

hfma's **financing the future III**



Healthcare Payment: Goals, Trends, and Strategies



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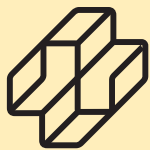


Financing the Future III
Report 1
Healthcare Payment: Goals, Trends, and Strategies

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Preface: Financing the Future III

Since 2003, HFMA's Financing the Future project has given healthcare providers the information they need to ensure their organizations have the resources necessary to deliver safe, high-quality care for their communities.

The first Financing the Future series featured six reports that brought together key stakeholders to share knowledge about and produce empirical evidence of healthcare capital needs, availability, and factors associated with access. One of the key findings was a growing gap between “have” and “have-not” hospitals with respect to financial condition. Further, the reports found the number of “have-not” hospitals growing at a greater rate than that of the “have” hospitals. This series was led by HFMA in partnership with GE Healthcare Financial Services, with research conducted by HFMA and PricewaterhouseCoopers.

The second Financing the Future series identified the best practices of capital planning and access. The cornerstone principle, carried through in each of its six reports, was that adherence to a rigorous corporate finance process is critical to a hospital's ability to increase access to capital, make wise investments in the organization's future, and improve financial performance. Thus, the goal of Financing the Future II was to define, provide examples of, and encourage the implementation of a successful, corporate finance-based approach to financial management in healthcare organizations. HFMA's partners for Financing the Future II were GE Healthcare Financial Services and Kaufman, Hall & Associates.

This report launches the third—and in many ways the most ambitious—Financing the Future series. HFMA, in partnership with GE Healthcare Financial Services, has set out to identify key industry trends that affect hospitals' capital position and ability to fund important future initiatives. For each trend, a report will identify the current state and implications for the future.

The trends are:

- *Payment trends*, including pay for performance, impact of consumerism, and coping with the consumer's rising financial stake in paying for healthcare services
- *Healthcare technology*, including innovations in clinical and information technology such as electronic health records
- *Unfunded liabilities*, including pensions, malpractice insurance, and other enterprisewide risk, with discussion of areas such as the impact from pension reform legislation, insurance captives, and funding mechanisms
- *New hospital construction*, including integrated planning, design, and financing that reduces costs and enhances efficiency and quality, with discussion of areas such as workflow redesign, workforce change, and the efficient layout of space to improve patient safety.

The Financing the Future project embodies the goal of HFMA and GE Healthcare Financial Services to give healthcare providers the business tools they need to be thriving assets to their communities.

Introduction

Today's healthcare payment system isn't working. In 1975, when health care represented 8 percent of the United State's gross domestic product, conventional wisdom held that healthcare costs were reaching the breaking point and that the economy couldn't sustain further cost increases. Today, these costs have jumped to 16 percent of the country's GDP, and overall healthcare spending is rising by 8 percent compounded annually, with no end in sight.

Additional economic pressures these days include a huge and rising federal budget deficit, the prospect of 80 million baby boomers coming into Medicare starting in about 2010, and the need for employers to streamline business costs to compete in a global marketplace. Health insurance premiums are rising 8 percent to 10 percent each year, escalating at three times the rate of the consumer price index. The confluence of these factors compels fundamental changes to the healthcare payment system.

There is some good news, however. The magnitude of these payment challenges and the consequences of failing to resolve them are convincing stakeholders

to give up adversarial relationships and competing agendas and work together to develop rational, customer-focused payment strategies. Health insurance companies, normally fiercely competitive, are finding common ground and collaborating to develop consistent standards and policies for information interchange. Partnership projects and collaborations among federal and state governments, health plans, employer groups, research organizations, and others are studying payment options and working out the thorny details.

To better understand the current and probable future states of the healthcare payment system, HFMA recently interviewed policy experts, a healthcare economist, and executives representing employers, health systems, insurance plans, and the federal government. These experts, who are involved in developing and evaluating the trends discussed in this paper, offer their perspectives on near-term goals, upcoming changes, and strategies that hospitals need to pursue to best serve their communities and position themselves for success given the changing payment environment.

Payment System Goals and Gaps

An ideal payment system benefits all stakeholders—providers, payers, employers, and consumers—by encouraging efficiency, quality, and consumer involvement, among other goals. Although many efforts are under way to help the payment system achieve these goals, glaring gaps still exist.

Efficiency

In many ways, efficiency equates to controlling costs. Traditional payment models based on per diems and diagnosis-related groups have sought to bring down

costs to payers through negotiated discounts with providers. Health maintenance organizations and preferred provider organizations penalize enrollees for using providers who don't discount their services. The strict limitations of managed care, particularly HMOs, have been criticized by providers and consumers alike. Patients have grown frustrated and angry by rules regarding medical necessity designed to control access to expensive diagnostic procedures and medical treatment. Heavy-handed cost-containment practices are evolving into policies promoting consumer education and responsibility. Still, healthcare costs are rising rapidly.

The current payment system is basically a piecework payment methodology. It compensates providers based on the volume of care delivered. The system overvalues specialty care and undervalues primary care. A disproportionately large percentage of payment goes toward high-cost interventions like orthopedics and cardiology, and relatively little is paid for chronic disease management and coordination of care.

Cuts in Medicare spending are forcing hospitals and physicians to charge higher prices for services delivered to their privately insured customers. Moreover, these serious if unintended consequences have come to characterize a “broken” payment system that has failed to keep costs from rising beyond levels that consumers, their employers, and the government are willing to pay.

Quality

Current trends are focused as much on improving quality, safety, and consumer satisfaction as they are on decreasing—or offloading—healthcare costs. Of course, the benefits of high quality are not just a healthier population, but reduced cost of care. Reports from the Institute of Medicine and others suggest considerable challenges facing U.S. healthcare quality. To name just a few:

- Between 44,000 to 98,000 Americans die each year from preventable medical errors. More people die from these lapses in quality than from breast cancer, AIDS, or motor vehicle accidents.¹
- In a random sample of adult patients treated for both acute episodes and chronic illness, only slightly more than half received the recommended standard of care.²
- Medication-related errors for hospitalized patients cost roughly \$2 billion annually.³

Overall, the nation’s healthcare system is delivering an inadequate return on a very large investment. In spite of an overall healthcare spend in this country of

about \$2 trillion—about double the fraction of GDP spent by the next most copiously spending nation—outcomes are mediocre at best. Statistics comparing life expectancy, child mortality, and other health measures put the United States squarely in the middle of the pack of nations.

“Quality is a huge issue,” notes Randy Fuller, manager of market intelligence, GE Healthcare Financial Services. “To the extent providers could become more efficient and raise the overall quality equation, they could go a long way toward making payers and consumers more content with the healthcare dollars they are spending.”

Consumer Involvement

Tomorrow’s payment system will likely be much different from the current model. Consumers will have more responsibility for choosing and paying for their healthcare options. Their decisions will be better informed by easy access to reliable “report cards” evaluating physicians and hospitals in terms of quality, safety, and value. Their financial obligations for treatment will be determined in advance, and their payments will be managed through flexible accounts offered by banks and other institutions at competitive rates coordinated with their health plans and integrated with their other investments.

As consumers take on greater payment responsibility, providers will receive compensation more fairly linked to the cost of providing care. Financial incentives will reward providers who can efficiently provide high-quality care that satisfies their consumers. By rewarding value and paying fees based on charges that are transparent and rational, payers expect to pay their fair share of the nation’s healthcare bill and to hold the line on rising costs.

Stakeholder Perspectives on Payment

It's clear where hospitals stand on the current payment system: Payment must be appropriate to cover costs, and policies that are implemented must be fair and reasonable to implement. The following provides a highlight of other key stakeholders' views on payment.

Employers. Most employers believe that 30 percent to 40 percent of the money that they pay for health care is wasted due to overuse of costly procedures and services that are either unnecessary or could be provided less expensively. Employers pay about half of this nation's \$2 trillion tab for health care, and most aren't convinced it's money well spent. Employers also are seeking transparency in provider performance and price, and an equitable and rational pricing structure.

Insurers. Insurers generally see new business opportunities in the trend toward consumerism. New, innovative health plans and alliances with financial institutions, along with insurers' traditional expertise and purchasing power, position the insurance sector for future growth. However, transparency in performance and price data, along with uniform pricing, could limit insurers' ability to use their purchasing leverage to negotiate lower prices on behalf of their customers.

Also notable, insurers must pay inflated fees to cover the costs of treating Medicare patients and the uninsured. "Most hospitals can't operate at a profit based on what they get paid in government programs, so those costs get shifted to the private insured population," notes Bob Greczyn, president and CEO

of Blue Cross and Blue Shield of North Carolina and board chairman of the Council for Affordable Quality Healthcare. "It is an added cost of business for employers and insurers."

Many insurers believe that they have a role in helping their members appreciate the true costs of health care and the real consequences of taking their health for granted. Says Greczyn: "We want to help people make good decisions about their health. There is an honest belief that we have so divorced people from the cost of health care, not to mention the value of health, that they believe it's free. Having them in the game will allow them to understand the true cost of health care and to make better decisions."

Consumers. Consumers generally dislike the idea of paying for their health care, and perhaps with good reason. Nearly half of personal bankruptcies in the United States are related to medical costs, according to a 2005 study by David Himmelstein and others published in *Health Affairs*. With healthcare costs having such a significant impact on personal financial security, most consumers are looking to their employers and the government to fix what's wrong with the healthcare payment and delivery system.

At a time when costs for insurance are significantly increasing and consumers are taking on an increasing portion of this burden, many individuals won't or simply can't pay for appropriate coverage. As a result, they are placing greater demands on hospitals to devote more resources to self-pay revenue cycle processes, provision of financial counseling, and charity care identification.

Pursuing the Goals: Today's Payment Trends

As demands have increased for a payment structure supporting greater efficiency, improved clinical and service quality, and greater consumer involvement, two significant trends have started to emerge: consumer-directed health care and pay for performance.

Consumer-Directed Health Care

Consumer-directed health care is the most recent in an ongoing series of cost shifts designed to move the responsibility of paying for health care away from traditional payers—insurance companies, health plans, and employers—to the consumers on whose behalf the services are delivered.

For an increasing number of employers who are grappling with competitive pressures, passing along greater responsibility for healthcare costs to their employees is a necessary bottom-line option far preferable to dropping health coverage completely.

Payers hope that giving consumers a larger financial stake in their health care will compel them to make value-driven healthcare spending decisions. In theory, this approach creates incentives for consumers to seek cost-effective care and encourages behavior changes that contribute to better outcomes and additional long-term cost savings.⁴

In practice, it remains to be seen whether consumer-directed health plans will bring about significant systemwide healthcare cost reductions or merely shift still-rising costs to consumers, with the undesirable consequence of discouraging low-income consumers from seeking needed care, further burdening our system with patients who are sicker once they do seek care.

Health savings accounts. Experts disagree on the speed and extent to which consumer-directed health care, in the form of high-deductible health insurance policies coupled with health savings accounts, will dominate the health insurance market. Many insurance companies

and quite a few banks are making significant investments in developing products around high-deductible plans and health savings accounts.

However, high-deductible plans with health savings accounts still cover a small percentage of insured consumers. At present, about 3 million people are enrolled in such plans. In some regions, these products are showing modest growth, representing 8 percent to 10 percent of new enrollees in individual policies.

Until recently, nearly 78 percent of all health savings accounts were opened by consumers. As more giant employers like Wal-Mart push their employees into consumer-directed plans with health savings accounts, the proportion of employer-sponsored accounts is expected to rise rapidly, reaching parity with individual accounts by 2008.⁵

Regulatory changes are likely to encourage greater use of health savings accounts and high-deductible insurance coverage. Politicians, long pressured to “do something” about rising healthcare costs and the growing uninsured population, are proposing major changes to the healthcare payment system.

“As a system, we are taking the high-deductible health plan movement seriously and believe the penetration rate among our patient base is going to grow. One reason is because consumer-directed health care is politically and legislatively supported,” says Cynthia Fry, system vice president of revenue for Catholic Health East, Newtown Square, Pa.⁶

Last year, the Centers for Medicare and Medicaid Services released a strategic plan for integrating health savings accounts into Medicare. President Bush has proposed allowing individuals as well as employers to make tax-free contributions to health savings accounts. “This is leveling the playing field,” says Richard L. Gundling, HFMA, HFMA vice president of product development. “That means a lot of employers may drop their employee coverage on the theory that the individual market will open up more, and people can shop, similar to how you buy auto or homeowner insurance.”

Health savings accounts, until recently offered primarily by niche banks catering to small businesses and the self-employed, are now entering the mainstream. Banks, credit unions, and other financial institutions are now offering health savings accounts to their customers, sometimes linking them to other investments. This is an expanding, competitive area where banks are starting to gain expertise and offer added value. Some of these new financial products make health savings accounts more attractive by letting holders invest their unused dollars in mutual funds. As more financial institutions enter this area of business, consumer awareness of health savings accounts will grow and is expected to lead to more widespread use.

Health savings accounts have the potential to make health coverage more accessible for some uninsured individuals, notes Herb Kuhn, director of the Center for Medicare Management at the Centers for Medicare & Medicaid Services. “We are seeing the number of account holders continuing to grow,” he says, noting that wealthy individuals aren’t the only ones taking advantage of these accounts. “It’s another way for people to get coverage who heretofore couldn’t afford coverage,” he says.

Such potential for expanding coverage and creating a more consumer-centered environment holds great allure. “The two most important things we can do are find ways to cover the uninsured and align incentives in the payment system to reward quality and efficiency,” notes Karen Davis, PhD, president of The Commonwealth Fund, a private, nonpartisan foundation that supports independent research on health and social issues.

Of course, growth of high-deductible plans also is leading to some concern that a new class of underinsured, disenfranchised patients will occur. Some experts fear that health savings accounts tied to high-deductible plans may lead to a two-tiered health system, channeling patients into the level of care they can afford.

“Health savings accounts are going to continue to grow as they have,” predicts GE’s Fuller. “Employers will continue to have strong incentives to offer health savings accounts, and they’re probably a very good financial deal for someone who’s relatively healthy and can control their share of the dollars. For the

chronically ill who tend to have less discretionary spend, health savings accounts may not be a good fit. Are we going to see a bifurcated insurance system with the chronically ill left in a risk pool by themselves, and what are the ramifications of that?”

Transparency. Although there’s some irony in offloading healthcare costs to consumers and calling it “consumerism,” there is universal agreement that inducing consumers to be more active in their healthcare decisions benefits the individual and the system. One benefit is a more open—and accountable—system.

Today, all consumers with Internet access can self-educate about disease mechanisms and treatment options. They are now taking this interest in their care to the next level, and wanting to view performance data for physicians and hospitals. Web sites supported by government, payers, or provider consortia are beginning to share quality “report cards” with consumers. The measurement and reporting of value metrics are less well developed, but are seen as essential and inevitable elements in a customer-centric healthcare system.

“I don’t think we can get away from the point that if you are charging somebody a price, and if in fact you are increasing the price, they are going to want to know what they’re getting for that price and why it makes sense,” says Peter Markell, CPA, vice president of finance, Partners Health Care System, Inc., Boston.

So far, there’s little evidence linking consumer healthcare purchasing behavior to the content of online quality reports. However, this is expected to change as a growing number of consumers realize that their own money is at risk and as these reports become more widely available.

Though many experts expect that consumers will soon have more influence in the destinations of healthcare dollars, it’s not clear exactly where those dollars will go. One view is that inpatient revenues are unlikely to change much, except for the few hospitals with such poor quality and value metrics that consumers will choose to take their business elsewhere. Inpatient services are less discretionary, and any hospital stay quickly surpasses the patient’s deductible or copayment.

However, many in the industry expect consumerism to dramatically affect the outpatient environment. Competition is likely to increase among physicians and hospitals as the decision of where to receive service is made more frequently at the consumer level. Hospitals may need to decide whether they will compete with physicians and freestanding services for lucrative outpatient services on price and be able to drive costs down to that price. In addition, some in the industry are predicting the popularity of many expensive—and profitable—outpatient diagnostic tests and procedures may wane as consumers begin to pay for them out of their own pockets.

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The Role of Government

An important first step in implementing pay for performance is for all healthcare stakeholders to reach consensus on what performance attributes should be measured and rewarded, then to enforce consistent performance metrics and payment policies nationwide. Performance data on quality and value need to be collected and managed by an arbiter consumers will trust. Some industry experts suggest that these vital tasks are appropriate roles for the federal government, and that Medicare should lead the shift to pay for performance and become a role model for private payers. Other experts would like to see pay for performance evolve from voluntary, not mandatory, policies and practices.

“The big trend in payment is that Medicare is really beginning to pivot, from being a passive payer to a more active purchaser of health care,” notes Herb Kuhn, director, Center for Medicare Management, Centers for Medicare and Medicaid Services. “Under the current payment system, we pay for resource use, and we don’t pay for outcomes. If there are complications with care or a high readmission rate, we continue to pay. In a sense, we are on autopilot when it comes to payments. Some major innovation is going on. Is there a way government can begin to pay more for higher quality and more efficient care?”

Regardless of what happens, it’s clear the age of greater transparency in health care has arrived. For decades, payer dissatisfaction with provider pricing and care delivery has caused payers to “look under the hood” of providers’ medical practices and revenue cycle processes. As the trend toward consumerism takes hold, newly empowered consumers are joining employers and insurers in holding providers more accountable for providing high-quality care at a competitive price.

Today’s consumers want to know how well a provider rates in terms of clinical performance and service excellence and how much they will be charged. As a result, hospitals will need to provide performance information in a timely manner, organized in a consistent format, and made easily available. In addition, they will need to rely on a fair and rational method to calculate price. Access to a provider’s performance data and pricing structure is vital for helping consumers make wiser, more value-based healthcare decisions.

Pay for Performance

Another key trend to note is pay for performance, a movement that supports provider payment for quality of healthcare services.

Critics of the current fee-for-service payment structure contend it provides the wrong incentives to providers. “The incentives are for more services, not the most effective services,” explains Robert Mechanic, director of the Health Industry Forum and senior fellow at the Heller School of Social Policy and Management at Brandeis University, Waltham, Mass. “There is no premium paid that recognizes value, so there are not strong incentives for value. In many cases, it’s not tied to costs or resources, either. It’s a little bit arbitrary.”

Many in the industry feel hospitals need financial incentives to deliver better, safer, more efficient care that meets patients’ service expectations. To this end, CMS has begun rewarding participating providers for reporting quality metrics.

“When it started, it was a voluntary effort by the hospitals, and participation was OK but not great,” says Kuhn. In 2003, Congress used the Medicare Modernization Act to include a 0.4 percent differential in the Medicare update for hospitals participating

in pay for reporting. “Overnight, virtually every hospital in the country started reporting quality information,” he says.

The Deficit Reduction Act upped the ante. “It is now a 2 percent differential,” says Kuhn, noting that CMS is now expanding the set of measures, including patient satisfaction information.

As a result of this program and similar quality-based incentives for those participating in other payer-specific programs, many hospitals are developing process improvements and investing in technologies necessary for improved performance reporting. As momentum builds, hospitals are being called on by the government and other payers to start achieving—not merely reporting—performance levels to receive payment.

The pay-for-performance movement holds great promise. Some government lawmakers view it as a means to reduce Medicare expenditures. Health industry experts believe its greatest potential could lie in giving providers the financial incentive to accelerate efforts to deliver higher-quality care efficiently.

Barriers. Tempering this industry enthusiasm for pay for performance is the realization that significant implementation barriers exist. Quality-based payment depends on a system that is meaningful, fair, and reasonable to implement.

To begin, agreement is needed on which metrics should be measured. “In this country, we don’t have consensus on how to define quality,” says Mechanic. “What should we measure, and what should we reward? Some of the most important outcomes that you would want to reward—such as reducing medical errors or hospital-acquired infections—aren’t reported. Therefore, you default to rewarding what you can measure, and these metrics are fairly limited today.”

Robert Galvin, MD, director of global health at General Electric Company, notes that the Institute of Medicine has made recommendations that pay for performance should not be introduced unless three types of performance are rewarded at the same time: quality, experience of care, and efficiency. “As an industry, we are getting better at measuring effectiveness

or quality, although we have a long way to go,” he says. “And we now have a couple of very good tools to measure patient satisfaction or patient experience of care. But measuring efficiency, or the cost of care, is simply not there yet.”

In part, measuring value is difficult because of the long lag time between care delivery and the reconciliation of the resources consumed and the costs incurred and paid. What’s more, outcomes aren’t always the best metric for comparing performance since they are affected by severity of illness, patient compliance, and other factors that are outside the provider’s scope and control.

Widespread acceptance of common metrics is likely to come gradually. Many in the industry predict there will be iterations. Some measures will be dropped, and others added. In addition, enough revenue has to be put at risk, either as a reward or penalty, to create a true incentive.

Largely because of difficulties in deciding what performance parameters need to be measured and developing consistent policies and practices for reporting quality metrics, some in the industry doubt pay for performance will become the dominant payment method anytime soon.

“There is not a lot of consistency among systems used by different payers,” notes Mechanic. “Because the system is fragmented, most of these programs account for a miniscule amount of money. My sense right now is that with some specific market-based exceptions, pay for performance has been relatively ineffective. It’s a truly appealing concept, and it makes sense to continue developing it. But it is not a slam dunk by any means.”

Richard L. Clarke, DHA, FHFMA, president and CEO of HFMA, suggests that “The next phase [of pay for performance] may have more impact, once we get a handle on what are the true outcomes that we’re trying to achieve. Also, the industry and the information systems we depend on must mature in their ability to collect, analyze, and apply outcomes data to a payment formula.”⁷

Early experiences. Despite the considerable challenges noted, some inroads in the pay-for-reporting and pay-for-performance environments are being made. As of January 2005, there were 36 initiatives examining the potential benefits and implementation barriers of pay for performance. By the beginning of 2007, there were more than 100 such studies. Here are some highlights.

Bridges to Excellence

This not-for-profit coalition engages multiple stakeholders in projects aimed at improving quality of care by recognizing and rewarding providers able to demonstrate performance improvements based on healthcare attributes recommended by the Institute of Medicine. Several programs are under way to pay bonuses to physicians treating patients covered by participating employers or plans that implement specific processes for reducing errors and improving quality, and for high performance in diabetes and cardiac care.

CMS/Premier

CMS, in partnership with Premier, Inc., a not-for-profit hospital alliance, initiated a pilot program to reward hospitals for quality improvements. Hospitals in the Premier alliance that performed in the top two deciles in established quality criteria were rewarded, and those in the bottom two deciles saw their payments reduced. In 2005, Medicare paid \$8.85 million in performance bonuses to 123 of nearly 270 hospitals that took part in the program. Hackensack Medical Center in New Jersey received the largest bonus check, \$848,000, for high-quality care delivered in five clinical areas measured by the project: heart bypass, joint replacement, heart attack, heart failure, and pneumonia.

The Council for Affordable Quality Healthcare Initiatives
CAQH is a coalition of insurers working to strengthen and simplify their interactions with providers. CAQH has developed a Universal Credentialing Data Source enabling physicians to submit a single credential application to a single source of data available to all insurers. Another CAQH project is creating rules and standards of interoperability so that insurers can share benefits information and eligibility determinations with providers at the point of service.

Leapfrog Group's Hospital Rewards Program

The Leapfrog Group, a consortium of healthcare purchasers, seeks to mobilize the purchasing power of employers to trigger improvements in the quality and value of health care. The organization's Hospital Rewards Program rewards excellence in care for five high-volume, high-cost areas: coronary artery bypass graft, percutaneous coronary intervention, treatment of acute myocardial infarction, treatment of community-acquired pneumonia, and obstetric deliveries and neonatal care.

These and similar initiatives show the potential of pay-for-performance to drive healthcare quality up and costs down. "With hospitals, what we wanted to see was improvements in the quality and efficiency of care that was delivered, with improvements quarter by quarter by hospital," says Kuhn, describing the CMS demonstration project. "That's exactly what we have been starting to see in the five disease categories that we were looking at with these hospitals. All of the hospitals performed better by quarter, and all were able to show greater adherence to a set of evidence-based guidelines, therefore improving the reliability of the care delivered by those hospitals."

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Your Strategy for Performance-Based Payment

Hospitals that have succeeded in pay-for-performance programs offer the following advice to others.

- Engage all clinicians in quality improvement initiatives.
- Make high-quality care the chief priority of the executive team—and everyone else.
- Have a dedicated quality, safety, and performance improvement department.
- Manage data collection effectively and strongly consider new automated workflow tools.
- Regularly share performance data with staff.
- Commit to sharing best practices.
- Celebrate achievements.

Ideal Payment Strategies

When looking to the future, most in the industry seek a payment system that better accommodates the needs for *quality, efficiency, and consumer involvement*. Additional principles cited as important are *fairness, administrative simplicity, social responsibility, and encouragement of innovation*.

For example, elements of fairness might include all payers equally sharing the burden of the uninsured, equitable payment among payers (removing the need for cost shifting), and equitable payment for similar care provided in different settings. Elements of administrative simplicity might include standardized policies among all payers and bundling of payment for hospital services and hospital-based providers. Elements related to quality might include payment that encourages high-quality outcomes, appropriate resource use, and prevention. An element related to social responsibility might be shared responsibility among payers for medical education.

Yet exactly how such a system should be structured remains to be seen.

Commonwealth Fund president Karen Davis, PhD, envisions the ideal payment system as one that would blend fee-for-service, no-risk capitation, and performance-based elements.

“Part of your payment would continue to be like it is now, fee for service,” she says. “But for hospital care, we would move to a bundled global fee for the entire episode of care, including physician services and multiple hospitalizations if they happen over time. Primary care physicians would be paid a flat amount per patient per month for providing core services and coordinating their care—what you would call a non-risk capitation. A third component would be bonuses for high-quality performance.”

David W. Young, DBA, emeritus professor of management at Boston University, suggests a number of challenging ideas for a revamped payment system. They include requiring not-for-profit hospitals to

place their tax exemptions in a state fund to help pay for care for the uninsured, requiring health insurance companies to pay a percentage of total premium revenue to help fund graduate medical education, charging insurance premiums per person rather than per family, and replacing drug copayments with a requirement that patients pay the brand-generic cost difference if they wish to use a brand-name drug when a generic equivalent is available. He writes that creative thinking about ways to increase access and control costs needs to address these and other “contentious cross-subsidization issues that no one has wanted to discuss in a serious way for decades.”⁸

Scott Johnson, FHFMA, CPA, vice president of finance at Legacy Health System in Portland, Ore., makes a strong case for standardized payment structures across all payers. “Entire industries are built around helping insurance companies and providers deal with the myriad payment structures we have allowed to develop over the years,” Johnson says. A standardized system would allow the system to “automate countless manual processes and eliminate countless ‘bolt on’ programs and consultants whose purpose is to deal with exceptions.” Although Johnson is no fan of Medicare’s payment methodology, and especially the complexities in the APC formulas, he believes that a simplified version of the Medicare payment methodology could become the standard. “Billions of dollars could probably be saved by changing to a common payment structure,” Johnson says. “Payers and providers would still negotiate rates within the common structure to achieve the results they need by service and in total. The savings would come in being able to automate billing and collections. And a common structure would go a long way toward advancing the cause of transparency.”

Johnson cautions that such a change would take courage in leadership. A national collaborative effort would be necessary, and the change would likely hurt some providers, payers, and vendors.

Revamping the payment system is the classic “wicked problem”—a problem involving such complex interdependencies that any solution seems to create other problems. In the case of changes to the payment system, proposed solutions also frequently are accompanied by

howls from the stakeholder most affected. Yet the destabilizing force of rising entitlement costs, rising healthcare costs, and the rising number of uninsured citizens may be at the point of creating the political will for even more significant change than today’s level.

Getting Ready

With changes to the payment system growing ever more likely, hospitals need to begin orienting themselves now toward more consumer-focused, quality-driven practices. Providers are advised to set the stage for pay for performance, including investments in IT where necessary, and establish quality delivery and measurement as the highest priority.

In particular, financial executives should work closely with clinical and operations leaders to measure quality and patient satisfaction, alter strategic plans to move the organization toward operational and clinical excellence, and adjust the portfolio of services to those where high standards of quality can be achieved and maintained.

Revenue cycle operations also will need to reflect the changing times. Organizations will need to be able to gather and communicate pricing information in a manner that will be meaningful for patients. As part of this endeavor, hospitals will need to strengthen relationships with payers to encourage simplification of charge systems and greater transparency in contracting. Timely exchange of eligibility and benefits information will take on increasing significance due to high patient deductibles and increasingly complex financial transactions involving payment from sources such as health savings accounts.

In addition, financial managers should embrace a culture that recognizes that people make the difference. As self-pay accounts continue to grow, training and staffing practices will need to support a new breed of patient financial services professional with the sophisticated knowledge base and customer service skills to respond to patient demands for pricing information and financial counseling.

Also key will be staying abreast of policy changes, particularly those originating from CMS. Medicare policies usually are discussed and announced with considerable lead time, so financial executives should listen to these messages and act proactively when possible to align the hospital’s medical protocols, IT capabilities, and revenue cycle processes with Medicare policies and practices.

However, commercial payers at times are out front of Medicare, particularly in the area of pay for performance. So close contact with major commercial payers can help ensure that providers communicate their needs as payers are considering policy changes, and also that providers are prepared when changes take place.

Ultimately, all stakeholders need to work together to transform a fragmented, irrational payment system to one characterized by increased consumer involvement and financial responsibility, transparent processes, value-based fees, and better coordination and parity between private payers and Medicare.

Endnotes

- ¹ Kohn, L.T., Corrigan, J.M., and Donaldson, M.S., eds. "To Err is Human: Building a Safer Health System," Institute of Medicine. Washington, D.C.: National Academy Press. November 1999.
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- ⁴ Spotlight Report: "Healthcare Revenue Cycle Management," TripleTree, LLC, 2006. Quoted in "Data and Dollars: How CDHC is Driving the Convergence of Banking and Health Care," Hammer, David C., *hfm*, February 2007.
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- ⁶ "Health Savings Accounts: Are You Prepared?" HFMA Executive Roundtable, Healthcare Financial Management Association, December 2006.
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Financing the Future III

Since 2003, HFMA's Financing the Future project has given healthcare providers the information they need to help their organizations have the resources necessary to provide safe, high-quality care for their communities. The project began with a series of reports highlighting strategies hospitals and other healthcare providers could use to improve access to capital. The series was a partnership between HFMA and GE Healthcare Financial Services with research conducted by HFMA and PricewaterhouseCoopers. Following the success of these reports, a second series took the concepts identified a step further by exploring best practices in capital management and providing practical tools and strategies hospitals could use for financial improvement. This series was a partnership between HFMA, GE Healthcare Financial Services, and Kaufman, Hall & Associates. With Financing the Future III, HFMA, in partnership with GE Healthcare Financial Services, sets out on its most perhaps its most ambitious effort to date: identifying key industry trends that affect hospitals' capital position and ability to fund important future initiatives. For each trend, a report will identify the current state and implications for the future. For more information about Financing the Future III and to access the complete archive of project reports, visit www.financingthefuture.org.



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