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Utilizing Data to Prepare for the Changing Healthcare Reimbursement Environment

“Understanding the Total Cost of Care”

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Preparing for Change

- Managing the ever-increasing level of data available
- Reducing the cost of care while increasing value to patients
- Providing valuable information to influence key decisions while managing limited resources

Time for Analytics

- Data is only useful if time is taken to understand it
  - Management must make time for planning for the future & not just manage from crisis to crisis
  - Hard to accomplish without adequate resources
- Why is this so important?

Value-Based Reimbursement (VBR)

- Without a healthy flow of cash from patient service revenue, most community health centers (CHCs) cannot survive
- The Affordable Care Act (ACA) makes substantial changes to reimbursement methods
- Moving away from volume-based reimbursement over time

VBR, Cont.

- Transitioning from a fee-for-service (FFS) reimbursement model to a patient-centered system based on what the patient needs (value-based care)
  - Improve quality of healthcare
  - Reduce costs
  - Increase risk of health care providers
  - If managed correctly, can result in operating margin from providing services

VBR – What do I need to do?

- Transitioning from “pay for volume” mentality to “pay for value”
- Data aggregation is the foundation of clinical & business performance management
  - Key part of this transition will be health IT which must continue to evolve in tandem with the changing reimbursement landscape

Does the Quality & Availability of Data Impact Revenue?

Where Data Intersects with Revenue

- Medicaid Prospective Payment System – data needed to determine whether a change in scope may be needed to increase Medicaid reimbursement
- Risk-based models – data needed to identify margins & acceptable levels of risk
- Quality incentives – did we meet them or not?
- Accountable Care Organizations (ACOs)
  - Did we save money to the ACO?
  - How do we know?
  - Are we owed some of the shared savings?

Where Data Intersects with Revenue

- Medicare “G” code & overall fee schedule
- Fixing revenue cycle breakdowns
  - No shows
  - Registration problems
  - Denied claims
- Have we determined how generational differences will impact utilization of services?
  - Baby boomers – increased utilization
  - Millennials – delivery expectations

Accumulation of Data

- Key will be to have access to lots of data
  - But what data?
  - Where do I obtain this data?
- Obtaining benchmarking data
  - Use data wisely, realizing that your CHC is not the “average CHC”
  - Choose wisely before comparing yourself to others

Data from Where?

- General ledger/financial statements/audit
- Uniform Data System (UDS) report
- Practice management software
- Electronic health record (EHR)
- Medicare cost report
- Medicaid cost report or scope change filing
- IRS form 990
- Other

Medicare Cost Report Data

- The new Medicare cost report form provides a lot of new data to analyze
  - Comparison of the cost per visit by provider type & service (medical vs. mental health)
  - Medicare cost per visit vs. overall cost per visit
  - Productivity information, visits by location, etc.

Medicare Cost Report Data Example

- Cost per visit
  - Physician - $225
  - Nurse Practitioner - $175

- Physician leaves the CHC – questions arise:
  - What level of provider should we hire as a replacement?
  - What are the productivity levels of the other providers?
  - What market share is out there for our CHC to capture?

Medicare Cost Report Data Example

- Overall cost per visit - $190
- Medicare cost per visit - $215
- Board directs staff to attempt to capture the increasing Medicare market share
  - What questions should be asked?
  - What is the appropriate staffing in order to prepare?
  - Should charges be examined in comparison to available reimbursement rates?

UDS Data

- Bureau of Primary Health Care (BPHC) metrics
  - Medical cost per medical visit
    - Total accrued medical staff & medical other costs after allocation of overhead (excludes lab & x-ray) ÷ non-nursing medical encounters (excludes RNs & psychiatrists)
  - Cost per patient
    - Total accrued cost before donations & after allocation of overhead ÷ number of patients

U.S. Department of Health and Human Services
HRSA
Health Resources and Services Administration
Bureau of Primary Health Care

UDS Data, Cont.

- Health care program grant cost per patient = total accrued BPHC section 330 grant draw-down for the period from 1/1 to 12/31 ÷ by total unduplicated patients for the 1/1 to 12/31 period

- Key is to look for trends & then ask:
  - What do these trends indicate?
  - What decisions should be made considering those trends?

Sharing Data

- In most VBR models, sharing of data is critical as working together may lead to stronger outcomes & more savings
- Communication with all partners in care will be crucial
  - Third-party payers
  - Other members of the ACO, etc.

Common Data Pitfalls to Avoid

- Starting with the end in mind – manipulating the data to make it read like we want
- What decisions are we trying to make with the data? Is our measurement influenced?
  - External users
  - Internal users

You Have to Start Somewhere

- Incremental progress is better than no progress
- Great barrier is time, but followed by confusion
- Consistency vs. perfection of data
- You can only manage what you can measure

Defining the Total Cost of Care

"Where the rubber hits the road"

Determining the Total Cost of Care

- What does IT cost?
- Direct costs
- Indirect costs
- When considering the cost of care, consider both a quantitative & qualitative analysis

Direct Costs

- Specific to the grant/project/department
- Salaries
- Supplies
- Potentially equipment
- Potentially single purpose facilities

Indirect Costs

- Common to the organization
- Administration
  - Executives, accounting, human resources, etc.
- Many facilities' costs
  - Depreciation & interest on facilities
  - Operations, maintenance & utilities
- Not direct

Cost Analysis

- What are fixed costs vs. variable costs?
  - Fixed
    - Rent/mortgage
    - IT/Depreciation, etc.
    - Salaries?
  - Variable
    - Supplies
    - Purchased services

- Labor cost can be both fixed & variable

Cost Analysis, Cont.

- What is the impact on the bottom line for each of the following:
  - Department or service line
  - Operating location
  - Provider
  - Relative Value Unit (RVU) analysis

- Not every program or location must add to the margin, but other qualitative value must be present

Qualitative vs. Quantitative Analysis

- Do the numbers tell the whole story?
  - Community needs
  - Future opportunities
  - Playing defense
  - Strategic partnerships
  - Other
- The disconnect between finance & operations

Comparing Costs to Revenue Streams

- Once costs have been determined, how does it compare to revenue received?
  - Fee for service
  - Risk-based contracts
  - Insurance contracts
  - ACO reimbursement

What about capital costs?

- Can we expect all future capital needs will be funded by grants?
- Studies show newer facilities attract patients & generally lead to better outcomes & patient satisfaction
- Planning for capital needs will be crucial

Penny wise, pound foolish

- Significant investment may be needed for IT going forward
- Bench strength in the accounting & data analytics area will be a must
- Being cost conscious is good, but cutting in some areas may lead to lost revenues that exceed the amount of cut cost

Sustainability

- Ability to:
  - Control costs
  - Receive full payment for services
  - Capture & keep new patients to keep up with demand for services
  - Manage (somewhat) the case mix of patients

Demonstrating Value

- Anecdotes vs. statistics
- Where can CHCs save the most money?
  - Efficiently providing care?
  - Preventing more expensive medical situations?
- Tell the story **AND** gather the data!
- How do we get paid for extra costs?
  - ACOs, quality incentives, etc.

Demonstrating Value

- Proving a negative – how do we show we prevented something from happening?
- Are your patients' numbers your numbers?
  - How many emergency room visits from your patients?
    - Categorize between preventable & non-preventable
  - How many hospital nights?
  - How many hospital readmissions?

Demonstrating value – Example Areas of Consideration

- Identify the top providers' codes – especially chronic conditions (*i.e.*, diabetes, hypertension, etc.)
- Determine efforts that could be implemented or improved to enhance care
  - Diabetes education classes, cooking classes, coordinating lab tests, etc.
- Measure indicators (*i.e.*, weight loss, non-insulin vs. insulin dependency, etc.)
- Demonstrate improved "value" or "quality" of care

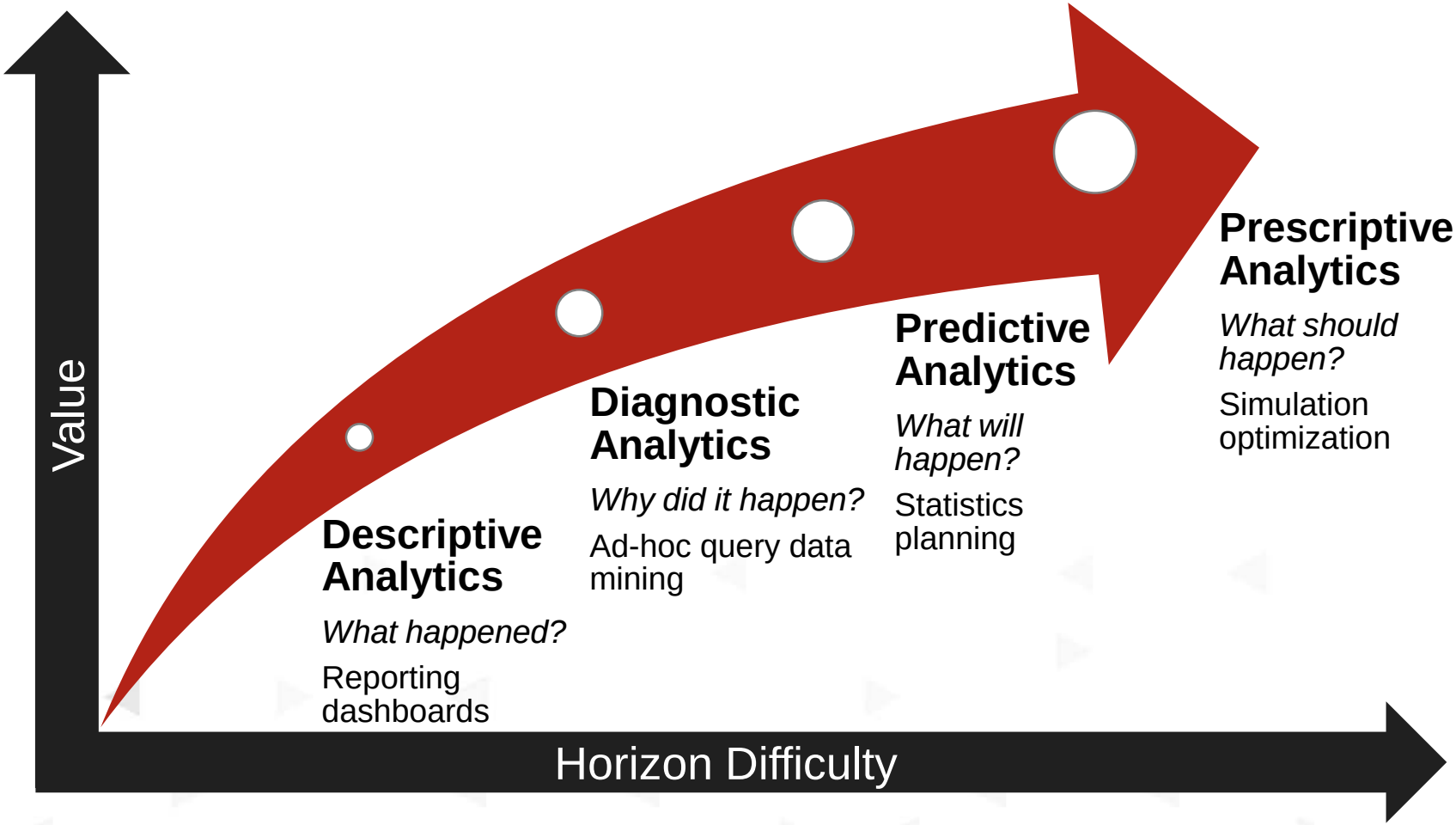
How to Demonstrate Value

- Learn from others
- Improve your data
  - Accuracy & completeness of diagnoses
  - Document all services rendered
- Improve your use of data
  - Categorize patients & results
  - Correlate data – what leads to better outcomes
- Show your work

Taking Action

- Identify 2 to 3 biggest opportunities
  - Consider asking key managed care organizations what they want to see from you
- Choose at least one metric to start tracking for each opportunity
  - Automate as much of this tracking as possible
- Revise, refine & improve

Data Analytics: Improving Insight & Business Value



Questions?

Thank You!