Revenue Cycle of the Future

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Will bundled payments replace FFS?
Will denials “matter”?
Will we need claim forms?
Who is going to pay for all of this, really?
Healthcare Reform Impacts

INCREASED COVERAGE  Improve Performance and Efficiency  PAYMENT CUTS

Eligibility Processes
Patient Liability Collections
Patient Care Management

Revenue Cycle Imperatives

Denials Management
Charge Capture
Appropriate Level of Care
Population Cost Management

Revenue Cycle of the Future

• Value Based Reimbursement
• Denials Management and Prevention
• Patient Responsibility
• Staffing
• Metrics and Reporting

Illustration adapted from HFMA Revenue Cycle Excellence presentation on Reform Impacts
Value-Based Reimbursement
CMMI’s Demise Is (For the Moment) Greatly Exaggerated

“The fact that neither Congress nor the Trump administration has suggested cutting funding for the agency leads him to believe that the trend of furthering value-based reimbursement has a good chance of continuing.”


Shift from Volume to Value

Secretary’s Goals

1. **30%** Medicare payments are tied to quality or value through APMs by the end of 2016, 50% by the end of 2018
   - ACOs, PCMH, bundled, CPC, etc.

2. **80%** Medicare FFS payments are tied to quality or value by the end of 2016, 90% by the end of 2018
**Value-based Contracts**

- CMS goal to shift half of Medicare payments to value-based model by 2018
- Fewer than a quarter of U.S. Hospitals on track to hit goal
  - Only 3% hit target today
  - Only 23% expected to hit by 2019
- 62% have less than 10% of their care tied to “risk-based” contracts
- Analytics sited as the most important organization element
- Managed care organizations following CMS

*2016 Study by Health Catalyst*

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**Value-based contracts**

- Healthcare executives are more pessimistic about value-based contracts
  - 45% expect a drop in profits
  - 25% expect a significant drop in operating income
  - Expect to make patient care changes with move to account for decline in reimbursement

*KPMG Survey, May 5, 2016*
Value-Based Payment Models

1. CMS Value-Based Purchasing
2. CMS Bundled Payment Pilot
3. Merit Incentive Payment System (MIPS)
4. Chronic Care Management (CCM)
5. Annual Wellness Visits
6. Transitional Care Management
7. End-of-Life Counseling
8. Telemedicine Care Delivery
9. Diabetic Preventive Care

Hospital / Provider Implications

- It is likely that as many hospitals will be penalized with payment reductions under the program as will benefit from payment increases from the incentive payments.
- According to the AHA, it can be argued that the true significance of the program is not so much in the incentive payments as it is in the measurement tools it provides.
Physician Movement

Physicians practicing alone fell 41% to 17% from 1983 to 2014. Physicians in practices with 25+ doctors grew fourfold (5% to 20%).

Physicians identifying as independent practice owners or partners:
- 1983: 49%
- 2012: 33%
- 2014: 30%
- 2016: 49%

Physicians identifying hospital or medical group employees:
- 1983: 20%
- 2012: 12%
- 2014: 17%
- 2016: 20%

20% of physicians practice in groups of 101+ in 2012. 44% of physicians believe hospital employment is a positive trend.

Measures to be Included with VBP

- Mortality Measures
- Hospital Acquired Conditions (HAC)
- Agency for Healthcare Research & Quality (AHRQ) Patient Safety Indicators
- HCAHPS Patient Satisfaction Measures
- Readmissions

Note: Clinical measures account for approximately 70% of VBP score with 30% based on HCAHPS scores.
HCAHPS

- Hospital Consumer Assessment of Healthcare Providers and Systems
- HCAHPS (pronounced “H-caps”), also known as the CAHPS® Hospital Survey,
- National, standardized, publicly reported survey of patients' perspectives of hospital care.
  - 32-item survey instrument and data collection methodology for measuring patients' perceptions of their hospital experience
  - Since 2008, HCAHPS has allowed valid comparisons to be made across hospitals locally, regionally and nationally.

Prepare

- Value-Based Reimbursement is not specific to Medicare; many commercial and managed care payers are adopting.
- Be pro-active in measure and monitoring. Data reporting is more important than ever
- Revenue cycle and managed care leaders need to involve their clinical and quality peers in contract discussions
- Coordination with physicians and other post-acute services
- Consumer transparency and patient satisfaction
The Changing Nature of Denials

- Increasing need for clinical expertise to manage
- Key clinical elements:
  - Medical necessity
  - Clarity of documentation
  - Accurate coding
- Questions will require input from a physician, nurse or outside expert…in an instant
- Understanding payer behavior helps package response in a way that mitigates objections and, ultimately, preempts denials
- Upward pressure far outweighs downward pressure on denials volume
Supporting Measurements

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Leading Practice</th>
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</thead>
<tbody>
<tr>
<td>Overall denials rate</td>
<td>≤ 1 – 3%</td>
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<tr>
<td>Clinical denials rate</td>
<td>≤ 1 – 3%</td>
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<tr>
<td>Technical denials rate</td>
<td>≤ 1%</td>
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<tr>
<td>Underpayments additional collection rate</td>
<td>≥ 75%</td>
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<tr>
<td>Appeals overturned rate</td>
<td>30% - 50%</td>
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<tr>
<td>Electronic eligibility rate</td>
<td>≥ 75%</td>
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<td>Physician pre-certification double-check rate</td>
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<td>Case managers time spent securing authorizations rate</td>
<td>≤ 20%</td>
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<tr>
<td>Total denial reason codes</td>
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</table>

Journey from Management to Prevention

Prevention concurrent
- prior authorization
- 2 midnights/level of care support
- physician concurrent review

Management retrospective
- denial management
- audit & appeals management
- process, coding & documentation

denials analytics
## Denials Prevention Analysis

1. **Define the types of denials and categories as controllable/avoidable.**
   - Can the denials be avoided prior to claim submission?
   - Can the outcome of the appeal for payment be controlled after the denial?
   - What percentage of denials are in each category?

2. **Further categorize denials by significance and impact to revenue cycle.**
   - Which departments/functions contribute to the most significant denials?
   - Within the claim life cycle, where can these denials be controlled/avoided?

3. **Track denial history and trends by denial type, charge code, payer, etc.**
   - Which payers represent the majority of denials?
   - What is the write off volume due to denied claims?
   - Which denial types have the biggest impact on revenue?

4. **Develop KPI’s around denials and impact to billing and collections.**
   - Are denials decreasing or increasing seasonally?
   - Where are the areas of opportunity to reduce denials and increase collections?

5. **Build work flows to process current denials and to avoid/reduce future denials.**
   - Are the work flows clearing denials and producing cash?
   - When will the new processes positively impact the denial volume?
   - Are all payer denials impacted by these changes?

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### Patient Responsibility
Patient experience

- Patient out-of-pocket increasing
- Patient satisfaction directly related to resolving patient balance
- 70% of hospitals rate the patient experience/satisfaction as a top-three priority
- Patient’s satisfaction rates drop by more than 30% from post-discharge through the billing process
- Patients satisfied with the billing process are 5x more likely to recommend a hospital
- Lifetime Value of Patient (LVP) for a household influencer exceeds $1.5 million

Future considerations

- Put more emphasis on patient satisfaction, coordination of care and creating transparency throughout the continuum.
- Implement programs that monitor and measure patient and physician satisfaction
- Create loyalty with the “brand” and continuously validate consistency throughout the organization
What does “Patient Focus” mean?

Patient

- Pricing Transparency
- Access to Care
- Financing Options
- Care Responsibility
- Insurance Exchange
- High Deductible Plans
- Access to Care

Staffing
The fundamental underpinning is the need to integrate the clinical situation with the financial situation and move most of that financial work to the front-end.

Sandra Wolfskill
Director, Healthcare Finance and Revenue Cycle
Healthcare Financial Management Association
Staffing Considerations

- Competency: Specialized expertise
- Capacity: Increased capacity
- Cost: Lower expense

Revenue cycle management

- Account resolution: Claims processing, Payment posting, Online bill pay, Self pay, Accurate payer reimbursement
- Denial management & prevention: Denial mitigation, Root-cause analysis, Translation to accurate charge transactions, Analysis of technical and clinical denials
- Patient/provider experience: Adoption of culture, Loyalty, Patient advocacy, Increased referrals

Continuous analysis and improvement: Intelligence + expertise
Selective resource augmentation

<table>
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<tr>
<th>Denials</th>
<th>Specialized Expertise</th>
<th>Better Results</th>
<th>Lower Expense</th>
<th>Internal Focus</th>
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• Access to required talent
• Requirement to flex resources
• Fosters focus on improvement initiatives
Data collection and analysis

- New data collection and analysis focuses on improving and “tweaking” processes for incremental improvement
- Moves beyond the map keys and looks at key control points or “switches” in the process
- Can be overwhelming when mapping out all of the places to measure and track data and the key to success in improvement is focus and consistency of reporting

Data collection and analysis

- Return Adjustment Reason Codes
- When items are retuned from bad debt, data should be collected to determine reason account was sent to bad debt
  - Insurance identified
  - Charity Care identified
  - Patient satisfaction adjustment
- This data should be included in a standard revenue cycle dashboard for revenue cycle teams
Defining the Industry’s Standards

Task Force Purpose

- Leading industry representatives
- Supported by HFMA staff
- Charged to identify a common set of revenue cycle performance indicators that will allow hospitals to measure in a consistent way for the purpose of peer to peer comparison
Task Force Charge

- Review current KPIs and other industry definition sources for completeness, validity and relevancy
- Identify and prioritize the top KPIs
- Finalize and approve KPI definitions
- Review work product with NACs
- Prepare recommendations for HFMA Board approval

Typical fee-for-service metrics

Predictors used today:

1. Net days in A/R
2. Denial rate
3. Aged A/R 90 days and greater
4. DNFB, FNSB, DNSP
5. Cash collections as % of NPSR
6. POS collections
7. Cost to collect
8. Bad debt
9. Charity care w/o
Future KPIs to Consider

1. Will new metrics reside in revenue cycle? Contracting? Reimbursement?
2. Will revenue cycle metrics include a patient satisfaction indicator?
3. Will incentive payments be included as “cash”?
4. How will quality indicators be used in predicting a high-performing revenue cycle?

Perspectives from a CFO

Bryan G. Jackson, Vice President and Chief Financial Officer
Jefferson Regional Medical Center
Pine Bluff, AR
Perspectives

- As it relates to the payer mix for your organization, what trends are you seeing and how do you predict the future as it relates to your current reimbursement models?

- How are you preparing for Medicare / CMS value based reimbursement? Are you doing anything differently? Other payers? What is your strategy for the next 12 – 24 months?

- Patient satisfaction (or lack thereof) is sometimes related to the billing process. What are you seeing at JRMC and how do you predict that might change in the future?

- What trends are you seeing in terms of outsourcing vs. insourcing? What are your considerations for the future?

- What do you see in terms of metrics and reporting that will change as it relates to “value” and patient experience?
Basic Expectations

• Efficient low-cost workflows
  • Automation through EDI
  • Patient self-service options

• Accuracy
  • Insurance plan selection
  • Authorization
  • Patient liability at POS
  • Real-time concurrent review

• Payment efficacy
  • Patient and payer

• New KPIs

Success at Predicting the Future
Our vision is a fully transparent financial experience for the patient

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Dr. John Showalter
Chief Health Information Officer
University of Mississippi Health Center

The Triple Aim: Institute for Healthcare Improvement

Patient Experience
• Satisfaction
• Quality and Outcomes
• Access and Information

Population Health
• Managing Risk
• Preventive Care

Reduce Costs
• Productivity
• Sustainability
• Cost effective

Managing Change

- From production worker to knowledge worker
  - Education
  - Recruitment
  - Retention

- Challenges
  - Local resources vs Outsourcing vs Offshoring
  - Millennials in the workforce

- Strong Leadership is critical

— The best way to predict the future is to create it.

Peter Drucker
Author and Professor
Claremont Graduate University
Questions?

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