



Webinar: Next Generation Revenue Cycle

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- Welcome
- Poll 1
- Next Generation Revenue Cycle
 - Poll 2
 - Poll 3
 - Poll 4
- Q&A



- How do you currently manage your billing/revenue cycle operations?
 - In house
 - Outsourced to a dedicated medical billing company
 - Outsourced to your practice management software vendor



Today's Speaker



Robin Brand
Senior Consultant,
The Advisory Board Company

During her six years with The Advisory Board Company, Robin has spent much of her time focused on service line strategy and finance, authoring multiple studies and white papers focused on revenue capture, pricing, patient consumerism and referral capture. As a senior consultant within the Financial Leadership Council, she oversees research examining revenue cycle and margin management, as well as financial performance under risk.

Robin holds a Master of Science in international political economy from the London School of Economics, where she focused on international trade and development. She earned her bachelor's degree in political science from the University of North Texas. Prior to joining the Advisory Board, Robin worked in health care policy at the Cato Institute, a Washington, DC based think tank, and served as a domestic policy researcher at the Wall Street Journal.



Financial Leadership Council

Next-Generation Revenue Cycle

Prepared for Greenway Health

Two Forces Transforming the Revenue Cycle

1

Shift in Coverage



- Increased coverage from public, private health insurance exchanges
- Rise of high-deductible plans, cost-shifting onto patients under exchanges, through commercial payers challenges collection attempts

2

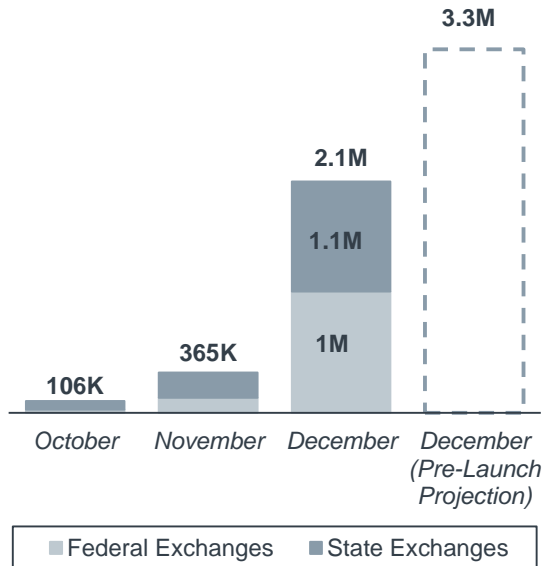
Shift in Risk



- Total cost of care contracts (shared savings and capitation) reward low-cost, high quality care
- Revenue cycle must continue to maximize capture while also supporting care management initiatives

Exchange Enrollment Marked by Slow Start

Cumulative Enrollment in Federal and State Exchanges



8M

Number of enrollees through February 2014

28%

Percentage of Enrollees Ages 18-33

63%

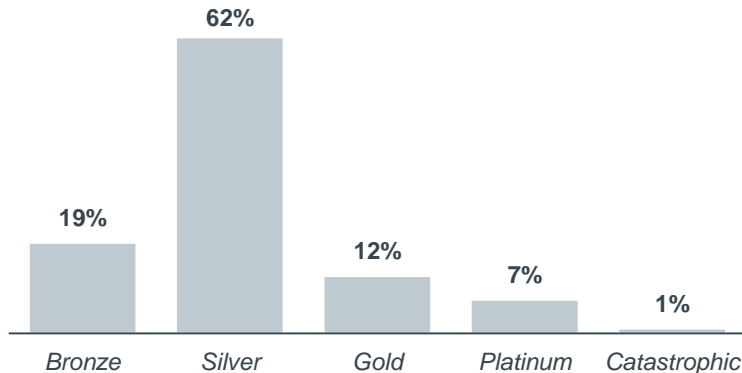
Percentage Enrolling in Silver Plans

Newly-Covered Face Large Obligations on Exchanges

Majority of Enrollees Selecting Plans With High Deductibles

Health Insurance Exchange Plan Enrollment

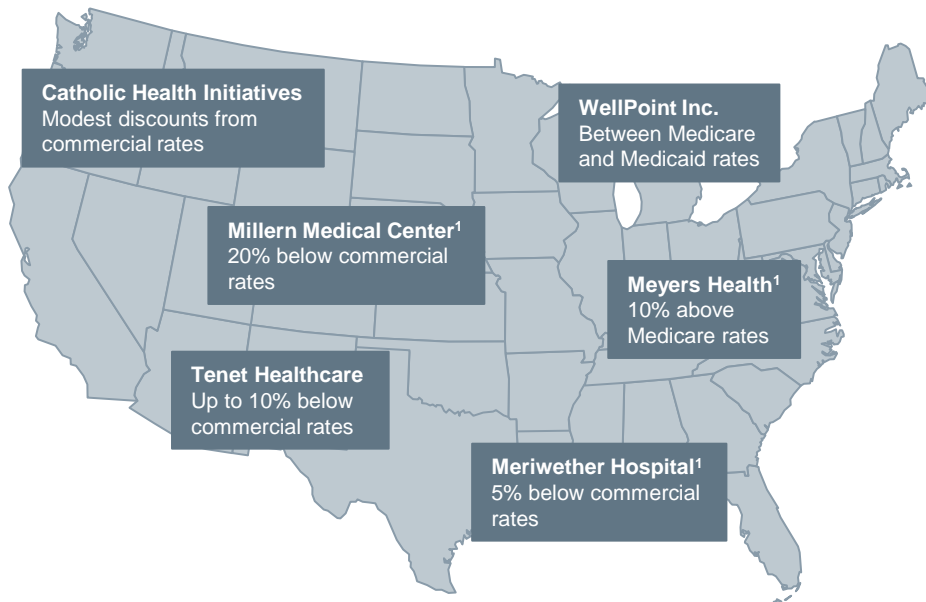
Percentage of Enrollees Within Each Plan Tier



Trading Price for Volume on the Public Exchanges

Reimbursement Information Still Anecdotal, but Rates Not Generous

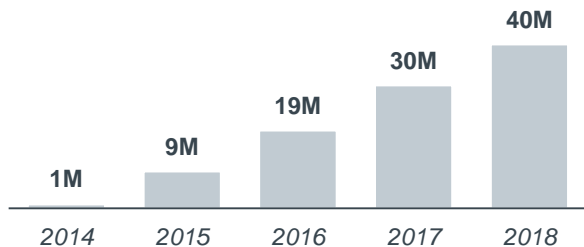
Anticipated Provider Reimbursement Rates for Exchange Plans



The Future of Employer-Sponsored Insurance?

Private Exchanges Poised For Rapid Growth

Projected Private Exchange Enrollment



27%

Percentage of consumers receiving employer-sponsored coverage today projected to receive benefits through private exchanges in 2018

Factors Influencing Move to Private Exchange Models



Logistical difficulty of benefit renegotiations



Internal politics of benefit changes



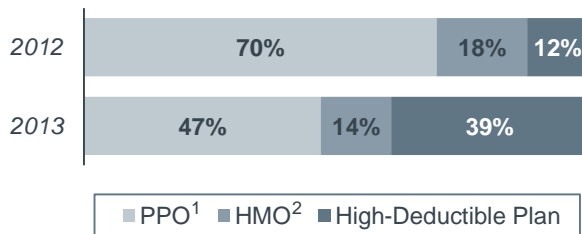
Attractiveness of other options

Igniting a Race to the Bottom

Exchange Shoppers Trading Premiums for Deductibles



Results of Open Enrollment Process



42%

Employees on Aon Hewitt health insurance exchanges selecting plans less rich than the previous year



Case in Brief: Sears, Darden Restaurants

- For 2013 open enrollment, self-insured large employers redesigned benefits to reduce health spend through defined contribution model
- Employers offered employees lump sum credit to choose coverage in Aon Hewitt's online marketplace

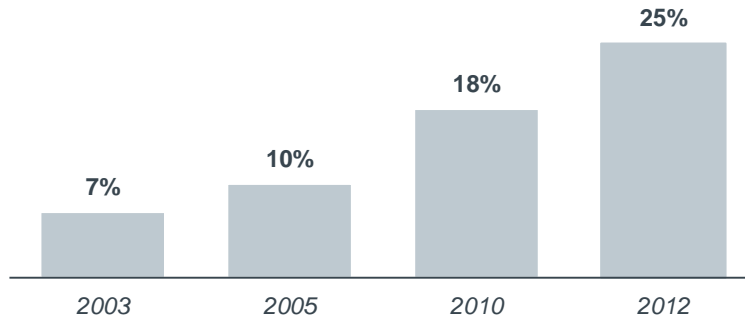
1) Preferred provider organization.

Encouraging Patient Frugality

High-Deductible Plans on the Rise

Increasing High-Deductible Health Plan Enrollment

Enrollees with Deductibles of \$1,000 or More



43%

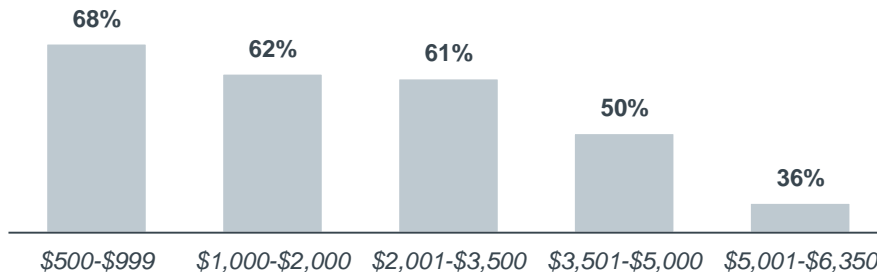
Decline in proportion of individuals
with a deductible under \$500¹

Source: Altarum Institute, "Altarum Institute Survey of Consumer Health Care Opinions," Fall 2012, available at: www.altarum.org; Kaiser Family Foundation, "Explaining Health Care Reform: Questions About Health Insurance Exchanges.," Financial Leadership Council interviews and analysis

Likelihood of Payment Drops as Deductibles Rise

Increasing Obligations Already Impacting Bad Debt

Patient Propensity-to-Pay¹ by Deductible Size



Year	Bad Debt as Percentage of Net Patient Revenue	Percentage of Patients with Deductibles of \$1,000 or more
2003	4.52%	7%
2010	4.84%	18%

1) Percentage of patients paying any portion of bill.

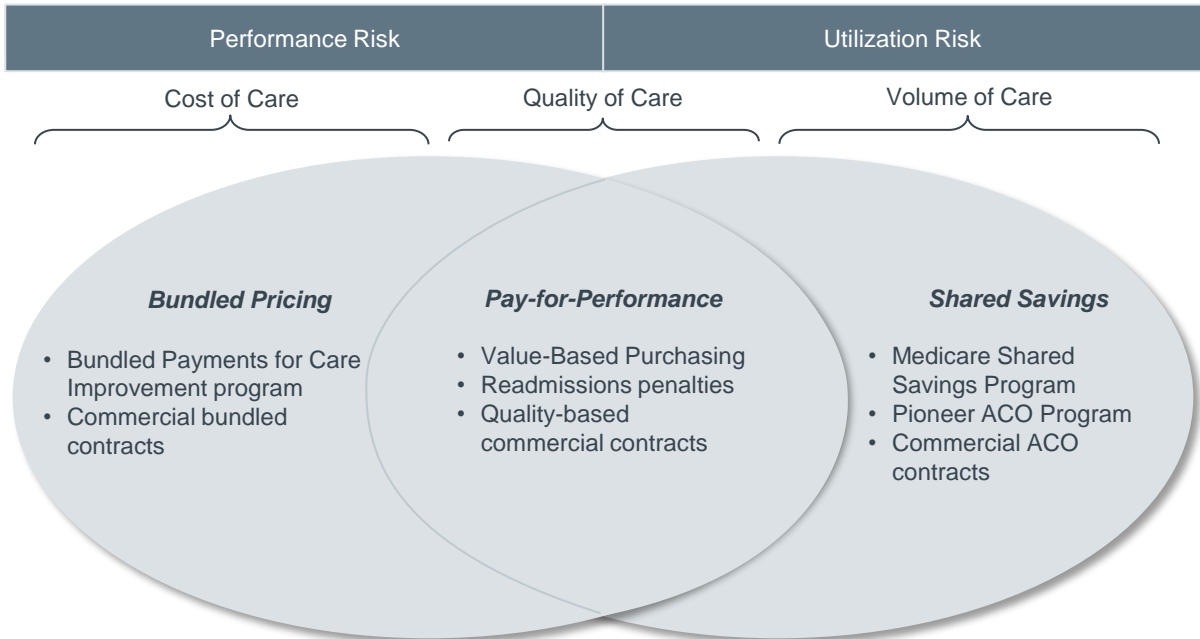


- Are you seeing any changes in bad debt or the percentage of total revenue that comes from patient collections at your practice?
 - Yes, we are seeing increases in bad debt
 - Yes, we are seeing increases in patient collections
 - Yes, we are seeing increases in both bad debt and patient collections
 - No, we have seen no change in either
 - No, we are seeing improvements in bad debt

Embracing New Types of Risk

Emerging Payment Models Calling Old Imperatives Into Question

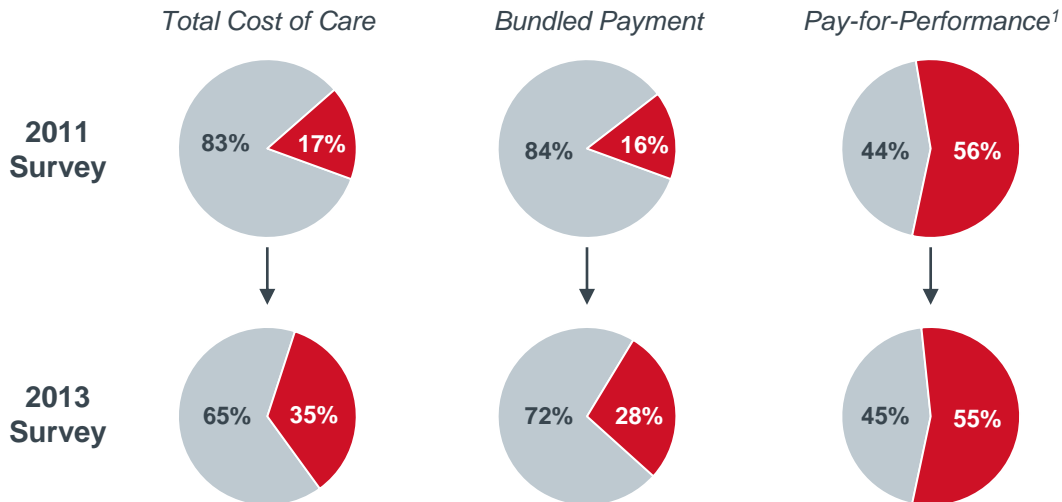
Accountable Payment Models



Risk-Based Contracting on the Upswing

Twice as Many Providers Have Risk-Based Contracts as in 2011

Percentage of Providers with Risk-Based Contracts in Place











■ Without Risk-Based Contracts ■ With Risk-Based Contracts



The number of providers with total cost of care and with bundled payment contracts has doubled in two years.

¹ 2011 question asked as, "Have commercial insurers in your market introduced new P4P initiatives in the last 24 months?"; 2013 question asked as, "Does your organization currently have any pay-for-performance contracts, besides Medicare's mandatory VBP and readmissions penalties."

Continuing Investments in the Revenue Cycle

Revenue Cycle Challenge	Importance Under Risk vs. Fee-For-Service ¹
Tracking and reporting quality metrics	
Tracking utilization of attributed patients	
Tracking cost of services provided	
Identifying patients covered under total cost of care contracts at the time of service	
Coding and clinical documentation	
Developing financial projections	
Minimizing cash flow deceleration	
Identifying and appealing underpayments and denials	



Equally Important



Somewhat More Important



Much More Important



- Does your practice participate in any risk-based contracts/programs today?
 - Yes, we are participating in a risk-based program with a government payer (Medicare/Medicaid)
 - Yes, we are participating in a risk-based program with a commercial payer
 - Yes, we are participating in both commercial and government programs
 - No, we are not currently participating in any risk-based contracts or programs.

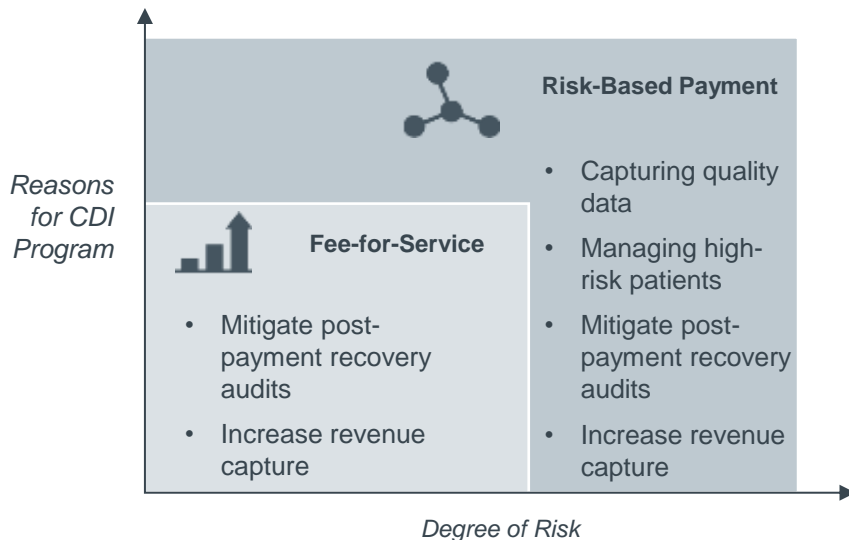
Elevating Revenue Cycle Under Reform

Eight Strategies for Revenue Cycle Under Reform

1. Maintain focus on high-opportunity cases through the transition
2. Use CDI to support risk segmentation and care management
3. Document to meet quality targets
4. Retool collections to manage larger, more complex obligations
5. Enhance insurance verification processes
6. Expand Medicaid and HIX eligibility screening and enrollment
7. Shift denials focus to root causes rather than appeals
8. Develop disbursement abilities for physicians and external providers

Risk Elevates Importance of Documentation

Goals of CDI Increase as Programs Transition from Fee-for-Service



Assessing Current CDI Program Performance

2010 CDI Financial Benchmarking Results*

	Low Performance n=6	Average Performance n=13	High Performance n=6
Beds per FTE	128	113	92
Annual Revenue Impact per FTE	\$0.3M	\$0.7M	\$1.4M
Programs Reporting to Finance	33%	46%	83%

*Revenue impact reflects the cumulative value of all DRG reassignments associated with CDI interventions over the course of fiscal year 2009. Figures do not account for DRG reassignments that would have occurred over the course of a patient's stay independently of CDI queries, nor do they include potential CDI impact on denials or post-payment audit takebacks.

Source: Financial Leadership Council interviews and analysis.

From Revenue Capture to Cost Management

Incremental Revenue Capture Under Fee-for-Service

Patient: J. Smith	
Date	DRG Assignment
Monday, 5/10	192 – COPD without CC/MCC
Wednesday, 5/12	191 – COPD with CC
Friday, 5/14	191 – COPD with CC
Monday, 5/17	189 – Respiratory Failure

\$1,400 incremental reimbursement impact

\$2,200 incremental reimbursement impact

\$3,600 incremental revenue impact



Elevated Care Management Under Risk



Documentation efforts aimed at supporting care management



Greater specificity leads to more accurate risk scoring, better care management

High Risk Medicare Patient



Annual Cost: \$70,709



Medium Risk Medicare Patient



Annual Cost: \$20,060

Risk Ties Quality to Reimbursement

Documentation Necessary to Receive Full Bonus Payout

Quality Performance Contingent on Documentation



- 24 of 33 MSSP¹ quality performance standards focus on preventive health, outcomes, screenings
- Most include documentation-centered items such as how often physicians report follow-up plans following screening
- E.g. BMI screening reveals patient is overweight, physician will be required to document follow-up plan

Case Study: Snow ACO²



39

Distinct performance metrics within ACO contract

2.4%

Percentage of bonus based upon performance on each measure

1) Medicare Shared Savings Program.

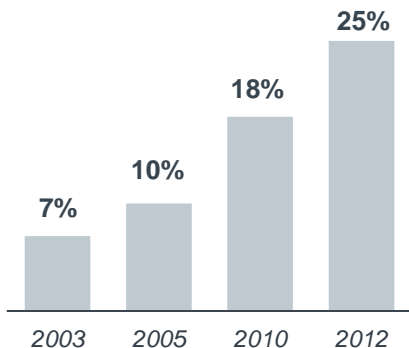
2) Pseudonym.

Rise of Deductibles Complicates Collections

Patient Obligation Growing Component of Contracted Rates

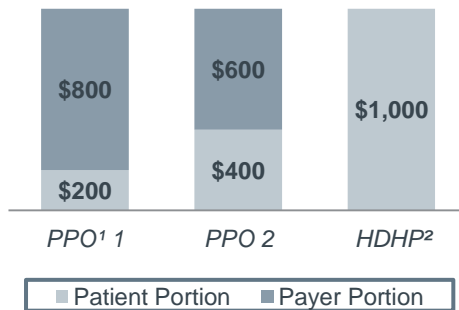
Increasing High-Deductible Health Plan Enrollment

Enrollees with Deductibles of \$1,000 or more



Sample Contracted Rates for MRI

Patient Obligation by Payer and Plan







43%
Decline in proportion of individuals with a deductible under \$500

Source: Altarum Institute, "Altarum Institute Survey of Consumer Health Care Opinions," Fall 2012, available at: www.altarum.org; Kaiser Family Foundation, "Explaining Health Care Reform: Questions About Health Insurance Exchanges.," Financial Leadership Council interviews and analysis

Cost-Sharing Varies Under Most Popular Plan

Subsidies Add Another Layer of Complexity

Different Cost-Sharing Subsidies Within a Silver Tier Plan

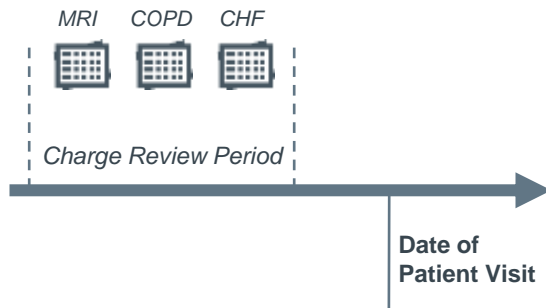
				
<i>Income Level</i>	100-150% FPL	150-200% FPL	200-250% FPL	>250% FPL
<i>Percentage of Total Cost Covered by Cost-Sharing</i>	24%	17%	3%	0%
<i>Actuarial Value</i>	94%	87%	73%	70%

 **60%**
Percentage of enrollees selecting Silver Tier Plans

Deriving Patient Estimates From Historical Data

Patients Asked to Pay Deposit According to Calculated Averages

Rolling Retrospective Charge Review



Standardized Down Payment Schedule

Procedure/Setting	Global Deposit Amount
Inpatient Admission	\$250
Outpatient Lab	\$25
MRI	\$100
CT Scan	\$100



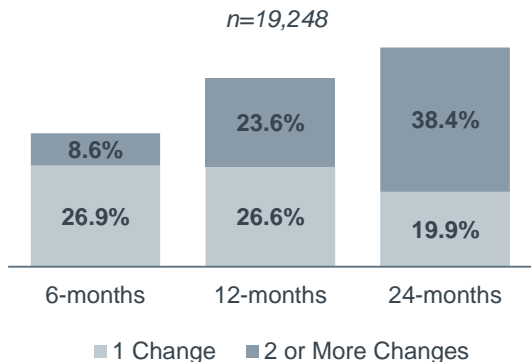
Case in Brief: Mercy Medical Center

- 228-bed hospital in Sioux City, Iowa
- As a bridging strategy, patient access management team reviews top 50 DRGs and APCs by volume to determine average charges
- Patients shown average charges for previous 90-day period when asked to pay a deposit

Increasing the Complexity of Enrollment

Significant Crossover Expected Between Medicaid, Exchanges

Percentage of Future Enrollees with Change in Eligibility Between Medicaid, Exchange¹



28 M

Adults projected to undergo shift in eligibility across Medicaid-exchange market within one year²

Impact of Coverage Transitions



Plan Benefits

Fluctuations in plan design, resulting in variable levels of benefits, premiums, and cost-sharing



Provider Networks

Potential disruption of existing provider networks, steering enrollees to new care sites



Payment Rate

Likely increase in hospital reimbursement with shift from Medicaid to commercial insurance on state exchange

1) Among adults with family incomes below 200 percent of the federal poverty line
 2) Using 133% of the federal poverty level as the eligibility threshold

Source: Benjamin D. Sommers and Sara Rosenbaum, "Issues In Health Reform: How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges", Health Affairs, 30, no.2 (2011):228-236.; Marketing and Planning Leadership Council interviews and analysis.

Spreading the Word

Trinity Health Planning to Educate Patients About Exchanges, Subsidies

Building Exchange Awareness



Trinity counselors available at hospital to help patients understand eligibility, apply for Medicaid, exchange coverage



Computerized enrollment kiosks available to encourage patients to enroll in exchange plans online



Community health workers knock on doors, promote coverage at football games, visit laundromat patrons to provide information



Awareness Matters for Hospitals

“There are so many moral and pragmatic reasons why hospitals should be engaged in outreach and [health insurance exchange] education... it’s a lot like political organizing”

*Tina Weatherwax Grant
Director, State Advocacy*

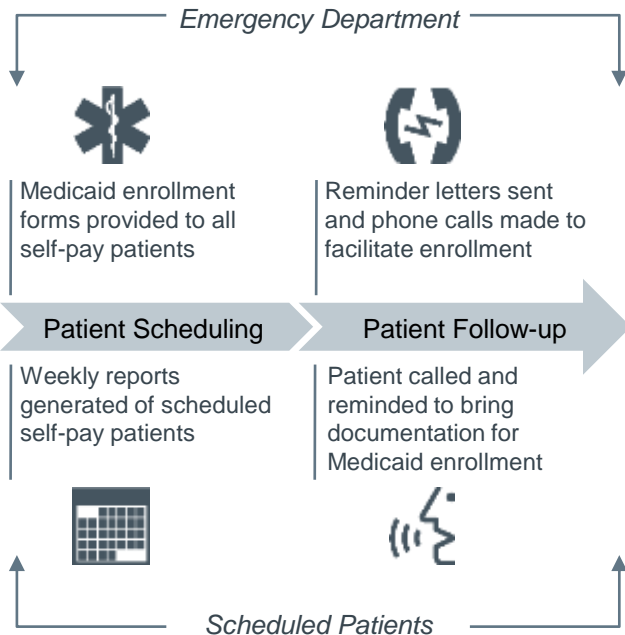


Case in Brief: Trinity Health

- 47-hospital health system based in Livonia, Michigan
- Extending current health insurance awareness and enrollment programs to reach newly-eligible Medicaid and exchange patients

Continuing Attempts to Enroll Patients in Medicaid

Montefiore's Medicaid Registration Process



Financial Impact of Enrollment

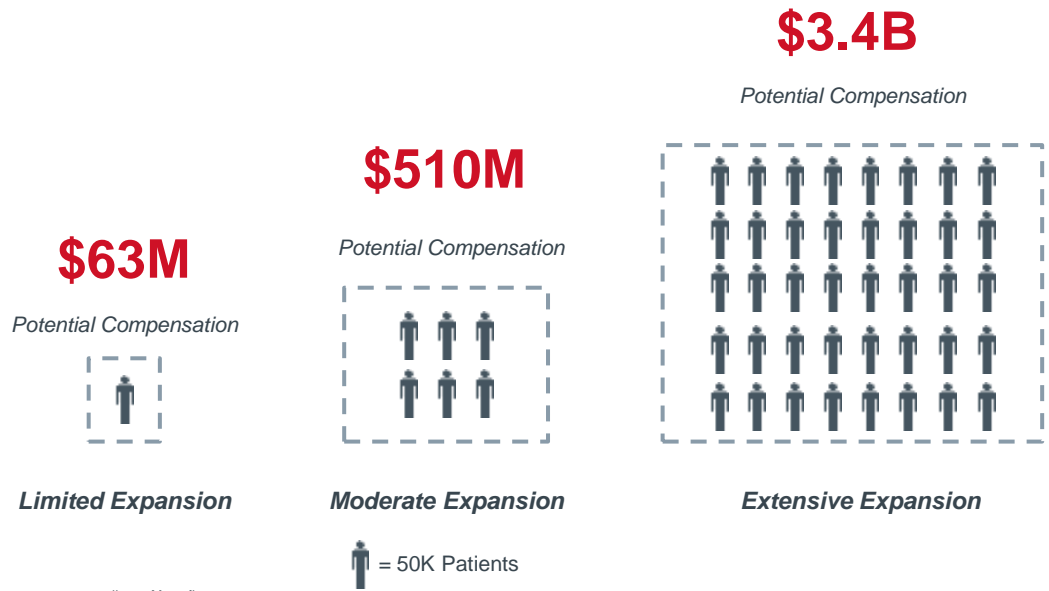
6,000 Total indigent care enrollment in 2009

\$1,700 Average Medicaid revenue per patient

\$10.2M Annual revenue impact of added Medicaid enrollment

New Revenues From Medicaid Enrollment

Projected Increases in Patient Revenue From Medicaid Expansion For Three Representative States, By Absolute Extent of Expansion



1) Calculated based on revenue per enrollee at Montefiore
Based on projected eligibility in DE
2) Based on projected eligibility in KY
3) Based on projected eligibility in CA

Source: Advisory Board interviews and analysis; The Center on Budget and Policy Priorities

Denials Data Provide Clues On Appropriate Care

Managing Medical Necessity Denials at Presbyterian



Case in Brief: Timmons Health¹

- Two-hospital health system in the Southwest
- Finance using denials data to understand medical necessity, inform future care efforts
- Findings relayed to clinicians, who then may alter care protocols, revisit utilization assumptions

Current Revenue Cycle Centered on AR

Traditional



Revenue Cycle Focus

Billing

Collections

Managing denials, underpayments

Under Risk



Disbursement Added to Responsibilities Under Risk-Based Payment



Payment to physicians, post-acute care facilities necessary under value-based contracts



- Does the transition to risk and value based contracts make you more or less likely to consider outsourcing your billing/revenue cycle operations?
 - More likely
 - Somewhat likely
 - Neutral/No Impact
 - Somewhat unlikely
 - More unlikely



Questions?





ENGAGE 14

September 4-7

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