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FEATURE STORY

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is your organization ready for value-based payment?

Value-driven health care will be an integral part of any healthcare reform enacted in 2010. Here are five ways that providers can prepare for this change and concomitant payment changes.

AT A GLANCE

To prepare for value-based healthcare reform and payment reform, healthcare finance leaders should:

> Evaluate their organizations' competencies related to integration, risk management, and pricing
> Understand value-based payment models currently under study
> Enhance transparency of quality of care and pricing
> Become actively involved in efforts to measure and publish their organizations' quality data
> Establish contracting priorities and initiatives based on stakeholder input

The year 2009 was challenging for hospital financial leaders. Turbulent economic conditions, coupled with public and private scrutiny of the healthcare system, created a perfect storm for payment reform. The key trends driving the movement toward payment reform include:

> Healthcare spending that has drastically outpaced growth in the gross domestic product
> Rising unemployment that has exacerbated the problem of the uninsured and underinsured
> The fragmented delivery system
> The reliance of hospitals and physicians on reimbursement from commercial insurers to offset below-cost payments from government payers
> A lack of broad-scale adoption of IT
> Insufficient clinical integration across the provider continuum

Given the prospects for change, CFOs and other hospital leaders must not only develop thoughtful and appropriate plans to prepare their organizations for healthcare reform, but also determine which internal issues are priorities for their organization to respond to this year. As they set these priorities, healthcare leaders should keep in mind the different models of value-driven health care being piloted by health plans and governments. Following are five steps that will be critical to this effort.

1. Evaluate Competencies Related to Integration, Risk Management, and Pricing

Early evidence suggests that the value-driven approach to health care can significantly improve the quality and accessibility of care while controlling the price of health spending. Changing the way that health care is paid for, however, will change the way care is delivered. Tight integration among providers is needed to accept new reimbursement methods. Hospitals should be prepared to move away from volume-driven to value-added services. As a necessary next step, hospitals should evaluate their core competencies related to clinical integration, risk management, and pricing.

The ultimate success of payment reform will depend heavily on collaboration across the care continuum, especially between physicians and hospitals. To prepare, hospitals should consider their physician strategies, including employment and integration models. The continuum of payment bundling can be correlated to the continuum of the provider organization, as shown in the exhibit on page **II**.

2. Understand Value-Based Payment Models

The current value-based payment methodologies under study by government and commercial payers can be categorized into four major models. Although each has its own distinct advantages and disadvantages, these models collectively represent a positive step in the evolution of healthcare reform.

Reimbursement models continue to evolve toward being more episode-based, with payment

components tied to quality and outcomes. Current payment models have shown signs of being unsustainable in the long term. Although contracts largely use traditional per diem, diagnosis-related group (DRG), or percentage-of-charge methodologies, evolving methodologies encourage clinical integration and enhanced coordination among provider types. To be effective, these models must demonstrate the capacity and expertise to manage the full episode of care and the associated payments, and they must create mechanisms to assist patients to use high-value providers and services.

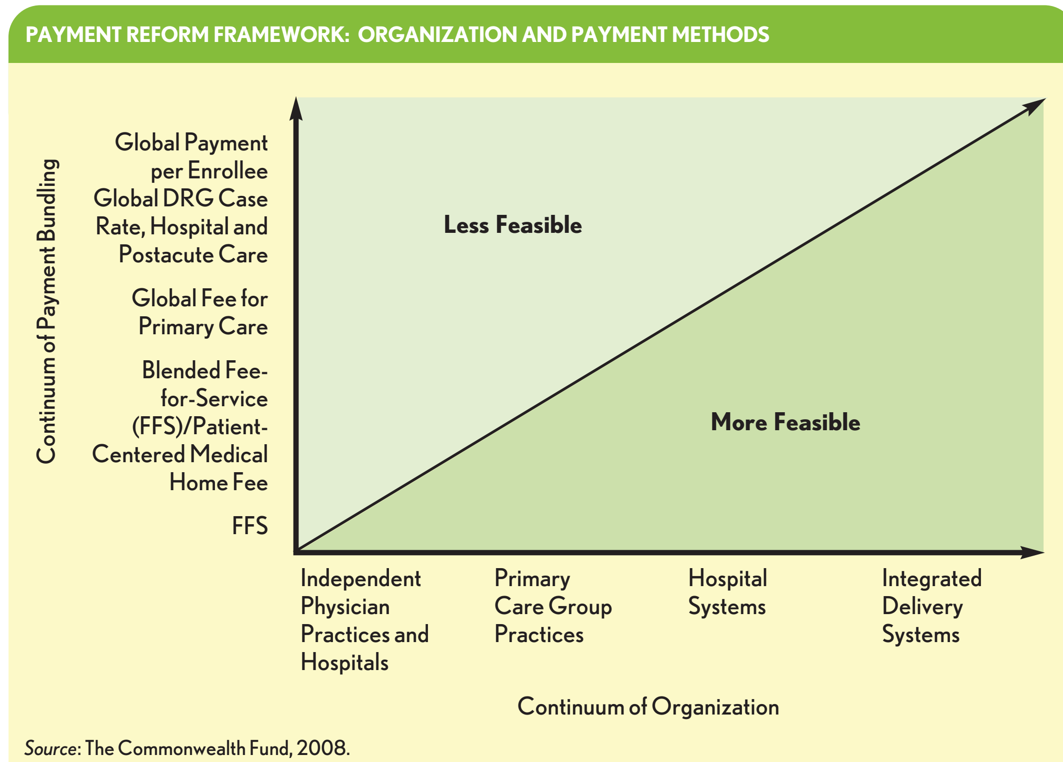
Pay for performance. Pay-for-performance models pay providers based on the achievement of preset quality and performance measures. These programs are designed to align financial rewards with improvement in outcomes. Pay for performance was initially slow to gain traction, mostly because of pushback from providers regarding concerns over the reliability and inconsistency of the data and measures. But this method of reimbursement has picked up steam in recent years, as quality indicators have become more sophisticated and public and private payers have been more aggressively seeking to rein in costs.

Hospitals are expected to incur more financial risk and to be held clinically and economically accountable for what happens across the continuum of care.

In a recent survey of medical groups, 63 percent of survey respondents indicated some level of involvement in pay for performance.[a] Although participation was high, an average of only 3 percent of net revenues in these programs was tied to pay for performance. Health plans typically view pay for performance as one component of their overall cost and quality management strategy.

a. The survey, *2006 Pay-for-Performance Survey*, was conducted by ECG Management Consultants, Inc., and the American Medical Group Association in 2006.

PAYMENT REFORM FRAMEWORK: ORGANIZATION AND PAYMENT METHODS



Source: The Commonwealth Fund, 2008.

Pay-for-performance measures vary from program to program. Most use a combination of measures that may include clinical quality and effectiveness, utilization and cost management, patient satisfaction, administrative involvement, and patient safety. The Centers for Medicare & Medicaid Services (CMS) facilitated widespread physician adoption of pay for performance through its Physician Quality Reporting Initiative (PQRI), which requires physicians to satisfactorily report data on quality measures.

Although pay for performance points us in the right direction by focusing providers on specific measures of quality, safety, and efficiency, the programs are limited in scope and breadth, and they need constant revisions to ensure continual improvement.

Bundled payments. Reimbursement today is based on payment systems that encourage volume rather than value-driven health care. Under the current payment systems, physicians, hospitals, and other providers have strong financial incentives to deliver more services to more people, but often are financially penalized for providing better services and improving health. The "episode-of-care payment" systems under study (such as Geisinger's ProvenCare℠, PROMETHEUS Payment™, and Minnesota Health Reform baskets of care) involve paying a single price for all services a patient requires for a major acute episode, such as congestive heart failure and hip replacement. Hospitals should expect payment rates to grow at a slower pace in the next five years. They are expected to incur more financial risk and to be held clinically and economically accountable for what happens across the continuum of care.

The term *bundled* can be used broadly to include a wide range of payment models. Typically, bundles

OVERVIEW OF VALUE-BASED PAYMENT METHODOLOGIES

Model	Advantages	Disadvantages
Pay for Performance	> Simplicity and clarity > Focused approach produces results on select measures	> Only limited dollars are tied to outcomes > Focused approach limits comprehensive overhaul > Has not typically facilitated hospital-physician alignment
Bundled Payments	> Facilitate hospital/physician alignment > Comprehensive, outcomes-based approach	> Complexity > Organization structural requirements between physicians and hospitals limits participation
Patient-Centered Medical Home/Guided Care Models	> Involve focused management of all high-risk populations > Enhance patient satisfaction > Have shown positive results for both medical expense savings and improved clinical outcomes	> Require major infrastructure investments > Necessitate cross-practice coordination and cultural transformation > Complicate physician compensation in the multispecialty group setting > May negatively affect hospital reimbursement under current payment structures
Risk Sharing	> Facilitates hospital/physician alignment > Aligns financial incentives > Major upside financial opportunity	> Complexity > Infrastructure requirements are significant > Care management sophistication and focus limits participation and success > Has historically lacked clinical outcomes basis > Major downside financial risk

are defined as payments that encompass more than discrete patient encounters, including global and packaged payments. Global payments include payments to several care providers (e.g., hospitals, physicians). Packaged payments are organized based on particular conditions (e.g., diabetes) or particular episodes of treatment (e.g., cardiac surgery, including 90 days of follow up).

CMS is preparing to pilot bundled payments for select conditions beginning in 2013. To implement this program, the U.S. Department of Health & Human Services (HHS) secretary initially must select eight conditions for the pilot program. The program's bundled payment would be made to each participating Medicare provider to cover the costs of acute care inpatient and outpatient hospital services, physician services, postacute care, and any rehospitalizations that occur during that time period. Any Medicare provider, including hospitals or physician groups, would be eligible to participate; however, any entity assuming responsibility for bundled payment would be required to have an arrangement with an acute care hospital for initiation of bundled services.

If the pilot is successful in reducing costs and increasing quality, the HHS secretary would be required to submit an implementation plan in FY16 to make the program part of Medicare in FY18.

MedPAC also notes that bundling payments could produce undesirable consequences, such as underutilization of services on the part of hospitals and the avoidance of certain "low margin" patients (those who require extensive hospital resource use) on the part of physicians.

The Medicare Payment Advisory Commission (MedPAC) has suggested that bundling payments would produce many benefits. For one, it would allow Medicare to pay a set fee per hospitalization episode instead of separate hospital payments (including inpatient prospective payment system [PPS]), physician resource-based relative value scale [RBRVS], skilled nursing facility PPS, and outpatient PPS payments. For another, it would have the potential to improve efficiency and quality, reduce Medicare costs, and better align the interests of hospitals and physicians, particularly in regard to requests for specialty consultations, discharge planning, and the utilization of ICUs and durable medical equipment.

COMPARING THE PRIMARY CARE AND PATIENT-CENTERED MEDICAL HOME (PCMH) MODELS

Current Model	PCMH
Care is episodic and based on illness and patient complaints.	Care is coordinated and focused on a long-term healing relationship.
Providers operate in silos with limited communication.	A physician-led care team takes responsibility for all patient-care needs, arranging for referrals as appropriate. Communication among providers and the patient (and family) is continuous.
Patient is a passive participant with limited say in treatment.	Patients actively participate in decision making, and patient feedback is sought to ensure that expectations are being met.
Practice patterns vary widely according to physician preference.	Evidence-based medicine and clinical support tools guide consistent decision making.
Payment is procedure-based, and volume is rewarded.	Payment recognizes value of care management and communication with patient outside of face-to-face visits. Measurable and continuous quality improvements are rewarded.

Source: NCQA.

MedPAC also notes that bundling payments could produce undesirable consequences, such as underutilization of services on the part of hospitals and the avoidance of certain "low margin" patients (those who require extensive hospital resource use) on the part of physicians. The commission further notes that it would require changes in the way hospitals are reimbursed for readmissions, and would necessitate revision of existing restrictions that inhibit hospitals from financially rewarding physicians.

Patient-centered medical home/guided care models. Many states, payers, and providers are trying to improve the quality of primary care delivery by implementing the principles of the patient-centered medical home (PCMH). According to the National Committee for Quality Assurance (NCQA), PCMH is a model in which each patient has an ongoing relationship with a personal physician who leads a team that takes collective responsibility for patient care. PCMH incorporates five major areas of change from the current primary care model, as shown in the exhibit on page **IV**.

Providers are beginning to see a resurgence of traditional risk contracting.

The exhibit below summarizes the major elements of PCMH that must be implemented to achieve best practices and NCQA standards for PCMH.

Initial studies of PCMH show improved outcomes, care efficiency, and patient satisfaction, prompting commercial and government payers to implement pilots throughout the country to further study the benefits of the model.

Risk sharing. Providers are beginning to see a resurgence of traditional risk contracting and should be mindful of the critical drivers of success and failure associated with previous models.

COMPONENTS OF PMCH THAT MEET BEST PRACTICE OR NCQA REQUIREMENTS

Element	Source—Best Practice or NCQA	Present at practice?
Organizational commitment	Best practice	
IT/e-prescribing	NCQA and best practice	
Clinical integration	Best practice	
Physician commitment and leadership	Best practice	
Support staff	Best practice	
Management of care transitions	Best practice	
Referral tracking	NCQA	
Test tracking	NCQA	
Performance reporting and improvement	NCQA and best practice	
Care management	NCQA and best practice	
Data access/patient tracking and registry	NCQA and best practice	
Access and communication	NCQA	
Patient self-management support	NCQA	
Advanced electronic communications	NCQA	

Many providers that participated in risk-sharing arrangements in the 1990s are now risk averse, while others (although less prevalent) continue to do well under these models. The most important lessons learned from previous risk failures are that providers should only accept risk for care elements over which they have control, and that the patient pool under control must be large enough to mitigate negative financial consequences due to adverse selection.

Further, providers should consider their ability to track and manage these risks. This means working closely with quality and clinical departments to perform careful analyses on areas for improvement, such as readmissions. Hospitals also should analyze how much revenue is lost in the CMS core metrics.

3. Enhance Transparency of Quality of Care and Pricing

Price transparency is an integral component of value-driven health care. It is defined as providing consumers with real-time estimates of their out-of-pocket expenses for recommended medical procedures. It involves disseminating complete, relevant, and reliable information related to the price and quality of healthcare services in a clear and uncomplicated way to allow consumers to compare healthcare services.

Creating positive incentives to motivate consumers to make better decisions about their care will be an integral component of payment reform. Efforts are under way to develop uniform approaches to measuring and reporting price information for the benefit of consumers. Many

OVERVIEW OF VALUE-BASED PAYMENT METHODOLOGIES

Hospitals	Physicians	Health Plans
Physician alignment: Will seek stronger ties to physicians	*Hospital alignment:* Will seek stronger ties to hospitals to mitigate reimbursement/expense pressures	*Membership stabilization:* Experienced membership decreases due to declines in the insured population
Volumes: Will seek to stabilize volumes and grow strategic service lines	*Variability:* Strategies will vary based on size and sophistication	*Competitive discounts:* Respond to employer comparison shopping with aggressive contracting
Quality: Will become more focused on quality reporting, outcomes, and data management	*Small groups:* Will look to maintain and/or increase rates and strengthen ties to larger groups	*Product focus and differentiation:* Will focus on targeted product growth strategies that may span commercial, Medicare Advantage, leased, workers' compensation, and secondary
Service lines: Will differentiate service strengths in the marketplace	*Large groups:* Will get organized around quality and data management and embrace innovative payment mechanisms	*Consistent payment methodologies:* Will streamline methodologies within similar provider types
Cost coverage: Will be more active regarding contract performance, and may be more apt to terminate bad contracts	*Technical revenue:* Will continue to seek opportunities for accessing technical revenue	*Pricing transparency and consumer-directed care:* Will increasingly involve members in making choices to access lower-cost providers
Consistent payment methodologies: Will attempt to streamline methodologies across commercial business		*Payment reform pilots:* Will test innovative care management and bundling models through select pilots
Employed physicians: Will seek to improve financial performance through contracting and revenue cycle		*Medical management:* Will refine medical management policies and procedures
Provider-based billing: Will seek provider-based billing opportunities		*Pay for performance:* Will implement pay for performance and/or increase percentages tied to existing pay-for-performance components

of the nation's health plans are providing select pricing tools to their subscribers on their web sites. In addition, strategies are being developed to measure the overall cost of services for common episodes of care and the treatment of common chronic diseases.

Having this synthesis readily available in an understandable format empowers consumers. Theoretically, informed consumers are more apt to seek the best available care at a competitive price. When enough consumers do this, the entire system will be stimulated to provide better quality and efficiency as the standard. High-quality, efficient health care promotes savings on an ongoing basis, both in terms of patient outcomes and clinical resources used.

Health care is unique among industries because, unlike in other industries, prices for services are difficult to obtain and often meaningless when they are published. The commonly held view is that providers do not disclose the price prior to treatment because they do not want to compete for patients based on price. Providers perceive that because third parties pay the prices and patients are responsible only for coinsurance and deductibles, patients have no reason to care about prices.

The lack of real competition for patients based on price has a profound impact on the cost and quality of health care. The complex system for establishing prices in U.S. hospitals is incomprehensible to the average consumer. From an economic perspective, there is price discrimination in the way hospitals bill and are reimbursed for services due to the inconsistencies from one hospital to the next and the markup and discount variations that exist based on costs. Third-party payers also have their own medical management policies that may be different from what is covered and paid by Medicare. The result is a highly confusing and artificial market.

In the U.S. healthcare market, when third-party payers do not cover certain services, providers do not behave the same as when the services are covered. Consider for example, cosmetic surgery: Patients are offered one global price (hospital and physician fees) covering all aspects of care, which has resulted in price competition and declining prices over the past 15 years.

Ultimately, transparency of pricing and quality of care is a consumer-owned issue, and by virtue of being such, will continue to evolve to meet consumer needs. Healthcare providers should prepare to meet consumers' increased demands for such transparency.

4. Review Your Organization's Quality Data Before It Is Published

Data regarding healthcare quality should be published in a way that is comprehensible. Purchasers of healthcare services are clamoring for payment methodologies that reward quality. To make confident decisions about healthcare providers and treatment options, consumers need quality-of-care information. To that end, employers are demanding more comprehensible information for their subscribers. This information is also important to providers interested in improving quality.

Hospitals should make a concerted effort to address with payers the right to review data thoroughly before it is published. Published information tends to be dated and limited to select services, such as magnetic resonance imaging, CT, obstetrics, and cosmetics. With the emphasis on value-driven health care, cost and quality issues need to be paramount within the organization. The hospital's clinical and finance departments therefore should collaborate to thoroughly review published information. Payer initiatives to publish data also will require amendments or new agreements, which will require involving the hospital's legal department to ensure clauses that affect reimbursement are addressed in the contract and not in the provider manual.

Quality measurement should be based on measures that are developed through consensus-based processes involving all stakeholders. Consumers will use measures to evaluate and assess health

plans, providers, and health facilities if the information provided is comprehensible and relevant to their needs. With the anticipated developments in IT, the potential for disseminating comparative cost and clinical data is even greater. It is imperative that purchasers and policymakers standardize quality reporting.

5. Use Stakeholder Input to Establish Contracting Priorities and Initiatives

Hospitals and other providers will need to make major structural and integration changes to achieve the improvements in healthcare quality and reduction in healthcare costs intended under value-driven payment reform. Ultimately, the ability to make the changes envisioned in both healthcare payment systems and healthcare delivery will depend on the support and engagement of all the stakeholders in the healthcare system.

The Critical Element to Success

Value-driven health care is a collaborative effort that must involve all stakeholders. The right kind of model will improve competition and outcomes. Patients will receive better care, physicians will be rewarded for excellence, and costs will be managed more effectively.

When preparing for health reform and changes in reimbursement methodologies, each provider should address the following questions:

> Are we able to accept new payment methodologies, and do we have the infrastructure to deliver value-added care?
> Are we appropriately aligned with physicians?
> How will new payment methodologies affect our bottom line and drive quality?
> How will payers encourage patients to use high-value providers and services?
> Are there specific strategic service areas we can pilot for innovative programs (e.g., orthopedics, cardiac services)?
> How can we encourage payers to participate with us in new payment and delivery systems?
> How will quality and cost information be communicated to patients and the community?

The right kind of model will improve competition and outcomes.

As a transitional step toward payment reform, hospitals should focus on creating organizational structures that facilitate clinical integration, improve processes for care coordination, achieve broad-scale adoption of IT, and work collaboratively with payers to develop and test new payment methods that target defined and controllable service areas where clear quality and cost improvement opportunities exist.

Providers that take the time to answer these questions now, with input from stakeholders throughout the organization, will be better positioned to enhance quality of care, decrease costs, and protect their bottom line under a value-driven system. ●

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