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The Tidal Wave of Change In Healthcare Today

Why Hospitals and Providers are Struggling to Stay Afloat

Presented by

TOPLINEHealthcare

Introduction

The Centers for Medicare & Medicaid Services (CMS) processes 4.4 million claims worth more than $1 Billion a day. With the exponential growth of the baby boomer of approximately 11,000 new senior citizens becoming eligible for Medicare each day. Even with the nearly trillion dollars per year allotted in the United States budget, CMS will find it unsustainable to handle. In the 2015 IPPS proposal, CMS changed the payment structure with a larger percentage held in reserve for errors. Given this climate of change, it is important for you to examine this question:

Will your facility be able to maintain fiscal stability?

In this presentation, we will review the Inpatient Prospective Payment Systems (IPPS) changes that have occurred since 2006 and how this will affect the financial stability of healthcare today. We will also review the changes proposed in the 2015 IPPS along with what impact that will have on you.

Why the State of Healthcare is Rapidly Changing

Given the exponential growth of the baby boomers in the current financial state of the country, it is understandable that the system is unsustainable and CMS is looking for ways to reduce cost. Because CMS has one of the largest sections of the US budget, it becomes a target by Congress with every new fiscal budget review. It is apparent that CMS will not be able to continue to function as a clearinghouse for claims. It is also apparent, by the changes that have occurred since 2006, their

goal is to move CMS from a "per claim system" to a "global payment system". This can be done in a number of ways. However, we believe CMS is moving for a radical change in healthcare by creating a climate where bundled payments are made to Accountable Care Organizations (ACO) and Health Maintenance Organizations (HMO) in order for them to remain financially sound, thus relieving the burden of processing approximately 4.4 million claims a day. This would allow CMS to do small random reviews to ensure quality, decrease their administrative costs, and increase the total number of dollars used per member per year.

Up until 2014, CMS did not have prior approvals for anything. The first f*oray* into prior approvals was power mobility, which is where much of fraud was detected in the past. It is unfortunate that the inappropriate actions of few have affected many, however, it is a reality in today's world. Therefore, CMS has no choice but to make radical changes in order for them to stay viable. In their 2015 IPPS, they discussed the strategic plan and the business alliances; therefore it is important for you to know that they are working to help shift the burden from CMS to private companies. For years, HMOs have had prior authorizations for most items. However, CMS did not require authorization — they only required clinical evidence to prove the need. As a reaction to the large-scale fraud that was found in the power mobility industry, CMS created a process of review. Along with that process came the Recovery Audit Contractor's, better known as RAC.

The RAC process has had a large-scale problem over the last few years with their denials and reviews. In 2014, CMS reached a settlement with hospitals for 68% of the total amount due on

all claims that were before the Administrative Law Judge (ALJ). The reason this occurred was because the ALJ did not have enough judges to hear the cases before them within their own legal timeframe. This occurred because of the large number of appeals being submitted by providers. We caution that this problem will only persist and increase given the change in the payment to the RAC now at the second level of appeals. Prior to this, the RAC got paid for every denial, and then had that payment reversed if it were found incorrect at the ALJ level. The new process does not allow the RAC to be paid until the claim hits Level II denial. The RAC completes the second review before it goes to the second level. This creates an environment where the RAC benefits from allowing the claim to remain denied until it hits Level II, at which time they get paid. This entire process was started with good intention. However, its implementation has left much to be desired on both sides.

With the many moving parts in government systems, it's understandable there is no clear way to make this process simple. It is our opinion that the shift CMS is making is a logical and intelligent move to save time and money. For many seniors and providers, this changeover will be difficult due to the change in practice. A major concern for most seniors is tracking and being able to understand the prior authorization process. Uncertainty is causing many seniors choose to stay with a traditional Medicare with a secondary insurance to avoid the HMO prior authorization process. Success of this process will be determined by the ability of CMS and its partners to adequately inform seniors in multiple ways.

Although CMS spends millions of dollars a year on education, it is primarily presented in the form of written communication.

Therein lies a problem, especially for many seniors with decreased vision. It is challenging for them to fully comprehend all of the legal information provided to them. For those of us that currently work in health care, is difficult enough to understand all the rules, regulations, nuances and legalese in most of these transmittals. It will be next to impossible for them to understand and implement these changes unless the information is presented in a way that is in clear and simple language without all the legalese.

Seniors today are much more sophisticated, educated and computer literate. It stands to reason that some of this training can be computer-based and will alleviate the need to print and mail large volumes of information. Printed, computer-based and community-based education will be vital to getting the information properly distributed to the seniors. This process needs to begin today.

The H.R.2 - Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act of 2015 further reinforces the opinion that CMS is moving towards an ACO platform. In this new piece of legislation, the authority to create the expansion of pre-authorizations has been granted and expanded. This is a dynamic move from the fee-for-service payment system that CMS was originally constructed with, and is more evidence of the rapid change in healthcare today. Herein, we are outlining the trends and changes that will drastically affect the bottom line for every health provider in the United States today. With our combined experience in healthcare examining the laws, regulations and current strategies as spelled out by CMS; we believe this change is already in process. As a healthcare provider, you must be

willing to change and evolve rapidly, especially with the upcoming October 15, 2015 implementation of ICD 10 codes, which is when this radical shift will occur and increase the current 17,000 ICD 9 codes to over 140,000 primary and modifier codes. Are you ready for this change?

How Growth in Medicare is Causing a Major Shift

CMS was not designed to handle the volume or complexity of claims that now exist. In 1965, the United States' healthcare system was a fee-for-service system, which basically meant you billed it and CMS paid it. With approximately 19.1 million seniors over 65 and no disabled population included at the time, the load of claims processed was significantly lower. However, as healthcare throughout the world changed, so did the role of CMS. In an attempt to keep up with those changes, CMS has implemented changes to help balance out the challenges they now face. It is often felt that CMS is the bad guy, however, that is not the case. They are simply like any other company creating new business strategies in an attempt to keep up with the rising cost of healthcare.

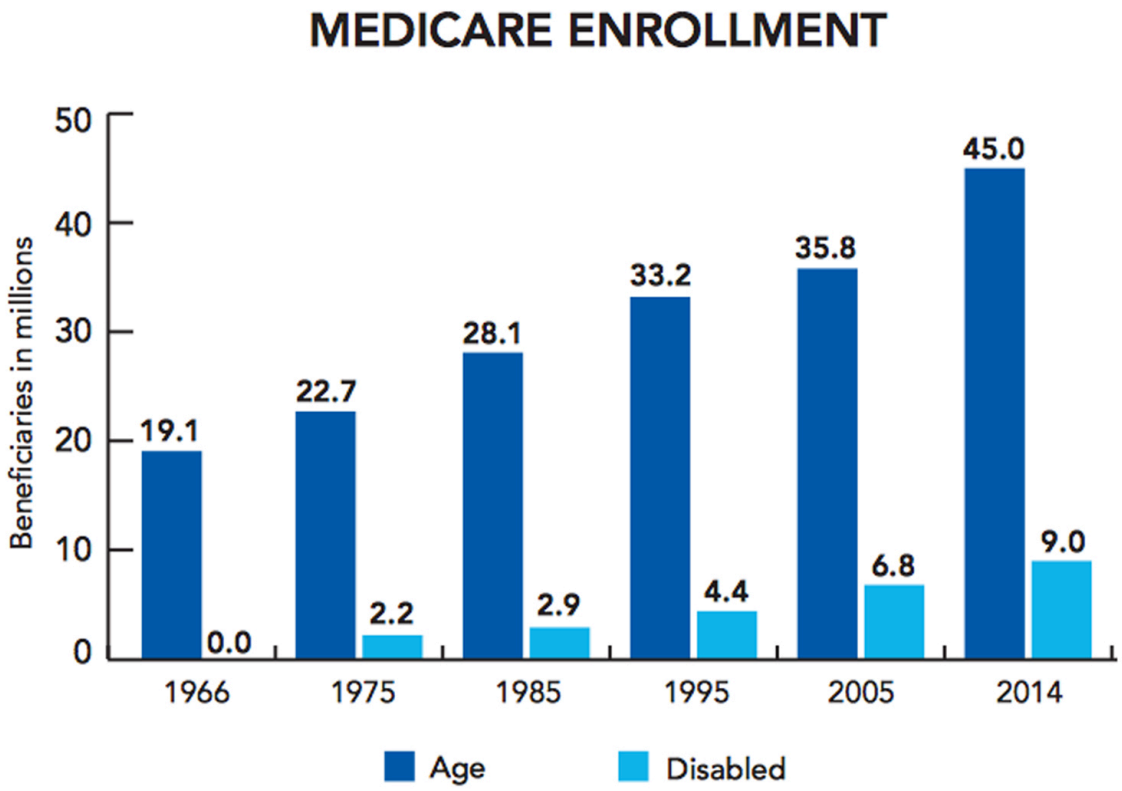
According to the financial report for 2010, the Medicare Audit Recovery Act recovered 92.3 million dollars. In 2011, the program identified approximately 939 million dollars in improper payments. As a result, CMS collected 797.4 million dollars in overpayments and returned to providers 141.9 million dollars in underpayments. In 2012, Recovery Auditors collectively identified and corrected 1,272,297 claims for improper payments, which resulted in 2.4 billion dollars in improper payments being corrected. The total corrections

identified include 2.3 billion dollars in overpayments collected and 109.4 million dollars in underpayments. In 2013, Recovery Auditors collectively identified and corrected 1,532,249 claims for improper payments, which resulted in 3.75 billion dollars in improper payments being corrected. The total corrections identified include 3.65 billion dollars in overpayments collected, and 102.4 million dollars in underpayments repaid to providers and suppliers. In FY 2014, approximately 1 billion dollars were recovered, and in FY 2015, an estimated 2 billion dollars would be recouped, leaving another 8 billion dollars to be recovered by FY 2017.

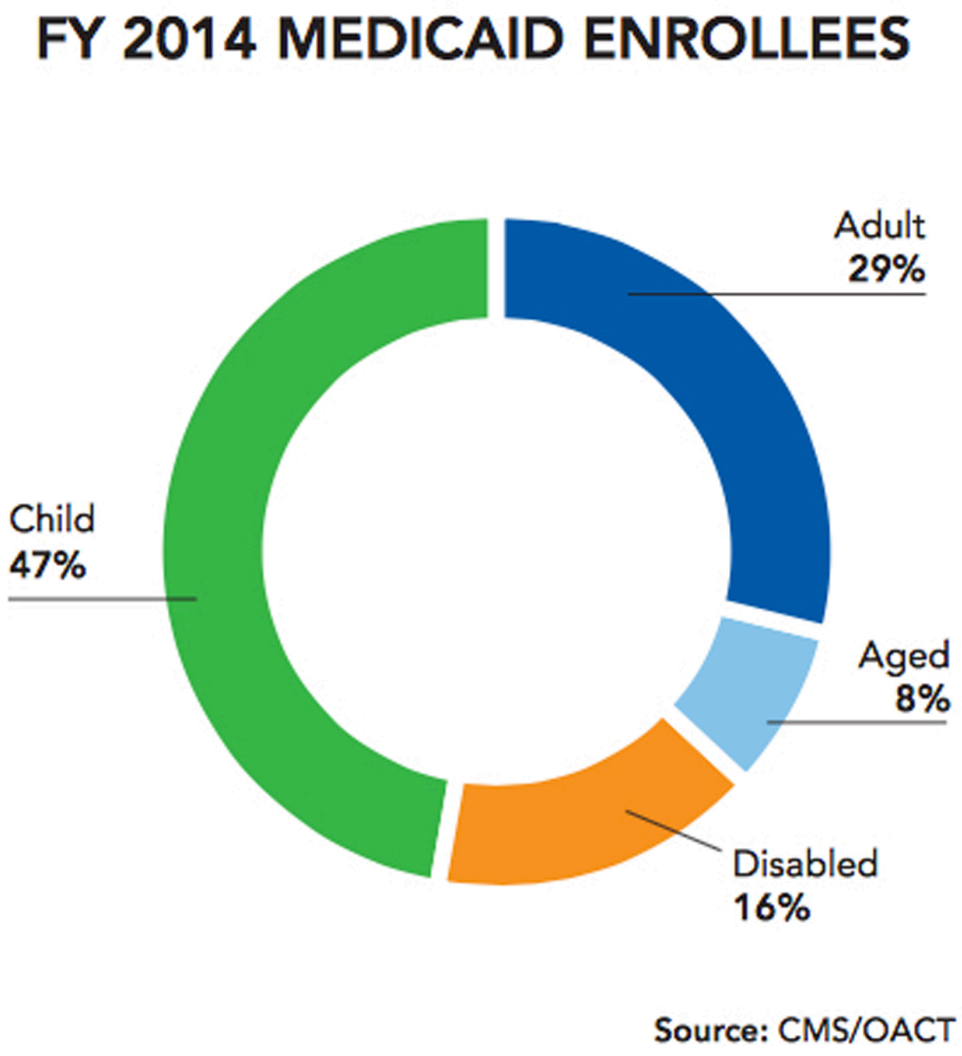
With this rapid progression you can see the change from 2010 from 92.3 million dollars to a projected 8 billion dollars by 2017.

Given the history and current trend, it is clear change must happen. Healthcare is often too slow to change business practice with a long history of waiting until they are forced to change. This is a luxury no longer available in this industry. Healthcare providers must keep changing or get left behind. Technology has forced the healthcare system to become better at change. With the implementation of Electronic Medical Records (EMR), we find the ability to keep better statistics on outcomes. CMS offered financial aid to any facility willing to change to EMR's from 2007 – 2012. This was an attempt to take part of the burden off the facility. However, many facilities did not take the option and now are faced with the complete financial burden and potential fines for not having an EMR. This move was made in preparation for outcome based payment and electronic submittals of all medical records reducing the cost of processing and storing information.

Looking at the 2014 CMS fiscal report chart below, it can be seen that Medicare enrollment has taken on a drastic change since 1966.



In the following graph, the current disabled population is 16%. In 1966 there were no disable beneficiaries. Almost half of the enrollees are children totaling 47%; this age group receives a lot of care from wellness programs. Although, a larger portion of the budget for children is taken in NICU, PICU, and coverage for those children were catastrophic illnesses. The preventive care, given in wellness programs, has proven to be effective in decreasing long-term effects of childhood illnesses and reduced the overall cost.



With the explosion of baby boomers becoming seniors along with the rapid expansion of health care today, CMS is struggling to keep up with the demands. Of the CMS budget, Medicaid enrollment for children is at 47% of the budget, Adults is at 29%, Aged is at 8%, and Disabled is at 16%. These percentages will rapidly change with an exponential increase in the adult population as the baby boomers continue to hit the age of 65+. CMS talks about business transformation in this report. They spell out their plan to move things from a fee-for-service into an

ACO/ HMO format in order to decrease the workload of the daily bills process.

CMS: A Business in Transformation

The role of CMS in today's healthcare system is rapidly evolving. New legislation is continually mandating and changing in the external environment (including budgetary pressures, demographic changes and technological advances). This dramatically expands CMS's responsibilities and placed new operational demands on the agency. As a result, CMS must find methods for carrying out its current activities more efficiently while simultaneously developing a host of new capabilities.

CMS embraces these challenges and the expanded responsibilities that come with them as an opportunity to strengthen the U.S. healthcare system, as well as to increase access to affordable, high-quality care. In order to do so, CMS is undertaking a comprehensive, long-term transformation of its business operations. Transformations are defined as high-priority, complex operations initiatives that require coordinated, cross-component management and oversight. Their business transformation lays the foundation for a five-year program that will manage a coordinated, agency-wide transformation of critical operational capabilities that will enable CMS to:

- Guide and prioritize investments.
- Enhance enterprise excellence by improving performance and operational efficiency.
- Promote increased transparency, collaboration, and agility.

- Develop a comprehensive review of the Agency's internal capabilities and future needs, as well as best practices in transformation programs.

There is a clear shift CMS is making in the business practice and language. The groundwork is being laid for the transformation of CMS from claims processing to a bundled payment system. Many things in government require a process given the numerous laws and ancillary regulations that apply. Every time a piece of legislation is implemented that provides for payment to CMS, rules and regulations are added. Often times, these rules are made without input from the staff at CMS, thus creating an environment of confusion. Lawmakers without full understanding of the medical process implement rules that drastically affect healthcare today. This is evident on closer review of the IPPS and yearly budgets.

Consider this: CMS manages more money than any other single department of the US government, and it is the most regulated department in the US government. In an effort to fix the problem, more laws are written with each new budget increase in an attempt to change the system. Fraud is a major problem when dealing with these large sums of money. However, it could argue that the majority of providers in the system only want to care for their patients; not skim money. The RAC system was designed to do just that. However, the implantation of the program failed due to the structure of the payments to the auditors. It set up a process of "pay-for-performance" that increased rather than decreased the error rates. Since CMS does not except any one "standard" of review, all of the reviews are open to the reviewers' interpretation. This led to the settlement CMS made with the providers in 2015 of 68% of the

total amount due.

CMS Alliance to Modernize Healthcare (CAMH)
Federally Funded Research Development Center (FFRDC)

In September 2012, CMS established the CAMH. The CAMH is sponsored by CMS and is a federally funded research and development center operated by MITRE, a not-for-profit company chartered to work in the public interest. The CAMH FFRDC is an objective, independent advisor for Health and Human Services (HHS) organizations to advance the Nation's progress toward an integrated healthcare system with improved access and quality at a sustainable cost.

Following are the capabilities of the CAMH FFRDC:

- Strategic and Tactical Planning and Analysis
- Conceptual Planning and Proof of Concept
- Acquisition Assistance
- Organizational Planning and Relationship Management
- Continuous Process Improvement
- Strategic Technology Evaluation
- Feasibility Analysis and Design

With the implementation of CAMH and FFRDC in 2012, the framework for change was being established. And being listed as objective and independent advisors to HHS allows CAMH and FFRDC to test new ideas and create strategic plans for implementation. This will include sections of development for cyber security, data analysis, structured note development and other processes designed to decrease the error rate. Large number of complaints received by Congress from healthcare providers about the RAC process is also considered in this

program.

Medicare and Medicaid Innovation

CMS continually tests innovative payment and service delivery models that have the potential to reduce Medicare, Medicaid and CHIP expenditures while preserving or enhancing quality of care for beneficiaries. The Affordable Care Act provides 10 billion dollars in budget authority for fiscal years 2011 through 2019 for the design, implementation, and evaluation of these payment and service delivery model tests. CMS's efforts, coupled with transformational payment changes instituted by the Affordable Care Act, will help drive continual improvement of health and healthcare for Medicare, Medicaid and CHIP beneficiaries and achieve better value for our healthcare dollars.

CMS is transforming itself from a claims payer in a fragmented care system to do the following:

- Be a partner working with healthcare providers to provide better quality healthcare at lower cost.
- Align business operations with the Agency's key strategic objectives.
- Develop new capabilities required to meet the changing demands posed by regulatory requirements and the rapidly evolving care landscape
- Center the healthcare system where individuals receive the right care, in the right setting at the right time, every time.

In order to promote innovation in healthcare payment and delivery, CMS actively consults with a wide array of stakeholders from the healthcare community, including sister agencies,

healthcare providers, healthcare organizations, clinical researchers, insurers, academic medical systems, advocacy groups, State Medicaid Directors, and the healthcare industry as a whole. CMS also posts Requests for Information (RFI) to learn more about healthcare community interests and needs. They also hold listening sessions for targeted groups and call-in "Open Door Forums" for both providers and beneficiaries along with webinars and conference calls about new healthcare model tests and initiatives. In addition, CMS has actively sought to partner with professional societies, healthcare education and research institutions, the media, other organizations to disseminate best practices and encourage further innovation, and developed a significant online presence in support of these efforts including a website devoted to Medicare and Medicaid Innovation.

CMS tests and evaluates new models of healthcare payment and delivery in three primary ways:

1. Through initiatives designed to advance and diffuse best practices.
2. Through the development and oversight of congressionally mandated demonstrations, and through the development.
3. Testing of new payment and service delivery models based on ideas from the caregiver community, on current research, and on specific model of improvements in care and payments suggested in the Affordable Care Act.

The above underlined portion of this report says it all — CMS is testing and evaluating new models of healthcare payment and delivery. This congressionally mandated section is designed to reduce cost, confusion, and lack of confidence in the system.

Medicare Shared Savings Program

The Medicare Shared Savings Program facilitates coordination and cooperation among providers to improve the quality of care for Medicare fee-for-service beneficiaries and reduce unnecessary costs. Eligible providers, hospitals and suppliers may participate in the Shared Savings Program by participating in an ACO. The program will reward ACOs that lower growth in healthcare costs while meeting performance standards on quality of care and putting patients first.

Management's Discussion and Analysis

Over the course of the agreement period, ACOs will better coordinate care, engage their beneficiaries, report on quality, and promote evidence-based medicine. CMS will measure the ACOs' performance on thirty-three quality measures relating to care coordination and patient safety, appropriate use of preventive health services, improved care for at-risk populations, and patient and caregiver experience of care. CMS will also monitor the ACOs' activity throughout the length of the agreement period.

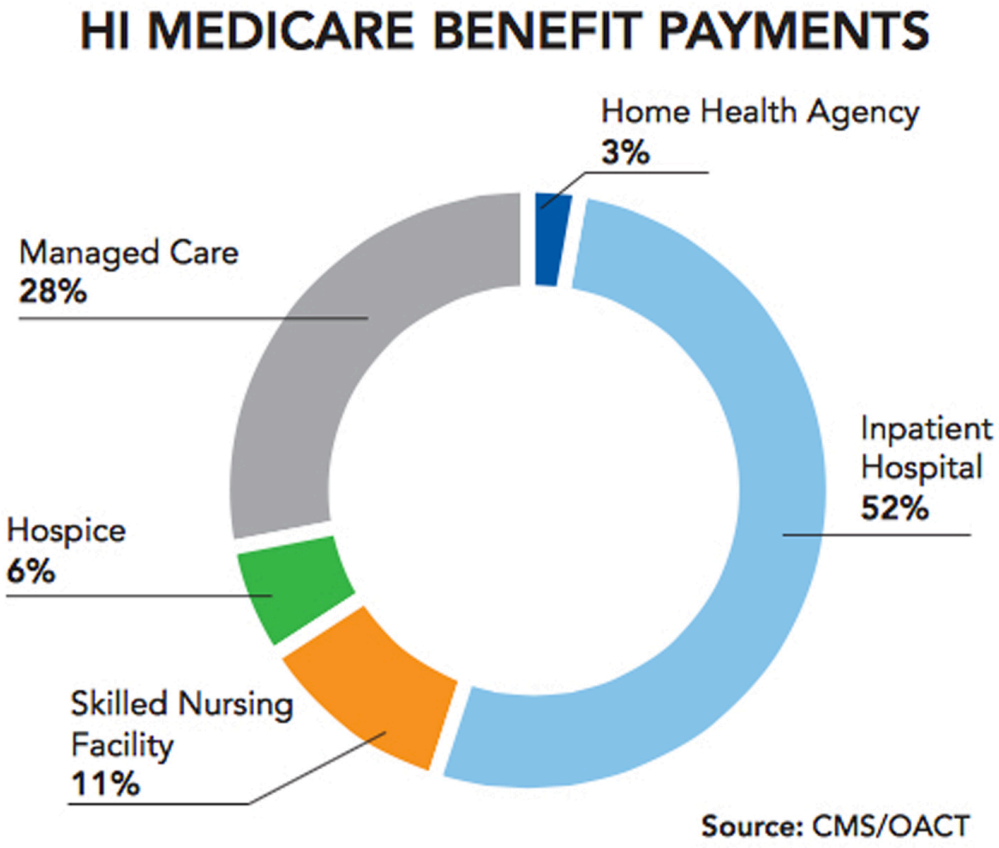
As part of the final rule, 42 CFR 425, CMS estimated that between 50 and 270 ACOs would participate in the Shared Savings Program and generate 470 million dollars in net Federal savings between 2012 and 2015.

With the exception of ACOs with 2012 start dates, ACOs enter the program January 1st of each year with an agreement period that spanned three performance years (equating to calendar years). CMS offered start dates on April 1, 2012 (agreement

period of 3 years and 9 months), and July 1, 2012 (agreement period of 3 years and 6 months). The first performance year for April 1 and July 1 starters was defined as 21 and 18 months, respectively. The methodology for determining the first year financial performance of 2012 starters included interim payment determination (§425.608). To be eligible to receive a shared savings payment based on interim reconciliation, ACOs with 2012 start dates must have elected interim payment on their program application and established the required repayment mechanism, generated sufficient shared savings and have met the program's quality performance standard. For a typical performance year, retrospective reconciliation will occur after the end of the calendar year (performance year), allowing for three months claims run out and determination of the ACO's quality performance.

CMS publicly announced Performance Year 1 Interim financial reconciliation results for all ACOs with 2012 start dates in January 2014, and made payments to eligible ACOs between December 2013 and February 2014. CMS also announced Performance Year 1 Final financial reconciliation results for ACOs with 2012 and 2013 start dates in September 2014. The Shared Saving Program accepts applications on an annual basis with the next group scheduled to start January 1, 2015. This clearly outlines the use of the ACO. One of the advantages of CMS in the use of an ACO is outcome-based payment. ACOs receive a payment based on risk stratification of the patient and have the potential for additional payments based on outcomes. Claims are not submitted to CMS for payment of day-to-day care of the patient, thereby reducing the total number of claims reviewed and paid by CMS. This bundled payment program

can be difficult to manage for a small ACO. However, as seen in the past, it is a viable and substantial improvement to the overall care of the patient.



CMS arrived at its proposed rate of 1.3 percent (which only apply to hospitals that report quality data and pass meaningful use with EHRs) through the following updates:

- A positive 2.7 percent market basket update
- A negative 0.4 percent update for a productivity adjustment
- A negative 0.2 percent update for cuts under the Patient Protection and Affordable Care Act
- A negative 0.8 percent documentation and coding adjustment.

CMS included the 0.8 percent documentation and coding adjustment as part of the American Taxpayer Relief Act of 2012, better known as The Fiscal Cliff Deal. Legislators included 11 billion dollars in MS-DRG documentation and coding adjustments in that bill. As a result, hospitals and other providers would lose 11 billion dollars in Medicare payments between FY 2014 and FY 2017 due to past overpayments the government made to hospitals as the country transitioned to MS-DRGs. In FY 2014, approximately 1 billion dollars were recouped, and in FY 2015, an estimated 2 billion dollars will be recouped, leaving another 8 billion dollars to be recouped by FY 2017.

Hospital Value-Based Purchasing Program (VBP)

The Patient Protection and Affordable Care Act (PPACA) established the VBP program. In FY 2014, CMS took back 1.25 percent of Medicare reimbursements at hospitals paid under the IPPS. The resulting 1.1 billion dollars were dispersed to hospitals based on how well they performed on healthcare quality measures, such as treatment of heart attack and congestive heart failure, as well as patient satisfaction. In FY 2014, 778 hospitals lost more than 0.2 percent of their Medicare pay, while 630 hospitals received a bonus of more than 0.2 percent. For 2015, CMS is keeping 1.5 percent of Medicare reimbursements, resulting in an estimated 1.4 billion dollars in value-based incentives.

Hospital Readmissions Reduction Program (HRR)

Similar to the VBP program, the HRR program looks to align

Medicare reimbursements with better quality healthcare. The HRR program penalizes hospitals for heart attack, heart failure and pneumonia 30-day readmission rates for Medicare patients that are greater than predicted, after adjusting for patients' illness severity. In 2015, by law, CMS will increase the maximum penalty from 2 percent to 3 percent. This will also include total hip/total knee arthroplasty and chronic obstructive pulmonary disease as new measures. CMS expects that over 2,600 hospitals will see their Medicare payments cut, which is more than last year due to the added readmissions measures totaling 422 million dollars in decreased payments. The government estimated that Medicare hospital readmissions have declined by 150,000 from January 2012 through December 2014 due in part to the program.

With a clear picture at the direction of transformation, CMS is proposing that healthcare providers brace themselves for a major shift in the way they do business. Since most hospitals work on an approximate 2% margin, and the new IPPS reduces that margin to 1 to 3%, drastic changes need to be made in order to run a successful practice.

Three main factors must be considered:

1. Reducing our error rates with better process.
2. Increasing workforce efficiency.
3. Creating a better environment for physician engagement.

Physicians Can Now Be Denied

With the new ruling transmittal 540 stating that the physician can now be denied their part B payment when the facility is denied, it is probable that there will be a greater buy-in by the

providers to get it right the first time. Up until September 14, 2014, and even though they carried a great deal of weight in the billing process, there was very little or no repercussions for physicians' noncompliance with documentation. Most physicians believe they are there to treat a patient, not to complete paperwork. However, with Transmittal 540 implemented, this now means that CMS must have the same denial process for part B as it does for part A. However, the appeal used for part A will not stand for the part B benefit, which means the part B denial will be an entirely separate process.

Given the number of denials and the backlog that has occurred since 2012 at the ALJ level, we see the potential for even more delays in response at the ALJ level. Currently, it is our understanding that there are not enough judges to hear the denials from part A. Can you imagine having the same number of denials in part B and the ensuing workload before the ALJ?

Solution

Solutions to the aforementioned problem are relatively simple:

1. Review every chart for clinical validity and the technical components of the regulations that apply.
2. Start reviewing your denials processes. Conduct a complete review of everything — from how you receive your ADRs, denials and responses, to how you are tracking payments.

3. Educate providers on clinical validity. This will greatly impact the number of denials of part B claims that the provider will receive.

By implementing these three simple steps, you can begin the process of reclaiming lost revenue as well as the ability to improve and grow as healthcare changes. These steps are vitally necessary to the success of every private practice, skilled nursing, home health, hospice, DME provider and hospital. Without implementation of these three vital steps, many of the facilities will face financial difficulty and a lengthy process of appeals. This will not only be with the claims that are paid by CMS, but also with all of your HMO and PPO providers. Keep in mind that these providers have started the same denial process as with those being used by CMS — so much that they are hiring the same companies to do reviews of all of their senior claims and are planning to roll this out to all claims.

About Us

TOPLINE Healthcare is a leading edge performance-based solutions and technology company assisting healthcare providers with documentation, billing, and revenue generation. We provide all services to the highest degree of client satisfaction while changing the course of heath care for the better.

We focus on a holistic approach to denials. This is accomplished through review of your ADR's, processes, actual denials and clinical documentation. We help you to get it right

the first time, thus saving you time, reducing your risk for denials, and increasing your growth revenue.

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Census for 1965

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