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John Glaser

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AT A GLANCE

Strategies that healthcare finance professionals should incorporate to help their organizations respond effectively to payment reforms include:

> Assessing the organization's ability to capture and share relevant data
> Educating themselves, the board of trustees, and the medical staff on pertinent rules as payment reforms are rolled out
> Examining inefficiencies related to care processes
> Establishing policies and procedures to address "commingled" data

In my 20-plus years in the healthcare industry, I've not witnessed anything like what's currently unfolding with payment reform. Payment reform itself is not new—since the 1990s, we've seen efforts in the areas of capitation, DRG payments, and pay-for-performance programs, to name a few. But this time, the federal government has put into law its priorities for the near-term future of health care and how providers will be paid.

With last summer's publication of the meaningful-use definition for electronic health record (EHR) incentive programs, and this spring's publication of the proposed rule for formation of accountable care organizations (ACOs), we're in the first stage of a multiphase federal effort to improve care and reduce its costs.

Certainly, success within payment reforms will build upon the enabling foundation of meaningful use of certified EHR systems—and health systems are making good progress in implementing the required technology. The major changes health systems will face will be in the areas of *payment structure* and *the organization of care*.

The evolving healthcare ecosystem won't take shape strictly in the form of ACOs, in which providers accept accountability for the quality and cost of care of a defined patient population. Nor will it be limited to bundled payment models, in which a fixed payment must cover episodic and acute care as well as all services needed to care for chronic disease patients. Changes in payment structures and care organization also will require new technological capabilities throughout the revenue cycle, including capabilities of:

> Aggregating charges to form bundles and episodes, with the aggregation logic
> Managing the distribution of payment for a bundle to the physicians, hospitals, and nonacute facilities that delivered the care
> Enabling revenue cycle process efficiency through the use of workflow and rules engines that help to orchestrate processes, reducing the "defect rate" and improving their efficiency
> Streamlining transitions between disparate payment methodologies and contracts when billing and collecting
> Providing tools for retrospective analysis of clinical and administrative data to identify areas for improving the quality of care and reducing the cost of care delivered

> Improving transparency with business analytics that facilitate proactive management of key performance metrics

Several revenue cycle application systems will be essential to responding effectively to payment reform. Healthcare organizations should prepare now to efficiently handle a complex mix of payment mechanisms while meeting quality goals.

From the Top

Federal and state governments account for about 50 percent of medical payments in the United States. And as the government moves, so does the private sector. In terms of high-level planning, 2014 and 2015 may seem like a long way off, but fundamentally, healthcare leaders and finance professionals should be thinking of this timeframe as "tomorrow." Although we are not yet able to map out all of the nuances of what's ahead, we should acknowledge that three significant realities lie ahead in our collective future:

> The absolute amount hospitals and care providers are paid will be lower relative to inflation. Margin pressures will increase.
> Providers and healthcare facilities will have to prove the quality of their outcomes as well as their processes, amid requirements where risk relative to performance is greater than we know today.
> Healthcare providers will move to support more holistic care, focused not solely on the instance of care, but also on the total care provided.

These changes in payment structure will drive changes in the organization of care. For example, payment mechanisms that are holistic will lead providers to establish integrated partnerships with other providers to span the care continuum.

From a board-level perspective, the overriding concern of board members will be whether to position their organizations as market leaders or "close followers."

As a market leader, a healthcare organization will benefit from being at the forefront of the dominant mode of care over the next several years. However, if organizations focus on eliminating unnecessary procedures as a cost-saving measure, they should also consider the revenue that will be lost when these procedures are no longer performed. With hospital operating margins typically at 1 to 2 percent, these organizations may have to plan for deficits until they begin reaping longer-term gains.

As a close follower, a healthcare organization will be able to experiment in a more focused manner, perhaps by identifying a small number of episodes and bundles for which it will accept payment responsibility. If the organization is self-insured, it may choose to begin its efforts with its own employees, viewing them as a covered subset of patients in the provision of health and wellness benefits. The downside to this approach is that it takes a long time to transition from a narrow to a broad set of interventions and changes, and the transition may be incomplete when payment changes take full effect.

CFO Challenges and Solutions

Regardless of top-level philosophy, emerging regulatory and business requirements will intensify the need for healthcare organizations to maintain a consolidated view of delivering care and managing revenue across multiple providers. For example, in its 2010 report *The New IT Strategy Map*, The Advisory Board suggests that hospitals will respond to the emergence of new payment methodologies tied to increased performance risk by assuming the role of a "banker" for distributing bundled payments.

Responding effectively to profound changes in payment structure and care organization will require considerable time, expense, and consultation among all levels of the healthcare finance team, including the CFO. Healthcare finance leaders should concentrate their efforts in nine areas.

Assessing the organization's ability to capture and share relevant data. It is important that the finance leader analyze whether the organization is equipped to manage patients with certain episodes or chronic conditions, taking into consideration the organization's location and the demographics of its patients. The finance leader should organize and define how the healthcare entity will deliver care in areas that are likely to be part of the accountable care terrain.

Educating themselves, their organizations' boards of trustees, and medical staff on pertinent rules as payment reforms are rolled out. Initially, the "rules" for payment reforms will likely be in flux, with greater clarity provided over time. As rules are defined, finance leaders should listen to the summaries, encourage input from colleagues, and take advantage of the opportunity to provide feedback to the government during designated public-comment periods.

Ensuring that the organization's suppliers are up to speed with new payment models. Industry analysts question the ability of most IT vendors to manage new payment models, particularly where contracts include fee-for-service, bundled payments, and shared-savings agreements. Revenue cycle capabilities should work off of a single database supporting all venues of care and should integrate with the EHR. The finance leader should look for embedded workflow and rules-engine technologies that optimize clinical, operational, and financial processes. Business intelligence and data-analysis capabilities will help predict a care model's impact on revenue and cash flow.

Working on foundational elements that will be important in an era of reform. It's impossible to anticipate every detail of how the future will unfold. However, healthcare organizations can predict with great confidence that quality measures will be integral to payment reform, whatever course reform takes. Providers will be required to submit performance data regarding quality, and quality deficiencies can take months, if not years, to solve. Focusing on quality improvement today will serve healthcare organizations well in any future-state scenario that takes shape. Organizations should keep moving forward with their EHR and quality data efforts and track progress against their plans.

Examining inefficiencies related to the organization's care processes. The complexity of delivering high-quality care will continue to increase, while tolerance for poor processes and disjointed workflows will decrease. Under value-based purchasing (VBP) programs, the Centers for Medicare & Medicaid Services will withhold 1 percent of all Medicare inpatient operating payments from qualifying hospitals in FY13 (2 percent by FY17). The funds will be redistributed to hospitals based on performance-versus-care and patient satisfaction measures.

Commercial payers are likely to introduce their own versions of VBP programs. "Process improvement" should be an organization's mantra. There will be real ramifications for providing care that is poor in quality; there also will be increased visibility of improved care, which will yield a positive financial return. A hospital can prepare for this new era by focusing on areas of the organization that are currently demonstrating low levels of performance. The finance leader should look at the data, make changes based on the data, and work with quality and clinical staff to adapt processes accordingly, keeping in mind that positive movement forward will be rewarded. In a VBP model, even low-performing areas can qualify for high payments if they demonstrate strong year-on-year improvement.

Preparing for personal health records. Current adoption rates are low for personal health records, but will increase with payment reform. Personal health records provide patients with access to their data. They also provide a means for patients to communicate with providers—for example, to ask questions, report unusual symptoms, request medication renewals, and schedule appointments. Personal health records are likely to be important tools for helping patients manage their health.

Establishing policies and procedures to address "commingled" data. With data coming in from multiple organizations, the finance leader should specify what the healthcare organization is permitted to do with these data (i.e., determine allowable "secondary use"), and make provisions for correcting data received from others as needed (e.g., when amending a case report).

Deciding how the organization will work with health information exchanges (HIEs). Initial HIE grants have concentrated on the need to support providers' ability to push data out to other providers. The finance leader should focus on how the organization will request data from other providers under HIEs to get a composite picture of their patients, regardless of where they receive care.

Working from the motto "Good fences make good neighbors." The finance leader should use this motto as a daily reminder to open communications with the organization's medical staff and other providers in the region. If relationships between the organization and its medical staff are not ideal, the finance leader should work with other administrators toward re-establishing these relationships and making them stronger. Likewise, if relationships with key groups with which the organization will need to partner to ensure continuity of care or build a successful shared care model are in need of repair, finance leaders should start mending the fences.

The Importance of Data

As we move forward with payment reform, keep in mind that data management will become increasingly significant in the years to come. Business intelligence technologies will provide support to CFOs in a variety of areas—for example, assessing quality and costs not only for internal consumption, but also to meet reporting requirements. Providers also will use data to look at different care alternatives—perhaps by shifting care delivery to a nurse practitioner rather than a physician, or moving care from one specialty group to another.

Data also will help providers improve at predictive modeling, allowing us to identify which patients (often the frail elderly) are likely to experience distress or require additional care in years ahead.

Technologies that capture data for healthcare organizations—such as EHRs, business intelligence tools, personal health records, and advanced revenue cycle technologies—will all need to be in place and provide robust capabilities. An organization's revenue cycle system in particular will form the foundation of an organization's response to payment reform.

The time has come for a thoughtful approach to payment reform. Although the changes to care practice and organization will be significant, they are our best hope for addressing long-standing care and cost issues. ●

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