The Key to Transitioning from Fee-for-Service to Value-Based Reimbursement

By Bobbi Brown and Jared Crapo

The switch to value-based reimbursement has turned the traditional model of healthcare reimbursement on its head, causing providers to change the way they bill for care. Instead of providers being paid by the number of visits and tests they order (fee-for-service), their payments are now based on the value of care they deliver (value-based care).

A lot of this change is long overdue and quite exciting because it’s driving improvements to the delivery of care by mandating better care at a lower cost. But for those providers and health systems that can’t achieve the required scores, the financial penalties and lower reimbursements will create a significant financial burden.

Shifting Revenue Mix: The Rise of Medicare and Medicaid

The first hospital challenge we want to address, shifting revenue mix, is clearly seen in the graph below. The percentage of commercial payers will continue to shrink, while payer types with lower reimbursement rates will increase.

The shifting revenue mix from commercial to government payers means tighter hospital margins.
We’ve known for a long time that Medicare expenditures would grow as the baby boomer population aged, but over the same time period, Medicaid has grown at a faster rate. We expect this trend to continue as the boomers continue to age — and as the Medicaid expansion authorized in the Affordable Care Act is fully implemented.

This change in revenue mix impacts a hospital’s bottom line because Medicare and Medicaid patients are generally not profitable. In 2011, the average hospital margin on Medicare patients was -5 percent. A growing proportion of Medicare business puts considerable strain on hospital revenues.

Transitioning to Value-based Payments

The transition from the fee-for-service (FFS) reimbursement system to one based on value is one of the greatest financial challenges health systems currently face. This challenge is so big that we will only address a few of its aspects here. We have more information about value-based purchasing on our website.

Reconciling Value-Based Payments in a Fee-for-Service Environment

Value-based payment contracts are in their infancy, and most are structured according to a shared savings model. Shared savings arrangements differ, but in general, they incentivize providers to reduce spending for a defined patient population by offering them a percentage of any net savings they realize. The Medicare Shared Savings Program is the most well-known and standardized example of this new model.

Tracking performance in this kind of arrangement is a significant challenge for health systems because it requires keeping track of two very different payment systems simultaneously. Medicare continues to reimburse health systems on a FFS basis; then, at the end of the year, shared savings bonuses are calculated. Medicare benchmarks each provider against the rate of increase for the overall FFS population. If a hospital did better than the FFS population, they get a piece of the savings. Hospitals must operate in the FFS world while attempting to anticipate this value-based bonus.
Tracking shared savings reimbursements that come in at the end of the year requires health systems to be much more sophisticated in their accounting capabilities than most are today. It simply won’t work to account for all payers and all patients in the same way. A hospital has to know every patient in the accountable care organization (ACO), what services they’re getting, and what it costs. An ACO environment requires considering questions like: for each defined population of patients, what was our financial performance and how did it compare to the contract? The ability to measure performance at this level of granularity will require much more sophisticated IT capabilities than most health systems now have.

Tracking a Wide Variety of Quality Measures

A lot of today’s value-based incentives — and penalties — rely on quality measures. For many years, providers have submitted quality measures for programs such as Hospital Inpatient Quality Reporting (IQR), Hospital Outpatient Quality Reporting (OQR), and Physician Quality Reporting System (PQRS). The fact that these measures are now tied to penalties and incentives is new. These new value-based models require providers to prove that they’re meeting quality standards and benefitting patients while cutting costs.

Providers need sophisticated analytics to help them measure financial and quality performance for each population of patients. They don’t want to learn that their reimbursement is going to be poor after it’s too late to do anything about it. Rather, they want to know in the first quarter so they can improve their performance before the end of the year rolls around.

To do this, they need to be able to measure performance on a continuous basis. Furthermore, if they aren’t meeting quality standards, they need to be able to pinpoint the cause: Does performance differ by facility? Which providers are performing best and what can be learned from them?

It’s one thing to handle this level of performance analysis for a single patient population or a single quality measure. It’s another story altogether when you consider how quickly the number of measures a health system must track is multiplying. As an example, let’s look at a small but important area of performance measurement: tracking 30-day readmissions.

For the last few years, Medicare has required hospitals to track their 30-day readmissions rates for heart attack, heart failure, and pneumonia patients. Medicare is about to add three additional populations to this requirement. Many private payers are also asking health systems to track this measure for populations covered in their contracts.
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And now health systems are being asked to track 90-day readmission rates. Multiply this example by all the potential quality measures and patient populations, and you can see how complex this process can become.

**Optimizing Margins as Revenue Drops**

The transition from FFS to value-based reimbursement is one that will occur over many years. Frankly, that transition is going to hurt in the short run. To meet value-based goals, hospitals are going to have to reduce utilization among their populations, which will reduce their procedure volume, which will reduce their revenue.

The following simple graph illustrates this trend.

**Transitioning from Fee-for-service to Value-based Reimbursements**

Notice how there’s no specific unit of time to mark the transition from fee-for-service to value-based reimbursement. Nobody knows yet how long this process will take.
You’ll notice that no specific units of time have been included on this graph. That’s because no one really knows how long this process will take. What we do know, however, is that there will be a transition period during which time total revenue is likely to decrease because the pressure on a hospital’s FFS revenue will increase faster than it can grow its revenue through value-based reimbursement. And that can be scary.

The key to succeeding in the midst of this transition — and beyond — is to constantly wring out costs. With revenue going down, hospitals have to improve margins as much as possible. To do so, hospitals need to focus on doing three key things:

1. **Effectively manage shared savings programs to maximize reimbursement.** Hospitals are going to have to manage shared savings contracts with real expertise to qualify for every possible bonus. Effective management of these contracts not only gets shared savings payments, but it also improves quality and lowers costs.

2. **Improve operating costs to deliver care more efficiently than today.** In a value-based environment, any investment in streamlining operations and eliminating waste from the system goes directly back to the hospital, not the payer. Hospitals must develop the sophistication to understand their cost structure in real, granular detail. Reducing every category of waste — waste that occurs when work isn’t standardized, waste that stems from unnecessary orders, and waste that results from patient injury — is absolutely essential for improving margins.

3. **Capture an increased number of patients.** As hospitals eliminate waste, improve quality, and reduce costs, they will attract increased patient volume. Payers will see that a given hospital is a top performer and will include it in their networks. Payers and even large employers like Wal-mart are becoming laser-focused on this issue. They want their employees and their members to go to the highest-performing facilities for care, and they will give them every incentive to do so. Attracting a high volume of patients is the key to counterbalancing the loss of procedure volume that comes with a value-based system.
An Analytics Infrastructure to Meet These Challenges

The challenges health systems face may seem insurmountable. A healthcare enterprise data warehouse (EDW) creates an analytics foundation that makes meeting these challenges possible. Sure, an EDW can’t stop the influx of baby boomers into the Medicare ranks, but it can give the tools and insight needed to:

- Understand the complete picture of the cost structure
- Succeed in shared savings arrangements
- Automatically track quality measures
- Improve performance
- Streamline operations
- Reduce waste
- And, ultimately, improve margins

Resources

- Rising Healthcare Costs http://www.healthcatalyst.com/hospitals-solve-rising-healthcare-costs

About the Authors

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Healthcare Analytics Applications [http://www.healthcatalyst.com/analytics-applications/]

### About the Authors

Jared Crapo joined Health Catalyst in February 2013 as a Vice President. Prior to coming to Catalyst, he worked for Medicity as the Chief of Staff to the CEO. During his tenure at Medicity, he was also the Director of Product Management and the Director of Product Strategy. Jared co-founded Allviant, a spin-out of Medicity, that created consumer health management tools. In his early career, he developed physician accounting systems and health claims payment systems.

### About Health Catalyst

Based in Salt Lake City, Health Catalyst delivers a proven, Late-Binding™ Data Warehouse platform and analytic applications that actually work in today’s transforming healthcare environment. Health Catalyst data warehouse platforms aggregate and harness more than 3 trillion data points utilized in population health and ACO projects in support of over 22 million unique patients. Health Catalyst platform clients operate 96 hospitals and 1,095 clinics that account for over $77 billion in care delivered annually. Health Catalyst maintains a current KLAS customer satisfaction score of 90/100, received the highest vendor rating in Chilmark’s 2013 Clinical Analytics Market Trends Report, and was selected as a 2013 Gartner Cool Vendor. Health Catalyst was also recognized in 2013 as one of the best places to work by both Modern Healthcare magazine and Utah Business magazine.

Health Catalyst’s platform and applications are being utilized at leading health systems including Allina Health, Indiana University Health, Memorial Hospital at Gulfport, MultiCare Health System, North Memorial Health Care, Providence Health & Services, Stanford Hospital & Clinics, and Texas Children’s Hospital. Health Catalyst investors include CHV Capital (an Indiana University Health Company), HB Ventures, Kaiser Permanente Ventures, Norwest Venture Partners, Partners HealthCare, Sequoia Capital, and Sorenson Capital.

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