Revenue Cycle
in the
New World

Alaska HFMA

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Overview

- Update on CMS Cost-Control Initiatives
- Current Revenue Cycle Trends
- Current Revenue Cycle State vs. Future State
- Transition to Future State

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CMS Cost Control Initiatives

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CMS Cost Control Initiatives

- Bundled Payment Initiatives
  - CJR (Comprehensive Care for Joint Replacement)
  - Cardiac
  - BPCI (Bundled Payments for Care Improvement)
- Readmission penalties
- ACOs (Affordable Care Organizations)

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Medicare Cost Control Themes

- Clearly "signaling" their goals
  - Reduce utilization through new payment initiatives
  - Shift patients to lower-cost settings
  - Improve quality by "forcing collaboration"
  - Implement cost controls by passing risk to providers
  - Fix their costs in as many settings as possible

REDUCE COSTS

CMS Bundled Payment Initiatives

- Bundled Payment for Care Improvement (BPCI) - CMS
  - **$8-10B** of healthcare spend
  - Participants include SNFs, hospitals, hospitalists, ortho groups and home health agencies
- CJR Program has been in effect since April 1, 2016
  - CMS recently added DRGs 480-482 to the bundle
  - **Estimate to impact $3B in health care spend**
- Cardiac Bundled Payment – Effective July, 2017
  - 98 MSAs
  - **$6B in health care spend**
  - DRGs 231-236, 246-251 and 280-282

Key Elements of CMS Bundled Mandates

- CJR covers 5 DRGs
- Cardiac bundle will cover 13 DRGs
- 90-day bundled period covers:
  - All related care covered under Medicare parts A and B
  - Inpatient stay to 90 days after discharge which includes hospital care, post-acute care (PAC) and physician services
  - 90 days starts on day of discharge
- Any provider in designated MSAs providing any of the designated DRGs are automatically included
- BPCI is voluntary – started in 2014 and extended until 2018

Readmission Penalties

- Readmission defined as admission to a hospital within 30 days of a discharge from the same or another hospital;
- Readmission measures for acute myocardial infarction (AMI), heart failure (HF), and pneumonia (PN);
- CMS calculates the excess readmission ratio for the 3 categories being tracked
- Hospital's excess readmission ratio is measure of your readmission performance compared to national average for the hospital's set of patients

Readmission Penalties

- Use risk adjustment methodology endorsed by the National Quality Forum (NQF) measures to calculate the excess readmission ratios
- Readmission ratios include adjustments for factors that are clinically relevant including:
  - Patient demographic characteristics
  - Comorbidities
  - Patient frailty
- 2,597 hospitals expected to be penalized in FY17 with penalties totaling $500M

ACO Key Features

- Patients managed by one entity
- 1,217 ACOs across the country – Alaska??
- 28.3M total lives covered in ACOs
- Incentivized to reduce utilization and improve quality through provider collaboration
- 3 options for participation:
  - Medicare Shared Saving Program
  - Advanced Payment Model
  - Pioneer Model

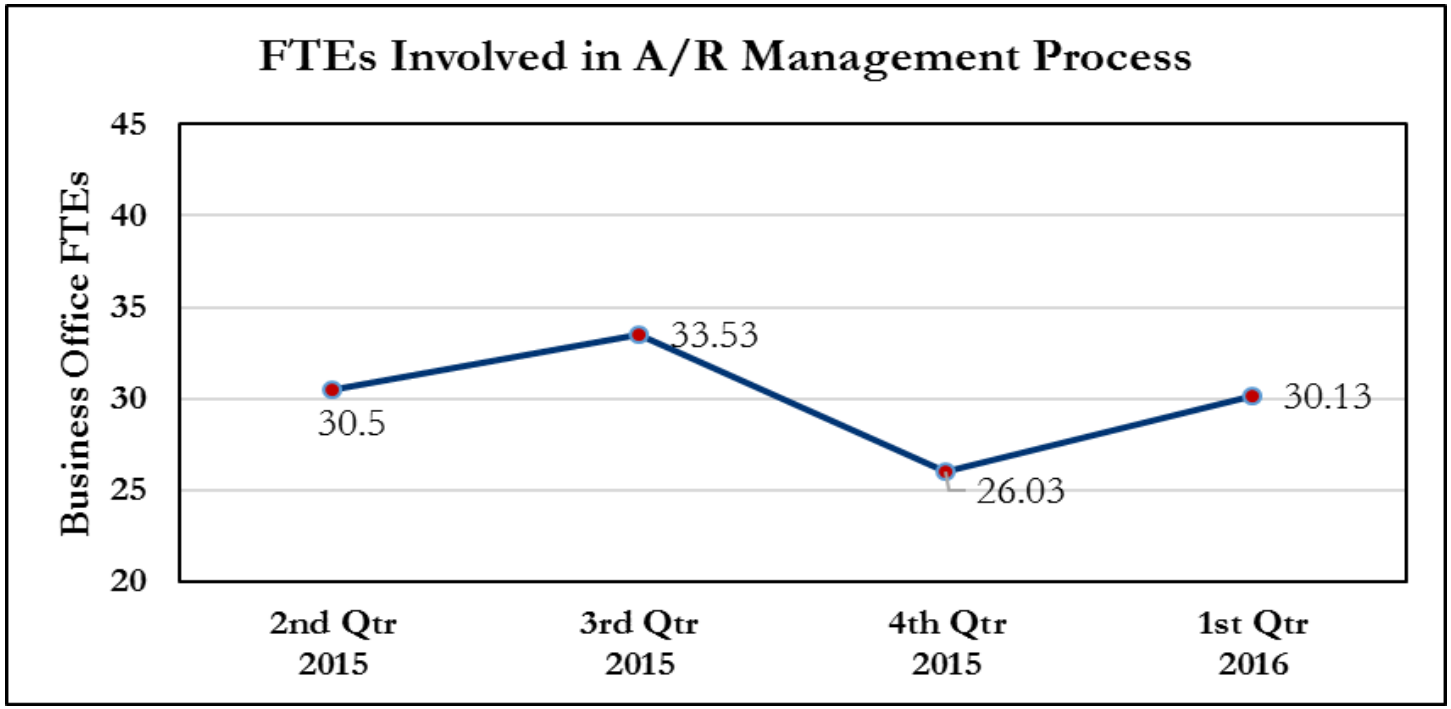
ACO Payment Models

- Patient assigned based on Fee-For-Service beneficiaries who receive plurality of primary care services from professionals using the Tax Identification Numbers (TINs) of ACO participants
- Participating organizations can chose either one-sided or two-sided risk model
- 3 tracks that can be chosen by participants with different risk/reward corridors
- CMS measures quality of care using measures in four key domains: patient experience, care coordination/patient safety, preventive health, and at-risk population

Current Key Performance Indicators

- Staffing
- Days in AR
- Bad Debt
- Charity

FTEs in Receivables Management



Source: HARA Report

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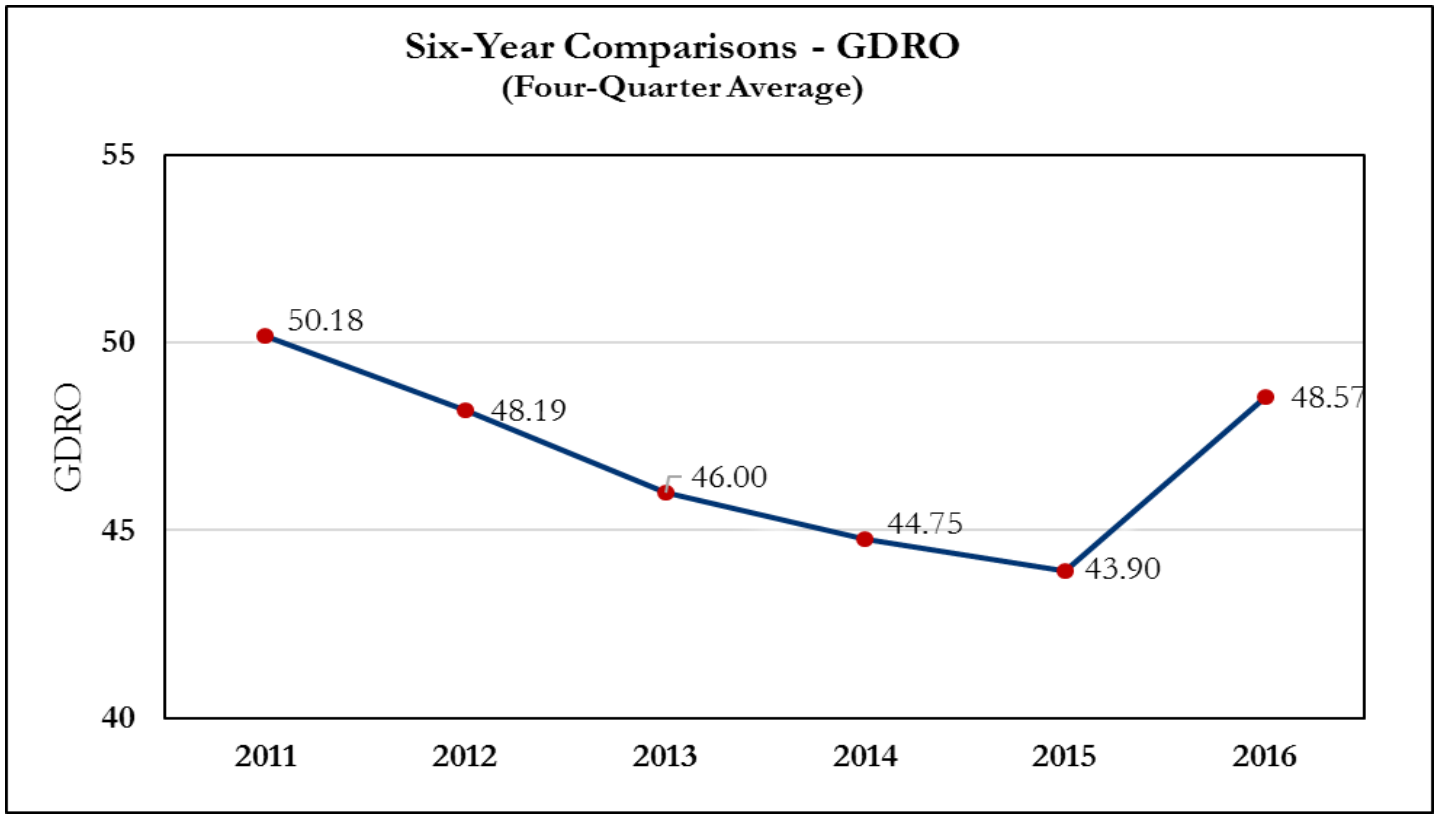
Gross Days Revenue Outstanding (GDRO)



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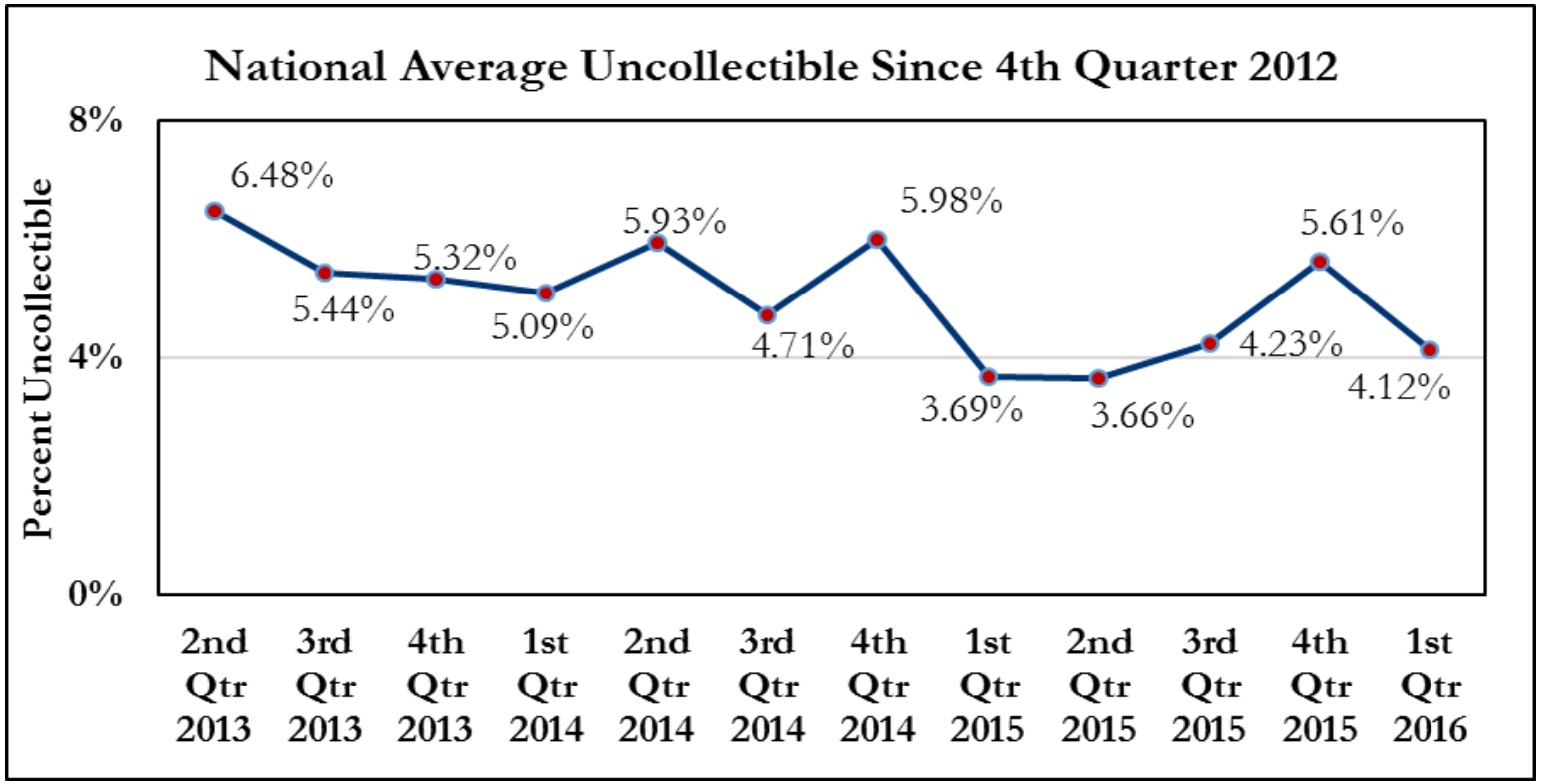
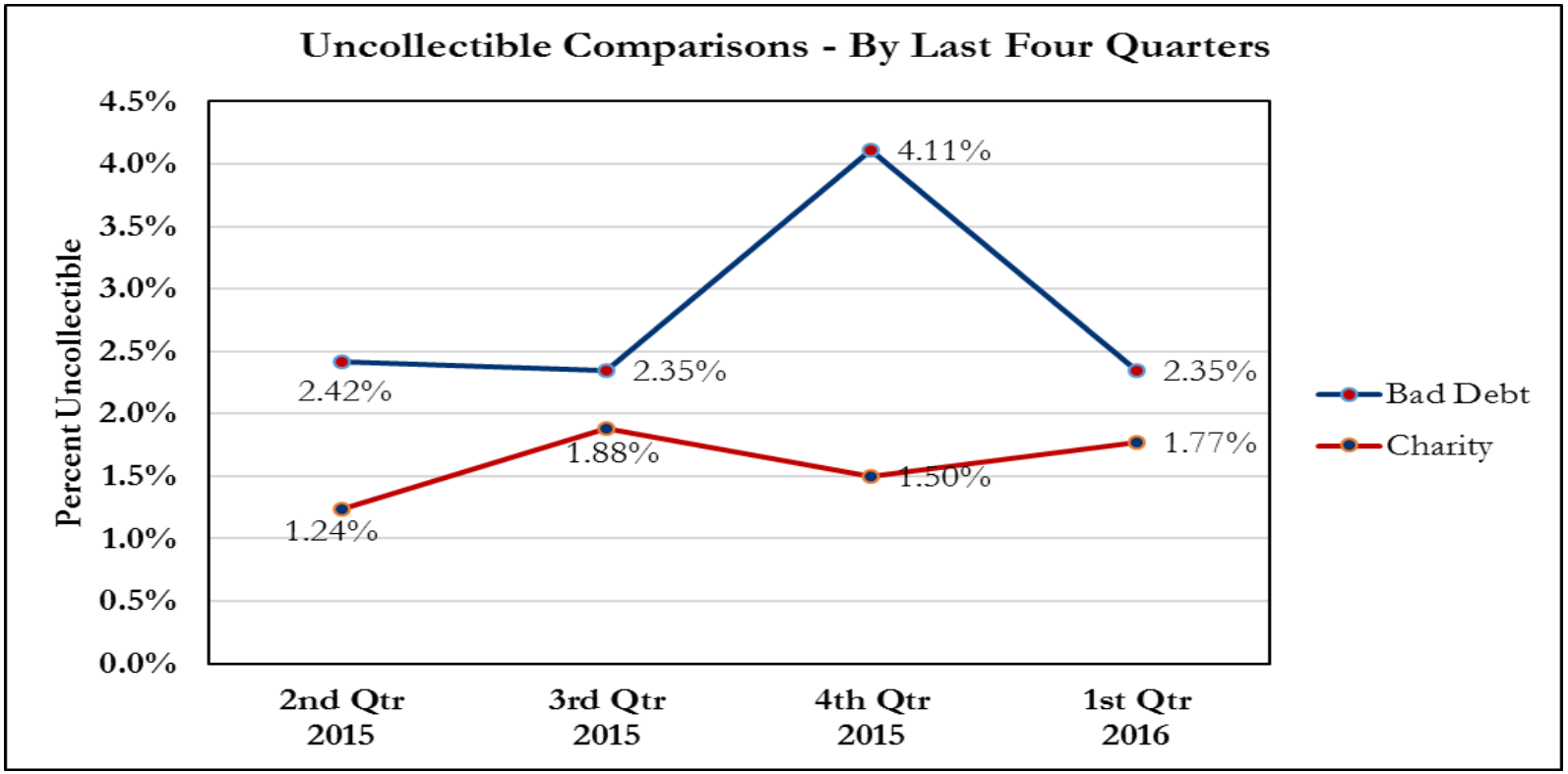
Total Uncollectible



Source: HARA Report

Uncollectible – Bad Debt vs. Charity



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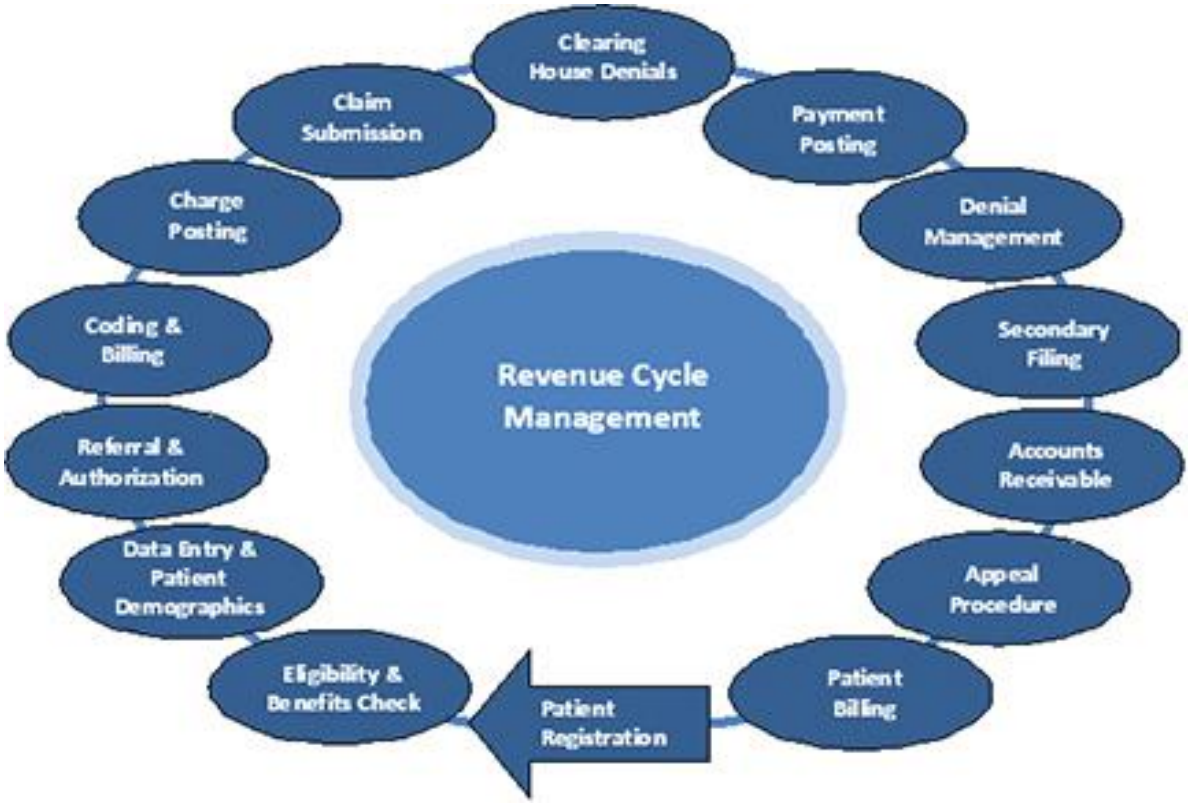
Overall Picture

- Revenue cycle operations have stabilized considerably in last 10 years
- Good progress with reducing days in AR and staffing levels
- Continued decline in bad debt and charity statistics resulting in improving cash flow
- Considerable improvement in automation and analytics
- Substantial increase in conversions to new systems

Revenue Cycle Operations
Current State vs Future State



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Patient Access

Current State

- Schedule/register patients
- Most have traditional coverage – Caid, Care, Comm, Mg Care
- Might have deductible/co-ins
- Pre-auth process may involve case management support
- Limited need for clinical information

Future State

- Still register patients BUT
- Less with traditional coverage – more critical thinking?
- Part of population managed by another provider?
- Are they in a 90-day bundle or regular bundled payment?
- Who is the payer?
- Is clinical information required?

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Care Management

Current State

- Starts in the ED at time of admission decision
- Assist in getting authorization
- Works with physicians during inpatient to track discharge plans
- Some have role in discharge planning
- Appeal Clinical denials

Future State

- Starts prior to admission for "risk" patients
- Discharge plan starts at time of admission
- Constant updates to care plan during stay
- Significant role in discharge plan
- Monitoring of "risk" patients during continuum

Billing

Current State

- Limited variability in billing
- Electronically bill major payers
- Edits built based on standard payment models
- Limited clinical info at billing
- Electronic billing rate over 90%
- Efficient – low staffing level required

Future State

- Potentially billing smaller payers
- Multiple payment models
- Capitation
- Reduction in % billed electronically
- More clinical documentation
- Less efficient
- Higher staff costs

Follow Up

Current State

- Medicare pays clean claim 14 days
- Follow up through payer portals
- Limited payment variability
- Reduced need for phone follow-up
- More efficient – less people

Future State

- Do I know who the payer is?
- Smaller payers – less electronic access and tools
- Is it a payable service?
- What is included in payment?
- Not as efficient – more people
- Follow up for capitation? Other incentives not paid?

Cash Posting

Current State

- Primarily electronic
- Little manual effort
- Traditional payers - limited variability
- Hard to identify small balance denials
- Significant reduction in staffing
- Low skill level required

Future State

- Reduction in electronic posting
- More variability in payments received
- Reconciling member lists
- Identifying and posting incentives or reductions
- Increased staffing
- More analytic skills

Self-Pay/Charity/Eligibility

Current State

- Mostly outsourced at specific dates
- Vendors for:
  - Eligibility
  - Collections
  - Some charity
- Significant declines in states with expanded Medicaid

Future State

Does It Exist?

Other Revenue Cycle Challenges
Future Model

- Bundled payments
  - Risk Pool Management
  - Allocation of bundled payments among multiple sources
  - Tracking of quality
  - Clinical management integrated to billing?
  - Claims processing?
- Accountable Care
  - Roster management
  - Spend tracking
  - Utilization identification and management
  - Proactive case management

TRANSITIONS

LET
THE
FUN
BEGIN!!

Alternative Payment Operations Structure

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Managing the Migration Process Technology

- Begin meeting with technology vendors to address new models and demands
  - Do they have plans to address future contract models?
  - How integrated will those be with current technology?
  - Timing of roll out?
- If considering conversion address in the selection process
- What if vendor has no plan?`
- What is the right timing to migrate to new system?

Managing the Migration Process
Staff

- Quick identification of shifts by payers to new models
- Impacts to staffing tracked closely by productivity measures
- Skills required:
  - Analytic skills more critical
  - Well-trained and adaptable
  - More college graduates or at least college attendance
  - More investment in training on new jobs
- Need for staff from other parts of health care

Managing the Migration Process Management

- Do you need two organization structures?
  - Traditional FFS management
  - Alternative payment processing structure
- Begin doing training sessions now to prepare for new models
- Create a strategic plan that includes:
  - Systems requirements for alternative models
  - Staffing needs based on potential transition timing
  - Assess potential financial impact during transition
  - START NOW!

About McBee Associates

- A recognized national leader in providing financial, clinical, and operational consulting services exclusively to the health care industry
- Serving a client base of more than 3,800 acute and post-acute providers
- Growing team of more than 300 health care experts working with clients in all 50 states
- Over 30 years of delivering significant improvements in clients' revenue cycle operations

Contact

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