CHAPTER 1

THE CONTEXT OF HEALTH CARE FINANCIAL MANAGEMENT

Never before have health care professionals faced such complex issues and practical difficulties in trying to keep their organizations competitive and financially viable. With disruptive changes taking place in health care legislation and in payment, delivery, and social systems, health care professionals are faced with trying to meet their organizations' health-related missions in an environment of uncertainty and extreme cost pressures. These circumstances are stimulating high-performing provider organizations to focus on innovation to help lower costs and find creative ways to deliver services to a population whose members, while aging, are more informed and more demanding of a voice in their care and value for dollars spent than ever before.

The Patient Protection and Affordable Care Act (ACA) is the largest effort toward reform of the health care system since the advent of government entitlement programs in the 1960s. The goal of the ACA is to provide mechanisms to expand access to care, improve quality, and control costs.

But even before the enactment of the ACA in 2010, the Centers for Medicare and Medicaid Services (CMS) had articulated a vision for health care quality: "the right care for every person every time." CMS's stated objective is to promote safe, effective, timely, patient-centered, efficient, and equitable care.

CMS also needs to control the rising cost of care, which has become unsustainable. To accomplish its objectives CMS has been working to replace its old financing system, which basically rewarded the quantity of care, with value-based purchasing (VBP), a system that improves the linkage between payment and the quality of care. The

LEARNING OBJECTIVES

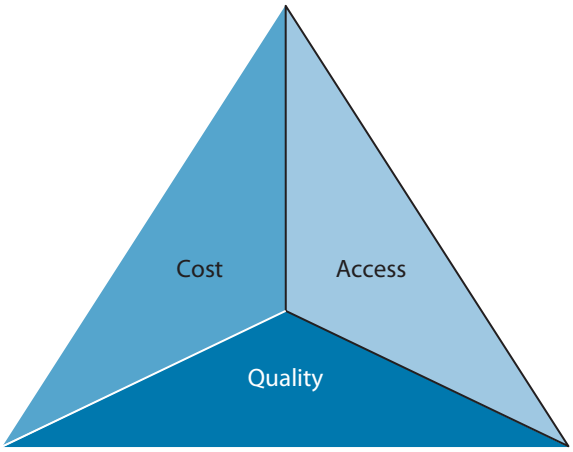
- Identify key elements that are driving changes in health care delivery.
- Identify key approaches to controlling health care costs and resulting ethical issues.
- Identify key changes in reimbursement mechanisms to providers.

Deficit Reduction Act of 2005 authorized CMS to develop a plan for VBP for Medicare hospital services beginning in fiscal year 2009. The ACA provided the implementation plan.

Many of these changes have been the source of controversy and lawsuits. Until President Obama's reelection in 2012, state governments as well as many providers faced uncertainty about whether the ACA provisions, even though found to be constitutional earlier in 2012, would be repealed. Some hesitated to move forward with implementation plans.

Regardless of whether or not all parties agree about the legislative outcome, the goal of the U.S. health care system remains to finance and deliver the highest possible quality to the most people at the lowest cost (Exhibit 1.1). But responses to today's challenges have resulted in a new business model that providers are embracing by controlling costs, developing new service offerings, and implementing new information technology, thereby creating added value (see Perspective 1.1 and Exhibit 1.2).

EXHIBIT 1.1 HEALTH SYSTEM GOALS REMAIN UNCHANGED



To establish a context for the topics covered in this text, this chapter highlights key issues affecting health care organizations. It is organized into three sections: (1) changing methods of health care financing and delivery, (2) addressing the high cost of care, and (3) establishing value-based payment mechanisms. Without question the health care industry is under-

PERSPECTIVE 1.1 HEALTH CARE SYSTEM IN REFORM

No matter what their political view is, people generally agree that the financial platform on which the health care system rests cannot be sustained. There is a clear need to reduce the proportion of the gross domestic product (GDP) spent on health care. Since the 1960s, hospitals have experienced increases in utilization, accompanied by increases in payments from government as well as from commercial payors. Medicare market basket updates have increased an average of 3.2 percent annually since that time. Under Medicare's new payment model, utilization and reimbursement are expected to decline over time, limiting market basket and utilization increases to only 1.5 percent to 2 percent a year. In addition, the value-based payment structure will reward those organizations with better quality while penalizing those with poorer scores. Since Medicaid and commercial payors tend to follow Medicare models, this effect will be magnified.

Several disruptive trends are changing the competitive landscape. Where commercial and not-for-profit providers had distinct differences, now they are both heavily focused on cost, quality, market share, and how quickly they can get innovative products to market. For example, Duke University Health System, a not-for-profit health system, and LifePoint Hospitals, Inc., a commercial health system, formed a joint venture, Duke LifePoint Healthcare, to provide community hospitals and regional medical centers with innovative means of enhancing services, recruiting and retaining physicians, and developing new service lines. Insurers such as Humana and private equity groups have acquired health systems. Certain integrated health care organizations, such as the Mayo Clinic and Geisinger Health System, are directed by physicians. New technologies like mobile apps provide mid-level providers and consumers with the latest evidence-based guidance to aid in diagnosis and management of health issues. And hospitals are consolidating, taking the view that big is good, bigger is better, and biggest is better still.

Source: Adapted from K. Kaufman and M. E. Grube, The transformation of America's hospitals: economics drives a new business model, in Kaufman, Hall, & Associates, *Futurescan 2012: Healthcare Trends and Implications, 2012–2017* (Health Administration Press, 2011).

going rapid change (Exhibit 1.3). The providers who are open-minded and informed, embrace change, and look for effective solutions will be the ones who thrive in this uncertain environment.

Changing Methods of Health Care Financing and Delivery

The push toward health care reform began back in the early 1990s during the Clinton administration. However, it did not make significant inroads

EXHIBIT 1.2 KEY ELEMENTS OF HEALTH CARE BUSINESS MODEL CHANGE

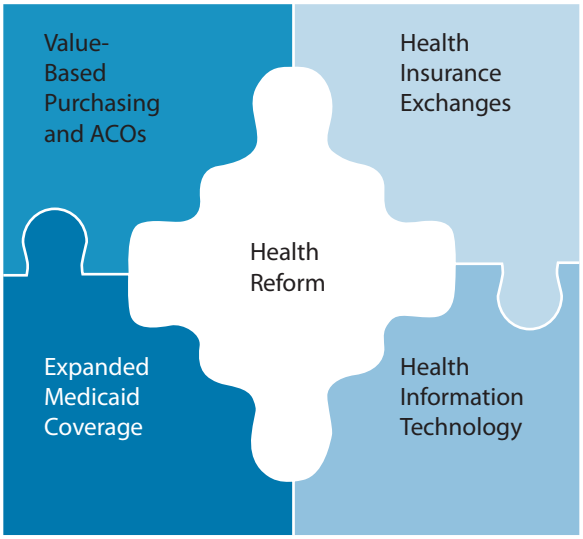
	Old Medicare Business Model	New Post Reform Business Model
Value proposition	More market share, more patients, more services, more revenues	Best possible quality at the lowest price
Direction of price	Upward—Saks Fifth Avenue	Downward—Walmart
Cost environment	Cost management	Cost structure
Direction of utilization	Always up since 1966, growth industry	Flat/maybe down, mature industry
Relationship between hospital and doctors	Parallel play	Highly coordinated and integrated
Payment	Fee-for-service	Something else
System of care	Patient services	Patient/population management
Organizing for value creation	One patient at a time	Comprehensive health care for covered population
Importance of scale	Small and medium hospitals could survive	Big, bigger, biggest

Source: Kaufman, Hall, & Associates, published in *Futurescan 2012: Healthcare Trends and Implications, 2012–2017*, Society for Healthcare Strategy and Market Development of the American Hospital Association and the American College of Healthcare Executives.

until President Obama signed the ACA into law in early 2010, though the ACA is complex and has numerous provisions. The provisions that are expected to have the most significant impact on the delivery and financing of care are noted in the following list and discussed in the remainder of this chapter.[1]

- *Requirement that almost all individuals have insurance coverage.* This individual mandate lies at the heart of the legislation.
- *Requirement that states create insurance exchanges* where individuals and small businesses can obtain coverage. The ACA contains requirements for an essential benefits package and provides for changes to the tax law that include penalties for individuals who choose not to have insurance.

EXHIBIT 1.3 SELECTED FACTORS CONTRIBUTING TO HEALTH CARE INDUSTRY UNCERTAINTY



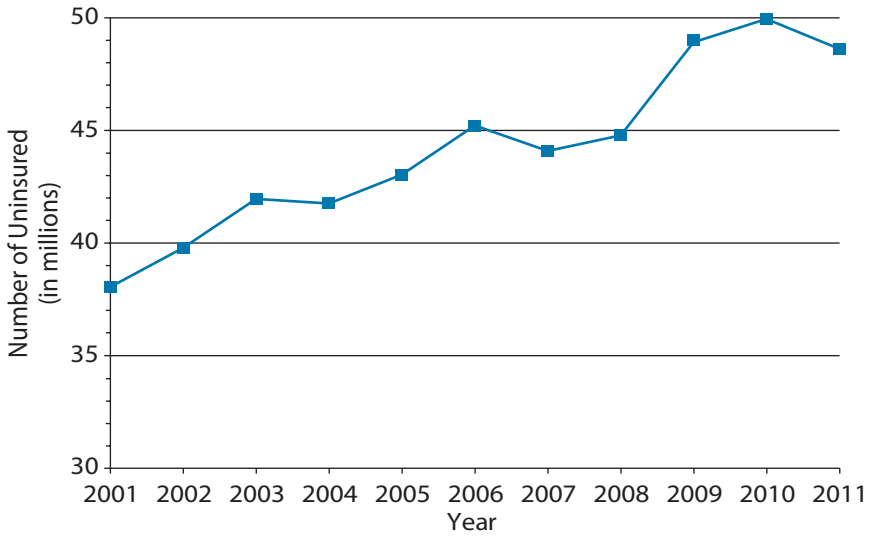
- *Provisions for expansion of Medicaid coverage to all eligible individuals under age sixty-five.* Since adults represent only 25 percent of those covered presently by Medicaid, this will be a significant expansion to include entire families. Federal funds will be made available for the expansion at a decreasing rate, down to 90 percent in 2020. This expansion is a state option and remains controversial as states realize that they will need to be equipped to shoulder the expense as the federal subsidies decrease.
- *Provisions for medical loss ratio and premium rate reviews for health plans.* Rebates will be paid to health plan enrollees by health plans that do not meet a required minimum level of spending on medical care.
- *Establishment of payment mechanisms for bundled payments and a value-based purchasing system* along with the restructuring of certain aspects of the Medicare payment system.
- *Provisions for providers organized as accountable care organizations (ACOs)* to share in cost savings that they achieve for the Medicare program.

Health Insurance Exchanges

Between 2001 and 2010, the number of uninsured rose from 36 million to 50 million people, before decreasing slightly (Exhibit 1.4). This rise is due to several factors, including (1) health insurance and out-of-pocket costs becoming too costly for many individuals, even when they are working; (2) individuals being screened out by insurance underwriters because of *pre-existing conditions*; (3) employers either scaling back employees' benefits or eliminating them altogether by hiring part-time workers; (4) state governments tightening Medicaid eligibility criteria; and (5) individuals voluntarily deciding not to purchase insurance for a variety of financial and nonfinancial reasons, including the assumption that they will not need care or that they will be taken care of by the "system" anyway. As a result, uncompensated care costs have doubled over the past decade (Exhibit 1.5), which has placed a tremendous burden on health care facilities, especially community hospitals.

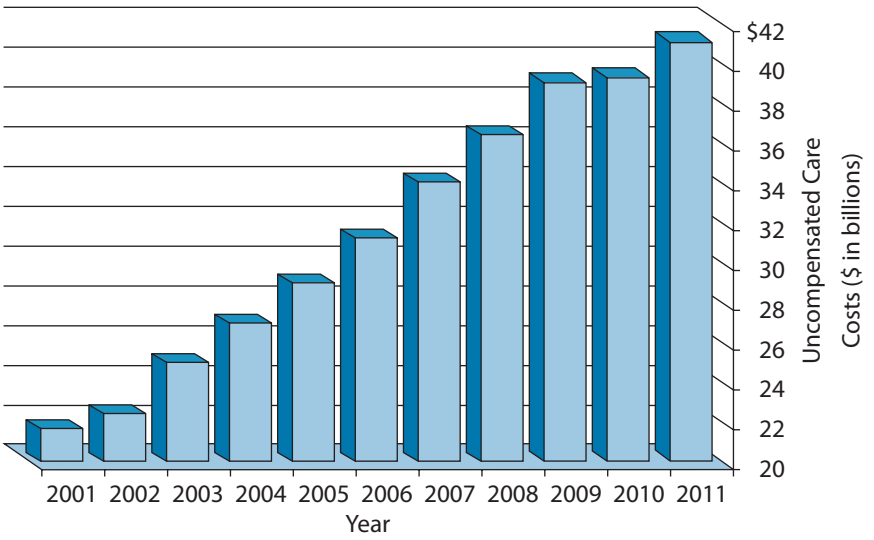
The ACA authorizes a competitive insurance marketplace at the state level and provides for two types of exchanges, an individual exchange and

EXHIBIT 1.4 NUMBER OF UNINSURED, 2001–2011



Source: Data from U.S. Census Bureau, *Current Population Survey*, 2012 Annual Social and Economic Supplement.

EXHIBIT 1.5 UNCOMPENSATED CARE COSTS FOR THE UNINSURED, 2001–2011



Source: Data from Health Forum, American Hospital Association Annual Survey Data, 1980–2011 (January 2013).

a small business exchange. The individual exchange provides a mechanism for implementing the individual mandate for those who either do not have access to health insurance through an employer plan or who are uninsured for other reasons. The small business exchange provides access for small businesses, enabling them to improve the quality of health insurance for their employees by pooling their buying power and providing multiple health insurance options.

States have the ability to choose whether they want to operate their exchanges themselves. For those that do not want to develop and manage their exchanges, the federal government will do it for them. These exchanges begin operation in 2014.

The ACA provides for a minimum benefits package; however, participants will be able to shop for health insurance from among an array of commercial health insurance products with varying levels of deductibles, coinsurance, and additional benefits over and above the minimum. The benefit packages are referred to as *bronze*, *silver*, *gold*, and *platinum*, depending on how much participants choose to pay.

Tax credits are available to low-income consumers, phasing out at 400 percent of the federal poverty level. In addition, consumers will not need to worry about denial of coverage because of any preexisting conditions they may have. The exchanges should promote transparency, to assist the participants in making an informed decision.

The health insurance exchanges, along with other ACA provisions, are expected to make coverage available to 32 million previously uninsured people by 2019. If this works as intended, it should reduce the amount of charity care currently being provided by providers, especially hospitals. However, because the rules providing for a tax penalty for individual noncompliance with the insurance mandate have some exceptions, it is possible that the benefit to providers will not be as effective as originally forecast.

Accountable Care Organizations

An ACO is a voluntary group of health care providers who come together to provide coordinated care to a patient population in order to improve quality and reduce costs by keeping patients healthy and by reducing unnecessary service duplication. This mechanism was initially created to serve Medicare beneficiaries but has now expanded into the non-Medicare population.

Participation is open to networks of primary care doctors, specialists, hospitals, and home health care services in which the network members agree to work together to better coordinate their patients' care. In June 2012, there were 221 ACOs in the United States. The majority were sponsored by hospital systems (118), followed by physician groups (70), insurers (29), and community-based organizations (4), and were located primarily in urban settings with relatively dense populations. By January 2013, there were more than 250 ACOs. As will be more fully discussed in Chapter Thirteen, ACOs are rewarded for reducing the cost of care while maintaining or improving quality under a variety of risk-based or risk-sharing mechanisms now being tested. Although certain medical groups, such as the Permanente Medical Group, Mayo Clinic, Intermountain Health Care, and Geisinger Health System, have shown positive correlations between practice organization and better performance, the ACO mechanism is too new to conclude that it will ultimately show the savings and quality improvements it was designed to achieve.[2]

Patient-Centered Medical Home
A partnership between primary care providers (PCPs), patients, and patients' families to deliver comprehensive care over the long term in a variety of settings.

Patient-Centered Medical Home

The *patient-centered medical home* (PCMH) is a partnership between primary care providers (PCPs), patients, and their families to deliver a

coordinated and comprehensive range of services in the most appropriate settings. The PCP takes full responsibility for the overall care of the patient over an extended period of time, including preventive care, acute and chronic care, and end-of-life support. The PCMH is a patient-centered model using evidence-based medicine, care pathways, updated information technology, and voluntary reporting of performance results. In 2011, the National Commission on Quality Assurance created a program that recognizes providers as PCMHs on one of three levels, based on meeting certain administrative standards and achieving a degree of quality reporting. Practices with robust information technology, which includes electronic record keeping, electronic disease registries, internet communication with patients, and electronic prescribing, are the ones most likely to achieve level 3 status.

The PCMH is a good way for a primary care provider to distinguish itself as a quality practice. Until recently there has been little payment advantage associated with being a PCMH; however, programs run by various Blue Cross Blue Shield plans and other insurers are demonstrating that the concept pays off. For example, in late 2012, Horizon Blue Cross Blue Shield of New Jersey identified savings due to reduced emergency department use (26%) and reduced hospital readmissions (26%). At the same time, CMS announced that 500 practices with over 2,000 total physicians will participate in the comprehensive primary care initiative. WellPoint is expanding its program after announcing that it earned $2.50 to $4.50 for every dollar invested in its PMCH program.[3]

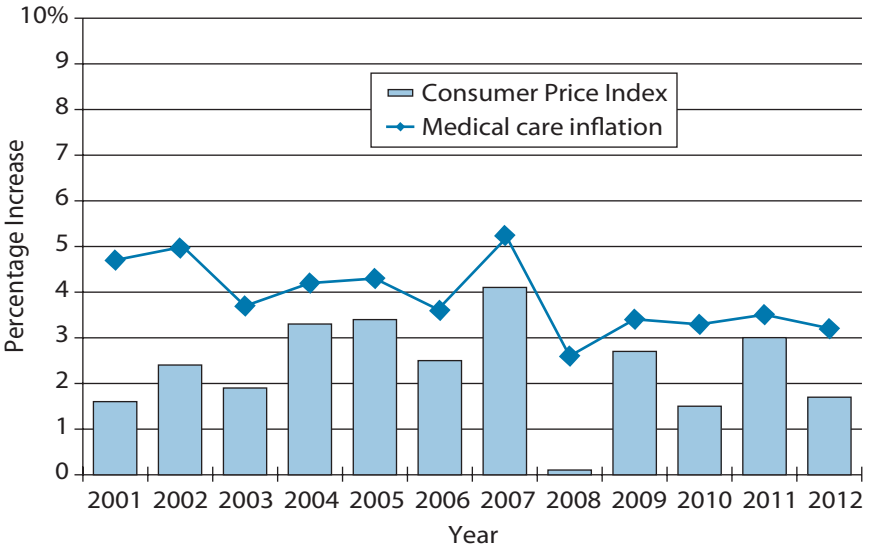
Addressing the High Cost of Care

Over the last decade health care costs have increased faster than has general inflation (Exhibit 1.6). The cost to keep people healthy has approximately doubled from 2001 to 2011 (Exhibit 1.7), although the average life expectancy of the general population has risen by only approximately five years since 1980. Even though the increases in the medical inflation rate are higher than those for the Consumer Price Index, the rate of growth has slowed, declining from approximately 5 percent at the turn of the century to 3.5 percent a decade later. However, looking ahead, forecasters are uncertain of what will happen. Certain factors tend to increase costs and others tend to lower them (see Exhibit 1.8).

Factors That Could Contribute to an Increase in Costs

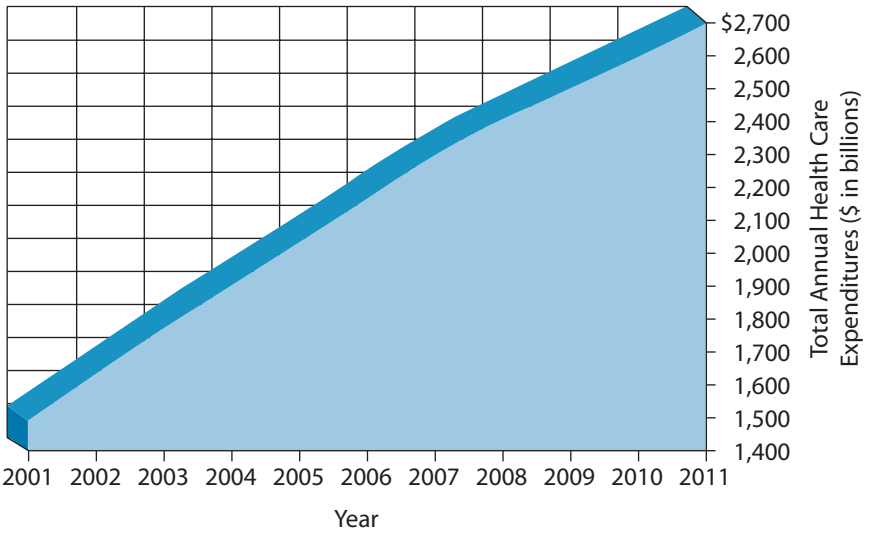
- *The population is continuing to age.* As a person ages, the care he or she requires becomes significantly more costly. By the year 2035, 20

EXHIBIT 1.6 CONSUMER PRICE INDEX VERSUS MEDICAL CARE INFLATION, 2001–2012



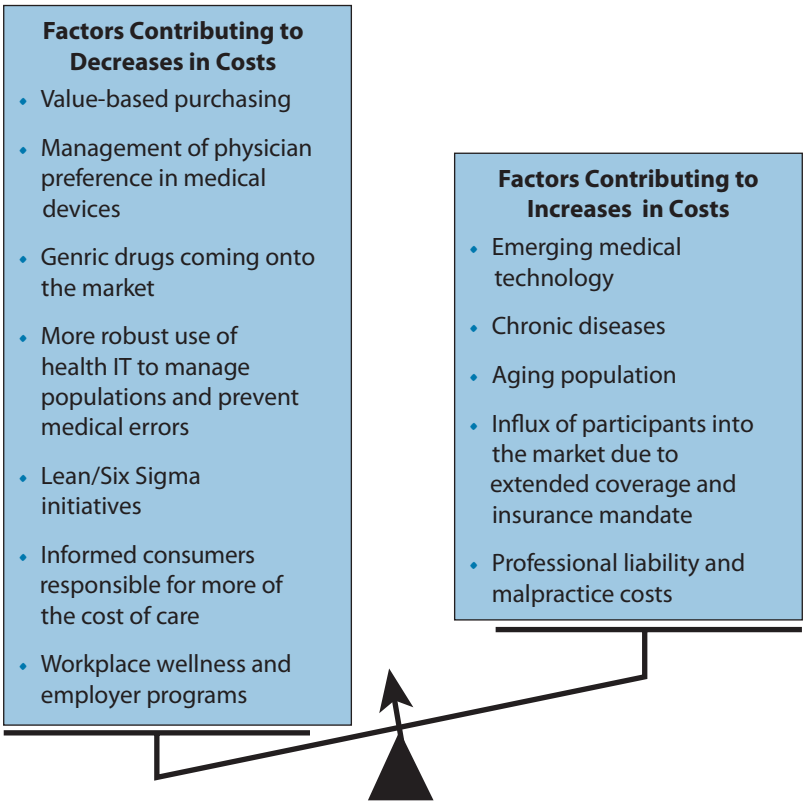
Source: Data from U.S. Labor Department, Bureau of Labor Statistics (January 2013).

EXHIBIT 1.7 ANNUAL HEALTH CARE EXPENDITURES IN THE UNITED STATES, 2001–2011



Source: Data from Centers for Medicare and Medicaid Services, Office of the Actuary, 2012.

EXHIBIT 1.8 FACTORS AFFECTING THE COST OF CARE



percent of the population is expected to be sixty-five or older. However, research also supports the notion that the many baby boomers are demanding wellness and life enhancement services in order to be able to continue to work into their seventies or eighties, which may help. Nevertheless, as people live longer, their medical issues become more complex and costly.

- *New consumers will enter or reenter the marketplace.* Once fully implemented, the ACA will bring millions of newly insured people into the system. As they obtain services, their needs will likely raise total health care costs. The expectation is that receiving the appropriate care in the appropriate setting at the appropriate time will, in the end, reduce costs.

- *The medical technology industry continues to develop new systems.* Some of these advances, such as the positron-emission tomography (PET) scan, proton beam therapy for prostate cancer, and defibrillator implants, may improve outcomes for some patients, but not all. And more and more hospitals are performing robotic surgery, which may be highly effective. But all this use of advanced technology comes at a high cost.
- *Chronic disease contributes to the high cost of care.* Many chronic conditions, such as heart disease, are associated with the elderly, but long-term issues affect younger populations as well. A 2011 article in *Academic Pediatrics* stated that 43 percent of children have a chronic disease.[4] The top five chronic diseases reported in 2011 for adults were arthritis, cardiovascular disease, diabetes, asthma, and obesity,[5] and the effect and expense of chronic disease are compounded when multiple diseases are present. Chronic disease often requires costly drugs and monitoring over the span of a person's entire life. Higher rates of chronic disease also lead to higher rates of organ failure, and transplants have become one of the most expensive medical procedures. AIDS and mental health issues are also very costly chronic illnesses.

Factors That Could Contribute to a Decrease in Costs

- *Certain behaviors have begun to change, spurred in large part by employers who can no longer afford to pay for employee health care the way they have in the past.* Employers are shifting health care costs to their employees through changes in benefit plan design. Some larger companies offer workplace wellness centers, while others build wellness programs into insurance options that have incentives behind them. For example, to help reduce the cost of medical care associated with employees who smoke, are obese, or who have other unhealthy behaviors, some employers with self-funded health plans have raised the stakes by penalizing them unless they begin a behavior remediation program.
- *Employees faced with paying for a larger portion of their health care costs have become more informed and better consumers.* Consumers are demanding more price transparency and are comparing providers. Some go to alternate sites of care, such as a CVS/pharmacy retail clinic where they can see a nurse practitioner for a fraction of the cost of a traditional physician visit. Some are receiving cost reductions or bonuses to travel overseas where their health plans have negotiated

lower rates for procedures that are especially expensive; this has become known as *medical tourism*.

Medical Tourism
Travel to a foreign country to obtain normally expensive medical services at a steep discount. Even with a family member escorting the patient (and getting the added benefit of foreign travel), the total cost is typically less than it would be at home.

- *Providers are using health information technology (IT) in a more robust way.* Providers are making large capital investments in technology to better understand costs, improve quality, reduce medical errors, and provide the information needed to participate in value-based purchasing initiatives. Both insurers and providers are working, oftentimes together, toward increased connectivity. Many are making use of population and disease management techniques to provide the appropriate level of care and enhance quality, which should continue to lower cost.
- *Pharmaceuticals are going off patent, creating opportunities for cost savings with generic drugs.*
- *Providers are embracing lean, Six Sigma and other techniques so that they can deliver better quality care with fewer resources.* The effects of these initiatives can be to streamline operational processes. For example, a project to improve the discharge process could result in freeing up beds to be used by other patients, thereby enhancing revenue. Other initiatives aimed at reducing medical errors and improving quality could also pay additional dividends on the reimbursement side of the equation.
- *Hospitals are overriding physician preferences in medical supplies.* Because medical supplies can amount to 40 percent of the cost of a procedure, the ability to achieve economies of scale by bulk purchases can have a significant impact on hospital costs. Many hospitals use the services of a group purchasing organization.

Information Technology

For the last several years providers have made significant investments in information technology, and perhaps the largest investment of time and resources in this area is the *electronic health record* (EHR). The HITECH Act (2009) was enacted with the goal of creating and expanding the current health care IT infrastructure, promoting electronic data exchange, and substantially and rapidly increasing EHR adoption to 90 percent for physicians and 70 percent for hospitals by 2019. The provisions of the act are intended to increase efficiency and reduce medical errors, at an expected savings to the government of billions of dollars. In addition, the HITECH Act substantially expanded HIPAA (Health Insurance Portability and Accountability Act of 1996) privacy and security rules and increased the penalties for HIPAA violations.

Electronic Health Record (EHR)
Also called an *electronic medical record* (EMR), this online version of patients' medical records can include patient demographics, insurance information, dictations and notes, medication and immunization histories, ancillary test results, and the like. Under strict security permissions, the information can be accessed either in-house or in private office settings.

Health Insurance Portability and Accountability Act (HIPAA)
A set of federal compliance regulations enacted in 1996 to ensure standardization of billing, privacy, and reporting practices as institutions convert to electronic systems.

The HITECH Act provides incentives for providers (hospitals, physicians, and other eligible providers) to achieve *meaningful use*. *Meaningful users* are those able to demonstrate that their EHR technology has been implemented in a manner that improves the quality of the health care they provide. This meaningful use includes, for example, e-prescribing, electronic exchange of health information, and submission of quality measures to CMS.

For achieving meaningful use, hospitals can receive up to $2 million, plus additional amounts calculated in accordance with each hospital's Medicare discharges. Medicaid permits up to six years of incentive payments. To achieve these incentives, a hospital must increase its use of comprehensive EHR systems from 10 percent to 55 percent by 2014.

Eligible physicians (a category that excludes physicians who are hospital based or in hospital-owned practices) and other eligible providers can receive incentive payments ranging up to $44,000 over five years under Medicare, or $63,750 over six years under Medicaid. Incentive payments are gradually reduced each year, ceasing in 2016.

Meaningful use is achieved in three stages. Stage 1 should have been achieved by 2012. Through July 2012, approximately 117,000 eligible professionals and 3,600 hospitals received some sort of incentive payment.

The stage 2 final rule, issued in 2012, requires hospitals, physicians, and other eligible providers to continue to increase interoperability among disparate forms of data, increase standardization of electronic formats, and demonstrate that they are relying on the EHR to improve patient care.

Stage 2 begins in 2014, and Medicare will impose penalties for not achieving meaningful use by 2015. A third and final stage of meaningful use is scheduled to begin in 2016.

Cost-Accounting Systems

Many hospital accounting systems have a strong billing and collections component but a weak cost-accounting system. This is due in large part to the fact that, historically, financial incentives were typically put in place to maximize reimbursement, not to control costs. Now that the environment has changed, providers have found it increasingly important to understand their costs at a more granular level. As a result there has been a major movement to separate cost-accounting systems from financial accounting systems and to move away from traditional allocation-based cost systems to activity-based cost systems (discussed in more depth in Chapter Twelve). Although this is an expensive endeavor, declining reimbursement is forcing hospitals to invest in more sophisticated cost-accounting systems.

Group Purchasing Organizations

With the rapid advances in computer hardware and software applications, many institutions have invested in information technologies in an effort to receive the most accurate information as quickly as possible. Most applications revolve around materials management, budgeting, accounts payable, payroll, patient registration, and human resource needs. An organization must track the flow of materials through its system and purchase supplies in the most cost-effective manner. Hospitals can keep funds longer and reduce inventory costs by incorporating *just-in-time* ordering techniques, and opportunity exists for cost savings by joining *group purchasing organizations* (GPOs) that can negotiate cost discounts through large volumes (discussed in more detail in Chapter Ten). When organizations can more accurately follow the flow of materials through the organization, they can better track costs and have better reporting and control over their budgets.

Reengineering or Redesigning

Health care organizations have been redesigning their work processes in order to achieve efficiencies and reduce cost. Common techniques include process analysis, layout redesign, work redesign, total quality management and care mapping, and layoffs of unnecessary personnel.

One such method that has gained widespread attention is Six Sigma, including the related concept of *lean thinking*, which offers a systematic approach to analysis and performance improvement. The five major components of the Six Sigma approach are define, measure, analyze, improve, and control (nicknamed DMAIC). Lean thinking breaks processes down into identifiable steps to ensure that each component is a value-added activity. A main tenet of lean thinking and Six Sigma is to reduce the variation in how activities are conducted, an important step toward quality improvement.

Mergers and Acquisitions

Mergers and acquisitions among health care organizations have increased significantly in response to health reform and especially since the passage of the ACA and the Health Care and Education Reconciliation Act of 2010. According to Levin Associates, there were 453 mergers and acquisitions in 2010, and Fierce Health Finance reported nearly 1,000 in 2011.[6] Health insurers and private equity firms are responsible for many of them.

From an accounting perspective, a *merger* requires that neither of the parties coming together has control. The two (or more) entities merge to start an entirely new entity with no step-up in basis of the assets. The new

entity comes into being on the date of the merger. In an *acquisition*, there is a controlling party, and the assets and liabilities are marked to fair value. Acquisitions are more common than mergers in the health care industry. Health care systems are consolidating to be larger players in the market in order to

- Spread fixed technology and administrative costs over a larger revenue base.
- Strengthen market penetration.
- Gain better access to capital.
- Add new service lines.
- Obtain better contracts from commercial payors.

According to *Becker's Hospital Review*, although health systems acquire other health systems, transactions also exist whereby smaller community hospitals are acquired by larger systems. In addition, currently the biggest area of acquisition for community hospitals is in physician groups (see Perspective 1.2); such acquisitions were up 200 percent in 2011.[7]

Retail Health Care

Retail Health Care
Walk-in medical services for basic preventive health care provided in a retail outlet, such as a pharmacy, by a licensed care provider.

Doctors' offices and hospitals are no longer the only settings where health care services are being provided. Given the tendency of consumers to use shopping malls, various retail outlets such as CVS/pharmacy and Walmart, which had already been providing pharmacy services for years, have expanded by offering basic preventive health care services in some of their stores. These *retail health care* outlets hire licensed professionals, such as nurse practitioners, to offer flu shots and provide remedies for minor ailments like a sore throat or the common cold. These sites of care are popular among the uninsured, students, and those who are simply in a hurry. The retailers also reap additional benefits by providing patients with convenient in-store purchase options for medications.

Litigation

Unfortunately, the ACA falls short when it comes to *malpractice reform*. The legislation addresses medical liability in two ways:

PERSPECTIVE 1.2 LIFE IN THE "GAP"

In discussing accountable care organizations, economic futurist Ian Morrison refers to a hospital's "life in the gap." The "gap" is the period of time during which payments are still being made largely on a fee-for-service basis but health care organizations are being pressured to lower costs and improve quality. The question is how to prepare. Some hospitals and health systems have become pioneer accountable care organizations, while others have developed programs with commercial payors such as Cigna. Many are acquiring other health care organizations to become larger or are focusing on building relationships with physicians and community organizations.

Greater Baltimore Medical Center formed an ACO, the Greater Baltimore Health Alliance, which sought approval for Medicare's Shared Savings Program. It is the only ACO in Maryland with a hospital component and is working to increase the number of primary care access points it has in Maryland. The risk is that it may drive down utilization of services and then not be paid adequately for doing it.

The preparation for the future could involve a number of moves:

1. Drive out waste.
2. Implement new payment models, such as participating in CMS pilots like Pioneer ACOs or with insurers.
3. Collaborate with other health care providers such as physician practices, ambulatory centers, and rehab facilities. This will help when the organization later may need to be responsible for the continuum of care.
4. Partner with past competitors to combine resources, find creative ways to gain better operational effectiveness, and negotiate with payors.
5. Invest in primary care. By improving coordination of care with primary care practices and integrated health information systems, hospitals may be able to reduce unnecessary readmissions and utilization.
6. Develop health data analytics to assist in decision making. Hospitals can develop better ways to measure, track, analyze, and apply data to patient care.
7. Establish employee health programs, which may be a springboard toward beginning to prepare for population management, and which carry less risk. Hospitals can lower insurance costs for employees who perform certain wellness activities, such as going to a wellness center or having a nutrition consultation.
8. Begin a cultural revolution. The challenge is to develop a focus on the whole patient and wellness rather than on a single episode of care and sickness. This is a cultural shift as well as a financial one.

Source: Adapted from S. Rodak, Managing the transition to value-based reimbursement: 8 core strategies to mind the gap, *Becker's Hospital Review*, October 2, 2012, accessed November 25, 2012, from www.beckershospitalreview.com/strategic-planning/managing-the-transition-to-value-based-reimbursement-8-core-strategies-to-mind-the-gap.html.

- Extension of federal malpractice protections to nonmedical personnel working in free clinics.
- Authorization of $50 million over five years for HHS to award demonstration project grants. These grants would be provided to states to develop, implement, institute, and evaluate alternatives to the present system used in the United States to resolve charges against physicians and other health care providers of wrongdoing to patients.

As the health care system moves closer to the practice of evidence-based medicine, certain demonstration projects could help to reduce health care errors by encouraging the collection and analysis of data on patient safety. But many believe that evidence-based medicine is not likely to do much.

Compliance

Compliance
The process of abiding by governmental regulations, whether in the provision of care, billing, privacy, accounting standards, security, or any other regulated area.

Providers spend a significant amount of time and expense on processes needed to comply with governmental regulations in such areas as the provision of care, billing, privacy, security, accounting standards, and the like. Examples of compliance requirements are

- HIPAA, the Health Insurance Portability and Accountability Act
- Health and safety regulations
- EMTALA, the Emergency Medical Treatment and Active Labor Act, also known as the patient anti-dumping law
- Billing, coding, and other standards designed to eliminate the following: charging for items or services not provided, providing medically unnecessary treatment, upcoding, diagnosis related group (DRG) creep, improperly providing outpatient services in connection with inpatient stays (in violation of the seventy-two-hour window rule), failure to follow teaching physician and resident requirements for teaching hospitals, duplicate billing, false cost reports, billing for discharge in lieu of transfer, failure to refund credit balances, providing hospital incentives that violate the anti-kickback statute, improper financial arrangements between hospitals and hospital-based physicians, and violations of the Stark physician self-referral law.
- Billing standards such as the move to ICD-10 (deferred to 2014), as discussed later in this chapter.

Recovery Audit Contractor (RAC) Program
A program created under the Medicare Modernization Act of 2003 to identify and recover improper Medicare payments to health care providers.

Recovery Audit Contractors

For over a decade now, significant media and public attention has been focused on the hospital industry due to ongoing investigations related to

referrals. CMS's recovery audit contractor (RAC) program is designed to reduce overpayments (and underpayments) by addressing the root cause of provider billing errors. This program, which became permanent under the Tax Relief and Health Care Act of 2006, has been rolled out to all hospitals and to other targeted providers as well. In 2010, the RAC program was extended to Medicaid through the ACA.

RAC auditors are independent contractors hired by CMS to focus primarily on clinical documentation supporting billings under the Medicare program. They use proprietary software and systems in order to determine what areas to review, but they cannot simply randomly select claims or focus just on high-dollar claims. Instead, the purpose is to identify improper payments related to incorrect amounts, noncovered services (including services that may not be reasonable or necessary), incorrectly coded services, and duplicate services.

There are two types of reviews: automated and complex. The automated review requires no medical records. The complex review ensues when the automated review provides evidence of a high likelihood that the service received improper payment or that there is no Medicare policy, Medicare article, or Medicare-sanctioned coding guideline for the service provided. The RACs use medical literature and apply clinical judgment to make claims determinations, and a RAC can go on site to view or copy the medical records or request that the provider do so. When a RAC identifies an overpayment, it provides written notification requesting repayment in full. Providers can appeal within thirty days of the demand letter.

RACs are paid on a contingency basis: the more they find, the more they collect. As a result the provider community has had difficulties with the concept since the inception of the program, believing that RACs tend to focus on claims and services most likely to result in error to enhance their chances of payment.

Provider concern over the RACs has led to a significant increase for providers in personnel time, consulting fees, and new technologies to "scrub" claims prior to submission, not to mention the time it takes to research and defend claims identified by the RACs. The American Hospital Association believes that hospitals are experiencing a significant number of inappropriate denials, which has resulted in hundreds of unfair recoupment payments, with approximately 75 percent of the RACs' assessments being overturned by Medicare. Unfairly requested payments are returned to the hospitals.

The Medicare Audit Improvement Act of 2012 was designed to promote transparency and fairness in RAC reviews, and if passed, it would establish

a penalty for a RAC's failure to follow the program requirements. It would also, among other things:

- Establish a consolidated limit for medical record requests.
- Require medical necessity audits to focus on widespread payment errors.
- Allow denied inpatient claims to be billed as outpatient claims when appropriate.
- Require physician review for Medicare denials.

Value-Based Payment Mechanisms

The introduction of Medicare and Medicaid in 1965 was in large part intended to guarantee health care coverage to the country's most vulnerable populations: the poor and the elderly. Unfortunately, many officials at the time failed to recognize that these "Great Society" programs would become the impetus for health care costs rising far beyond any costs ever predicted. The role of the federal government in health care has changed from being a small participant before the mid-1960s to being a major force in both setting amounts of payment and defining payment systems. Since that time numerous payment mechanisms have been used to compensate providers for services to patients. As more fully discussed in Chapter Thirteen, fee-for-service, flat fee, cost-based, and capitation reimbursement methodologies have been used for years by governmental and private payors, with varying degrees of success (see Exhibit 1.9).

EXHIBIT 1.9 PAYMENT SYSTEMS INTRODUCED BY MEDICARE SINCE THE 1960s

1960s	**1980s–1990s**
Fee-for-service (FFS) and cost-based reimbursement	Prospective payment (DRGs) Capitation and global payments
2000s	**2013**
Ambulatory payment classifications (APCs) and pay for performance (P4P) Pay for reporting (P4R)	Value-based payment Accountable care organizations Shared savings programs

Movement to a New DRG System

In 2008, CMS changed the way it paid hospitals. The new system, based on Medicare severity-adjusted diagnosis related groups (MS-DRGs), has 25 major disease categories, 745 diagnosis related groups, and 3 subclasses of complications and comorbidities. It is intended to more closely align reimbursement to patient severity of illness, which means that certain hospitals will earn more but many will earn less.

The purpose of the Deficit Reduction Act of 2005 was to reduce overall hospital costs by improving care, thus combining quality and cost control and improving equity. Under this act and in response to rising health care costs and knowing that the aging population would be consuming more health care services in the coming years, CMS began piloting new forms of reimbursement in 2005 with the objective of obtaining better quality care for patients at a lower cost. The value-based purchasing system was initially rolled out to hospitals for their inpatient services in demonstration projects, under the expectation that some sort of value-based system would improve quality and reduce costs. In this demonstration phase, the mechanisms being tried were referred to as *pay for performance*, or P4P.

Establishing Value-Based Purchasing

Value-Based Purchasing (VBP) A payment methodology designed to provide incentives to providers for delivering quality health care at a lower cost. The financial rewards come from funds being withheld by the payor; these funds are then redistributed on providers' achievement of and improvement on specific performance measures, including patient satisfaction.

As more fully discussed in Chapter Thirteen, the ACA of 2010 established the inpatient Hospital Value-Based Purchasing Program, which became effective for discharges in late 2012. MS-DRGs form the basis of payments for this system, and providers are still reimbursed on this basis. However, the reimbursement is reduced in order to provide a pool of money to be used for value-based incentive payments.

The ACA requires that the total amount of value-based incentive payments available for distribution be equal to the total base operating DRG payments reduction, making this change budget neutral. Base operating payments represent payments for the health care services rendered. Hospitals also receive capital payments, which are not a part of this incentive calculation. The first incentive payments were based on hospital performance from mid-2011 to early 2012.

For high-performing hospitals, preparation for the new system has been expensive and challenging. Smaller hospitals oftentimes have found it next to impossible, forcing many of them into acquisitions by larger systems.

The federal government, of course, is not the only payor for hospital services, but its policies and reimbursement mechanisms for services

Shared Savings
A payment strategy that offers incentives for providers to reduce health care spending for a defined patient population; these incentives are a percentage of the net savings realized as a result of provider efforts.

Prospective Payment System (PPS)
The payment system used by Medicare to reimburse providers a predetermined amount. Several payment methods fall under the PPS umbrella,, including methods based on DRGs (for inpatient admissions), APCs (for outpatient visits), a resource-based relative value scale (RBRVS) (for professional services), and resource utilization groups (RUGs) (for skilled nursing home care). Use of DRGs was the first method that fell under this type of predetermined payment arrangement.

greatly influence the practices of other payors, including state governments and major insurance companies.

Although the initial push in value-based purchasing was toward inpatient services, demonstration projects and data collection have already started and will continue to be rolled out for other hospital services as well, and eventually to other providers over time. Additional VBP initiatives are being conducted in hospitals for services other than inpatient services and in physicians' offices, nursing homes, home health organizations, and dialysis facilities.

Even critical access hospitals that presently receive cost-based reimbursement, and other hospitals that are excluded from value-based purchasing owing to their low number of measures and cases, could at some point be subject to this legislation, given that demonstration projects, a precursor to implementation for these institutions, are already underway.

ICD-10

The World Health Organization's International Statistical Classification of Diseases and Related Health Problems (ICD) is a coding system for diseases that is used in the United States for health insurance claim reimbursement. Currently the United States uses the ninth version of the codes, which was developed in the 1970s. However, the ninth version has constraints in terms of structure and space limitations that hamper its ability to accommodate advances in medical knowledge and technology.

The tenth version, ICD-10, addresses these issues and also assists in morbidity and mortality data reporting, another important facet of what these codes were designed to do. The fact that the United States still uses ICD-9 while other countries are already using the more advanced version is also making it difficult to compare U.S. health information with information from other countries.

The final rule adopting ICD-10 as the U.S. standard was published in January 2009, with an original compliance date set for October 2013. This date was then pushed back by a full year because the government was concerned about the administrative burdens placed on providers in the midst of all of the other regulatory changes; however, health insurers, large hospitals, and large medical practices appear to have the majority of their planning complete. The American Health Information Management Association (AHIMA) has noted that the cost to the industry related to the delay is likely to be between $1 billion and $6.6 billion.[8] Nevertheless, there should also be some savings since earlier implementation could have

resulted in health care providers and health plans having to process health care claims manually in order to be paid. In addition, small health care providers might have had to take out loans or apply for lines of credit in order to continue to provide health care in the face of delayed payments.

Once this standard is effective, entities covered under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) will be required to use the ICD-10 diagnostic and procedure codes.

Key Point Pay for reporting is a precursor to value-based purchasing. Before the beginning of VBP, Medicare's Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program, which is a pay-for-reporting (P4R) program, provided an incentive for hospitals to report on the care they provide to all adults, regardless of payor. Originally, hospitals reported on ten clinical performance measures to avoid a reduction in the Medicare annual payment update for inpatient services. In 2007, hospitals were required to report on twenty-one measures in order to receive their full payment update, or else face a penalty of 2 percent for failing to do so.

Summary

The health care administrator today and in the future will be faced with numerous complex issues to consider when making strategic and financial decisions. This is an exciting time to be in the health care field, and providers appear to be embracing a new business model. High-performing organizations will evaluate the possibilities of doing business a different way, focusing on populations instead of individuals, rightsizing the costs of the organization, focusing the necessary resources on the implementation of technology to ensure interoperability, and using data to manage costs and care. Through it all, the administrator must constantly maintain a high ethical standard in all decisions, not only for the obvious health and financial impacts but also for the myriad personal, professional, community, and societal implications.

The remainder of this book focuses on essential health care financial management topics such as how to analyze financial statements, manage internal funds, make sound business investments, borrow funds, analyze costs, and prepare a budget. It also provides in-depth analyses of the ways in which regulations and restrictions affect the operation of health care institutions. Although this knowledge is essential in the financial decision-making process, health care administrators always need to carefully weigh nonfinancial factors as well.

KEY TERMS

a. Accountable care organization (ACO)

b. Capitation

c. Care mapping

d. Compliance

e. Electronic health record (EHR)

f. Evidence-based medicine

g. Group purchasing organization (GPO)

h. Health insurance exchange

i. Health Insurance Portability and Accountability Act (HIPAA)

j. ICD-10

k. Malpractice reform

l. Medical tourism

m. Medicare severity-adjusted diagnosis related groups (MS-DRGs)

n. Patient-centered medical home

o. Patient Protection and Affordable Care Act (ACA)

p. Pay for performance (P4P)

q. Pay for reporting (P4R)

r. Prospective payment system (PPS)

s. Recovery audit contractor (RAC) program

t. Retail health care

u. Shared savings

v. Value-based purchasing (VBP)

REVIEW QUESTIONS

1. **Definitions**. Define the terms listed in the key terms list.
2. **Increased costs**. What are several factors that have led to increased health care costs?
3. **Cost control**. What are several of the efforts that have been attempted by payors to control costs?
4. **Malpractice reform**. What specific impacts will the provisions of the ACA have on malpractice reform?
5. **Information technology**. What is the trend of information technology usage in health care, and what effects are likely from that trend?
6. **Mergers and acquisitions**. What advantages do health care organizations seek to obtain by merging with each other or by acquiring or being acquired by another health care organization?
7. **Process techniques**. What are two or more techniques that health care organizations can implement to increase operational efficiency?

8. **Overall costs**. Which two factors may have the strongest tendency to increase health care costs? Which two may particularly decrease those costs? Why?
9. **The "gap."** Describe the "gap" that health care organizations are facing. What unique problems does it present? And what benefits?

Notes

1. The full text of the ACA can be found at www.kaiserhealthnews.org/final-health-reform-bill-patient-protection-and-affordable-care-act.aspx (last accessed June 9, 2013).
2. J. J. Crosson and L.A. Tollen, eds., *Partners in Heath: How Physicians and Hospitals Can Be Accountable Together* (San Francisco: Jossey-Bass, 2010).
3. R. S. Raskas, L. M. Latts, J. R. Hummel, D. Wenners, H. Levine, and S. R. Nussbaum, Early results show WellPoint's patient-centered medical home pilots have met some goals for costs, utilization, and quality, *Health Affairs*, 2012;31(9):2002–2009, doi: 10.1377/hlthaff.2012.0364.
4. C. D. Bethell, M. D. Kogan, B. B. Strickland, E. L. Schor, J. Robertson, and P. W. Newacheck, A national and state profile of leading health problems and health care quality for US children: key insurance disparities and across-state variations, *Academic Pediatrics*, 2011;11(3 Suppl):S22–33.
5. H.-Y. Chen, D. J. Baumgardner, and J. P. Rice, Health-related quality of life among adults with multiple chronic conditions in the United States, Behavioral Risk Factor Surveillance System, 2007, *Preventing Chronic Disease*, 2011; 8(1):A09, retrieved November 24, 2012, from www.cdc.gov/pcd/issues/2011/jan/09_0234.htm
6. Irving Levin Associates, Inc., Health care M&A accelerates in second quarter after passage of reform according to new report by Irving Levin Associates, Inc. (Press release), July 28, 2010, retrieved August 6, 2013, from www.levinassociates.com/pr2010/pr1007mamq2; R. Shinkman, Healthcare M&A finishes healthy in 2011, *FierceHealthFinance*, January 17, 2012, retrieved August 6, 2013, from www.fiercehealthfinance.com/story/healthcare-ma-finishes-healthy-2011/2012-01-17
7. 10 biggest hospital stories of 2011, *Becker's Hospital Review*, November/December 2011, retrieved August 6, 2013, from www.becker'shospitalreview.com/pdfs/hospital-review/Nov_Dec_2011_HR.pdf
8. C. Dimick, HHS announces ICD-10 delayed one year, *Journal of AHIMA*, August 24, 2012, retrieved August 6, 2013 from journal.ahima.org/2012/08/24/hhs-announces-icd-10-delayed-one-year