



5 Steps for Financial Success in a Value-Based Payment Environment

Healthcare Payment Structures Don't Have to Mean Negative Financial Impacts

Healthcare executives are well aware that both government agencies and private insurers are moving away from the fee-for-services model and towards a value-based payment methodology. Public and private payers and providers currently using a mix of value-based reimbursement and fee-for-service models project that payment with some form of value measurement will make up two-thirds of the market by 2020. That's up from one-third today, according to The 2014 State of Value-Based Reimbursement, an independent research study of 464 payers and providers that was released last year.

Very few expect the journey to this new world to be without challenges. The same study finds, for example, that providers as well as payers believe that the pay-for-performance model will experience the most growth, but that it also will be the most difficult to implement. More worrisome, two-thirds of providers believe that value-based care will have a negative financial impact on them. Backing that up, a recent Kaiser Health News analysis finds that the average penalty for hospitals under Medicare's Hospital Value-Based Purchasing initiative --not including the other penalty programs -- was a 0.30 percent reduction. Meanwhile, under The Affordable Care Act, many of the payments made to physicians and hospitals that treat patients with insurance offered through federal and state exchanges are decreasing, adding to financial pressures.

No hospital, physician practice, or long-term care facility executive wants to see negative financial outcomes occur in their institution or office. And neither need that be the case -- at least not for organizations embracing the changes and looking now to maximize operational efficiency in ways that will lead to better support for changing healthcare payment structures.

To achieve those ends, they can start with these steps:

1. Drive towards patient volume. There is a way to make up for lower payments-per-patient, and that is by increasing patient volume. How? The successful strategy for institutions and physician groups will be to demonstrate that they are of greater value to payers than their competitors are, and the way to do that is by providing higher-quality managed care that dramatically lowers payers' total system costs. That can earn a practice or facility admission to payers' limited ranks of hospitals and doctors, so that the healthcare organization can make up in volume what it has lost in per-patient fees for services rendered.

2. Build internal quality management systems and structures. Practices and healthcare facilities earn their stripes as the most valuable payer-partners -- maintaining or even increasing fees for services rendered -- by providing optimal care for a given patient population. But developing the quality systems that will enable them to increase performance excellence for existing fee-for-service models, and so drive down payer costs, will be even more important as value-based payment models increase their hold.

In order to measure themselves against existing quality metrics from The Centers for Medicare & Medicaid Services, the Joint Commission, specialty colleges, or other sources, facilities and practices must develop systems that are capable of correctly capturing data on applicable points

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and which also leverage analytics to turn that massive data into information to push ahead on quality measures. That includes driving towards taking preventative or corrective actions in real-time. In line with that, they must develop internal quality management structures that help them put quality measures into a workable format for the facility, and roadmap their strategies to move higher up in the quality ranks.

3. Embrace the virtuous cycle of raising quality and lowering internal costs/external penalties. Improvements in quality measures should be compared against an organization's own cost structures, and undertaken with the goal of reducing both internal costs and payer penalties.

As quality improves through better management of internal processes and patients' chronic conditions, for example, risks such as hospital-acquired infections and acute care episodes decrease, which should have a positive financial impact. After all, it takes more time and money to cure a condition that a patient didn't have when he walked into the hospital than it does to put in place the processes to keep such an incident from happening in the first place. Indeed, a hospital may have to bear the costs of problems such as hospital-acquired infections all on its own, as payers like Medicare will consider the issue the facility's own fault and won't compensate the institution for the care.

Improving quality through internal process management to drive cost-savings also should encompass the concepts of Lean in healthcare. Applying Lean management approaches in a healthcare organization requires understanding every step in a process and its value – or lack thereof – to the process. Non-value-added steps can then be eliminated so that value flows throughout the process, positively affecting productivity, cost and quality. Results of embracing Lean include the fact that all parties in the provider chain are empowered to ensure that patients are directed to the appropriate care, provider and setting they need at the start, so that they don't have to repeatedly cycle through care environments and treatments. Waste also is eliminated, thereby creating more capacity in existing programs and practices so that the organization needn't continually invest in new facilities or expansions.

4. Once you begin ramping up quality management, do not stop. There's no such thing as a static environment when it comes to healthcare, especially as it relates to value-based payments. Quality measures for which organizations must account move on and off lists, as institutions and practices overall reach certain performance thresholds. What you measure is what you get. How will you maintain your current level of performance if you're not tracking

and reporting your results to the medical staff? Will you even know if your compliance rate drops 5, 10 or 15 percent? In such a dynamic environment, it's important for healthcare executives to ensure there is a structure in place to continually review and recheck how their organizations' performance matches to the latest priorities.

5. Get involved in a care coordination program.

Increasingly CMS and even private payers want to work with total system provider communities, where collaboration takes place across all the parties involved in the spectrum – primary care providers, hospitals, and rehabilitative or long-term care facilities – to keep patients from sliding into acute care.

In such scenarios, providers are rewarded as a group for delivering high-quality, low-cost care, or penalized as a group for not doing so. Part of increasing revenue here includes sharing data from electronic records and ensuring that participants adhere to coding best practices. All constituents in such communities who do find ways to work together to improve their value to payers will emerge as winners compared to those who don't put game plans in place to coordinate care.

Fiscal performance does not have to suffer as trends in payment methodologies evolve. Focusing on optimizing operational efficiency through steps such as the ones above will put you on the right track to lowering your costs and maximizing your revenue.