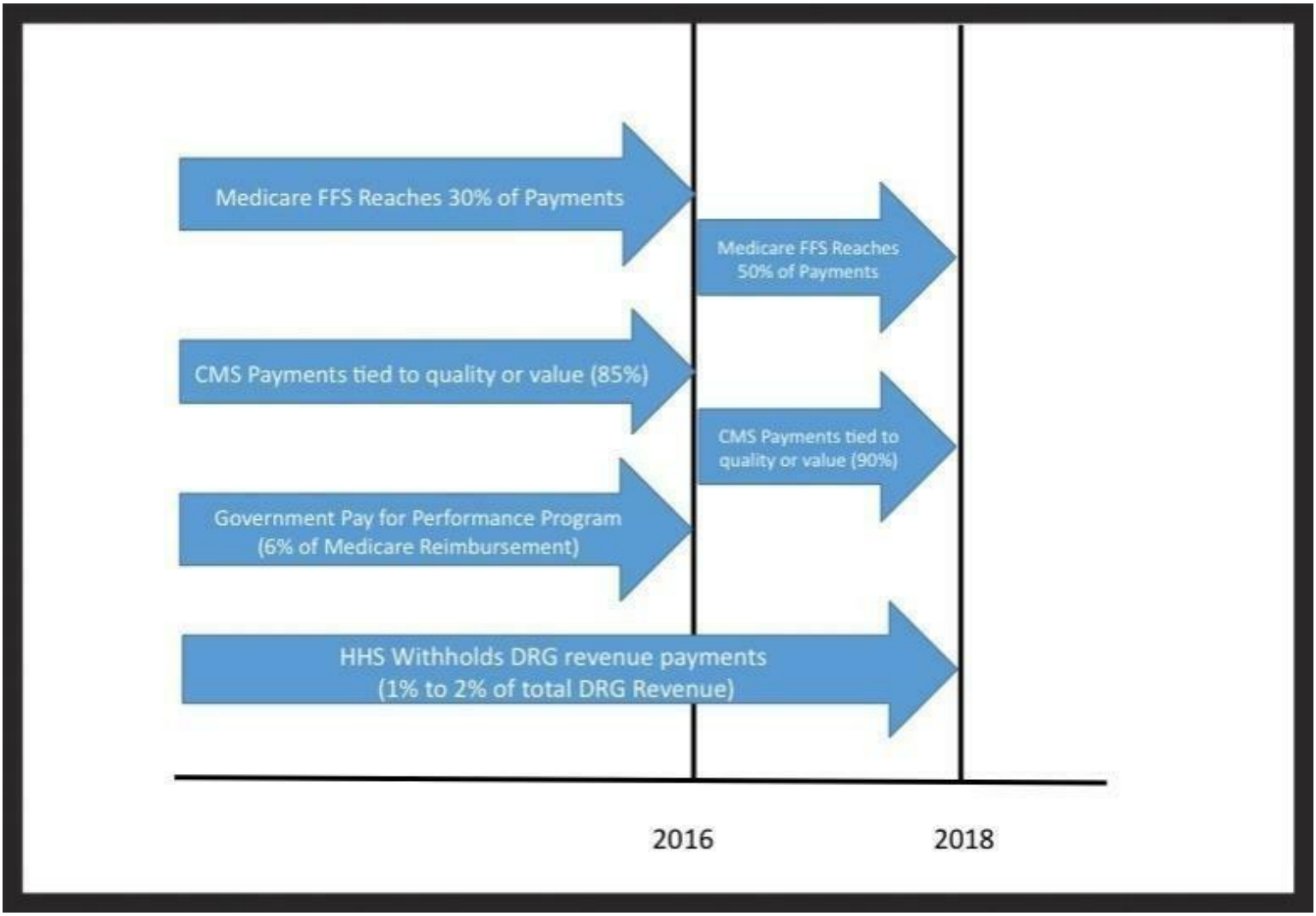
The Evolution of Pay-for-Performance Healthcare and Reimbursement: Part One



The healthcare industry is experiencing a significant shift in the primary reimbursement method as the industry moves from Fee-For-Service (FFS) to Fee-For-Value (FFV) reimbursement.

Over the next five years, the healthcare industry will experience a significant change in the primary reimbursement method as the industry moves from Fee-For-Service (FFS) to Fee-For-Value (FFV) reimbursement. Also known as Value-Based (VB) Purchasing, Pay-for-Performance, or Pay-for-Value, value-based reimbursement is not new to the healthcare industry.

What is notably significant about the shift to value-based programs as the primary reimbursement method is the degree of dominance and the aggressive time frame. There are several recent examples that indicate this transition is indeed coming in the near future.

In Part One below, I'll outline three major value-based transition goals taking place in the coming years, discuss why the transitions and timeline are significant for hospitals, and highlight some of the tools hospitals can use to mitigate risk. In Part Two, I'll expand on the best tools and practices organizations should be using, and offer key tips and recommendations for achieving success in the switch to pay-for-performance systems.

Three Goals for Value-Based Transitions

In January 2015, HHS Secretary Sylvia Mathews Burwell announced a new Medicare payment reform plan to replace the majority of FFV systems with more value-based reimbursement programs. Shortly thereafter, a group of large healthcare systems and insurers (including Advocate Health Care, Aetna, and Blue Cross) formed a coalition committed to implementing value-based and alternate payment systems.

1. **HHS announced the goal of tying 30% of traditional fee-for-service Medicare payments to quality or value by the end of 2016 and 50% by the end of 2018.**
   Alternative payment models such as Accountable Care Organizations (ACOs) or bundled payment arrangements will be used to meet this goal.
2. **HHS also set a goal of tying 85% of all traditional Medicare payments to quality or value by 2016 and 90% by 2018.**
   This goal will be met through programs such as Hospital Value-Based Purchasing and Hospital Readmissions Reduction Programs.
3. **20 major health systems and health plans announced a goal to have 75% of their contracts based on value-oriented incentives by the year 2020.**
   This announcement is a significant indicator that the healthcare industry will be moving towards value-based reimbursement as the predominant model. By 2017, the government's pay-for-performance programs such as hospital-acquired conditions and readmission reduction programs will represent a 6% risk to hospitals' Medicare reimbursement. This is yet another indication of a shift to this new primary reimbursement model.

What does value-based reimbursement mean for hospitals?

This relatively rapid shift to pay-for-performance and value-based reimbursement stands to have a large impact on hospitals, where many administrators rely on razor-thin margins (averaging 3.1%) and use a manage-by-crisis approach to keep the lights on. Physicians and medical practices face similar challenges. The recent HHS-

mandated reimbursement models administered by Centers for Medicare & Medicaid Services (CMS) should alleviate but not significantly reduce hospitals' risk.

HHS began withholding 1% of DRG-related revenue from providers in 2013, and has now begun redistributing the held-back reimbursements based on quality or value scores as part of the CMS-administered Value-Based Purchasing program. In 2015, CMS increased the reimbursement withheld to 1.5%, and is expected to increase it to 2.0% in future years.

Considering the low operating margins of hospitals and providers, this still represents a moderate risk to hospital reimbursement levels. Similarly, CMS will begin applying value-based modifiers to physicians' fee-for-service (FFS) reimbursement in 2017, increasing the percentage modified over time. Reporting programs such as the Physician Quality Reporting System (PQRS) also apply a penalty for failure to meet quality thresholds.

Image courtesy of Mark Jahn

How can hospitals transition?

Hospitals, physicians, and private medical practices will need to get ahead of the curve and develop strong capabilities in several areas to make a successful transition. Many of these areas require several years of iterative development before reaching proficiency, and include:

- Measurement programs
- Health Analytics
- Contract management systems
- Cost accounting systems
- Remote patient monitoring
- Process and quality improvement
- Care coordination
- Health information exchange
- Patient portals
- Social media
- New or enhanced patient accounting systems
- Population health

Most of these areas will require investment from hospitals and providers in order to achieve efficiencies and capabilities in support of a successful transition. Since increasing the efficacy of capture, reporting, and measurements will allow hospitals and physicians to maximize their reimbursements, the investment is recommended. Measurement programs and Health Analytics in particular will be crucial to pay-for-performance

transitions.

Measurement programs

"*Measurement is the first step that leads to control and eventually to improvement. If you can't measure something, you can't understand it. If you can't understand it, you can't control it. If you can't control it, you can't improve it.*" – H. James Harrington

At the core of a successful reimbursement model transition is measurement-based reporting and health analytics. The government will assess and reimburse hospitals and providers for their services based on these measurement programs. Measures-based reporting includes capturing, reporting, and monitoring value-based measurements and improvement initiatives directed at enhancing the measurements.

The primary measurement and reporting programs are:

- PQRS (Physician Quality Reporting System)
- HEDIS (Healthcare Effectiveness Data and Information Set)
- CMS Value-Based Purchasing
- Meaningful Use
- Joint Commission's "Core Measures"
- CQM (Clinical Quality Measures)

Today we find that many hospitals and physician organizations are challenged by effectively collecting and reporting measures that, in the future, will become vital to reimbursement and survival. Often, multiple hospital departments and medical group staff are assigned manual measurement collection and reporting responsibilities in an uncoordinated fashion, resulting in duplication and unnecessary effort.

Providers should expect an expansion of the measurement programs as the industry expands to more value-based reimbursement programs, and as these programs evolve in definition and maturity. As an example, in January 2015, the National Quality Forum (NQF) already recommended 199 new quality measures across 20 government programs.

Health Analytics

Health Analytics is defined as using healthcare-related information to dramatically lower costs, enhance profitability, improve patient outcome, grow customer intimacy, and drive innovation in new and creative ways. Health Analytics will play a critical role in the world of value-based reimbursement. Most components of an effective value-based measurement program will require access to data and analytics to support measurement

reporting and improving the measurements used to drive reimbursement levels.

Hospitals, medical groups, and physicians will need timely access to healthcare data and analytical tools for dashboarding and performance. They will also need predictive analytics in order to support process and quality improvements, to achieve measurements worthy of high reimbursement levels. Data warehouses and analytical platforms designed to adapt to new and changing measurements will be the most sought-after solutions.

The level of granularity that ICD-10 (International Classification of Diseases – version 10) provides will further supplement the data access and analysis capabilities available in the future. Data warehousing, data management, data quality, dashboarding, and predictive analytics will all become common terms hospitals will use to mature their measurement improvement efforts and maximize their reimbursements.

Where To Start?

I recommend that hospitals, medical groups, and providers prioritize the shift to Value-Based (VB) reimbursement as a strategic and mission-critical initiative. Gaining executive buy-in and organizational commitment is critical to putting in place an effective VB-focused reimbursement readiness program.

The second step is to assess the organization's current performance versus existing pay-for-performance programs, and identify initiatives to improve measurement scores and results.

The third step is to develop an overall road map, multi-year plan, and organization structure to prepare the organization for future expansion of the VB-reimbursement programs. Development of the road map and plan is not a trivial activity, as there are many organization areas that need to provide input into this long-term readiness effort.

In Part Two, I'll expand on the tools and resources hospitals need to successfully transition to pay-for-performance plans, and provide additional tips and guidelines for how to use them efficiently and effectively.

Mark Jahn *is a Freed consultant who specializes in managing healthcare IT programs and projects. He is experienced in healthcare analytics, decision support, ICD-10, IT strategy, IT governance, PMO assessment, design and implementations, business process re-design, and software package selection. Prior to working with Freed, he was the ICD-10 Program Director for the number one-rated health system in Texas.*

