EXECUTIVE SUMMARY

Healthcare providers are bracing for a “perfect storm” of changes to the way healthcare is currently delivered, managed, and reported. These changes include unprecedented—and ongoing—regulatory uncertainty, compliance with strict new meaningful use standards, staff training, pressure on operating margins and system testing to support new ICD-10 codes.

This paper explores the key challenges healthcare providers must successfully navigate if they are to avoid a cash flow “crunch” and prosper in this rapidly-evolving landscape.
AFFORDABLE CARE: UNCERTAINTIES ABOUND

While the ultimate fate of President Obama’s landmark healthcare legislation remains uncertain, some providers have already begun cutting costs in anticipation of lower revenues in the future. It’s not hard to see why.

The legislation grants coverage in 2014 to more than 32 million currently uninsured Americans. Although that should increase volumes and revenue for providers, those gains are offset by a number of initiatives that could negatively affect revenues:

• Providers this year will see a reduction in payments from CMS (Centers for Medicare and Medicaid Services) for unnecessary hospital readmissions.
• Beginning in October 2012, hospitals for the first time will be reimbursed by CMS through the Value Based Purchasing program, based on how they score on a set number of quality indicators.
• Disproportionate Share Hospitals (i.e., those that provide a disproportionate amount of care to uninsured patients) could see as much as a 75% reduction in DSH payments over the next several years.
• Hospitals are experiencing an unprecedented slowdown in spending growth by consumers. According to one report, in 2009 and 2010, U.S. healthcare spending grew more slowly than in any of the previous 51 years monitored by the National Health Expenditure Accounts.

Here’s another change to consider: The law’s new reimbursement models favor hospital and physician alignment, as opposed to the traditional private practice model. Bundled payments, Accountable Care Organizations, medical homes, and quality-based reimbursement will require hospitals and physicians to become what one report calls “partners in payment.”

That same report also notes that the number of Medicaid recipients will increase by more than 40% from 2010 to 2019, which means hospitals will need to learn to operate on Medicaid rates. Historically those rates haven’t covered all costs, so hospitals will need to address their fixed costs immediately. Multiple methods of reimbursement will also likely create additional overhead and costs.

Then there are the unanticipated impacts of the law. For example, it may be that the greatest threat to the healthcare overhaul isn’t the Supreme Court after all. Instead, it’s more likely to be a lack of medical providers. If the law succeeds in extending health insurance to 32 million more Americans, there may not be enough doctors to see them. According to one report, the anticipated shortfall of primary-care providers by 2015 is 29,800. By 2020, it is expected to be a staggering 91,000.

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Derek Ellington
Healthcare Treasury Solutions Manager
Bank of America Merrill Lynch
Bottom line: The government is moving from being a passive payer to an active purchaser, which for healthcare providers means they will be reimbursed based increasingly on outcomes and patient satisfaction.

“Maintaining a disciplined cash management strategy has never been more important to an organization’s financial health,” says Derek Ellington, healthcare treasury solutions manager at Bank of America Merrill Lynch. “Controlling patient and payor receipts while sustaining adequate cash reserves can create a foundation to withstand today’s strong winds of change.”

MEANINGFUL USE: THE BAR KEEPS GETTING HIGHER

2012 has been called a “make or break year” for Meaningful Use. Starting last year, hospitals and other qualified providers became eligible for increased Medicare and Medicaid payments if they could demonstrate Meaningful Use of electronic health records by “meaningful users.” This year the bar will be raised higher as providers will be required to submit their Meaningful Use data to CMS electronically. In 2013, the criteria for Meaningful Use will become even more complex and require greater interaction with other providers and payers. All told, hospitals and providers stand to receive up to $27 billion in financial incentives over the next decade.

According to a PricewaterhouseCoopers report, only 50% of hospitals expected to meet the Meaningful Use criteria last year, while 79% expected to meet them in 2012. Providers that do not meet deadlines will face CMS reimbursement penalties, further compounding their cash flow issues. An American Hospital Association survey reported that 55% of hospitals expect to incur penalties. So far, the main barriers to achieving Meaningful Use include the lack of clarity about criteria, a shortage of skilled staff, vendor readiness, and questions about existing infrastructure capabilities.

While the government’s reimbursement incentives will cover only a portion of implementation costs, the benefits of achieving Meaningful Use outweigh the challenges, experts say. Research shows that organizations are leveraging Meaningful Use requirements to create strategic opportunities, align with physicians and health insurers, and engage and empower patients.

“It is critically important to properly manage your working capital structure on a daily basis,” Ellington notes. “Maximizing the monitoring process means defining benchmarks that fit your organization and holding yourself accountable to meeting the measures.”

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ICD-10: GREATER THAN Y2K IN SCOPE AND COMPLEXITY?

Even though the October 2013 deadline for upgrading to new ICD-10 codes has been pushed back, providers continue to struggle to stay on track. That’s partly because ICD-10 raises the number of codes to more than 140,000, compared with 17,000 used with ICD-9. It’s also because of the serious administrative burdens providers face in the years ahead.

Some providers have estimated that the coding changes stemming from ICD-10 will double their claim-coding expenses and reduce productivity by one-third. And that doesn’t take into account an expected increase in denials.⁸

The American Medical Association, which led the movement to delay the implementation date, said the substantial number of new codes to be learned, combined with initial problems in implementing the new 5010 electronic transaction standards that are a prerequisite for taking on the new code sets, create a substantial burden for physician offices.

Healthcare Industry – Medical Payments

Medical claim payments will continue to pose a unique collection problem that HC reform does not fix.

While major players have automated some reconciliation, all parties struggle with the Large-to-Small and Many-to-Many challenge.

On average, providers collect 50-60% of owed balances after insurance, and only 10-20% of out-of-pocket balances.

To date, industry solutions have not delivered

- Administrative costs continue to rise
- To save money, HC providers must turn to cheaper transactions and simplify administration
- RCM is a key driver of administrative costs
- RCM space is fragmented; IT providers compete with banks
- Banks are positioned well to handle payment, receipt and patient information
- Slow adoption – scarce IT resources (providers); little incentive to change (payers)

Healthcare reform attempts to address administrative costs, but…

- PPACA – does not mandate electronics payments, but:
  - DHHS to issue new rules for further electronic transaction adoption
  - Requires new rules to foster automated reconciliation of payments to remittance
- Creates Insurance Exchanges – new player
- Adds 32 MM insured
- ARRA – expanded HIPPA, drove up costs, provided incentives to adopt EHR
- Reform and industry stress will increase out-of-pocket payments
- Requires Medicare all-electronic by 2014
The Deloitte Center for Health Solutions has gone so far as to say that ICD-10 implementation has the potential to eclipse Y2K in terms of cost and complexity. ICD-10 implementation could touch nearly all operational systems and procedures of the core payer administration process and the provider revenue cycle.\textsuperscript{11}

At the same time, Deloitte says ICD-10 offers potential benefits not seen in earlier regulatory initiatives. Innovators that embrace the remediation effort will have an opportunity to develop new business partnerships and create new care procedures.

Industry observers, citing international entities’ experience with ICD-10, add that the more specific codes can lead to better patient safety and improved claims adjudication and reimbursement rates. The caveat: More accurate coding requires improved documentation.

**CONCLUSION**

Healthcare has been described as the most difficult and complex industry to manage. Given the imminent challenges on the horizon, few providers would disagree. That’s why you need to take steps now to keep your cash flow healthy, whether it’s to speed up collections, gain control over payments, manage liquidity/risk more efficiently, or improve treasury efficiency.

At the same time, it’s always a good idea to keep these “best practices” front and center:

- Focus on your core competency, which is the delivery of superior healthcare. While cash flow from patient receivables is mission-critical, does ownership of processing actually enhance receivables performance/turnover?
- Communicate with your patients, and be open to greater transparency about pricing.
- “Go electronic” as much as possible to increase efficiency and reduce expenses (both payables and receivables).
- Simplify your sourcing in order to forge closer relationships with fewer vendors.

To learn more about how Bank of America Merrill Lynch Healthcare Banking\textsuperscript{\textsuperscript{\textregistered}} specialists can help reduce your organization’s costs and increase cash flow, contact your client manager today.

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**Don’t underestimate these five challenges**

While the Affordable Care Act, Meaningful Use and the move to ICD-10 coding will consume significant bandwidth over the next year, they’re hardly the only challenges to a healthy cash flow. Expect the following trends to have a major impact on providers in the year ahead.

1. **Cost containment**
   Look for opportunities to improve cash visibility/control, update financial technologies, outsource non-core tasks, and enhance current processes.

2. **Improved operating efficiencies**
   Where can you remove silos, consolidate accounts, accommodate new collection volumes, and streamline billing, collections, and reporting?

3. **Pressure on revenues**
   You’ll want to review liquidity strategies to optimize returns while considering risks. You’ll also want to renegotiate payer contracts that provide stable revenue for high-volume patient populations.

4. **Increased technology investments**
   Plan for tech investments that track patient health/utilization/payments over time. Enhance your systems for increased online/mobile transactions.

5. **Social media growth**
   Plan for greater investments in these technologies. Also expect to see consumers share more physician references and hospital programs and services they like with their social network. Also consider setting up a channel on YouTube.
1 “The Top Ten Hospital Trends to Watch in 2012,” HealthStream, March 2012
2 Ibid.
3 Ibid.
4 “Health Reform: Prospering in a Post-Reform World”
6 “The Top Ten Hospital Trends to Watch in 2012”
7 “Ready or Not: On the Road to the Meaningful Use of EHRs and Health IT,” PricewaterhouseCoopers’ Health Research Institute, June 2010
8 “The Road to Meaningful Use: What It Takes to Implement Electronic Health Record Systems in Hospitals,” American Hospital Association TrendWatch, April 2010
9 “Ready or Not: On the Road to the Meaningful Use of EHRs and Health IT”
10 “ICD-10’s Potential Impact on Provider Reimbursement,” Angela Carmichael, ICD-10 Monitor, December 2011
11 “ICD-10: Turning Regulatory Compliance into Strategic Advantage,” Deloitte Center for Health Solutions, 2009

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