

Michael E. Nugent

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payment reform complexities to consider

AT A GLANCE

Providers and payers should take the following actions to prepare for imminent payment reforms from CMS and commercial payers:

- > Adopt industry standard value-based pricing principles.
- > Identify variations in costs, reimbursement rates, and payment terms within your managed care contracts and day-to-day operations.
- > Establish core, evidence-based costs and payments to cover those core, evidence-based costs.
- > Adopt new delivery tactics to manage a sustainable margin on lower unit reimbursement increases.

Providers and payers alike are concerned about payment reform—

both how care will be paid for in the future and what healthcare services will be paid for. Although many agree that the current “pay for production” method will be replaced with “pay for outcomes,” each party seems to be waiting for the other one—or the Centers for Medicare & Medicaid Services (CMS)—to somehow deliver the “magic” value-based fee schedule, bonus structure, or capitation arrangement to get reform moving. With few exceptions, both payers and providers seem to be in a waiting mode.

But individual payers and providers cannot simply wait for each other to make the first move. Rather, they need to familiarize themselves with major CMS changes including 30-day bundled readmissions (www.hfma.org/reform), cooperate in an organized fashion to rally around a few core issues, and together begin to implement payment and delivery reforms in their own communities.

Key Barriers to Payment Reform

Providers and payers are hindered, in part, by the immensity of the task.

Provider issues. Consider the magnitude of work providers need to undertake to change what services they are paid for and how they are paid. Most providers have hundreds of contracts with different payers, and the payment methods vary considerably from contract to contract—ranging from cost-based payment to per diems, percentage of charge, and case rates. To complicate matters further, how terms such as *case rate* are used varies among payers, given the myriad proprietary groupers in place for inpatient services (e.g., APR-DRG, MS-DRG, and DRG), let alone outpatient services (e.g., EAPGs, APCs, and ASCs).

To make matters worse, the managed care staffs of even the largest U.S. health systems are contending with constrained resources and spending the majority of their time tracking down unpaid claims rather than standardizing what and how they are paid. As a result, many managed care teams simply move from one payer issue or renegotiation to the next without delving into substantive change, thereby introducing even more variability into what and how they are paid by different payers for the same service.

For example, one provider had literally 100 different ways to be paid for an emergency department (ED) visit for a broken leg. The hospital’s unit payment varied

widely, depending on the payer, for an identical set of services. At the low end, one payer bundled all the services into a single, low payment of approximately \$100, while at the high end, another payer paid the equivalent of \$3,500 for a standard 99283 CPT code once all the ancillaries, supplies, and physician and hospital services were added in. In between, dozens of complex payment formulas and grouping logic were applied by various payers, much of which neither the provider nor the payers could audit or monitor to determine whether the correct payment had been made.

One payer paid all imaging, laboratory, supplies, and pharmaceuticals related to the ED visit payment on a percentage-of-charge basis, with an end-of-year settlement based on costs. Other payers used a tiered payment schedule for the ED visit, whereby they would pay 90 percent of charges for the first procedures performed during the ED visit, 50 percent for second procedures, 30 percent for third procedures, and so on.

The chaos came to a head when the provider attempted to pilot some “next-generation” payment approaches, such as shared savings and bundled

payments, with some of its commercial payers. In doing so, the provider uncovered many instances of overpayments and underpayments from several of its payers. Correcting these errors took so much time that the provider had to put the well-intentioned “pay-for-outcomes” pilots on hold while it dealt with more pressing issues related to the current payment system.

Payer issues. On the flip side, payers also need to undertake considerable work to change their part in the payment system. Many payers have hundreds, if not thousands, of different ways to determine what they pay for and how they pay providers.

For example, one payer had hundreds of ways it contracted and paid for simple lab tests. For tests processed at large reference laboratories, the payer reimbursed those labs a relatively low percentage of Medicare rates in return for “steering” volume from high-cost, hospital-based labs to these lower paid reference labs. For smaller labs owned by physicians, the payer had negotiated hundreds of different prices, from less than 100 percent of Medicare rates to several times Medicare rates, depending on the physician lab and when the contract was last updated. When these lab tests were combined with other services, such as ED services, the payment became significantly more complex and variable, even though the basic cost and resources used to perform the tests were the same. As a result, the payer paid from a few dollars to several hundred dollars for the exact same service, depending on the provider, how the service was billed, and how the service was delivered to the patient.

When this issue came up as part of the payer’s annual rate setting and planning process, value-based payment for lab services received less priority than other, more pressing opportunities to renegotiate rates that had a larger ROI than establishing lab rates that paid for outcomes.

Payment Reform: The Need for Common Ground

The barriers to payment reform, such as lean staff and complex contracts and fee schedules, are quite real. Despite good ideas and even better intentions, neither providers nor payers can change the system

Example: Price Bundling Without Evidence-Based Costs

In a rush to satisfy internal pressures to “go ACO,” a large health system pieced together various facility, ancillary, and professional resources to form an acute care episode “bundle” to encourage specific employers and payers to use its new facility. The problem was that underlying laboratory resource prices were completely out of line with market rates, cost, and Medicare rates. The basic lab resource alone was priced at 800 percent of the Medicare rate. To make matters worse, the team included low revenue-producing supplies in the bundle (e.g., \$1 toothbrushes), which actually cost more to track than they generated in revenue.

The result was not only an overpriced bundle composed of mispriced resources, but also a complex, administratively burdensome fee schedule with similarly complex funds flows to track. In addition, considerable time was wasted adjusting the severity ratings of the bundles. In the end, patients with increasing out-of-pocket payments had no interest in buying the bundled services.

PAYMENT

overnight. Rather, a multifaceted approach to payment reform is needed. Providers and payers should work together to achieve payment reform by taking the following actions.

Adopt common value-based pricing principles. Payers and providers should review two HFMA reports: *Reconstructing Hospital Pricing Systems* (2007) and *Healthcare Payment Reform: From Principles to Action* (2008). In *Reconstructing Hospital Pricing Systems*, HFMA describes several characteristics of a rational and transparent pricing system to guide the national payment reform effort, including:

- > Meaningful, timely, and relevant information
- > Simplicity
- > Comparability of price and quality
- > Ease and equity of administration
- > Equity for providers
- > Defensibility
- > Protection of community benefit activities
- > Fairness to consumers

In *Healthcare Payment Reform: From Principles to Action*, HFMA discusses five principles of a new payment system:

- > Quality
- > Alignment
- > Fairness/sustainability
- > Simplification
- > Societal benefit

These characteristics and simple principles support payment reform efforts by encouraging providers and payers to put patients first and seek ways to reward top providers for strong performance.

Identify cost, rate, and payment term variations within your contracts and day-to-day operations. Payers and providers should work together to review their current contracts and identify which contract language, terms, utilization, and rates are “outliers”—that is, things that would not stand up well to public scrutiny.

Example: Core Evidence-Based Costs and the Economics of an Acute Care Bundle

A comparison at one health system of the current and future economics of one of its more profitable service lines, orthopedics, found significant savings could be achieved using evidence-based costs to improve its margin. The key step was to quantify cost drivers by applying analytics to administrative and clinical data. Using PROMETHEUS, Medicare data, medical records, and registry data, a menu of delivery changes was created to achieve sizeable per case and per diem cost savings that would allow the provider to maintain margins on lower unit payment. The provider was able to arrange favorable managed care contract terms by getting the payers to share claims data to identify opportunities and monitor savings, and to pay a bonus if the provider reduced utilization.

IMPACT OF CHANGES IN DELIVERY STRATEGY ON ORTHOPEDICS SERVICE LINE		
Strategy	Current Economic Status	Future Economic Status
Contribution Margin	25%	15% target
Volume Growth Driver	3% annual historical growth, due in part to new physician recruits	Slower growth, more Medicare, more outpatient business
Unit Payment Driver	8-10% annual unit payment increases	Considerably lower unit payment increases
Cost Driver	Relatively high costs due to avoidable costs and complications	\$5,000 per case savings opportunities if patient falls are reduced, supplies are standardized, length of stay is reduced by one-half day, and certain patients with certain diagnoses are not operated on
Patient Selection/Mix Driver	Emphasis on performing procedures	Emphasis on providing therapy rather than performing procedures
Physician and Payer Strategy	Traditional fee-for-service	Explore bundles and pay-for-performance

For example, they should identify:

- > Huge discrepancies in how payment is calculated for the same service or the amount paid and collected (e.g., charging some patients \$50 and others \$5,000 for the same service, depending simply on what insurance they have)
- > Obvious areas of overuse, misuse, and underuse of resources, such as duplicative tests, excessive inpatient days, and use of high-cost sites of care when lower-cost sites exist
- > Onerous payment and/or prior authorization terms that impede patient care more than they deter abuse

Beyond reviewing their contracts, payers and providers should also analyze their claims data to identify and then quantify the cost and revenue implications of overuse and misuse of resources, and very high reimbursement rates compared with the rest of the market.

Establish core, evidence-based costs and payments to cover those costs, rather than paying for avoidable costs and complications. Providers and payers are increasingly adopting new algorithms such as PROMETHEUS to quantify avoidable costs and complications across the care continuum for particular high-cost episodes. These algorithms are allowing providers to look beyond traditional variable cost-cutting opportunities in supplies and begin to quantify the cost and revenue implications of excessive days, readmissions, complications, and errors. This effort in turn will allow payers and providers to begin to establish core, evidence-based costs to cover particular conditions on a risk-adjusted basis. These analytics also help payers and providers jointly identify specific tactics to reduce avoidable costs and complications over time and share the benefits of lower costs with the purchaser of the insurance and patients. For example, payers and providers are working together to lay out standard protocols for various joint procedures, quantifying the input costs to deliver those procedures, and then putting together a fair and reasonable market-based price and incentive plan to improve both efficiency and quality. See the sidebar on page 3 for details.

Adopt delivery tactics to manage a sustainable margin on payment rates that cover core, evidence-based costs. Payment reform and delivery reform need to occur in a coordinated fashion if payers and providers are to

bend the trend in a sustainable manner that generates adequate margins. Unfortunately, providers are struggling to implement the delivery changes necessary to survive on lower unit payment increases.

Although many are saying they have all the pieces in place to manage under a new payment model, such as shared savings and capitation, in reality, only a few appear to have the delivery system to systematically reduce avoidable costs and complications and in return, reduce the size of cost increases in a sustainable manner.

To illustrate this point, think of the car you drive. The car consists of myriad parts. The parts, however, do not constitute a useful mode of transportation, unless they are configured to specification, tuned, fed, and cared for. But if you put bad fuel in the tank, even the best-configured car will fail to operate properly. That is the case with the current payment and delivery system. Even the best-tuned health systems find that the fuel—payment—gums up the delivery of care, in part due to the incentives it creates.

But payment aside, much of the current delivery system operates as a series of independent components (e.g., physician-hospital organizations, multispecialty groups, primary care physicians, skilled nursing facilities, home health agencies, and inpatient hospitals). Even the most rational payment model (fuel) cannot enable the delivery system to reform itself overnight. Until providers' and payers' finance executives start to reform payment and delivery simultaneously, with a focus on patient and caregiver, payment reform will continue to exist in its own silo, resulting in further fee schedule cuts rather than a major move toward true value-based payment. ●

Michael E. Nugent, CHFP, MBA, is a director, provider practice, Navigant Consulting, Inc., Chicago, and a member of HFMA's First Illinois Chapter (mnugent@navigantconsulting.com).