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Code Red: Part 1

# Payment Complexity is the Root of All Healthcare Evils

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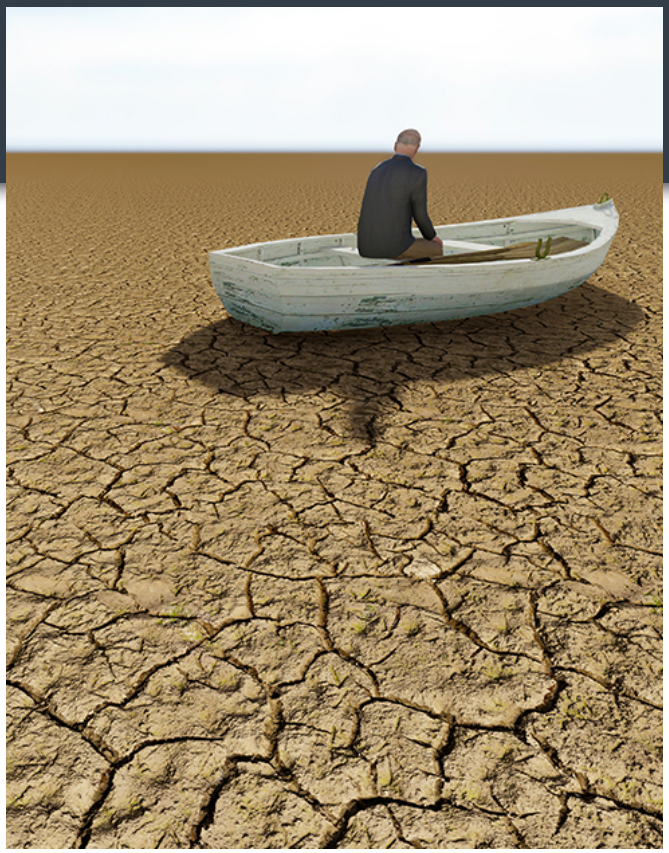

As a CEO in healthcare for 35 years, I have been responsible for helping different organizations improve their operating margins, cash flow and overall balance sheets.

From this frontline vantage point, I've seen firsthand how the increasing complexity in healthcare payment models have warped medicine's ability to provide compassionate, appropriate and cost-effective care.

Here's a disturbing trend: During the past four decades, the healthcare payment model has become increasingly complex, putting increasing pressure on providers to collect payment for their care. If it keeps going like this, I predict in the next five or so years that powerful demographic and economic realities will compound with this complexity to force real change in healthcare payment models.

## DEMOGRAPHICS DON'T LIE

Today there are 78.5M Baby Boomers. By 2030, which is just seven years away, all of these folks will be on Medicare and Social Security. This generation will comprise 25 percent of the total population. Between now and then, there will be a 60 percent increase in Medicare recipients.

Simultaneously the US workforce — called upon to fund these growing obligations — is shrinking as a percentage of the population. If healthcare providers feel underpaid today, the economic future is looking parched. There simply isn't going to be enough money to cover the increasing costs of the current system.

My perspective is that our best opportunity in the future is to change the payment model now, by simplifying and standardizing the payment formula. We should not be using a payment model that encourages volume and encourages fraud and abuse.

It's impossible to correct a problem without defining it first. With that in mind, let's examine the complexity and dysfunction embedded within healthcare's payment mechanics.

## 3 BASIC TRUTHS ABOUT AMERICAN HEALTHCARE

Here are three underappreciated truths about American healthcare:

1. Fee-For-Service (FFS) physician payment undermines everything it touches.
2. The coding system is the suffocating force behind physician billing, burdening physicians with needless complexity. It seems like a futile effort to quantify the unquantifiable.
3. Despite over 20 years of promotional efforts, value-based payment has not gained any meaningful traction in healthcare. Why? It's complicated and depends on coding.

Allow me to elaborate on each of these.

**FFS and Coding:** The fee-for-service method dates back to the 1960s, like Medicare, and was never intended to be used for billing in healthcare. It evolved from a merger with the World Health Organization (WHO) coding system used to organize and document patient care in order to classify diseases and facilitate research.

Today's healthcare system uses two distinct but interrelated coding systems for physician billing:

- The American Medical Association's 70,000 CPT codes
- The WHO's 69,000 ICD codes

These complex codes, all 139,000 of them, drive all payments to providers and overwhelm clinicians. Research studies have documented that physicians now spend almost twice as much time (49 percent) on administrative activities as they do with patients (29 percent).

Under today's physician payment model, billing and coding obligations literally take precedence over caring for patients.

Research studies also document that one-third of healthcare services provided are unnecessary. Once again FFS billing is the primary culprit. FFS billing incentivizes activities that increase care volume. This is the driving force behind overtreatment.

While these concerns about FFS billing are well-known, the problems persist. In fairness, there have been numerous initiatives over the last few decades to address these concerns, but my experience is that each initiative has failed and made healthcare even more dysfunctional. Most disturbing is that FFS documentation is a leading contributor to clinician burnout.

In the early 1990s, Medicare implemented a cap on physician payment to control rising costs through legislation called the Omnibus Reconciliation Act of 1989 (OBRA). Some argue that the mechanics of this cap incentivized physicians to increase procedures and treatments to offset their income losses.

Volume has become the driving force in healthcare because of limits on individual FFS payments. OBRA was a miserable failure at limiting the growth of costs. Every year Congress overrode the cap as part of the Federal budget. It took over 25 years for Congress to replace OBRA. Fast forward to now and we see replacement legislation has proven to be no more effective.

**Compliance:** Beyond coding complexity, healthcare dedicates enormous time and resources to limit fraud and abuse of medical claims procedures. The federal bureaucracy to police claims has mushroomed along with a myriad of rules requiring caregivers to comply with fraud and abuse legislation and regulations. It should be no surprise that compliance consulting is a booming business in healthcare today.

None of these payment and policing initiatives have controlled healthcare spending. Such initiatives will not curtail spending because the real culprit behind excessive healthcare spending is a payment model that unnecessarily encourages volume. It's that simple. Oversight cannot correct a system riddled with inappropriate incentives. Instead, more expansive oversight complicates caregiving and raises costs.

To paraphrase the economist Thomas Sowell, adding government bureaucracy and expensive consultants to the mix does not make already expensive healthcare any more affordable.

**Suboptimal Outcomes:** Another problem with FFS payment is that it does not distinguish between bad care and good care. Payment does not depend on quality, so poor care is paid at the same level as superior care — as long as the coding is correct!

As you might expect, CMS has launched regulatory initiatives to measure quality as part of FFS payment. While well-intentioned, these new regulatory quality obligations — much like those addressing fraud and abuse — increase the complexity and costs of delivering healthcare services.

Research shows that these quality measures have, at best, an ambivalent impact on the quality of care. Each payor has their own unique set of quality measures, forcing providers to comply with a never-ending list of quality metrics and reporting mechanisms.

**Revenue Cycle Mania:** The business of healthcare billing has become its own industry, one that is far more lucrative than medicine.

This industry is called Revenue Cycle Management (RCM). Unbelievably, this massive and growing industry generated $140.4 billion in revenues in 2022. It is forecasted to grow 10.3 percent annually through 2030. Last week, 4sight Health asked the question "How Big is the Revenue Cycle Management Business?" trying to get a sense for how large the industry has grown.

To offer some sense of comparison, the entire US automobile market was $100.9 billion in 2022. In sum, the RCM industry only exists because of insane coding complexity and the fear of fraud accusations — and all this expense adds zero value to patients.

## PHYSICIAN PAYMENT REFORM REVISITED

In 2015, the federal government tried again to address the flaws in FFS payment. This new mandatory process attempts to marry value-based care, quality, and FFS Medicare payments through new payment models. This model officially replaced the flawed OBRA structure with two new reporting requirements called MACRA and MIPS. I will spare you their full names.

These new systems attempt to reward physicians for cost-effectiveness and quality through the new FFS payment formularies. These mandatory new reporting systems operate by tracking select physicians' results within 225 performance new measures!

Insanity is doing the same thing over and over again and expecting different results, according to Albert Einstein. These new measures are based on coding. These new models increase billing complexity to a new level. After six-plus years of these new regulations and many expensive consultants, healthcare costs are higher than ever. The impact of this new payment model on quality is unclear.

## VALUE-BASED CARE

The primary alternative to FFS payment is value-based care. In 2014 CMS began experimenting with alternative payment models through Accountable Care Organizations (ACOs). Caregivers and health systems volunteered to participate in new programs where Medicare's successes in controlling costs and improving quality is modest at best. Participation has been limited. The shared cost savings with caregivers as long as certain quality measures were achieved.

The reporting requirements and risks associated with the ACO were extensive. After 7-plus years of operation, ACOs successes in controlling costs and improving quality have been could be characterized as modest. Participation has been limited. Few providers judged the complexity of the program worth the benefits. Consequently, ACO's have not achieved much scale and don't materially impact Medicare's operations.

Value-based care originated out of a payment system known as capitation. Capitation seeks to pay a fixed sum annually for all the health costs of the patient. Capitation is supposed to slow down healthcare spending and improve the quality of care. Operating under capitation is risky because the level of sickness of the patient determines most of the costs.

Insurers use coding to adjust payments for the sickness of the patient. Coding manipulation and confusion in this space is rampant. Another complexity with capitation is the allocation of patient cost among the providers. What share of the risk goes to the physician, or the hospital or the insurer? There is a great deal of money to be made by cleverly allocating risk payments.

All our nation's private Medicare Advantage (MA) plans (United and Humana to name two larger ones) have perfected the risk allocation in ways that benefit themselves. Today, MA Plans have privatized 50 percent of Medicare using capitation. Unfortunately, most of the savings from this capitation is going into private insurance profit. These insurers allocate the risk to providers and keep most of the profit for themselves. The benefit to the providers is the patient volume. The benefit to patients is broader insurance coverage for less cost.

Capitation, like FFS, is complicated. Its effectiveness requires an integrated team of caregivers, a broad spectrum of health facilities, a large population of patients to spread risk, and an insurer that fairly compensates each element of the delivery system. The best example of an effective capitation model is the Kaiser Permanente Health System.

Kaiser has a massive integrated network of physicians, numerous hospitals, and other needed health facilities, along with an insurance product covering millions of patients. All of these components operate within a single corporation. This minimizes risks of allocating payments among multiple providers. Although bureaucratic, this integrated insurer and provider model has proven to be very successful at driving better care outcomes at lower costs. So why hasn't this model spread more extensively?

Unfortunately, the vast majority of healthcare in the US is not integrated like Kaiser. Most providers resist integration. They resist integration because of the perceived negative aspects to integration. One negative aspect of capitation is that it limits choice - both for the patient and the provider.

In America, we do not like limiting choice. The vast majority of US healthcare services are with individual physicians, individual hospitals, independent diagnostic, surgery centers, and nursing homes. The US's dominant health system structure is based upon independent (non-integrated) caregivers. This fragmented ownership and delivery structure makes it difficult to offer coordinated care for patients. Capitation does not work well without an integrated system.

Generally speaking, private insurers do not like capitation. Why? Insurers do not like risks that they cannot predict. Furthermore, private insurers do not have easy access to integrated health delivery systems. Interestingly these private insurers are investing heavily in acquiring and owning primary care practices.

Even with an integrated network, predicting medical costs for patients is difficult and it requires a large patient population among which to spread financial risk. Private health insurers prefer to eliminate this risk by not insuring it. Today, most private insurance is self-insured by employers.

Most large health insurers just process claims through Administrative Services Only (ASO) contract arrangements. These insurers offer employers a provider network, claims processing, and premiums based on the employer's actual health cost. The more costly the care and the more complex the claims the more money is made by the insurer.

Another important characteristic of current health insurance administration is claims denial. Insurers deny claims they deem is "medically unnecessary" and/or improperly coded. The insurers use this denial strategy to allegedly save money for the self-insured-employer clients, but claims denial is a win-win proposition for health insurers.

Self-insured employers pay their health insurers to process claims. The more complex the claims processing, the more payment the insurer receives. So hiring a team of staff to challenge a physician's orders, delay payments, and use their powerful bureaucracy to limit payments is lucrative for health insurers.

Claim denials, in aggregate, do not save on healthcare costs but do increase insurers profits. Meanwhile, claims denial drives physicians and patients crazy. In short, insurers benefit from making and keeping the FFS system in place. They do not promote value through capitated payments.

So one might ask why private insurers like MA Plans and its capitation model. Well they get Medicare to give them a payment level equal to or greater than the Medicare FFS rate. They create a limited network of providers (those purchased primary care groups) and encourage them not to over-treat patients. They also focus on coding. Their payments from Medicare go up if they code sicker patients. So they use coding to allegedly document they have sicker patients and then receive higher Medicare payments.

Of course, the government uses the fraud and abuse industry to fight this upcoding. Unfortunately, the private sector wins this battle. The private insurer sector does well on MA. Look at their profits.

Given these realities, neither capitation nor value-based care payment models like ACOs have demonstrated much success. FFS medicine continues to dominate healthcare. The significant difference, of course, is that over the last 20 years FFS medicine has become increasingly more complicated.

The most serious consequence of these "progressive" payment initiatives is that caregivers no longer have enough time for their patients. They are consumed by compliance and payment details. Physicians are burned out. In short, healthcare has become both dysfunctional and unaffordable.

Let me summarize some of the consequences of these overly complex physician compensation models used by the insurance industry.

- The US health system has a severe shortage of primary care, palliative care and geriatrician physicians. These physicians live in a world based on procedures and outcome measurement and their critical work is cognitive and conversational. Consequently, FFS dramatically undervalues their services. They are underpaid and overworked. Hence the shortage.

- Expensive ER visits have grown dramatically because the ER has become the de facto alternative to primary care for patients, especially patients on Medicaid. ERs are more expensive than primary care and they promote fragmented care.

- There has also been a rapid expansion in Urgent care Centers due to poor access to primary care. Urgent care is convenient and less costly. However, this care model promotes fragmented care and is often set up as a loss leader to sell prescriptions.
- Perhaps the most invidious impact of FFS medicine is that it discourages physicians from talking with patients. Coding does not like conversations. Physicians cannot afford to spend their time in a way that conflicts with how we pay them. This restriction makes practicing as a physician a miserable existence.
- Over the past few decades there has been an explosion in chronic illness. This means that most older patients have several physicians. Unfortunately, FFS coding discourages physicians from talking to one another about common patients. Consequently, no physician assumes the responsibility for coordinating a patient's care.
- The administrative burden on physician offices is overwhelming and tremendously expensive.
- The focus on coding has hijacked the electronic medical record. Originally the electronic record was supposed to help patients and physicians. However, because of the economic importance of coding, the electronic record is now designed around billing.
- FFS coding encourages volume of services. Because the FFS system pays for volume it is encouraging fraud. If healthcare payment were not based on volume there would be no need for fraud and abuse oversight. Fraud and abuse oversight costs the system billions annually because now making billing mistakes can lead to criminal prosecution.
- All of these problems more significantly impact elderly patients because they are the patients that need care coordination and open conversations from their physicians the most.

Many individuals complain about the problems with healthcare. What we need are solutions, not more descriptions of the problems. My concern is that our past solutions do not fix our real problem: The payment model. We are running out of time to face the growing cost of healthcare and the expanding elderly population. Our next segment offers some new solutions to physician payment formulas.

## PART 2 OF CODE RED: SOLUTIONS

Some suggest we should go to Medicare for all, some argue for more competition and transparent pricing, and some argue we just need more value-based care. Frankly, my experience suggests that none of these solutions connect to the real problems with healthcare. None of these actions have lowered healthcare costs or will improve physician morale.

Reforming health care desperately needs simplicity as its primary focus. Secondly, the payment model needs to be singular for all the payors. We cannot have each insurer creating unique requirements for the payment formula. The conflicting incentives and administrative burden created by all the different payment formulas is costly and does not create value for patients or caregivers.

For at least one simple alternative, read Part 2 of Code Red: Solutions (coming soon).

## ABOUT THE AUTHOR

***Michael Dorning Connelly*** may be the nation's leading expert on end-of-life care. His outstanding book, "The Journey's End," is an informed and practical guide for managing healthcare decision-making in elderhood and avoiding the industry's pernicious "death trap."

Incorporated within "The Journey's End" is an insider's frustration and disgust with healthcare's all-encompassing billing, payment and collection mechanics and practices. In his two-part "Code Red" series, I can feel Mike blood pressure increasing in Part 1 as he describes the overly complex and counter-productive coding system healthcare uses to fund itself. Is there really a diagnostic code for being bitten by a cow? I also can feel his passion in Part 2 as he outlines common-sense reforms to align service delivery with consumer needs.