GE Healthcare

The Need to Embrace Profit Cycle Management in Healthcare

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Top 5 Takeaways

1. Healthcare leaders need to start analyzing and controlling costs with the same vigor used on the revenue side of the equation.
2. **Profit cycle management** is an emerging model that matches the revenues from new payment models with an improved understanding of the true costs to deliver patient care.
3. Costs associated with diagnosis, treatment and recovery all need to be factored into the equation, even when these services are delivered across several locations via several caregivers.
4. Organizations need to implement information technology systems that are capable of supporting this new paradigm through enterprise-wide profit cycle management – enabling the organization to track profitability across care settings.
5. The acceleration of value-based payment models (e.g. shared savings, capitation, bundled payments) reinforces the need for profit cycle management, as reimbursement rates are squeezed and risk is shifted to providers.

EXECUTIVE OVERVIEW

Healthcare organizations have been operating under a fee-for-service model for many years. As such, financial leaders have become well versed in implementing revenue cycle management systems and processes that primarily focus on the money that comes into an organization. Today, a new need is emerging. Healthcare reform and other system changes are moving the industry toward hybrid payment models such as bundled payments, shared savings, and capitation. To thrive in this new environment, financial leaders need to move toward profit cycle management – an emerging model that matches the revenues from new payment models with an improved understanding of the true costs to deliver patient care. The result: Positive financial performance – even in the face of declining payments – that can be reinvested in the mission to provide better care.

The foundation of any business or household is profit, defined as revenue net of expenses (and applicable as such even to not-for-profit organizations). Regardless of whether you are start-up, a Fortune 500 company, or a family of four, you need to ensure that you are bringing in more money than you are spending. In many businesses, the formula to determine your "profitability" is fairly straightforward. In healthcare, however, the situation is significantly more complex, as existing and new payment models make it difficult to determine exactly how much revenue is going to come in the door. On the cost side, the move to accountable care and value-based payment has shifted the management of risk and cost onto the providers and delivery networks, yet most providers lack the tools that would provide a detailed understanding of the costs required to deliver quality care, especially when that care is delivered in multiple locations. A new model of software tools is required – representing the next generation of revenue cycle management tools and an emerging class of healthcare cost accounting tools. The end goal? A solution for profit cycle management that will help organizations generate a positive financial performance and can be reinvested in the mission to provide better care.

This change will not happen overnight. Rather, it will be an evolution over the next five years, as integrated delivery networks update their revenue cycle solutions to accommodate the new payment models, and as they deploy new activity-based costing solutions.

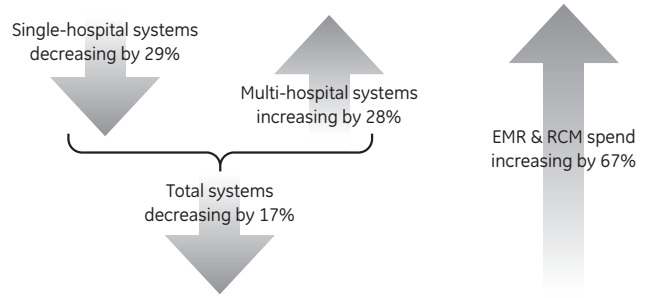
FACING THE CHANGE

Several industry trends are prompting healthcare organizations to think more broadly about evolving their financial management tools, including:

1. The shift toward larger, integrated systems

Healthcare organizations continue to focus on acquisitions or alliances to grow market share and coordinate better care. As these institutions grow into more integrated systems, they need to manage resources efficiently to take advantage of their scale. According to recent Gartner research and internal GE analysis, the number of single hospital systems in the United States is expected to decrease by about 29%, while the number of hospital-based systems is slated to increase by 28%. As such, the total number of systems will decrease by about 17% during this time period.[1] Also, according to SG2 Consulting, inpatient procedures are expected to decline by four percent while outpatient procedures will increase by 28%—all while the total population increases by about 18%.[2] In essence, care must be delivered in the most efficient location (and the most efficient manner given payment pressures)—all while maintaining or even improving quality. The upshot: There will be fewer, bigger and more integrated systems attempting to treat a bigger population in a more efficient manner.

Healthcare networks forming and increasing IT spend, 2012-2017

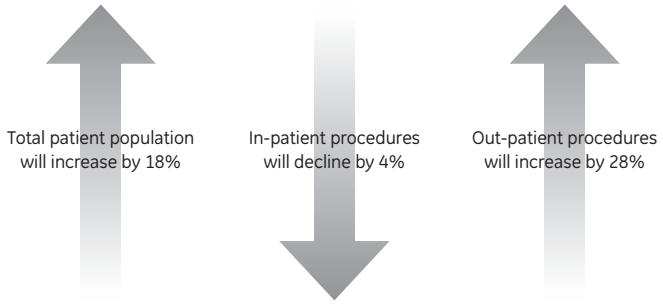


Source: Gartner Research with GE Analysis

2. Moving toward value-based payments

The acceleration of value-based payment models are intended to simultaneously reduce costs (or at least cost growth) and improve the quality of care delivered to Americans. Such models reinforce the need for profit cycle management, as payment levels are squeezed and risk is shifted to providers, who will increasingly operate in complex and sometimes loosely integrated organizations. The shift away from fee-for-service models reflects the view of many observers from across the policy spectrum that the U.S. healthcare system should reduce its reliance on models that pay for volume rather than value or outcomes. For example, according to the 2011 National Scorecard on U.S. Health System Performance, a report from the New York City-based Commonwealth Fund, reimbursement incentives under the fee-for-service model "do not support healthcare providers' efforts to improve quality, integrate care, or make more efficient use of resources." As a result, the U.S. health system continues to perform far below benchmarks of what is achievable, yet still outspends other industrialized countries such as Canada, Germany, France, Australia and the United Kingdom.[3]

Moving to the most quality and cost-efficient locations, 2012-2022



Source: Research by SG2 Healthcare Intelligence

Value-based models seek to better align spending levels with outcomes. For example, under Medicare's Hospital Value-Based Purchasing program, started in October of 2012, hospital payments will, in part, reflect performance on a set quality and patient experience measures. This initiative helps support the goals of the Partnership for Patients, a public-private partnership designed to help improve the quality, safety and affordability of healthcare for all Americans. According to the Department of Health and Human Services, the initiative has the potential over the next three years to save 60,000 lives and save up to $35 billion in U.S. healthcare costs, including up to $10 billion for Medicare .

Although it's difficult to determine exactly how value-based payment will play out, a few payment models have emerged in addition to payment adjustments to fee-for-service that are based on quality and performance measures – and are expected to continue and evolve, but possibly with different names and specific features. These models are characterized by shifting greater financial risk to providers, while also using quality and performance measurement as an additional factor (in some cases).

- The **shared savings** model is often used as part of an Accountable Care Organization. Under this model, providers are financially and otherwise responsible for managing care and improving outcomes for a population of patients. Under typical shared savings models, payers continue to pay claims on a fee-for-service basis, but then evaluate total spending against a defined budget. At the end of a specified period, shared savings are disbursed and shared losses assessed (where applicable to the contract or program) to the provider based on both spending relative to the baseline and performance on quality and other performance metrics. As such, providers need to meticulously maximize the net upside and minimize the downside, given the risk undertaken through the shared savings model.

1 Internal GE analysis of proprietary Gartner market research study in August 2011

2 Internal GE analysis of proprietary research by SG2 in July 2012

3 Source: Partnerships for Patient: Better Care, Lower Costs posted by www.healthcare.gov on April 21, 2011. Click here to read the Fact Sheet

- **Capitation** is a model similar to the approaches that reached prominence in the 1990s (and then declined in use), with financial risk for specified patients and areas of care shifted to provider organizations. Under this model, payers provide a lump sum per patient and then the provider, typically a medical group or an integrated delivery network, manages and is financially responsible for the patient's overall care. Of course, some patients will cost more and others will cost less. The overall objective is to manage the health of and services provided to a patient population to high levels of quality within the budget defined by the aggregated capitated payments—and, therefore, maintain healthy margins to reinvest in the business or maximize profits for growth. Under this model, providers need to seek innovative and cost-effective ways to keep patients healthy, while closely managing costs when patients do require treatment, such as use of the least costly settings.
- **Bundled payments** also are increasing in current and planned use and have been tested and used to some extent by Medicare, Medicaid and private payers. With bundled payments, payers pay a specific flat fee for all services associated with a given procedure or condition – such as a knee replacement. In this instance, a bundled fee might cover all the pre- and post-operative doctor visits, the surgery itself, the ambulatory surgery center fee, and physical therapy sessions. The challenge for the provider organization and for individual professionals is to deliver this array of services as cost-efficiently as possible. As such, providers need to assess, manage and reduce costs across the entire continuum of care.

Glossing over cost concerns in an era of evolving reimbursement models

Although healthcare financial leaders acknowledged rising healthcare costs in the current fee-for-service world, the issue needs more focus in the era of healthcare reform.

Under fee-for-service models, which have historically dominated the U.S. healthcare landscape time, providers are paid to deliver individual services, treatments and tests – thereby creating a "more is more" volume-based mentality.

With a shift towards value-based care, healthcare financial leaders need to integrate costs with revenues. This approach is a change from today, where organizations typically track costs separately from revenue and do not evaluate costs and revenues at the same episode of care or other higher level. In fact, they often think of cash as flowing through two separate pipes, one where dollars came in and one where dollars move out. Typically, costs are monitored at the department or service line level but are not directly tied to specific episodes of care.

Under this model, financial leaders might know what they spend on a line of supplies (i.e. gloves) or category of labor (i.e. nursing) but they don't know what costs are tied to a specific service delivered to an individual patient. As such, financial leaders typically cannot determine if their organization made a profit or experienced a loss on a procedure provided to a particular patient.

As payment and delivery system reform prompts the industry to adopt value-based payment models, the "more is more" mentality that worked to help healthcare organizations stay profitable under fee-for-service paradigms will be less and less dominant, and healthcare leaders will need to get a much greater understanding of profit by considering and analyzing costs as well as revenues.

Snapshot of Payment Models

Shared Savings: Incentivizes effort to deliver quality care at low cost for a population

Bundled Payments: Incentivizes efficient episode management

Capitation: Rewards provider institutions with high-risk appetite for managing efficient care

3. Shift toward population health management

With more integrated health systems and changing payment models, the intention is to move along a continuum of payment methods towards greater provider financial risk, robust quality measurement, and a shift from a sole focus on individual patients toward managing "populations" of patients, which can include an overall population or sub-populations, such as patients with diabetes or other chronic diseases. Population health management is intended to involve monitoring of healthcare spending, quality, access, and outcomes, with the goal to improve the health of an entire population while controlling costs of care. As such, population health management stresses wellness and prevention through disease management and management of complex cases. Once again, under this model, providers are likely to employ various strategies to keep populations healthy – with the goal of mitigating financial risk by supplying preventive services and reducing the need for acute and chronic care.

Regardless of what specific payment models providers are operating under, to better manage population health, they will need to build a deeper understanding of the following:

- The demographic attributes of the population(s) they are managing
- How to stratify healthcare and financial risk within the population(s)
- The organizational changes required to ensure success
- The need for specific information technology

In addition, a close analysis of the costs associated with serving the population(s) covered will provide the organization a better understanding of financial risk and the factors potentially associated with the financial success of the provider organization. With an in-depth understanding of costs, leaders can better negotiate risk-based contracts with payers, bring about process changes in the organization to reduce cost, and finally target the right population(s) with appropriate health interventions, so as to remain profitable into the future.

EMBRACING PROFIT CYCLE MANAGEMENT

With all of these industry changes, healthcare organizations need to move beyond revenue cycle management and start to embrace profit cycle management. Under this model, leaders measure financial success through the following equation, which we're all familiar with: Revenue - Costs = Profit

Seemingly simple, the model takes on quite a bit of complexity when applied to healthcare. Under a profit cycle management model, when a patient comes in for a treatment, healthcare leaders must manage and understand costs with the same precision as they manage and understand revenues. To do so requires going beyond the basics – and diving deep into cost management and analysis.

For example, when a patient comes in for a kidney transplant, the financial leader needs to know exactly how much it costs to deliver the care for a transplant and to be able to evaluate both revenues and costs for a kidney transplant service line. As such, the financial team needs to go beyond traditional cost analyses, which were carried out at the organizational level and provided little, if any, insight into the overall costs of an actual kidney transplant across multiple providers and care settings. Understanding the true cost of a service, such as kidney transplant, is important for several reasons. First, this cost figure will help provider institutions negotiate better contracts with payers, so providers can maintain a healthy margin on the service line – specifically when signing bundled payment contracts. Second, understanding the true cost of a service helps identify bottlenecks in providing the specific service, and hence can help organizations improve process optimization efforts.

Today, healthcare organizations use various methodologies to evaluate costs. Some of these methodologies, such as Ratios of departmental Costs to Charges (RCC), cost apportionment based on price of charge code items, or statistics and allocation methods from the HCFA 2552, bury overhead in product costs through very general allocation. These methodologies calculate the accounting costs to serve the patients. Accounting costs are not necessarily the true costs provider institutions incur because they are based on historical charges for services without clear visibility into the cost of actually delivering the service. Hence provider institutions tend to receive cost indicators that have a level of inaccuracy – and these indicators are costly to construct and maintain.

Financial leaders instead need to adopt a sophisticated cost analysis. When evaluating costs for kidney transplants, they need to know the cost of each supply and labor component that went into the treatment. For example, they need to calculate how much it costs for the patient to spend 15 minutes with the registration clerk, 20 minutes with the nurse and 10 minutes with the doctor. They need to know how much it costs for the operating room supplies as well as the gauze needed during recovery. From there, they could figure that the entire treatment cost $10,456 while the reimbursement came to $11,000, leaving the provider organization with a $554 profit.

While plugging numbers into a profit equation is fairly simple for most other businesses, a number of complications add murkiness to the healthcare waters.

Top profitability questions for financial leaders

1. How do you measure the true cost of care?
2. Are your current cost control methodologies working?
3. How do you negotiate more profitable contracts with commercial payers, without understanding the cost of serving their patient population?
4. Would profitability information be of value in streamlining clinical pathways and monitoring physician performance?

To start, leaders need to understand and assess the costs of services rendered internally as well as the costs associated with services delivered across the continuum of care (for which the organization or provider is responsible) to measure the profit associated with a specific episode of care. In essence, costs associated with diagnosis, treatment and recovery all need to be factored into the equation, even when these services are delivered across several locations via several caregivers.

In addition, costs and revenue need to be managed at the population level. For example, if a provider is responsible for delivering care to a group of diabetic patients, the provider needs to get a handle on the profit equation not only for individual patients but for the entire defined population.

To help healthcare organizations move toward a profit cycle model, organizational leaders need to implement information technology systems that are capable of supporting this new paradigm through enterprise-wide profit cycle management – enabling the organization to track profitability across care settings. To accomplish this goal, healthcare organizations might consider adopting systems that offer advanced analytics, process optimization and contract analysis functions. The data gathered through these systems will enable provider institutions to truly understand the cost of care at the patient level.

In summary, healthcare industry leaders need to broaden the horizon – and start studying, analyzing and controlling costs with the same vigor used on the revenue side of the equation. Leaders need to measure and control costs across the board through process optimization and standardization. To make this happen, healthcare financial professionals need to supplement traditional cost accounting with innovative methodologies, such as activity-based costing, that result in a true understanding of the costs of care, making it possible for organizations to successfully implement profit cycle management initiatives. With these programs in place, healthcare organizations can maintain profitability while delivering the high quality care that people across the country are seeking.

About GE Healthcare
GE Healthcare provides transformational medical technologies and services that are shaping a new age of patient care. Our broad expertise in medical imaging and information technologies, medical diagnostics, patient monitoring systems, drug discovery, biopharmaceutical manufacturing technologies, performance improvement and performance solutions services help our customers to deliver better care to more people around the world at a lower cost. In addition, we partner with healthcare leaders, striving to leverage the global policy change necessary to implement a successful shift to sustainable healthcare systems.

Our "healthymagination" vision for the future invites the world to join us on our journey as we continuously develop innovations focused on reducing costs, increasing access and improving quality around the world. Headquartered in the United Kingdom, GE Healthcare is a unit of General Electric Company (NYSE: GE). Worldwide, GE Healthcare employees are committed to serving healthcare professionals and their patients in more than 100 countries. For more information about GE Healthcare, visit our website at www.gehealthcare.com.

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