Revenue Cycle Optimization

Tools and Strategies for Success

NMC
Northwestern Medical Center

Acmeware

Introductions

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

Audience Survey

- Who is in attendance?
  - Finance
  - IT
  - Compliance
  - Clinical

Agenda & Goals

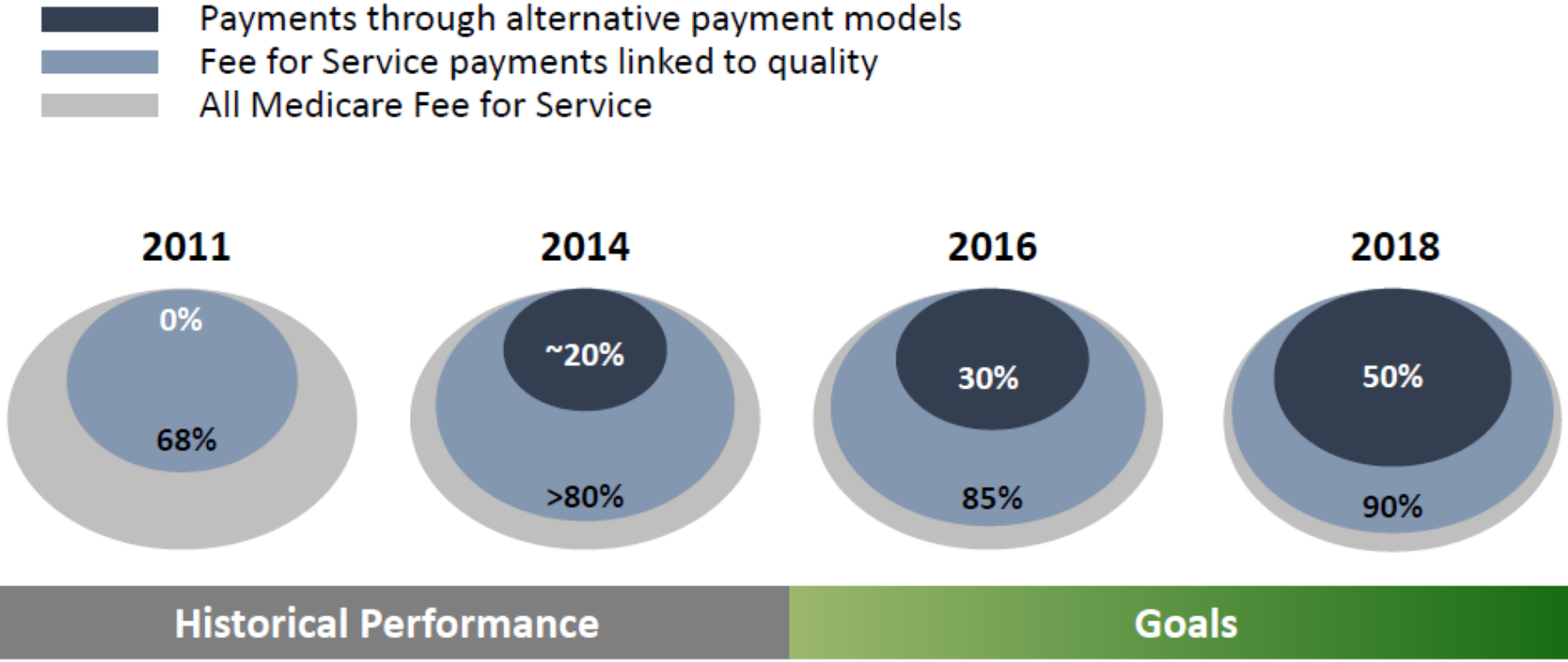
- Background: Why Optimize Revenue Cycle?
- Areas of Opportunity
- Metrics that Matter
- Optimizing Reimbursement Through Quality Outcomes
- Financial Impacts of Patient Engagement

- **Goal: Participants take back concepts that facilitate**
  - **Improved Revenue Capture and/or**
  - **Transition to Value Based Reimbursement**

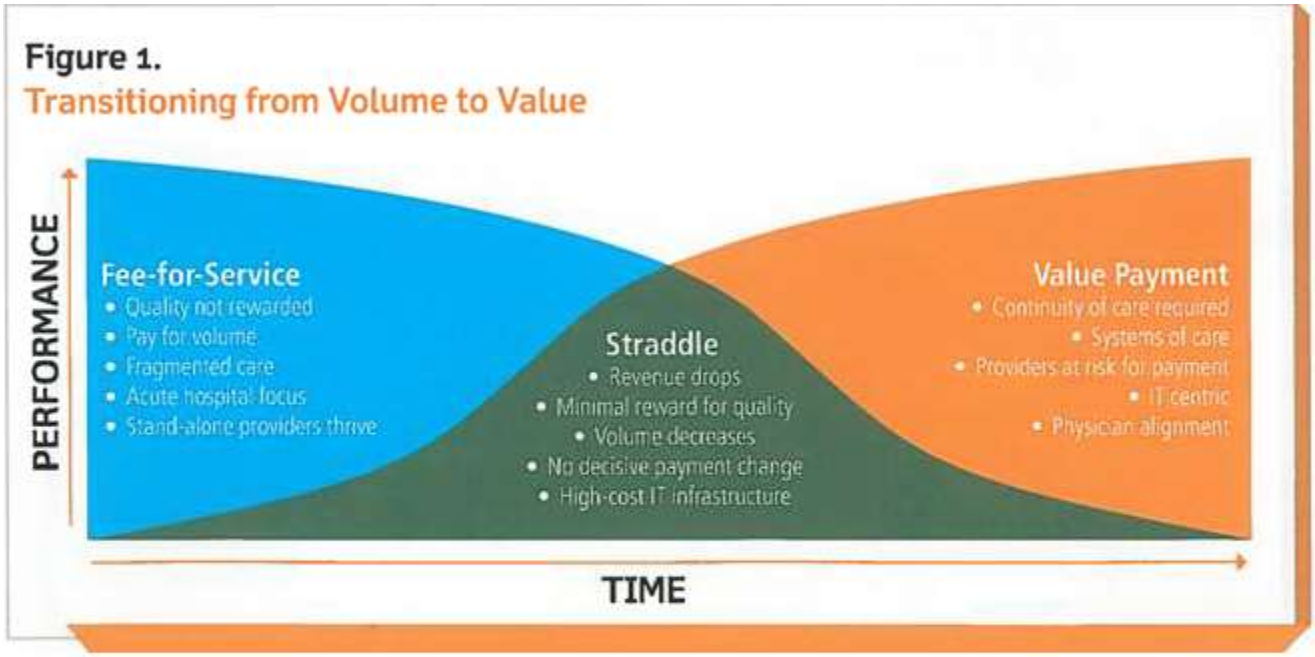
Background: Revenue Cycle Optimization

- Payment Reform Challenges
- Incentives and penalties driving effective, cost efficient care

Rising MCR Payments Associated with Quality



Transitioning From Volume to Value



SOCIETY FOR
Healthcare Strategy & Market Development™
of the American Hospital Association

http://www.shsmd.org/

Payment Reform: Challenging Environment

- In Vermont,
  - Revenue Cap
  - Capitated Payment Models: Population Health
  - Ambulatory Surgical Centers & Urgent Cares
    - Directing high revenue procedures elsewhere
  - ACO Federal Funding Deficits funded by hospital

All necessitate need to scrutinize/re-evaluate Revenue Cycle processes

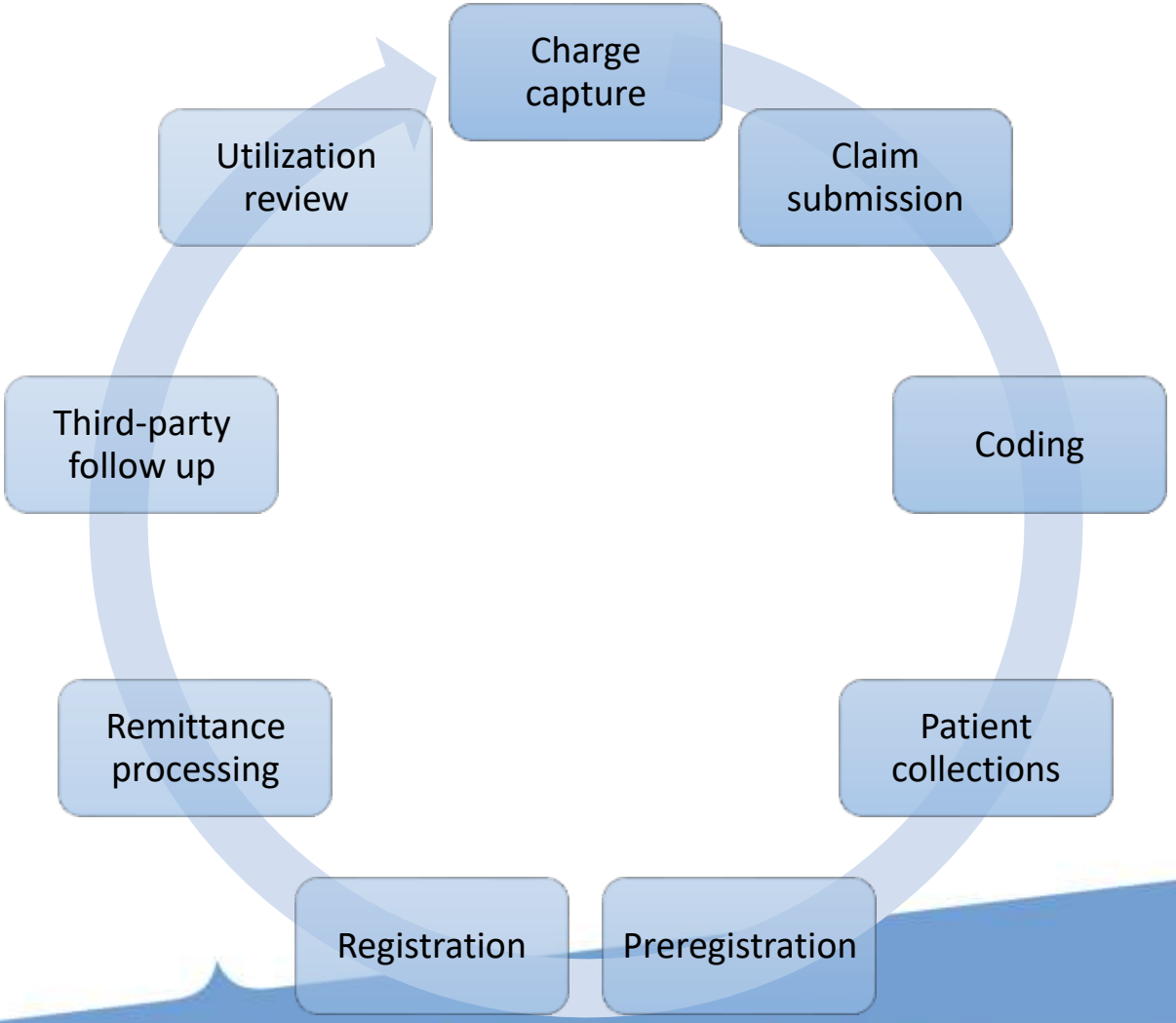
Audience Survey

- Are you participating in an Alternative Payment Model?

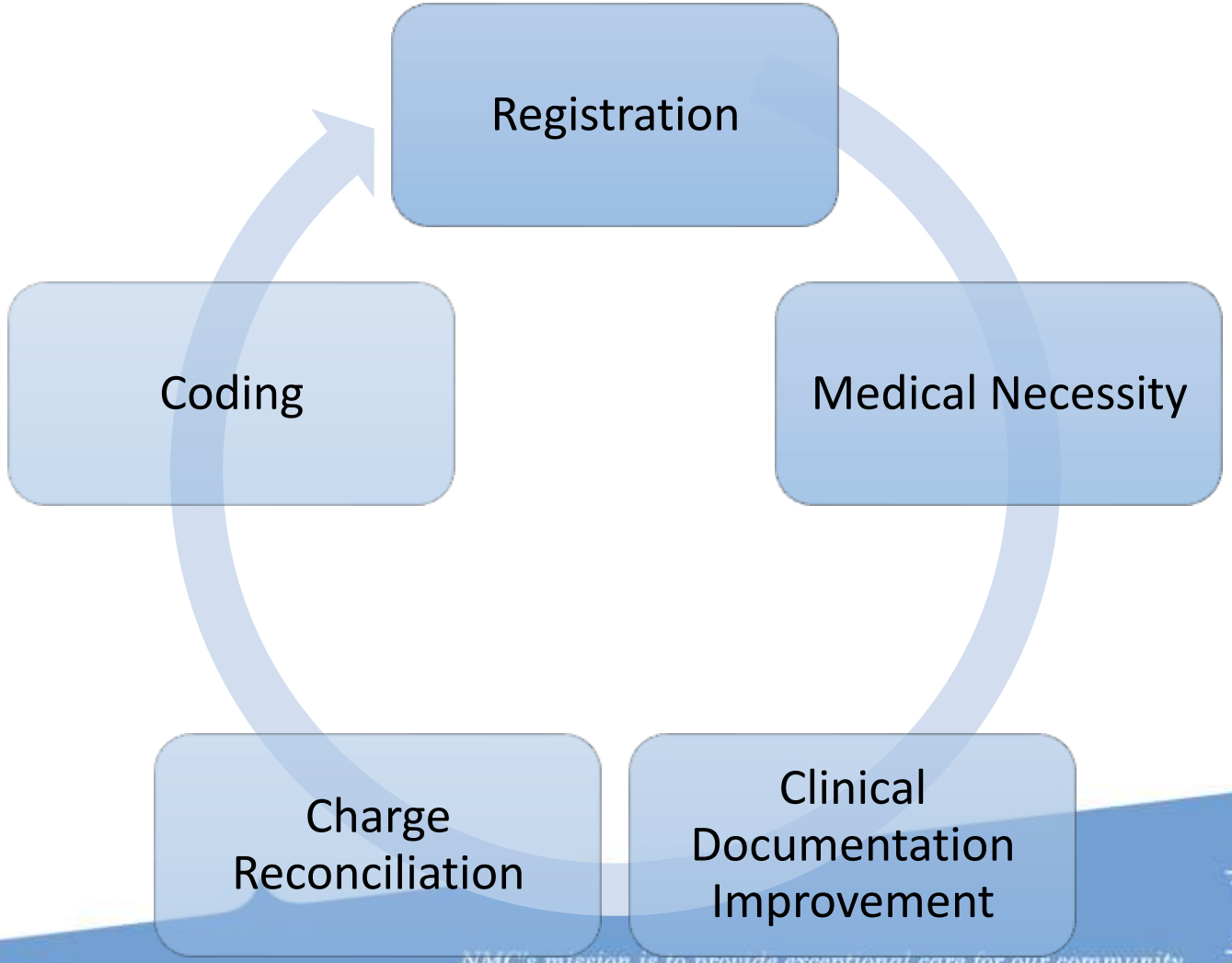
Examples

- Risk Sharing
- Shared Savings
- Capitated Payments
- Bundled Payments
- ACO

Revenue Cycle Management



Rev Cycle Optimization: Areas of Opportunity



Transition to 6.16

- Strategic initiative
- 12-16 month long project
- New Web ED/Acute
- Rewrite of Registration, B/AR, Surgery and HIM

- Many successes…many lessons learned
  - Revenue Cycle!

Registration

- Back to the Basics:
  - Accuracy: Confirm Every field, Every Encounter.
  - No assumptions
- Build logic to support coding and billing workflow
  - Reg Types drive specific coding lists – CLIs all go to coders, RCRs do not
  - Locations drive coder worklists - Lab CLIs to Sue; DI CLIs to Sara
- Educate, Educate, Educate!!!
  - Above logic and workflows are specific and complex
  - Continuous training
  - In absence, risk lost/delayed revenue capture

Medical Necessity

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

- Risk lost revenue

Advance Beneficiary Notice (ABN)

Patient: Savoie,Eugene M
Account: EB0000021064
Ordering Physician: Fitton,Mary

Provider notice:

Medicare will only pay for services that it determines to be reasonable and necessary under Section 1862 (a) (1) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is not reasonable and necessary under Medicare program standards, Medicare will deny payment for that service. I believe that, in your case, Medicare is likely to deny payment for:

Order	Description	Qty	Estimated Charge	Probable Status
ABDWW.CT.RAD.STD	CT abdomen wo/w con	1	858.25	Rejected

_____ Medicare usually does not pay for routine screening work.
_____ Medicare does not pay for this service for this diagnosis
_____ Medicare does not pay for tests pending FDA approval.
_____ Other _____

Beneficiary agreement

I have been notified by my provider that it believes that,in my case, Medicare is likely to deny payment for the services identified above, for the reason stated. If Medicare denies payment, I agree to be personally and fully responsible for payment.

_____ _____
Beneficiary's Signature Date

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 - $5,389
  - MS-DRG 178 Complex pneumonia with CC - $7,922
  - MS-DRG 177 Complex pneumonia with MCC - $11,302
- Many on line resources available
  - Certifications of CDI Specialists
  - Program implementation

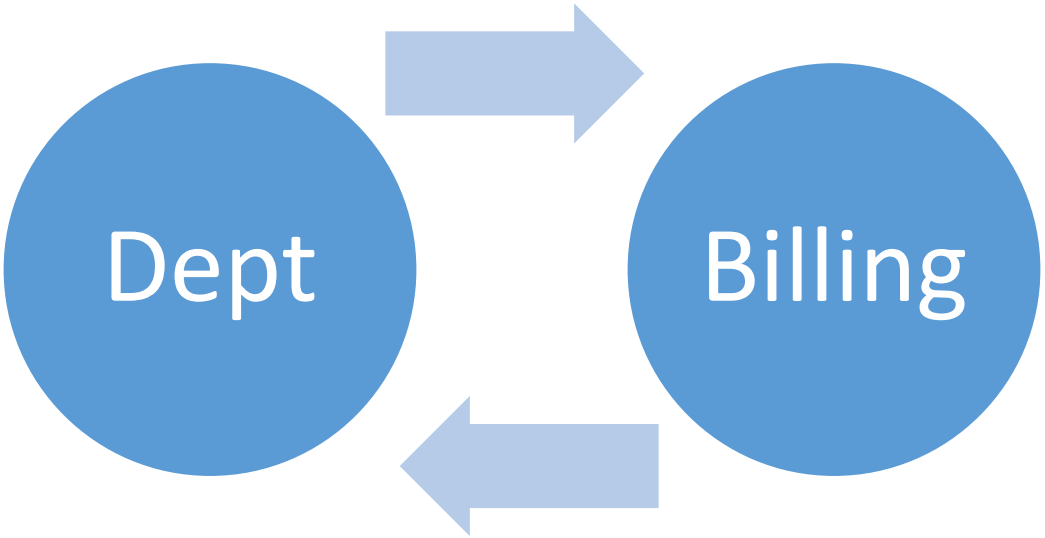
CCs and MCCs

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

- Impacts Readmissions Scoring as well

Charge Reconciliation

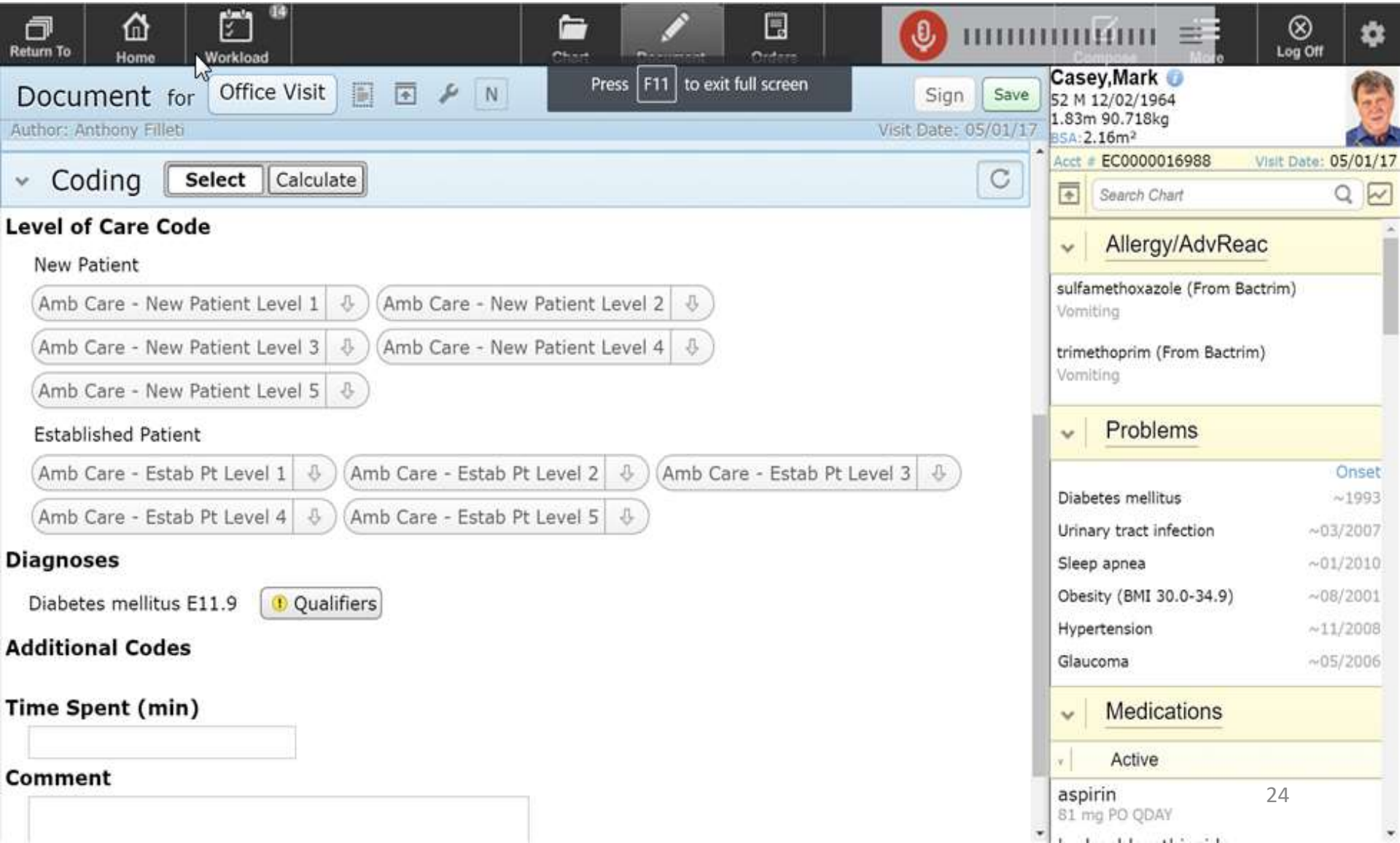
- Revenue Generating Departments



Coding

- Use of Computerized Coding
  - Understand ROI
- Coding for professional services: Manual or automated?
  - Extent of history, extent of examination can be automated
  - MDMing more difficult to automate
  - Understand the impact on adding new areas coded by HIM
    - Increased workload, decreased efficiency can delay charges

Coding Logic Embedded



Metrics That Matter

- Days in AR: Accounts Receivable: 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 average charges per day.

CMS Has Many Quality and Reporting Programs

(991 unique measures!)

Hospital Quality

- 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

Physician Quality

- Medicare and Medicaid EHR Incentive Program
- Quality Payment Program (QPP)
- Merit-Based Incentive Payment System (MIPS)
- Advanced Alternate Payment Model (APM)
- Maintenance of Certification

PAC and Other Settings

- Inpatient Rehabilitation Facility
- Nursing Home Compare Measures
- LTCH Quality Reporting
- Hospice Quality Reporting
- Home Health Quality Reporting

Payment Model

- Medicare Shared Savings Program
- Hospital Value-Based Purchasing
- Physician Feedback
- ESRD QIP
- Innovation Pilots

"Population" Quality

- Medicaid Adult Quality Reporting
- CHIPRA Quality Reporting
- Health Insurance Exchange Quality Reporting
- Medicare Part C
- Medicare Part D

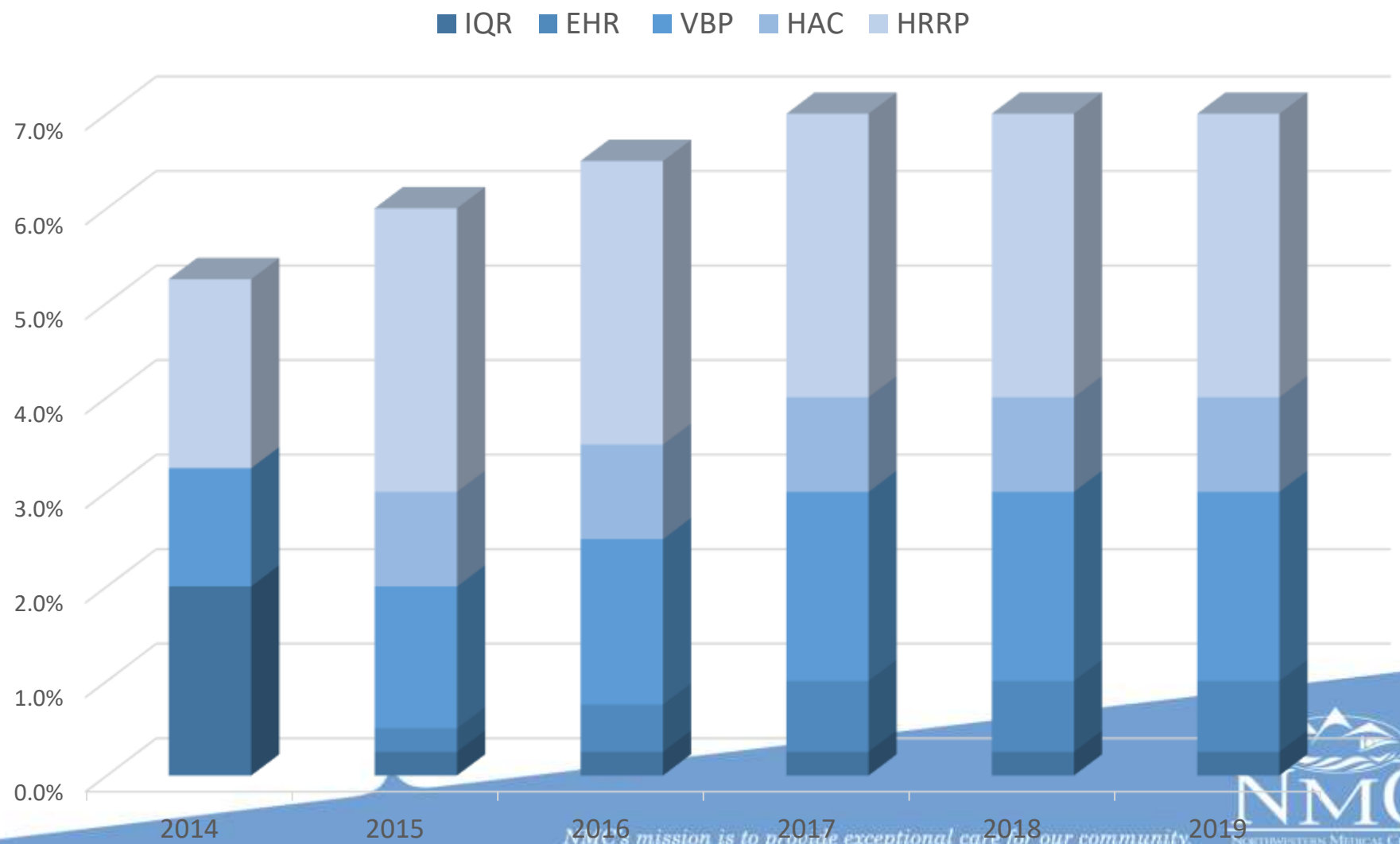
= Public Reporting Focus for Hospitals/ CAHs/ Eligible Providers

Hopsital 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



VBP Domains and Measures

PSI-90
CLABSI
CAUTI
SSI
MRSA
CDI, PC-01

MORT-30-AMI
MORT-30-HF
MORT-30-PN
Pneumonia (PN)
THA/TKA

MSPB: Medicare Spending by Beneficiary:

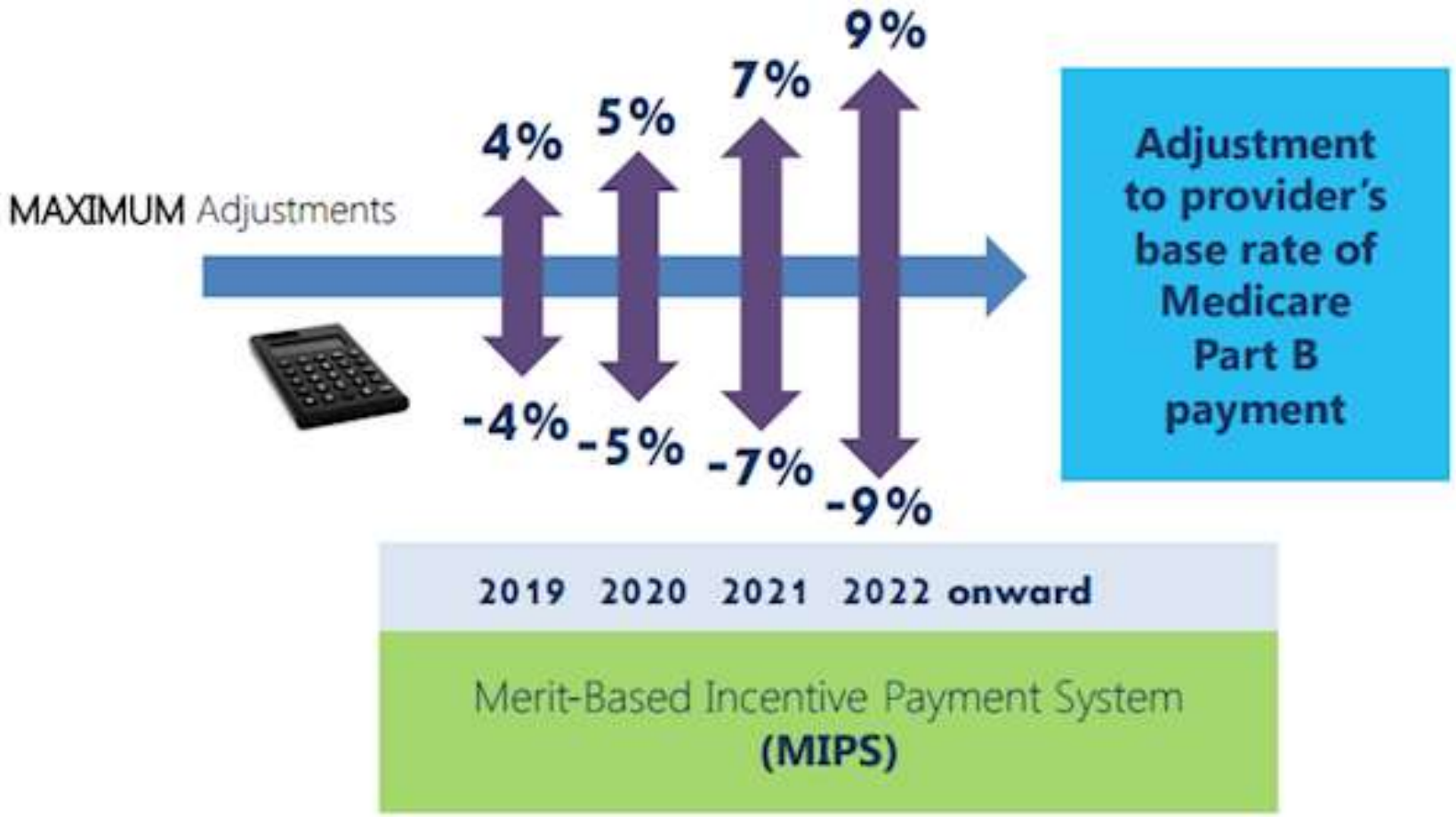
- Claims-Based Measure
- Risk-adjusted and price-standardized payments for Part A and Part B services provided three days prior to hospital admission through 30 days after hospital discharge

Patient Survey
HCAHPS

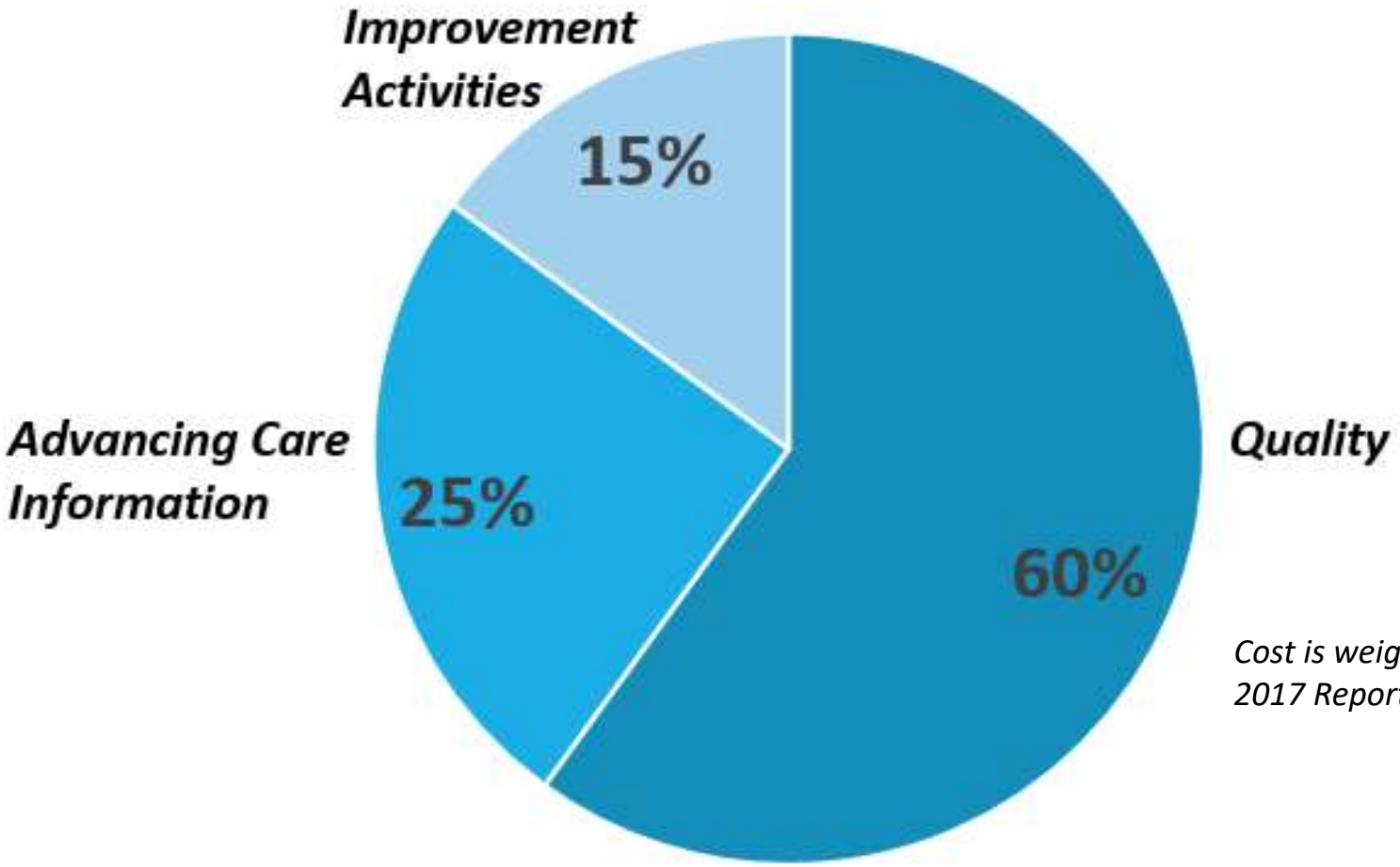
Surveillance: Improving Outcomes

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		

Financial Impact: MIPS



MIPS Categories



Cost is weighted at 0% for 2017 Reporting.

01/01/2017 through 01/07/2017 ▾ Group Individual Ann Mather ▾

MIPS Score: 47.75

Quality

11/60 points

Measures	10
Bonus	1

Advancing Care

87/100 points

Base	50
Performance	37
Bonus	0

Improvement Activities

70/40 points

High Weight	20
Medium Weight	50

MIPS FINANCIAL IMPACT ANALYSIS

FOR PROGRAM YEAR 2017

Tax ID Name: ACME MEDICAL CENTER

Tax ID Number: XXXXX1234

NPI	NPI Name	Provider Specialty	Total Part B PFS Charges	Subject to MIPS Reporting	MIPS Score	Estimated Adjustment Percent	Estimated Financial Impact
254895452	Ann Mather	Emergency Medicine	$198,380.27	Yes	47.75	0.5%	$991.90
254895453	Dorothy Breault	Family Medicine	$60,976.66	Yes	85.54	2.0%	$1,219.53
254895455	Justin Poore	Family Medicine	$118,507.98	Yes	87.34	2.1%	$2,488.67
254895456	William Witt	Ophthalmology	$384,143.94	Yes	50.21	0.5%	$1,920.72
254895459	Sukesh Kansal	Ophthalmology	$251,871.54	Yes	30.24	0.0%	$0.00
254895463	Justin Klaassen	Surgery	$2,996.25	Yes	64.32	1.0%	$29.96
254895464	Robyn Burwell	Nurse Practitioner	$56,848.49	Yes	95.32	3.5%	$1,989.70
254895465	Layce Siemsen	Physician Assistant	$2,980.52	Yes	54.68	0.5%	$14.90
254895466	Lace Sie	Physician Assistant	$59,888.78	Yes	0	-4.0%	($2,395.55)
254895467	Eric Wu	Surgery	$32,873.78	Yes	87.25	2.1%	$690.35
254895468	Ian Wong	Surgery	$0.00	No	61.23	1.0%	$0.00

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

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

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

Readmission Reduction Impact Analysis

	FFY 2015					FFY 2016					FFY 2017				
Condition	Excess Ratio		Revenue by Condition		Excess Readm. Dollars*	Excess Ratio		Revenue by Condition		Excess Readm. Dollars	Excess Ratio		Revenue by Condition		Excess Readm. Dollars
AMI	0.9384	X	$351,097	=	$0	0.9545	X	$300,198	=	$0 ▲	0.9641	X	$349,336	=	$0 ▲
HF	0.9078	X	$1,028,500	=	$0	0.8930	X	$965,779	=	$0 ▼	0.8904	X	$924,800	=	$0 ▼
PN	0.9807	X	$2,632,126	=	$0	1.0232	X	$2,460,855	=	$57,005 ▲	1.1284	X	$2,538,489	=	$325,829 ▲
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 ▲
COPD	0.9849	X	$1,061,157	=	$0	0.9536	X	$1,000,770	=	$0 ▼	1.0293	X	$1,026,791	=	$30,043 ▲
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) ▼				

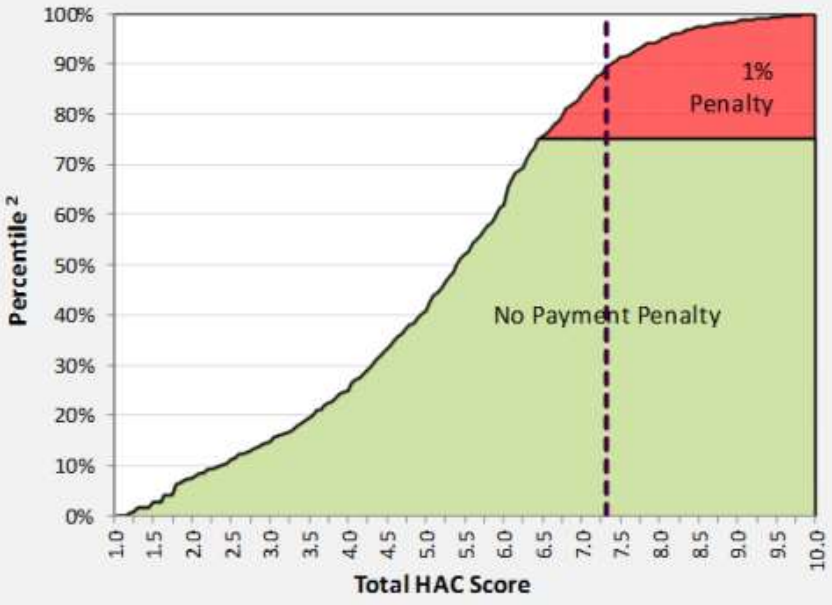
HAC Reduction Impact Analysis

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)

Audience Survey

- Do you use these reports?

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

Challenges

- Disparate Systems
- Difficult to assess performance across settings
- Creation of Clinical Alerts
- Coding occurs post discharge
- Understanding workflow required by eCQMs

Summary

- Re- visit revenue cycle workflows
- Understand your Quality programs
  - Financial Impact
  - Areas of focus
- Leverage your EHRs
- Engage your patients!
- Persist!

Questions?

- Jodi Frei, Director of Quality, 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.ahima.org/topics/cdi
- https://www.edibasics.com/benefits-of-edi/
- https://e-medtools.com/drg_modifier.html