Alternative Payment Models:
Warranties Reward Quality the Right Way

The healthcare marketplace has struggled for years to manage the tension between payment for healthcare services and the quality of care delivered. In fee-for-service arrangements, poorer quality is financially rewarded due to the need for additional services. Capitation also rewards the delivery of poorer quality care because margins increase as fewer services are delivered.

The lack of transparency and the complexity of evaluating and communicating value to healthcare consumers has prevented the traditional market forces of supply and demand from resolving this tension. As a result, payers have attempted to manage it through programs like pay-for-reporting, pay-for-process, and pay-for-performance. These efforts have proven counterproductive or, at best, ineffective. Payer-driven quality initiatives have been add-on programs that attempt to patch deficiencies in the payment structure rather than organic approaches that tightly couple incentives for quality with the underlying payment system.

This tension continues to challenge the implementation of alternative payment models. The vast majority of these efforts are relying on the same quality metrics and quality incentive approaches that have met with limited success in past initiatives. However, incorporating properly constructed healthcare warranties into alternative payment models offers a clean and powerful resolution. The reward for high quality and the penalty for substandard quality is built into the standard provider payment.

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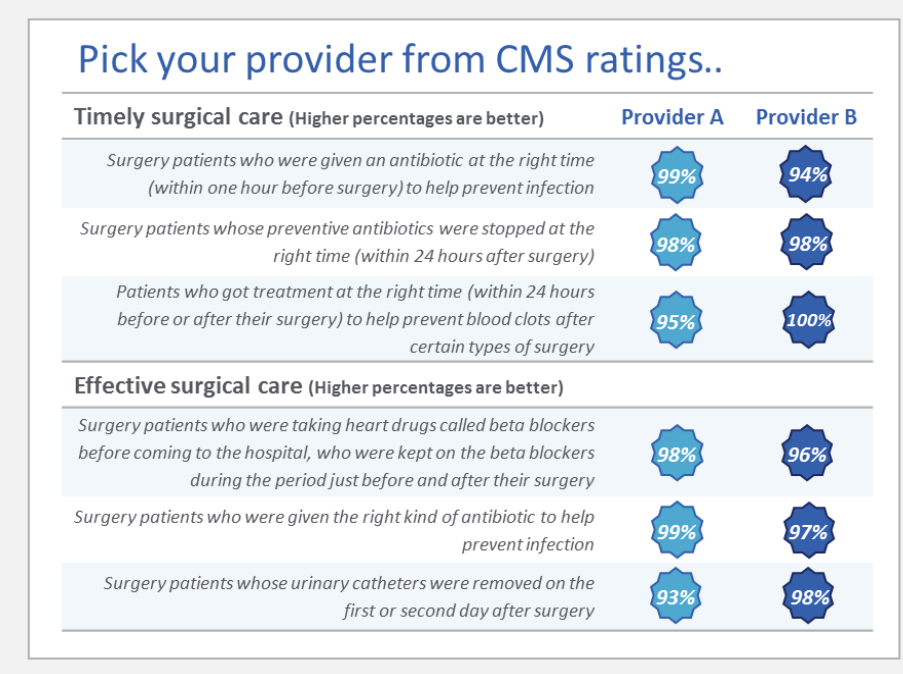
Limitations of traditional market forces

In non-healthcare markets, the tension between price and quality is managed through supply and demand. Information about a product is available to potential purchasers. An internet search about virtually anything from toasters to cars to restaurants can reveal insights into the quality of a product or service. Information from trusted sources can be consolidated into terms that consumers can readily interpret and use in their decision making. Consumers, therefore, are very unlikely to purchase poorer quality goods or services when higher quality goods or services are available at a lower price. As a result, economics provides pressure to align price and quality.

The intrinsic complexity of healthcare prevents these market forces from substantially influencing the alignment of price and quality. To have a positive influence, information available to patients must communicate understandable and credible information about measures of quality that matter to them. Unfortunately, there are numerous quality measures and assessment methodologies that are almost impossible for industry professionals, much less patients, to reconcile. For example, CMS Hospital Compare, the government's effort to provide healthcare quality transparency, offers over 200 different measures of provider quality. Professional opinion surveys, process measures, structural measures (e.g. residency programs, nurse per patient ratios, trauma center levels), and outcomes measures alone or in combination are prevalent in public reports of healthcare quality.



Unfortunately, an overwhelming number of metrics that often contradict each other undermines the credibility among patients. Patients rarely know how much they should care about the percentage of patients that receive a beta blocker or ACE inhibitor or if the fact that their hospital has a residency program matters to them. And if so, how should they interpret the results on those measures against rates of adverse outcomes like readmissions? Further, different adverse outcomes like stroke and pulmonary embolism are both clearly undesirable, but it is difficult to understand how to interpret them when one rate is higher than average and the other is lower than average.

Organizations like MPIRICA have taken significant steps in consolidating and simplifying reliable quality metrics that matter to patients into understandable and actionable reports. However, until these valuable resources are recognized by patients as valid, the economics of consumer-driven healthcare will fail to reward high quality care.

Traditional quality incentive programs

In the midst of this market dysfunctionality, where payment systems have created perverse incentives, payers have attempted to created programs that reward high quality care. After establishing measurements of quality, these efforts essentially fall into two categories: programs that penalize substandard quality and programs that reward high quality.

In establishing quality standards, payers have been exposed to the same convoluted space of healthcare quality metrics confronted by patients. Payers' programs generally have concentrated on reporting measures, process measures, and outcomes measures. Reporting measures focus on the collection of data that may be useful in subsequent analyses of quality, in the hope that encouraging the collection of data about quality will increase provider awareness and performance. While the data collected may have some future value, there is little evidence that providers with high reporting rates demonstrate low rates of adverse outcomes.

Process measures act as surrogates for outcomes measures, tracking the adherence by a provider to processes of care that are generally believed to

result in good patient outcomes. Unfortunately, adherence to a process may not translate directly to the desired outcomes. Correlations between high scores on process measures and low rates of adverse outcomes are weak. Additionally, when there are uniformly high rates of adherence to specific processes among providers, the utility of measuring these processes is questionable.

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Outcomes measures have the most direct association to high quality care and have the greatest relevance to patients. A patient probably cares much more about whether or not they are likely to have a complication of care than whether their provider consistently reports data or whether they were given an aspirin on admission. However, outcomes measurement is more complicated and, unlike reporting measures and process measures, requires risk-adjustment to account for patient characteristics that may influence the outcome of interest but are outside the control of the provider.

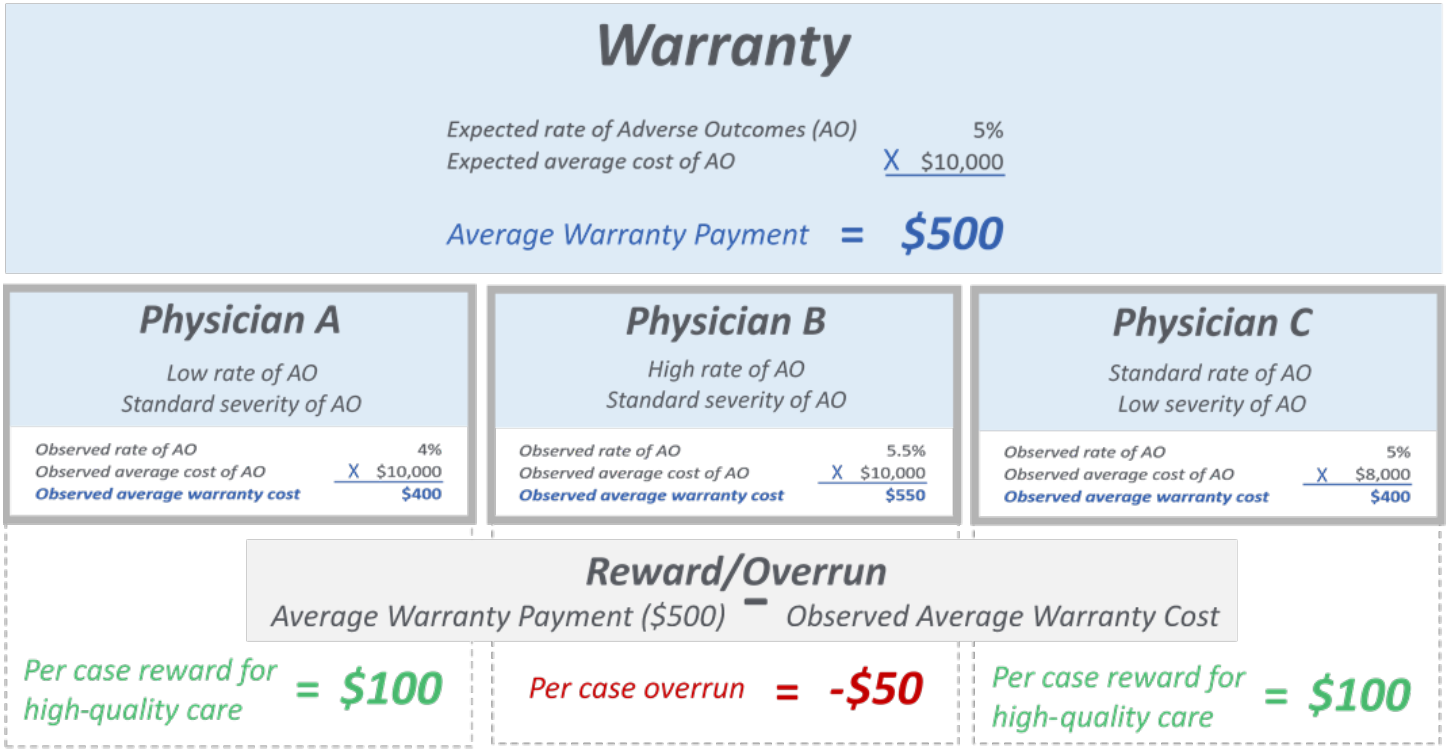
There also are a wide variety of adverse outcomes that can be measured. Programs that select a limited subset of outcomes to measure risk misaligning incentives by focusing attention on what is being measured without accounting for performance issues in areas that are not explicitly being measured. An additional challenge is the identification of an adverse outcome. Some, like death and readmission, are objective and easily measured. Others, like surgical site infection rates, rely on coding that may be defined differently by different coders or providers contributing data and is subject to manipulation by selecting a "definition" most favorable to a provider.

Payers have imposed penalties on providers that fail to meet quality standards by imposing fines or claw backs and through member steerage. CMS fines hospitals with high rates of readmissions for some conditions, and likely that list will be expanding. Other programs use quality standards as a basis for entry into narrow networks. Increasing member out-of-pocket cost for care at identified substandard providers drives volume away from those entities and to identified higher quality providers.

In addition to the benefits to high quality providers of steerage, payers have also offered direct financial incentives. Payers have based these incentives upon the absolute achievement of a quality score, upon the improvement of a score, upon per case conformance to practice guidelines, or upon some combination of these. Rewarding absolute achievement recognizes providers that demonstrate high quality, but provides little incentive for improvement by providers that are currently below the best practice standard and are not yet in striking range of the threshold. On the other hand, rewards for improvement are meaningful for substandard performers but may be viewed as unfair by high quality providers that are already operating near the upper limits of performance.

Payers, patients and providers would likely all agree that maximizing quality of care is a worthwhile pursuit. However, the current use of all-or-nothing thresholds as the basis for administering penalties or rewards is not an approach that provides much incentive to this end. Once the threshold is passed and the penalty avoided or reward secured, there is no benefit to further improvement, especially if that improvement required additional investment of resources that may not be readily available. As providers well know, performance measures are also subject to the effects of random variation. These thresholds may fail to recognize quality providers who fall just short of the threshold due to random events in patient care. And for those lower quality providers who don't see a manageable change in care process that will lift them above the threshold, they may be resistant to investing any additional resources in quality improvement.

Traditional payer-driven quality initiatives represent supplemental programs introduced to counteract deficiencies in the payment system. As a result, the quality measurement and incentives may conflict with the financial incentives of the underlying payment system. Depending on the program design



and the magnitude of the rewards for good quality or penalties for substandard quality, providers may focus their efforts in specific areas at the expense of other areas (effectively "teaching to the test") or ignore the quality initiative altogether. The magnitude of the rewards rarely mirror the benefit of the quality a provider achieves. In addition, rewards must be funded either through the introduction of new dollars into the system or the withholding of funds that are later redistributed. Finally, these programs carry an appreciable administrative cost.

The Healthcare Warranty

The introduction of alternative payment models like bundled payments provide a structure in which a warranty can be incorporated into healthcare payments in much the same way as they are into commercial products. The concept of a warranty is very familiar. Warranties come standard with virtually every product we purchase and, unless we are buying an extended warranty, their cost is built into the sales price. In its most basic form, the warranty cost is computed by determining the defect rate and multiplying it by the expected cost of repairing the defect.

Healthcare warranties can be computed by determining the rate of adverse outcomes and multiplying that rate by the expected cost of treating those adverse outcomes. The resulting warranty cost can be folded into provider payments in the same way it would be in a commercial product like a microwave. The provider receives one payment in which the payment for services and the warranty payment are lumped together.

The warranty provides a powerful incentive for high quality that eliminates much of the need for traditional payer-driven quality initiatives. The rate of adverse outcomes built into the warranty establishes the target quality standard and the expected cost of treating those adverse outcomes establishes the target standard of adverse outcome severity. Providers that deliver high quality care that results in a lower rate of adverse events or less severe adverse events will spend less money than they are being paid by the warranty to treat those adverse events. As a result, these providers will make money and they will always have an incentive to improve because they keep any additional savings they generate.

Substandard providers who have high rates of adverse outcomes or more severe adverse outcomes than the standard will pay more for the treatment of their adverse outcomes than they collect on the warranty. These providers will be penalized in the form of cost overruns, but they will always have an incentive to

improve because any improvement they can make will reduce their overrun.

Because the warranty is built into the core payment, it provides protection against underutilization. Providers that reduce utilization too much in an effort to cut costs and increase margins will experience increased rates of adverse outcomes and more severe adverse events. As a result, these providers will be penalized by the warranty.

Healthcare warranties should always be based upon objectively defined outcomes of care that are holistic in nature. Since outcomes may be influenced by patient characteristics beyond the control of providers, appropriate risk-adjustment is essential. Payers or providers seeking to take advantage of healthcare warranties should work closely with experts in risk-adjustment and warranty design.

Properly designed and implemented healthcare warranties offer a compelling alternative to traditional payer-driven quality initiatives. They eliminate administrative burdens of traditional programs while rewarding the delivery of high quality care and providing strong incentives for meaningful quality improvement. These warranties reflect the fact that the same care that drives price drives quality and resolve the tension between price and quality. Also, when properly constructed, they solve the problem of funding the reward system since the financial benefit to a provider comes directly out of the savings they achieve.

For more information about healthcare warranties and how your organization can benefit from their incorporation into alternative payment models or shared savings arrangements, contact us.

For over 15 years, MPA has worked extensively with episodes, global fees, and bundled payment designs. We have found that this framework for bundle design is robust and translates easily across the spectrum of surgical and medical bundles. This approach to bundled design also provides a strong foundation for the evolution of bundled payment.

Please contact us to learn more about how to win with bundles, or about our enhancements of this bundle strategy to address concurrent bundles, transfer pricing, site of service, and high level appropriateness.

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