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Health Care Costs: Quality vs. Quantity

by Katie Louden, Communications Specialist

An emerging concept in the health care world is tying reimbursement to the quality of a hospital's care rather than the quantity of care it gives. From a financial perspective, questions arise as to whether it is better for health care facilities to have patients that don't need to come in as often because the quality of their care is good, or better to have the same patients coming back for more services?

Currently, health care providers are often reimbursed on volume and not quality; however, some hospital evaluations are set up where reimbursement levels will increase for health care providers who have higher quality scores. According to Tony Rinkenberger, director of revenue cycle services at Ridgeview Medical Center in Waconia, Minn., more payer contracts are moving to include quality measures as part of the reimbursement mix. Under this standard, health care facilities with high volumes of services don't necessarily succeed more than hospitals who have better patient outcomes.

"Regardless of whether it's volumes or outcomes, being able to manage the cost of providing the service will more likely measure the financial success of the organization," Rinkenberger said. "Better clinical outcomes should result in tandem."

Tom Gavinski, vice president at I.C. System, Inc. in St. Paul, Minn., noted that Medicare has implemented a patient readmissions policy for hospitals.

"If a hospital's patient readmission rates are above established thresholds at that hospital, they will be penalized by Medicare on future reimbursements," Gavinski said. "This is for hospital readmissions for the same illness within 30 days of patient discharge."

If there is a heavier focus on quality and patient outcomes, would that increase or decrease the cost of health care since there are fewer services being provided? That is the million dollar question. Would this also mean less people not paying their medical bills? The paradigm shift to pay providers for health outcomes versus fee for service could change the whole delivery of health care.

"With the reimbursement vision focusing more on quality for payment reimbursement, several new health care delivery models are emerging that are designed to focus on improved health outcomes," Gavinski said. "These models are designed to improve the quality of care and reduce patient cost."

Today, health care relies on patient procedure volumes to meet financial goals. Full beds and full physician appointment calendars are what drive financial success. A lower patient volume could cause strain on a hospital's financial goals.

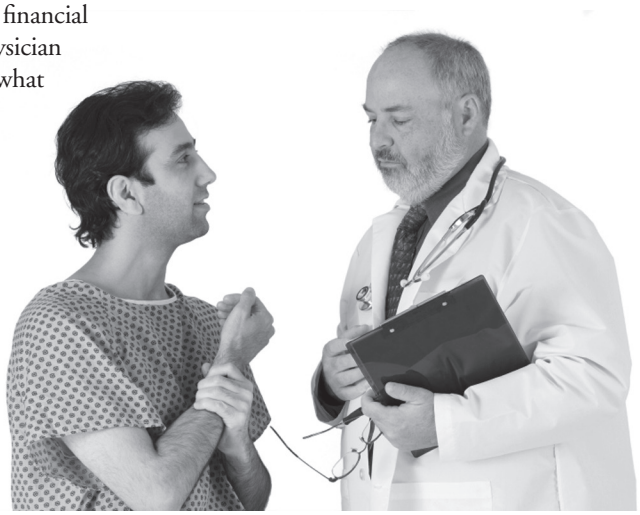
Even with improved health care delivery models and improved insurance coverage for patients, Gavinski thinks patient self-pay volumes will continue to rise.

"I predict less uninsured patient volumes and more out-of-pocket patient volumes with increased co-pays and deductibles," Gavinski said. "Also, the baby boomer health care treatment volumes will increase along with more expensive treatments due to improved technology advancements in treatment."

Rinkenberger predicted that, given the current market and demographic trends, it is unlikely we will see fewer non-paying consumers.

"Once we know how many consumers will end up in the insurance exchanges and the plans they choose, we will have a better sense what the trend might be," Rinkenberger said.

The idea of tying reimbursements to the quality of a hospital's care rather than the quantity of care is still in its infancy stages of development, and while this may not necessarily be an immediate industry wide trend, it is something for health care providers to think about.



HHS Issues Final Rule on Essential Health Benefits

In February, the Department of Health and Human Services (HHS) released a final rule establishing insurance standards for the coverage of essential health benefits, as set forth in the Patient Protection and Affordable Care Act.

Beginning in 2014, all non-grandfathered health insurance plans in the individual and small group markets must provide coverage of benefits and services in 10 statutory categories, such as hospitalization, prescription drugs and maternity and newborn care. The final rule also expands coverage of mental health and substance use disorder services, including behavioral health treatment.

The rule additionally outlines actuarial value levels in the individual and small group markets. Beginning in 2014, plans that cover essential health benefits must cover a certain percentage of costs, known as actuarial value or "metal levels." These levels are 60 percent for a bronze plan, 70 percent for a silver plan, 80 percent for a gold plan, and 90 percent for a platinum plan. These "metal levels" help consumers compare insurance plans with similar levels of coverage and cost-sharing based on premiums, provider networks and other factors.

Policies in the rule also provide more information on accreditation standards for qualified health plans (QHPs) that will be offered through the Health Insurance Marketplaces (also known as Exchanges).

To view the rule, visit *http://www.ofr.gov/inspection.aspx.*

Final Rule for Health Insurance Market Reforms

Final rules implementing group and individual market insurance reforms under the Affordable Care Act were issued on Feb. 22, 2013. The regulations will generally prevent insurance companies from discriminating against individuals with pre-existing health conditions.

The final rules for insurance plans providing coverage in 2014 implement five key provisions of the Affordable Care Act that are applicable to non-grandfathered health plans:

- **Guaranteed Availability of Coverage**
  Nearly all health insurance companies offering coverage to individuals and employers will be required to sell health insurance policies to all consumers. No one can be denied health insurance because they have or had an illness.
- **Fair Health Insurance Premiums**
  Health insurance companies offering coverage to individuals and small employers will only be allowed to vary premiums based on age, tobacco use, family size, and geography. Basing premiums on other factors will be illegal. The factors that are no longer permitted in 2014 include health status, past insurance claims, gender, occupation, how long an individual has held a policy or size of the small employer.
- **Guaranteed Renewability of Coverage**
  Health insurance companies will not be able to refuse to renew coverage because an individual or an employee has a pre-existing condition or has become sick.
- **Single Risk Pool**
  Health insurance companies will not be able to charge higher premiums to higher cost enrollees by moving them into separate risk pools. Insurers are required to maintain a single state-wide risk pool for the individual market and single state-wide risk pool for the small group market.
- **Catastrophic Plans**
  Young adults and people for whom coverage would otherwise be unaffordable will have access to a catastrophic plan in the individual market. Catastrophic plans generally will have lower premiums, protect against high out-of-pocket costs, and cover recommended preventive services without cost sharing.

More information on this final rule is available at *http://cciio.cms.gov/resources/factsheets/marketreforms-2-22-2013.html.*

Updating Business Associate Agreements to Comply With New HIPAA Regulations

It may be time for health care providers and their vendor partners to review and refresh their business associate agreements (BA) to ensure compliance with the recent HIPAA omnibus rule and HITECH Act.

According to the U.S. Department of Health and Human Services (HHS), BA agreements must include provisions that:

- Establish the permitted/required uses and disclosures of protected health information (PHI) by the BA
- Provide that the BA will not use or further disclose the information, other than as permitted or required by the contract or by law
- Require the BA to implement appropriate safeguards to prevent unauthorized use or disclosure of PHI, including implementing requirements of HIPAA's Security Rule with regard to electronic PHI
- Require the BA to report to the covered entity (CE) any use/disclosure of information not provided for by its contract, including incidents that constitute breaches of unsecured PHI
- Require the BA to disclose PHI as specified in its contract to satisfy a CE's obligation with respect to individuals' requests for copies of their PHI, as well as make available PHI for amendments and accountings
- To the extent the BA is to carry out a CE's obligation under the Privacy Rule, require the BA to comply with the requirements applicable to the obligation
- Require the BA to make available to HHS its internal practices, books, and records relating to the use and disclosure of PHI received from, or created or received by the BA on behalf of, the CE for purposes of HHS determining the CE's compliance with HIPAA's Privacy Rule
- At termination of the contract, if feasible, require the BA to return or destroy all PHI received from, or created or received by the BA on behalf of, the CE
- Require the BA to ensure that any subcontractors it may engage on its behalf that will have access to PHI agree to the same restrictions and conditions that apply to the BA with respect to such information
- Authorize termination of the contract by the CE if the BA violates a material term of the contract

BA agreements must comply with the new rules by Sept. 23, 2013; however, those that were in place as of Jan. 25, 2013 (and are not renewed or amended thereafter) are granted grandfathered status and deemed in compliance until Sept. 23, 2014.

HHS has also released a new sample BA agreement that reflects the changes made by the HITECH Act and omnibus rule, available at *http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/contractprov.html*.

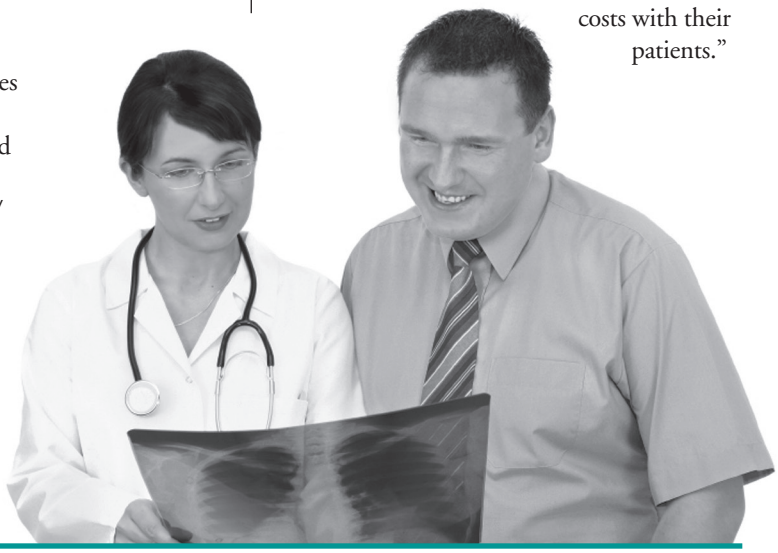
Patients May be Reluctant to Focus on Costs

One proposed initiative to cut health care spending is to get patients involved in weighing costs of treatment options when making medical decisions. A recent study in *Health Affairs* assessed patients' willingness to consider costs when choosing care options.

Following a study of twenty-two focus groups of insured individuals, researchers identified four barriers to patients' willingness to consider comparable lower-cost care options.

- Preference for what patients perceive as the best care, regardless of expense;
- Inexperience with making trade-offs between health and money;
- Lack of interest in costs borne by insurers and society as a whole;
- Noncooperative behavior characteristics of a "commons dilemma," in which people act in their own self-interest despite recognizing, they are depleting limited resources.

According to the abstract, "Surmounting these barriers will require new research in patient education, comprehensive efforts to shift public attitudes about health care costs, and training to prepare clinicians to discuss costs with their patients."



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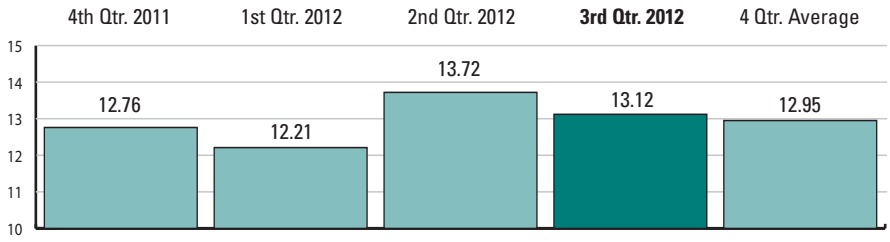
DATA WATCH

Days from Discharge to Bill

U.S. hospitals lopped a half day from the discharge-to-bill (DTB) average in third quarter 2012, submitting claims within 13.12 days. The DTB benchmark is to submit claims within ten business days. The half-day DTB improvement generated a four-quarter DTB average of 12.95 days.



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