

Guiding Principles for Payment System Reform

Commentary on “Achieving Cost Control, Care Coordination, and Quality Improvement Through Incremental Payment System Reform”

William P. Kelly, MBA, MPH; Steven W. Wendt, MBA; Barbara B. Vogel, MS

Abstract: The focus of healthcare payment reform must be on the “value equation”—improving the quality of care while reducing or controlling costs. Adhering to key principles related to value will yield successful payment transformation and result in more coordinated care and improved patient outcomes. Actionable data and information for setting goals and measuring progress is an essential element. **Key words:** *actionable information, coordinated care, cost savings, patient outcomes, payment transformation, quality, value*

FOR CLOSE TO A DECADE, Treo Solutions, a national healthcare business intelligence firm, has been at the forefront of payment innovation and reform. Our payment comments are offered on the basis of our extensive experience in implementing payment changes, which include calculating payment levels, facilitating the link between payment and provider performance, communicating with providers, and maintaining and updating the system once implemented.

Imagine a healthcare system that is patient-centered, focused on improving the quality of care and the “outcomes” for patient service. One that rewards providers for keeping patients healthy and helping them get well. One that encourages coordinated care and controls costs and reduces the growth in spending. General agreement exists that such a sys-

tem, combined with expanded coverage, is the ultimate goal of healthcare reform.

Unfortunately, today’s healthcare system does not coordinate care and control costs. Instead, the existing system is driven by the perverse incentives of fee-for-service payment, which rewards providers for the volume and intensity of services rather than the “result” or outcome of patient care. This has led to a total lack of accountability from any stakeholder to improve the quality or outcome of care or to reduce costs—creating unsustainable growth in healthcare costs.

Most healthcare and public policy experts, Congress, and the Obama Administration agree that health reform is essential and that it must be driven by changes in the payment system, but they do not necessarily agree on the approach to payment reform. We believe that the bottom line of payment reform is fairly straightforward—there must be a fundamental shift to paying for improved patient outcomes rather than paying for volume. Regardless of payer or purchaser of healthcare, the overriding principle of payment reform should be enhancing “value”—that is,

Author Affiliations: *Treo Solutions, Troy, New York.*

Corresponding Author: *William P. Kelly, MBA, MPH, 125 DeFreest Dr, Troy, NY 12180 (wkelly@treosolutions.com).*

improving the quality of care while reducing or controlling costs. If you believe “you get what you pay for,” and we do, the value equation can be achieved only when the financial and clinical aspects of healthcare are directly linked through payment.

The need for enhanced “value” is not a new premise. In fact, the Centers for Medicare & Medicaid Services (CMS) has its own roadmap for value-based purchasing (VBP) that outlines plans for moving from fee-for-service payments for all types of providers and services (e.g., hospitals, physicians, home health and nursing home providers) to payments linked to national performance metrics as well as the incorporation of financial incentives for coordinated care delivery. While CMS and other organizations test different models for VBP—from reducing payments for hospital-acquired complications to medical homes demonstrations projects—leading health plans across the country are engaged in transforming payment systems, with quantifiable results showing enhanced value.

Working with health plans across the nation, we have focused on achieving the value equation in healthcare payment. A number of guiding principles for payment reform have emerged based on our work in payment transformation. These interrelated principles work with each other to build a stronger payment system that improves care for patients, generates both short- and long-term savings in healthcare spending, and enhances accountability for all stakeholders. Our experience shows that these payment transformation principles can yield substantial savings, which can be redistributed and/or invested into creating a more accountable health delivery system that truly focuses on improving patient outcomes while lowering costs.

PRINCIPLE # 1

The motivation for payment reform must be enhancing healthcare value—improving the quality of care while reducing costs.

Payments for healthcare should encourage improved value while inextricably linking pay-

ment and quality. Beyond distributing dollars based on value-driven criteria, changes need to be made in the unit of payment—that is, the unit of service being paid. Existing fee-for-service payment systems reward unconstrained proliferation of services without a link to value. The goal of payment reform should be to pay for units of service, including a bundle of services, consistent with the sphere of influence of the provider being paid and the requirements of quality care. These aggregate payment units could include admissions, visits or annual expenditures, or episodes of care.

PRINCIPLE #2

Reform efforts should be targeted to areas where the return on investment will provide the greatest measurable increase in total value.

Initiatives must focus on those patients and sites of service that cost the most, with resulting savings subsequently invested into value enhancements. Inpatient hospitalizations are the first place to start, with a focus on readmissions and complications as outlined in the pay for performance section of the Averill et al article, “Achieving cost control, care coordination, and quality improvement through incremental payment system reform.”

There are real and quantifiable savings associated with targeting initiatives to maximize value. Recent research conducted by Treo Solutions shows that more than 50% of hospital readmissions can be attributed to only 8% of a health plan’s population. Using a combination of data that groups populations on the basis of health status (Clinical Risk Groups) and potentially preventable readmissions (PPRs), we identified individuals classified as “chronic pairs”—those with 2 chronic conditions—represent 53% of all potentially preventable readmissions within widespread commercial populations.

Once the definition of potentially preventable services is expanded to include physician costs associated with PPRs, key technologies, and emergency department (ED) visits with specific “preventability”

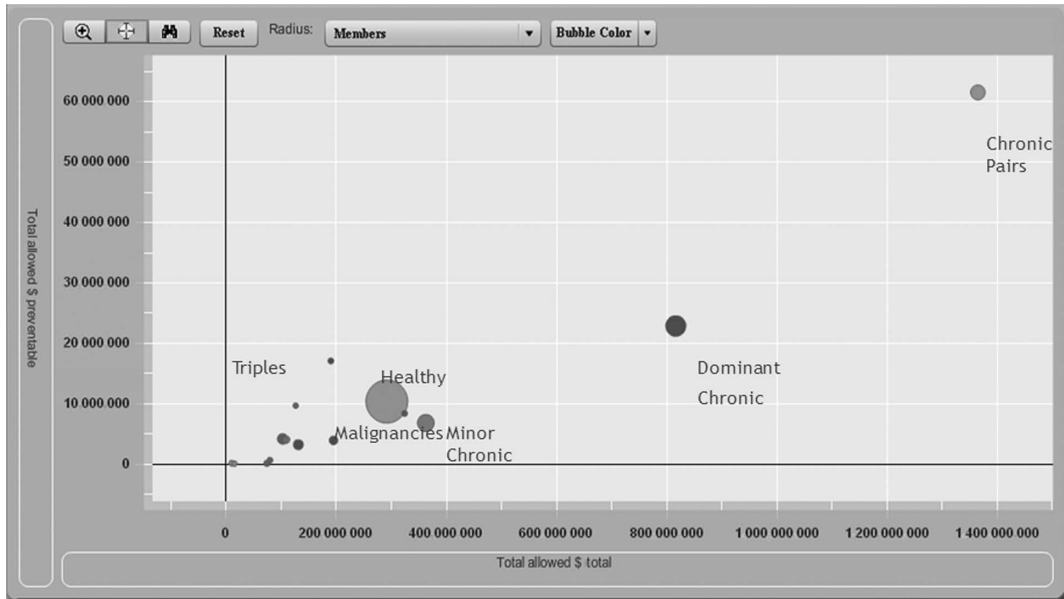


Figure 1. BUBBLES present CRG Health Status Categories: Chronic Pairs: Multiple Dominant and/or Moderate Chronic Disease; Dominant Chronic: Single Dominant or Moderate Chronic Disease; Triples: Multiple Chronic Disease; Healthy; Malignancies: Dominant, Metastatic, and Complicated Malignancies; and Minor Chronic: Single Minor Chronic Disease. The population is individuals from commercial health plans, and the size of the bubbles represent the number of members from the plan.

clinical criteria, our research shows that more than 40% of the costs of potentially preventable services are related to the “chronic pairs” group (see Fig 1). Targeting interventions—including payment and care innovations—for a key population, such as chronic pairs, can achieve significant savings while improving patient outcomes.

PRINCIPLE #3

Payment systems should use categorical clinical models, which are risk adjusted and able to link the clinical and financial aspects of care.

In their article, Averill and colleagues refer to this principle as “the unit of payment should be expressed in clinically meaningful terms to facilitate effective management and clinical response to financial incentives,” but we expand this principle to include the essential element of risk adjustment.

Diagnosis Related Groups (DRGs) were among the first of these models to catego-

rize patients on the basis of resource utilization, but they did not include adjustments to account for patient complexities or severity of illness. Payment tools, such as All Patient Refined-Diagnosis Related Groups (APR-DRGs) for inpatient care, expand the basic structure of DRGs and take into account patients’ severity of illness and the risk of mortality, enabling provider payments to be based on the complexity of a patient’s illness. Payment tools, because they rely on clinically relevant data, form the foundation for linking payment to quality and outcomes. The tools also enable credible comparisons of provider performance, to benchmarks and to other providers, which helps to facilitate communication between providers and payers.

Today, the tools exist to bundle payments, adjusted for severity, for each type of health-care encounter (ambulatory visits, hospital stays, year-long episodes of illness, and post-acute care). Aggregating the unit of service should begin with the ambulatory visit, then move to the hospital stay, and then link these

together into a classification tool describing, longitudinally the patient over a year's period of time. These tools, developed by 3M Health Information Systems, include the following:

- APR-DRGs, as referenced earlier, are more precise with respect to hospital severity of illness adjustment, and can be used to both ensure that payments more accurately reflect the true costs of care and to credibly measure and monitor outcomes and quality (eg, they are the basis for potentially preventable complications and potentially preventable readmissions).
- Enhanced Ambulatory Patient Groups (EAPGs) shift payment to reflect the clinical reason for an outpatient visit, rather than the effort put forth by providers. Similar to DRGs used for inpatient payment, EAPGs provide a product definition for outpatient services inclusive of incidental and frequent ancillary services routinely provided with those services.
- Clinical Risk Groups (CRGs) form the foundation of a population classification system that helps to predict the amount and type of healthcare services that individuals should have used in the past (retrospective) or can be expected to use in the future (prospective). CRGs help to manage financial risk and deliver quality healthcare to individuals on the basis of their needs and health status.

Of utmost importance, the logic behind each of these tools is transparent and open to examination and dispute by all healthcare providers.

PRINCIPLE #4

Public reporting is key to increasing value.

In "Achieving cost control, care coordination, and quality improvement through incremental payment system reform," the authors cite the distribution of provider performance reports as a method to provide consumers

(patients) with information on provider cost and quality, which enables them to make an informed choice of providers. The consumer/patient engagement is important, but we would argue that public reporting of validated outcome metrics goes beyond information dissemination and acts as a strong catalyst for care improvement and value enhancement; thus, this principle should be incorporated into all payment reform initiatives.

PRINCIPLE #5

Actionable data and feedback is important for providers to be able to improve performance.

Financial incentives and rewards for improving outcomes and care coordination are necessary, but, so too is frequent, clear, and actionable feedback. Data that enables comparisons to "risk-adjusted" expected values and to other providers' performance offer the first step in identifying and addressing variances in care and payment. While not directly addressing the point about payment in relation to practice variances noted by Averill and colleagues ("variations in practice should not be perpetuated and payment should be based on national prices with explicit adjustments for legitimate reasons for higher provider costs"), actionable data and feedback provide information to gauge current performance and track progress over time.

Equally important to feedback are initiatives to help providers identify tools and strategies for improvement. The Florida Hospital Association, in conjunction with the Agency for Health Care Administration, has developed a statewide hospital collaborative to reduce hospital readmissions. Through potentially preventable readmission data (which is also published on a consumer Web site) and detailed analyses, hospitals are able to benchmark their performance on readmissions against state averages as well as peer groups. As part of the collaborative, these same hospitals are sharing successes and lessons learned for implementing

effective interventions that reduce hospital readmissions.

Other important principles for payment reform include the following:

- New payment initiatives can and should be built on the existing payer and provider infrastructures.
- While there are many common and critical elements of payment reform, no “one size” solution fits all, particularly in the private sector. Payment reform must offer all payers and purchasers the same parameters and incentives and should rely on common metrics. For health plans, in particular, it is the local dynamics that must drive the configuration and pace of change.
- Fact-based, data-driven solutions must be fair and equitable to all payers, providers, purchasers, and consumers.
- Focus must be on outcomes of care not care processes.
- Transparency is key—the same information and incentives must be available for all stakeholders.

And, finally, a comprehensive strategy is important, but implementation is what ultimately drives success.

These broad, overarching principles form an actionable foundation for effective reform. Without adherence to these key principles, we have found that payment reform will fail to play its central role in facilitating the operational change that improves patient outcomes.

Practical implementation is happening at health plans across the nation—starting with the area for most return on investment in terms of value (inpatient hospitalizations).

EXAMPLE: A LARGE HEALTH PLAN BUILDING THE FOUNDATION FOR PAYMENT TRANSFORMATION

A large health plan with more than 1.5 million members implemented a severity-adjusted DRG payment system to meet its strategic objectives of improving control over cost trends, enhancing the ability to predict and model impact of changes in payment

rates, increasing pricing transparency for customers and providers, and rewarding hospital quality and efficiency. In the initial stages, the health plan decided that these objectives would be met within the existing payment infrastructure, be budget neutral across hospitals, and be developed working closely with hospitals.

The plan began its payment transformation with the implementation of APR-DRGs, replacing All-Patient Diagnosis Related Groups (AP-DRGs). This enabled more precise payments that better reflected the true cost of care based on patient severity of illness. Equitable payment levels across services were achieved by creating payment weights based on hospital costs, instead of charges, or current payment. The plan found that costs provide a more accurate reflection of resources used to provide inpatient care, even including expenditures related to new technologies.

One of the issues faced by the plan was that outlier payments had been substantially increasing. Payment for outliers was also raised as an issue in “Achieving cost control, care coordination, and quality improvement through incremental payment system reforms.” Averill and colleagues recognized, as one principle, that payments should be provided for extremely costly cases/individuals in order to avoid an unreasonable level of financial risk for providers. In its payment reform implementation, the plan used outlier thresholds based on costs instead of charges. An average outlier cost threshold was developed for each APR-DRG, regardless of severity, so that the majority of outliers would fall appropriately into higher levels of severity. As a result, the plan saw decreases in outlier cases as well as outliers as a percentage of inpatient payments, while at the same time it increased the average payment for outlier cases to reflect higher severity and costs. At the end of 2 years, the plan reduced the number of outlier cases from 5.3% to 1.1%, and outliers as a percentage of inpatient payments decreased from 11.2% to 3.8%.

Beyond payment, the health plan now has the foundation for measuring and rewarding

hospital performance and is moving toward payment constructs to reduce rates of admissions for ambulatory care sensitive conditions, potentially preventable readmissions, potentially preventable complications, and the costs per admission.

Additional important principles incorporated into its overall payment transformation plan are transparency of information and communication with the healthcare provider community. One year before the implementation of APR-DRGs, the plan developed a workgroup of hospital chief financial officers to ensure an open channel of communications where ideas could be easily shared and discussed; as implementation grew closer, the plan invited representatives from all hospitals in the service area to participate. To support the dialogue and communication between the plan and the providers, we developed a Web-based environment for publishing documents, tracking issues, and posting other communications. In addition, impact reports were shared with all hospitals, with claims detail reports to enable hospitals to gauge the financial impact of the shift to APR-DRG payments.

With close to 3 years of experience and sound results in inpatient payment transformation, the plan is now turning its attention to making changes in its outpatient payment system using the same communications process with providers as well incorporating the additional tools (e.g. EAPGs) previously discussed.

PAYMENT REFORM: SETTING THE STAGE FOR ACCOUNTABLE CARE

Transforming the payment system through financial incentives to encourage coordinated, efficient care not only results in accountable care but can also help to power and fund delivery system reform. Payment reform—indeed overall health reform—has the potential to improve clinical quality, reduce adverse events and improve patient safety, encourage more patient-centered care, avoid unnecessary costs in care delivery, stimulate investments in effective structural components, and make performance results transparent and comprehensible.

Payment reform will clearly shift more financial risk to providers, and can also result in rewards for both providers and patients. Providers will be rewarded for enhancing clinical care and decision making using clinically credible tools and information to set goals, measure progress, and quantify improved outcomes. Patients will be more engaged in their own care and will have a provider that is assigned responsibility to assist patients stay healthy and improve health in an increasingly complex and technologically advanced medical system.

A great deal of today's health reform dialogue is focused on "building" the foundation for reform. We believe that the foundation currently exists and that payment reform is already driving accountable care among leading health plans across the country.