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The Changing Nature of Healthcare and its Effects on the Revenue Cycle

Looking Back 50 Years and Forward to 2020

Presented By:
Doug Fenstermaker,
Managing Partner & E.V.P. Healthcare
Warbird Consulting Partners

“We cannot solve our problems with the same thinking we used when we created them.”

Albert Einstein

Learning Objectives

- Gain an understanding of how the revenue cycle has evolved
- Discuss options hospitals have for revenue cycle going forward
- Describe efficiencies and ROI for each piece of the revenue cycle

> *“The only source of knowledge is experience.”*
>
> Albert Einstein

Past: Looking Back 50 Years

Timeline Overview

Historical Background

1965

President Lyndon B. Johnson signed into law the bill that led to Medicare and Medicaid

1970s

Medical costs rapidly escalate now that millions more are insured

1983

Medicare introduces Diagnostic Related Groups (DRGs) as prospective payment system

Effects on Revenue Cycle

With the combination of Medicare, Medicaid and insurance, it required a quantum leap for hospitals/physicians to bill and collect

Cost-based reimbursement (cost reports) and Periodic Interim Payments (PIPs)

Costs get out of control, transitioned from cost-based to fixed-rate basis for DRGs

Timeline Overview

Historical Background

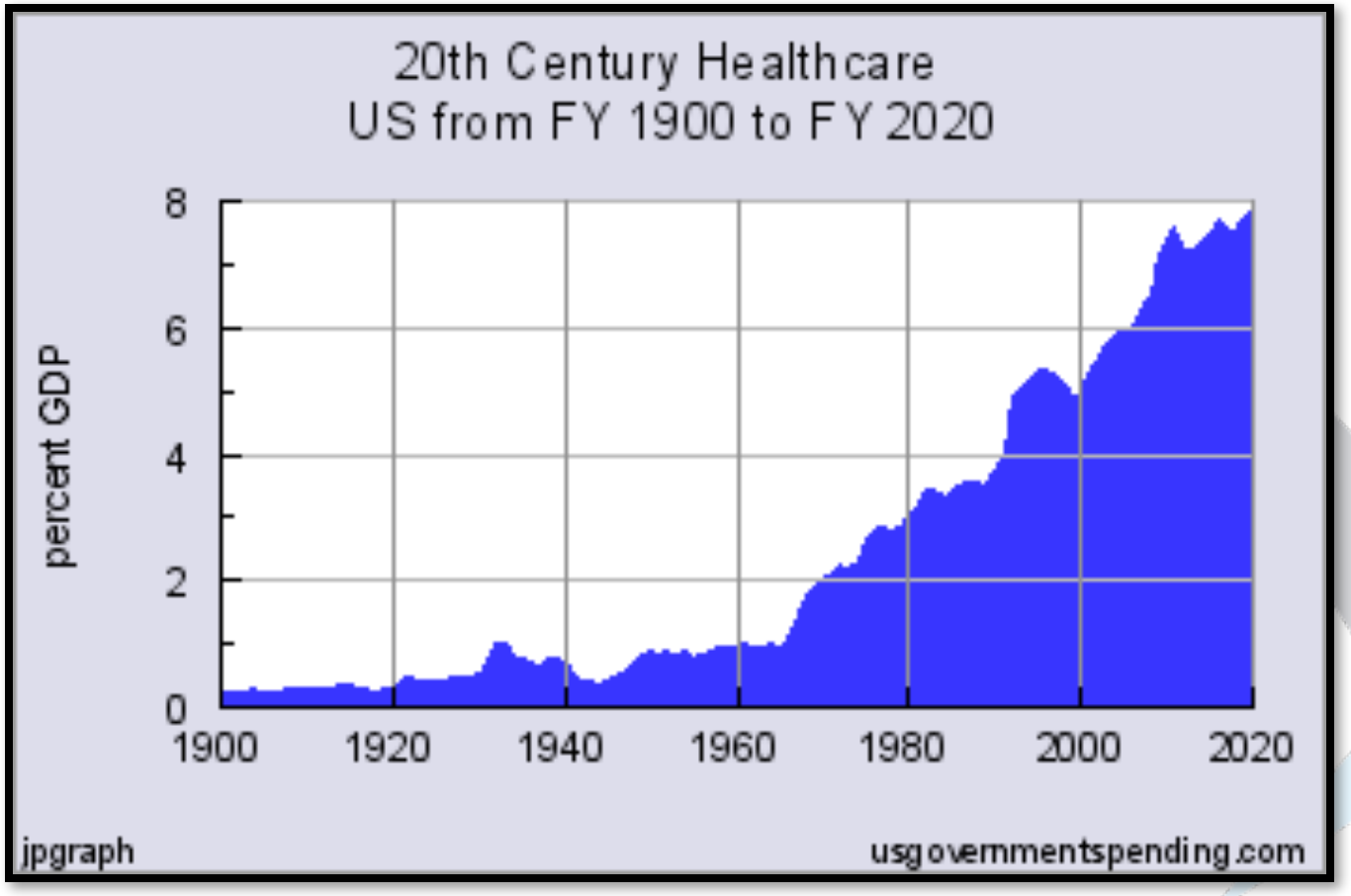
1985	1990s	2000s
Dale Stockamp took just-in-time principles and applied them in hospital revenue cycle	Health Security Act failed; Health Insurance Portability and Accountability Act (HIPPA) put into effect; Balanced Budget Act passed	Medicare Drug Improvement and Modernization Act passed

Effects on Revenue Cycle

1985	1990s	2000s
Industry took notice of benefits and also started applying these principles	Healthcare costs rise at double rate of inflation; Expansion of managed care helps temporarily moderate increase in healthcare costs	Healthcare costs rise again; Medicare is viewed by some as unsustainable under present structure

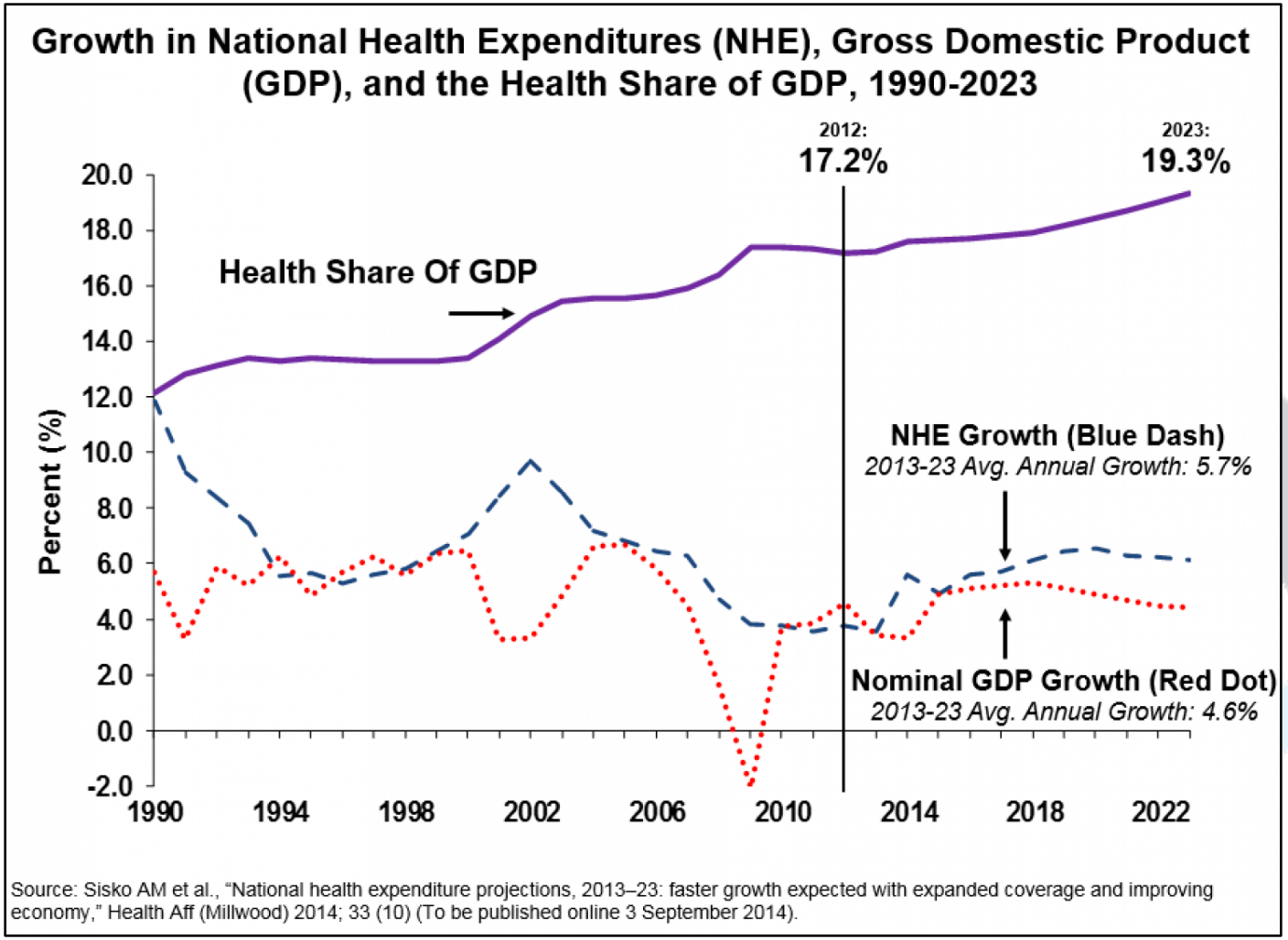
The Context for Change

What governments have spent on healthcare since 1900



The Context for Change

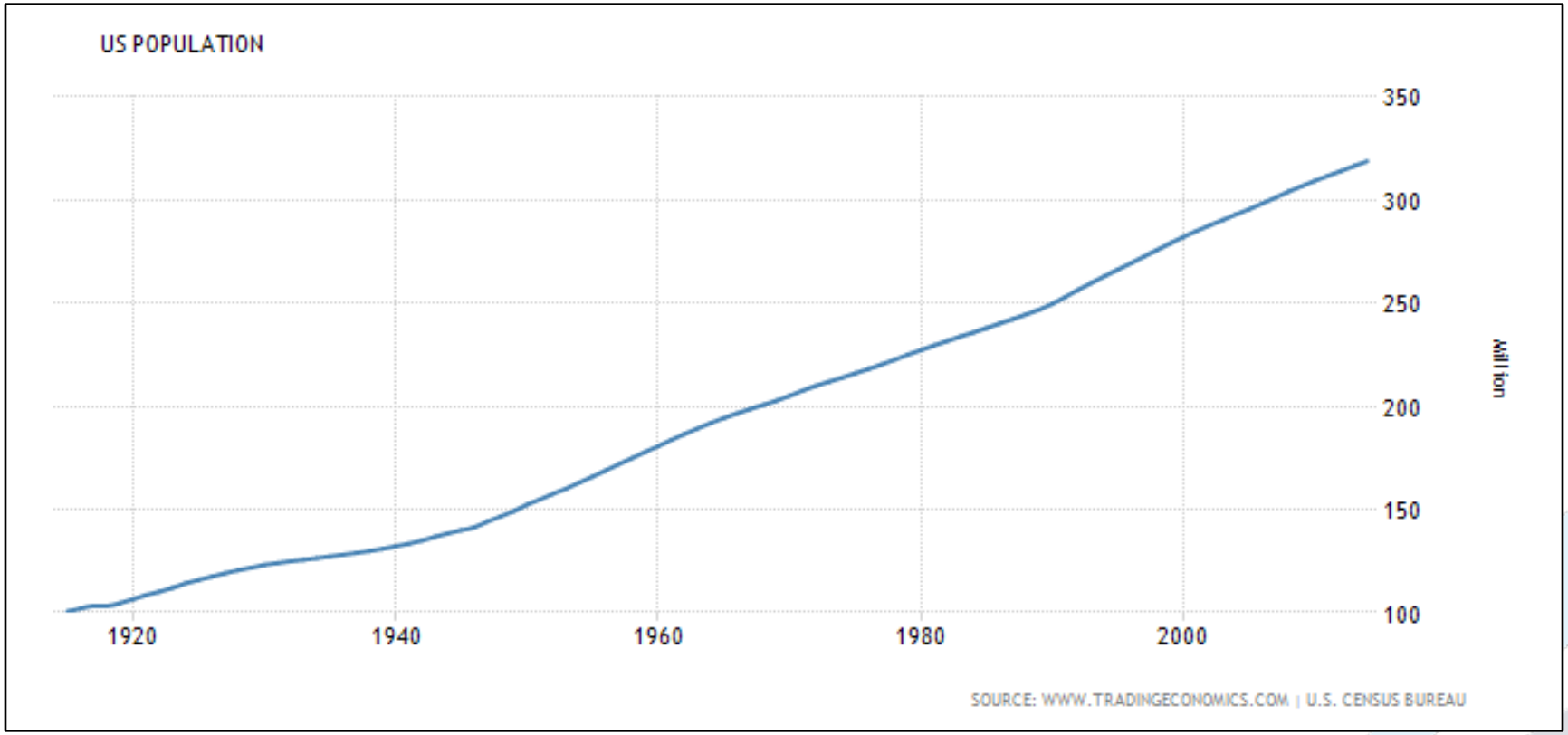
Overall National Healthcare Expenditures since 1990, as a percent of GDP



Source: Sisko AM et al., "National health expenditure projections, 2013–23: faster growth expected with expanded coverage and improving economy," Health Aff (Millwood) 2014; 33 (10) (To be published online 3 September 2014).

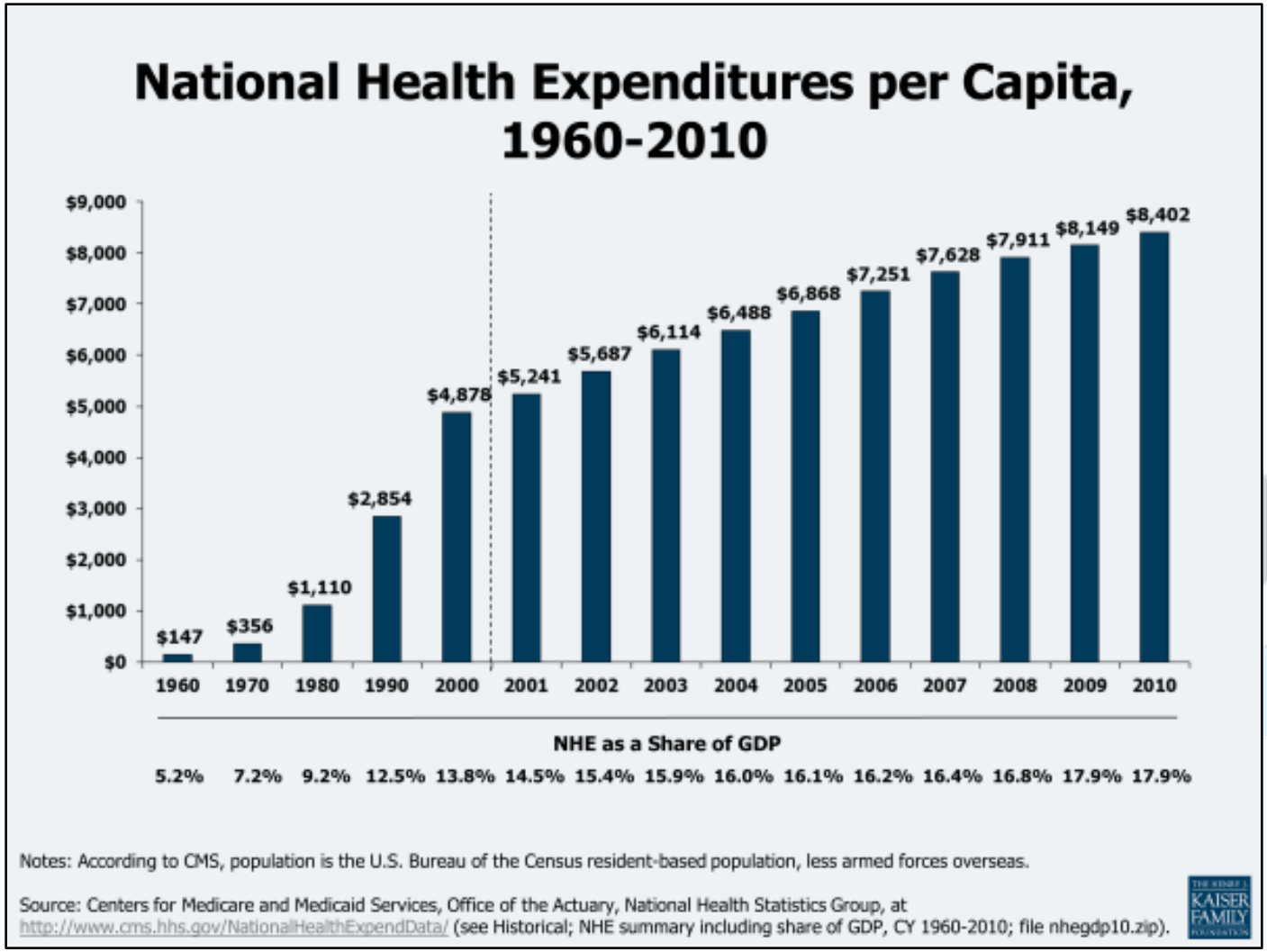
The Context for Change

Change in population in US since 1900



The Context for Change

National Health Expenditures per Capita in the U.S.



1965: The Impact of Medicare and Medicaid

- Required hospitals and physicians to bill and collect
- Charity care was a big component of payment prior to billing and collecting
- Medicare was vastly resisted

Nurses serve patient meals at the Johns Hopkins Hospital Women's Clinic, 1939.

Source: *http://web.jhu.edu/jhnmagazine/spring2010/departments/on_pulse.html*

1970s: Cost-based Reimbursement and PIPs

- Real growth took place in 1970s
  - Original Medicare program was cost-based reimbursement then added Periodic Interim Payments (PIPs)
  - Hospitals submitted cost reports and the federal government provides an interim payment

1983: Introduction of DRGs

- Huge impact on hospitals
- Costs getting out of control – transition from cost-based to fixed-rate basis, multiple studies done on what the rate would be based on care
- Hospitals had basic billing systems – lots of issues with the process of information flow (very manual)
- Medical records (now Healthcare Information Management) became core to the ability for hospitals to bill Medicare and Medicaid for the first time
- Groupers were required to produce 475 DRGs
- Hospitals were not efficient and IT systems were rudimentary for billing and collections

1985: Process Reengineering Introduced

- In 1985, Dale Stockamp of Stockamp & Associates applied just-in-time process flow principles into billing and collections – attaining accurate information from beginning to end
- The industry took notice and saw the benefits of applying these principles
- New concept: The billing and collections is a cycle of a process from the point of which the patient comes to the hospital to the point where they're discharged

  ** The birth of Revenue Cycle **
- IT systems and financial consulting firms expanded to assist hospitals in managing or reengineering their revenue cycles; both for government and non-government payers

1990s: HIPPA Introduced

- Health Security Act ("Hillarycare") failed
  - Highly effective ad campaign "Harry and Louise" was instrumental in helping this fail
- Health Insurance Portability and Accountability Act (HIPAA) restricted conditions in health insurance coverage determination, set standards for medical records privacy, and established tax favored treatment of Long Term Care Insurance
- Healthcare at this time caused costs to rise at double the rate of inflation
- Major expansion of the "cost shift" from government payers to private insurers
  - Causing massive increasing in cost to employers and sometimes employees
  - Employers dropped insurance coverage, expanding the uninsured population
- Expansion of managed care helps moderate increase in healthcare costs
  - Introduction of capitation in many markets
  - Pre-authorization and controlling access makes HMOs unpopular
  - Many communities attempting to emulate Kaiser Permanente form of care delivery
- Estimated 42.4 million uninsured in United States

1997: Balanced Budget Act

- $160 billion in spending reduction between 1998-2002
- Netted down to $127 billion due to welfare and children's care
- Medicare and Medicaid - $112 billion of which inpatient and outpatient services was $44 billion

2000s: Healthcare Costs Rise Again

- Medicare Drug Improvement and Modernization Act (MMA) creating a voluntary subsidized prescription drug benefit
- Healthcare costs are on the rise again
- Medicare is viewed by some as unsustainable under the present structure and must be “rescued”
  - Little if no political will to do so
- Ambulatory Payment Classifications (APCs) – the government’s method of paying facilities for outpatient services for the Medicare program. Created a new Medicare “Outpatient Prospective Payment System” (OPPS), an outpatient version of DRGs

Late 1990s into 2000s

Identification of…

Revenue Risk

- Increasing number of patients in "risky environments" (sub-acute)
- Patients getting "risky services" in post-discharge environments
- Providers who "over-utilize"
- Patients who "over-utilize" service"
- Facilities who are "high priced"

Cost Drivers

- Long Length of Hospital Stays (LOS)
- High Hospital Bed Day Rates (bed days/1000)
- Higher pressure for early discharge and outpatient surgical services
- Overutilization of Sub-Acute Care, Home Care, Hospice Care

Cost Controls

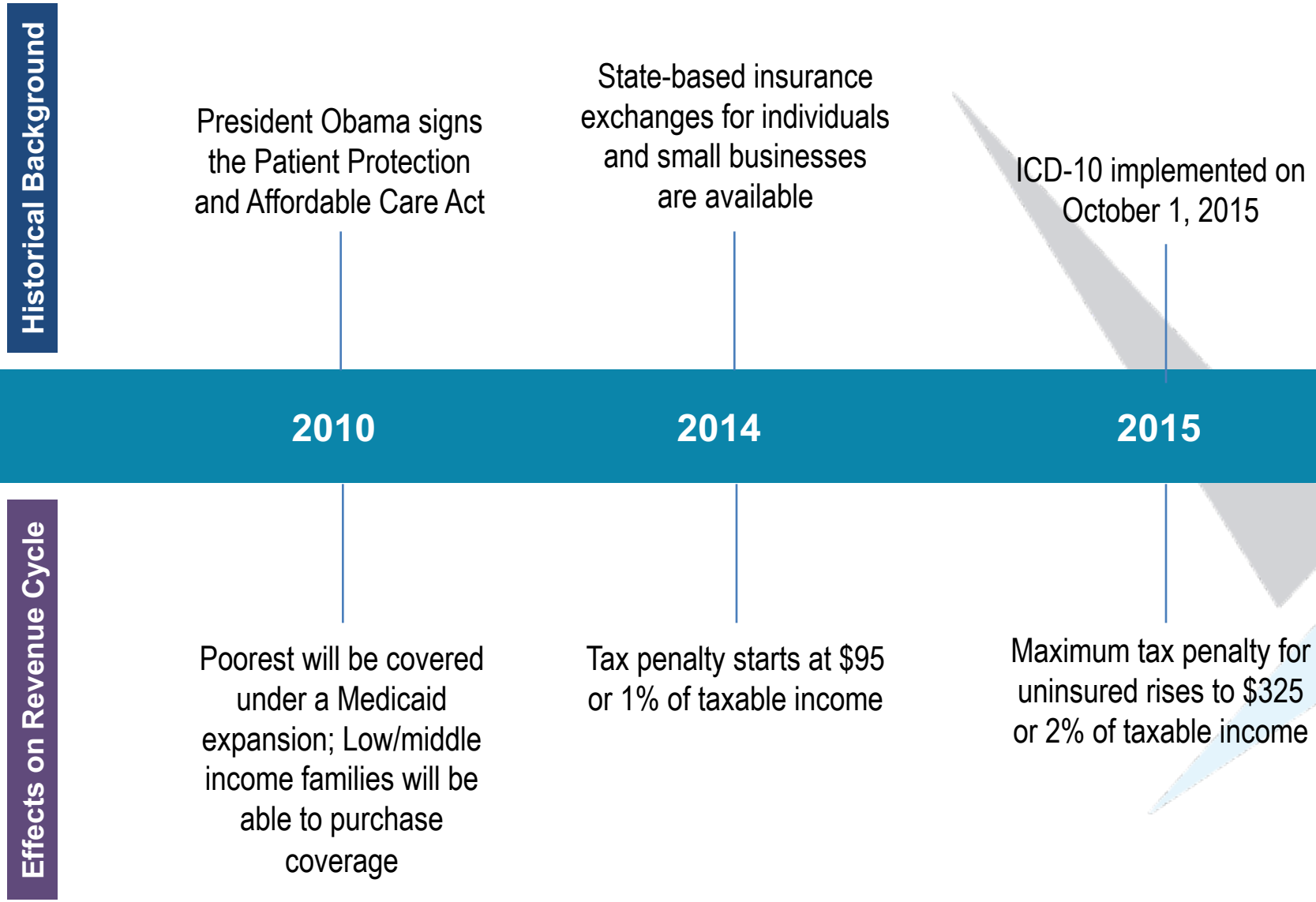
- Capitation for specialists (PMPM)
- Moving PCPs to "Fee for Service" away from capitation
- Carve outs for Disease Management Providers (global payment, e.g. St. Luke's Cardiology) and select procedures (particularly in orthopedics)
- Intense medical management at insurance plan
- Daily hospital utilization review (nurse on site)
- Preauthorization for outpatient services
- Aggressive "Fee for Service" hospital contracting

“Insanity: doing the same thing over and over again and expecting different results.”

Albert Einstein

Present: Looking at 2010-2015

Timeline Overview



2010: Patient Protection and Affordable Care Act Signed

- President Obama signs the Affordable Care Act
- The poorest will be covered under a Medicaid expansion
- Low and middle income families who do not have access to health coverage due to cost will able to purchase coverage with federal subsidies
- Employers not mandated to provide health benefits; but large businesses who's employees receive insurance subsides will pay penalties. "Cadillac" health plans are penalized.
- Healthcare plans will not be allowed to deny coverage
- Young adults will have the option of being covered under their parent's plan up to age 26
- Two major supreme court tests of the PPACA law
  - One modified Medicaid component of the law as it related to the states
  - Second one failed

2014: State-based or Federal Exchanges

- State-based or federal insurance exchanges for individuals and small business is available utilizing four standard levels of care

- Tax penalty starts at $95 or 1% of taxable income and thereafter

2015: ICD-10 Implemented

- ICD-10 implemented on October 1, 2015 after 2 year delay
  - Soft implementation for hospitals for the first year, but not physicians

- Maximum tax penalty for not having insurance rises to $325 per year or 2% of taxable income

2012 into 2015

Identification of…

Revenue Risk

- Analytic applications to pre-determine risk and measure **over**-utilization
- Benchmarks to measure variations in outcomes
- Evaluation of community needs and services (Especially in light of Ebola)
- Shift from Volume-based Reimbursement to Valued-based Reimbursement
- Accumulation of all data depositories to analyze and measure trends

Cost Drivers

- Health plan limits on medical costs
- Reduction or elimination of small group insurance
- Shift from employer paid plans to private exchanges
- Shifting insurance plan's administrative medical costs to providers
- "Pay for Performance" measures introduced and tested
- 2009 HI-TECH Act for economic and clinical health - $27 billion (Meaningful Use process)

Cost Controls

- "Payment Incentive" Contracting with all health care providers
- Detailed medical coding (ICD-10) to define global fee contracting (Delayed until October 1, 2015)
- Significant reduction or complete elimination of medical management by insurance plan – shifted to providers
- Rise of fully integrated real-time data systems via ERP systems (e.g. Epic, Cerner)

> ***The mere formulation of a problem is <u>far more essential than its solution</u>, which may be merely a matter of mathematical or experimental skills. To raise new questions, new possibilities, to regard old problems from a <u>new angle</u> require creative imagination and marks real advances in science.***

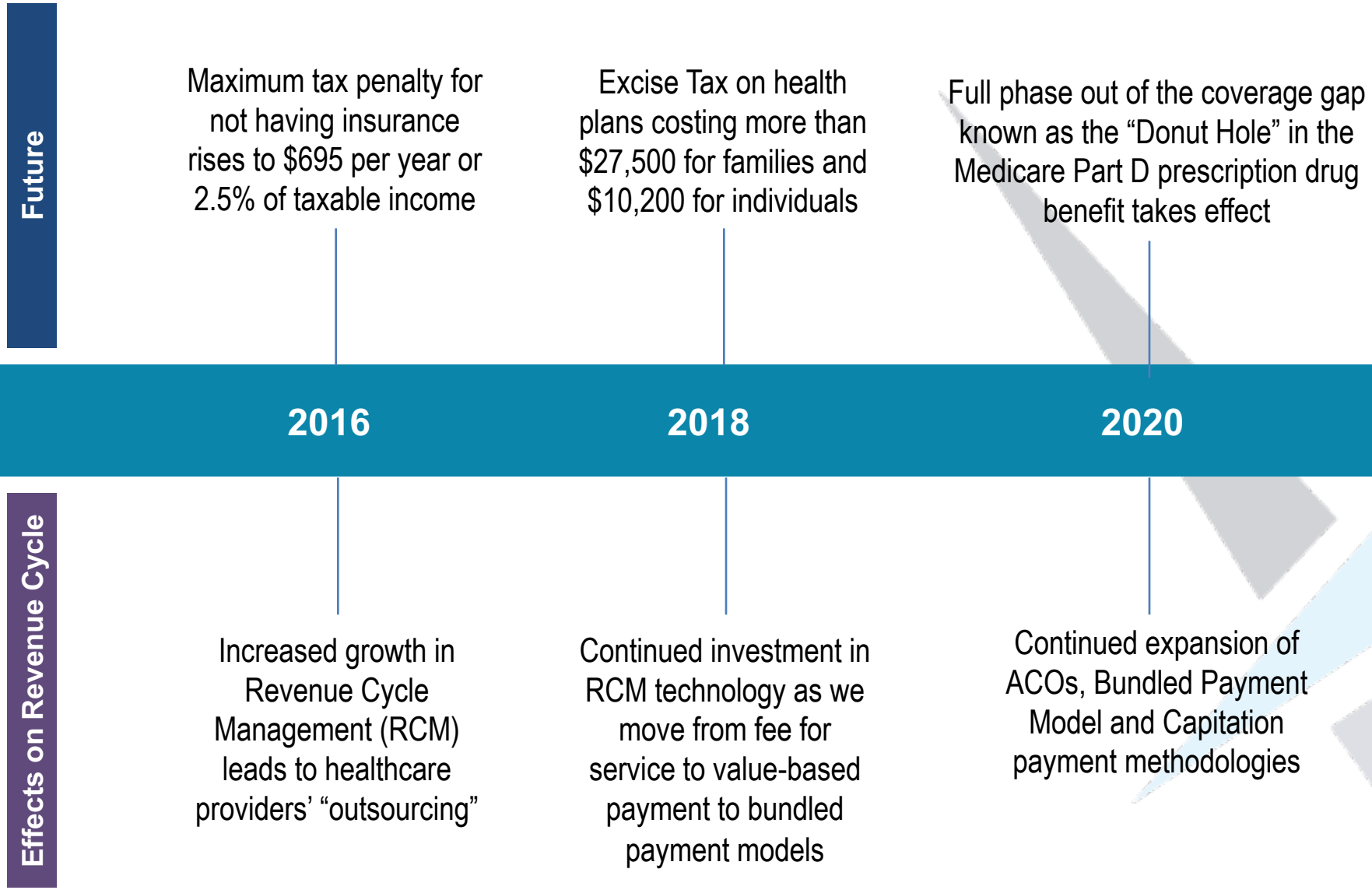
Albert Einstein

Future: Forward to 2020

> ***When you come to a fork in the road, take it.***

Yogi Berra

Timeline Overview



2016

- Increased growth in Revenue Cycle Management (RCM) leads to healthcare providers'; major reengineering, incremental improvements, partial or total outsourcing
- Prioritize technology investments (both capital and operating): complete application portfolio assessments and improvements/streamlining
- Consolidation of hospitals into larger healthcare systems through mergers and acquisitions

"Resurgence of Old Ideas for the New Times"

- **Accountable Care Organization (ACO)** expansion that is accountable for managing and coordinating the care for a defined group of patients in an effective and efficient manner
- **Development of Bundled Payments Model** (or "Case Rates or Episode-based Care-single Payment") that includes all services related to specific treatment or condition possible spanning multiple providers in multiple settings
- **Growth of Capitation** (Lump sum, per person payment to providers to provide all care for specific individuals or group) utilizing a "Per Member Per Month" (PMPM) – Payment Methodology for Providers

2018 – Revenue Cycle Expectations

- Continued investment in RCM technology as we move from fee for service to value-based payments, bundled payment models and other more complex reimbursement models

- Continued outsourcing (smaller and medium-sized hospitals) and consolidation with more stable healthcare systems

- Continued expansion of ACOs, Bundled Payment Model, and Capitation payment methodologies

Future into 2020

Identification of…

Revenue Risk

- Population based medicine
- Predictive analytic applications to pre-determine risk, concurrent forecast utilization and measure **under**-utilization (readmissions)
- Demonstrating value of mergers and acquisitions to all stakeholders
- Aggregation of huge, integrated data depositories to analyze and measure trends
- Computer generated analytics to alert for clinical and financial interventions
- Computer assisted decision support engines

Cost Drivers

- Sufficient evidence based on multiple aspects of care and cost
- Mergers and acquisitions of large group insurance (e.g. Anthem and Cigna July 2015)
- Development and pricing of new clinical technologies
- Revenue cycle systems that can distribute PMPM reimbursement
- Payment incentives driving volume for high cost services

Cost Controls

- Valued-based purchasing based on “outcomes”
- Need to build technology systems (integrated & connected)
- Consider options for health information that meets “meaningful use” and reimbursement
- Technology systems that allow seamless integration for exchange and flexibility in capturing data within regions of the country and across the U.S.

Future: Accountable Care Organizations (ACO)

- **ACO:** refers to a legal entity composed of a group of providers that assume responsibility (are accountable) to manage and coordinate care for a defined group of patients in an effective (high quality) and efficient (low cost) manner.

Who is included in ACOs?

- Primary Care Providers
- Specialty Providers
- Hospitals
- Insurance Companies

Payment Options:

- Shared Savings
- Partial Capitation/Bundled Payment Models
- Full Capitation

*** Payment model addresses how ACO is paid, ***not*** how ACO will distribute funds to participating providers. **The latter is a major issue.**

- ACO Shared Savings Incentive Model-Based on Quality Measurements – 33 Quality Measures 4 Key Domains: (1) Patient/Caregiver experience, (2) Preventive health, (3) Care coordination/patient safety and (4) At-risk populations

Source: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Quality_Measures_Standards.html

Future: Accountable Care Organizations (ACO)

Important to obtain good legal advice when forming an ACO:

- Federal Antitrust Law
- Federal Physician Self-Referral (Stark) Law
- Federal Anti-Kickback Law
- Federal Services Reduction and Beneficiary Inducement Civil Monetary Penalty Laws

Issues:

- Risk Adjustment: Remains Imperfect
- How big or small is size? Is not clear
- Providers keeping on actuary based risk without actuaries (underwriting)
- ACO: Insure and Enforcer? Unanswered Question
- Managing populations that have high coal morbidities and chronic disease
- Hospitals who go on ACOs take on risk-based reserving requirements: impacts on P&L and balance sheets
- Other issues: Rural Area ACO (Critical Mass Issue, critical care hospitals), Medical Tourists/Snowbirds? Patients who goes outside the ACO? High-risk/Non-complaint Exclusions and academic medical centers who have a different mission

Future: Bundled Payments

- Known as “Case Rates” or “Episode-based Care-single payment” for all services related to specific treatment or condition possible spanning multiple providers in multiple setting. Example: Coronary Artery Bypass Graft Surgery (CABG)
- Providers assume financial risk for the cost of services for a particular treatment or condition as well as costs associated with preventable complications
- **Goals:**
  - Close working relationships between hospitals and specialist physicians
  - Reduce spending: computer-assisted clinical pathways with agreement by physicians
  - Based on design of the payment system
  - Eliminate unnecessary services and reduce cost: 80/20 rule more effective management of the 20% of patients that represent 80% of the healthcare costs

- **Ten Performance Dimensions:**
  - Physician support and cooperation
  - Spending
  - Waste
  - Patient Experience
  - Coverage
  - Operational Feasibility
  - Consumer Financial Risk
  - Reliability
  - Health
  - Capacity

Future: Bundled Payments

Issues:

- Providers risk large losses due to catastrophic event
- Re-insurance mechanism may needed to convince providers to accept bundle payments
- Multiple bundles that overlap each other
- Some illnesses may not fit into an “episode”
- Financial Risk: Administrative and Operational Burden establishing compensation rates
- Hospitals maximize profit by limiting access to specialists
- Providers may avoid patient with limited reimbursement
- Does not discourage unnecessary episodes of care
- Scientific evidence very limited with uncertain outcomes
  - Measurement of physician outcome performance is complex, fragmented and patient age/disease related

However, it is feasible – example:

- 1984: Dr. Cooley at The Texas Heart Institute began to charge flat fees for both hospitals and physician services for cardiovascular surgeries. Institute claims the approach “Maintained a high quality of care while lowering cost”
- 1985: Coronary Artery Bypass Surgery at the institute was $13,800 versus the average Medicare payment of $24,588

Future: Bundled Payments

Impact to Revenue Cycle:

- Need sound system and strategies in place
- Need good contract management system
- Good communication across departments is critical
  - Understanding accountability and ownership of the changes
- Need accurate payment distribution mechanisms for tracking and reporting
- Aligned physician compensation and incentives
- Proper accounting for posting and distribution of payments: improved process flow

Future: Capitation and PMPMs

- **Capitation:** Lump sum, per person payment to providers to provide all care for specific individuals or group

- **Per Member Per Month (PMPM):** Payment methodology for providers; "Meaningful financial responsibility for patient care"

Resurgent need for Capitation Management:

- Medicare's Shared Savings Program
- Medicare Accountable Care Organization
- Private-sector Initiatives
- Physician Hospital Bundled Payments (form of capitation)
- Cost accounting and cost analysis decision support systems

Future: Capitation and PMPMs

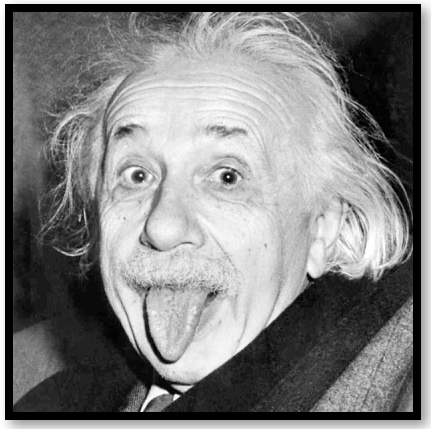
Have lessons of the 1990s been applied?

- Healthcare remains in the same situation: Unsure of how to bend the cost curve while maintaining or improving the quality of care
- Continued fragmented reimbursement mechanisms negatively impact alignment of cost management incentives (e.g. fee-for-service payment for physicians, DRGs to hospitals)
- "Sweet spot" for payers and providers risk continues
- Need for a "much smarter" approach to managing capitated risk in 2015-2020 compared to 1990s

Revenue Cycle (maximize reimbursement) Critical Success Issues:

- Clinical and Financial Integration
  - Cost accounting and cost aggregation
  - Financial forecasting models
- Intelligent Automation: business intelligence clinical prompting
- Flexible RC Technology Platform
- Predictive analytics at the front-end of the healthcare system
- Improved financial tools to manage and distribute capitated or bundled payment mechanisms

The “Real” Future of Revenue Cycle



Albert Einstein

"I really didn't say everything I said."

Yogi Berra

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Contact

Doug Fenstermaker

Managing Partner & E.V.P., Healthcare

C: 815-345-1111

E: dfenstermaker@warbirdcp.com