Hospital Focus
A Quarterly Governance Institute Newsletter
JULY 2021

The Impact of Pay-for-Value Reimbursement on Healthcare Governance

By **Jon Burroughs, M.D., M.B.A., FACHE, FAAPL,** President and CEO,
The Burroughs Healthcare Consulting Network, Inc.

The transition from pay-for-volume to pay-for-value reimbursement is a profound change to the business model of the healthcare industry. "Value" is typically defined as quality × risk/severity adjustment divided by the cost of care. Thus far, approximately 18 percent of all payer contracts and reimbursement models (including Medicare and Medicaid) are now value-based and this percentage has increased every year. Wall Street analysts predict that when this number approaches 30 percent will be the "tipping point" when there will be significant movement away from traditional fee-for-service to value-based payer contracts.

What does this mean for healthcare governing boards? The traditional emphasis for optimizing financial performance was filling beds and keeping average daily census (ADC) near capacity. Since quality and cost had no bearing, boards wanted beds filled with "high-margin" patients who could undergo sophisticated testing and procedures; hence, the creation of service lines, centers of excellence, and surgical-focused factories. Most healthcare boards encouraged the recruitment and retention of surgeons and sub-specialists (even within rural facilities) who could generate significant revenues for the organization. Under pay-for-value and risk-based capitated arrangements (e.g., paying for covered lives over a defined timeframe), this model is being turned upside down. Unnecessary procedures and tests will no longer be reimbursed and the reimbursement for sub-specialty and surgical procedures/tests is declining towards primary care reimbursement. Thus, the old business model of brick-and-mortar supporting large diagnostic and therapeutic treatment facilities is becoming an albatross.

More importantly, boards will need to focus on quality, risk-severity adjustment, and cost of care, which were not significance governance issues in the past century.

Quality

The most important concept that the governing body must understand is that in the infinite universe of quality with its infinite number of measures, there are what the 19th-century engineer Vilfredo Pareto called the "vital few." If quality measures are monetized within the context of specific payer contracts and payer mixes, it will be rapidly noted that each quality metric has a different financial value—some positive and some negative. The board, management team, and medical staff should work together to identify the "vital few" by determining what few quality metrics will have the greatest impact on clinical, operational, and financial performance in light of overarching strategic goals and objectives. This process creates a strategic quality plan, which should equal in scale and detail to the organization's strategic plan.
A strategic quality plan gives an organization's vision focus and enables both the management team and medical staff to execute to accomplish the strategic quality goals and to be united around those goals through aligned compensation agreements. A key missing party in the 20th century was the payer itself and many of these quality goals should be the result of payer contract negotiations that can align the organization's interests with those of the payer.

➜ Key Board Takeaways

- Learn about value-based payment models that impact your specific organization and the payer models that are available and may benefit your organization. Pay-for-value represents a significantly different business model from fee-for-service.
- Work with the management team and medical staff to identify the "vital few" quality metrics and create a strategic quality plan, which should be at the center of your organization's strategic plan.
- Ask management about the skill level required for clinical personnel that are performing documentation functions. Optimized risk and severity adjustment requires professional clinical scribes who are coders with clinical experience.
- Ensure your organization is utilizing cost-accounting analytics. Reduction of cost requires the use of cost-accounting analytics, which are now widely available and necessary.

Risk and Severity Adjustment

All payers risk and severity adjust payment for both inpatient and outpatient services. On the Medicare side, inpatients are risk and severity adjusted through the Case Mix Index based upon the complexity, acuity, and severity of Medicare inpatients as reflected in the clinical documentation. Outpatient Medicare patients are risk and severity adjusted through Hierarchical Condition Categories (HCC), also based upon the complexity, acuity, and severity of Medicare outpatients as reflected in clinical documentation.

Why is this so important? Risk and severity adjustment has a profound impact on payer reimbursement and can be the difference between payment that enables a positive or negative margin and quality score. For instance, if the hospital has a significant mortality rate for certain types of patients but fails to adequately document the true acuity and complexity of these patients, the quality score may reflect negative performance, whereas with appropriate documentation, the quality score may be good when properly adjusted for acuity and complexity. Differences in payment can be as much as 500 percent.

To achieve this level of accuracy, it is imperative that clinical personnel who are skilled clinical scribes and bring both clinical and coding expertise to bear perform the documentation functions. The ideal clinical scribe is a registered or licensed nurse with three to five years clinical experience in a specific area who is also a certified coder and understands what documentation elements lead to what code. The level of the codes determines the risk and severity adjustment score and is a multiplier for both payer reimbursement and establishes the payer budgets for future years.

Cost of Care

In the traditional fee-for-service era, nobody cared about the cost of care and, in fact, rural hospitals under cost-based reimbursement were financially rewarded for increasing their costs. Today, healthcare costs have become a burden to the federal and state governments, payers, and patients alike and are almost double that of any other nation in the world. Increasingly, healthcare organizations are utilizing cost-accounting analytics to track variations in the cost of care among physicians and other healthcare practitioners as well as the total cost of care per episode of care (e.g., bundled payments) or throughout the continuum of care for capitated models of reimbursement. The differences in cost between providers, service lines, and facilities can be remarkable, and it is a key management function today to help drive down the

cost of care through the elimination of non-value-added cost and waste. Payers are increasingly turning to healthcare systems that can generate high-quality measures at low cost and this will be a significant driver of market share going forward.

Conclusion

Value-based payment is on the rise and governing boards should educate themselves as to its impact upon organizational performance. Boards should already have a quality committee; however, the shift in the business model of our industry requires that the quality committee be equal in scope and function to the finance committee—as the two are now inextricably joined. Clinical documentation is vital to ensure the optimization of coding that will yield optimized quality scores and financial performance. Finally, the cost of care must be tracked and managed, through the use of cost-accounting analytics that can rapidly identify variations in the cost of care in both real time and proactively. Hence, as the business model of our industry shifts, governance functions must shift to ensure optimal performance in a different and more complex oversight world.

The Governance Institute thanks Jon Burroughs, M.D., M.B.A., FACHE, FAAPL, President and CEO, The Burroughs Healthcare Consulting Network, Inc., for contributing this article.
He can be reached at (603) 733-8156 or jburroughs@burroughshealthcare.com.