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FEATURE STORY

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payment reform
how should your organization prepare?

New approaches to financial stewardship and clinical process improvement are critical to a hospital's success in this era of payment reform.

AT A GLANCE

To prepare for payment reform, hospitals should:
> Convene a permanent task force to monitor risk and lead performance improvement in the postreform era
> Identify the metrics linked to new and emerging incentive payments (e.g., readmission rates, prevention quality indicators)
> Quantify their financial risk exposure and identify all performance improvement areas
> Pair a member of the finance team with either the CMO or CNO to monitor performance on a weekly basis

Changes in payment are coming from Medicare and commercial payers that will challenge traditional models for managing healthcare organizations. Many of these changes are highly anticipated, and many are as yet unforeseen. Whatever form they take, over the next five to 10 years, a higher percentage of operating revenue will be linked to how well hospitals and physicians coordinate services for patients with specific disease types, reduce inappropriate utilization of emergency department visits and inpatient services, and improve performance on a growing array of process and outcome metrics.

The combination of changes in incentives, inevitable reductions in Medicare update factors, and the gradual shift of baby boomers into Medicare create both a multimillion dollar revenue risk for providers and a mandate to change the way senior executives and physicians manage health systems. Traditional approaches to financial stewardship and clinical process improvement will not ensure success today or in the future.

We are in an era that requires a new approach to management—one that anticipates new payment models over both the short and long term. Over the next several years, services will shift dramatically to the outpatient setting. Forward-thinking providers should focus on coordinating and managing patients and treating diseases seamlessly across multiple care sites that extend beyond the four walls of the hospital.

Shifts in Medicare Payment

To control long-term healthcare spending, the Centers for Medicare & Medicaid Services (CMS) is shifting from paying providers based on volume to paying based on performance.

CMS has already implemented a policy of not paying for hospital-acquired conditions (HACs) in the inpatient setting. Looking toward the future, Medicare payments also will likely be tied to readmission rates and the ability to eliminate potentially avoidable admissions. Providers therefore should assess key metrics and implement improvements today to capture tomorrow's patients and payments.

Providers should proactively initiate healthcare-specific financial risk assessments (with quarterly updates) that look at near-term recovery auditor contractor (RAC) audit targets, short-term CMS changes, and the long-term shifting incentive structure that will result from inevitable healthcare reform. Organizations need to pinpoint utilization patterns that are or will be subject to regulatory pressures and/or lower payment today and in the future.

Analyzing Short-Term Risks

Short-term risks are those considered to likely result in lower reimbursement from CMS in the next one to five years: one-day stays, HACs, and 30-day readmissions.

One-day stays. One-day stays have been a major focus of RAC audits that have sought to determine whether cases would more appropriately have been designated for outpatient observation/treatment. One-day stays are also being scrutinized to determine whether patient stays are being prolonged to complete the three-day stay necessary for a patient to qualify for admission to a skilled nursing facility (SNF). Hospitals should conduct regular audits to ensure that medical necessity for admission and treatment is documented and that bills for Medicare services are correct.

The exhibit below presents the financial implications if a hospital were to reduce one-day stay rates to regional average levels. It assumes that these cases would be treated as outpatient observation cases rather than inpatient one-day stays. If one-day stay rates for a condition are below the regional average rate, the analysis assumes no changes.

HACs. CMS no longer pays for 12 HACs unless other diagnoses present on admission warrant it. Instead, these cases are paid as though the secondary diagnosis is not present. Therefore, if these conditions develop during a patient's hospital stay, hospitals will not be paid at a higher level of severity. Hospitals should review and ensure compliance with all patient care protocols involving the following HACs:

- Pressure ulcers, stages III & IV
- Catheter-associated urinary tract infections (UTIs)
- Foreign object retained after surgery
- Air embolism
- Blood incompatibility
- Falls and trauma
- Vascular-associated infection
- Manifestations of poor glycemic control
- Surgical site infection—mediastinitis—following coronary artery bypass graft (CABG) surgery
- Surgical site infection following certain orthopedic procedures
- Surgical site infection following bariatric surgery for obesity
- Deep vein thrombosis and pulmonary embolism following certain orthopedic procedures

POTENTIAL FINANCIAL IMPACT IF ONE-DAY STAYS ARE REDUCED

Condition	Current One-Day Stay Volumes	Adjustment	Average Payment per Case		Net Change
			One-Day Stay	Observation	
Heart failure	217	–24	$9,296	$1,674	–$182,298
Chest pain	173	–19	$6,161	$1,901	–$80,940
Esophagitis, gastroenteritis, and miscellaneous digestive disorders	460	–38	$7,779	$1,565	–$236,132
Total	850	–81			–$500,000
Total Revenue Exposure: –$500,000					

Source: Sg2 data, 2009.

CMS is likely to expand the list of HACs in the future. A sample analysis of the annual revenue exposure for two HACs is shown in the exhibit below.

30-day readmissions. It has been predicted that CMS will reduce or eliminate payment for common readmissions that may be more effectively managed outside the acute care environment. According to the Program for Evaluating Payment Patterns Electronic Report (PEPPER) report and other sources, hospitals should especially be aware of their readmission rates for heart failure, chronic obstructive pulmonary disease (COPD), pneumonia, acute myocardial infarction, CABG, and percutaneous transluminal coronary angioplasty.[a] Organizations also need to know what their current scenarios are for reduced payment (25 percent, 50 percent, 100 percent) to evaluate true impact on revenue, as shown in the exhibit on page 77.

Thirty-day readmissions occur to 19.4 percent of geriatric patients discharged from the hospital; 51.6 percent are readmitted within one year. These alarming figures exemplify the breakdown of care between the acute care setting and the postacute home environment. The strongest predictors of readmission include previous rehospitalization, a longer hospitalization as compared with the norm for the diagnosis-related group (DRG), the need for dialysis, and the DRG to which the patient is assigned at the end of his/her stay. The highest readmission rates are for patients with heart failure (26.9 percent) and pneumonia (20.1 percent). Several hospitals are already shortening 30-day readmission rates with transitional care models, a model developed specifically to address the gaps between the acute care and post acute care settings.

Transitional care models. In a study involving 332 patients, HealthEast, a four-hospital system based in St. Paul, Minn., found that approximately 40 percent of the patients had medication discrepancies at home after discharge, placing them at high risk for readmission. The organization trained three RNs as "transition coaches" to visit patients' homes and conduct medication reconciliations. The result was a reduced readmission rate of 38 percent, from 11.7 to 7.2 percent). This result prompted two payers to outsource chronic patient management services to HealthEast, and one payer wrote a "no strings attached" check for $85,000 that the system used to pay for another transition coach.

A study published in the Sept. 25, 2006, *Archives of Internal Medicine* described a similar intervention used by the University of Colorado Health Sciences Center, Denver, a large, not-for-profit capitated delivery system that cares for more than 60,000 patients 65 years or older (Coleman, E.A., et al., "The Care Transitions Intervention: Results of a Randomized Controlled Trial"). The organization's intervention began with a predischarge visit to establish initial rapport, introduce

a. The PEPPER report is an electronic data report developed by the Hospital Payment Monitoring Program of the Quality Improvement Organization Support Center under contract with CMS.

ANNUAL REVENUE EXPOSURE OF TWO HOSPITAL-ACQUIRED CONDITIONS (HACS)

HAC	ICD-9-CM Codes	Volume	Average Incremental Revenue/Case	Total Incremental Revenue
Pressure ulcer, stages III and IV	707.23(MCC) 707.24 (MCC)	15	$13,324	$199,860
Catheter-associated UTI	996.64 (CC)	25	$955	$23,875
Total		40		$223,735

Annual Revenue Exposure: −$223,735

Source: Sg2 data, 2009.

The Role of the CFO in the Payment Reform Era

As payment becomes increasingly linked to how well an organization performs clinically, it is essential that CFOs and other senior leaders redesign their roles for higher accountability and rapid response to new incentives. A proper response includes a heightened understanding of the interplay of financial, clinical, and operations management. To prepare, hospitals should take the following steps:

> Convene a permanent task force to monitor risk and lead performance improvement in the postreform era (including, at a minimum, the CFO, CNO, COO, CMO, and head of compliance).
> Identify the metrics linked to new and emerging incentive payments (e.g., readmission rates, prevention quality indicators).
> Measure and benchmark the hospital's performance over the past four to six fiscal quarters. Quantify the organization's financial risk exposure and performance improvement areas.
> Identify what parts of the organization, processes, and people affect the different performance levers. Understand how previous attempts to improve on key metrics have succeeded and failed.
> Review the implications of improving performance on staffing, workflow, operations, medical staff and nursing training, etc.
> Develop and implement action plans with specific goals, accountabilities, and time frames for improvement. Consider pairing a member of the finance team with either the CMO or CNO to monitor performance on a weekly basis.
> Advise the appropriate board committees on progress against the performance improvement goals.
> Use successes and failures from your approach to refine your management model as incentives from CMS and commercial payers evolve.

the personal health record, and arrange a home visit within 48 to 72 hours after hospital discharge. Reconciliation of all of the patient's medications (before and after hospitalization, including over-the-counter medications) was a primary goal of the home visit. Red flags signaling a worsening of the patient's condition were also reviewed. Where appropriate, caregivers were included in all visits. Patients with transition coaches had lower rehospitalization rates at 30 days (8.3 versus 11.9, P = 0.048; N = 750).

The University of Pennsylvania, Philadelphia, assigns a transitional care nurse to geriatric

REDUCED PAYMENT SCENARIOS FOR 30-DAY READMISSIONS

Condition	Average Payment per Readmission	Revenue Exposure with:		
		25% Reduction in Payment	50% Reduction in Payment	100% Reduction in Payment
Heart failure	$5,892	–$157,611	–$315,222	–$630,444
Chronic obstructive pulmonary disease	$5,292	–$71,442	–$142,884	–$285,768
Pneumonia	$4,735	–$66,290	–$132,580	–$265,160
Acute myocardial infarction	$8,488	–$63,660	–$127,320	–$254,640
Coronary artery bypass graft	$34,402	–$154,809	–$309,618	–$619,236
Percutaneous transluminal coronary angioplasty	$16,570	–$248,550	–$497,100	–$994,200
Total		–$762,362	–$1,524,724	–$3,049,448

Annual Revenue Exposure: –$3,049,448

Source: Sg2 data, 2009.

POTENTIALLY AVOIDABLE ADMISSIONS BY PATIENT TYPE

Patient Type	Inpatient Volume		Average Revenue		Difference in Average Revenue
	Nonavoidable	Avoidable	Nonavoidable	Avoidable	
Complex critical	3,755	48	$17,445	$11,655	$5,790
Perpetual	5,113	972	$15,162	$8,089	$7,073
Occasional	4,671	404	$12,007	$6,096	$5,911
Elective	1,770	0	$18,526	N/A	N/A
Total	15,309	1,424	$15,785	$8,613	$7,172

Annual Revenue Exposure*: –$2,721,264

*Assumes a 25 percent reduction in payment for preventable admissions.

Source: Sg2 data, 2009.

patients with two or more risk factors, including multiple chronic conditions and a history of recent hospitalizations ("Transitional Care Models," *Innovations Review from Sg2*, Sg2: 2009). The transitional care nurse performs a preliminary assessment of the patient's physical and psychosocial needs while the patient is in the hospital. The nurse then follows the patient in his or her home setting for anywhere from one to three months. In a study of this approach, the organization found that six-week readmission rates under the transitional care model were 10 percent, versus 25 percent for the control group.

Organizations that decide to use the transitional care model should:

> Assess access to necessary resources (e.g., salaries, office space)

> Establish a clear, detailed job description

> Train transitional care providers to address both the physical and emotional needs of patients

> Determine which patients are at greatest risk for readmission by creating patient criteria for involvement in the transitional care provider model

Long-term Risks

Long-term risks are those changes in CMS reimbursement that are likely to occur more than five years out. Successful organizations will proactively monitor and change policies to minimize potentially avoidable admissions using prevention quality indicators (PQIs).

Potentially avoidable admissions. The "potentially avoidable admissions" designation refers to patients who are admitted to the hospital, but who, due to their diagnosis, may be more effectively managed outside the acute care environment. These admissions provide insight into potential gaps within the current integration between the acute care hospitals and the clinical management of patients outside of the inpatient environment. CFOs should communicate with other parts of the organization to understand how to close such gaps and prevent unnecessary admissions. Stakeholders across the system of care, from admissions to discharge, include the CFO, CNO, and COO, as well as coders, home care coordinators, skilled nursing practitioners, primary care physicians, specialists, and hospitalists.

PQIs are a set of measures defined by the Agency for Healthcare Research and Quality. They include the following conditions:

> UTIs

> Perforated appendix

> Diabetes

> Dehydration

> Hypertension

> COPD

> Congestive heart failure

> Angina

PATIENT TYPES DEFINED BY THE PRIMARY DIAGNOSIS CODE

Occasional	Patients with a condition that can be resolved within a short period of time and does not require substantial ongoing medical therapy
Elective	Patients with a condition or disease that does not pose any significant threat of loss of life or substantial reduction in their functional ability if treatment is delayed
Perpetual	Patients with a disease that extends over a multiyear period and requires ongoing medical therapy
Complex critical	Patients with a life-threatening condition that requires immediate hospitalization and that could require an ICU stay, or with a condition that could become life-threatening if surgery is not performed within 36 hours

Source: Sg2 data, 2009.

> Bacterial pneumonia
> Adult asthma

The PQIs can be used with hospital inpatient discharge data to identify ambulatory case-sensitive conditions (i.e, conditions where appropriate outpatient care could potentially prevent complications or hospitalization). RACs are currently focusing on PQIs, and CMS is likely to change payment incentives for these cases in the future.

For the example hospital shown in the exhibit on page 78, the most potentially avoidable admissions came from aging "perpetual patients" (see the exhibit above), who would likely be better managed with better coordinated care in the outpatient setting. Hospitals should quantify how much revenue is associated with these admissions and assume that CMS will reduce payment for them in the future.

Integration Is Key to Managing These Challenges

Simply put, the more integrated an organization is, the better its performance will be and the better it will be able to withstand new payment reform based on performance.

Hospitals should understand their depth and breadth of integration across both inpatient and outpatient care delivery. A hospital's ability to monitor gaps in hand-offs of care and performance will improve with the increasing integration of its services (*Health Care's New Math: Sg2's Annual Business and Technology Forecast*, Sg2, 2009).

In this era of payment reform, hospitals should take these action steps—today and on an ongoing basis:

> Quantify financial risk under current, future, and long-term payment scenarios
> Uncover financial improvement opportunities
> Develop strategies to optimize inpatient and outpatient care delivery
> Identify utilization patterns that may be the target of RAC audits
> Deliver high-quality services more efficiently
> Track improvement initiatives and quantify progress with quarterly report updates

Taking steps to improve integration will help hospitals improve immediate financial risks as well as those that will have an impact on future clinical and financial performance. Proactively working toward improved integration will help hospitals sustain their competitive position, reduce costs, and, ultimately, provide more efficient and effective patient care. ●

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