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Stopping Healthcare Waste at Its Source.

Why it's time for a provider-focused waste solution

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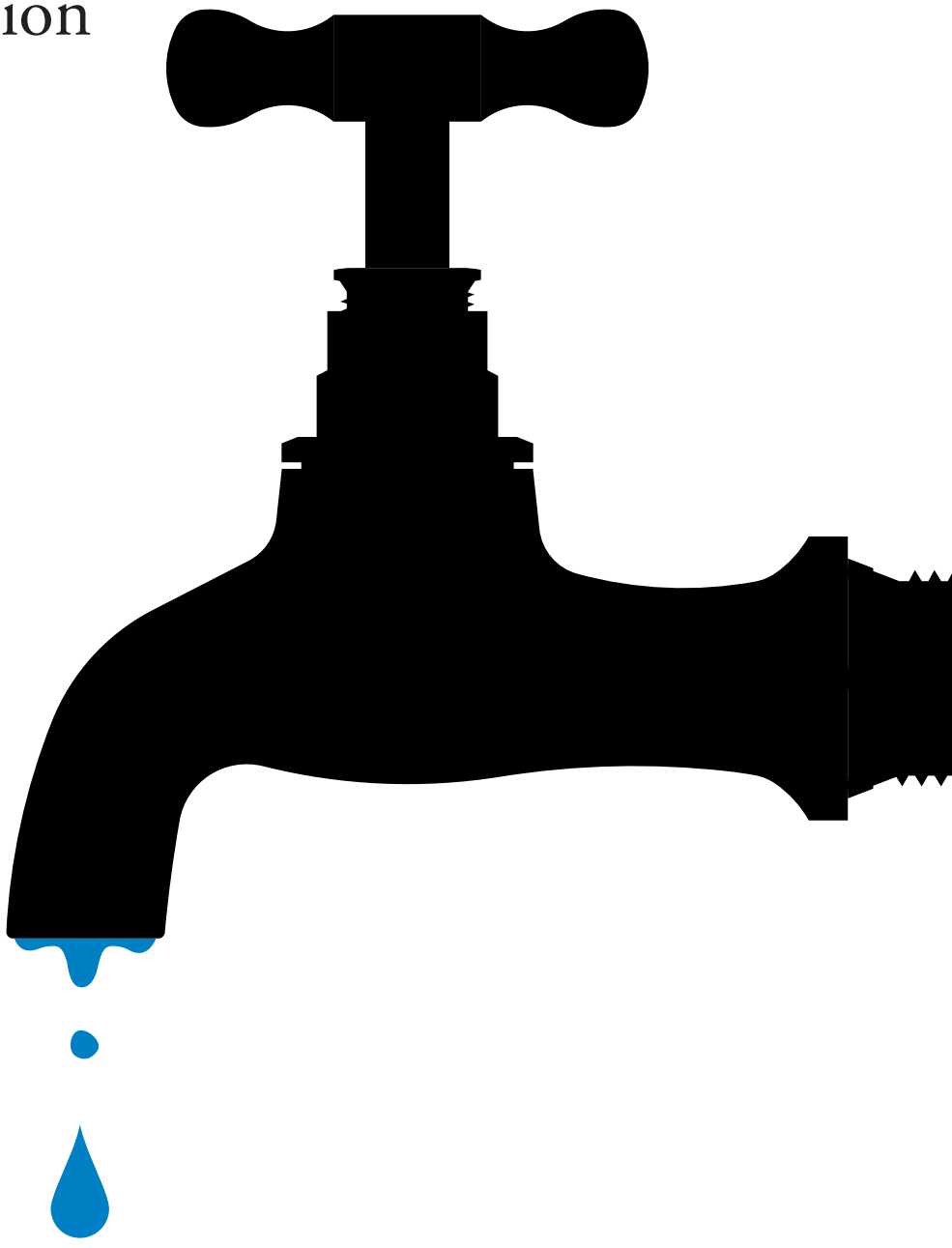

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The healthcare industry is undergoing a seismic shift designed to improve the quality of patient care and manage overall costs. However, while the over arching aim is to reduce administrative burden and waste within the system, the near-term impacts actually increase the cost of running a hospital and lower overall provider revenues. A new trend is emerging in the wake of this impact; one that focuses on addressing waste at the provider level and helping hospitals protect their revenues from the onslaught of mandated change and increased scrutiny.

At The Confluence of Healthcare Changes

If the reforms and changes within the healthcare industry were represented as rivers, providers would be at the point where all of them flow together. This confluence of change is positioned to overwhelm already cash and resource strapped organizations by mandating compliance-related activities and updates to current business and clinical processes. Providers are left footing the bill for programs that—while designed to improve overall patient care—cost millions to implement and increase the risk of revenue losses.

Many of these current and upcoming changes are aimed at targeting the $750 Billion in healthcare waste associated with:

- *Unnecessary services*—those services that are overused, discretionarily used beyond industry standards, or unnecessarily chosen for their higher-cost of service
- *Inefficiently delivered services*—those services that were the result of mistakes, fragmented care, operational inefficiencies, or the unnecessary use of higher-cost providers
- *Excess administrative costs*—those costs associated with paperwork costs above industry standards, inefficiencies on the insurer's side, or inefficiencies due to documentation on the provider's side
- *Prices that are too high*—services and product prices that go beyond industry or competitive benchmarks
- *Missed prevention opportunities*—missed primary, secondary, or tertiary prevention opportunities
- *Fraud*—across all segments within the industry

(Committee on the Learning Health Care System in America 2012)

The size of the waste problem is daunting. Recognizing this, the Centers for Medicare & Medicaid (CMS) has been investing in fraud, waste, and abuse systems while also encouraging commercial businesses to adopt initiatives that curb losses. Some of these efforts have worked. More than $2 Billion in cash payments have been saved while more than $7 Billion erroneous payments have been prevented. But these initiatives have focused primarily on government mandated healthcare reforms and payor-driven solutions; providers have typically been left out of the solution side of the waste problem. This means that providers, who are at most risk of operational, financial, and clinical impacts, have had the least amount of influence on healthcare waste solutions.

Government Steps in to Address Waste and Improve Patient Care

Established and emerging regulatory changes have put an increased focus on improving care delivery. These include:

- *Meaningful Use*—incentivizes providers for adopting electronic health records and meeting certain, established criteria
- *The ICD-9 to ICD-10-CM Code Conversion*—mandates the conversion from the current ICD-9 to the ICD-10 coding scheme, which provides for a higher level of specificity and granularity in reporting
- *Enhanced Provider Screening and Enrollment Requirements*—requires that providers at higher risk of fraud, waste, and abuse undergo a higher level of scrutiny before participating in publicly funded insurance programs
- *The Value-based Purchasing program*—offers financial incentives based on improved quality of care
- *Accountable Care Organizations*—comprises a group of providers and suppliers that work together to coordinate care for the patients that they serve
- *Electronic health record adoption*—outlines new rules to simplify paperwork and address administrative burdens through broader adoption of electronic health records
- *Bundled payments*—establishes a program to encourage hospitals to bundle the payments for a single encounter thereby reducing administrative costs and increasing efficiency
- *Quality-of-care based revenues*—ties physician payments to the quality of the care that they provide rather than volume

(Centers for Medicare & Medicaid Services 2012); (HIMSS 2012); (U.S. Department of Health & Human Services 2013)

The challenge with all of these programs is that they require providers to make significant changes to processes, technology, and/or organizational structure. ICD-10 is a great example. CMS has mandated that the industry convert from the current ICD-9

Government and Payor Reactions to Waste

- Regulatory reforms designed to reduce waste and improve patient care
- Investments in waste prevention systems and detection algorithms
- Mandated technology changes including ICD-10 and electronic health record adoption
- Adoption of emerging technologies including Big Data to extend current detection capabilities

coding scheme to ICD-10 by October 2014. This code set is what is used by hospitals and other providers to communicate patient encounter information (diagnosis and procedures) to payors for reimbursement. By expanding the number of characters from five to seven and providing for alphanumeric combinations, ICD-10 increases coding specificity nearly eight times thereby enabling the level of detailed reporting needed to support a large portion of the changes mandated by healthcare reform. Without this new code set, many of the benefits embedded within programs designed to improve patient care and reduce healthcare waste are gone.

But ICD-10 comes at a price. Reprogramming systems, training coders, educating physicians, and initial productivity losses following the implementation will cost providers an estimated $425 Million to $1.15 Billion (Healthcare Finance News 2010). And this cost doesn't include the potential reimbursement impacts resulting from the code shift. According to a recent Jvion study, reimbursement impacts for a single facility will vary between 2 and 10% of total revenues depending on an organization's case mix and business model. So while the move to ICD-10 has long term benefits for the industry, it stands as a clear example of how healthcare reforms put a burden on providers who have to comply with mandates that actually decrease revenues, increase costs, and impact operations—at *least* in the near term.

Payor Reaction to Waste

Payors manage revenue risks. That is their job—their core competency. While providers focus on treating patients, payors focus on measuring, analyzing, and adjusting reimbursements. This isn't a bad thing; but it does explain why waste solutions have been the business of payors more than providers. It has always been in the payors' best bottom-line interest to identify areas of fraud, waste, and abuse. And they are likely to continue to advance the tools that they have to ferret out waste.

Healthcare reform is driving payors to improve efficiency. And mandates within the Patient Protection and Affordable Care Act (PPACA) are pushing payors to improve their Medical Loss Ratios (MLR). This measure, which requires insurance companies to spend 80-85% of their premium dollars on actual medical care (The Center for Consumer Information & Insurance Oversight 2013), will likely increase the focus on detecting and preventing healthcare fraud, waste, and abuse. In addition, claim adjudication challenges are likely to increase with the adoption of ICD-10 as new algorithms are applied to the auto-adjudication processes. Moreover, the increased specificity within the new code set is expected to increase claims denials by 10%.

Payors—both commercial and public—are also investing in advanced technologies to curb fraud, waste and abuse, and ensure the success of evidence-based medicine. For example, CMS has been developing a Fraud Prevention System (FPS) aimed at identifying and preventing "improper" Medicare fee-for-service claims. And private payors are investing in similar IT technologies to detect and prevent payments to providers based on proprietary formulas that analyze claims for fraud, waste, and abuse evidence. Emerging technologies like Big Data will extend current capabilities so that payors can apply predictive algorithms on all of their claims before a single dollar is paid out. The net result of these advancements and investments is an increase in transaction costs for providers who have to manage more denials, appeals and claim adjustments, and longer Accounts Receivable periods.

In addition to detection algorithms and technologies, payors have other methods of reducing their revenue risk. One of most palpable is the continued shift in payment responsibility onto the patient. Increasing insurance premiums have driven employers to choose High Deductible Health Plans and driven employees to invest higher amounts in Health Savings Accounts. Patient responsibility has increased from an average of 21% in 2009 to 26 % in 2011 (InstaMed 2012). For hospitals, the increase in the patient portion of revenue is both costly and less reliable to collect. In 2010 providers wrote off approximately $65 Billion in patient bad debt. And the larger number of insured people driven by the Affordable Care Act is projected to increase the portion of patient bad debt, as well as put cost pressures for managing the increased numbers.

How Providers are Impacted

- Increased technology implementation costs as providers try to comply with mandated conversion dates
- Increased operational costs due to increased denials, appeals, and claim adjustments
- Longer Account Receivable periods
- Increased revenue risks including lower reimbursements
- Increased patient bad debt

"If the reforms and changes within the healthcare industry were represented as rivers, providers would be at the point where all of them flow together"

Stopping Waste At the Source and Protecting Providers

To protect providers, it is time for the industry to think about waste from the provider-side of the equation. This means addressing waste at the source and helping providers find ways to keep more of their revenues.

Traditional and legacy revenue cycle management, decision support, utilization analytics, claims submission, and management solutions have worked in isolation, providing defined measures of success within their silos. But these solutions fall short in today's healthcare industry. They lack the predictive capability needed to understand the complex interplay that drives various aspects of waste.

To address this gap, a provider-side waste solution needs to start by leveraging advanced data technology capabilities like Big Data and heuristics. The new data landscape within a provider's environment is more complex now than it as ever been; and it will only become more complicated and entangled. As a result, it is difficult to uncover meaningful patterns and understand the interplay between systems, documentation, public data, and external sources. The integration of data from disparate systems and functional areas is key in this new information reality because it provides more relevant and richer insights into systemic inefficiencies. Only then can outputs be transformed into actionable inputs that improve quality of care and reduce unnecessary costs.

Provider solutions have to build off available predictive analytic capabilities to account for the clinical, compliance/regulatory, and financial nuances that are intrinsic to the hospital setting. Using this approach, waste solutions can extend embedded predictive analytics through machine learning, which will lead to advanced algorithms that prevent inefficiencies at their foundation. Delivering analytics that target those areas with the biggest impact on reducing waste will enable preventative measures that can be applied at the source of the revenue leakage. Using this approach, providers can proactively stop their revenue losses and avoid many of the burdens created by healthcare reforms and increased payor scrutiny.

"Providers can proactively stop their revenue losses and avoid many of the burdens created by healthcare reforms and increased payor scrutiny"

For more information on Jvion, please e-mail contact@jvion.com or call 678.889.1842

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Surya comes to Jvion with more than 14 years of leadership experience in the healthcare consulting space. Before Jvion, he spent a majority of his career as a Senior Manager at Accenture in the Health and Life sciences practice. He was responsible for delivery of several transformational and IT initiatives architecting, developing and delivering complex solutions with large teams in the U.S. and offshore for large payor and provider clients. Surya is also Sun Certified Enterprise Architect and possesses unique skills to lead and develop innovative IT solutions. He is the Architect of Jvion's icdcomplete and is responsible for product engineering and client services. Surya is a very active member of the HIMSS and AHIMA organizations.

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