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payment change

3 ways to set your course for success

Although the success of federal healthcare reform legislation remains uncertain, reform efforts by other government agencies, private payers, and providers will certainly not end. If recent legislation is a harbinger of things to come, providers should anticipate significantly slower spending growth in the future.

AT A GLANCE

Healthcare organizations can take three approaches to preparing for significantly slower spending growth:

- Reflect on lessons learned from past spending cuts
- Chart their course for the payment reform journey
- Learn from early adopters: accountable care organizations

With this in mind, the fundamental question industry leaders are asking is: What should my organization be doing now to prepare itself for a future of significantly slower spending growth?

Option 1. Reflect on Lessons Learned from Past Spending Cuts

The transitions from a cost-based to case-based diagnosis-related group (DRG) reimbursement in the early 1980s and the Balanced Budget Act of 1997 (BBA) reduced Medicare reimbursement by hundreds of billions of dollars. Yet there was a major difference between the two approaches to reducing spending growth.

The BBA simply cut the unit reimbursement trend and did not incentivize or change the way care was delivered. But DRG payment reform did not simply cut unit reimbursement. The DRG case payment replaced the historical cost-based reimbursement system that was yielding double-digit annual increases. The case rate approach greatly reduced the average length of stay and resulted in a major decrease in inpatient capacity within a few years of implementation. Thus, payment changes influenced changes in the delivery model that afforded lower unit reimbursement trends than previously possible.

Fast forward 25 plus years, and payers and providers face an important decision once again: What and how should we pay differently so that we optimize our spending? Will providers and payers choose to wait for a BBA II? Or will they take the lead, and design payment mechanisms that incentivize a more efficient way of delivering care? If recent experience is any indication, an increasing number are pursuing the latter approach.

Option 2. Chart Your Course for the Payment Reform Journey

No one knows precisely how payment reform will play out in the future. However, a quick look outside the healthcare industry and/or the United States brings a few different choices into focus.

Scenario 1. Wait for the government to change payment. In this scenario, providers and payers would choose to wait until the economic and political pressures to reduce spending become too great, and watch the federal (and/or state) government take a hatchet to provider unit payment and more carefully audit and deny payment associated with overutilization.

Scenario 2. Adopt payer/provider payment pilots. In this scenario, payers and providers would not wait for federal legislation to start to change what and how they are paid. Instead, they would pursue an ever-expanding menu of payment pilots, such as medical home bundled reimbursement and pay for performance, in an attempt to slow spending growth. This pilot-driven path appears to be the one most payers and providers are beginning to explore. The problem with the pilot-driven path is that, behind the scenes, dueling medical policies, administrative burdens, and massive cross subsidization of programs would continue to drive providers and payers apart on the core issue of managing unit reimbursement, utilization, and intensity/mix of services to reduce their reliance on 8 to 12 percent annual managed care rate increases. Thus, bolder action is ultimately necessary.

Scenario 3. Pursue an integrated approach to payment and delivery reform. In this scenario, payers and providers would take a lesson their forefathers took in the early 1980s, and systematically design payment mechanisms to promote the creation of a more accessible, efficient, and quality-driven delivery system.

One of the first milestones along the journey would be for payers and providers to expose the massive service level cross subsidization (*not* simply the public-private cost shift) problem at the root of billions of dollars in administrative waste, internal political battles, and misinformed capital decisions that yield mismatches in demand and supply of care. (The exhibit below illustrates a provider cross subsidy matrix.)

Both sides would readily come to acknowledge that the typical hospital makes well over 200 percent of its operating margin from a handful of service lines that subsidize money-losing services, which oftentimes the provider cannot afford over the long term, and the community may not even need. In other industries, manufacturers and distributors resolve these sorts of issues with "cash for clunkers" programs and productivity bonuses, which reward manufacturers to remove excess capacity from the system, optimize productivity of current assets, and/or transform excess physical and programmatic capacity to highest and best uses. These programs force payers and providers to re-evaluate staffing models, case management programs, and off-peak capacity

PROVIDER CROSS SUBSIDY MATRIX

Results	Hospital Cross Subsidy in Action	Physician Cross Subsidy in Action
Margin makers	> Radiology > Lab > Supplies > Drugs > High-end cardiac procedures	> Lab > Injections > Radiology > Crowns > Other ancillaries
Margin losers	> Emergency care > General medicine	> Evaluation and management codes > Procedures
Unintended consequences	> Overinvest in high-end, acute, specialty services > Underinvest in access to primary care, prevention, etc.	> Overinvest in the proliferation of commodity services > Underinvest in access to primary care, prevention, etc.

JOURNEY TOWARD VALUE-BASED PAYMENT SYSTEM™

Current System	Cost-Based, Market-Based System Milestones	Value-Based Payment System Milestones
> "Pay me more" versus "pay you less" rhetoric > Major cross subsidies and cost shifts > Payment success = contractual loopholes + negotiation power > Limited (if any) relationship between price, cost, quality, value	> Awareness of cross subsidies, irrational unit reimbursement, over/mis/underuse of services > Establishment of a method that bases prices on incremental costs and market competitors, and qualitative indicators of value	> Customer first > Payer and providers agree to a "pay me right" method > Managers spend (unit reimbursement, utilization, and mix) strategically > New payment mechanisms such as hospital/physician bundling, 30-day episodic payments, guarantees, and peak pricing that clarify who is accountable to maximize patient value for the incremental dollar

utilization before additional capacity is added. Payers and providers cannot afford to overlook these sorts of productivity improvement opportunities if they are looking to manage lower spending trends.

But attacking cross subsidization is only part of the journey toward lower spending growth. A second milestone in the journey is for providers to understand how payers systematically evaluate current spend, which is captured in a simple formula:

Total spend = Unit reimbursement × unit utilization × unit mix/intensity

Payers are becoming much more payment savvy at reporting unit reimbursement, utilization, and billing behaviors—and uncovering patterns of increased billing (e.g., billing multiple units instead of one) and/or utilization (repeating tests) when unit reimbursement is not increased. Consequently, providers cannot expect to simply increase the units billed or utilization of certain services (e.g., laboratory, operating room minutes, radiology, and injections) to offset unit reimbursement cuts in the future. Nor can providers expect Federal Trade Commission scrutiny to wane—limiting provider ability to consolidate to gain the upper hand at the negotiation table with payers.

Rather, payers and providers need to move from the current "pay me more" versus "pay you less" rhetoric to a cost- and market-based reimbursement system—and eventually commit to transition to a value-based payment system as summarized in the exhibit above.

As the exhibit indicates, the transition to a cost- and market-based reimbursement system entails an awareness of where current prices are most out of line with costs and market. The $500 aspirin (500 times markup of cost) and the $1,000 basic metabolic panel (100 times markup of cost) are two examples of reimbursement not being aligned with cost, market, or value. Until this level of awareness (and ultimate alignment) exists, motivating colleagues to change the delivery model is unlikely because it's easier to bill another unit of an overpriced service than it is to change how care is delivered.

Option 3. Learn from Early Adopters: ACOs

To thrive in a fundamentally lower-cost, higher-quality industry, healthcare leaders will need to move beyond modeling and commit to reforming the payment system to pay on value—including productivity. Healthcare leaders will also need to commit to creating new delivery systems, called accountable care organizations (ACOs), aimed at improving clinical outcomes, care processes, and lower costs for specific patient populations. The transformation of the payment system and delivery system need to happen simultaneously to yield the lower-cost, higher-quality solution most stakeholders seek.

Several healthcare leaders are beginning to use the ACO concept to influence a change in their internal organizational conversations. Historical debates around autonomy, control, and power—which have

been producing far more heat than light—are being replaced by conversations about clinical integration, standardization, quality, incentives, and accountability. Like "going green," ACOs embody the "right thing to do," which is why they are garnering significant attention as vehicles to manage accountability to lower unit costs, utilization, and appropriate mix/intensity of service.

Finance leaders, along with clinical leaders, play a unique role in framing the accountable care dialogue within their organizations. (See the exhibit below.) They need to take the lead in exposing where their current rates are decoupled from a reasonable markup off cost, market rate, and Medicare. They need to provide a vision for how reimbursement and compensation should evolve over time to reward providers for specific quality, access, and efficiency improvements in a manner that puts the patient first. They should selectively pilot ACO payment and delivery model innovations such as bundled hospital-physician reimbursement, shared savings, and no-readmission "guarantees" that change both how care is paid for and how it is delivered.

Fortunately, finance leaders have some early adopters to learn from. Focusing simultaneously on clinical innovation and value for the dollar, these early adopters are sustaining margins with a lower top line, lowering trend, simplifying payment infrastructure and reducing overhead. Geisinger ProvenCare® Model, CMS's bundled payment demonstrations, and some Blue Cross Blue Shield plans' medical home models, are a few success stories that are generating savings and delivery improvements simultaneously. Their efforts illustrate how payers and providers need to work together to transform the delivery model and payment model simultaneously—unlike what has been done in the past. CFOs play a pivotal role in connecting the dots between payment and care, which promises to make the job more rewarding in the future. ●

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FINANCE LEADER'S ROLE IN ACCOUNTABLE CARE

Discussion Area	1990s Model	ACO Model
Medical cost inflation target (versus actual)	8%-12% historical results	3%-5% target
Business model focus	Sustain margin with a higher top line; target managed care rates at 150% of Medicare; push cost/risk to patients	Sustain margin with a lower top line; breakeven on Medicare; manage input unit cost, site of service mix and utilization; pool actuarial risk in a manner that brings significant transparency to the value for the healthcare dollar
Administrative standards/ targets	30% administrative overhead was OK	Drastically simplify today's payment infrastructure, reducing overhead to 5%-10% from 30%
Delivery system efficiency and productivity targets	Consolidation = higher prices	Consolidation = more productivity = lower prices
Pricing and payment tactics	Discount for steerage that never materialized, which reduced capital to invest in cost-saving tactics	Pay for performance is not simply "free money"; it must drive tangible access, quality, productivity improvements; replace pay for performance with out-of-industry tactics such as guarantees, rebates, peak pricing
Payer/provider dynamic—agenda	Payer versus provider versus patient	Payer and provider in collaboration to serve end customer—the patient

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