contracts to determine the key drivers of revenue. We also administered a survey of all clinical staff and practitioners to assess the staff's knowledge level of population health management, patient-centered medical home processes, documentation standards, and workflows used across the sites. Finally, we analyzed reimbursement related to quality performance on all levels and from all payers, commercial and governmental.

Following the assessment, we developed a three-tiered action plan, focusing on the following key areas deemed critical to achieving the goal of increased revenue:

1. **Improving** quality performance to trigger higher reimbursement from payers.
2. **Identifying** and closing gaps in patient care.
3. **Developing** a system that supports the transition to value-based payment and population health.

This action plan was developed and implemented with input from senior leaders in the practice, practitioners, and nonclinical staff from all departments. In order to facilitate implementation of the action steps, a software vendor was hired to assist with system and reporting enhancements and temporary medical assistants were hired until appropriate internal staff could be hired and trained.

Solution

The practice established a Quality Department and began working on developing processes and workflows designed to maximize reimbursement from all value-based care programs. It implemented a quality measure code sheet to assist with documentation, transition of care protocols, and a wellness program, and it established regular internal team huddles as well as monthly meetings with quality care team members from each of the payers. The transition of care process improvement effort involved a team approach taken with the local community hospital. The practice established a data feed enabling it to receive daily updates on emergency room (ER) admissions, ER discharges, and hospital admits and discharges for its patients.

Results

The practice reported additional reimbursement due to better documentation and coding and also reported a significant increase in quality incentive payments. It saw a 20% increase in the number of wellness visits, which helped to address gaps in care, improve physician performance ratings, and increase fee-for-service revenue. The additional quality incentive payments and increases in fee-for-service reimbursement resulted in an approximate 5% increase in annual gross revenue, net of annual fee schedule increases. Because of the improvement in processes and physician engagement needed to succeed in a risk-sharing program, the practice joined an accountable care organization (ACO) the following year.

CONTACTS
Laurie Lingefelt
laurie.lingefelt@milliman.com

Rod Martin
rod.martin@milliman.com