BECKER'S HOSPITAL REVIEW

Revenue Cycle Optimization

Tools and Strategies for Success

Introductions

- Jodi Frei, PT, MSMIIT, Northwestern Medical Center
- William Presley, Vice President , Acmeware

Agenda

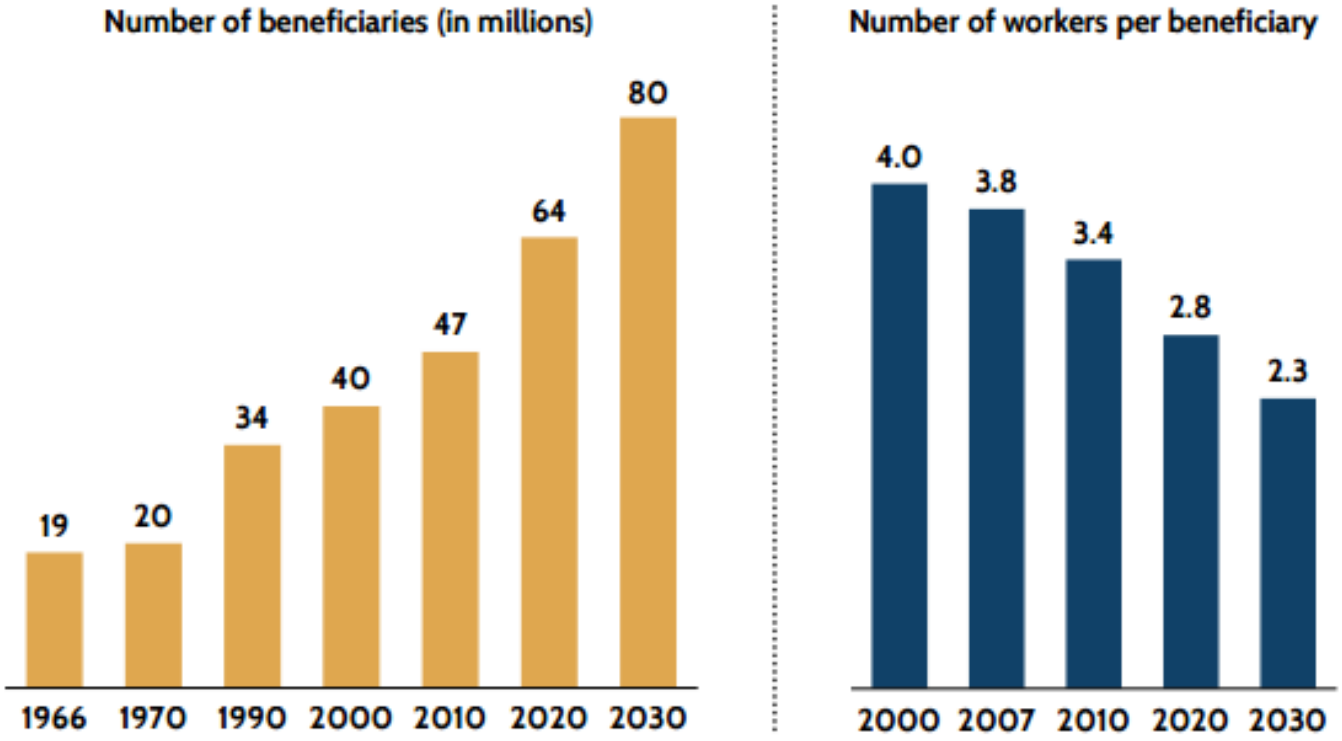
- Background: Why Optimize Revenue Cycle?
- Areas of Opportunity
  - Registration, Billing, Collections
- Metrics that Matter
- Optimizing Quality Outcomes and Reimbursement
- Financial Impacts of Patient Engagement

Revenue Cycle Optimization

- External environment cinching the belt on payments
- Incentives and penalties driving effective, cost efficient care

Medicare Solvency

Exhibit 4. Federal Budgetary and Trust Fund Solvency Concerns as the U.S. Population Ages



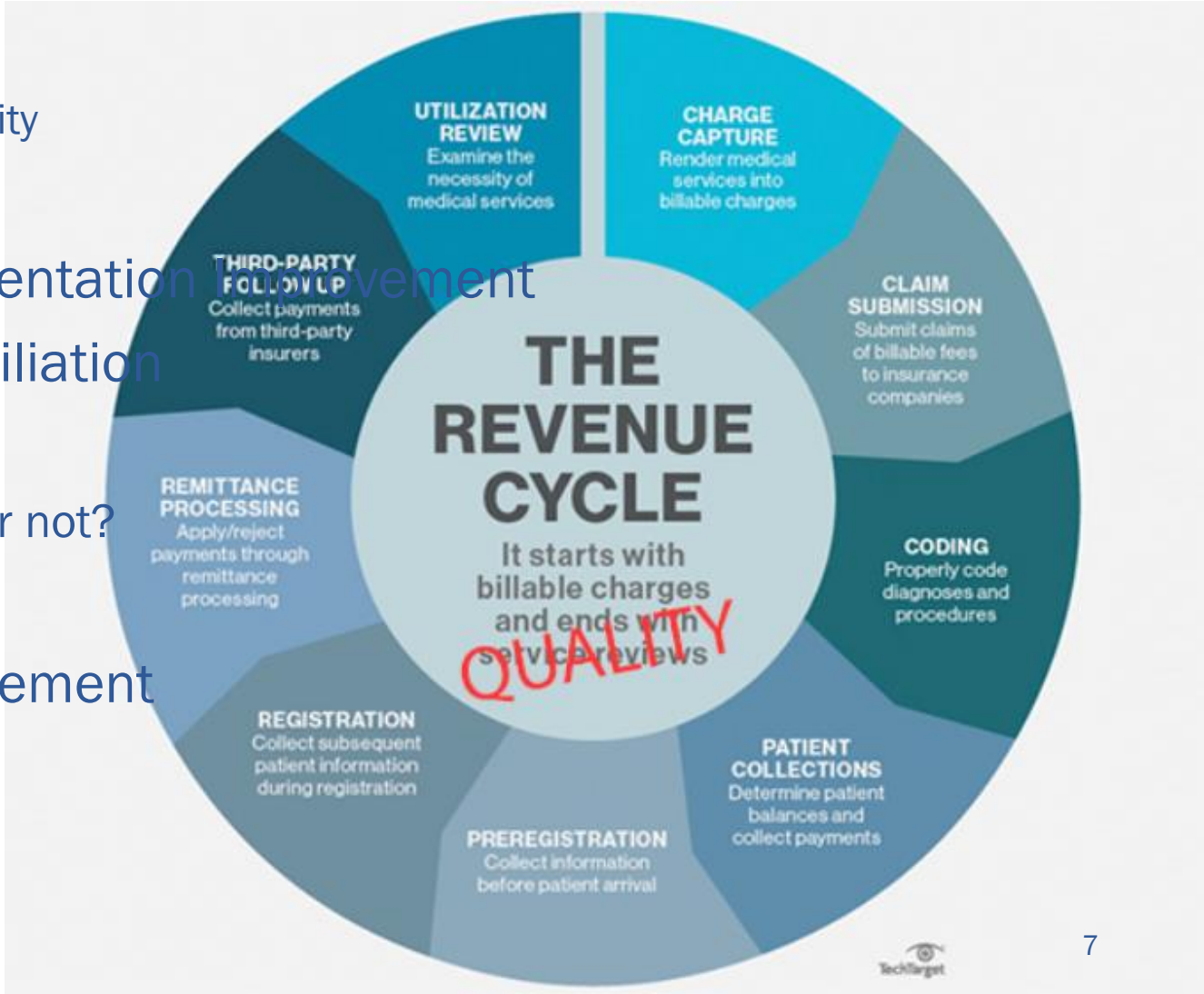
Source: 2010 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.

Payment Reform: Challenging Environment

- In Vermont,
  - Reduced Disproportionate Share (DSH) Payments
  - Revenue Cap
  - Risk Based Payment Models: Population Health
    - Risk 1: Costs exceed payments
    - Risk 2: Costs of participants seeking care outside of "network"
  - Ambulatory Surgical Centers & Urgent Cares
    - Directing high revenue procedures elsewhere
  - ACO Federal Funding Deficits funded by hospital

Rev Cycle Optimization: Areas of Opportunity

- Registration
  - Medical Necessity
- Supply Chain
- Clinical Documentation Improvement
- Charge Reconciliation
- Coding
  - To automate or not?
- Billing
- Denials Management



Registration

- Back to the Basics:
  - Every field, Every encounter, Every time
  - No assumptions
- Build logic to support workflow
  - Reg Types drive specific coding lists, drive billing – CLIs all go to coders
  - Location drives dept specific coders worklists (Lab CLI vs DI CLI)
- Educate, Educate, Educate!!!
  - Above logic and workflows are specific and complex
  - Solid orientation program with ongoing elbow support

Medical Necessity

- System generated ABNs
- Ideal at Order Entry
- If not, at Point of Care

Supply Chain

Lesson Learned: Eliminate paper processes!

- Effective automated systems

Require reliable workflows

How does stocking occur?

Centralized or decentralized?

How do clinicians decrement?

Is there a delay between pulling and distributing?

EDI: Electronic Data Exchange

- Saves time by eliminating manual transaction process
- Eliminates manual costs
  - "A major electronics manufacturer calculates the cost of processing an order manually at $38 compared to just $1.35 for an order processed using EDI"
- Allows staff to focus on other high value areas
- Improved transaction quality - reduced errors and rework
- Increased business efficiency/ transaction turnaround time

Clinical Documentation Improvement

- Appropriateness and Specificity of documentation
  - Goal – Bill DRG best aligned with patient presentation
  - BMI/Obesity/Morbid Obesity/Malnutrition
  - Failure to Thrive as opposed to weakness
- Complications & Comorbidities: CCs and MCCs
  - MS-DRG 179 Complex pneumonia without CC or MCC, Hospital reimbursement $5,389
  - MS-DRG 178 Complex pneumonia with CC, Hospital reimbursement $7,922
  - MS-DRG 177 Complex pneumonia with MCC, Hospital reimbursement $11,302
- Many on line resources available
  - Certifications of CDI Specialists
  - Program implementation

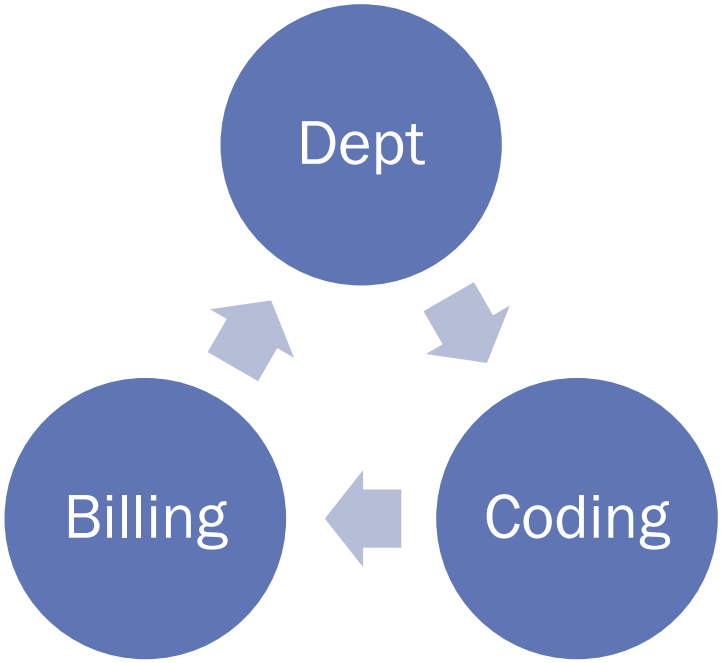
CCs and MCCs

NON CC	CC	MCC
Altered Mental Status	Delirium d/t Xanax Withdrawal	Toxic Encephalopathy
Angina	Unstable Angina	Non ST Elevation MI
CHF	Systolic CHF	Acute Systolic CHF

- Impact Readmissions Scoring as well

Charge Reconciliation

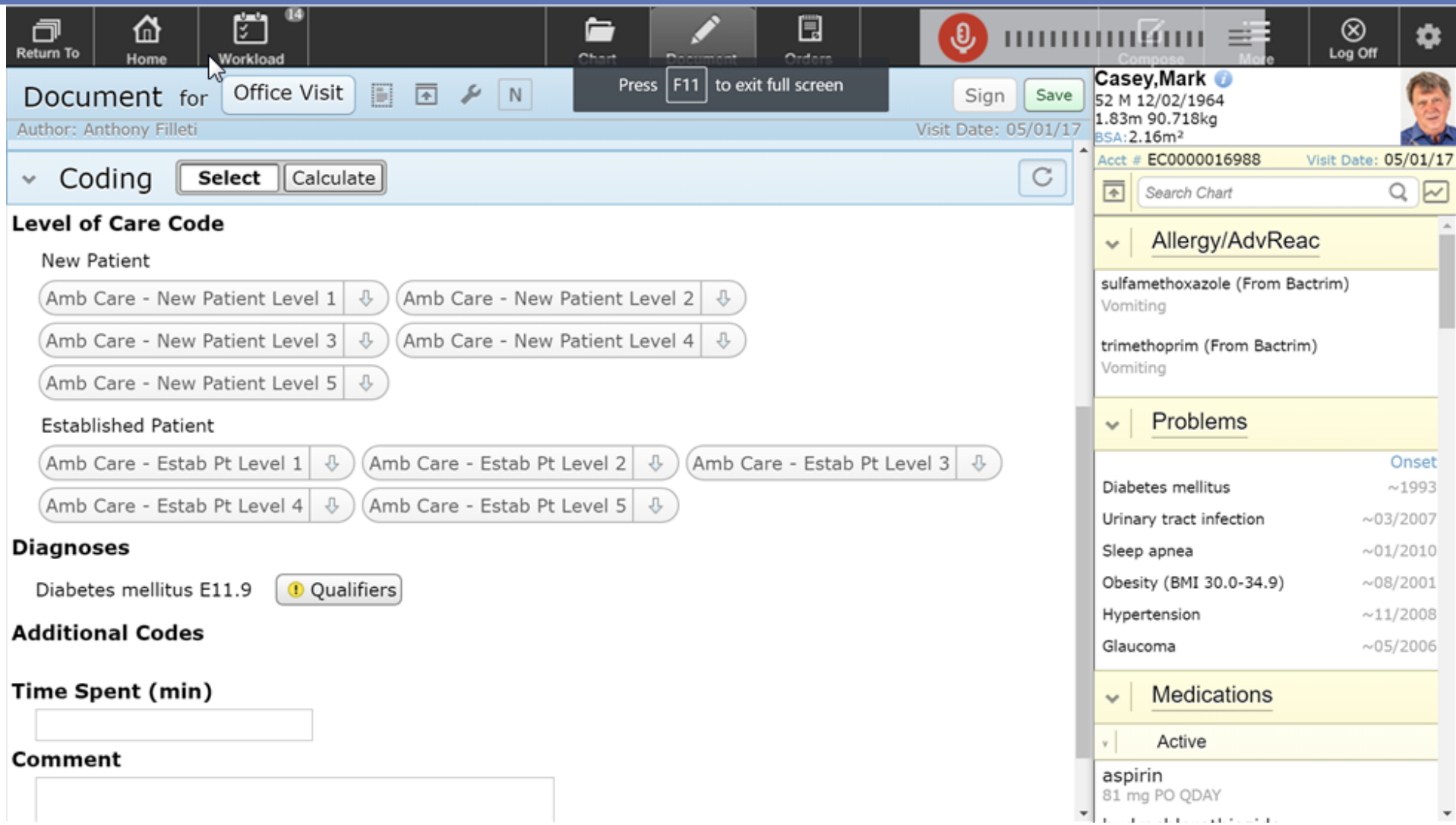
- Revenue Generating Departments
- Charge check before transmission to billing



Coding

- Use of Computerized Coding
  - Understand ROI
- Determination of which services are and are not coded by coders
  - ED? Inpatient? Rehab? Clinics? Labs?
- Evaluation and Management Coding: Manual or automated?
  - Extent of history, extent of examination can be automated
  - MDMing more difficult to automate

Coding Logic Embedded



Metrics That Matter

- Days in AR: Accounts Receivable: Low
- UR: Unbilled Receivables: Low
- DNFB: Days Not Final Billed: Low

- If upgrading, expect these to go up – plan for increased need for cash on hand based on projected number of days increase and ave charges per day.

CMS Has Many Quality and Reporting Programs (991 unique measures!)

Hospital Quality	Physician Quality Reporting	PAC and OTHER Setting Quality Reporting	Payment Model Reporting	"Population" Quality Reporting
• Medicare and Medicaid EHR Incentive Program	• Medicare and Medicaid EHR Incentive Program	• Inpatient Rehabilitation Facility	• Medicare Shared Savings Program	• Medicaid Adult Quality Reporting
• PPS-Exempt Cancer Hospitals	• Physician Quality Reporting System (PQRS)	• Nursing Home Compare Measures	• Hospital Value-based Purchasing	• CHIPRA Quality Reporting
• Inpatient Psychiatric Facilities	• Value-based Payment Modifier (VM)	• LTCH Quality Reporting	• Physician Feedback	• Health Insurance Exchange Quality Reporting
• Inpatient Quality Reporting	• Maintenance of Certification	• Hospice Quality Reporting	• ESRD QIP	• Medicare Part C
• HAC Payment Reduction Program		• Home Health Quality Reporting	• Innovations Pilots	• Medicare Part D
• Readmission reduction program				
• Outpatient Quality Reporting				
• Ambulatory Surgical Centers				

= Public Reporting Focus for Hospitals/ CAHs/ Eligible Providers

http://www.cms.gov/eHealth/downloads/eHealthU_PQRSQualityManagement101.pdf

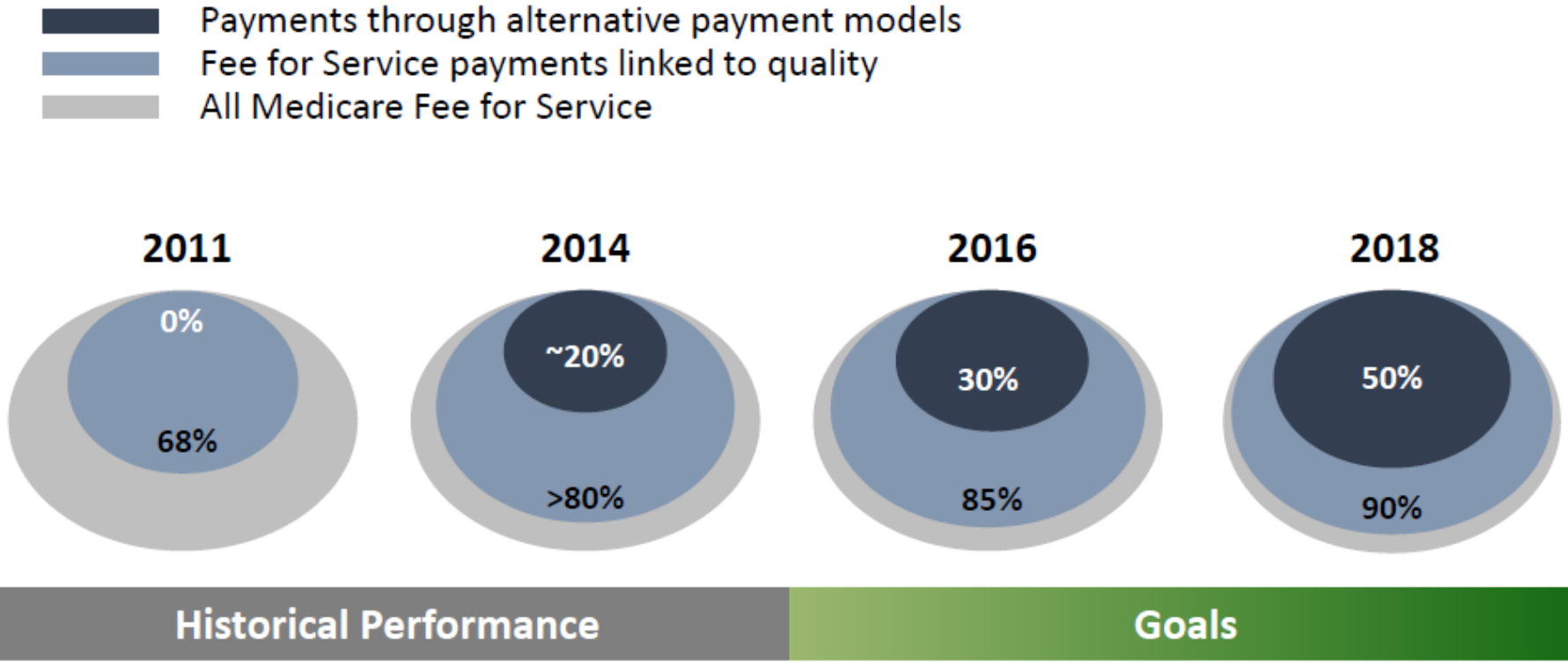
Fiscal Impact of Quality Programs

Hospital Quality	Physician Quality Reporting	PAC and OTHER Setting Quality Reporting	Payment Model Reporting	"Population" Quality Reporting
• Medicare and Medicaid EHR Incentive Program • PPS-Exempt Cancer Hospitals • Inpatient Psychiatric Facilities • Inpatient Quality Reporting • HAC Payment Reduction Program • Readmission reduction program • Outpatient Quality Reporting • Ambulatory Surgical Centers	• Medicare and Medicaid EHR Incentive Program • Physician Quality Reporting System (PQRS) • Value-based Payment Modifier (VM) • Maintenance of Certification	• Inpatient Rehabilitation Facility • Nursing Home Compare Measures • LTCH Quality Reporting • Hospice Quality Reporting • Home Health Quality Reporting	• Medicare Shared Savings Program • Hospital Value-based Purchasing • Physician Feedback • ESRD QIP • Innovations Pilots	• Medicaid Adult Quality Reporting • CHIPRA Quality Reporting • Health Insurance Exchange Quality Reporting • Medicare Part C • Medicare Part D

Surveillance: Improving Outcomes

Name Acct. # A/S	Location Room/Bed Admit Date/Time	Count	Sepsis Go To	CAUTI Go To
Lahr,Liam EB0000000719 5 M	**8 East** 813 1 12/17/14 08:40	1		
Fullerton,Robert E. EB0000000840 55 M	**6 North** 606 1 01/06/15 14:36	1	✓	
Fullerton,Sandra F. EB0000000841 52 F	**6 North** 606 2 01/06/15 14:37	2		
Vita,John EB0000000877 51 M	**3 South** 308 2 01/08/15 17:30	1		✓
Stone,Richard EB0000000921 65 M	**3 East** 316 1 01/14/15 11:48	1		
Smith,John EB0000001254 70 M	**9 East** 926 1 01/28/15 13:00	2		
Smith,Jeffrey EB0000001255 52 M	**3 North** 302 1 01/28/15 13:36	2		✓
Damon,Jordan EB0000001627 45 F	**9 South** 915 2 06/03/15 09:00	2		

Rising MCR Payments Associated with Quality

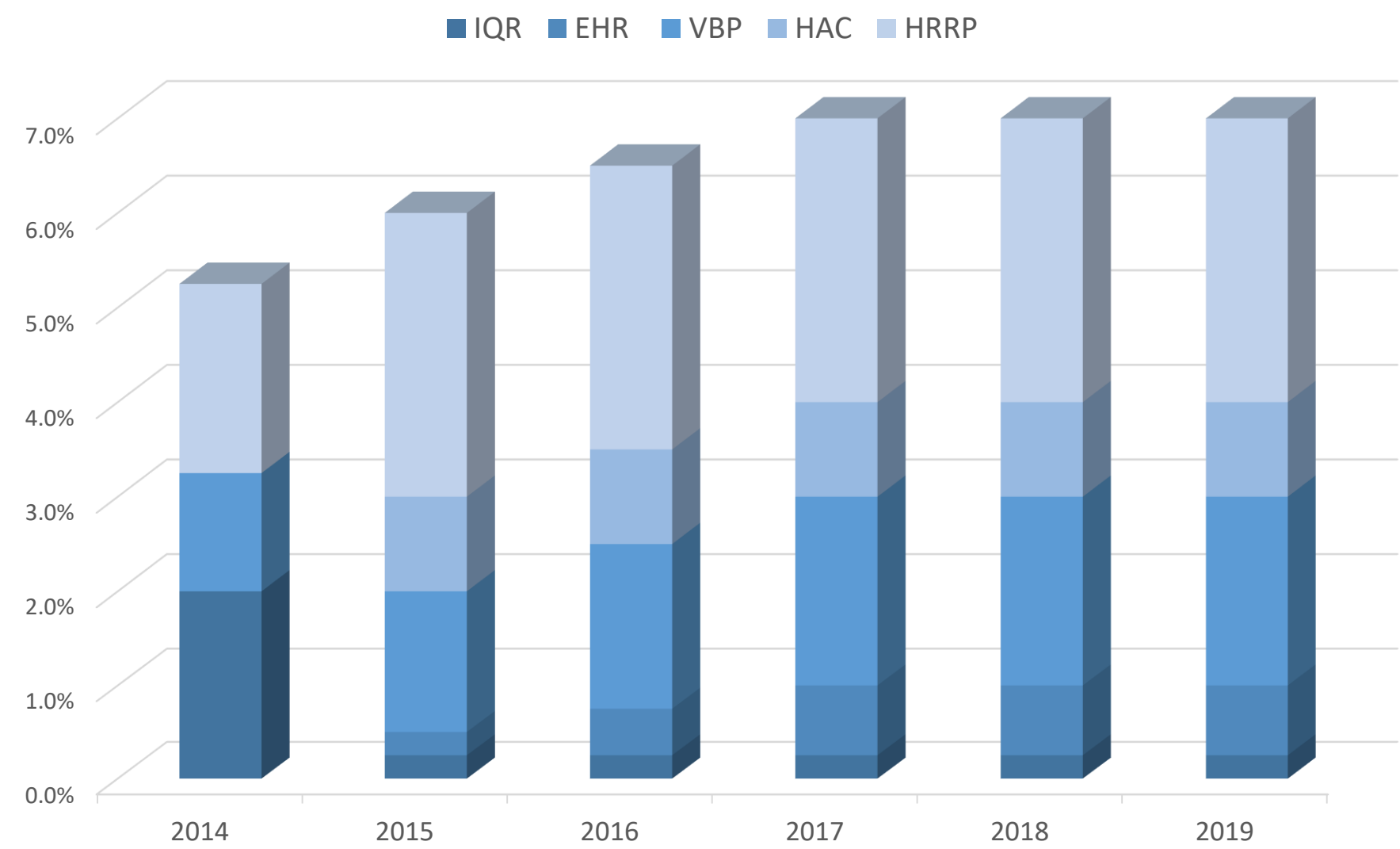


Revenue At Risk

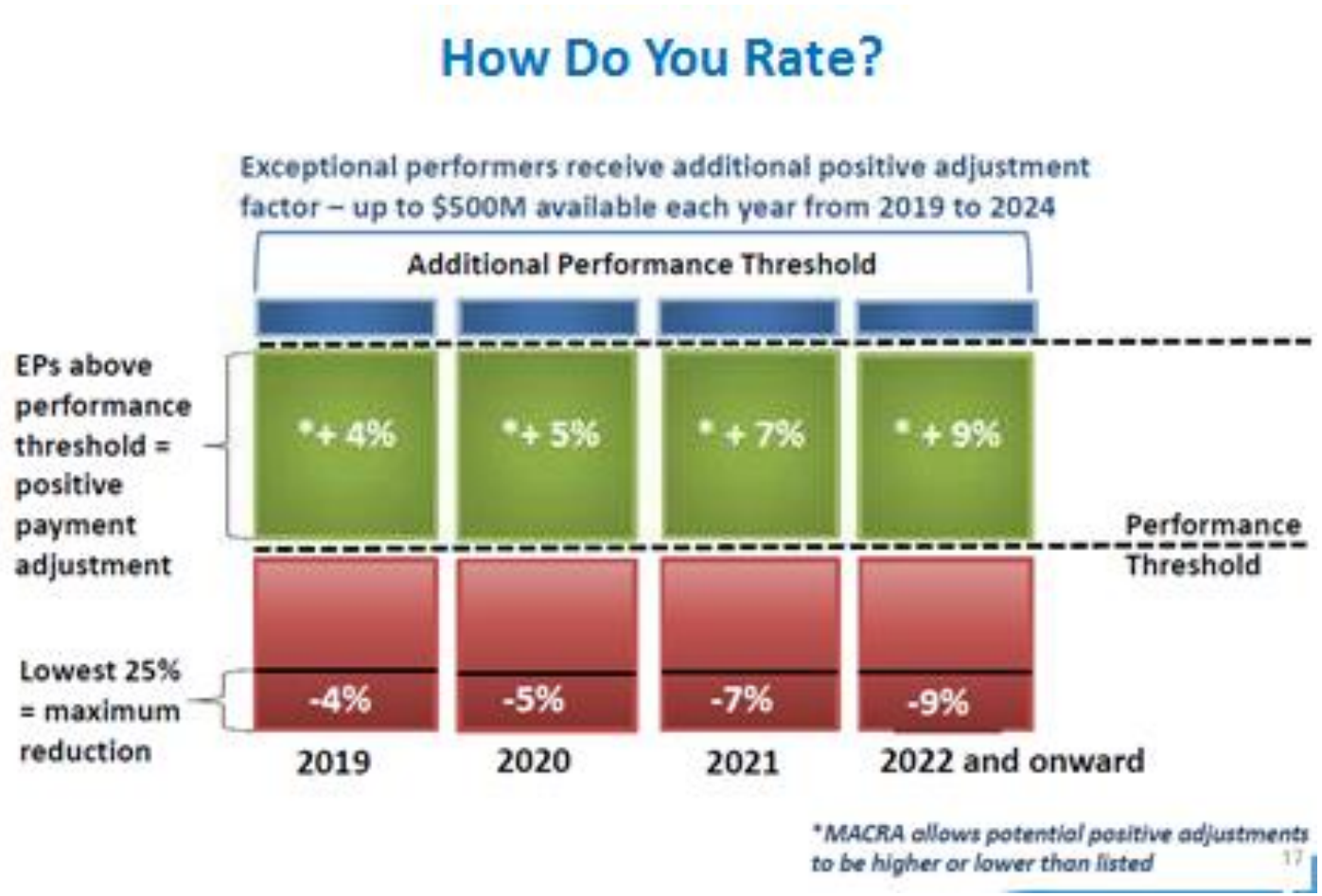
Year	IQR	EHR MU	VBP	HAC	HRRP
2016	25% MBU	50% MBU	1.75% DRG	1.0% DRG	3.00% DRG
2017	25% MBU	75% MBU	2.00% DRG	1.0% DRG	3.00% DRG
2018	25% MBU	75% MBU	2.00% DRG	1.0% DRG	3.00% DRG
2019	25% MBU	75% MBU	2.00% DRG	1.0% DRG	3.00% DRG

- 2,573 hospitals will receive cuts in Medicare payments up to 3% starting in Oct 2017
- Equates to a projected 564 million dollar federal savings

Increasing Risk Over Time



Financial Impact: MIPS



Hospital Analysis Tools

- Medicare Hospital Value Based Purchasing (VBP) Impact Analysis
- Provider Statistical & Reimbursement (PS&R) Report
- Inpatient Prospective Payment System (IPPS) Federal Fiscal Year Analysis
- Readmissions Reduction Program Analysis
- Hospital Acquired Condition (HAC) Reduction Program Analysis

Provider Analysis Tools

- Physician Quality Reporting System (PQRS) Payment Adjustment Feedback Reporting
- Annual Quality and Resource Use Report (QRUR)
- Physician Quality Reporting System (PQRS) Measures: eCQM Benchmarks

Readmission Reduction Impact Analysis

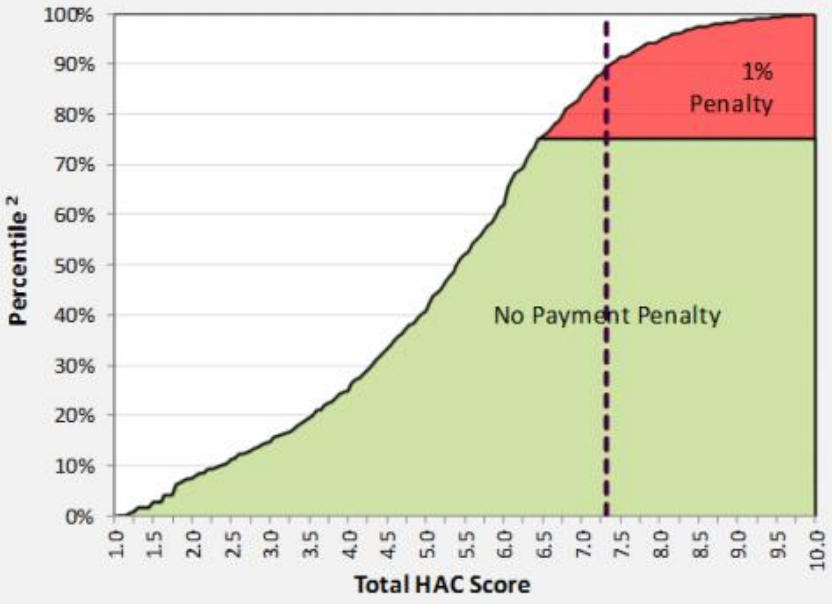
	FFY 2015					FFY 2016					FFY 2017				
	Excess Ratio		Revenue by Condition		Excess Readm. Dollars*	Excess Ratio		Revenue by Condition		Excess Readm. Dollars	Excess Ratio		Revenue by Condition		Excess Readm. Dollars
Condition: AMI	0.9384	X	$351,097	=	$0	0.9545	X	$300,198	=	$0 ▲	0.9641	X	$349,336	=	$0 ▲
Condition: HF	0.9078	X	$1,028,500	=	$0	0.8930	X	$965,779	=	$0 ▼	0.8904	X	$924,800	=	$0 ▼
Condition: PN	0.9807	X	$2,632,126	=	$0	1.0232	X	$2,460,855	=	$57,005 ▲	1.1284	X	$2,538,489	=	$325,829 ▲
Condition: THA/TKA	1.0311	X	$3,037,179	=	$94,491	0.9464	X	$2,597,674	=	$0 ▼	1.0467	X	$2,142,161	=	$100,015 ▲
Condition: COPD	0.9849	X	$1,061,157	=	$0	0.9536	X	$1,000,770	=	$0 ▼	1.0293	X	$1,026,791	=	$30,043 ▲
Condition: CABG	Does Not Apply					Does Not Apply					0.0000	X	No Data	=	No Data
Est. Excess Readmission Dollars	$94,491					$57,005 ▼					$455,887 ▲				
Final RRP Adjustment Factor	0.9975					0.9982 ▲					0.9843 ▼				
Percentage Impact	-0.25%					-0.18%					-1.57%				
Estimated Annual Impact	($21,500)					($15,500) ▲					($136,700) ▼				

HAC Reduction Impact Analysis

Estimated Program Performance

	Raw Score		Domain Weight		Weighted Domain Score
Domain 1 - AHRQ Claims Based Measure	**8.00**	X	**15%**	=	**1.20**
Domain 2 - CDC Chart Abstracted Measures	**7.20**	X	**85%**	=	**6.12**
Total HAC Score (Sum of Weighted Domain Scores)[1]			**7.32**		

Estimated Program Impact



Hospital Revenue Exposure Estimate:

Estimated FFY 2017 Revenue	$44,599,600
Revenue at Risk For Payment Reduction (1%)	$446,000

Total HAC Score Performance Summary:

Estimated Total HAC Score	7.32
Lowest Total HAC Score Receiving Payment Penalty[3]	6.45

HAC Payment Penalty Determination:[3]

Hospital Estimated to be in the Top (worst) Quartile?	YES
Estimated HAC Program Payment Impact	($446,000)

PROVIDER STATISTICAL AND REIMBURSEMENT SYSTEM

Program ID: INPATIENT
Paid Date: 10/01/2015 - 09/30/2016
Provider FYE: 09/30
Provider Number: **550045** Acmeware Medical Center

PROVIDER SUMMARY REPORT
INPATIENT - PART A

Page: 2
Report #: 0D2341
Report Type: ACME

	SERVICES FOR PERIOD 10/01/15 - 09/30/16
REIMBURSEMENT SECTION	
OPERATING PAYMENTS	$30,955,000.00
HOSPITAL READMISSION ADJ	-$430,000.00
VALUE BASED PURCHASING ADJ	-$525,000.00
GROSS REIMBURSEMENT	$30,000,000.00
LESS	
HAC Reduction	-$300,000.00
CASH DEDUCTIBLE	$0.00
OTHER ADJUSTMENTS	$0.00
NET REIMBURSEMENT	$29,700,000.00
TOTAL LOSS	($1,255,000.00)

DIAGNOSIS-RELATED GROUP (DRG) REIMBURSEMENT

Period: 10/01/2016 - 09/30/2017

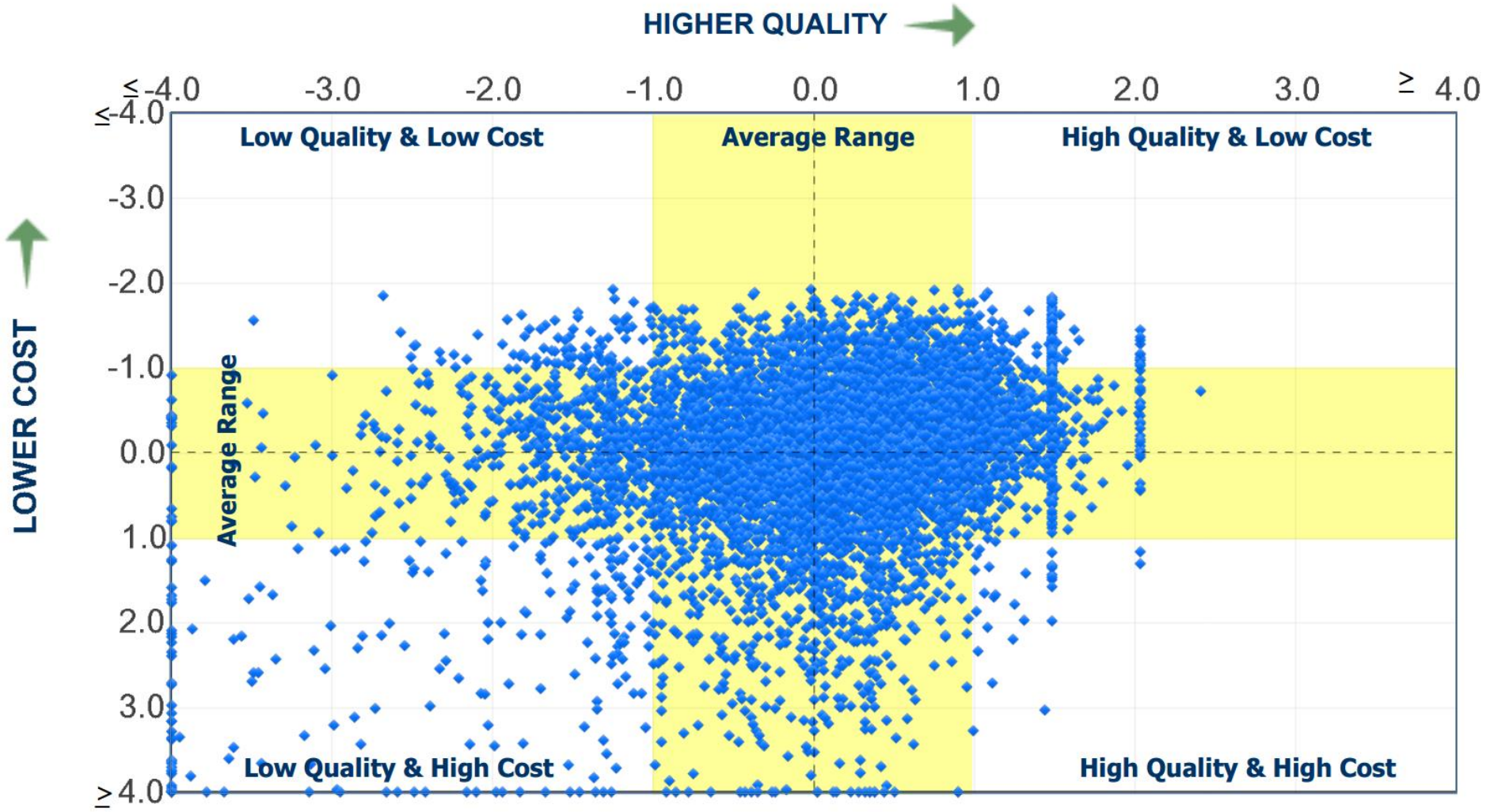
DIAGNOSIS-RELATED GROUP (DRG) REIMBURSEMENT

DRG 2017 (FORECAST)	$40,000,000.00
MARKET BASKET UPDATE (MBU) ADJUSTMENT	0.90%
MARKET BASKET UPDATE (MBU) ADJUSTMENT	$360,000.00
INPATIENT QUALITY REPORTING (IQR) PENALTY	-25%
EHR INCENTIVE PROGRAM (MU) PENALTY	-75%

LESS

INPATIENT QUALITY REPORTING (IQR) PENALTY	$90,000.00
EHR INCENTIVE PROGRAM (MU) PENALTY	$270,000.00
OTHER ADJUSTMENTS	$0.00
NET ADJUSTMENTS	$360,000.00

Quality and Resource Use Report



Patient Engagement : Outcomes

- "…in the 2016 Healthcare Management Forum, there was a study from McGill University [on strong patient engagement] that showed a 20% improvement in patient experience of care, a 25% decrease in C. diff and antimicrobial-resistant infections, and they calculated savings of $340,000 in one year,"

  - Joe Kiani, founder of the Patient Safety Movement Foundation and chairman and CEO of Masimo

Transitional and Transformative Strategies

- Use of Impact reports to determine areas of focus
- Provider Cost Analysis by DRG
- Using EHR to present cost data at order entry
  - Meds
  - Labs
  - High Risk Medications
- Qualified Clinical Data Registry (QCDR) to promote patient engagement

Challenges

- Disparate Systems
- Difficult to assess performance across settings
- Creation of Clinical Alerts
- Coding occurs post discharge
- Understanding workflow required by eCQMs
- Transition from free text and customized reporting

Conclusion

- Transformation
- Disruptive Innovation
- Mission/Vision/Values trump Personal Preference
- Provider, Staff, Patient Engagement
- Relate, Don't Compare
  - Benchmark yourself against the outside world
- Accountability and Execution
- Perseverance

Questions?

- Jodi Frei, PT MSMIIT Northwestern Medical Center
- William Presley, Vice President Acmeware

Resources

- https://www.studergroup.com/resources/articles-and-industry-updates/articles-and-whitepapers/why-patient-engagement-matters
- http://www.commonwealthfund.org/~/media/files/publications/fund-report/2015/jun/1821_davis_aca_and_medicare_v2.pdf
- http://www.ahima.org/topics/cdi
- https://www.edibasics.com/benefits-of-edi/
- https://e-medtools.com/drg_modifier.html