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Healthcare's Productivity Paradox:

Ferocious Exploitation of Payment Formulas

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By David Johnson, CEO

Las Vegas is a strange place to attend a medical conference. In June 2014, the Healthcare Financial Management Association (HFMA) convened its Annual National Institute ("ANI") at the Venetian Hotel and Casino. Several thousand healthcare finance professionals assembled to network and improve their business acumen. I was there to speak on hospital affiliations and acquisitions.

Here's something not seen every day. ANI attendees intermingled with almost two-hundred thousand young people attending the Electric Daisy Carnival at the Las Vegas Speedway. These kids wore makeup, danced all night in their underwear and consumed illegal substances. Three died. Hundreds stumbled through the casino each morning bumping into straight-laced accountants. What happens in Vegas.…

Upon arrival I wandered through the massive exhibit floor. The number of revenue cycle companies exhibiting was staggering. My rough estimate was three-fourths of the exhibitors. Later that day, the official program kicked off with six hospitals winning awards big trophies for revenue cycle excellence. The audience exploded with applause. Clearly, revenue rules in modern American healthcare. It's more electric than a Las Vegas rave.

U.S. healthcare exhibits a profound productivity paradox. Private company exploitation of activity-based payment formulas distorts care delivery protocols and misuses care resources. Perhaps even worse, activity-based payments disconnect healthcare consumers from healthcare providers. Fee-for-service payment fragments patient-caregiver relationships, which are the central feature of effective healthcare delivery.

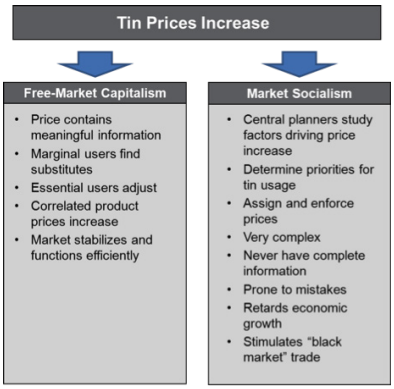
The Price of Tin

Capitalism's inherent beauty is its ability to allocate resources efficiently among market participants. Outcomes, not process, triumph. Confession time. I'm addicted to the Great Courses program. On a drive through Indiana several years ago, I listened to a lecture by Macalester College Professor Timothy Taylor on the Austrian economist Friedrich Hayek. Little did I expect to gain insight into centralized health systems.

Born in Vienna in1899, Friedrich Hayek was a leading mid-century economist who championed liberal democracy and free-market capitalism. He taught at the University of Chicago, won the 1974 Nobel Prize for Economics and expounded on market behavior, government's role and social planning.

Hayek maintained markets and competition were the best mechanisms for calculating and coordinating economic choice. He believed that prices contain sufficient information to guide and adjust economic decisions.

Hayek stressed that decentralized planning by individuals and companies is the most effective system for allocating resources and generating wealth. To illustrate, Hayek contrasted how Free-Market Enterprise and Market Socialism respond to increasing tin prices.



Under Free-Market Capitalism with decentralized planning, primary and marginal users of tin "read" the pricing information and adjust consumption accordingly. In response, manufacturers substitute materials, improve their production mechanics and/or adjust prices. The cycle repeats until the market stabilizes.

In contrast, Market Socialism with centralized planning requires complex protocols to determine why the price of tin increased, establish priorities for its use, assign prices and enforce market compliance.

Before long, complexity overwhelms managerial capabilities and companies make mistakes, such as manufacturers producing too many gutters and too few pans. "Managed" economies create supply-demand imbalances, impede economic growth and stimulate 'black market" trading activity.

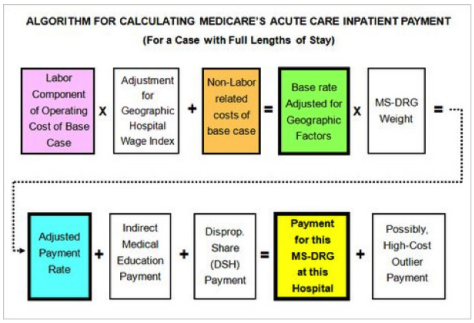
While listening to Professor Taylor's lecture, I had an epiphany. Medicare is market socialism. Its centrally managed practices for pricing, regulating and policing healthcare services distort market function, create supply-demand imbalances and stimulate "black market" behavior. By this point in my drive, I was approaching Indianapolis, where health systems were constructing four new cardiac surgical centers even as new therapies were reducing the need for cardiac surgery.

Centralized administration breeds mistakes. Remember the Soviet Union's remarkably consistent record of missing its five-year economic forecasts? They weren't much better at manufacturing. An old joke makes the point: owners could double the value of their Lada, the Soviet Union's marque automobile, by putting a liter of petrol in its gas tank.

Despite global success with free-market capitalism, the U.S. government relies on centralized planning (a.k.a. Medicare) to design, administer and police healthcare services. Medicare's centralized operating model is contrary to American trust in competitive markets. Native distrust of bigger government is a core reason attempts to create a "national" health system in the U.S. have failed.

Where Process Trumps Outcomes: Medicare's Reimbursement Algorithm

Noted Princeton economist Ewe Reinhardt uses the diagram below to depict Medicare's complex analytic methodology for calculating treatment payments. Medicare's actual methodology is even more complex. The payment process begins by calculating an average inpatient case rate sufficient to cover operating and capital costs for efficient facilities. In 2014 , the operating base rate was $5370 and the capital base rate was $429.



Medicare adjusts this base rate for geographic variation in labor and non-labor cost as well as treatment complexity based on the primary diagnosis, coexisting medical conditions and complications. The adjusted-payment rate incorporates these geographic and care-intensity factors.

Then, Medicare adds payment to compensate hospitals for medical education and indigent care costs. It also makes allowance for high-cost, "outlier" cases.

Medicare's payment algorithm incorporates multiple factors, homogenizes complex relationships and requires massive data entry for processing. Notably absent from Medicare's algorithm is payment for superior outcomes and penalties for inferior outcomes.

To its credit, Medicare now incorporates some value-based payments and readmission penalties into care reimbursement. It's also expanding its use value-based payment, including "bundling" for joint replacement surgeries. Some employers and commercial insurers also are creating incentives for better care management, but it's still "small potatoes". Fee-for-service payments still constitute over 80% of provider revenues.

In his book Healthcare Beyond Reform, Joe Flower identifies "the two core rules of [healthcare] economics:

- Rule 1: People do what you pay them to do; and
- Rule 2: People do exactly what you pay them to do."

Flowers' assessment is harsh, but directionally right. Healthcare won't change until payment incentives change. Process wins. Outcomes lose.

Hayek observed that resource allocation mistakes occur when central planners manage complex business sectors with incomplete information. His insight certainly applies to Medicare. Mistakes abound. It takes years to plan and construct new acute facilities.

The Indianapolis health systems planned and built new cardiac centers to maximize reimbursement payments for cardiac care. They made facility investments predicated on then-existing treatment patterns and payment rates. They didn't envision the emergence of new cardiovascular drugs that would reduce the need for surgical intervention.

Overbuilding leads to over-treating. To make up for lost volume and income, cardiologists "over-treat" by performing justifiable, but unnecessary, procedures. If "Deep Throat" were a mole in "Healthgate", he would whisper, "Follow the reimbursement."

Healthcare's payment complexity enables hospitals and doctors to optimize payment by seeking the highest reimbursement within allowable guidelines (hence the importance of revenue cycle management). The government, commercial payors and health systems invest enormous resources to prevent, identify, investigate, negotiate and settle payment disputes.

Medicare has no official estimate of how much it loses annually to fraudulent billing practices. The FBI estimates three to ten percent of all health care billings are fraudulent. That is a wide estimate range. Even at the low end of that range, the fraudulent billing represents a huge cost (almost $100 billion) for a $3 trillion industry. Officials concede that billions more tax dollars are misspent every year because doctors and hospitals exaggerate their patient's illnesses when billing for treatment.

Value, What Value?

In comparison to other industries, healthcare's operating model has changed relatively little during the last fifty years. Americans rely on doctors and hospitals to distribute healthcare services in accordance with pre-determined fee schedules. What about value?

Given complex Medicare reimbursement formulas and undisclosed chargemasters, it's challenging for consumers to align healthcare products with their prices. Instead, consumers make healthcare decisions anecdotally, querying friends and/or Internet resources to find caregivers and facilities.

America's activity-based, fee-for-service reimbursement system has conditioned providers to optimize revenues through agile manipulation of coding and treatment guidelines. This has created hospitals with robust revenue cycle capabilities, but little understanding of per-unit revenue and cost relationships. Most hospitals allocate their costs in relationship to their charges. This methodology provides no useful information for efficiently using labor, supplies and capital.

Health companies' intense revenue focus has atrophied their ability to understand and manage operating costs. This operating deficiency poses a serious challenge for providers as the market moves toward value-based purchasing.

Moreover, few health companies have the organizational cultures necessary to improve quality and efficiency while reducing costs. This is a big problem. It's impossible to assess and deliver value-based healthcare services without a solid understanding of business unit costs.

Walden Pond Revisited

The U.S. health system costs too much and delivers sub-par outcomes because it incentivizes ferocious private-company pursuit of process-based reimbursement payments. This is healthcare's productivity paradox. Activity-based, fee-for-service payment is its weapon of mass-value destruction.

In 1845, writer and philosopher Henry David Thoreau moved to a small cabin on Walden Pond in Concord, Massachusetts to "live deliberately," experience the "essential facts of life" and learn "what they had to teach." Like a stone thrown into his Walden Pond, Thoreau's observations on nature, minimalism, politics and and civil disobedience have rippled through the ages and influenced leaders as diverse as Gandhi, Frank Lloyd Wright and Martin Luther King.

Thoreau believed that activity without value-creation was purposeless. He emphasized this in an 1857 letter,

"It is not enough to be industrious; so are the ants. What are you industrious about?"

American healthcare is too "industrious" in its pursuit of revenues. In contrast, industrious health companies that deliver better care at lower prices in customer-friendly venues will dominate the post-reform healthcare marketplace.