

# Quality- and Severity-Based Payment: Will You Receive What You Earn?

**P**ay-for-performance programs that call for healthcare providers to meet external quality metrics are being proposed by the Centers for Medicare and Medicaid Services and other payers in order to increase the value of dollars spent on health care. While linking payment with the quality of health care may be a laudable goal, such programs have the potential to test the relationships between hospitals and physicians and unfairly penalize hospitals for factors that are beyond their control. In the following article, HFMA, with sponsorship from 3M Health Information Systems, asks five industry leaders to share their thoughts about what pay-for-performance programs may entail, how these programs and severity-based payment adjustments may affect their healthcare facilities, and strategies healthcare organizations should employ to best prepare.

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## What is your understanding of the relationship between severity/mortality risk adjustment and performance measurement on healthcare payment systems?

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**Weymouth:** My understanding of the current severity/mortality risk measurement system is that it was originally established as a single body system measurement tool. The problem is that, in many cases, it is not reflective of the care that we deliver, which is multisystem, multidimensional, and more intense than it has been in the past. Thus, it is not effective for basing payment because it does not capture a genuine level of treatment in the assessment.

**Yates:** At present, DRGs themselves may not be indicative of everything that goes on with a patient. One patient may be classified in a single DRG but stay in the hospital only one or two days and use very few resources, but another patient in the same DRG may be in the hospital for five or six days and make use of many more resources. Part of what CMS is looking to do with severity/risk adjustment and pay for performance, in my understanding, is to find a way of capturing the differences among patients. The goal is adjusting payment so the care of a patient with lower resource utilization is paid at a lower rate of reimbursement than is the

care of a patient with higher resource utilization without rewarding a facility for whatever complications might have occurred during the patient's stay.

**Strack:** I see hospital quality incentive demonstrations as a chance to level the playing field. I'm from a non-CON (certificate of need) state, so, as an example, I have cardiologists who want to build a heart hospital right in my backyard to capture the most lucrative services while my community hospital has a disproportionate share of the poor and medically indigent patients. I get the sense that the federal government has said, 'Just because you're a heart hospital doesn't mean you should get the higher-based DRGs (that pay at increased rates) than Clark Memorial Hospital, which isn't a heart hospital, because patients can get good care in both places.' I see these programs as a way of saying to hospitals like Clark Memorial that payers are not going to give a payment advantage to some other institution.

**Price:** At first blush, pay for performance sounds like a great idea—reward providers for quality—because we want to promote high-quality health care. But what worries me is that we will have a whole new system of cherry-picking. It's easier to provide high-quality care to people who aren't as sick, and I worry that many hospitals will take only the

‘healthier’ sick people so the performance measures that their payment will be based on will look better. Then you still will have the other hospitals that take the sicker people. The quality of care provided by these hospitals may be just as good, but their outcomes won’t appear to be as good.

**Yates:** When you look at CMS demonstration projects in particular—and I suspect projects by managed care organizations will be the same—they are not pay-for-performance plans. These programs really impose a penalty for failure to perform, because a payer will not say, ‘I’m going to give you an extra 5 percent or 10 percent in payment if you perform above x line on these metrics.’ The payer will say, ‘If you don’t perform above x line on these metrics, I’m going to take away 5 percent or 10 percent of your payment.’

**Rothermich:** To link payment to quality, one must be able to account for the variations between patients that are not related to the quality of care provided. These factors include the differences that exist in the demographic and underlying clinical conditions that patients present upon admission to the hospital. Multiple, severe conditions that interact together contribute to an increased need for health-care resources and an increased risk of complications or death. Adjusting for patients’ underlying severity of illness and risk of mortality helps ensure fair and accurate performance comparisons. It also helps us get closer to measuring actual differences in the quality of care provided. Severity and risk adjustment is a critical and foundational step in moving toward linking performance and payment.

#### PARTICIPANTS

**Mandy Lynn Price, FHFMA**, is CFO, Nemaha County Hospital, a 20-bed critical access hospital in southeastern Nebraska, and a member of the board of directors of the Nebraska Chapter of HFMA.

**Kirk W. Strack, CHE**, is vice president of finance and CFO, Clark Memorial Hospital, a 241-bed county hospital in Jeffersonville, Ind.

**Deborah K. Weymouth** is senior vice president of operations and CFO, Thompson Health, Canandaigua, N.Y., which includes the 113-bed F. F. Thompson Hospital and 188-bed M.M. Ewing Continuing Care Center.

**Thomas W. Yates** is vice president of finance, Baylor Jack & Jane Hamilton Heart and Vascular Hospital, Dallas. Baylor Heart and Vascular Hospital is a 50-bed joint venture between 50 physician partners and Baylor University Medical Center.

**Cheryl L. Rothermich, RN**, is a clinical analyst with 3M Health Information Systems’ Clinical and Economic Research Group and specializes in severity and risk adjustment, healthcare quality measurement, and the 3M APR DRG Classification System.

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#### If pay-for-performance and severity-based payment systems are implemented, how will they affect your hospital or healthcare system?

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**Yates:** The impact is thus far unknown, because we really have to understand what payers are going to measure. I think right now physicians and hospitals are still in the mode of, ‘We need to make sure we’re doing exactly what we think is best for the patient, and address the performance measurement issue at a later date.’ Until we know how payment is going to be adjusted, we cannot know what the financial impact on the hospital will be. Until incentives for hospitals and for physicians are aligned, the impact is, in many respects, out of our hands.

**Price:** What really measures quality? What measures need to be adjusted for severity of illness or risk of mortality? Process measures don’t need to be adjusted, because a patient fits the criteria or he doesn’t.

**Yates:** When you look at the performance metrics that are on the table, the question is, do they really indicate performance? The performance metrics that are being used in demonstration projects tend to focus on physician compliance with protocols. One of the reasons our facility is successful is because our physicians have an incentive to adhere to quality metrics. The physicians become advocates of evidence-based medicine, resulting in the highest quality metrics, the highest patient satisfaction metrics, and the highest employee satisfaction metrics. The challenge arises when physician incentives are not aligned with the facility’s needs, and it becomes very difficult to get physicians in line to follow those metrics.

**Rothermich:** One early and fundamental impact of severity-based payment and/or pay for performance is the need for hospitals to address the accuracy and completeness of the data that are used to represent the clinical complexity of their patient mix, and ultimately to determine payment. Comprehensive documentation and coding of a patient’s underlying conditions that contribute to the care provided in the hospital are required to adequately capture and reflect the severity of illness driving resource consumption and the level of risk for complications and mortality. In severity-based payment systems, underreported factors contributing to severity of illness may result in lost revenue. In pay-for-performance systems, underreporting of factors contributing to a patient’s severity or risk of mortality may result in inaccurate comparisons and inflated negative outcome reports.

**Provisions of the Deficit Reduction Act will require hospitals to begin collecting data by October 2007 on which diagnoses are present on admission. By October 2008, the treatment of some conditions that are considered to be high in volume, high in cost, and hospital-acquired will not be paid for if they are not present on admission. What impact will this have on hospitals?**

**Yates:** I believe that the logic in this incentive system is entirely misplaced. Incentives to keep people out of the hospital through preventive care and/or improving the overall health status of the entire community are not addressed. Currently we are treating the obese, smokers, and patients with other risk factors who haven't been accountable for their health care or their health status.

**Strack:** I'm very nervous about the future if payment is going to be based on factors I may not be able to control. Indiana is a leading state in the number of people who smoke. Will hospitals bear the responsibility for outcomes associated with poor lifestyle choices? What if a patient comes in with pneumonia and then suffers a stroke, and the payer says the stroke was acquired in the hospital? Where does it stop? This may be an exaggeration of the system, but the point is that patients are not necessarily accountable for their own health because most don't pay for health care in the true sense. My sense is that payers are looking for a way to pay providers less. Not necessarily the physicians, but the hospitals are going to suffer significantly from a plan like this. These sorts of systems are going to press on critical access institutions in particular. I don't know how a financially distressed hospital will be able to provide high-quality care if it can't make the payroll. I believe hospitals will teeter on the brink of financial insolvency or disappear.

**Yates:** Right now, the focus is on penalizing one portion of the industry. There is a lot of discussion about physician-owned specialty hospitals, but none about ambulatory surgery centers or other physician ventures. Payers are completely excluding one part of the industry and focusing on another. That's the problem with the system. The system picks one piece of the industry and goes after it because it is the biggest bucket in terms of utilization and cost.

**Rothermich:** My understanding of the intent of the Hospital Quality Improvement section in the Deficit Reduction Act is to address some misaligned incentives in the current payment system related to hospital-acquired infections. The plan calls for the discontinuation of a higher payment for specific conditions conditions, yet to be defined, that that are not present on admission, were acquired in the hospital, and could reasonably have been prevented. This will require

hospitals to assess, document, and indicate in the coded medical record the conditions a patient has present when admitted in order to avoid the condition being defined as "hospital acquired." Defining the predisposing risk factors and whether the condition could have been prevented will need to be key elements to the implementation. Yes, this particular aspect of the plan could be described as a 'disincentive' for poor quality when compared with some other demonstrations that reward high-quality care.

**What recommendations would you give to other hospitals to prepare for pay-for-performance or severity-based payment?**

**Price:** I would try to make the hospital/physician relationship as minimally adversarial as possible. When you're building relationships with physicians or physician groups, try to make them partnerships, even if there isn't necessarily an ownership or a monetary tie-in. Try to get everybody on the same page, because physicians need a place to admit patients, and if you go bankrupt, what will they do? In the future, we will need to have a partnership, a marriage between the physicians and the hospital. We need to cultivate that better than we have in the past.

**Weymouth:** We hired hospitalists several years ago to align incentives with members of the medical staff. We now have a concurrent coding program so all patients get a working DRG and an assigned length of stay when they come in. The only way we could have control over a program like that was to hire hospitalists and give them clear and specific deliverables.

The issue we did not envision was the disconnect that would occur with the nonemployed physicians in the community. The physicians had no reason to walk in the door of the hospital every morning. They expanded their office hours to see more patients. In the past three years, the disconnect has continued to grow because the nonemployed physicians in the community have not been in the hospital



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on a regular basis. We are now at a point where the physicians in the community are feeling disconnected because they have not been a part of the hospital process for a while.

**Yates:** In addition to finding a way to work with physicians, we will need to find out what it really costs to track all these performance metrics. I don't know of any information system that will handle all the registries that are required. We're dealing with PCI (percutaneous coronary intervention) and ICD (implantable cardiac defibrillator) registries now, and it's such a huge effort that I have to get an extra full-time equivalent just to gather the data. In the pay-for-performance environment, I think you have to be open-minded enough to say, 'Maybe it is worth an additional employee's salary to help potentially save a million dollars' worth of payment.' I think healthcare executives need enough vision to be willing to either invest in information systems or invest in the personnel required to make sure their hospital is capturing all the data and reporting on all the performance indicators possible.

**Strack:** I view these systems as unfunded mandates. We talk about the electronic health record and how it will benefit health care, but we don't have the money for it. Eventually, however, the federal government will say every hospital will have to have an electronic health record. This is very much the same thing. We will go to a pay-for-performance system and see that there is a tax, so to speak, for making it work. And we'll pay it, because we have to.

**Rothermich:** Invest in your data and involve the physicians in improving the quality of the documentation and coding that ultimately represents the clinical complexity of their patients. Generally, hospitals are out to provide high-quality care and accomplish that goal. Often they don't get credit for the increasing difficulty and risk of treating the patients who are hospitalized. When a physician's quality measures are presented as lower than expected, or a hospital is attempting to explain why its length of stay is higher than the hospital down the road, what is often the first

stated reason? "My patients are sicker." When physicians understand the link between accurately capturing the severity and risk of their patients and the results of performance comparisons, they are ready to get on board. Whether it is severity-based payment or linking payment to performance, the key is to get credit for the complexity of the patient mix for which you provide care. In addition to being represented accurately, you will have better information with which to identify real opportunities for clinical quality improvement.

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**What kind of help or assistance do you as a CFO need to respond to these types of incentives?**

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**Yates:** In addition to getting more clarity regarding the direction payers want to take, many unresolved issues are not strictly hospital-related. Work needs to be done to encourage a sense of responsibility on the part of the American public, both financially and physically, for their health and their health care. Only when we realize that kind of responsibility and link physicians and hospitals together, will we succeed.

**Price:** Maybe I'm being naïve, but I don't think most of us work in a hospital to make a bunch of money. It's about the mission of the institution. And for most of us, if you tell us we're doing something wrong or we need to do better or that our patients are not getting well fast enough, we want to fix it. So fine, ding us once on our payment and then tell us what we need to do, and we'll do our darndest to fix it. But we have to have something to go on. Payers can't just keep slapping our hands and telling us we need to do better but not tell us what better is.

**Weymouth:** I came up with the five A's we need help with. *Access:* Who gets help, who gets care when, where, and how. *Accountability:* Who is accountable for care? *Alignment:* How do we align incentives within that framework? *Availability:* Who is available to help us? My last A is *All*. We're *All* in this together, and we need to answer the fundamental question: What will best serve our communities?



## Health Information Systems

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