nrhi Network for Regional Healthcare Improvement

Payment Reform Series | No. 3

The Building Blocks of Successful Payment Reform:

Designing Payment Systems that Support Higher–Value Health Care

Harold D. Miller
President and CEO
Center for Healthcare Quality and Payment Reform

Executive Summary

CENTER FOR HEALTHCARE QUALITY & PAYMENT REFORM

Robert Wood Johnson Foundation

Prepared with generous support from the Robert Wood Johnson Foundation

Executive Summary

Many physicians, hospitals, and other providers across the country are actively working to redesign the way they provide services in order to deliver higher value care and improve patients' health. However, they often find that the current fee–for–service payment system creates barriers to implementing or sustaining better approaches to health care delivery. Consequently, payment reforms must be an integral part of any strategy to create a higher–value health care system and a healthier population.

Criteria for Successful Health Care Payment Reforms

It is unrealistic to expect physicians, hospitals, and other health care providers, no matter how motivated they are, to provide higher value care, to improve quality or reduce spending if the payment system does not provide adequate financial support for their efforts. On the other hand, it is also unrealistic to expect that patients, businesses, or government will be willing to pay more or differently to overcome these barriers without assurances that the quality of care will be improved, spending will be lower, or both. In order to be successful from the perspective of patients, purchasers/payers, and providers, a payment reform needs to be explicitly designed to achieve four separate goals:

1. **Sufficient Flexibility in Care Delivery.** The revised payment system should provide sufficient flexibility to enable providers to deliver care in a way that they believe will achieve high quality or outcomes in the most efficient way and to adjust care delivery to the unique needs of individual patients.
2. **Appropriate Accountability for Spending.** The revised payment system should assure purchasers and payers that spending will:
   - decrease by the amount expected, if the principal goal of the change in care is to reduce spending without harming the quality of care; or
   - stay the same or increase by no more than the amount expected, if the principal goal of the change in care is to improve the quality of care or the outcomes for the patients.

The payment system should hold providers accountable for utilization and spending they can control, but not for services or costs they cannot control or influence.

3. **Appropriate Accountability for Quality.** The revised payment system should assure purchasers and payers that the quality of care and/or outcomes for patients will:
   - remain the same or improve, if the principal goal of the change in care is to reduce spending without harming the quality of care; or
   - improve by the amount expected, if the principal goal of the change in care is to improve the quality of care or the outcomes for patients.

   The payment system should hold providers accountable for quality and outcomes they can control, but not for aspects of quality and outcomes they cannot control or influence.
4. **Adequacy of Payment.** The size of the payments in the revised system should be adequate to cover the providers' costs of delivering the new approach to care at the levels of quality that are expected for the types of patients they see and at the levels of cost or efficiency that are feasible for them to achieve.

Building Blocks of Payment Reform

Each of the four goals defined in the previous section is addressed by one of four fundamental "Building Blocks" in a payment system:

1. The definition of the services that will be covered by a single payment.
2. The mechanism for controlling utilization and spending.
3. The mechanism for ensuring good quality and outcomes.
4. The mechanism for ensuring adequacy of payment.

No design for a payment system or a payment reform is complete until decisions are made about how all of the Building Blocks will be structured, and there are multiple ways to design each Building Block.

Building Block 1: Services Covered by a Single Payment

The more services that are covered by a single payment, the more flexibility a provider has to change the number and types of services they provide to their patients without resulting in financial losses. There are several different options for providing additional flexibility in payment:

Option 1–A: Adding new service–based fees or increasing existing fees. Payment would be made for one or more specific services that are not currently eligible for payment or for specific circumstances in which current payments are inadequate.

Option 1–B: Creating a treatment–based bundled payment for a single provider. A single payment would be made for a group of existing or new services that a provider delivers as part of a particular type of treatment, with no change in payment based on which or how many services from the group are delivered.

Option 1–C: Creating a multi–provider treatment–based bundle. A single payment would be made for a group of services delivered by several different providers as part of a particular type of treatment.

Option 1–D: Creating a condition–based payment. A single payment would be made for addressing a particular health problem, with no difference in payment based on which particular approach to treatment is used.

Option 1–E: Creating a population–based payment. A single payment would be made for all of the services a provider or group of providers delivers to a group of patients for all of the health problems managed by those providers.

In multi–provider bundled payment structures, the less–bundled options (i.e., those with fewer services or providers included in the bundle) can be used as mechanisms for compensating individual providers. The payer would make a bundled payment to one of the providers or to an organizational entity formed by all of the providers. The entity receiving

the payment would then use those funds to pay the individual providers for the services they deliver to patients using a payment/compensation method that reduces or eliminates any barriers they would face to implementing the desired changes in care delivery.

Building Block 2: Mechanism for Controlling Utilization and Spending

There are three basic options for how accountability for utilization and spending can be incorporated into a payment system:

Option 2–A: Adjustments in payment (pay for performance) based on utilization. This would involve a) setting targets for the rates of utilization for specific services, and b) defining adjustments in payments to the provider based on achievement of the utilization targets. Only the utilization of the service would be measured, not the spending.

Option 2–B: Adjustments in payment (pay for performance) based on spending or savings. This would involve setting targets for spending on specific services and defining adjustments to payments based on achievement of the spending targets. This requires the provider to take accountability for the price of services as well as how many and which types of services are used.

Option 2–C: Bundled payment. The target amount of spending for specific services would be bundled into the provider's payment, and the provider would then be responsible for covering any spending beyond the target amount.

The specific measures of utilization or spending used in these mechanisms will depend on which types of services are bundled into individual payments to the provider through Building Block 1. Bundling a larger number of services into a single payment not only provides greater flexibility but also requires providers to control more types of utilization and spending, reducing the need for separate payer–managed mechanisms for utilization/spending control.

Building Block 3: Mechanism for Assuring Adequate Quality and Outcomes

There are three basic approaches for how accountability for quality can be incorporated into a payment system:

Option 3–A: Establishing minimum performance standards. Under this approach, if the provider does not meet a minimum level of performance in delivering a service, there would be no payment, even if the service has already been delivered.

Option 3–B: Payment adjustments (pay for performance) based on quality. A quality–based pay for performance system would involve a) setting targets for performance on specific quality measures, and b) defining adjustments in payments to the provider based on achievement of the quality targets.

Option 3–C: Warrantied payment. If a provider offers a warranty on a service or bundle of services, the provider would be responsible for treating preventable complications or correcting quality problems that occur, with no additional payment from the payer. The total amount of payment for the service or bundle would be designed to cover the costs of preventing quality problems and correcting those that cannot be prevented.

The specific measures of quality used in these mechanisms will depend on which types of services are included in a single payment. The larger the range of services incorporated into a bundled payments, the greater the risk of underuse of services, increasing the need for quality measures to protect against underuse.

Building Block 4: Mechanisms for Assuring Adequacy of Payment

Greater flexibility in payment under Building Block 1 may make it easier to deliver a lower–cost mix of services that achieves better outcomes for patients than is possible under the current payment system. *Flexibility* is not sufficient, however; the amount of the payment must be *adequate* to cover the cost of the new mix of services. Before attempting to design a change in the payment system, a business case analysis should first

be conducted. A key part of this analysis is to project what costs will be under the new approach to care delivery. This analysis can then be used to determine the appropriate amount of payment needed to support the planned changes in care.

The payment system should also ensure that both the *amount* and *type* of financial risk for providers that would be required under the payment system can be successfully managed by the providers receiving the payments. An effective payment system should ensure that *payers retain insurance risk* (i.e., the risk of whether patients have health problems or more serious health problems) and that *providers accept performance risk* (i.e., the risk of whether care for a particular health problem is delivered efficiently and effectively).

There are several options for adjusting payments to ensure they are adequate to enable providers to deliver high quality care and to ensure that providers only take on performance risk and not insurance risk:

Option 4–A: Risk adjustment or risk stratification. A *risk adjustment* system increases or decreases the amount of payment for a bundle of services based on a risk score derived from characteristics of the patient that cause more or fewer services to be needed for that patient. Risk *stratification* defines two or more discrete levels of payment for a particular bundle of services based on different severities or combinations of patient characteristics.

Option 4–B: Outlier payments. An outlier payment is an additional payment made to a provider if an *individual patient* needs services that are significantly more expensive than the predefined amount of payment would cover.

Option 4–C: Risk corridors. In a risk corridor, the provider receives an additional payment if its total spending on *all of the patients* treated under a bundled payment exceeds the aggregate amount of payments it receives.

Option 4–D: Volume–based adjustments to payment. A volume–based adjustment increases the amount of payment for a service if fewer services are delivered or if the service is delivered

by a smaller provider, in order to address the fact that the average cost of delivering services will be higher with a lower volume of services if significant fixed costs are involved in the service.

Option 4–E: Setting and periodically updating payment amounts to match costs. The amounts paid for services or bundles of services are set and periodically evaluated and revised to ensure that they cover the costs of delivering those services.

Multiple options in Building Block 4 can and often should be used as part of a payment system, since each option addresses a somewhat different issue needed to ensure the adequacy of payment for a provider and the appropriate separation of insurance and performance risk. The greater the degree of bundling defined in Building Block 1, the more likely it is that multiple options from Building Block 4 will be needed.

Transitioning to Payment Reform

No one approach to payment reform will be best in every community. The opportunities to improve care will differ from community to community, providers will differ in their capabilities to manage under alternative payment systems, and payers will have different capabilities to implement changes in payment systems. The key is to ensure that if different payment systems are used to support a particular aspect of health care in a particular community, each payment system provides the necessary flexibility, accountability, and adequacy to enable providers to successfully provide high–quality care at an affordable cost. The different options for each building block provide the ability to customize a payment system to a specific approach to care delivery, to the capabilities of the providers who will be receiving the payment, to the needs and capabilities of the purchasers and payers who will be making the payments, and to the unique characteristics of the market in which the providers and payers are located.

In addition, the different options also provide a way to help providers and payers incrementally *transition* from the current fee for service system to better payment models over time. A provider and payer might start with more incremental changes, such as new fees for currently uncompensated

services combined with targets for reducing avoidable services. Treatment–based bundles of services could then be implemented, followed by condition–based payments and ultimately population–based payments.

Providers and payers with greater capabilities to manage bundled payments and accountability mechanisms could move immediately to more advanced steps; other payers and providers could work to develop those capabilities while still paying and being paid in a way that overcomes the barriers to better care.

Alternative Ways of Structuring Payment Systems and Transitioning to Different Systems Over Time