

Evaluating and Negotiating Emerging Payment Options

This “how-to” manual is intended to help physicians who are considering transitioning from fee-for-service payment to risk-based reimbursement. It covers the nuts and bolts of payment systems based on a physician’s ability to stay within a specified budget for health care services provided to a specified population, including shared savings, bundled payments, pay-for-performance and capitation. This manual describes the steps physicians will need to take to make these payment systems work for their practices, and covers the concepts more commonly associated with health insurance than physician payment, including, “actuarial soundness,” “risk adjustment” and “risk mitigation,” the mastery of which is necessary to the successful navigation of risk-based contracting and revenue cycle management.

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Introduction: Evaluating and negotiating emerging payment options

Catherine I. Hanson

The health care delivery system in the United States is undergoing a paradigm shift with regard to physician and other health care provider reimbursement methodologies. In an effort to control the growth of health care costs, risk-based reimbursement methodologies are slowly replacing fee-for-service as the predominant means through which physicians and providers will be paid. AMA has many excellent resources which discuss the reasons for and policy implications of this shift and potential physician responses, including the excellent monograph entitled “**Pathways for Physician Success Under Healthcare Payment and Delivery Reforms**,” by Harold D. Miller.

The purpose of this resource is simply to help physicians who are considering transitioning to one of these emerging payment models, whether by choice or payer request, by providing the nuts and bolts information they will need to evaluate the proposal, negotiate an agreement, if appropriate, and manage the revenue cycle associated with any emerging payment model to which they are ultimately subject. This resource will help you figure out the likely economic consequences of the different payment proposals you may face, e.g. whether you can afford the bundled payment you are being offered by a payer that has traditionally paid you fee-for-service, or whether you would actually get a bonus if you participated in another payer’s shared savings program.

Fee-for-service

Physicians have a general understanding of fee-for-service payment. Generally speaking, the higher the fee and the higher the volume, the more money the physician receives. Of course, the reality is much more confusing, as physicians typically have challenges with every single step of the process, from figuring out which fee schedule will apply, to getting a copy of that fee schedule, to deciphering which claim edits and payment rules will be applied to determine the final payment. Indeed, under the current system, a physician could negotiate a \$20 fee for a particular Current Procedural Terminology (CPT®) code, only to get remittance advices indicating that the physician was paid \$0, because that CPT Code is “never allowed!”

As this manual indicates, fee-for-service issues typically do not go away even when a physician is being paid pursuant to a risk-based payment system, whether that system involves capitation, bundled payments, shared savings or pay-for-performance arrangements. Fee schedules and their associated edits and payment rules are still critical:

- to manage payments for services which have been carved out of the risk arrangement;
- for cases that trigger stop-loss coverage; and
- to create fee-for-service equivalents for benchmarking purposes.

In addition, many emerging payment proposals are a hybrid, coupling a base fee-for-service payment with a risk-based bonus opportunity. Best practice recommendations for managing fee schedule issues are included in chapter two, “**Fee-for-service issues**.”

Risk or “budget-based” payment systems

As complex as it is to manage fee-for-service payments, payments based on a “budget”—that is, a prediction of how much it will cost to treat a particular patient population or a particular condition—raise a host of new issues that physicians must understand to successfully negotiate the evolving payment environment. Budget-based payment systems include most of the emerging payment models designed to incentivize value rather than volume, including capitation, bundled payment and shared savings arrangements, as well as those pay-for-performance systems that are based on achieving certain cost targets or outcomes, rather than on simply reporting whether certain activities were done.

Under “budget-based” payment systems, rather than being paid for each service provided, physician income is tied to the physicians’ ability to successfully predict future utilization for a patient population by thoroughly understanding the past utilization for a similar patient population as well as the practice expenses to deliver these services. To succeed in a budget-based payment system, physicians must ensure that the actual health care expenses of their patient populations do not exceed the budgeted allowance. To determine whether any budget-based payment proposal will be financially viable, physicians must first figure out whether the budget is “actuarially sound” for the patient population that the budget will cover. In other words, is it likely that the costs of providing health care to this patient population will be equal to or less than the budgeted amount? The size of the covered lives pool, the health status of the enrollees, the spectrum of services directly controlled by the physician group contracting for the budget-based payment, its ability to negotiate outsourced services at attractive rates (or sub-capitate them), and its ability to manage supply and staff costs, will all play a role in achieving acceptable financial performance.

Successful navigation of budget-based payment systems requires mastery of concepts more commonly associated with health insurance than physician payment, including “actuarial soundness,” “risk adjustment” and “risk mitigation.” A physician’s failure to assess accurately and manage the risk associated with capitated, shared savings, bundled payment, or risk-based pay-for-performance agreements may threaten the viability of the practice, even to the point of forcing the practice into bankruptcy. However, physicians who are able to estimate accurately and manage their risk can succeed and even thrive under budget-based payment systems.

Evaluating a utilization budget

The evaluation of a utilization budget requires 4 steps:

1. determine precisely the services that are to be included in the budget;
2. determine the volume of these services that the population to be covered by this budget will use;
3. determine the cost allocation for each of the covered services; and
4. determine whether the services covered by the budget can be provided within the budgeted allowance.

The following discusses these steps generally, while the chapters which follow discuss the issues specific to each payment model.

Get the health plan’s data and actuary’s certification

As a threshold matter, always ask the health plan for the data on which it based the utilization budget which underlies the payment proposal, along with a copy of a certification from the health plan’s actuary that the utilization projection is actuarially sound. Generally speaking, this should be the same data that the health plan used to set the health insurance premium rates for the population to be covered by the budget-based payment model. You should also have the health plan’s actuary certify that this is so, or if not, provide a complete explanation of any ways in which the utilization projection being used to calculate the utilization budget for the payment proposal you are being offered differs from that used to calculate the premium. Because you will need to understand the difference between actuarial analyses on the health insurer’s population versus what you will attract as a subset of that population, you will generally be best advised to seek assistance from a professional actuary. An actuary can help you evaluate certain safeguards to protect

yourself from adverse selection issues or the “law of small numbers.” Although retaining an actuary will involve some up-front expense, the more favorable utilization budgets and associated payment terms resulting from that assistance should more than compensate you for that expense. See chapter ten, “**Working with actuaries**” for further information regarding how best to use an actuary’s services.

Step one: Determine what services are included within the budget

To establish an actuarially sound utilization budget, you must first know with the greatest degree of specificity ALL of the services which are to be covered by the budget. This means that you must have an exhaustive list defining each and every service which will be charged against the budget by CPT, HCPCS, ASA, CDT and ICD-9-CM codes, and the financial impact of any applicable modifiers, as well as any facility-based services. Areas deserving careful consideration include mid-contract changes to legal coverage mandates, new technologies or drugs, and out-of-network and out-of-area services. To eliminate any confusion as to what services the utilization budget covers, you should clarify that the budget expressly excludes any service which is not specifically included.

Step two: Determine the volume of these services that the population to be covered by this budget will use

Once you have identified the services which will be covered by the budget, the second essential step in establishing an actuarially sound utilization budget is accurately predicting the extent to which your expected patient population will utilize those services. To do this, you must gather the following types of information from the health plan:

1. **Expected number of enrollees.** The health plan should provide you with information that will enable you to estimate the number of patients who will either be assigned to, or select your practice, over the term of the contract.
 - a. **Guaranteed minimum number of patients.** The number of patients assigned to you is a significant risk factor under budget-based payment arrangements. In general, you should attempt to secure large patient populations, because they offer some protection from the financial impact of catastrophic cases. A high-use patient can have a large impact on your utilization budget if you have a small number of patients covered by that budget.
2. **Age and sex breakdown of your expected patient population.** No matter what your specialty, you should know what age and sex groups are most likely to use your services, as certain age and sex groupings can have a significant impact on the utilization of specific specialty services. For example, women ages 20 to 35 are most likely to seek OB services. Children ages 0-5 will take up most of a pediatrician's time. So insist that the health plan provide you with the expected age/sex breakdown of your expected patient population so that you can ensure that your utilization budget is appropriately sex and age adjusted.
3. **Expected utilization profile, by CPT code.** You should ask the health plan to tell you the average number of the services covered by your utilization budget you can be expected to provide, per patient for your specialty, by CPT code. This information will help you continually monitor current utilization against projections, and thereby manage your risk during the course of the contract.
4. **Demographic considerations.** Demographic considerations can also significantly affect the amount and type of services that your expected patient population will utilize. For example, if a significant number of your expected enrollees will come from high-crime, high-violence areas, this will impact your utilization budget and thus may function as a basis to negotiate for a budget increase. Similarly, patients who are likely to have significant problems travelling to their appointments or otherwise complying with their physicians’ instructions will, at least in the long run, likely use more, potentially higher-cost services than those who do not face such challenges.

5. **List of employer groups enrolled.** There is some evidence that professionals and white-collar workers are higher utilizers. For example, workers in the medical field—hospital workers, doctors, dentists, etc., may utilize more services than others, simply due to their occupational experience. Also, certain employees may have dangerous jobs which require them to seek more care, e.g., stunt people, police officers, fire fighters, and chemical plant workers. Again, if your patients have high-risk jobs which are likely to affect utilization in your specialty, this may be a basis for negotiating for an increase in your utilization budget, unless these claims will likely be covered by workers' compensation, outside the budget-based payment system.
6. **Marketing information.** You need to find out how the health plan will be marketed, and to whom, and negotiate for a utilization budget that will reflect the cost of serving that population. Is the health plan marketed to employees without previous insurance, or who have not had insurance for a long time? These employees may need more care to make up for a lack of care in the past. Is the health plan marketed as if it is an indemnity, open-access product? If so, it may attract patients inclined toward multiple, potentially unnecessary visits.
7. **Copayment information.** Copayments need to be set high enough to discourage unnecessary utilization but low enough to ensure that patients seek care when medically necessary.
8. **Transition costs.** Take into account the possible increases in utilization that may result from transitioning from fee-for-service to a budget-based payment arrangement.
 - a. **Primary care.** If the budget-based payment arrangement makes you a gatekeeper, you may be seeing a different mix of patients than had been the case under your fee-for-service arrangements. This difference may be a direct result of the health plan prohibiting direct access to specialists. Thus, patients that formerly went directly to allergists, dermatologists, orthopedic surgeons, rheumatologists, etc., may be treated first by you, thus increasing your utilization rates. In such systems, only those requiring specialty care as determined by you may subsequently be referred.
 - b. **Specialty care.** Specialists' utilization budgets are based, in part, on the expected frequency of utilization of the particular specialty services. These determinations are generally based upon data reflecting frequency of the utilization of services by specialists paid on a fee-for-service basis. However, referrals from primary care providers (PCPs) may increase in payment systems where there is no financial risk to the PCP for making the referral to the specialist. For example, minor urinary infections may be referred to a capitated urologist, although historically such infections would have been treated by the PCP.
 - c. **Optimizing care delivery.** Ongoing discussion between the PCPs and specialists over referral and consultation practices is critical to developing optimal working relationships and efficient care delivery. All physicians and their patients benefit when PCPs handle all matters within their capability and refer all matters for which specialty care is appropriate, and specialists provide full reports back to PCPs on a timely basis. By carefully tracking actual utilization patterns against projected utilization budgets, peer norms and outcomes, utilization budgets and associated payment arrangements can be refined as appropriate to optimize the distribution of the workload.
9. **Risk adjustment.** Finally, you should insist that the health plan provide you with all factors used to risk-adjust your utilization budget. These factors should include age and sex (as described above) and benefit plan type and design, including copayment or deductible levels, as well as: localized geographic area; acute clinical stability; principal diagnosis; severity of principal diagnosis; extent and severity of co-morbidities; physical functional status; psychological, cognitive, and psychosocial functioning; non-clinical attributes, such as socioeconomic status, race, substance abuse, and culture; health status and quality of life; and patient attributes and preferences. Unless your utilization budget is adjusted to take into

account factors that can significantly increase utilization, that budget will not likely be actuarially sound and your corresponding budget-based payment will be inadequate. Again, an actuary can provide invaluable assistance in evaluating the accuracy of the health plan's risk adjustment methodology. For further information concerning risk adjustment, see chapter eight, "[Risk adjustment](#)."

Step three: Determine the cost allocation for each of the covered services

A credible utilization projection is not enough to determine the likely financial impact of a budget-based payment system. You also need to know how much money has been allocated for each of the services that have been projected. Comparing fee-for-service revenue with your proposed budget-based revenue is not an extraordinarily difficult task. Every budget-based payment arrangement contains an imputed fee schedule. You, or perhaps more appropriately, your actuary, can determine this imputed fee schedule by comparing the total payment available under the budget, and then dividing that sum by the type and number of services covered by the budget that your expected patient population is expected to utilize, using a relative value scale such as the Medicare resource-based relative value scale (RBRVS). This will allow you to determine the budget-based payment arrangement's imputed fee schedule, i.e., how much of your proposed budget will be allocated to each covered service that you can expect to provide to your patient population. You can then compare this imputed fee schedule with what you would receive under fee-for-service.

Step four: Determine whether the services covered by the budget can be provided within the budgeted allowance

The final step in evaluating the budget you have been offered is to making the determination as to whether you will likely be able to provide the services required within the budgeted amount. This will, in turn, require that you have a detailed understanding of your practice costs, and potential areas for savings. For further information on how to determine your practice costs, see chapter one, "[How to establish your baseline costs](#)."

Clearly, where the imputed fee schedule is less than what you would have received on a fee-for-service basis, the agreement may only make economic sense to you if you are confident that you can reengineer the delivery system in some way that makes you confident that you can be more cost effective than has been the case in the past. Even if the imputed fee schedule is the same as your historical fee schedule, you will have to determine whether there is enough margin to cover the additional risk you are assuming that your patient population will actually need more services than those projected by the utilization budget. Again, it will generally be wise to retain the services of an actuary to help you make these assessments.

Getting more specifics

Developed by the AMA and experts in physician payment issues, the following chapters discuss each of the various payment options physicians are now being offered and set forth the key issues physicians must consider when determining whether to agree to a particular payment system, how to determine a fair price, and how to reconcile any payments received to ensure that they are accurate. There are also several chapters discussing the issues that apply to all risk-based payment systems. Topics addressed include:

- How to establish your baseline costs;
- Fee-for-service issues, including issues raised by fee schedules based on the Medicare fee schedule or the Medicare RBRVS;
- Pay-for-performance programs;
- Capitation;
- Shared savings proposals;
- Bundled payments;
- Withholds;
- Risk adjustment;

- Stop-loss insurance;
- Working with actuaries;
- Negotiating the deal;
- Joint contracting/Collective bargaining; and
- Ethical implications of risk-based payment arrangements.

The AMA also welcomes questions and comments from its members on this resource or the emerging payment models in which they are being asked to participate. Please feel free to contact Wes Cleveland at [**wes.cleveland@ama-assn.org**](mailto:wes.cleveland@ama-assn.org)

Chapter 1: How to establish your baseline costs

Robert Barbour

The move from fee-for-service to “value-based” payment models will require physicians to adopt more detailed accounting practices than they have typically used in the past. There are two reasons that this will become important. First, many of these payment models require physicians to assume a level of risk with respect to the services they provide to their patients. Under these models, physicians can no longer assume that they will actually receive payment for each service they provide; to the contrary, they must assume that they will not be paid for services that are determined to be unnecessary or required only because of the physician group’s inefficiency or error. Moreover, and especially if the physician group has assumed risk for the services provided by others, they will also have to track the services that have been provided but have not yet been captured by their cash-based accounting systems because of delays between the provision of the services and the posting of the bills for those services. These are “incurred but not yet reported” or IBNR accruals.

Second, governmental, employer and other purchaser demands for cost-containment are likely to result in less payment for services regardless of the payment method. With smaller margins and greater risk, physicians will have to undertake a very serious, business-like review of the services they provide.

Ultimately, this analysis will need to answer these key questions:

1. What does it cost you to deliver clinical service that you provide?
2. What does each payer pay for that service?
3. What is the difference between revenue and expense for each key service?
4. Can you close the gap on services that have a negative delta?
 - a. Can you provide the service more efficiently by re-engineering the process; will your suppliers, landlord, staff, and other expense sources lower their costs to the practice; or will all of the gap be carried by physician cuts in salary?
5. Do you stop providing those services where you cannot close the gap between revenue and expense and the impact is detrimental to your practice?
6. Do you stop contracting with payers that are not willing to provide you the data you need to manage the risk they are demanding, or that are not willing to pay fairly for that risk?

In the commercial world, accounting practices are set up to easily answer these questions and these evaluations are routinely done. In health care, however, a detailed cost accounting approach is the exception rather than the rule. Typically, financial statements are done at the macro level of the enterprise (practice) or major service area. It is rare that there is a further breakdown like, “What does it cost to do an office visit for a new patient, return patient, patients with diabetes, etc.” Conceptually, it is not difficult to setup such a system; it is just foreign to the industry.

Generally, cost accounting requires allocating costs to the products and services sold. Some are allocated on a step-down basis using an established formula (like administrative overhead) and others require direct allocation. This latter expense tracking usually is the challenge, as it requires tracking and capturing into the accounting system the supplies used, staffing resources and other expenses unique to that service. This tracking can be manually intensive if technology solutions are not employed. Allocating supply costs in

turn requires sophisticated inventory controls and assignment of costs. The answers to questions like, “What cost do I assign for the vaccine just used?” if inventory costs varied over time and the precise cost for that vial is not known are not obvious. Assume, for example, that what is known is that in inventory there are 10 vials that cost \$150.00 each and 5 that cost \$125.00. Applying actual costs to a particular inventory item would require bar-coding or employing other cost tracking methods for each inventory item. Reasonable people would generally say that the cost of that precision outweighs the value of the obtained data accuracy. Thus, reasonable accounting compromises are expected.

So, how do you begin? This resource will discuss simple approaches that will give you basic insight into your costs that can be done quite quickly and progress to explore what it will take to establish a more sophisticated accounting practice. We will suggest questions to guide you on whether or not your practice needs anything more than a basic cost of service report. Finally, we will recommend approaches on what you can do to manage costs in your efforts to close the gaps you identify, including coming to terms with the reality that your practice may need to stop providing certain services it cannot practically do anymore.

Capturing Relative Value Unit (RVU) and cost data

Before agreeing to transition from fee-for-service to an emerging payment system, physician practices must determine whether they will be able to stay in business if they are paid pursuant to the new methodology.

The first step to making this evaluation is determining the practice’s underlying costs of doing business. While practice consultants use different methodologies to determine the cost of providing services, one of the easier methods is to use the Centers for Medicare & Medicaid Services (CMS) Resource-Based Relative Value Scale (RBRVS) and its underlying Relative Value Units (RVUs).

Each Current Procedural Terminology (CPT®) code has associated with it a total RVU (tRVU) which can be adjusted based on any modifiers used. RVUs are created and updated by the Specialty Society Relative Value Scale Update Committee (RUC) which meets three times a year to set new values, determine the RVUs for each new code, and revalue all existing codes at least once every five years. RVUs measure the relative level of time, skill, training and intensity to provide a given service. Total RVUs are a combination of physician work RVUs + malpractice expense RVUs + practice expense RVUs and are intended to reflect the relative costs of providing care, including geographical variances in costs. Most payer fee schedules are created by multiplying the total RVU by a conversion factor to create a fee schedule amount. More than one conversion factor may be used to address differences in ranges of CPT codes.

At the most basic level, calculating revenue per tRVU by payer is done by capturing tRVUs for all of your services billed to a payer and their associated payments. Simply divide the total revenue by the tRVUs and you now have your number. This is also the equivalent of a conversion factor you can use to compare how close you come to the conversion factor in your contract with that payer. It will never be the same as the real world one you calculated, however, as bad debt costs, denials and other factors will always create a gap between your internal conversion factor (revenue per tRVU) and the one contractually agreed to.

Calculating costs per tRVU can be done in a similar fashion. For a blunt analysis, simply add up your total practice costs (physician and non-physician salaries and benefits, rent, professional and other insurance costs, supplies, etc.) for the period for which you captured the tRVUs, and divide the total costs by the total tRVUs. A simple comparison of costs per tRVU to the revenue per tRVU will quickly let you know if there is an issue with one or more of your payers.

This is the absolute minimum analysis that you must do before you embark on any payment system that involves risk. There is no magic in risk-based payment systems. If you agree to a contract that does not cover the costs of the services you must provide plus the additional overhead associated with risk-based

contracting (actuarial assistance, stop-loss insurance, accrual accounting, etc.) you will ultimately go bankrupt.

You can refine this analysis somewhat to separately evaluate practice overhead associated with practice expense RVUs and labor costs associated with the work RVUs (wRVUs) by using tools available from the AMA, including:

- **Fee schedule analysis: Using your complete practice cost as a guide**
- **Interactive fee schedule tool**

Following 12 simple steps, these tools help you calculate your practice's cost per wRVU and practice expenses RVU, as well as tRVU. These tools also help you calculate your labor and practice expense costs for each CPT code, based on these RVU values. To use these tools, the physician practice should have the necessary reference sources, including current copies of the AMA Current Procedural Terminology (CPT®) book, Healthcare Common Procedure Coding Systems (HCPCS), Medicare RBRVS, RBRVS Data Manager and Medicare's National Correct Coding Initiative (NCCI) or similar resources.

While these tools were specifically developed to assist physician practices in developing a fee schedule which reflects the physician practice's underlying costs, you can also use these tools to create a document showing your costs for each service you provide by simply omitting any profit or other mark-up in the calculations.

Deeper dive: The need for accurate and comprehensive analytics

While the very basic financial assessment described above is an absolute necessity for any physician practice considering moving to a risk-based payment arrangement, physicians who anticipate that a significant portion of their revenue will come from risk-based payments in the future are well advised to undertake a more sophisticated analysis of the economics of their practices. Ask yourself, what other large industry manages itself by simply looking at the bottom line to know if it is working well? Few, if any, physician practices do much more than that. As emerging payment methodologies develop, knowing at the granular level which services you actually make money on and which you lose money on will become the norm. Without that data, the most likely response to less revenue will be for physicians to reduce their personal income as employee salaries, rent, malpractice costs and other costs of doing business are more difficult to control. With good analytics, you will know what costs you can and cannot control, which payers are costing you money, which services are not the ones you should be providing, and whether you are being paid properly under the terms of your agreement.

If under the emerging payment model, your practice assumes risk for services it does not directly provide and refers those services to others, accruing IBNR (incurred but not reported) expenses is not only critical but requires you to adopt accrual based accounting. Another lesson learned from past risk contracting experience is that not accurately managing IBNRs was one of the most likely reasons for physician practices to fail.

You will also need to have analytics that measure outcomes and quality. Today, most payers do that by data-mining claims to indirectly make those assessments. States are now creating "all payer claims databases" that will combine data from all payers to be able to see a complete picture of your practice. You will need to be able to emulate their analytics, as well as develop your own for measuring what you believe is important. Here is a short list of concepts, approaches and things to consider in moving to the more sophisticated practice analytics you will likely need to thrive as payers increasingly move to "value-based" payment models.

1. Develop an internal analytics capability?
 - a. First, accept that Excel will not meet your needs.
 - b. Second, few if any practice management system (PMS) vendors do anything other than report frequency and quantity data. You will need to merge cost data, clinical data and

be able to do statistical analysis of data not often found in PMS basic analytics. Thus, you may need to purchase a third-party analytics tool.

- i. This will require hiring one or more competent analysts.
 - ii. It will require the ability to extract data from the PMS and populate a relational database for you to do the necessary analytics and data mining. Depending on the size and complexity of your practice, the extractor alone can cost anywhere from \$15,000 to over \$100,000.
 - iii. Cost data from other systems like accounts payable, inventory management, HR and other sources will need to be extracted and defined in the relational database. Extraction tool costs will be incurred here as well. Your analysts may have to develop most of your reports from scratch.
- c. Some revenue cycle examples of the types of analytic reports you will need include:
- i. Evaluation by CPT code for which you associated costs by linking direct costs (like supplies, pharmaceuticals, implantables, depreciation, etc.) and by doing step down allocations of indirect costs. Then you can specifically calculate your costs and associated revenues that will now distinctly highlight the positives and negatives.
 - ii. Direct cost allocations will be an unfamiliar process for most physician practices.
 - iii. It requires both an inventory management system that assigns costs to items, plus a workflow process that captures that data and associates it with the services provided.
 - iv. Step down allocation simply takes indirect costs and allocates them to predefined areas using rules to allocate percentages (or actual fixed costs) to given cost items/areas that are then allocated to the associated services.

2. Different views

- a. How this data is sorted can give you different insights into what you are doing well and what needs to be scrutinized.
- b. Doing this for the whole practice is the first step. If there are items of concern, then other views like these may be needed:
 - i. By payer, by location can let you know if costs are more problematic in one area versus another.
 - ii. By physician can highlight that variance.
 - iii. By payer, by physician can let you know if physicians have issues only for specific payers or it is a broader issue.
 - iv. By location, by physician can let you know if the negative variance in a location is driven by a particular physician(s).
 - v. The same example can be expanded by replacing physician by specialty, by ranges of CPT codes, and many other variables
- c. Depending on your analytics software, each view is another report that needs to be developed or can be a different presentation of a larger report.

3. Dashboards and drill downs

- a. For physicians to have confidence in the new data, they need to be able to see it for themselves and create the different views (drill down, filter or re-sort) by themselves. This is accomplished by creating meaningful dashboards that allow for these different views.
 - i. The dashboards and reports physicians use to do this must require little training.
- b. Ad hoc reports
 - i. No matter how good any report is, it will basically only help you formulate a question: “What is happening with ‘X’ that does not look the way I want?,” “Why does this area look better than another?,” “Why are my payments from that payer suddenly dropping?,” “Why are my costs for this service so high compared to the reimbursement I am receiving?”
 - ii. It is rare that a report also provides the answer without any workplace or environmental knowledge. Analysts should be able to help you formulate these

- high-level questions, and with your staff's input, postulate some reasons that may support an answer to the question. Ad hoc reports are then created to look specifically at data that support the reasons, if appropriate.
- c. You will find that much of the value from your analytics will first come from your standard reports that create the general question(s) with ad hoc reporting providing the additional information that guides the formulation of the best answers.
4. Interpreting the data for practice improvement
 - a. With the pressure from declining reimbursements and the increased complexity of the emerging payment models, the talent and experience needed to properly understand and respond to the data will itself become a new challenge for physician practices.
 - i. Adjusting contract terms you will need to be armed with more than the observation that your costs are above your payments. You will need to show that your costs cannot be further reduced, that you are meeting quality and outcome expectations (with the reports that support that), and the reasons for the cost variances that are impacting the practice.
 - ii. Possible dropping of some services – You may find that others in your area are not having the same cost challenges for certain services and you may need to consider no longer providing them.
 1. Rather than providing the flu shot, directing your patients to go to the pharmacy.
 2. Referring patients for ancillary services that you can no longer provide in a cost effective manner.
 3. Closing an office in an area where rental costs are too high.
 4. Joining a purchasing group – buying office and medical supplies on your own may no longer be the way to go.
 5. Replacing some physicians with nurse practitioners, physician assistants or other limited license professionals – if payers have attractive contract terms that support this alternative, you will need to evaluate it.
 5. Risks – creating the metadata definitions and cross-mapping from disparate systems is always a bigger challenge than expected.
 - a. Populating the database is easy.
 - b. Associating the data meaningfully is not.
 - c. Trust your instincts. If your reports clearly state something that does not look right to you, it may be that your data definitions/mappings maybe the root cause creating results that do not seem correct, so double check them.
 6. The need for an accounting platform that does accrual-based accounting.
 - a. As noted above, not accounting for expenses that you have not yet received an invoice for often invites physician practices to issue bonuses as their bank account is overflowing. Later, when the large, unrecognized expenses come in, there may be no funds to cover them in a capitated (or similar) environment.
 - b. Accrual-based accounting will also require you to recognize revenue when billed, rather than when received. The amount recognized is adjusted by historical contractual adjustments and bad debt that you have experienced.
 - i. These historical adjustments need to be evaluated regularly and kept up to date.
 - ii. The new accounting practices may require you to retrain or even replace existing staff that are unfamiliar with it.
 - iii. As part of this IBNR process, you should build a grid for what you are responsible for, what your organization has sub-capitated, and/or what the payer is still responsible for (a Division of Financial Responsibility report). Have the payer sign off on the accuracy and completeness of this DOFR. See chapter four, “**Capitation**,” for more discussion of DOFRs, as well as a sample DOFR form.
 7. Using the data for emerging payment methodologies – capitation, bundled payments, shared savings arrangements, etc.

- a. The AMA recommends that you require the payer to provide you with a minimum set of reports you will need before you agree to any risk-based contract. It is important for you to have expert advice here, not only for what these reports should contain, but guiding your analytics staff to create similar reports so you can independently verify what the payer represents in its reports.
 - b. Restating the reimbursements you get into a usable benchmark that meets your needs is important for the practice to assess its performance under these emerging reimbursement approaches. At this time, the most common recommended benchmark is to create fee-for-service (FFS) equivalents of the data. One approach to do that is to:
 - i. Continue posting to your PMS all of the individual services as if you were going to bill them as FFS.
 - ii. Calculate the historical revenue per tRVU for these services.
 - iii. Calculate the tRVUs for the new services, regardless of how they are reimbursed. Divide the payments plus bonuses you receive for those services, less non-practice expenses like referrals you have to pay by the associated tRVUs (where you have assumed payment responsibility for services that will be performed by others), and likewise calculate revenue per tRVU and compare. For even more accuracy, you can adjust for the changes in the particular RVU values that ordinarily occur over time so that those changes do not skew the data.
 - iv. You must be able to calculate your payments pursuant to each risk-based payment arrangement as a FFS equivalent or revenue and expenses per total RVU so as to make assessments that can be compared to historical experience, at least as you are transitioning.
8. Outsource the analytics to a trusted source
- a. The type and breadth of the robust analytics you may require can quickly appear daunting and too expensive.
 - b. Experienced and well-qualified analysts who can not only help you create the reports and dashboards you need, but also help you interpret the results, are a scarce resource. Even if available, they can be expensive.
 - c. With the success of cloud-based and Software as a Service (SAAS) strategies, you may wish to explore partnering with a third party who can provide turnkey services with no capital investment (just monthly fees).
 - d. Even if this is your choice, the retention of an actuarial expert is still recommended if you are considering any budget-based payment arrangement, such as capitation, shared-savings or bundling, where your financial success is dependent on your ability to keep your costs within a specified budgeted amount.
9. Clinical analytics
- a. Capturing the data your payer uses from claims data to assess your performance is the next step after you are satisfied with your revenue cycle efforts.
 - b. Since this is an emerging area, you may wish to also partner with third parties to provide these analytics for you, in addition to any internal analytics you develop.
 - c. The challenge may not be in emulating internally how a payer creates reports, but rather in integrating that data with cost data and data you do not have.
 - i. You need to know if you have positive outcomes and quality but you are losing money.
 - ii. You need to know pharmaceutical costs and other costs your payer sees that you do not. Consider getting that data from your payer, a pharmacy benefit manager (PBM), or from all payer claims databases that are now developing.
 - d. For more information, see **“Take charge of your data: The physicians’ guide to reviewing and using claims data to improve their profiles, practices and payment”**.

Conclusion

As this brief outline indicates, physicians with a sophisticated understanding of their practices' financial and clinical analytics will be best positioned to manage the changing payment environment. While many practices will ultimately want to pursue very robust evaluation and monitoring systems, even small physician practices will benefit from doing the basic evaluation of their costs discussed at the beginning of this chapter. In no event should physicians embark on emerging payment arrangements without understanding what the likely financial impact of those arrangements are likely to be.

Chapter 2: Fee-for-service issues

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I. Introduction

Although emerging payment systems may well dominate physician payment in the not-too-distant future, it is highly unlikely that those systems will replace fee-for-service entirely. Whether you continue to receive payment primarily on a fee-for-service basis, you transition entirely to an emerging “value-based” payment system, or you end up with some hybrid payment model involving both fee-for-service and payments based on some alternative system, fee-for-service payment will likely continue to play some role in your payment. It will almost certainly play a major role during this period of transition as the methodology for at least a portion of your payment and as a benchmark against which you will want to evaluate any alternative payment proposals.

Regardless of whether you will be compensated entirely on a fee-for-service basis or pursuant to a combination of an emerging risk-based payment system and fee-for-service, you should carefully evaluate the financial adequacy of offered fee-for-service payments. Indeed, the importance of this evaluation only increases as more of your payment is risk-based; the more risk you assume, the more important it is that you understand the economics of your practice and the impact the fee-for-service portion of your payment will have. However, this is not a simple task.

First, you must determine what it actually costs you to provide services, including enough to cover salaries, office overhead, professional liability and other insurance and reserves needed to maintain up-to-date health information and other necessary technologies. For more information describing one strategy to determine your practice costs, see chapter one, “[How to establish your baseline costs.](#)”

Second, you must determine what fee-for-service payments the health plan is proposing to pay you, and you must do this separately with respect to each separate product in which you are considering to participate. This means that, for each product, you must understand each of the three components that go into health plan payment determinations:

1. the base, negotiated fee schedule;
2. the claim edits which the health insurer applies to eliminate payment for certain services; and
3. the payment rules that the health insurer applies to increase or reduce payment in certain circumstances, such as when a procedure is performed on both sides of the body, or multiple surgeries are performed during the same session.

This chapter will discuss the key issues inherent in determining the negotiated fee schedule, the claim edits and the payment rules you will need to take into account whenever you are attempting to determine the actual payments that you are likely to receive under a fee-for-service agreement. It will also help you identify the kinds of information that you will need to request from the health plan so you can properly evaluate the economic impact of a fee-for-service payment agreement.

II. How health plans process electronic claims

To help you identify the types of information that you should obtain from the health plan, and to understand why that information is essential for you to determine the actual payments that you are likely to receive, you need to have a grasp of the role that contract language, your fee schedule, claim edits, and payment rules play in determining what you will actually be paid. What follows in this section is a

general description of the steps that a health plan takes when it processes your electronic claims and how contract language, fee schedules, edits, and payment rules factor into that process.

- **Step 1: Electronic claim received in the health plan’s claim processing system.** The first step in the claims processing system is the health plan’s receipt of your claim. The health plan may receive the claim directly from the physician or through an intermediary, such as a billing service or clearinghouse.
- **Step 2: The patient’s eligibility and benefit level is determined.** Once the health plan receives your claim, the health plan’s claim adjudication system determines if the patient is a “match” in the health plan’s system and eligible to receive benefits for the date(s) of service identified on the claim. If the patient “matches” and is eligible, the health plan’s system then typically determines if the services are “covered services” according to the patient’s benefit plan.
- **Step 3: Contractual discount applied**
 1. **Adjusting your payment to reflect the contractual discount.** Once the health plan determines the covered benefit level, the health plan reprices the amount of the claim to reflect your contractual discount. It is likely that, under the language of your managed care contract, the health plan will be obligated to pay you no more than the discounted fee schedule you agreed to, or the billed charge, whichever is lower. This reduction in payment is applied even prior to the application of claim edits and payment rules.
Thus, unless you intend to get paid less than the amount the health plan has agreed to pay in its fee schedule, it is critical that you do not bill less than the fee schedule amounts (yet another reason why it is critical that you know what the fee schedule dollars and cents amount is for each service you will bill).
- **Step 4: Health plan claim edits and payment rules applied.** Once the health plan adjusts the claimed amounts to reflect the contractual discount, the health plan may apply additional claim edits and payment rules that further reduce the health plan’s payment obligation. Such claim edits can include those resulting in the denial of a service on the grounds that it is included within another reported service. Payment rules include reimbursement methodologies such as the use of multiple procedure reduction logic. Some of these edits and payment rules may be fully transparent to you. This will be the case, for example, if the health plan uses the same edits or payment rules as the Medicare program. It is likely, however, that the health plan will also apply health plan-specific claim edits and payment rules that reflect the specific prerogative of the health plan.
 1. **The continuing problem of health plans’ use of black box edits.** Commercial use of black box edits remains a continuing source of physician frustration. The Medicare program inaugurated a new era of transparency in 2000 when it replaced black box edits with fully transparent, newly published National Correct Coding Initiative (NCCI) claim edits. However, most commercial health plans use significantly more edits than those based on CPT, NCCI and Medicare. To see the potential application of payer-specific edits by the nation’s largest health plans, view the AMA’s [National Health Insurer Report Card](#) (NHIRC). The NHIRC separately reports those payer-specific edits that are disclosed on the payer’s website, and those that are not disclosed.
 2. **Examples of claim edits that disallow a line item on a claim.** Some claim edits are non-controversial. For example, if an obstetrician bills the global obstetrical CPT code, that obstetrician does not expect to be paid for each of the components of that code. If some of those components are billed separately, the obstetrician will not object to the application of a claim edit denying payment on those lines involving CPT codes which were included in the global CPT code. On the other hand, the application of a claim edit to deny a line that the physician expects to be paid is a source of great strife and distrust. For example, in 2011 some payers applied a claim edit to deny payment for the

reading of an echocardiogram on the same day as an inpatient Evaluation and Management (E&M) code was billed. Because the reading of the echocardiogram involves extended work that is not included in the E&M code, physicians who experienced these edits were understandably angry. In the middle are edits that the health plan has disclosed on its website, but which the physician didn't anticipate. For example, some health plans do not pay for a urinalysis that is done with an E&M code, even though physicians would typically expect to be paid for the urinalysis billed with a modifier 25. When the health plan discloses edits, it is at least theoretically possible for the physician to negotiate for an increase in the E&M payment to cover for the services which the health plan will not pay separately. However, as a practical matter, many physicians have not established a mechanism for evaluating the economic impact of the various edits used by each of the payers, and even if they have, many have no negotiating power against a dominant payer.

3. **Example of a payment rule that reduces the amount you will be paid.** Medicare and commercial health plans apply any number of payment rules that can significantly reduce the amount of money that Medicare or commercial health plans will pay you. For example, both Medicare and commercial health plans apply what is often referred to as “multiple procedure reduction rules” to particular categories of services. For example, suppose you have submitted a bill to a health plan for three surgical procedures provided during a single surgical session. Under Medicare’s multiple procedure reduction rule, the health plan will pay you 100% of your fee schedule amount for the most expensive surgery, but only 50% for each of the two additional procedures.
4. **Wide, diverse use of payer-specific claim edits and payment rules compounds the difficulties physicians face.** As is demonstrated by the NHIRC, health plans vary widely in their use of claim edits. Moreover, in an AMA-commissioned study, it was determined that health plans were using 18 different versions of multiple procedure reduction logic rules. These variations can have a significant impact on your bottom line, not only by virtue of the payment reductions they cause, but also because of the additional administrative costs you incur in trying to reconcile the unanticipated payment reductions. For more information regarding health plan application of claim edits and payment rules, access “[Standardization of the claims process](#)” and “[Standardization of a code-editing system](#)” and additional [white papers](#) on administrative simplification issues.
 - **Step 5: Auto adjudication is completed.** The health plan then pays you the difference between what it believes it is obligated to pay you for the services and procedures you provided, after it has applied its contractual discount and all of its edits and payment rules, and then subtracted the amount that the patient is obligated to pay you, e.g., in the form of copayments, deductibles, etc.
 - **Step 6: The health plan generates an explanation of benefits or electronic remittance advice and sends payment.** The health plan sends you and the patient an explanation of benefits or an electronic remittance advice detailing the paid amount for the medical service provided.

III. Obtaining your fee schedule

The first step you need to take in your effort to determine your actual fee-for-service payments is to obtain a complete fee schedule from the health plan upon which your compensation will be based. This may not be as easy as one might imagine. Health plans’ refusals to completely and accurately disclose fee schedules has been a chronic problem in physician managed care contracting. Some health plans have refused to disclose complete fee schedules, on the grounds that it is too cumbersome to provide a list of fees for each CPT code that a physician practice might report. Instead, a health plan may provide the practice with a “fee schedule” that lists “sample” fees for the most commonly reported CPT codes for

select medical specialties. Unfortunately, such “commonly reported” CPT codes may have little relation to the CPT codes that the practice typically reports. Health plans have at other times provided medical practices with a list of CPT codes which, while paid favorably, will also rarely be reported by the physician practice. Sample fees of rarely used CPT codes are of little, if any, help to a physician practice seeking to estimate the adequacy of proposed fee-for-service reimbursement rates.

However, as the pressure for administrative simplification and transparency increases, particularly as health insurance deductibles continue to rise and the need to be able to calculate patient responsibility at the point of care becomes a necessity, health plans will have less and less justification for refusing to provide physicians a complete copy of their negotiated fee schedules. As a practical matter, health plans must load these fee schedules in their repricing engines in order to pay physician claims, so there is no technological impediment to providing this same information to physicians. In addition, some states have laws that mandate fee schedule transparency. For more information, refer to Article 8 of the [National Managed Care Contract Database](#) (NMCC).

For the special issues raised by fee schedules based on the Medicare physician fee schedule, or Medicare Resource-Based Relative Value Scale (RBRVS), see [Fee schedules based on Medicare RBRVS or the Medicare Physician Fee Schedule](#).

IV. Claim edits and payment rules

Claim edits and payment rules can significantly reduce the value of the fee schedule. Accordingly, in order to accurately estimate your payments, you will also need to obtain all of the health plan’s pricing and payer-specific edits and understand the circumstances under which the health plan will apply those edits to the specific types of claims and CPT codes that you will be submitting to the health plan for payment. Thus, during your contract evaluation phase you must obtain specific information concerning the entire claim edits and payment rules that will be applied to your claims. You should insist that the payer disclose:

- each and every payment rule (sometimes called a “pricing edit”) that will be applied to reduce your charges below the fee schedule amount, such as multiple procedure adjustments; and
- each and every “claim edit,” that will be applied to eliminate payment for any claim line.

Without this information, you are not getting the whole story, and there will be no way for you to truly assess the impact of the fee schedule, nor to reconcile payments assuming you decide to contract, nor to let your patients know what they owe at the point of care. You must also understand how any of these payment components may be changed, including what notifications you will receive and what rights you have with respect to accepting or rejecting these changes.

V. Other key issues

Although fee schedules, edits and payment rules play an essential role in determining actual payment, they are not the only aspects of claims processing that can affect the total value of your fee-for-service contract. Key additional concerns include, but are not limited to, any “clean claim” requirements, timeliness of payment or denial, and recourse available to you if timely action is not taken on your clean claims. The Appendix to this chapter, entitled “[Checklist to help physicians evaluate key payment-related issues under fee-for-service contracts](#),” is a resource that will help you analyze these issues, in addition to questions concerning fee schedules, claim edits and payment rules.

VI. Conclusion

Although risk-based payment methodologies may ultimately replace fee-for-service as the predominant means by which physicians are paid, fee-for-service is likely to play a significant role even if it no longer enjoys dominance. And while you may be more familiar with how fee-for-service works when compared with risk-based reimbursement methodologies such as capitation, bundled payments or shared savings, that greater familiarity does not mean that predicting your actual payments under a proposed fee-for-service contract is an easy task. Fee-for-service can be fraught with complexity and ambiguity, and you

should expect that obtaining sufficient information to predict your actual fee-for-service payments will require a significant degree of perseverance on your part. This chapter is designed give you the tools you will need to maximize the rewards of such perseverance.

Chapter 2 Appendix: Fee-for-service issues: Checklist to help physicians evaluate key payment-related issues under fee-for-service contracts

Have you received a complete fee schedule from the health plan? A complete fee schedule is not just a listing of the Current Procedural Terminology (CPT®) codes and the associated contracted rate with the health plan, but includes all the information you need to determine if payment is accurate for the procedure and services reported. The following checklist can be used as a guide to assist you in receiving all the information you need to determine your complete contracted fee schedule with a health plan prior to signing or renegotiating a contract. Do not be satisfied with generalities—information provided to you by the health plan needs to contain detail sufficient to enable you to determine what your actual payments will be.

- Does the fee schedule describe each procedure and service with an applicable CPT, HCPCS, ASA, and any applicable modifiers?
- Has the health plan disclosed all of the payment rules, coding edits, modifiers and other factors that it will use to calculate payment amounts? For example, has the health plan disclosed: specific payment rules regarding consolidation of multiple services or charges; reimbursement for assistant surgeons; reimbursement for the administration of immunizations and injectable medications; definition of global surgery periods, etc.?
- To what extent will the health plan use nationally recognized, generally accepted CPT codes and guidelines, including all relevant modifiers, and to what extent will that use be consistent with nationally recognized, generally accepted bundling edits and multiple procedure reduction logic?
- Has the health plan disclosed the publisher, product name, edition and model version of any software that will be used to edit your claims?
- Has the health plan provided you with all the information, including but not limited to, all fee schedules, payment rules and coding edits that the health plan will use to calculate payments due to you *under each of the products in which you will participate*?
- Will the health plan provide you with actual payment examples using combinations of CPT codes for services that you frequently perform so that you can fully anticipate actual amounts that you will receive under the contract?
- Does the health plan have a continuing obligation to disclose to you all of the factors it uses to calculate contractual payments once you have signed the agreement? Will the health plan disclose those factors to you upon request?
- When and how will the health plan be able to change the factors it uses to calculate payments once you have signed a contract? Will the health plan notify you in advance of proposed changes? If you find those changes objectionable, will you be able to terminate the contract prior to the effective date of the proposed changes?
- Has the health plan provided you with clear, accurate and complete information concerning the health plan's clean claim requirements and companion guides?
- Will you be required to file claims electronically? If you do not wish to conduct business electronically with the health plan, are there any circumstances in which the health plan cannot require you to engage in electronic claims filing as a condition of contracting?

- If you and the health plan agree to conduct business electronically, will the health plan be contractually obligated to comply with the requirements of the Health Insurance Portability and Accountability Act (HIPAA) Transactions and Code Set standards and provide end-to-end pre-testing for future upgrades?
- Will you be required to submit claims for covered services within a specific time period or otherwise be barred from seeking payment for providing those services? If so, are there any exceptions which require the health plan to accept and process claims submitted after that time period?
- Does the agreement specify any deadlines within which the health plan must take specific actions with respect to submitted claims? For example, is there a time limit within which the health plan must pay, deny or contest your clean claims?
- Is the health plan obligated to ensure that you receive electronic remittance advices or explanations of benefits that contain useful information, e.g., information that will readily permit you to reconcile claims payments and denials with submitted claims?
- What recourse do you have if the health plan fails to timely process a clean claim? For example, if the health plan fails to pay a clean claim within a specified deadline, will the health plan be required to pay you the amount of the clean claim and accrued interest on that amount?
- Do you understand how the health plan recognizes appropriately reported procedures and services by fee schedule and/or product type? Do you understand what portion of the payment will be the responsibility of the health plan, patient and your practice through contractual adjustments? For example, do you know what will happen when a preventive medicine E&M (service Y) is billed with a Well E&M visit (service X)? Will the health plan, for each product type or select product types:
 - Recognize and pay for both services?
 - Recognize and pay for X, but treat Y as a non-covered service for which you can bill the patient, if your state law permits?
 - Recognize and pay for X, but treat Y as a contractual adjustment which you must write-off?
 - Recognize and pay for X and then inappropriately, according to RBRVS valuations, apply multiple procedure reduction to Y?
- What about when an immunization/vaccine (service X) is billed with administration (service Y)? Do you know which of the following three different payment scenarios will pertain? Will the health plan, for each product type or select product types:
 - Recognize and pay for both services?
 - Recognize and pay for X, but treat Y as a non-covered service for which you can bill the patient, if your state law permits?
 - Recognize and pay for X, but treat Y as a contractual adjustment which you must write-off?
- How about multiple procedure reduction logic? Which one of the following is the health plan following?
 - CMS rank ordering?
 - CMS percentage hierarchy?
 - CMS multiple procedure exempt listing?
 - Health plan specific rank ordering?
 - Health plan specific percentage hierarchy?
 - Health plan specific multiple procedure exempt listing?
- In which of the following ways will the payer respond to the reporting of consultation codes?

- Health plan recognizes and pay for consultation codes?
- Health plan recognizes then crosswalks to E&M codes?

If you have any doubt as to how any of these scenarios will be handled, and any time the health plan informs you that it uses a plan specific rule, it is critical that you ask for the specifics. Only with the specific rules will you be able to determine what the fee schedule is worth, as a general matter, and how to reconcile each specific payment you receive.

Fee schedules based on Medicare's Resource-Based Relative Value Scale or the Medicare Physician Fee Schedule

Important SGR update notice: On numerous occasions since 2003, Congress has had to pass urgent legislation to prevent, or quickly reverse, significant reductions in Medicare physician payment rates in response to the so-called "Sustainable Growth Rate" formula (SGR) Congress enacted many years ago. Sometimes these payments fix have lasted for as little as a month or two at a time. Once again, on February 22, 2012, President Obama signed into law the Middle Class Tax Relief and Job Creation Act of 2012, which freezes Medicare doctor pay rates for the rest of 2012. Medicare physician payments were set to decrease by 27.4% on March 1, 2012, after Congress had postponed the SGR cut for two months in December 2011 through the passage of the Temporary Payroll Tax Cut Continuation Act of 2011. Unless subsequent legislation is enacted, Medicare physician payments are scheduled for an estimated 32% cut in January 2013.

Because many commercial payers utilize at least some aspect of the Medicare Physician Fee Schedule to determine physician reimbursement, and because, until the SGR is repealed, Medicare physician payments are perennially exposed to the risk of significant reductions, physicians should review their managed care contracts to determine: (1) if a Medicare payment cut will result in a corresponding reduction in their commercial payments; and (2) the extent to which they should negotiate contractual amendments that will protect them from commercial payment reductions should Medicare payment rates be reduced.

Visit the AMA's [Medicare Physician Payment Action Kit](#) for more information on the SGR, including the current status of repeal efforts.

I. Introduction

According to a 2006 survey conducted by the American Medical Association (AMA) ("2006 survey"), more than 75 percent of private, non-Medicare payers (health insurers, HMOs, PPOs, self-insured employers, etc.—collectively, "managed care organizations" [MCOs]) were utilizing the Medicare Resource-Based Relative Value Scale (Medicare RBRVS) in at least one of their product lines. Many commercial managed care contracts offered to physicians contain fee schedules purporting to base payment on the Medicare RBRVS, although recent developments indicate that payers often modify the rules such that payments made pursuant to these contracts are not always consistent with the current Medicare payment system. Contractual fee schedules may also state that payment will be based on a percentage of the "Medicare Physician Fee Schedule." These references to the Medicare RBRVS or the Medicare Physician Fee Schedule may encourage physicians to make a number of assumptions concerning contractual payment. These assumptions often include the belief that: (1) payment will be calculated based on the relative values that the current Medicare RBRVS assigns to the physician's services, multiplied by a conversion factor to which the parties have agreed; or (2) payment rates will be based on what Medicare **actually pays** for the physician's services. Yet fee schedule language may use the terms "Medicare RBRVS" or the "Medicare Physician Fee Schedule" imprecisely and may not include recent improvements in the Medicare RBRVS valuation.

This resource is designed to help physicians identify, understand and potentially rectify through negotiation problematic issues that frequently arise when managed care agreements purport to base payment on the Medicare RBRVS or the Medicare Physician Fee Schedule. This resource suggests

questions that physicians may employ in their efforts to minimize confusion, confirm the payment amounts and judge whether signing the contract makes sound business sense.

MCO employees and representatives—even those who draft managed care agreements—may not fully understand the Medicare RBRVS or the various meanings which may be ascribed to the term “Medicare Physician Fee Schedule.” A physician should not, therefore, assume that the individuals who drafted the contract or other MCO personnel understand: (1) that the term “Medicare Physician Fee Schedule” may not mean what they think it means; (2) the Medicare RBRVS itself; (3) how the MCO will use the Medicare RBRVS to determine payment; or (4) whether the “Medicare RBRVS” referenced in the contractual fee schedule is identical to the Medicare RBRVS as it is currently used by the Medicare program to pay Medicare claims. The questions contained in this resource are designed to help physicians alert MCO personnel of the confusion that often accompanies reference to the Medicare RBRVS or Medicare Physician Fee Schedule in managed care contracts. Knowledge is power, and physicians who can educate MCO personnel concerning contractual deficiencies may buttress their ability to seize the initiative in framing contract negotiations.

II. A possible alternative approach

One method of dealing with concerns and confusion fostered by language purporting to base payment on “a percentage of the Medicare RBRVS” or “a percentage of the Medicare Physician Fee Schedule” is to replace that language. For example, the physician may want to suggest replacing such references with something like the following language:

“MCO will pay the physician:

1. _____% of the **actual physician rates** paid by Medicare, effective 01/01/20__ [nationally][for the physician’s geographic location];
2. _____% of Medicare Average Sales Price (ASP) Drug Pricing, effective 01/01/20__;¹
3. _____% of Medicare Clinical Laboratory Fee Schedule (MCLFS), effective 01/01/20__ [nationally][for the physician’s geographic location];
4. _____% of Medicare Durable Medical Equipment, Prosthetics/Orthotics, and Supplies Fee Schedule, effective 01/01/20__ [nationally][for the physician’s geographic location].”²

Restructuring the contract’s language in this way clarifies the scope of the MCO’s payment obligations and enables the physician to calculate expected payment because payment is now defined in terms of what Medicare **actually pays**.

In addition to suggesting this language, the physician should consider suggesting that the MCO update each of these schedules contemporaneously with Medicare’s updates to the extent that these updates increase payment. If the MCO’s fee schedule already contemplates using one or more of the schedules listed in (1) through (4) above, the physician should consider verifying when the MCO will perform updates relative to Medicare. For example, some MCO contract fee schedules using ASP update their ASP quarterly just as Medicare does. Nevertheless, these MCO quarterly updates often do not occur contemporaneously with Medicare’s. Instead, MCO ASP quarterly updates often occur at least 30 days after Medicare’s updates. On the other hand, as noted above, physicians should attempt to protect themselves against the application of an SGR reduction to their commercial managed care contracts.

¹ If the physician expects to be paid for furnishing drugs, basing drug payment on a percentage of ASP drug pricing will generally provide more clarity than drug payment based on the Average Wholesale Price (AWP). Unlike the ASP rate, there is no single recognized rate establishing the AWP. Additionally, ASP rates are easily accessible on the Centers for Medicare and Medicaid Services (CMS) Web site, are available prior to their effective date, and cover a broad range of HCPCS codes.

² This sample language has been suggested by Mark Rieger, Chief Executive Officer of National Healthcare Exchange Services (NXHS).

III. Meaning of “Medicare Physician Fee Schedule”

Many managed care contracts purport to base payment on a percentage of the Medicare Physician Fee Schedule. Use of the term “Medicare Physician Fee Schedule” may, however, be subject to interpretive ambiguities. For example, an MCO may intend “percentage of the Medicare Physician Fee Schedule” to mean that the MCO will pay a percentage of what Medicare actually pays the physician. But a physician may understand “Medicare Physician Fee Schedule” to refer only to the relative values in the Medicare RBRVS. As long as any ambiguity exists, the physician may be unable to predict contractual payment rates, as more fully discussed below. Unless other language in the contract eliminates all ambiguity as to how the physician will be paid, it is advisable that the physician seek additional information from the MCO concerning the precise meaning of its use of the term “Medicare Physician Fee Schedule.”³

IV. A brief explanation of the Medicare RBRVS

A. The Medicare RBRVS measures the amount of physician resources required to provide a specific service.

The Centers for Medicare and Medicaid Services (CMS) uses the Medicare RBRVS to measure the total amount of physician resources required to provide a specific physician service. The total amount of physician resources is referred to as the service’s “relative value.” A service’s relative value is measured by determining the “relative value units” (RVUs) with respect to the following three factors: (1) physician work; (2) practice expense; and (3) professional liability insurance. The Medicare RBRVS determines each service’s work, practice expense and professional liability insurance RVUs.

The physician work RVU accounts, on average, for 48.3 percent of the total relative value for each physician service. The factors used to determine the physician work RVU include: the time it takes to perform the service; the technical skill, physical effort, mental effort, and judgment required to perform the service; and the stress on the physician resulting from the service’s potential risk to the patient. The physician work RVUs are updated each year to account for changes in medical practice. These updates are based on recommendations from a committee involving the AMA and national medical specialty societies: the AMA/Specialty Society RVS Update Committee (RUC).

The practice expense RVU measures physician resources used to provide a particular service. Expenses included in this RVU are those associated with the physician’s use of nonclinical personnel to provide the service and expenses for office space, equipment and supplies. The practice expense RVU accounts, on average, for 47.4 percent of the relative value assigned by the Medicare RBRVS to each physician service.

The professional liability insurance RVU accounts, on average, for 4.3 percent of the relative value for each physician service, and is designed to reflect the cost of obtaining medical liability insurance.

Once the Medicare RBRVS assigns the appropriate numerical values to the work, practice expense and professional insurance liability RVUs for a specific service, the Medicare RBRVS then adds these numerical values to derive the specific service’s relative value. Calculating a particular service’s relative value does not, however, determine what Medicare will pay the physician.

³ The AMA believes that the term “Medicare Physician Fee Schedule” should be understood to refer to the Medicare RBRVS and its relative values, in part because the Medicare Physician Fee Schedule published every year in the Federal Register by CMS only lists the relative values assigned to the services for which Medicare pays. To view the 2012 Medicare Physician Fee Schedule, visit <https://www.cms.gov/PhysicianFeeSched/PFSFRN/itemdetail.asp?filterType=none&filterByDID=99&sortByDID=4&sortOrder=descending&itemID=CMS1253669&intNumPerPage=10>

B. Geographical Practice Cost Index⁴

After the Medicare RBRVS determines the numerical value of a service's work, practice expense and professional liability insurance RVUs, CMS adjusts each of those RVUs using the Geographical Practice Cost Index (GPCI) in an effort to reflect broad differences in the costs of operating medical practices in 89 different localities in the United States.

The work GPCI adjusts the work RVU to take into account geographic differences in the cost of living in the 89 localities. The work GPCI is **not** based on **physician** earnings. It is instead based on the earnings of the following seven professional occupational groups: architecture and engineering; computer, mathematical and natural sciences; social scientists, social workers and lawyers; education, library and training; registered nurses; pharmacists; writers, artists and editors.

The Medicare Prescription Drug Improvement and Modernization Act of 2003 required all GPCIs in 2004–2006 to be set at least at 1.0—the national average. Subsequent legislation extended this 1.0 floor until June 30, 2008. Fortunately for many physicians, Section 134 of MIPPA (“Section 134”) continued the 1.0 floor through December 31, 2009, the Patient Protection and Affordable Care Act (ACA) extended the 1.0 floor through 2010, and the Medicare and Medicaid Extenders Act of 2010 (MMEA) further extended the 1.0 GPCI floor through 2011. The Temporary Payroll Tax Cut Continuation Act of 2011 extended the 1.0 GPCI floor through the end of February 2012, and the Middle Class Tax Relief and Job Creation Act of 2012 extended the 1.0 floor until then end of 2012.

The practice expense GPCI adjusts the practice expense RVU to reflect geographic differences in the prices of medical practice inputs (e.g., office rent per square foot and staff hourly wages) in the 89 GPCI localities. The practice expense GPCI is not physician-specific. In other words, it does not reflect geographic differences in the amount of space that physicians rent nor in the number of non-physician personnel they employ. It is important to distinguish between the practice expense component of the practice expense RVU and the practice expense GPCI—the practice expense RVU reflects average direct and indirect practice expenses, but the practice expense GPCI takes into account only the differences in these costs across geographic areas relative to the national average.

The professional liability insurance GPCI reflects geographic differences in premiums for a mature claims policy that provides \$1 million/\$3 million of coverage.

C. CMS determines physician payment for a particular physician service by multiplying the relative value of that service by a *conversion factor*.

Once the Medicare RBRVS determines a service's relative value, CMS determines what Medicare will pay for that service by multiplying the service's relative value by a **conversion factor**, a monetary amount set by CMS. The Medicare conversion factor varies from year to year. In 2011, the conversion factor was 33.9764, in 2012, the conversion factor is \$34.0376. Generally speaking, the greater the relative value assigned by the Medicare RBRVS to a physician service, the more Medicare will pay a physician for providing that service. This is because Medicare applies a single conversion factor to calculate the majority of physician fees.

⁴ GPCI accuracy is subject to question. AMA policy reflects organized medicine's accuracy concerns. *See e.g.*, H-400.952 Consolidation of Medicare Fee Schedule Areas stating that “The AMA will continue to petition CMS to improve the accuracy of the Geographic Practice Cost Indices (GPCIs) through the use of accurate practice costs and timely data; and will petition CMS and, if necessary, the Congress to retain as distinct Medicare localities, cities where recent inclusion in state-wide localities by CMS is based on criteria that do not allow for appropriate recognition of the higher costs associated with practice in these areas.”

Please note that on February 22, 2012, the Middle Class Tax Relief and Job Creation Act of 2012 was enacted. This law prevented a Medicare physician payment reduction of 27% that otherwise would have occurred on March 1, 2012. Unless Congress takes subsequent action prior to the end of 2012, Medicare physician payment is scheduled for an estimated 32% cut in January 2013.

Physicians should therefore review their managed care contracts well before the end of 2012 to determine: (1) if a Medicare payment cut will result in a corresponding reduction in their commercial payments; and (2) the extent to which physicians should negotiate contractual amendments that will protect them from commercial payment reductions should Medicare payment rates be reduced on January 1, 2013. Physicians should also review their managed care contracts to determine the extent to which a possible discontinuation of the Medicare GPCI floor of 1.0 on January 1, 2013, may negatively effect their commercial payments and what pro-active steps they may need to take in order to protect themselves in the case of such a contingency.

V. Identifying and rectifying problems that may exist when managed care contracts purport to base payment on a “percentage of the Medicare RBRVS,” or on a “percentage of the Medicare Physician Fee Schedule”

A. Fee schedules paying a “percentage of the Medicare RBRVS” or a “percentage of the Medicare Physician Fee Schedule” may provide little, if any, information concerning actual payment.

Frequently, managed care agreements state that the MCO will pay the physician based on a “percentage of the Medicare RBRVS,” or “a percentage of the Medicare Physician Fee Schedule.” Such references to the Medicare RBRVS or to the Medicare Physician Fee Schedule may lead a physician to believe erroneously that the MCO will pay the physician based on a percentage of what Medicare actually pays. This belief may be mistaken because, as described above, Medicare’s RBRVS does not by itself determine payment rates. Accordingly, use of the phrase “percentage of the Medicare RBRVS” does not provide the physician with meaningful information regarding actual payment. References to the “Medicare Physician Fee Schedule” will be just as problematic if by that phrase the MCO means the Medicare RBRVS. Additional ambiguity arises to the extent the MCO uses the term “based on” to mean something other than “identical to” (i.e., that the MCO has made changes to the official, current Medicare RBRVS or Medicare Physician Fee Schedule).

B. Physicians should clarify fee schedules basing payment on a percentage of the Medicare Physician Fee Schedule.

As already noted, fee schedules that claim they will pay the physician a percentage of the Medicare Physician Fee Schedule may be ambiguous because “Medicare Physician Fee Schedule” could mean (1) what Medicare actually pays the physician or (2) the Medicare RBRVS. When offered a contract purporting to pay the physician a percentage of the Medicare Physician Fee Schedule, the physician should consider seeking clarification regarding whether (1) or (2) applies.

C. Will payment be based on the current version of the Medicare RBRVS or the Medicare Physician Fee Schedule?

Failing to ensure that your reimbursement is based on the current version of the Medicare RBRVS or the Medical Physician Fee Schedule may result in your receiving payment that is significantly less than what you would receive had the MCO used the current version of the Medicare RBRVS or Medicare Physician Fee Schedule. A payment methodology based on an out-dated Medicare RBRVS or Medicare Physician Fee Schedule is not consistent with AMA policy because it ignores the most current relative values.⁵

An MCO’s failure to update work RVU values is one way in which the failure to use current Medicare RBRVS values can result in decreased physician reimbursement. For example, for the 2007 and 2008 Medicare Physician Fee Schedules, CMS imposed arbitrary, across-the-board reductions to all work

⁵ D-400.999 Non-Medicare Use of the RBRVS

RVUs in an effort to achieve budget neutrality. In 2007 the reduction was 10.06 percent and in 2008 the reduction was 11.94 percent. But in 2008 the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) prohibited CMS from making such arbitrarily reductions in 2009 and subsequent years. As a result, MIPPA significantly increased the relative values assigned to many physician services vis-à-vis the 2008 Medicare RBRVS. And by increasing relative values, MIPPA resulted in a substantial increase in Medicare payment for physicians who perform services that involve more physician work compared with payments made under the 2008 Medicare RBRVS. Unfortunately, even though MIPPA prohibited arbitrary reductions of work RVUs in 2009 and subsequent years, some MCOs in 2009 continued to use the arbitrarily reduced work RVUs that existed in 2007 and 2008. The failure to update their Medicare-based fee schedules to reflect the increases in work RVUs resulted in many physicians receiving reimbursements significantly lower than what they should have received if MCOs had appropriately updated their schedules to reflect the current, post-MIPPA Medicare RBRVS values.

Of course, this discussion is subject to the caveat that, until the SGR issue is finally resolved, physicians will also want to consider the implications of a contract based on the current Medicare Physician Fee Schedule that does not contain an exception that prohibits application of any SGR reduction to the negotiated fee schedule.

A payment methodology based on an outdated Medicare RBRVS or Medicare Physician Fee Schedule is not consistent with AMA policy because it ignores the most current relative values.⁶ A method that fails to utilize current relative values will deprive some physicians of payment to which they would be entitled under the Medicare RBRVS current relative values. It is, therefore, imperative that physicians ensure that any fee schedules basing payment on the Medicare RBRVS incorporate updated relative values contemporaneously with Medicare's updates.

If the contract purports to base payment on a percentage of the Medicare Physician Fee Schedule in the sense that the MCO will pay a percentage of what Medicare pays, the physician should also consider clarifying whether the percentage will be based on what Medicare is **currently** paying.

D. How often will the MCO update relative values?

CMS updates the Medicare RBRVS relative values annually. CMS also reviews the entire Medicare RBRVS every five years and makes appropriate changes pursuant to that review. Even if the MCO uses the current Medicare RBRVS relative values, the physician should consider seeking clarification concerning whether, and how, the MCO's "Medicare RBRVS" incorporates all of the latest CMS updates. Medicare publishes its revised fee schedule in November of each year, with implementation on Jan. 1 of the following year. Some MCOs using the Medicare RBRVS update their relative values on Jan. 1, just as Medicare does. But other MCOs do not perform updates until April or July of the following year. Given this variation, the physician should not assume that updating will take place concurrently with Medicare's. Accordingly, the physician should consider asking the MCO whether it will automatically update its relative values and, if so, when those updates will take place.

Prompt updating is likely to be a key concern for the physician, since the physician community, through the CPT® Editorial Panel and the AMA/Specialty Society RVS Update Committee (RUC), is able to provide significant input to describe new technology to ensure that the Medicare RBRVS relative values are based on the current resources required to perform the service.

Questions concerning method and frequency of updates are equally important when contract language purports to pay a percentage of the Medicare Physician Fee Schedule, where "Medicare Physician Fee Schedule" means the amount that Medicare actually pays the physician. Here again, the physician should consider asking the MCO whether it will automatically update payment rates concurrently with Medicare's updates, or whether contractual amendments are prerequisites to updates.

⁶ D-400.999 Non-Medicare Use of the RBRVS

E. What are the MCO's conversion factors, in dollars and cents?

The conversion factor that an MCO uses in conjunction with its RBRVS system plays an instrumental role in payment determination. Although Medicare has used a single conversion factor (except for anesthesia), some MCOs use two or more conversion factors. Prior to signing a contract, the physician should feel confident that he or she understands what conversion factor(s) the MCO intends to use when calculating physician payments and the value of those conversion factors in dollars and cents. The physician may also be well advised to determine the scope of the conversion factors used by the MCO, as different conversion factors can be used to calculate payment for surgical, specialty and primary care services. Different conversion factors may also be used to determine payment that is contingent on the type of health plan product in which the physician has agreed to participate. The physician should also ask whether, when and how the MCO will update its conversion factor, including whether the conversion factor can decrease, whether due to the SGR, changes to the GPCI or any other reason. Generally speaking, physicians should seek to include language clearly prohibiting, or at least limiting any such decreases.

F. What are the components/relative values of the MCO's RBRVS?

Although a contract may purport to use a Medicare RBRVS, the physician should consider clarifying whether the components of the MCO's RBRVS are identical to those used by Medicare (i.e., physician work, practice expense and professional liability insurance RVUs). Because MCOs in commercial markets are not constrained by Medicare requirements, nothing prohibits MCOs from utilizing (intentionally or unintentionally) non-Medicare components in their RBRVS.

Even if the MCO RBRVS uses the same components as Medicare's, the physician may consider clarifying whether the MCO's RBRVS assigns the same numerical values to the work, practice expense and professional liability insurance RVUs that the Medicare RBRVS assigns to the CPT codes that correspond to the services that the physician will be providing under the contract. An MCO's assignment of differing numerical values to those CPT codes is likely to produce payments that deviate from Medicare's.

G. Physicians should determine how the MCO defines the components of its RBRVS system.

If the MCO's RBRVS uses only physician work, practice expense and professional liability insurance RVUs, the physician may wish to clarify whether the MCO's **definition** of these RVU components is identical to Medicare's. A fee schedule's reference to the Medicare RBRVS does not ensure that the MCO defines the work, practice expense or physician liability insurance RVUs identically with Medicare. For example, although the MCO's RBRVS may contain a "practice expense" RVU component, such inclusion does not guarantee that the practice expense RVU accounts for all of the expenses included within Medicare's definition.

H. Will the MCO use Medicare's GPCI and associated 89 localities?

A fee schedule basing payment on the Medicare RBRVS without further description does not communicate vital information regarding whether or not the MCO will geographically adjust payments. Even if the fee schedule alludes to geographical adjustments, the physician should not assume that those adjustments will be identical to those made by Medicare's GPCI. Nor should the physician assume that localities the MCO might employ in connection with its geographical adjustments are coextensive with Medicare's 89 localities. Accordingly, prior to signing an agreement, the physician may wish to clarify whether: (1) the MCO will geographically adjust some or all of the components of its RBRVS system; (2) those adjustments will correspond to GPCI adjustments; and (3) the extent to which any adjustments are performed in association with Medicare's 89 GPCI localities.

The aforementioned GPCI-related issues also exist if there is language that claims to base payment on "a percentage of the Medicare Physician Fee Schedule."

I. How often will the MCO update geographic adjustments?

CMS is required to update the GPCIs every three years and to phase in any changes over two years. CMS updated the GPCIs in the 2012 Medicare Physician Fee Schedule. Because of this recent update, physicians should be very careful to review any contracts that are being offered to them, or up for renewal, in 2012.

Even if the MCO uses the current Medicare GPCIs, the physician should consider seeking clarification concerning whether and how the MCO's "Medicare RBRVS" incorporates the latest Medicare GPCI updates.

Questions concerning method and frequency of GPCI updates are equally important when contract language purports to pay a percentage of the Medicare Physician Fee Schedule when "Medicare Physician Fee Schedule" means the amount that Medicare actually pays the physician.

J. Coding and payment policies and rules

1. Will the MCO use Medicare's coding edits and payment rules and policies or other, proprietary coding and payment methodologies?

Fee schedule language basing payment on the Medicare RBRVS or on a percentage of the Medicare Physician Fee Schedule carries with it **no guarantee** that the MCO will only utilize Medicare's coding edits or payment rules and policies, or even that the MCO will use **any** of those rules and policies. Because the MCO in its commercial business is not constrained by Medicare requirements, nothing prevents the MCO from utilizing a set of proprietary coding edits and payment rules and policies that are wholly distinct from Medicare's.

Accordingly, prior to signing the contract, the physician would be well-advised to seek answers to the following questions:

- Will the MCO conform to Medicare policies and rules concerning coding, edits, recoding and modifier use?
- Will the MCO delete Current Procedural Terminology (CPT®) codes that Medicare recognizes?⁷
- What documents or attachments will the physician be required to submit when claiming payment for specific services (e.g., those services billed under evaluation and management CPT codes)?
- Will the MCO bind itself to Medicare's coding edits and bundling policies (e.g., policies concerning multiple surgery reduction), or will it utilize other, proprietary bundling software?
- If the MCO utilizes proprietary coding edits or payment rules in place of, or in addition to, Medicare's, will the MCO make those coding edits and payment rules available to the physician prior to signing the contract?
- If the MCO will disclose its coding edits and payment rules, will the disclosure be in a format that can be readily uploaded into, and subsequently utilized by, the physician's practice management system?

Even if a fee schedule purports to base payment on the Medicare RBRVS and current relative values, use of the Medicare RBRVS and current relative value will be of little use to the physician in determining expected payment if the MCO does not also adopt and limit itself to Medicare's coding edits and payment policies.

Example illustrating how an MCO's application of proprietary payment policies, rather than those used by the Medicare Program, may result in lower reimbursement than the physician would have received had the MCO utilized Medicare's bundling policies.

⁷ CPT is a registered trademark of the American Medical Association.

The Medicare Program utilizes various payment policies. For example, Medicare utilizes multiple procedure reduction logic (MPRL) to reduce payment for multiple surgeries. This MPRL applies when those surgeries are separate procedures performed by a single physician or physicians in the same group practice on the same patient at the same operative session or on the same day for which separate payment may be allowed. Under its MPRL, when the same physician performs more than one surgical service at the same session, Medicare pays the full Medicare Physician Fee Schedule amount for the surgical code on the physician's claim that has the highest relative value. For each of the remaining codes with lower relative values, Medicare pays fifty percent of the Medicare Physician Fee Schedule allowed amount. For example, if Medicare applied its MPRL to three surgical procedures having the respective total relative values of 11.00, 13.00, and 15.00, Medicare would pay 100% of the allowed amount for the 15.00 code, and fifty percent (50%) of the allowed amounts for the 13.00 and 11.00 codes.

Although MCOs may apply an MPRL to the same kinds of services, e.g., surgeries, as does the Medicare Program, the MCO's MPRL may generate a payment significantly lower than that of the Medicare Program. For example, if a physician lists multiple surgical procedures on the CMS-1500 or ASC X12 837 Professional Claim Form, an MCO's MPRL might designate the primary procedure based on which code is reported first on the claim. For example, if the first reported code on the claim has the total relative value of 11.00 and the second and third codes have the respective relative values of 13.00 and 15.00, the MCO would pay 100% of the fee schedule amount for the 11.00 procedure, then fifty percent (50%) of the fee schedule amount for codes with the higher total relative values (assuming that the MCO's MPRL percentage reductions are the same as those of Medicare's MPRL—see the following paragraph). But this is just one method by which MCOs may identify the primary procedure. The following are other algorithms that MCOs use to designate primary procedures:

- first reported code without a modifier 51 appended;
- code with the highest allowed amount (contracted rate);
- code with the highest total relative value units;
- code with the highest physician fee schedule charge;
- site-specific RVUs (dependent on the rendering place of service);
- facility RVUs only; or
- non-facility RVUs.

Also, it is vital to recognize that, aside from differing from Medicare in the manner in which their MPRLs identify primary procedures, MCOs' MPRLs may diverge significantly from Medicare with respect to the percentages paid by the MCO for additional procedures. Although physicians often assume that an MCO's MPRL rule will be consistent with Medicare's—100% payment applied to the primary procedure, and 50% payment applied to the remaining procedures—MCOs' rules vary. Some examples of MCO rules include:

- 100% applied to the primary procedure and 50% applied to the second through sixth procedures;
- 100% applied to the primary procedure, 50% applied to the second procedure and 25% applied to the third through sixth procedures;
- 100% applied to the primary procedure, 50% applied to the second procedure, 25% applied to the third procedure, 10% applied to the fourth procedure, 5% applied to the fifth procedure and 0% applied to the sixth procedure; and
- 100% applied to the primary procedure, 50% applied to the second procedure, 50% applied to the third procedure, 25% applied to the fourth procedure, and 25% applied to the fifth procedure and sixth procedures.

2. Will the MCO use Medicare's global surgery periods?

Medicare pays surgical procedures according to a **global** period (i.e., one payment reimburses the physician not only for the surgery itself but also for preoperative and postoperative services provided by

the physician within specific time frames). For example, the preoperative period included in the global payment period for major surgery is one day and the postoperative period is 90 days. The global period applies regardless of whether the surgery is performed in a hospital, ambulatory surgery center or physician office. Medicare's global period does not include services such as: the surgeon's initial patient evaluation to determine the need for surgery; visits unrelated to the diagnosis for which the surgical procedure was performed; or treatment which was not part of the normal recovery from surgery.⁸

Even if an MCO utilizes the current Medicare RBRVS relative values, the MCO may not adopt Medicare's global payment periods. The AMA has learned that some MCOs have attempted to lower payments for surgical procedures by redefining Medicare global surgery periods. The AMA strongly opposes such redefinition and encourages MCOs using the Medicare RBRVS to employ Medicare's global periods.⁹ Notwithstanding the AMA's position, a physician should not assume that a MCO's global periods comport with Medicare's. Accordingly, before signing a contract, a physician may wish to determine which global periods the MCO will apply.

3. To what extent will the MCO utilize Medicare's site-of-service differential?

Sometimes the amount that Medicare pays for a service depends on where the service is provided. Payment that is contingent upon where the service is provided is referred to as the "Medicare site-of-service differential." The Medicare site-of-service differential is intended to take into account the difference in practice expenses between services provided in a facility (e.g., a hospital) and a non-facility (e.g., the physician's office). The Medicare RBRVS practice expense RVU methodology recognizes that physicians incur more costs when services are performed in the office (e.g., staff wages and supplies) vis-à-vis the hospital, where the hospital incurs the costs of supplies and staff wages. Some MCOs use fee schedules that employ non-Medicare site-of-service payment differentials. Prior to signing a contract, a physician may wish to clarify: (1) whether any fee schedules will utilize site-of-service payment differentials, and, if so, (2) the extent to which those differentials diverge from Medicare's.

K. What will the MCO pay for procedure codes to which Medicare has yet to assign a payment rate?

The physician may anticipate that he or she will seek payment for providing services to which Medicare has yet to assign a payment rate. If Medicare has yet to adopt codes, a fee schedule basing payment on the Medicare RBRVS or on a percentage of the Medicare Physician Fee Schedule may also lack applicable rates. If the physician expects to provide such services under the contract, the physician may wish to ask the MCO whether and how much the MCO will pay for those services.

L. Will the MCO provide specific payment examples?

Anytime the physician does not feel confident that fee schedule language or the MCO's explanation provides information sufficient to accurately predict payment, the physician may want to consider requesting examples showing how the physician will be paid for providing a specific service. In some cases, state law may even require the MCO to provide such examples.¹⁰

M. Will the MCO pay the physician for items and services not compensated by its conversion factor/Medicare RBRVS or Medicare Physician Fee Schedule methodologies?

Medicare sometimes pays physicians for providing items and services using payment mechanisms other than the conversion factor/Medicare RBRVS methodology. Contracts purporting to pay the physician based on the Medicare RBRVS or on a percentage of the "Medicare Physician Fee Schedule" may lead physicians to erroneously assume that the MCO will pay the physician for **all** of the items and services for

⁸ Further information can be found in Medicare Claims Processing Manual, Chapter 12: Physicians/Non-physician Practitioners, § 40, which can be accessed at <http://www.cms.hhs.gov/manuals/iom/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS018912&intNumPerPage=10>.

⁹ H-70.948 Exclusion of Preoperative Services from Surgical Global Fee; H-400.956 RBRVS Development

¹⁰ See e.g., Tenn. Code Ann. § 56-7-1013(b)

which Medicare pays. For example, in addition to paying physicians pursuant to its conversion factor/RBRVS methodology, Medicare also pays physicians utilizing:

- ASP Drug Pricing;
- the Clinical Diagnostic Laboratory Fee Schedule; and
- the Durable Medical Equipment (DME), Prosthetics, Orthotics and Supplies Fee Schedule.

References to a “Medicare RBRVS” or “a percentage of the Medicare Physician Fee Schedule” convey no specific information concerning: (a) whether the MCO will pay the physician in a manner analogous to 1, 2 or 3; and (b) the amount of that payment. Accordingly, the physician may wish to seek clarification concerning the extent to which the MCO will pay for drugs, clinical lab services, DME, prosthetics, orthotics or supplies.

N. Does the MCO utilize the Hospital Outpatient Prospective Payment System cap for imaging services?

Section 5102(b) of the Deficit Reduction Act of 2005 placed a payment limit on the technical component (TC) of many diagnostic imaging tests. This cap is based on the Hospital Outpatient Prospective Payment System (HOPPS). Under this cap, the amount Medicare Part B pays for the TC of a diagnostic imaging test performed in a freestanding setting (e.g., a physician office), must be the lower of what Medicare Part B pays for the TC or what the HOPPS pays for the TC. The HOPPS cap has sometimes lowered physician payment for the TC of diagnostic tests. If the physician anticipates billing the MCO for providing diagnostic imaging tests, the physician may consider asking the MCO to clarify whether and to what extent the MCO’s conversion factor/RBRVS payment methodology incorporates the HOPPS cap.

O. Does the contract contain one fee schedule or different fee schedules for different plans or products in which the physician will be required to participate?

A contract may obligate a physician to participate in more than one health plan or product offered by the MCO. Such plans or products may include, but not be limited to, a health maintenance organization, preferred provider organization, and governmental or self-funded employer plans or products. Each plan or product is likely to have a different fee schedule associated with it to reflect the fact that physician practices often have a different cost structure for participating in different health products and/or the fact payers are charging different premiums for those products. If a contract presents a physician with various fee schedules purporting to base payment on the Medicare RBRVS or Medicare Physician Fee Schedule, the physician should consider using this document to clarify the meaning and use of each such fee schedule.

VI. Conclusion

Many managed care contracts that purport to base payment on the Medicare RBRVS or on a percentage of the Medicare Physician Fee Schedule may not provide information sufficient to enable a physician to determine what actual compensation rates will be, and may not be based on current relative values.

Physicians should, therefore, be reticent to make assumptions concerning payment under the contract until they obtain satisfactory, clarifying information from the MCO offering the contract. This resource should facilitate such efforts. For further assistance or information, please contact Wes Cleveland at the AMA’s Private Sector Advocacy unit at (312) 464-4503. Visit

www.ama-assn.org/go/rbrvs for information on the Medicare RBRVS and the AMA/Specialty Society RVS Update Committee (RUC).

Chapter 3: Pay-for-performance programs

Steve Ellwing

I. Introduction

A. What is pay-for-performance?

Under a “pay for performance” (PFP) approach, a health insurer or other payer compensates physicians according to an evaluation of physician performance, typically as a potential bonus on top of the physician’s fee-for-service compensation. Typically this involves an evaluation of the quality of the health care services you provide, or how cost effective you are in treating your patients, or both. PFP methodologies can be used to measure your performance individually, or to measure the performance of a larger physician group within which you are included. This assessment of your quality and costs is frequently referred to respectively as your “quality profile” and “cost-effectiveness profile.” Although most health plans will use some combination of quality profiles and cost profiles to determine your performance, and thus your potential PFP bonus, some health plans may only use one or the other. Finally, some PFP programs are focused solely on getting the physician practice to do something, like adopt electronic prescribing.

Although this chapter discusses PFP methodologies separately from the other payment models discussed in this manual, it is highly likely that, with the advent of value-based purchasing initiatives in the public and commercial sectors, quality and cost-effectiveness profiling will play a significant role in determining your reimbursement, regardless of the applicable compensation methodology. So, whenever you encounter a payment model that uses physician profiling (all or in part) to determine reimbursement level, be sure to identify the extent to which your quality and/or cost-effectiveness profile will be a factor in determining your compensation.

B. You will need to evaluate carefully the advantages and disadvantages of participating in any PFP programs.

Although some studies have found strong potential support for financial incentives for quality, PFP programs have some downsides. In addition to the serious questions being raised about the validity and reliability of performance measures, some PFP programs have been poorly constructed and others are weighted too heavily in favor of cost savings over quality improvement. At their worst, often because they are not properly risk-adjusted, PFP initiatives can result in reduced access to care for poorer, older and chronically ill patients and perverse incentives against the most highly qualified physicians who care for such patients. This chapter addresses the key issues that you should consider when deciding whether or not to participate in a PFP program.

C. Examples of PFP programs

PFP programs are diverse, and there is no set standard concerning what should be measured, how measurement should be performed or how reward systems should be structured. The AMA has performed analyses that determine the extent to which some of the major national payer PFP programs’ comply with the [AMA’s Principles and Guidelines for Pay-for-Performance Programs](#). When comparing and contrasting various PFP opportunities, programs that physicians may also want to peruse include:

- the Bridges to Excellence Program, particularly its physician office link, diabetes care link and cardiac care link programs, at www.bridgestoexcellence.org;

- the Diabetes Physician Recognition Program, developed by the American Diabetes Association; and,
- the Integrated Healthcare Association's (IHA) program. The IHA has developed the most widely implemented PFP program in California. For more information on the specifics of the IHA program, including the specific clinical measures used, go to the IHA website at www.ih.org and click on "Pay for Performance."

II. Quality profiling programs

A. How will your quality profile be created?

To determine your quality profile, a health plan will examine your claims data and evaluate your performance relative to your peers with respect to quality goals or benchmarks, such as how frequently you complied with applicable evidence-based guidelines or how frequently you performed certain tasks specified by quality measures for conditions that are present in your patients (e.g. did your diabetic patients receive an annual foot exam?). These types of measures are frequently referred to as “process” measures; as they measure whether a task or process was completed. Additionally, your quality scores may be based, in part, on other types of metrics, which cannot be measured using claims only data, including but not limited to: patient outcome measures, which assess the results of process(es) performed; the results of patient satisfaction surveys; the avoidance or reduction in the occurrence of avoidable infections, readmissions, or other adverse events; and structural measures (e.g., the extent to which you have implemented electronic health records).

B. Key considerations when evaluating a health plan’s quality profiling methodology.

1. Are you confident in the measures that the health plan will use to determine your quality profile? The measures used to determine your quality profile must be scientifically sound, objective and reflect the best practices that currently exist in your particular specialty. The measures the health plan uses should be based on nationally recognized, evidence-based medical standards or consensus-based guidelines. If the measures are faulty, poorly constructed or directed at the wrong targets, the program has little chance for success. Ultimately, as payers begin to use standardized measures for various specialties, this process should become easier insofar as such measures are appropriately risk-adjusted and flexible enough to account for local variables.

2. Are you aware of all applicable measures used by the program? Prior to entering into a PFP program with a health plan, insist that the plan provides you with all of the quality measures that the health plan will use to determine your quality profile. Such disclosure is vital, since it will enable you to compare those measures with sound, objective measures reflecting best practices in your specialty that have been developed by reputable professional organizations.

3. Are the measures developed or adapted from nationally recognized measure development entities? One way to ensure that the health plan will employ appropriate quality measures is to determine the extent to which the plan adopts measures that have been developed and endorsed by nationally recognized entities whose work in the area of physician quality performance is generally accepted within the health care industry. The more the health plan utilizes nationally recognized measures, the more likely the health plan will accurately determine the quality of your health care services (assuming that all other aspects of the health plan’s quality measurement methodology are sound). *Note that even if the health plan does not utilize such measures, comparing the health plan’s measures with those developed by entities whose work in the area of physician quality performance is generally accepted may be an important factor in your evaluation of the soundness of the plan’s measures.* There are a number of entities whose work in the area of physician quality performance is generally accepted, including but not limited to the following:

- The Physician Consortium for Performance Improvement (PCPI) is an excellent source of quality measures.** Convened by the AMA, the PCPI is a physician-led initiative that includes methodological experts, clinical experts representing more than 50 national medical specialty societies and state medical societies, the Agency for Healthcare Research and Quality, and the Centers for Medicare and Medicaid Services. The PCPI has published numerous evidence-

based clinical performance measures, including but not limited to, measures concerning: adult diabetes; asthma; preventive care and screening; heart failure; hypertension; major depressive disorder; osteoarthritis of the knee; and chronic stable coronary artery disease. The PCPI's measures may be downloaded at the [Physician Consortium Performance Improvement](#) website.

- b. **The National Quality Forum is a measure endorsement entity that offers a reputable source of sound quality measures.** Once quality measures are developed by PCPI and similar entities, they are periodically reviewed and vetted -by the National Quality Forum (NQF). Measures brought before the NQF can be endorsed, endorsed with a time limit, referred back to the developer for revisions, or not endorsed. NQF endorsement essentially provides a seal of approval that measures are evidence-based and clinically relevant. The list of NQF endorsed measures may be accessed at http://www.qualityforum.org/Measures_List.aspx.
- c. **National medical specialty societies.** Many national medical specialties have developed their own quality measures. These too can serve as an appropriate basis upon which to evaluate the quality of your services. You may wish to contact your particular national specialty society to obtain a copy of those measures.

4. What about professional or accreditation criteria? In some cases professional or accreditation criteria can function as *part* of the basis of sound, objective quality measures. However, while professional or accreditation criteria may play an appropriate role in determining your quality profile, the health plan's should not judge quality based solely on such criteria.

5. To what extent will outcome measures be used? Although most quality measures are "process" measures, a health plan may also use, or be in the process of implementing, quality "outcome" measures, e.g., the percentage of patients who died as a result of surgery (surgical mortality rates), or the rate of surgical complications or hospital-acquired infections. However, patient outcomes may be influenced by many factors beyond your control. So, to the extent that the health plan employs, or anticipates implementing, outcomes measures, it is imperative that you determine the extent to which the health plan's risk adjustment methodology is capable of ensuring that your quality profile will not be determined by matters over which you have no control. For more information on risk adjustment, see chapter eight, "[Risk adjustment](#)."

6. Will the health plan base your quality score in part on so-called "structural" or "information technology investment" measures?

You should determine the extent to which the health plan will base your quality profile on structural measures, as they may constitute a significant percentage of your total quality profile. Structure or information technology investment measures can cover areas such as:

- electronic health records (EHRs);
- electronic prescribing systems (when separate from EHRs);
- medical order entry systems;
- care management;
- electronic clinical decision support at the point of care; and
- physician measurement and reporting.

In evaluating information technology measures, you should carefully consider the benefit and burden; for example, investment in an electronic health records system needs to be carefully planned or enormous amounts of money and time may be spent inefficiently. Ideally, your entire practice staff should participate in a needs assessment to determine which technology is most likely to lead to workflow efficiencies and improvements in quality. For further information, please access the AMA Practice Management Center's [health information technology resources](#).

7. Will the health plan evaluate your quality performance based in part on patient satisfaction measures? You should identify the extent to which the health plan will base your quality profile on the results of patient satisfaction surveys. Surveys will typically cover issues such as specialty care, timely access to care, doctor-patient communications and overall ratings of care. As there are different patient

satisfaction survey tools, you should review the particular tool that the health plan intends to use so that you can make sure the survey is not too long or worded unfairly, and that it can be easily implemented. Finally, if you work with ethnically diverse populations, you will want to consider the suitability of the proposed survey tool to that population. For more information, go to the [AMA's Patient Satisfaction Experience](#) website.

C. Key considerations regarding the methodology that the health plan will use to determine your quality profile.

1. How will the health plan determine your quality performance targets. Because your quality performance will be based on the extent to which you have achieved quality goals, it is vital for you to understand not only what those goals are, but also how the health plan arrives at those quality targets. The following considerations will help you identify, and evaluate the appropriateness of, your applicable quality targets, including any targets involving peer-to-peer comparisons.

- a. Insist that the health plan provides you with comprehensive information concerning the quality targets that will be applicable to you. This information should:
 - i. clearly identify all of your quality targets;
 - ii. describe the data the health plan used to determine those benchmarks by benefit plan type; and
 - iii. explain the methodology by which the health plan calculated your quality targets.

A key issue to consider is whether you and/or your peers can work with the health plan to establish local targets that are more relevant to your practice settings and/or demographic variables.

2. Methodology, including risk-adjustment. It is imperative that the health plan furnish you with comprehensive information describing the methodology it will use to generate your quality profile. This information must include, but not be limited to, the following two considerations.

- a. **Evaluating the statistical validity of your quality profile.** The health plan's use of sound quality targets and nationally recognized, evidence-based medical standards or consensus-based guidelines, is not, by itself, sufficient to ensure that your quality profile or score will produce reliable and accurate results. *Such results will only occur if the health plan bases your quality profile on a statistically valid number of disease states or specialty specific cases.* So, included within its description of its quality profiling methodology, the health plan must provide you with information sufficient to enable you to determine whether that methodology will produce statistically valid quality profiles, including but not limited to, the number of disease states or cases the health plan will utilize.
- b. **Risk adjustment.** It is likely that the validity of your quality profile will depend significantly on the accuracy of the risk adjustment technology used by the health plan's quality profiling methodology. This is particularly important if the plan uses outcome measures in addition to process measures. Insist that the health plan's explanation of its methodology includes a detailed description of its risk-adjustment tool. Some of the key questions to ask are whether or not that tool can make adjustments to your quality profile that may be skewed because of factors such as:
 - i. patient demographics;
 - ii. patient ethnicity and socio-economic status;
 - iii. patient compliance;
 - iv. patient health status; and
 - v. the location and type of setting in which care is delivered.

For further information, please see chapter eight, "[Risk adjustment](#)."

III. Cost-efficiency profiling programs

A. General description concerning how your cost-efficiency profile will be created.

The health plan will determine your cost-efficiency profile by looking at your claims data and all of the costs associated with your patients' episodes of care. Your cost will be evaluated based on the overall costs of these episodes. The term "episode of care" refers to a period of care, during which a patient's specific condition is present and is being managed – diagnosed, treated and completed – by you and other health care providers. Because chronic conditions do not have a finite conclusion, their episode of care is generally a calendar, or the plan's fiscal year. For acute conditions, the episode of care typically begins when the patient is first evaluated for the condition and ends when the care for that condition has been completed.

B. Practical steps used to determine your efficiency score.

Typically, the health plan will use the following process to determine your efficiency score (cost-of-care profile).

1. Establishing your cost-efficiency target or budget per episode of care. The health plan will determine the expected cost or budget for each defined episode. This budget is usually based on the average actual cost of all the health plan's episodes of the same type (e.g., all acute sinusitis episodes, all type II diabetes episodes, etc.).

2. Calculating the actual treatment costs for your patients' episodes of care. An actual cost figure is calculated for each of your patients' defined episodes by summing the costs of all claims included in the episode, including those for physician services, inpatient and outpatient facility services, prescription medications, and other services.

3. Attribution of actual costs. Responsibility for each episode's actual total costs is attributed to you or another physician based on an attribution rule; therefore, only one physician is responsible for the costs of all the services provided to a patient for that episode of care regardless of who or what provides those services. There are a variety of methods used to determine the physicians that will be attributed these costs, but frequently, they are assigned to the physician providing the services with the highest percentage of the costs, or the physician with the most patient visits, for that episode.

4. Summing of actual and expected costs. Sums of all your actual cost for episodes attributed to you, and of the health plan's expected costs for those episodes, are calculated.

5. Calculation of the cost efficiency measure. A cost-efficiency measure (i.e., ratio of total actual to total expected costs) is calculated for each physician or group, and physicians are compared, within specialty, on relative cost-efficiency performance. Therefore a score under 1.0 would be considered better, or lower than the average physician cost profile, and conversely, any score one would designate a physician with higher than average costs.

C. Considerations for when evaluating how the health plan will determine your cost-efficiency profile. The development of efficiency measurement programs has, and continues to be, highly controversial, due both to the complex risk adjustment process necessary to make any evaluative comparisons valid, as well as the fact that definitions of "efficiency" vary greatly depending on the relative weight assigned to the values used when health plans determine efficiency scores or profiles. Consequently, it is imperative that you understand, and be able to independently determine the validity of, the methodology that the health plan will employ to determine your cost-efficiency profile. The following considerations will assist you in this task. [The AMA has published an excellent report on the issues raised by "efficiency" measures, particularly as applied to individual physicians with smaller numbers of cases. To see a copy of the report "Economic Profiling of Physicians: What Is It? How Is It Done? What Are the Issues?" go to the [AMA Physician Profiling](#) webpage and follow the link to the report (currently available to AMA members only).]

1. What are the cost-efficiency targets or benchmarks that will be applied to you?

You will need the health plan to provide you with comprehensive information concerning all of the cost-efficiency targets that will be applicable to you. This information should:

- clearly identify all of your cost-efficiency benchmarks;

- describe the data the health plan used to determine those benchmarks by benefit plan type; and
- explain the methodology by which the health plan calculated those benchmarks.

2. Are the cost-efficiency targets applied to you responsible?

Your ability to have some influence over the targets set for you, your practice is a key issue to consider—regionally or nationally established cost-efficiency targets are likely to have less applicability than locally established targets. Some plans may have targets set at the average cost of an episode while others may set their target at the top 15% so it is important to know your target in advance. If a significant portion of your reimbursement will be contingent upon your cost-efficiency improvement, it will be important for you to determine if the cost-efficiency targets applicable to you have built in significant room for improvement.

3. What are the episodes of care upon which your cost-efficiency score will be based?

Since your cost-efficiency will be defined with respect to specific episodes of care, you must understand how the health plan defines those episodes. Therefore, after the plan has assigned an efficiency score or designation to you, they must also provide you with your data used to determine that designation, insufficient detail, so you know:

- a. the conditions or circumstances that triggered your episodes of care;
- b. when those episodes commenced and concluded;
- c. the episode grouper software program used to define each episode;
- d. all of the diagnosis code sets applicable to each specific episode of care;
- e. the clinical guidelines and other clinical bases used to determine the health services associated with each episode of care, and any adjustments made to those guidelines or bases to reflect local practice patterns;
- f. the methodology used to determine the total budget of all of the health care services associated with each specific episode of care, including, but not limited to, the use of any severity adjustment factors based on provider or enrollee characteristics, practice pattern variation, and potentially avoidable complication allowances;
- g. the specific procedure codes used to determine the total budget of all of the health care services associated with each specific episode of care; and

D. Evaluating the methodology that the health plan will use to determine your cost-efficiency scores

In addition to the information covered under III.C.1, 2, and 3 above, you should insist that the health plan provide you additional information that will enable you to independently evaluate the soundness of your cost-efficiency profile. This information will need to include, but not be limited to:

- the methodology that the health plan used to attribute episodes of care, and actual and budgeted episodes of care costs, to you, including any specific attribution rules used, (i.e. attribution to the physician with the most professional and prescribing costs included in the episode);
- the methodology the health plan used to calculate the expected and actual episode of care costs that are attributed to you;
- the number of episodes upon which the health plan based your cost-efficiency profile, so that you may evaluate the likelihood that that number will produce statistically valid results; and
- the targets that the health plan used to determine your status within the plan (i.e. was your status determined by reaching a certain absolute target, by being benchmarked against your peers or was it based upon improvement)

When evaluating these methodological considerations, you may wish to pay particular attention to the manner in which attribution is performed, because failure to properly attribute patients to physicians has been a major flaw in some cost-efficiency profiling programs.

E. Risk adjustment

As in the case of your quality profile, it is likely that the validity of your cost-efficiency profile will depend significantly on the accuracy of the risk adjustment technology used by the health plan's cost-

efficiency profiling methodology. For more information concerning risk adjustment, see chapter eight, “[Risk adjustment](#)”.

IV. Evaluating your quality and/or cost-efficiency profile reports

Over the course of your participation in the health plan’s PFP program, you will receive reports containing your quality and/or cost-efficiency profiles. Because you cannot assume that those profiles are accurate, you will need to perform your own evaluation of the profiles’ validity. Therefore it is important to ensure that;

- each report be complete, transparent, and specific, and that all underlying data be reported down to the patient-specific level;
- each report contains a complete analysis of all underlying data and the methodology used to determine the profile;
- the data referenced in the report with your actual claims/chart data are accurate--if your data shows significant variation from the health plan’s data, the health plan may have made a mistake that you should bring to the health plan’s attention;
- your data for outlier cases, severity of illness, co-morbidities, unusual demographics and patient compliance problems are accurate--if quality, or particularly cost-efficiency, indicators are not properly risk adjusted, your profile will be inaccurate;
- the number of cases used to determine your rating is adequate—small sample sizes are the single biggest cause of inaccurate ratings;
- any discrepancy between your actual performance and the profile results in a follow up certified letter, with return receipt requested, to the health plan, identifying the incorrect data or methodological issue; and
- you file a formal appeal as outlined in the payer’s PFP program description--note that some states have passed laws that govern physician profiling, and confer significantly expanded due process rights on physicians who want to challenge their quality or cost profiles.¹¹

For a detailed manual on understanding your own data for either identifying practice improvement opportunities or collaborating a health plan’s data results for your practice reference, view the AMA resource, “[Take charge of your data: A physician guide to reviewing and using your data to improve your profile, practice and payment.](#)”

V. What are your appeal rights?

Virtually every health plan that creates and uses quality and/or cost-efficiency profiles for PFP has a system to allow physicians to appeal their profile status; however, each appeal program operates differently and with different timelines, so it is important that you know and follow the rules for that health plan’s appeals program.

VI. Evaluating PFP programs from the perspective of data usage, reporting, self-analysis, and access

In addition to the specific guidance discussed in sections [II](#), [III](#), and [IV](#) of this chapter, determining the extent of your data reporting obligations and access to health plan data will help you determine whether or not participating in a PFP program makes sense for you. Physicians frequently find data reporting obligations to be some of the most concerning aspects of PFP programs, for several reasons. For example, abstracting data elements after the fact from your medical records is very expensive. Some data, like that from pharmacies and clinical laboratories, is notoriously hard to obtain and unreliable.

Nevertheless, to effectively participate in a PFP program, you will need to obtain, and analyze, your own data. While the health plan generally will be using your claims data to construct your quality and cost-effectiveness profiles, that data does not include much of the information that is crucial to appropriate analysis of your clinical issues. If you feel that you cannot collect and analyze your own practice data,

¹¹ Colo. Rev. Stat. § 25-38-101 et seq

consider having the collection and analysis performed by a trusted, neutral third party so that you are not dependent on reporting from the health plan. At a minimum, you should reserve the right to have the health plan's data audited by an outside expert of your choosing and insist that you have access to your patients' claims data.

The following questions are designed to help you determine your data-related rights under a PFP program and understand the health plan's intended use of your data. Answers to these questions may provide you with additional insight into the likely accuracy and fairness of the health plan's quality and/or cost-effectiveness profiling methodology:

- What data will you be obligated to report?
- How frequently will you be required to report?
- To what extent will you incur costs to develop the administrative and technological capability to satisfy the PFP program's reporting obligations and to perform your own data analysis?
- Will reporting obligations and practice data analyses require you to adjust, or implement new practice workflows? Will staff have to be trained?
- How, and to what extent, will you be able to access all of the data that the health plan used to determine your quality and or cost-efficiency profiles, e.g., claims, administrative, pharmacy and lab data?
- Will the health plan take into account your own data when determining your quality and/or cost-efficiency profile?
- To what extent will the health plan use medical records data in addition to claims data to determine your quality and/or cost-efficiency profile?
- Will the health plan self-administer its PFP program or outsource that function to a third party? If so, does that third party have a reputation for competence and fair dealing with the physician community?
- How will the health plan use your data? To the extent that the results are used solely to determine your eligibility for financial incentives and to educate you about your practice patterns, you will want to ensure that a timely and effective feedback loop is in place so that you can learn to both improve and correct data errors expeditiously should they occur. To the extent that the results will be used punitively, such as to exclude physicians from the network, reduce payment for services, or provide incentives to patients to use "high-scoring" physicians or physician groups, you will also want to ensure that the health plan has a fair appeals mechanism in place.

VII. Weighing the costs against your potential, additional compensation

As the foregoing discussion illustrates, participation in a PFP arrangement can impose additional out-of-pocket costs and administrative burdens on your practice. So, when deciding whether or not to enter into a PFP arrangement with a health plan, you will have to evaluate those costs and burdens against the size of the potential, additional compensation. The following considerations should help you perform this evaluation.

- How large is your potential incentive?
- What is required to "earn" that incentive – mere participation, any improvement or attainment of specified goals?
- Because many physicians have had bad experiences with "risk withhold" funds from which they never received any return, ascertain the likelihood that you will actually be paid if you qualify for the incentive.
- You should also understand where the incentive money is coming from; is it truly "new" money or is it simple redirection of money that would otherwise be paid in increased fee schedule or capitation amounts?

- To the extent that the PFP program lowers overall health plan costs through more efficient health management, will you receive your fair share of that benefit, initially and going forward? Your total payment needs to remain high enough to maintain these more sophisticated systems.
- Will your receipt of a bonus or reward be based on achievement of pre-specified absolute program goals or based on pre-specified relative improvement toward program goals?
- To what the extent will you receive a bonus or reward based on your performance ranking compared with other physicians in the PFP program? If part of your bonus or reward is determined by such comparisons, who are the physicians with whom you will be compared? What are their specialties?
- Will you receive, after the close of each contract year, a comprehensive payment report that includes a description of each and every amount of expense allocated to the PFP payment arrangement by member identification number, date of service, description of service by claim codes, net payment and date of payment? Further information concerning the timing and content of such reports may be found in chapter four, “Capitation.”

VIII. Final general considerations that may help you determine whether or not to you want to participate in a PFP program

There are some final considerations that may inform your decision regarding whether or not you want to participate in a PFP program.

- Are practicing physicians involved in the program’s design and administration? Experience to date with PFP programs suggests that they are much more successful if currently practicing physicians are heavily involved in PFP program design, development and implementation. It is especially important to have practicing physicians involved in selecting the performance measures and targets.
- Has the health plan fully explained all of the PFP program’s operational components, including all of the information described in this chapter?
- Will the results be publicized? If so, is there public reporting of performance at the medical group level or individual physician level? Will public reporting be done by general category (e.g. good, better, best) or more granularly? Will you be given an opportunity to review and challenge any report before it is publicly released?
- Has the health plan identified the potential long-term advantages and disadvantages of physician program participation?
- Is there a reliable mechanism to inform you about PFP program changes?
- Is the PFP program based on rewards rather than penalties?
- Will the health plan provide reimbursement for the costs associated with implementation its PFP program? What financial support, if any, will be provided for training and the cost of new hires, or for the implementation of information technology systems or software?
- Does the PFP program make allowances for physicians to use the best treatment options even when those options, are in conflict with the program’s established quality or cost-effectiveness measures or incentives?
- Is the PFP program restricted to a payment arrangement (capitated or fee-for-service), plan type (HMO, PPO, POS, etc.), or specialty (primary care or other specialists)?
- Does the PFP program focus on the evaluation of large physician groups rather than individual physicians? Focus on large groups reduces the validity issues associated with a small sample size, high-risk patient outliers, and possibly some attribution issues, all of which become crucial with respect to any evaluation of your performance.
- Will you be evaluated using different measures for different payers?

The AMA resource, **“Pay for Performance: A physician’s guide to evaluating incentive plans,”** provides a more comprehensive list of questions to ask when evaluating a PFP program (currently available to AMA members only).

IX. How can you prepare your practice for PFP?

There are some things that you can do to prepare your practice for PFP participation. The following are some steps you can take that will help you be proactive.

- **Develop the necessary infrastructure to capture and evaluate your own data**
Employ the full potential of your practice management system. A medical practice with a computer system can query patient records and administrative billing data for the appropriate ICD-9-CM codes for chronic diseases to obtain a listing of patients and their associated data. You can then use this data to evaluate, and where necessary challenge, the validity of your quality and/or cost-efficiency scores.
- **Use patient registries**
Use patient registries to evaluate your practice’s quality performance on chronic diseases, then use that data as a benchmark against which you can compare the health plan’s quality and/or cost-efficiency profiles. The AMA resource, **“Optimizing outcomes and pay for performance: Can patient registries help?”** provides additional information on using patient registries to improve your performance in PFP programs (currently available to AMA members only).
- **Ensure your staff is coding correctly and completely for diagnostic and CPT II codes.**
Ensure your staff is coding correctly and completely for diagnostic and CPT II codes as quality and cost-efficiency profiling systems are based on claims data, and all the relevant ICD-9-CM codes are essential for proper risk adjustment. Also, check that the documentation in the medical record supports the ICD-9-CM and CPT® codes selected.

X. Conclusion

PFP programs have emerged as one means of improving health care quality and responding to tremendous pressures to reduce the growth in the cost of health care services. It is possible that, when implemented appropriately, PFP programs can play an important role in quality improvement and cost growth reduction. However, you should not assume that PFP programs will find an appropriate balance between quality improvement and cost reduction, or that the PFP program’s priorities will not conflict with your obligations under the physician-patient relationship. So, whenever you are offered a PFP arrangement, or any health plan contract purporting to base your reimbursement on your quality and/or cost-effectiveness performance, use this chapter to help determine whether or not participation is appropriate for you.

Chapter 4: Capitation

Wes Cleveland

I. Introduction

Capitated payment systems are, as the name implies, based on a payment per person, rather than a payment per service provided. Physicians are, once again, receiving invitations from commercial health plans to enter into capitated arrangements. One example of this development is the Massachusetts Blue Cross and Blue Shield Alternative Quality Contract.¹² Governmental payers and federal policymakers are also reconsidering the possibilities of capitation as a means of controlling the growth of health care costs.

Although many capitated arrangements of the 1990s proved unpopular with much of the public, and sometimes disastrous for physicians, some believe that this time will be different. Capitation supporters argue that today's sophisticated information technology systems, data capture and performance measurement capabilities, and more accurate risk adjustment mechanisms will facilitate the development of capitation arrangements that will slow health care cost growth without alienating patients and employers.

There is no dispute over the fact that capitated payment models raise numerous issues. Physicians must carefully analyze these issues if they are to determine accurately the likely financial impact of the capitated contracts offered to them. Physicians must also be committed to developing business and practice operations acumen that is more sophisticated than that required under a purely fee-for-service regime. This chapter is designed to provide you with practical guidance concerning some of the key considerations you need to consider if you are thinking about transitioning from fee-for-service to capitated arrangements.

II. What is capitation?

A. General types of capitated arrangements. Capitated arrangements come in many varieties. Generally speaking, however, capitation arrangements can be organized into four general categories.

1. Per-member-per-month case management payments. Capitated payments may take the form of relatively modest per-member-per-month (PMPM) case management payments, e.g., to primary care physicians involved in patient-centered medical homes.

2. Practice capitation. Capitation may involve PMPM payments for services that the physician practice itself provides to enrollees. This type of capitation is sometimes referred to as “practice capitation.”

3. Partial global capitation. In partial global capitation, PMPM payments not only cover services provided by the physician practice itself, but also payment for all physician, laboratory, diagnostic and other outpatient services that are provided to enrollees who have selected, or been assigned, to the practice. Hospital inpatient services are not, however, covered by the capitation payments. State laws govern the extent to which a physician practice must obtain an insurance license or other formal authorization to participate in partial capitation arrangements, and may apply more stringent rules to physician practices that assume risk for services that they will not provide directly.

4. Global capitation. Under a global capitation arrangement, PMPM payments cover the total risk for all items and services that are furnished to the enrollees who have selected, or been assigned to, the physician practice: professional services; facility services—including hospital inpatient services;

¹² See e.g., <http://www.bluecrossma.com/visitor/pdf/alternative-quality-contract.pdf>

pharmaceuticals; clinical laboratory services; durable medical equipment, etc. Some states will not permit your practice to engage in global capitation, and in any state that does, your practice will be required to obtain an insurance license as a prerequisite.¹³

Again, there are innumerable variations on each of these basic capitation types, depending on the particular services the parties decide to “carve out,” on either a fee-for-service basis or by delegation to a separate benefit management company.

III. Determining the adequacy of proposed capitation payments when offered a capitated contract.

A. Ensure that the utilization budget on which the capitation payment is based is actuarially sound.

1. Your PMPM payments must be adequate to cover the costs of projected enrollee utilization.

Under a capitated contract, your PMPM payments compensate you for services that your expected patient population is projected to need over the course of the contract. It is therefore imperative that, to the greatest extent possible, this projected utilization, i.e., your utilization “budget,” is *actuarially sound*. Actuarially sound means that the PMPM payments provide for all reasonable, appropriate and attainable costs that can be expected for your patient population. The data used should be based primarily on your patient population with specifically identified adjustments for patient population change, large claims or fluctuations due to size. *PMPM payments that are based on unsound budgets will not adequately compensate you for your services.* Unfortunately, some health plans set capitation rates based on what they can get independent practice associations and physician practices to accept, without regard for actuarial soundness. You should not assume that the capitation rates initially offered to you will be adequate. This is why you must evaluate the utilization projections upon which the health plan is purporting to base your PMPM payments for yourself. *Remember—the ultimate goal here is to equip yourself with data that will help you negotiate adequate capitation rates.*

2. Evaluating the budget used to determine your proposed PMPM payments. To evaluate the actuarial soundness of proposed capitation payments, you must determine: (1) the specific services for which you will be capitated; (2) the type and amount of these services that your expected patient population will use; and (3) how much it will cost you to provide those services. The first step is to ask the health plan for the data on which it based the capitation rate, along with a copy of a certification from the health plan’s actuary that the utilization projection is actuarially sound. Generally speaking, this should be the same data that the health plan used to set the health insurance premium rates for the population to be capitated. Does that population used include your patient population? You should also have the health plan’s actuary certify that this is so, or if not, to the actuary should provide you with a complete explanation of any ways in which the utilization projection being used to calculate the capitation rate differs from that used to calculate the premium. You will generally be best advised to seek assistance from a professional actuary. Although retaining an actuary will involve some up-front expense, more favorable capitation rates resulting from that assistance should more than compensate you for that expense. See chapter ten, “**Working with actuaries**” for further information regarding how best to use an actuary’s services.

A. Determining the services that you will be obligated to provide under the capitation payment.

1. Specification of services and the Division of Financial Responsibility Matrix. To establish an actuarially sound budget, you must first know to the greatest degree of specificity ALL of the services for which the capitation payment will compensate you. Many physician practices that accept capitation payments use a chart referred to as a Division of Financial Responsibility matrix

¹³ The American Medical Association’s (AMA) comprehensive white paper “Pathways for Physician Success Under Healthcare Payment and Delivery Reforms,” contains additional information describing varieties of capitation arrangements. This resource is accessible to AMA members at <http://www.ama-assn.org/resources/doc/washington/x-ama/payment-pathways.pdf>

(DOFR matrix). The DOFR matrix delineates the responsibility for medical expenses (physician, institutional, ancillary and pharmacy) which will be allocated to your practice, any facility, and the health plan] under the capitated arrangement. The DOFR matrix should define each and every service paid under the capitation payment by CPT®, HCPCS, ASA, CDT and ICD-9-CM codes, and any applicable modifiers. Please see [Appendix one](#) for a sample DOFR that has been developed by the Integrated Healthcare Association (IHA).

2. Key issues to consider when attempting to identify the scope of capitated services. A comprehensive, well-organized DOFR will enable you to accurately identify your capitated services. Even so, because they have historically, in some cases, proved problematic in capitated arrangements, you should seek maximal clarity regarding the following services prior to entering into a capitated contract.

- a. **Pharmaceuticals.** In the past, many medical groups that were capitated for pharmaceuticals lost large amounts of money because the health plan set pharmaceutical budgets far too low. So insist that the health plan identify, to the highest degree possible, on the DOFR matrix any and all pharmaceuticals for which you will be capitated. It is imperative that you have such information if you are to determine an actuarially sound pharmaceutical budget. This is particularly true since physicians have disputed the methods that some health plans use for calculating the pharmacy risk pool, where physicians have not enjoyed the benefits of drug discounts or rebates negotiated by the health plan. Also, in your efforts to determine an actuarially sound pharmaceutical budget, you should consider: the impact of direct-to-consumer advertising; anticipated FDA approvals of new drugs currently in the drug development pipeline; and drug discounts or rebates. You will also need to do your best to manage your patients' pharmaceutical needs efficiently, and consistently with quality patient care.

Finally, you must also ensure that you have access, and are conspicuously notified of changes to, all health plan drug formularies. Of particular importance, the DOFR matrix should specify how new drugs and biologics that become available during the term of the capitation contract are to be handled.

- b. **Child immunizations.** Make sure the DOFR matrix identifies which immunizations you will be responsible for and how any new childhood immunizations that become mandated during the term of the capitation contract will be handled. This identification is important because the addition of new child immunizations will likely adversely affect the actuarial soundness of your utilization budget subsequent to such additions if no adjustment to reflect the addition is made.
- c. **Carved-out services.** Although most services will fall under the capitation agreement, you may wish to negotiate to be paid on a fee-for-service basis for “carved-out” services that are better handled on that basis because they can more efficiently be provided by others, or because they are rare and/or extraordinarily expensive, because you are simply not confident enough of the utilization projection for those services. The services paid on a fee-for-service basis are sometimes called “carve-outs.” For example, pediatricians may negotiate to be paid outside the capitation agreement for chemotherapy treatments and neonatal intensive care. If you are a retinal surgeon, you may wish the contract to specify that the capitation payment does not cover retina surgeries involving patients with chronic glaucoma. Other services that are often “carved-out” of capitation agreements include transplants, mental health care and biologics. It may be advisable to carve-out care needed for pre-existing illnesses or conditions. See [Appendix two](#) for an example of contract language creating a carve-out.

Remember, however, that there is no magic to “carve-outs.” The money to cover both the capitated and the carved-out services must still come from the health insurance premium dollars. Thus, when you request a carve-out, the health plan will reduce your capitation payment to cover the cost of the carved-out services. You should have your actuary carefully evaluate the amount the health plan is proposing to withhold from your capitation rate for each

and every carve-out you propose to ensure it is not withholding more than the original utilization budget projected the carved-out services would likely cost.

- d. **Injectables.** You should be cautious about accepting capitation for injectables that are administered in your office or that you prescribe for self-administration by the patient.

1. Example of California law.

A. General prohibition. In California, for example, physicians cannot be capitated for the following types of injectables unless they make a request *in writing* to accept financial risk for these services at the time of negotiating an initial contract or contract renewal:

- injectable chemotherapeutic medications and injectable adjunct pharmaceutical therapies for side effects;
- injectable medications or blood products used for hemophilia;
- injectable medications related to transplant services;
- adult vaccines;
- self-injectable medications; and
- other injectable medication in an implantable dosage form costing more than two hundred and fifty dollars (\$250) per dose.¹⁴

These injectables must be reimbursed on a fee-for-service basis at the negotiated contract rate or through an alternative funding mechanism mutually agreed to, subject to any applicable copayment or deductible.

- e. **New coverage mandates.** Be sure you understand if, and to what extent, you will be capitated for new obligations that arise pursuant to state and federal coverage mandates, as mandates may significantly increase your utilization profile beyond initial predictions. This is another area that you may want to “carve-out.”
- f. **New technologies.** Be sure you negotiate a workable approach to financial responsibility for the provision of new technologies which may become “required” during the term of the capitation agreement by virtue of the “standard of care.” You may wish to handle this in the same way in which you handled new coverage mandates.
- g. **Previously-referred services.** You should consider the extent to which the capitation payments will require you to furnish services that your practice has not previously provided. For example, if you are an internist who normally does not perform women’s pelvic examinations, but the capitation payment includes them as part of your primary care commitment, you need to consider whether your practice will provide them, or whether you will refer them to a gynecologist. If you determine that you can provide these types of services, you will need to factor projected utilization into your budget, as well any increase into your baseline practice costs resulting from the addition of the service. If you will be financially responsible for referred services, you will need to establish contractual relationships with the physicians who will receive these referrals, so you know what your financial liability will be.
- h. **Addition of services.** It will be crucial to identify any clauses in capitation contracts that allow the health plan to add services without your consent. The risk here is that the health plan could add services to your capitation rate that you do not normally provide, do not wish to provide, or that your utilization budget and corresponding capitation rate will not be adjusted adequately to account for the additional services. Changes to the services to be provided, including any representations on the DOFR matrix, should be subject to the mutual agreement of you and the health plan, or you should be able to terminate the contract if the health plan intends to add those services notwithstanding your disagreement.

¹⁴ Health and Safety Code § 1375.8

- i. **Point-of-service plans.** Be sure to understand whether or not your practice will be at risk for out-of-network services that your patients obtain pursuant to point-of-service plans. The assumptions made by health plans as to the percent in-network versus out-of-network become critical and could impact your financial success. In some states, e.g., California, health plans are prohibited from placing you at risk for out-of-network services received by enrollees under point-of-service contracts.¹⁵
- j. **Out-of-area services.** What if your patient needs to see a doctor in Italy while traveling? Because you will probably have very limited ability to contain such costs, you will be much better equipped to manage a capitated arrangement if the arrangement *excludes* out-of-area services and limits the geographic scope of the in-network services for which you are responsible. If you wish to take on the risk for out-of-area costs, you may wish to negotiate contract provisions to protect yourself, in the following ways:
 - you may negotiate for a specific stop-loss amount on out-of-area service claims; i.e., if you have to pay for out-of-area services out of your capitation, there should be a maximum threshold after which your liability ceases; and
 - the capitation contract should clearly articulate your ability to manage out-of-area care, including the ability to transfer patients in-area as soon as medically feasible, as determined by you.

B. Predicting utilization of capitated services. Once you have identified your capitated services, the second essential step in establishing an actuarially sound capitation rate is accurately predicting the extent to which your expected patient population will utilize those services. To do this, you must gather the following types of information from the health plan.

1. Expected number of enrollees. The health plan should provide you with information that will enable you to estimate the number of patients who will either be assigned to, or select your practice, over the term of the contract.

A. Guaranteed minimum number of patients. Although most managed care contracts guarantee no minimum number of enrollees, try to negotiate for such a guarantee anyway! The number of members assigned to you is a significant risk factor under capitation arrangements. In general, you should attempt to secure large plan membership panels because they offer some protection from the financial impact of catastrophic cases. A high-use patient can have a large impact on your average compensation if you have a small number of capitated patients. But if you have a larger volume of capitated patients, you will generally experience only a small drop in average compensation as a result of a high-use member. Check with a local practice consultant experienced in capitation to obtain advice on the minimum number of enrollees you should have. The minimum number will depend on the services you are capitated for but a safe harbor minimum of 1000 members will provide some stabilization of results. **Appendix three** describes a couple of negotiation strategies that you might use to help guard against excessive risk-assumption due an insufficient number of capitated patients.

2. Age and sex breakdown of your expected patient population. No matter what your specialty, you should ascertain what age and sex groups are most likely to use your services, as certain age and sex groupings can have a significant impact on the utilization of specific specialty services. For example, women ages 20 to 35 are most likely to seek obstetric services. Children ages 0-5 will take up most of a pediatrician's time. So insist that the health plan provide you with the expected age/sex breakdown of your expected patient population so that you can ensure that your utilization budget is appropriately sex and age adjusted.

3. Expected utilization rates for major expense service groups. You should insist that the health plan provide you with expected/projected utilization rates and unit costs for each major expense service group (inpatient, outpatient, primary care physician, specialist, pharmacy, home health, durable medical

¹⁵ See e.g., Health & Safety Code § 1374.66(e)

equipment (DME), ambulance and other), for which your practice will be capitated, by benefit plan type. This information should identify the source of this data, and the specific actuarial methods employed in determining these utilization rates and unit costs by benefit plan type. This information will greatly facilitate your actuary's ability to provide you with advice.

4. Expected utilization profile, by CPT code. You should ask the health plan to tell you the average number of annual visits and services you can be expected to provide, per member for your specialty, by CPT code. This information will help you continually monitor current utilization against projections, and thereby help your practice manage risk during the course of the contract. See section **VII. C** below.

5. Demographic considerations. Demographic considerations can also significantly affect the amount and type of services that your expected patient population will utilize. For example, if a significant number of your expected enrollees will come from high crime, high violence areas, this will impact your utilization budget and thus may function as a basis to negotiate for higher capitation rates. Similarly, patients who are likely to have significant problems travelling to their appointments or otherwise complying with their physicians' instructions will likely cost more than those who don't face such challenges.

6. List of employer groups enrolled. There is some evidence that professionals and white-collar workers are higher utilizers. For example, workers in the medical field—hospital workers, doctors, dentists, etc., may utilize more services than others, simply due to their occupational experience. Also, certain employees may have dangerous jobs which require them to seek more care, e.g., stunt people, police officers, fire fighters, and chemical plant workers. Again, if your patients have high-risk jobs which are likely to affect utilization in your specialty, this may be a basis for negotiating for a higher payment. On the other hand, these claims may be covered by workers' compensation, outside the capitation arrangement. You should also find out whether the health plan uses underwriting criteria, and if so, how.

7. Marketing information. You need to find out how the plan will be marketed, and to whom, and negotiate for the capitation rate to reflect the cost of serving that population. Is the health plan marketed to employees without previous insurance, or who have not had insurance for a long time? These employees may need more care to make up for a lack of care in the past. Is the health plan marketed as an indemnity, open-access product? If so, it may attract patients inclined toward multiple, unnecessary visits.

8. Copayment information. Copayments need to be set high enough to discourage unnecessary utilization, but low enough to ensure that patients seek care when medically necessary. Also, while higher copayments typically mean lower capitation payments, physicians need to ensure capitation payments are not reduced too much.

9. Take into account the possible increases in utilization that may result from transitioning from fee-for-service to capitation

A. Primary Care. If you are a capitated family physician or internist, you may be seeing a different mix of patients than had been the case under your fee-for-service arrangements. This difference may be a direct result of the health plan prohibiting direct access to specialists. Thus, patients that formerly went directly to allergists, dermatologists, orthopedic surgeons, rheumatologists, etc., may be treated first by you. Only those patients requiring specialty care as determined by you may subsequently be referred.

B. Specialty Care. Specialists' capitation amounts are based, in part, on the expected frequency of utilization of the particular specialty services. These determinations are generally based upon data reflecting frequency of the utilization of services by specialists paid on a fee-for-service basis. *However, referrals from PCPs may increase when a specialist is capitated, because there is no financial risk to the PCP for making the referral to the specialist.* For example, minor urinary infections may be referred to a capitated urologist, although historically such infections would have been treated by the PCP. Similarly, if a mammogram is abnormal, the PCP may have, traditionally, done additional studies and work-ups to determine whether the abnormal mammogram indicated

cancer. Where a surgeon is capitated, the PCP may, instead, immediately refer these cases for possible surgery. Another example is where the emergency group physicians are capitated. In such cases, PCPs may tend to send after-hours patients to the ED. In other cases, capitation may result in an increase in the acuity of patients who certain specialists are responsible to treat. For example, suppose a capitation arrangement incentivizes PCPs and other specialists, e.g., cardiologists, to more rigorously control referrals for cardiac surgeries. Such incentives could result in cardiac surgeons having to treat a greater proportion of higher acuity cardiac patients, i.e., patients with longer surgeries and more critical care encounters, even if the PCPs and cardiologists complied with applicable quality initiatives. In such cases, a prudent cardiac surgeon should endeavor to understand the protocols that will be in place that balance utilization and quality.

1. Ways to optimize care delivery in a capitated environment.

- **Financial incentives for appropriate referral should be considered.** Some capitation arrangements include a financial incentive for PCPs to hold down referrals to specialists. For example, PCPs may receive a bonus, depending in part on monies left over in pools for specialty care. Therefore, over-utilization that drives up the specialists' capitation rates would eventually be reflected in the PCPs' own incomes. Also some health plans have effected a "charge-back system" which requires PCPs to pay (on a fee-for-service basis) for specialty services that they should have performed themselves. However, the utilization review committee would need to become involved in such issues.
- **Increase communication between specialists and PCPs.** Ongoing discussion between the PCPs and specialists over referral and consultation practices is critical to developing optimal working relationships and efficient care delivery. All physicians and their patients benefit when PCPs handle all matters within their capability and refer all matters for which specialty care is appropriate, and specialists provide full reports back to PCPs on a timely basis.
- **Keep Data.** It is important to continuously review actual utilization patterns against projected utilization budgets and peer norms. Ultimately, capitation rates for PCPs and specialists may need to be adjusted depending on experience. For example, in systems where PCPs perform minor surgeries, their capitation rate will likely be higher than in those where these are all referred to specialists.

10. Risk adjustment. Finally, you should insist that the health plan provides you with all factors used to risk adjust your utilization budget, and consequently, your capitation payment. These factors should include age and sex (as described above) and benefit plan type and design, including copayment or deductible levels as well as localized geographic area, acute clinical stability, principal diagnosis, severity of principal diagnosis, extent and severity of co-morbidities, physical functional status, psychological, cognitive, and psychosocial functioning, non-clinical attributes such as socioeconomic status, race, substance abuse, and culture; health status and quality of life; and patient attributes and preferences. Unless your utilization budget is adjusted to take into account factors that can significantly increase utilization, that budget will not likely be actuarially sound and your corresponding capitation rates will be inadequate. An actuary can provide invaluable assistance in evaluating the accuracy of the health plan's risk adjustment methodology. For further information concerning risk adjustment, see chapter eight, "[Risk adjustment](#)."

C. Understand the role that quality measurement and benchmarks will play in you reimbursement. Your quality and resource utilization performance is likely to be a factor in determining your compensation. For more information concerning how to understand, evaluate, and negotiate the role that cost and quality measurement will play in your compensation, see chapter three, "[Pay-for-performance](#)."

IV. Analysis of practice revenue and costs.

Although obtaining an actuarially sound utilization budget is essential to negotiating adequate capitation payments, it is not the entire story. You will also need to ensure that the amount you will receive for these services will be adequate to cover your costs to provide them. Even if the budget appropriately projects that your group will provide 10,000 office visits, your capitation payment will still be inadequate

if it projects payment for those visits at \$1 each. To determine whether the projected payment rates will be adequate, you need to understand your practice's finances. This means understanding how much it costs to operate your practice and provide each of the services which are included in your capitation payment. You will likely also want to know how much revenue you are currently making under the fee-for-service reimbursement agreement the capitation arrangement will replace. You will need to make sure that your capitation payments cover your practice costs, and ideally will make it possible for you to achieve profit margins commensurate with your historic fee-for-service revenue.

A. Understanding your practice costs. Being profitable under capitation means developing an understanding of the true cost of delivering each service paid for under the capitation payment, by CPT code. Also, you need to determine if costs will increase as a result of transitioning from fee-for-service to capitation. You may, for example, need to augment the current capabilities of your practice's information systems in order to monitor and compare current utilization with capitation payments, report encounter data, move from cash to accrual accounting, hire actuaries and meet applicable quality benchmarks. If your practice is going to assume risk for other physicians or providers, you will need to take into account the cost of implementing claims payment, utilization review, and incurred-but-not-reported liability tracking systems. All of these cost considerations need to be taken into account when determining your practice baseline costs, which, in turn, will help you establish how much capitation revenue you will require in order to cover such costs. See chapter one, "[How to establish your baseline costs](#)," for further information.

1. Make your practice more efficient as a way to reduce practice costs. To profit under capitation, you need to evaluate how you can operate your practice more efficiently, and how you can cut overhead costs. Here are some tips:

- **Delegate.** Delegate administrative matters to your office manager.
- **Call triage.** Have clinical personnel trained to triage patient calls. Consider using an advice nurse. Move away from a fee-for-service mentality where patients are encouraged to come in to see you, when their problem could be handled by telephone.
- **Efficient treatment alternatives.** Develop alternative, less expensive treatment modes, *to the extent this can be done without compromising quality*. One key element to profiting under capitation is strong medical management.
- **Allied health providers.** Use allied health professionals appropriately.

Clearly, however, the level of care provided to each patient should be the same, irrespective of payment type.

B. Comparing your historic fee-for-service revenue with proposed capitation rates. Once you have identified your capitated services and obtained an actuarially sound prediction concerning your expected patient population's utilization of services, you are now in a position to determine whether or not the capitation payments offered to you are likely to meet or exceed your historical fee-for-service revenue (taking into account any increase in practice costs associated with a transition from fee-for-service to capitation).

1. Calculate your imputed fee schedule. Comparing fee-for-service revenue with your proposed capitation revenue is not a difficult task. Every capitation arrangement contains an imputed fee schedule. You, or perhaps more appropriately, your actuary, can determine this imputed fee schedule by summing your total annual PMPM payments, and then dividing that sum by the type and number of covered services that your expected patient population is projected to utilize over the term of the capitation arrangement, using a relative value scale such as the Medicare RBRVS. This will allow you to determine the capitated arrangement's imputed fee schedule, i.e., how much of your proposed PMPM payments will be allocated to each covered service that you can expect to provide to your patient population. You can then compare this imputed fee schedule with what you would receive under a fee-for-service model.

2. Factor in any fee-for-service revenue you will receive for any carved out services. To determine the adequacy of your entire compensation under a capitated arrangement, you will need to determine the adequacy of fee-for-service reimbursements you will receive for providing any carved-out services. To make this determination you will need to obtain from the health plan complete fee schedules, and have the carved out services specifically identified in the DOFR matrix by CPT, HCPCS, ASA, and ICD-9-CM codes, and by any applicable modifiers. You will also need a detailed description of the health plan's particular claims submission and processing requirements, including, but not limited to, the health plan's coding requirements, edits, and payment rules. See chapter two, "[Fee-for-service issues](#)" for further information regarding what information you will need to determine the adequacy of the fee-for-service payment rates offered to you with respect to carved out services. You will also need the health plan's fee schedule to determine when stop-loss coverage is triggered if you purchase that coverage from the health plan. See [IX](#) below.

3. Putting it all together. The steps described in [III](#) and [IV](#) will put in your hands informational tools that will help you compare capitation arrangements offered to you, as well as help you understand what you need to receive in PMPM payments in order to enjoy long-term success under a capitated arrangement. Keep in mind that you will also need to factor in other revenue received in conjunction with a capitation arrangement, such as risk pool revenue, coordination of benefits recoveries, copayments and other amounts received directly from patients, etc., as well as the effect that your quality performance may have on practice revenue.

V. Special considerations when you are offered a contract that will capitate you individually.

Most of the time capitation arrangements are offered to groups of physicians and not to individual physicians, and for good reason, since it is rare that a single physician have a sufficient number of patients to spread the insurance risk. Accordingly, most of the issues discussed in this chapter concern capitated physician *groups*. Straightforward statistics show major risk issues that individual physician capitation can create. For example, if a practice has 1,000 capitated patients, there is a five (5%) percent probability that the average per person medical expense will exceed an actuarially sound capitation payment by over seventeen (17%) percent. With only 100 patients, there is a five (5%) percent probability that the potential overrun exceeds fifty (50%) percent! It is vital, therefore, to have a broad enough panel in order to successfully take on a capitated arrangement.

VI. Timing of capitation payments.

Your capitation contract should specify that the capitation payments commence *at the time each covered beneficiary enrolls in the plan and not at the time of the first visit*. The whole theory of capitation is that the physician gets paid every month the patient is enrolled in the plan, whether or not services are provided, just as the patient pays premiums for each month of enrollment. If a patient who has not yet chosen or been assigned to a physician winds up in your office, you should be paid a retroactive payment to the date of the patient's enrollment in the plan. See [Appendix four](#) for a sample contract provision requiring that capitated payment commence at enrollment.

VII. After you have signed the contract: tracking eligibility and utilization, patient education, and capitation payment reconciliation.

A. Managing your risk over the course of the capitation arrangement. Establishing an actuarially sound budget, and negotiating corresponding capitation payments will not, by itself, be sufficient to maximize the probability of your long-term success under a capitated arrangement. *You will also need to manage your risk over the course of the contract*. This means that you need to: (1) regularly verify the eligibility of the enrollees assigned to you and that the associated capitation payments are correct and received on a timely basis; (2) compare the actual utilization of health care services by your capitated patients against the utilization projection; (3) investigate areas where utilization is either markedly under or over the projection to determine if changes in your treatment protocols should be made; and (4) regularly reconcile payments for carved out services and those for services provided after stop-loss thresholds have been met (if applicable).

B. Verifying eligibility and entitlement to benefits

1. What does it mean to “verify eligibility?” "Verifying eligibility" means determining whether a patient is indeed an enrollee who is entitled to be seen for the capitation rate, as well as the determining the benefits to which the enrollee is entitled.

2. Why is being able to regularly verify eligibility so important? Inaccurate eligibility can lead to significant problems for your practice. Sometimes a health plan will confirm an enrollee's eligibility and coverage for services even though the patient has disenrolled, or was terminated from, the health plan. It is likely that the health plan will attempt to recover PMPM payments made to you subsequent to that disenrollment or termination, even if you provided services to the patient in good faith reliance on mistaken eligibility information provided by the health plan. Such recovery efforts can hurt your practice's bottom line and disrupt practice operations. This is why it is important to be able, with confidence, to regularly verify your patients' eligibility.

3. To be able to regularly verify eligibility, insist that the health plan provide you with regular eligibility reports. To maximize the accuracy of eligibility information, the health plan will need to regularly furnish you with comprehensive eligibility reports. *At a minimum, you should receive these reports on a monthly basis.* However, physician groups with extensive capitation experience report that bi-monthly reporting is preferable. These reports should be transmitted to you electronically, and include all of the following information described in **A** and **B** below, ideally in a single file. If the information is not provided to you in a single file, then all of the files containing the following information **MUST** be processed as of the same date. This will ensure that all of the information contained in each of the files is consistent.

- a. **Specific information concerning the individual enrollees assigned to your practice.** The eligibility report should contain the following information concerning each enrollee:
 - identification number;
 - name;
 - birth date;
 - gender;
 - address (including zip code);
 - type of health plan or health insurance policy;
 - employer group identification;
 - the identity of any other third-party coverage, if known to the third-party payer;
 - enrollment/disenrollment dates;
 - the national provider identification number of the physician or physician practice that the enrollee has selected or to which the enrollee has been assigned;
 - provider effective date;
 - the name and national provider identification number of the primary care physician when the selection of a primary care physician is required by the enrollee's benefit plan or health insurance policy;
 - any applicable co-pays and/or coinsurance;
 - any applicable deductible;
 - if the risk arrangement involves a capitated payment, the amount of capitation to be paid per enrollee per month to you or your practice; and
 - type of health care coverage or health plan type, e.g., coverage under a health maintenance organization, point-of-service, preferred provider organization, workers compensation, indemnity, governmental, or private self-insured product, etc.
- b. **Specific information concerning enrollees assigned to your practice as a group.** The health plan should also provide you with an eligibility report that contains:

- the names of all enrollees who have been assigned to, or who have selected, you or your practice;
- the member identification numbers of all the enrollees assigned to, or who have selected, you or your practice; and
- the total number of enrollees added or terminated under each benefit plan contract served by you or your practice.

The health plan should provide you with the information described in A and B above *electronically*, and as soon as possible to the beginning of each month. For example, California law requires that these reports be made within ten (10) calendar days from the beginning of each report month with respect to each enrollee who has selected, or been assigned to, your practice.

4. What if a particular patient is not listed in the report? You must be able to verify whether any patient who claims to be enrolled in a health plan is indeed covered. Ideally you should accomplish this by sending an electronic eligibility request (ASC X12 270). While the ASC X12 271 eligibility response transaction does not have fields covering everything you need to confirm your capitation eligibility list, it will tell you whether a particular patient is covered by the health plan, and, to the extent the patient has been assigned a Primary Care Provider, the plan is required to identify the PCP in 5010 Section 1.4.7.1 item 5 requires “Primary Care Provider in 2120C/D if applicable” (see section 1.4.7.1 item 5 on page 20 of 005010X279). Many health plans also provide an internet or telephone verification service or alternative method of verification by which you may verify the eligibility of a person seeking services from your practice, but these methods are much more costly and provide less information than you would receive using the standard electronic transaction. For more information on automating your practice using the HIPAA standard electronic transactions, go to www.ama-assn.org/go/simplify.

5. What if I still receive information that is incorrect? Although receiving the eligibility reports described in this section will significantly reduce the likelihood that you will receive inaccurate eligibility information, there may be occasions when you will provide services based on health plan eligibility information that is inaccurate. Accordingly, you should review the contract language to determine the extent to which the health plan may be permitted to retract prior capitation payments. Your contract should provide a cap on the number of days that the plan can retroactively retract capitated payments. Many states limit the number of days within which a health plan may perform such retractions. For example, in Texas, a health plan may perform a retraction no later than the 180th after the date on which the physician or provider received the alleged overpayment.¹⁶ However, when negotiating a capitated contract, the optimal result from the physician perspective would be to have the health plan be bound outright by its eligibility determinations, which would eliminate the possibility of retroactive adjustments. If the physician cannot negotiate outright binding, the physician should attempt to shorten the potential retraction period as much as possible.

C. Posting capitation payments and reconciling any capitation deductions. You will also need to have a system for posting the capitation payments you receive and reconciling any capitation deductions. As noted above, the adequacy of capitation payments will depend in part on the circumstances in which the health plan is entitled to deduct money from those payments. Contract terms should spell this out in detail, including the circumstances under which deductions may be taken, the amount of such deductions and a limit on the period of time health plans may go back and retroactively deduct such payments.

D. Comparing concurrent utilization with capitation payments.

1. Determining if capitation payments are adequate. In order to manage your risk under a capitation arrangement, you need to be able to track your utilization against your PMPM payments. At least as

¹⁶ Tex. Ins. Code Ann. § 843.350(a)(1); Tex. Ins. Code Ann. § 1301.132(a)(1); 28 Tex. Admin. Code § 21.2818(a)(1)

you transition to capitation, you will want to be able to monitor current utilization and compare how much you would be receiving in revenue under a fee-for-service arrangement for providing those services with your PMPM payments. This comparison will give you an idea of how you are performing financially under capitation vis-à-vis fee-for-service. This is essential if you are to obtain an accurate picture of how your practice is doing financially because, no matter how painstakingly you have attempted to predict the utilization of your expected patient population, actual utilization may vary because the enrollment mix of health plans is constantly changing. You also need to keep in mind that utilization can be cyclical – some months will have higher utilization of services than others so a monthly jump is not necessarily signal that the rates are too low.

2. Identifying payment problems. In addition to helping you ascertain the adequacy of capitation payments, concurrent utilization monitoring and performing a fee-for-service comparison will enable you to identify early other issues that may have a negative effect on your practice's financial viability, such as whether or not:

- PMPM payments are simply too low;
 - PMPM payments are being appropriately risk-adjusted;
 - some services should be carved out, or the stop-loss level should be adjusted; and
 - the capitated group's hospital utilization, office services utilization, and/or specialist services utilization is too high to remain viable under the PMPM payments that you have negotiated, and remedial steps need to taken.
- a. **Example illustrating why ongoing utilization monitoring and fee-for-service comparison is important to management of ongoing capitation risk.** Suppose you are a specialist, and you have agreed to be capitated at \$2.35 PMPM, where, based on predicted utilization, the \$2.35 PMPM rate will be equal to about a fifty (50%) percent discount off what you would have received on a fee-for-service basis based on your retail charge. However, when tracking utilization, you realize that a PMPM payment of \$10.00 would actually have been the amount necessary to equal a fifty (50%) percent discount. Armed with this information, you have several options. First, determine whether you have satisfied your stop-loss coverage preconditions, and are eligible to obtain fee-for-services payments for a portion of the services you have provided. Second, you may be able to renegotiate a more accurate contract rate; many health plans are interested in establishing long-term, stable contracting relationships, and will be willing to work with you to stabilize such a situation. Third, if you cannot renegotiate, or if stop-loss coverage is not applicable or inadequate, you may then have the option of terminating the contract before the inadequate capitation payments can significantly undermine the financial viability of your practice.

E. Patient education. Educating your patients can be useful tool in managing your risk. You should ensure that your patients understand that, whenever feasible, care must be obtained within the contracted provider network. If patients go out of plan and say they did not understand plan requirements, generally, the health plan will back the patient and charge you for the care. Although the health plan is responsible for educating enrollees, it would be wise for you to do so as well, as you will most likely suffer the financial consequences when a patient inappropriately uses outside providers. Patients should know how to contact your practice during and after office hours for telephone advice, physician visits, urgent care, etc. They should be educated regarding the need to avoid non-emergent visits to the emergency room, especially via ambulance, and unnecessary visits to specialists, especially those who are not affiliated with your practice or capitated group.

F. Verification of income and expense allocation. Finally, to manage your risk during the course of the capitation arrangement and maintain an accurate picture of your practice's financial condition, you need to be able to regularly verify how expenses and income are being allocated between your practice and the health plan. You also must be able to reconcile PMPM payments received with the services you have provided.

1. Quarterly reports. To perform this allocation verification and reconciliation, you should insist on receiving quarterly reports from the health plan containing sufficient detail to allow verification and reconciliation. These quarterly reports should include the following information:

- the total number of member months covered by the capitation agreement;
- the total budget allocation for the member months by major service expense group (e.g., inpatient, outpatient, primary care physician, specialist, pharmacy, home health, DME, ambulance and other);
- the total expenses paid during the period by major service expense group;
- if your practice is paying claims, a description of the incurred-but-not-reported claims methodology used for reporting incurred expenses during the report period and aging thereof, and total amount allocated pursuant to that methodology;
- a description of each and every amount of expense allocated to the capitation arrangement by member identification number, date of service, description of service by claim codes, net payment and date of payment;
- a description of how your practice has performed with respect to each and every quality or efficiency measure applied to your practice's provision of health care items or services, and
- a downloadable file of any and all data elements accessible in the appropriate databases by the health plan to be available upon request to your practice so that you can conduct an independent analysis of all of the information contained in the quarterly reports.

2. Comprehensive payment report subsequent to the close of the contract year. In addition to your quarterly reports, you will need to receive from the health plan a comprehensive year-end report that will enable you to verify the health plan's final allocation of income and expenses and enable you to perform a final payment reconciliation. You should receive a preliminary, draft report that includes all of the information enumerated in **VII.D.1(a)** through (g) above prior to receiving the health plan's final report. This will enable you to review and discuss with the health plan any discrepancies that you believe are contained in the report that may affect your final payment. You should then subsequently receive a final report and payment.

- a. **When is the optimal time to receive your preliminary and final allocation and reconciliation reports?** There will always be a time lag between the date on which your practice provided health care services and the date on which the health plan reports those services. There are advantages and disadvantages to shorter or longer lag times between the end of the capitation year and your receipt of the final payment reconciliation. The longer the lag time between the final reconciliation and the close of each capitation year, the more accurate your final reconciliation payment is likely to be. On the other hand, you may want to receive final payment as quickly as possible after the close of the capitation year notwithstanding the possibility of reduced accuracy. Some practices have found it beneficial to receive the preliminary report 150 days after the close of the capitation year, and the final payment and report 180 days after the close.

VIII. Transitioning from cash-based to accrual accounting and tracking incurred-but-not-reported bills.

A. What is the difference between cash-based and accrual accounting? To succeed under a capitation arrangement, you will need to transition from the cash-based accounting that you are likely utilizing under fee-for-service to an accrual accounting system. Under cash accounting, your practice records income when the practice actually receives payments. Expenses are recognized when the practice actually pays its bills. In accrual accounting, your practice recognizes income that has been earned, even if the practice has yet to receive payment. Expenses are acknowledged immediately when they are incurred, even though the practice may have not yet paid, or even received, corresponding bills.

B. Why is transitioning from accrual accounting key to enjoying success under a capitation arrangement? Accrual accounting is a much more effective way of managing your practice's finances

under capitated arrangements than cash-based accounting. In a capitated arrangement you will receive PMPM payments well before you provide health care services and incur associated expenses. Accordingly, under a cash-based accounting system, income is recorded immediately when capitation payments are received, but, because anticipated expenses are not recognized immediately, eventual financial obligations are ignored until they are paid. In this way, cash-based accounting can significantly overstate income, mask the real profitability of a capitated contract, and lead you to draw out money or otherwise assume additional practice debt, not recognizing inevitable future obligations that will come due. A much more accurate sense of the practice's net income can be obtained under accrual accounting because those inevitable, future financial obligations are taken into account contemporaneously with the receipt of the capitation payment.

C. When your practice is paying claims, accrual accounting and tracking incurred-but-not-reported (IBNR) claims is essential. Accrual-based accounting is vital if your practice pays claims. In such cases, the capitation payment not only compensates your practice for the services it provides, but the fee-for-service claim payments that your practice makes must also come out of that capitation payment. Accrual accounting here is vital because of what is referred to as incurred-but-not-reported (IBNR) claims. IBNR claims are claims for services that your practice will have to pay but has not yet received. Because a significant time lag may exist between the times those services are performed and the time when your practice receives the associated claims, it is imperative that your practice not only uses accrual accounting, but also rigorously tracks its IBNR liabilities. If your practice uses cash-based accounting, it will not recognize the inevitable obligation to pay for these services until the practice receives a bill from the physician or other health care provider who is external to your practice, which may be unexpected. This can result in a cash flow nightmare and even bankruptcy. But if your group utilizes accrual accounting, you can anticipate expenses that have not yet been incurred, or even reported, to your practice. Another way physician groups reduce IBNR problems is to sub-capitate specialists. Unexpected claims for specialty services may be eliminated by paying the specialists a monthly payment.

IX. Stop-loss insurance

Because your practice is assuming risk under capitated arrangements, your practice will need to purchase stop-loss coverage, particularly if your practice is assuming risk for services that it does not provide and/or inpatient services. Stop-loss insurance establishes a maximum threshold amount beyond which your practice is no longer financially responsible for costs. Stop-loss coverage is designed to protect your practice from unlimited losses associated with catastrophic cases, e.g., transplants, severe trauma, neonatal intensive care. Whether your practice elects to obtain stop-loss insurance from a stop-loss insurer, or from the health plan directly, there are key issues you should consider when shopping for stop-loss coverage. If you purchase stop-loss coverage from the health plan, you will need to obtain a complete fee schedule from the health plan to determine when stop-loss coverage is triggered. For more information, see chapter nine, "[Stop-loss insurance](#)."

X. Contract termination

The capitated contracts offered to you will frequently require you to treat patients for a period of time subsequent to termination at the rate of payment required in the contract. The fact that you may have to continue to treat patients does not mean that you should continue to be obligated to accept capitation post-termination. You should seek different compensation for services that must be rendered after termination, especially when being paid on a capitated basis, as the number of capitated patients is a significant risk factor with capitation. After termination, it is likely that you will not retain a sufficient number of enrollees to render the capitation payment adequate. Moreover, the patients retained are likely to be patients who need a lot of care, another factor which is likely to lead to monetary losses. With this in mind, it would be prudent to negotiate adequate fee-for-service payment for your provision of post-termination services. For further information concerning how to determine and negotiate fee-for-service payments, see chapter two, "[Fee-for-service issues](#)."

XI. Managed care liability implications

In negotiating capitation, you will need to consider the financial implications of state and, subsequent to the Patient Protection and Affordable Care Act of 2010, federal, independent external medical review laws. You will also need to take into account any potential managed care liability. Independent external medical review laws require health plans to offer outside medical review of every denial, modification or delay based on medical necessity determinations. Health plans are generally immunized from liability for failing to use "ordinary care" to arrange for the provision of medically necessary health care services under the Employee Retirement Income Security Act of 1974 (ERISA). However, if you are involved in utilization review activities, you may not enjoy ERISA immunity or state tort-law liability protections that apply in other contexts. Contacting your medical liability carrier may be helpful in assessing potential liability exposure.

XII. Conclusion

Transitioning from fee-for-service to a capitated model raises a number of key issues. Some of these issues can only be resolved through careful data analysis. If you can obtain the types of data described in this chapter, then such data analysis is within your capabilities. There are also actuaries to whom you can turn for assistance when determining whether or not you can manage the risk associated with a particular capitated arrangement that may be offered to you. So, under the right conditions, capitation may offer a financially viable alternative for your practice in lieu of fee-for-service.

Chapter 4 Appendix 1: Division of Financial Responsibility Matrix

As part of its Administrative Simplification project, the Integrated Healthcare Association (IHA) assembled a workgroup of stakeholders that included staff from IHA as well as representatives from the health plan, hospital, physician organization, and health care consultant communities to develop a coded Division of Financial Responsibility (DOFR) template for use in contracts between hospitals, physician organizations, and health plans.

The DOFR provides a framework for plans and providers to use when allocating financial responsibilities for services in commercial HMO/POS and Medicare Advantage populations in California. It does not assign or recommend use of fee schedules, relative values, conversion factors, related components, contracting and/or designation of risk. Coded DOFR users may opt to customize the coded DOFR.

The IHA DOFR Release 1.0 was launched in September 2011 followed by a 60-day public comment period. All comments were tracked by IHA and reviewed and vetted by a multi-stakeholder workgroup. Changes accepted by the DOFR workgroup were incorporated into the DOFR Release 1.1 and a formal response to submitted comments was posted on the IHA website in January 2012.

The coded DOFR is a Microsoft Excel spreadsheet with 104 service subcategory rows, five (5) columns for diagnosis, billing, and revenue codes, seven (7) columns to assign financial responsibility to the plan, physician organization, or hospital, and over 10,000 codes (see sample screen image below). The categorization of codes to service categories is the “standardized” element of the DOFR, i.e., certain codes are assigned to service categories regardless of which physician organization, hospital, or health plan is assigned financial responsibility for the service category.

A		B		D		E		F		G		H		I		J		K		L		M		N		O	
CODED COMMERCIAL AND MEDICARE DOFR: CODING BY SERVICE																											
CODES														FINANCIAL RESPONSIBILITY													
Service Category	Service sub-category	CPT® Codes (*duplicate codes)	Updated HCPCS (*duplicate codes)	Revenue (*duplicate codes)	Dental Codes	Other	NON-FACILITY LOCATION OF SERVICE (PHYSICIAN OFFICE OR FREE-STANDING CENTER)			FACILITY LOCATION OF SERVICE																	
							Technical Services (Split Billing)	Professional Services (Split Billing)	Global Billing	Outpatient Professional Services	Outpatient Facility Technical Services	Inpatient Professional Services	Inpatient Facility Technical Services														
Acupuncture	Acupuncture	97813, 97814, 97810, 97811																									
Allergy	Allergy: Serum	95115*, 95117*, 95120*, 95125*, 95165*, 95170*	J0220																								
Allergy	Allergy: Testing & Treatment	95004, 95010, 95015, 95024, 95027, 95028, 95044, 95052, 95056, 95060, 95065, 95070, 95071, 95075, 95145, 95146, 95147, 95148, 95149, 95165*, 95170*, 95180, 95199, 95115*, 95117*, 95120*, 95125*, 95130, 95131, 95132, 95133, 95134, 95144, 86001, 86003, 86005	Q3031																								
Ambulance	Ambulance		A0210*, A0225, A0380, A0382, A0384, A0390, A0392, A0394, A0396, A0398, A0420, A0422, A0424, A0425, A0426, A0427, A0428, A0429, A0430, A0431, A0432, A0433, A0434, A0435, A0436, A0438, A0439*, A0499*, A0090, A0100, A0110, A0120, A0130, A0140, A0150, A0170, A0180, A0190, A0200, A0080, A0210*, A0998*, A0999*	540, 541, 542, 543, 544, 545, 546, 547, 548, 549		POS: 41, 42																					
Anesthesia	Anesthesia: General (except Pain Management)	SEE ANESTHESIA CODES TAB																									
Anesthesia	Anesthesia: Pain Management	62350, 62351, 62360, 62361, 62362, 64400, 64402, 64405, 64408, 64410, 64412, 64413, 64415, 64416, 64417, 64418, 64420, 64421, 64425, 64430, 64435, 64445, 64446, 64447, 64448, 64449, 64450, 64455, 96374*, 96375*, 96376*, 96379*																									
Audiology Testing	Audiology Testing	92504, 92506, 92540, 92541, 92542, 92543, 92544, 92545, 92546, 92547, 92548, 92550, 92551, 92552, 92553, 92555, 92556, 92557, 92559, 92560, 92561, 92562, 92563, 92564, 92565, 92567, 92568, 92570, 92571, 92572, 92573, 92576, 92577, 92578, 92580, 92583, 92584, 92585, 92586, 92587, 92588, 92590, 92591, 92596, 02087, 02091, 02101, 02111, 02121	S0618, S2230, V5008, V5010,	471, 479																							
Audiology	Audiology Implant	92601, 92602, 92603, 92604, 92640	V5273																								

In order to keep the coded DOFR manageable, service and coding detail is provided only to the extent necessary to capture differences in assignment or risk. To use the DOFR, organizations indicate in each column the financially responsible party for each service category or sub-category row. An illustrative example is provided below.

FINANCIAL RESPONSIBILITY															
CODES								NON-FACILITY LOCATION OF SERVICE (PHYSICIAN OFFICE OR FREE-STANDING CENTER)				FACILITY LOCATION OF SERVICE			
Service Category	Service sub-category	Diagnosis	CPT® Codes (*duplicate codes) CPT is a registered trademark of the American Medical Association (AMA). All rights reserved. CPT codes, descriptions, and data are copyright 2011 American Medical Association	HCPCS (*duplicate codes)	Revenue (*duplicate codes)	Dental Codes	Other	Technical Services (Split Billing)	Professional Services (Split Billing)	Global Billing	Outpatient Professional Services	Outpatient Facility/ Technical Services	Inpatient Professional Services	Inpatient Facility/ Technical Services	
Radiology (excluding Nuclear Medicine)	Radiology (excluding Nuclear Medicine) - Therapeutic		SEE RADIOLOGY CODES (EXCLUDING NUCLEAR MEDICINE) TAB AND SEE ALSO GUIDELINE #10	C1716, C1717, C1719, C2634, C2635, C2636, C2637, C2638, C2639, C2640, C2641, C2642, C2643, C2698, C2699, G0173, G0251, G0339, G0340, Q3001	330, 331, 332, 333, 335, 339, 400*, 409*										
								Plan	Group		Group	Hosp	Group	Hosp	
(for illustrative purposes only)															

The Integrated Healthcare Association (www.iha.org) is a nonprofit multi-stakeholder leadership group that promotes health care quality improvement, accountability and affordability in California. IHA convenes and collaborates with diverse healthcare stakeholders on a variety of critical health care issues, administers regional and statewide programs, and serves as an incubator for pilot programs and demonstration projects. Principal projects include the California Pay for Performance (P4P) program, measurement and reward of efficiency in health care, value-based purchasing of medical devices, health care affordability, bundled episode of care payments, administrative simplification, Accountable Care Organization (ACO) models, and prevention programs directed at obesity. For more information on the IHA Division of Financial Responsibility, please go to <http://www.iha.org/dofr.html>. To access the IHA Division of Financial Responsibility, select “DOFR End User Agreement and Registration.” Then, if you agree to the terms of the END USER POINT and CLICK AGREEMENT, you will be taken to a subsequent page that will require you to register. In addition to providing the requested information, to complete your registration you must input “AMA” in the Code field. You will then be taken to the “IHA Division of Financial Responsibility.”

Chapter 4 Appendix 2: Sample carve-out provision

The parties agree that certain covered services shall be paid by the plan at a fee-for-service rate, and are not included in the capitation payment. These mutually agreed-upon services are listed in Exhibit [] and shall be paid by the [HMO] [IPA] in accordance with the fee schedule also set forth in Exhibit []. Any new technology or procedure where billing is done "by report" and there is no CPT code, shall be paid at the fee-for-service rate.

Chapter 4 Appendix 3: Different contracting approaches that may be used to limit your capitated risk exposure due to an insufficient number of patients

One approach: Suggest adding to the contract a provision stating that you will not accept capitation until the number of enrollees is adequate. For example:

The physician will be paid on a fee-for-service basis pursuant to Exhibit [] until the physician has [] patients through plan, at which time physician will be paid on a capitated basis, as follows. . . [cap amounts stated].

Second approach: Ask for a capitation arrangement whereby you will be guaranteed a certain fee (e.g., eighty-five (85%) percent of UCR) until a certain number of patients are enrolled. Under such an arrangement you would receive a capitated payment each month. However, at the end of the year if this payment does not amount to the negotiated fee, the plan will owe you the difference. (Quarterly reconciliation is recommended.) If your capitated income is greater than it would have been under fee-for-service, negotiate **not** to have to refund the surplus.

Chapter 4 Appendix 4: Sample provision requiring capitation payment retroactive to enrollment

[Plan] shall pay Physician the per member per month amounts stated below as payment for those Covered Services set forth in Exhibit A which are made available by Physician to Plan Members. Capitated Payments shall begin at the time a patient is enrolled with the plan. All enrollees shall be required to choose or shall be assigned a primary care physician at the time of enrollment.

Chapter 5: Shared savings proposals

Wes Cleveland

I. Introduction

There are several types of shared savings payment models. In a shared savings model covering the total or partial costs of care for a population of patients, growth in spending for these patients over time is compared to some target rate of spending growth or budget for the patients. For example, the target could be an estimate of what spending growth would be for this population in the absence of the new payment model, the rate of growth for a comparison population, or the base year spending increased by an inflation factor. Under this model, if actual spending growth for the patient population is lower than the target rate, the payer gives the physicians who are responsible for the reduced costs a share of the savings they generated. Alternatively, a bundled payment model can incorporate a shared savings methodology so that, for example, physicians who accept payment bundles for an episode of care are able to receive a share of any discount they are able to obtain on the bundle, such as reduced prices for implantable devices.

Shared savings arrangements (SSAs) can be roughly divided into two categories based on whether any downside risk is involved. In the first category, if the actual total costs of all care received by the patients assigned to a physician practice, or provider organization, e.g., an accountable care organization (ACO), is lower than target or budgeted costs, the practice or organization receives a percentage of the difference between the actual and budgeted costs (i.e., a "share of the savings"). However, if actual total costs exceed budgeted costs, the practice or organization is not responsible for any portion of the difference. Because the practice or organization is only at risk for additional revenue, SSAs under the first category are sometimes said to involve the sharing of only "upside" risk.

Under the second category, the physician practice or provider organization can receive a percentage of savings, as described above. However, if actual total costs exceed budgeted costs, the practice or organization is responsible for a percentage of the difference. In an SSA falling under this second category the practice or organization is sometimes described as sharing both "upside" and "downside" risk.

Shared savings payment models are already being implemented in the private and public sectors. For example, the Medicare Shared Savings Program (MSSP), created by section 3022 of the Patient Protection and Affordable Care Act of 2010 (ACA) allows ACOs to share savings and risk with the Medicare program under both categories discussed above. Commercial health insurers are implementing similar programs. Although the MSSP is the type of SSA that seems to have recently garnered the greatest attention, other types of SSAs, e.g., gainsharing arrangements and service line co-management agreements, have been utilized in both commercial and governmental sectors for longer periods of time. This chapter will help you identify key issues associated with the SSAs in which you may be asked to participate. Although all of the issues discussed in this chapter may not be applicable to every SSA offered to you, the discussion below should be sufficiently comprehensive to help you evaluate the merits of any SSA opportunity presented to you.

For further, comprehensive information concerning SSAs and all other emerging health care payment and delivery models, please consult the excellent American Medical Association (AMA) resource entitled *[Pathways for physician success under healthcare payment and delivery reforms](#)*. Other resources on this topic, such as an archived webinar, also are available at www.ama-assn.org/go/paymentpathways.

II. Flexibility with respect to delivery and payment models

Given that so much has been said about SSAs within the context of the MSSP, it may be important to emphasize that SSAs can be used in conjunction with a wide variety of delivery models. For example, some Patient Centered Medical Homes (PCMHs) include a shared savings component which rewards the physician practice if the total cost of care for its patients is lower than expected, or if rates of utilization for specific types of services (e.g., avoidable emergency department visits and hospital admissions) decrease. One example of such a program has recently begun in Washington State. The Medicare Physician Group Practice (PGP) demonstration, which involved medical groups as well as physician and hospital integrated delivery systems, tested an upside-only SSA. SSAs could also be used in conjunction with independent practice associations, other types of physician-owned networks or organizations, or involve a hospital and a single medical group in a gainsharing or co-management arrangement. Some Medicare Advantage arrangements have for many years involved SSAs. At the same time, an SSA may be used in conjunction with a variety of payment mechanisms, e.g., fee-for-service, bundled payments, and per-member-per-month methodologies.

III. SSA: General characteristics and key issues

A. Shared characteristics with other risk arrangements. SSAs share many of the characteristics that are common to the other types of risk-sharing arrangements discussed in this guidance. Initially some SSAs may involve only upside risk. Generally, however, the upside-only approach is considered transitional and SSAs in which you will be involved may require you to also assume downside risk at some point. This is because organizational purchasers of health care are likely to view upside-risk only SSAs as not providing physicians and other health care providers sufficient incentive to implement the practice redesign necessary to produce desired reductions in cost and improvements in quality. Consequently, your analysis of a contract containing an SSA will likely have to take into account the core physician concerns common to all risk-based payment methodologies. These concerns include, but are not limited to:

- identifying the specific items and services that will be subject to the SSA, as well as those services that will be carved out (Division of Financial Responsibility matrix);
- identifying the utilization budgets and quality benchmarks that will be used to measure your performance;
- determining the actuarial soundness of your utilization budgets and quality benchmarks;
- predicting expected utilization;
- implementing a reliable risk-adjustment methodology, both to establish your utilization budgets and quality benchmarks, and to evaluate your performance with respect to those budgets and benchmarks;
- tracking your own utilization, cost and quality performance during the term of the arrangement so that you can compare your practice data with utilization and quality data that you receive from the health plan;
- verifying enrollee eligibility;
- determining how payment and losses will be attributed and distributed among SSA participants;
- implementing accrual accounting;
- working with actuaries;
- obtaining stop-loss insurance; and
- sharing sufficient risk to qualify for favorable treatment of certain types of joint conduct under state and federal antitrust laws.

Further information concerning these general core issues may be found in other chapters in this guidance, e.g., the chapters discussing how to establish your practice baseline, the differences between fee-for-service and budget-based payment systems, pay-for-performance, capitation, risk adjustment, stop-loss insurance, working with actuaries, and joint contracting/collective bargaining.

B. Additional considerations concerning benchmark calculation. To the extent that the following considerations are applicable, you should determine the extent to which your utilization benchmark will be:

- risk-adjusted in order to incentivize physicians with sicker patients to participate in the SSA and provide you with sufficient potential financial rewards to accept and treat sicker patients, such as the chronically ill;
- adjusted for differences in geographic practice costs, such as physician office expenses related to rent, wages paid to office staff and nurses, hospital operating cost factors (i.e., hospital wage index) and physician health information technology costs;
- adjusted to include a reasonable spending growth rate based on the growth in physician and hospital practice expenses, as well as the projected changes in patient socioeconomic and health status factors; and
- based on historical utilization or the utilization by a comparable control or peer group.

A key issue to consider is what aspects of patients' costs of care will be included in the benchmark being used for your SSA calculations. For example, Medicare ACOs are held accountable for the **total** Medicare costs of the patient population assigned to the ACO. Because the MSSP patients are in the Medicare fee-for-service program, however, Medicare will continue to cover and pay for services it receives from any provider, not just those who are participating in the ACO to which they have been attributed. Data for the expected patient population needs to be analyzed to assess the proportion of the patients' care that is unrelated to services provided by ACO participating physicians and providers, such as a rehabilitation facility or a group of specialists who are unaffiliated with the ACO. If the ACO is delivering services that only account for half the patients' total costs, it may be difficult to achieve the needed reductions in overall spending. It is especially important to analyze the magnitude of your own potential impact on the patient population's total costs and determine if it will be enough for you to have a chance of obtaining any savings. If 600 of the ACO's 8,000 patients have a particular condition, for example, and your practice believes it has the capability to reduce their costs by 15%, will that be enough to attain the minimum threshold necessary for the ACO to achieve shared savings?

For more information on benchmarking issues, see chapter one "[How to establish your baseline costs.](#)"

C. What is the shared savings methodology? Successful participation in any SSA, even one where you will be sharing only upside risk, involves a commitment of time, financial resources, sweat equity and practice redesign. Participation will involve some cost. Thus, it is essential that you fully understand, and are able to verify independently, the health plan's shared savings calculation methodology. This means having comprehensive information concerning the data and methodology that the health plan will use to determine: total shared savings amounts; the shared savings amounts that are attributed to you; and the amount of your shared savings payments. Such information should include, but not be limited to, all factors used to determine those savings amounts, e.g., the role that any quality score played in those calculations, what effect the health plan's risk adjustment methodology had on those calculations, etc.

1. Will initial savings thresholds have to be satisfied before your sharing in any savings commences? An SSA might have an initial threshold that any savings amounts must first satisfy before any actual sharing may commence. For example, in the Medicare Physician Group Practice Demonstration Project, sharing commenced only after a two percent (2%) savings threshold had been achieved. Initial thresholds of this type may be used by the health plan to ensure that any savings in which you share are the result of your practice redesign efforts and not the result of random utilization variations in your patient population. Such initial thresholds are also utilized in the MSSP. You may also find that the fewer patients under the SSA, the health plan may want to impose a higher threshold, on the rationale that the effect of random variation resulting in savings is greater in smaller populations vis-à-vis larger ones. Obviously, though, the higher the threshold, the lower your likelihood of receiving a shared savings payment. If the ultimate calculation of the savings is also limited to the amount of savings over the threshold, then the threshold will also reduce your potential shared savings payment. However, even if you are unsuccessful in negotiating the complete

elimination of a threshold, you can still seek to have the shared savings payment be based on the entire savings generated in those cases where the threshold is met.

2. Will you have to split savings with the health plan, and if so, at what percentage? As its name implies, in an SSA the physicians do not receive all of the savings they generate; they receive a share of the savings. You should clearly understand the extent to which you may be required to divide savings with the health plan, as this could limit the amount of your potential shared savings payments. For example, you might be required to split savings on a fifty percent (50%) basis, e.g., if your efforts resulted in total savings of \$200,000, \$100,000 is the most you could receive—the health plan receiving the other \$100,000. Obviously, the greater your share, the greater your potential shared savings payment. Also, as a general principle and matter of fairness, the more downside risk you assume under the SSA, the greater your percentage share of the upside risk should be.

3. Will limits be placed on the actual shared savings payment amounts you may receive? Just as limits may apply to your share of total savings, limits may apply to the amount of shared savings payments you may be entitled to receive. For example, with respect to upside-only SSAs in the MSSP, i.e., the one-sided or “Track 1” type of SSA, the amount of actual SSA payments an ACO can receive cannot exceed ten percent (10%) of the ACO’s expenditure benchmark. The Centers for Medicare and Medicaid Services (CMS) believes that this limit is necessary to avoid “creating incentives for excessive reduction in utilization which could be harmful to beneficiaries.” 76 FR 67934. Other types of state or federal regulations may have an effect on the amount of shared savings payments you may be eligible to receive. Because of the obvious impact that a shared savings payment limitation could have on your potential shared savings payment amounts, make sure you identify any such limits and fully understand its potential effects.

D. What can you expect in terms of shared savings payments? You should make every effort to accurately predict the shared savings payments you are likely to receive over the course of the SSA. Accurately predicting potential shared savings payments is an essential element in determining if entering into the SSA makes financial sense. As already discussed, participation in an SSA may involve a significant commitment of resources to achieve necessary practice redesign, and actual shared savings payments that are not commensurate with your efforts and performance may cause your practice or organization to take a financial “hit,” or may even jeopardize its ongoing financial stability. Furthermore, it is imperative that potential shared savings be large enough so that individual, participating physicians will be incentivized to change what they do and adopt more cost effective practices. If physicians do not view potential payments as sufficiently robust, physicians and other SSA participants may not commit to practice redesign efforts, figuring that they can generate more revenue simply through increased fee-for-service volume. (However, as more private and public payers adopt new payment models, maintaining revenue through increased fee-for-service may not be a viable long term strategy.)

1. It can be done. Although it may initially seem a daunting task, if the health plan is transparent with respect to its risk and shared savings methodologies, underlying data, and the other kinds of information described in this chapter, and if you have in mind concrete practice redesign projects such as some of the efforts described in IX below, you should be able to predict with a significant degree of accuracy the amount of shared savings payments you are likely to receive under the SSA. There are trained professionals, e.g., actuaries, who are experts in assessing and managing risk and who may provide you with invaluable assistance in accurately estimating the amount of your potential shared savings payments. See chapter ten, “[Working with actuaries](#)” for further information.

E. Will you be able to phase into downside risk assumption? If you have little or no experience managing risk, it might be prudent to determine if the health plan will be amenable to limiting your initial participation to upside-only risk sharing. Such a limitation may provide you with a much-needed opportunity to gain experience implementing the kinds of changes that are likely to reduce costs and improve quality without the angst of having to immediately place a portion of your revenue stream at risk. Accordingly, when offered an SSA opportunity, you may want to try negotiating your initial participation to involve only upside risk sharing. However, as previously noted, such participation will likely limit the

potential size of the shared savings payment, and may further be accompanied with an expectation that you will also assume downside risk in the near future.

F. What is the downside risk-sharing methodology? If you are accepting downside risk, it is vital that you fully understand the scope of your risk exposure. As is the case with respect to upside risk assumption, you must have complete information concerning the data and methodology that the health plan will be used to determine: total loss amounts; the loss amounts attributed to you; and your specific financial responsibility for losses. Such information should include all factors used to determine loss amounts, e.g., the role of your performance with respect to quality and/or cost effectiveness metrics, what effect any risk adjustment methodology had on those calculations, etc.

1. Are there any initial loss thresholds that must be satisfied prior to triggering your responsibility for losses? If you are accepting downside risk, you should determine if there are any thresholds that losses must satisfy prior to triggering your financial responsibility. Such a threshold might significantly benefit your practice, because it would help ensure that you will not be responsible for losses that occur simply from random variations in utilization by your patient population, rather than as a result of the conduct of your organization or practice. If the number of patients in your SSA is relatively small, you may want to try to negotiate for a correspondingly higher threshold, since the losses resulting from random utilization variations may be higher in smaller SSA patient populations than in larger ones. Finally, if the health plan is imposing a minimum savings threshold as described in III.D.1 above, you should insist that an equivalent (if not greater) corresponding minimum loss threshold described in this section also applies.

2. Will you share losses with the health plan, and if so, at what percentage? You should identify the extent to which you will share financial responsibility for losses with the health plan. For example, rather than assuming *total* responsibility for financial losses, e.g., utilization that exceeds your applicable utilization benchmark, your responsibility may be limited to, say, fifty percent (50%) or sixty percent (60%) of the difference between your patients' actual and predicted utilization, with the health plan assuming responsibility for the other fifty percent (50%) or forty percent (40%). Again, to the extent the health plan is sharing in the savings, it should also share in the losses.

3. Will there be limits to the actual amounts for which you may be responsible? You should identify the extent to which the actual amount for which you will be responsible is limited. For example, the amount of your financial obligation might be limited to five percent (5%) of your projected patient utilization budget, or might be limited to a percentage with respect to some other standard or budget. If you have little or no experience assuming downside risk, it might be prudent to try to negotiate limits as low as possible until you are confident that you can successfully manage risk.

Another option to consider is a stop-loss provision, which applies, like stop-loss insurance, to cap the potential risk of individual case outliers. For more information, see chapter nine, "[Stop-loss insurance](#)."

G. You may want to attempt to negotiate staggered increases in risk responsibility. If you are new to assuming downside risk, you might want to try to negotiate graduated risk exposure limits. For example, in the first year of the risk arrangement, you might want to try to limit the total amount of your financial responsibility to a low percentage, e.g., five percent (5%) of losses attributable to your practice. But, as you become more adept at managing risk, you may be more amenable to gradually increasing the percentages applicable in subsequent years. Ultimately, you may feel sufficiently confident in your ability to manage risk and in the relationship between you and the health plan, that you may ultimately conclude that you do not require the protection afforded by risk limits, assuming, of course, the possibility of concomitant financial reward.

H. Frequency of loss calculation and deadline to repay. You should determine how frequently over the course of the SSA you will be obligated to make repayments or how frequently losses will be attributed to you. If you have not assumed downside risk before, you might initially want to see if you could have any repayment obligations or loss attributions determined on relatively frequent basis, e.g., no longer than annually, and perhaps even quarterly. More frequent notifications of repayment obligations or loss attributions can help provide you with feedback concerning how well you are managing your risk,

and can help you make crucial practice changes that will enable you to deal proactively with losses or repayment obligations before those losses or obligations become more of a problem for your practice.

I. Issues concerning shared savings payments and loss responsibility discharge.

1. Will you receive full shared savings payments or will payments be withheld to ensure satisfaction of your loss obligations? If you will be assuming downside risk, a crucial issue concerns how the health plan will want to ensure that you will possess the financial wherewithal to satisfy your financial responsibility for losses. There are two basic approaches that the health plan might take. Under the first approach, rather than making full shared savings payments to you, the health plan might withhold some, or all, of those payments. The health plan would first apply any shared savings amounts to satisfy your financial loss obligations. Only subsequently will the health plan pay you shared savings, which will be comprised of any funds remaining after loss satisfaction. Based on the experience of the 1990s, when physicians rarely received withheld payments regardless of how well they performed, this approach may likely not be the favorable option (chapter seven, “**Withholds and risk pools**” contains an extensive discussion of key issues associated with withholds and risk pools). Under the second approach, the health plan will not retain any portion of your shared savings, but will make full shared savings payments to you. If, however, your practice or organization ends up being responsible for financial losses, the health plan will require you to repay the plan an amount sufficient to discharge those losses. If you do not have sufficient funds to cover the loss amounts, the health plan may carry over your remaining obligation to the next year and deduct amounts from future shared savings payments otherwise due you until that obligation is discharged.

- a. **What steps will the health plan require you to take to ensure that you will be able to satisfy any repayment obligation?** If the health plan will require you to make repayments to discharge losses attributed to you, you will need to identify and understand what kinds of assurances the health plan might want you to provide to ensure that you will have sufficient funds to cover those losses. You should, for example, understand what financial reserve, stop-loss, reinsurance, letter of credit, or other requirements may be applicable. You should also identify the extent to which the health plan will be able to recover losses by offsets against shared savings payments owed to you, if, for example, losses are carried over from one year to the next, and any applicable appeal rights you may have.

2. Advance notice of proposed shared savings payments and appeal rights. You should determine the extent of your notice and appeal rights with respect to potential shared savings payments. The health plan should provide you with advance notice that identifies the amount of your expected shared savings payment, if any. That notice should explain how the health plan determined the payment amount, including information sufficient to enable you to verify independently the health plan’s payment determination. Be sure that you also determine whether or not the health plan will make available to you a formal appeals process that will enable you to challenge, and expeditiously resolve, inaccurate payment calculations.

3. Timing of payments. It is likely that the health plan will not want to make shared savings payments more frequently than on an annual basis, and may desire an even longer period of time, e.g., at the conclusion of the entire SSA term. Less frequent payments will reduce the plan’s administrative expenses and enable the plan to earn more interest income on the monies ultimately due you. But payments made on a more frequent basis, e.g. quarterly, will expedite your receipt of financial resources that you can use to defray incurred practice redesign costs and hasten the addition of additional improvements that will, in turn, generate greater savings payments. More frequent payments, particularly if they are smaller than expected, may help you identify early on in the SSA where you should be more aggressive in implementing practice workflow redesign.

4. Notice and appeal rights with respect to losses; recoupment and interest. You should determine whether you will have access to a fair appeals process through which you can challenge the amount of your alleged financial loss responsibility. Also, if the health plan will make shared savings payments to you as opposed to placing those savings in a withhold fund, recoupment is a crucial

consideration. For example, to what extent will the health plan be able to recoup monies from your pending or future payments in order to satisfy loss obligations? Will the health plan be able to engage in recoupment if you are in the process of appealing your alleged loss obligation, or will recoupment efforts be suspended pending the appeal's outcome? Also, if, after the conclusion of an appeals process, it is determined that you do owe money, will you be charged interest on that money? If so, what is the applicable interest rate and when did interest accrue?

5. What are the applicable repayment deadlines? You will need to identify how much advance written notice you will have prior to any repayment deadline. For example, will you receive thirty, sixty, ninety, or 120 days' notice? If you are part of a smaller practice or organization, it may make sense to try to negotiate a longer notice period. This is because smaller practices or organizations, in contrast to some large systems or organizations, may not have the financial resources on hand to discharge repayment obligations within a relatively short period of time. Smaller practices or organizations may require relatively more time to gather the necessary funds from their participants or external sources, such as stop-loss insurers.

IV. Will the health plan provide you with up-front resources?

Because SSAs may typically provide for potential savings payments at the back-end, being able to fund the infrastructure necessary up-front to achieve the practice redesign sufficient to generate those payments may be a significant problem for many physicians. This resource challenge may be particularly acute for physicians practicing in rural communities and solo-small group practices. However, in some cases, health plans may be willing to provide physicians with up-front financial or in-kind resources that will help physicians offset the initial investment costs incur in order to successfully participate in an SSA. Depending on your need, you should determine if such up-front resources are available. If they are, you should consider asking the health plan to structure those resources so that they most closely align with your specific risks (e.g., start-up costs, systems investments, culture changes, and financial uncertainty). For example, as a direct response to AMA advocacy on this issue, CMS created an Advance Payment ACO program for smaller and rural Medicare ACOs that allows them to receive up to \$1.5 million advances on their Medicare shared savings to help cover start-up investments and initial operating costs.

A. Note on in-kind services. Health plans offer various in-kind services; the following categories of in-kind services are typical of many plans:

- Supportive services—the management of long-term supportive services and coordination of these services with members' medical benefits;
- medical management--management of clinical services, especially chronic conditions; the primary care physician plays the central role in this type of service;
- primary care--services and strategies designed to strengthen the primary care;
- behavioral health management--services that help coordinate the treatment needed to address behavioral health needs; and
- member services--a prominent service that focuses on frail populations with complex health issues.

Decision-making, types of interventions or contact with patients, targeted-initiatives, and self-directed services are common in-kind services or resources; however, how these resources are defined and implemented may vary across health plans. For example, patient follow up may be by mail, phone, or in person; or decision-making may be decentralized, providing care managers with broad authority to authorize service plans, make referrals, or authorize alternative therapies. Some health plans provide team-based services, where the PCP establishes the plan of care but works through the care manager to coordinate care and communication.

Research and narrative have revealed that services, such as care management and coordination, which generate outside of the office or clinical setting of care can fragment care, impede communication, and add bureaucratic layers to care management. The most productive care management generates from the physician's office and, ideally, the care manager is full-time staff. Communication and continuity are dependable; resource allocation is appropriate and timely; patient and family satisfaction is higher. When

utilizing in-kind services, physicians should strive to ensure that responsibilities are well-defined and accountability is transparent to the physician, staff, and patients.

For further information concerning how care management and coordination may improve quality and reduce cost, see [IX.B.6\(e\)](#) below.

V. How often, and upon what years' data, will your benchmarks be recalculated?

A key factor you should take into account is the prospect of your receiving worthwhile shared savings payments in the future. If you have not yet instituted any of the practice redesign and workflow changes that are expected to improve the quality of care provided to, and reduce unnecessary utilization of services for, your historic patient population, the potential for receiving substantial shared savings payments may be great. However, it may take at least a couple years into the SSA before your efforts begin to achieve actual savings. So, for example, if the initial term of your SSA is three years, you may not receive a shared savings payment, and thus begin to recover investment costs, until the end of the third and final year of the SSA. For this reason, you may wish to negotiate for the right to extend the SSA for an extra year or two to ensure you have the ability to recover your initial investment.

If the health plan is willing to extend the term of the SSA, a crucial consideration is whether or not the health plan will recalculate your quality and cost/utilization targets or benchmarks, and, if so, what performance year's or years' data will be used to calculate those benchmarks. If, for example, the health plan recalculates your quality and utilization benchmarks based only on your last year's performance, i.e., the third and final year of the initial term of the SSA, your potential for realizing substantial shared savings payments over subsequent years will not be as great as it would be had those benchmarks been based on the initial data, or at least on the data for the entire SSA period. This is because it was not until the last and final year of the initial SSA term that you were able to markedly improve quality and reduce costs. A similar problem could arise if the health plan recalculated your benchmarks, say, annually, based only on the previous year's numbers. So you should clearly understand both how often, and upon what previous quality and utilization data, the health plan will re-set your quality and utilization targets.

VI. Term of the SSA

You will need to know the term of the SSA. For example, is the term one year, which has often been the case in the Office of the Inspector General (OIG)-approved gainsharing arrangements, three years, five years, or longer? If you have not engaged in an SSA before, a longer-term SSA may work best for you, since it may take some time for your practice or organization to generate savings amounts to offset incurred practice and workflow redesign costs and other practice improvement investments you have made in order to realize those savings. Also, in many cases it will be necessary to perform high-cost procedures or expensive diagnostic tests up-front on some of your patients, e.g., bariatric surgery, in order to improve longer-term outcomes or reduce resource utilization. You do not want to be in a situation where you have made significant investments of time, sweat equity, and money, or have performed expensive up-front procedures or tests, only to have the term of the SSA expire and not be renewed by the health plan before you begin to benefit from the savings that can be expected to follow from your efforts.

VII. Termination and due process

You should identify the conditions under which you or the health plan may be able to terminate the SSA. If you are uncertain about your ability to manage risk or effect of the kinds of changes required by the SSA, your likelihood of receiving satisfactory shared savings payments, the transparency of the information you are, or will, receive from the health plan, e.g., actuarially sound utilization budgets, or your general business relationship with the health plan, you may want to try negotiating provisions that eliminate potential downside risk or will enable you to terminate your participation in any downside risk if early on it becomes clear that the SSA will be unsatisfactory. At the same time, you need to know the conditions under which the health plan may terminate. If the health plan has unfettered discretion to terminate the SSA, you may invest significant resources in SSA participation only to have the health plan end the SSA without you benefiting from the shared savings payments that your efforts would have generated. Also, be certain to understand what will happen to shared savings payments due you if the agreement is terminated, either by you or the health plan. For example, will you be subject to penalties if

you terminate the agreement, e.g., if you terminate your participation mid-term will you forfeit shared savings payments that the health plan was ultimately otherwise obligated to pay you? Are you protected from penalties when you are not able to comply with the SSA for reasons beyond your control, e.g., if you are required to maintain a minimum number of enrollees and your enrollees fall below that threshold due to no fault of your own, or if you terminate your entire participation agreement with the health plan for cause? Finally, be certain to identify what, if any, due process protections you will be afforded in case the health plan decides that it wishes to terminate you from the SSA.

VIII. Long-term prospects for continued savings payments

A. Will you face the prospect of diminishing returns, and if so, what opportunities will exist for bonus payments or other financial rewards for the continuing provision of high quality, cost-effective care?

1. The prospect of diminishing returns. A key factor you should take into account when evaluating an SSA opportunity is your long-term prospects of receiving sustained financial rewards for your continued provision of high quality, cost-effective care. If you have not yet implemented the kinds of practice redesign that is expected to improve quality and reduce costs, e.g., implementing evidence-based guidelines, the potential to receive substantial shared savings payments relatively early on in the SSA may be great. However, as you gain experience and begin to reduce the occurrence of hospital admissions, readmissions, emergency department (ED) visits or other events leading to significant expenditures of health care resources, and become adept at managing the care of your chronically ill patients, the differential between your cost reduction and quality improvement results and recalculated utilization and quality benchmarks or targets is likely to gradually lessen. If so, as you progress in the SSA, it is likely that the amount of your shared savings payments will lessen accordingly every year. At some point, you will probably find yourself at the end of a cycle of diminishing returns, where either the cost of taking further steps to achieve further cost-reductions or quality improvements significantly outweigh any potential savings or quality gains, or further efforts could raise legitimate concerns about the potential denial of medically necessary services to your SSA patient population.

2. If you reach the point of diminishing returns, will there be continued opportunities for bonuses or financial rewards? If you are concerned about the possibility of diminishing returns, there are at least two possible solutions to consider. First, even if no potential remains for generating further shared savings payments can reasonably justify further investments in practice infrastructure or redesign, it is still likely that health care purchasers will want to ensure that you are appropriately incentivized to sustain optimal performance and to implement emerging technologies to reduce costs and improve quality as they become available. Thus, you may be able to negotiate a general, continued bonus set, for example, at a certain percentage of your total fee-for-service payments, to reward you for sustained achievement of quality improvement and cost-reduction targets. At the same time, shared savings payments could still be available for specific instances where the adoption of new technologies or the provision of new types of services have produced hitherto unavailable reductions in cost or improvement in quality. This option may be more viable if the health plan does not view the SSA as a transitional step toward greater risk sharing arrangements, e.g., in cases where an organization due to geographic considerations or enduring resource challenges cannot be expected to capitate or otherwise assume significant amounts of downside risk.

Second, the SSA might be an intermediate step along the way to unlimited assumption of downside risk. Under this scenario, you might be able to continue receiving financial rewards as a result of steadily increasing the amount of downside risk you take on under the SSA. For example, as opposed to sharing the risk of financial loss with the health plan at, say, fifty percent (50%) or sixty percent (60%) of the difference between actual costs and your expenditure benchmark, you might take on greater downside-risk percentages as the SSA progresses, e.g., seventy percent (70%), eighty percent (80%). This greater downside-risk assumption could (and should) be accompanied by an ever-increasing, corresponding increase in potential shared savings rewards. Ultimately, you might be in a position where all savings and risk limits have been removed, and you can operate under partial or global capitation, depending on the scope of the participants in your organization.

IX. Identifying, and harvesting, the “low hanging fruit”

A. Introduction: How do you identify the areas with the greatest potential for savings?

One key to SSA success is identifying those areas where your efforts are likely to produce the most immediate savings with respect to your predicted patient population. If you are able to obtain from the health plan the kinds of information identified in this and other chapters of this guidance, e.g., chapter four “Capitation,” you should be able to put together an accurate picture of the demographics and health status of that population. This, in turn, will help you identify those areas where you should focus your practice redesign, workflow changes, and other quality improvement and cost reduction efforts. Although those areas will in part be contingent on population specifics, the following are some general areas where some physicians have had success in SSA contexts.

B. Potential focus areas

1. The most expensive services or episodes of care. In many cases, the most expensive services, items, or episodes of care will provide the greatest savings opportunities. Significant savings may be readily achievable by focusing on ways to reduce unnecessary and preventable hospital inpatient admissions and readmissions, emergency department visits, and by reducing unnecessary inpatient lengths of stay. Elimination or reduction of so-called “never events,” and hospital-acquired conditions may generate sizeable savings. Concentrating on reducing unnecessary invasive procedures and high-end diagnostic tests, regardless of site of service, may also generate considerable savings. To the extent the health plan is willing to pay you for savings measured against the hospital and ED costs your patients incurred previously, your SSA can be limited to your medical practice. Although reduction in some of these occurrences, particularly inpatient length of stay, means that your practice or organization will in some respect need to be affiliated with a hospital in the SSA, the affiliation can be structured in myriad ways that do not necessitate hospital employment.

2. Intra-organization peer comparisons. Another frequently-discussed cost savings and quality improvement focus area involves comparing the utilization patterns of physicians within a practice or organization. Under this approach, you will first need to develop a utilization profile for each of your practice’s or organization’s physicians, defined by the most specific Current Procedural Terminology (CPT®) or other code. You can then compare your physicians’ profiles, one with another. This comparative analysis, which should first be directed at the most expensive items or services that your practice or organization provides, will enable you to identify the highest utilizers of those items or services. If greater utilization cannot be explained on the basis of objective clinical guidelines or other clinical considerations, e.g., patient health status, then persuading your highest utilizers to alter their practice patterns may represent an excellent opportunity to achieve savings. For more information on this approach, see the AMA resource entitled “Take Charge of Your Data,” at www.ama-assn.org/go/physiciandata.

3. Practice or organization peer comparisons. Comparing a practice’s or organization’s utilization profile with its peers has been another fruitful savings strategy. To implement this strategy, you will first need to develop your practice’s utilization profile, defined in terms of the most specific CPT or other code. Once you have that profile, you can compare it against national aggregated data repositories such as the Dartmouth Atlas (www.dartmouthatlas.org) or state all payer claims databases, such as that of the Wisconsin Health Information Organization (www.wisconsinhealthinfo.org). You can also hire a consultant to help. As with the intrapractice review described above, you will want to compare that profile with the average profile in your geographic and product market, again, focusing initially on the most expensive items and services. If your practice’s or organization’s profile reflects substantially greater resource use than the average utilization of a specific item or service in your market, and you cannot justify that utilization rate based on patient severity, clinical guidelines or other objective clinical factors, significant savings opportunities may be present if you can bring utilization within appropriate norms, e.g., through the application of evidence-based guidelines.

4. Opportunities identified by gainsharing arrangements approved by the U.S. Department of Health and Human Services Office of Inspector General (OIG)

- a. **What are gainsharing arrangements?** Gainsharing arrangements (GAs) are a type of SSA. GAs typically focus on a narrower scope of services or costs, e.g., a particular service line or medical devices, than SSAs with a more global scope, e.g., SSAs that are being implemented under the MSSP. GAs also differ from MSSP SSAs in that GAs often compare actual utilization costs with historic utilization costs, whereas MSSP SSAs compare actual utilization against predicted utilization budgets. In GAs, if actual utilization costs are lower than historic costs, participants share in a percentage of the savings.
- b. **Opportunities for savings under GAs.** GAs that have been approved in advisory opinions issued by the OIG may give you an idea of where you might focus immediate efforts to achieve significant savings, at least in the physician-hospital context. The following are some of the areas identified in OIG GA advisory opinions:
 - standardization of devices (accompanied by negotiation of volume discounts), e.g., cardiac catheterization stents, balloons, interventional guide wires, pacemakers, defibrillators, vascular closure devices, contrast agents, spinal fusion devices, fluid warming hot lines;
 - opening packaged items, e.g., surgical trays, on an “as needed” basis;
 - substituting less costly items for items currently in use, e.g., disposable head supports, K-thermia blankets, slush drapes, wrist splints, arm boards, aortic punches, suture boots, ace bandages, reusable gel pads, catheters, nasogastric tubes;
 - limiting the types of patients who receive specific high-cost medications, as indicated by objective clinical standards;
 - substituting less costly medications for more expensive alternatives;
 - limiting use of certain surgical supplies and devices to an “as needed” basis, e.g., gelfoam, surgicel, vancomycin, and certain devices used for coronary interventional and diagnostic procedures, e.g., specific vascular closure devices and cutting balloons; and
 - performing blood cross-matching only as needed.

5. Savings opportunities with regard to drugs

- a. **Substitution.** As noted in the preceding GA discussion, substituting generic drugs for brand name medications and otherwise substituting less expensive drugs in place of more expensive medications may present an opportunity for you to achieve savings, assuming of course that the less expensive medication provides at least the same level of therapeutic benefit for the patient. Additional drug-related savings opportunities may also be available, as further described below.
- b. **Medication reconciliation to reduce adverse drug interactions resulting from polypharmacy.** Proactive medication reconciliation may provide a significant quality improvement and cost reduction opportunity. Some of your patients likely take medications that are not prescribed by your practice or organization. You may not know about, or have correct information concerning, these medications. The same may be true with respect to other practices’ or organizations’ knowledge regarding your prescriptions. At best, these knowledge gaps may result in harmless, but wasteful, redundancy. In other cases, however, the consequences may be much more serious. For example, unreconciled polypharmacy can cause symptoms that can themselves necessitate additional prescriptions to alleviate. Further, unmonitored polypharmacy may cause severe drug interactions, resulting in acute episodes that require intensive treatment to address, and/or hospital admission. Focusing your efforts on obtaining complete and current medication information from your sickest patients may be one way to start addressing polypharmacy-related issues. A relatively easy way of obtaining this information is to start asking your sickest patients to periodically bring all the medications that they are currently being prescribed to their office visits. This by itself may greatly increase your knowledge about the medications your patients are taking, and can help you coordinate patients’ medication regimens with other prescribers. This greater knowledge and potential for

more effective coordination can significantly improve quality or cost-effectiveness by reducing redundancy, error, and interactions that require treatment. Electronic prescribing programs typically include functionalities, such as allowing you to maintain patient-specific prescription drug lists and automatically alerting you to potentially dangerous interactions, which can help you reduce medication errors that can lead to waste and significant adverse events.

- c. **Monitoring and maximizing patient prescription drug compliance.** Nor is it always the case that reducing drug costs will maximize total health care savings. To the contrary, in many cases expensive ED visits and hospital admissions can be avoided if patients simply take their medications as prescribed. There are a number of strategies physicians can implement to increase medication compliance, from asking routine questions at each appointment, to obtaining an electronic report from relevant pharmacies of the prescriptions that have been filled, to monitoring refill requests and sending reminders to patients whose requests are late.

6. Managing patients with specific chronic conditions

- a. **Identifying and selecting the patients and conditions you want to manage.** Some physicians have achieved considerable savings success by focusing on ways to better manage the care of patients having the same type of chronic conditions. Implementing some relatively simple steps in this area may result in marked quality improvement and cost reduction, by, for example, trimming emergency department (ED) utilization, hospital admissions or readmissions, and chronic care exacerbations which, while perhaps not requiring hospital utilization, nonetheless consume substantial health care resources. Under this strategy, you will first want to identify the chronic conditions most prevalent in your patient population. Diabetes, hypertension, congestive heart failure, coronary artery disease, chronic kidney disease, and asthma are some of the conditions where physicians have achieved success. If you lack prior experience in chronic condition management, it might make sense to direct your initial efforts to a single chronic condition, selected based on the greatest likelihood of savings and/or your practice's familiarity with the condition.

b. Implementing a patient registry

- i) **An inexpensive, effective tool.** A patient care registry can be an inexpensive but crucial tool you can use to quickly improve your chronic condition management capability. A patient registry can be very useful even if you have not yet implemented an electronic health records system, or the registry is not yet interoperative with other persons or organizations providing care to your patients, e.g., community labs or pharmacies. Ultimately, you will want to integrate your registry with any electronic health records system you adopt, and have the registry and electronic health records system be interoperative with the other organizations providing care to your patients. But such integration and interoperability are not prerequisites for achieving significant quality improvements and cost savings by simply operationalizing a registry.
- ii) **How can a registry help?** Patient registries can dramatically improve your ability to identify, and then rectify, gaps in care where your chronically-ill patients are not receiving preventive services, evaluations, examinations, and follow-up. Patient registries can also increase the effectiveness of your office visits. For example, the day before a patient's visit, the registry could generate a brief written summary describing the patient's health status, demographics, and treatment regimen. Along with the summary, the registry could also create a checklist identifying what services, tests, or other interventions the patient should receive during, or subsequent to, the visit. Also, you could use the registry to help schedule patient tests on the day before, or on the same day of, an office visit, so that your interaction with the patient during that visit will be informed by the results of those contemporaneous tests. In this way, a patient registry can help optimize your ability to conduct an organized, intentional, and proactive approach to chronic care management that can be instrumental in achieving demonstrable quality improvement and cost reduction.

You can also use a registry to help make your practice more efficient. You could, for example, link your registry or your appointment scheduling process with an automatic telephonic notification system, which could automatically contact patients the day before their appointments to help ensure that those patients keep those appointments. Not only will this maximize time allotted to office visits and your ability to manage your chronically-ill patients via face-to-face encounters, but ensuring that medically appropriate appointments are kept may have a significant positive effect on practice revenue—particularly when state or federal requirements prohibit you from charging patients for missed appointments.

For more information on patient registries, see the AMA resource entitled (currently available to AMA members only) “[Optimizing outcomes and pay for performance: Can patient registries help?](#)”

- iii) **Facilitating practice redesign through monitoring compliance with clinical guidelines.** Patient registries can also be instrumental in helping you achieve the practice redesign that you may need to undertake in order to successfully participate in an SSA. Some patient registries can generate individual physician reports (so-called “report cards”) that can show how effective a physician has been in terms of ensuring that his or her patients have received the items or services identified in the registry. When registries incorporate evidence-based guidelines, or other clinically appropriate guidelines, registries can be an effective means of tracking how well physicians are adhering to those guidelines. So long as physicians have confidence in the fairness and accuracy of the feedback they receive, they typically make whatever changes in their practice patterns necessary to increase clinical guideline compliance and bring performance in line with that of their peers. By using report cards and other means, e.g., clinical dashboards, physicians can be presented with objective feedback and, where appropriate, be persuaded by their physician peers of the need for better performance. Such performance improvement is one of the key components needed to produce the improved quality and cost reduction that SSAs are designed to reward.
- iv) **Maximizing your ability to report quality data.** It is likely that any SSA in which you participate will have significant quality data reporting requirements. Much of the potential savings payments you may receive under the arrangement may depend on the amount and accuracy of the data you report. Because a registry helps ensure that you consistently provide recommended care and identify, and rectify, care gaps, you can use a registry to capture and document any and all data concerning your quality improvement efforts, results, and outcomes. Having this robust quality data will maximize the accuracy and completeness of your quality reporting data, which, in turn, may have a significant, positive effect on the amount of the shared savings payments you ultimately receive.

c. Facilitating communications with affiliated hospitals. Having staff at any hospital with which you are affiliated notify you when one of your patients has visited the hospital ED or has been admitted to, or discharged from, the hospital may significantly augment your chronic care management capabilities. Of course, in some cases you will already know when one of your chronically-ill patients has been admitted or discharged, e.g., when you yourself are the admitting physician. But this may often not be the case in some communities. But having even an informal system in place that alerts you promptly to admissions, discharges, and ED visits will enable you to timely: obtain copies of any discharge documents from the hospital; follow-up with those patients to address any questions or concerns; monitor patient comprehension of, and adherence to, discharge instructions; schedule follow-up appointments, if necessary; and determine the extent to which improvement in chronic care management might forestall similar utilization in the future.

d. Patient compliance

- i) **The importance of patient compliance.** You might have care plan templates, registries, electronic health records, and state-of-the-art systems and infrastructure in place, but if you do not proactively help your patients follow your treatment recommendations and learn how to self-manage their care, your ability to achieve an adequate return on your practice

- investments may be delayed or even compromised. However, taking a few relatively inexpensive actions may greatly increase the likelihood of patient compliance with your treatment recommendations and motivate patients to be proactively engaged in their care.
- ii) **Education.** Taking time to educate the patient, both orally and through written materials, about the nature of his or her chronic condition, the rationale underlying the treatment recommendations the patient is being asked to follow, e.g., why you have prescribed the specific medications the patient is being asked to take, the likely negative health effects resulting from a failure to follow those recommendations, and the availability of any community support groups, will help empower the patient to adhere to treatment recommendations. Providing effective written materials may not be difficult, since many of the chronic conditions on which you are likely to focus your efforts, e.g., diabetes, are represented by national medical specialty and disease specific associations that have already developed brochures and other educational materials that are tailored to your patients' health literacy levels. Depending on the context of your registry, you could buttress your patient education efforts by using your patient registry to help you generate patient compliance "report cards" to help patients understand how well they are following their prescribed treatment regimen and where they need to improve. Also, to the extent that the patient permits, providing similar education to the patients' family and intimates may in many cases greatly improve patient compliance. Although these efforts may take some staff time and repeated effort, it is likely that those efforts will pay off by reducing preventable exacerbations in chronic conditions. Finally, your efforts need not be limited to the chronic condition in question. For example, you might be well served to educate your patients, and their families and intimates, regarding how to avoid risks associated with their demographics, e.g., the need for annual flu vaccinations, minimizing the likelihood of falls at home, medication safety, etc.
 - iii) **Benefits for patient satisfaction.** It is likely that some aspect of your overall quality performance will depend on the results of patient satisfaction surveys. Thus, patient satisfaction scores may have an effect on the amount of your potential shared savings payments. Although patient satisfaction will not be the primary object of your efforts to educate, empower, and engage your patients in their care, those efforts may have a significant positive effect on your patient satisfaction evaluations. Some physicians have found that their patient satisfaction scores have benefitted when they closely monitor and work with their patients to help them meet treatment goals, because the patients feel that their physician cares about, and is invested in, their well-being.

e. Use of care management professionals. Use of a clinical professional to perform case management activities can also be very useful in managing the treatment and/or administrative aspects of your chronically ill patients' care. The qualifications of the professional can vary based on the tasks you want that person to perform. If you want that person to discuss and coordinate care between your practice's physicians and clinical professionals and other physicians and facilities, and facilitate the clinical transition from one care setting to another, an advance practice nurse, RN or PA may be the most appropriate. The same would be true if you wanted the professional to advocate for your patients in cases where health plan or hospital case management staff take positions that you believe may not adequately address a patient's needs. But other, less clinically intensive, or administrative, duties may be performed by a licensed practical nurse, social worker, medical assistant or other appropriately qualified and trained individual.

Although adding staff to perform certain care management tasks will involve extra costs, those costs might be less than you initially suspect. You might make costs manageable by initially narrowing the focus of your care management professional to your most high risk, chronically-ill patients. For example, you might implement an automatic telephonic system whereby your sickest, or otherwise most at-risk, diabetes patients call in daily to report their blood sugar levels. Your care management professional could then monitor the recorded messages and proactively initiate any interventions, e.g., an immediate office or home visit, to prevent an exacerbation or acute

episode. Using a care manager in this or similar cost effective ways may not require you to hire a full-time employee (FTE). You could, for example, lease the services of the professional from a large physician practice or a hospital on a part-time basis. Or you and several other smaller practices or organizations could jointly share the costs of such a person, with the person working part-time at each such organization or practice. It is also possible that in some cases, a health plan that understands the value of care management services might be willing to pay for some, if not all, of the costs associated with adding a clinical professional to your staff to perform select clinical or administrative functions essential to effective chronic care management.

X. Conclusion

Much has been written and discussed about shared savings arrangements recently, particularly because of the MSSP and ACOs. SSAs can, however, assume many different forms both in terms of the delivery models and payment systems in which they are utilized. When approached with forethought, physicians may find SSAs to be a useful means of learning how to adapt to, and succeed in, emerging payment and delivery models. It is hoped that physicians will find this chapter to be instrumental in that adaptation and success.

Chapter 5 Appendix 1: A sample of shared savings and gainsharing projects

- [The CalPERS Shared Savings pilot](#)
- [Care Management for High-Cost Beneficiaries Demonstrations](#)
- [Carilion Clinic—Roanoke, Virginia](#)
- [Coastal Medical of Rhode Island \(contract with Blue Cross Blue Shield\)](#)
- [Commonwealth Care Alliance: Plan-Funded Team Coordinates Enhanced Primary Care and Support Services To At-Risk Seniors, Reducing Hospitalizations And Emergency Department Visits](#)
- [Goodroe Healthcare Solutions \(Hospital-Physician Gainsharing Solutions\)](#)
- [HealthCare Partners—Torrence, California](#)
- [Independence at Home Medical Practice Demonstration Program](#)
- [Indiana Health Information Exchange \(IHIE\) Demonstration](#)
- [Medicare Health Care Quality Demonstration Programs – Gundersen Lutheran Health System](#)
- [Monarch Healthcare—Irvine, California](#)
- [Multipayer Advanced Primary Care Practice](#)
- [North Carolina Community Care Network \(NCCCN\)](#)
- [Norton Healthcare—Louisville, Kentucky](#)
- [Physician Group Practice Demonstration, which ran from April 2005 through March 2010](#)
- [The Physician Group Practice Transition Demonstration.](#)
- [The Sutter Care Coordination Program: Chronic Care and Disease Management Improves Health, Reduces Costs for Patients with Multiple Chronic Conditions in an Integrated Health System](#)
- [Tucson Medical Center—Tucson, Arizona](#)

Office of the Inspector General of the U.S. Department of Health and Human Services, Advisory Opinions regarding gainsharing arrangements:

- [Blue Cross and Blue Shield of Minnesota shared savings contracts with Allina Hospitals & Clinics, Essentia Health, Fairview Health Services, and HealthEast Care System](#)
- [Commonwealth Medicine of UMass Medical School](#)
- [Genesee Health Plan HealthWorks PCMH Model](#)
- [Greenway- Carrollton, GA](#)
- [Geisinger health system proven health navigator PCMH model](#)

- Group Health Cooperative of Puget Sound
- Health Care Partners Medical Group Best Care PCMH model
- Johns Hopkins guided Care PCMH Model
- Maryland's Patient Centered Medical Home Program
- Office of the Inspector General Advisory Opinion No. 01-1
- Office of the Inspector General Advisory Opinion No. 05-01
- Office of the Inspector General Advisory Opinion No. 05-02
- Office of the Inspector General Advisory Opinion No. 05-03
- Office of the Inspector General Advisory Opinion No. 05-04
- Office of the Inspector General Advisory Opinion No. 05-06
- Office of the Inspector General Advisory Opinion No. 05-5
- Office of the Inspector General Advisory Opinion No. 06-22
- Office of the Inspector General Advisory Opinion No. 07-21
- Office of the Inspector General Advisory Opinion No. 07-22
- Office of the Inspector General Advisory Opinion No. 08-09
- Office of the Inspector General Advisory Opinion No. 08-15
- Office of the Inspector General Advisory Opinion No. 08-21
- Office of the Inspector General Advisory Opinion No. 09-06
- Patient Centered Medical Home and Shared Savings Community Health Solutions of Louisiana

Chapter 6: Bundled payments

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Bundled payments for health care services are nothing new. In the last century, before the advent of Medicare, third-party payer health insurance, and increased sub-specialization by physicians, patients often would receive a single bill for a hospitalization or a surgical episode that might state simply: “Professional Services” or “Hospital Care.” At one time, a stay in the hospital for a normal obstetrical delivery might generate a bill for \$250 or \$300, with no further explanation. But as physicians increasingly diversified into scores of specialties and sub-specialties in the latter half of the twentieth century, and as third-party payers required increasing proof of the medical necessity and description of the services provided, health care claims became more detailed and complex. A patient hospitalized for an emergency appendectomy today might receive a bill from emergency room physicians, a radiologist, a surgeon, an anesthesiologist, a consulting physician, a pathologist, a hospitalist, and the hospital. Some of those providers may not even be contracted with that particular payer, and thus to the reasonable question, “How much will this cost?” no ready answer is available.

This increased stratification of providers makes coordinated care more difficult, and thus, economic and efficiently-driven care occurs more by chance than design. It is no wonder that Congress and payers are demanding and proposing alternative delivery and payment systems, both to be able to better coordinate the episode of care delivered, and to have predictable costs for such care. Bundled payment formulas are one of those alternatives. For more information concerning congressional activity with respect to bundled payment initiatives, see [Appendix one](#). Information regarding bundled payment programs in the private sector can be found in section [IV](#) below and in [Appendix two](#).

I. Frequently Asked Questions

A. What is a bundled payment?

As distinguished from traditional fee-for-service medicine, under bundled payments, doctors, hospitals and other health providers share one fee for treating all aspects of a procedure, such as a hip replacement or a chronic disease, such as asthma or diabetes. The approach is intended to encourage various disciplines of health providers to work together to control costs, eliminate unnecessary care, and improve quality and outcomes. Bundled payments may be clinical episode of care-related, or concern a specific condition over a defined time period.

Some bundled payments are simple and well accepted. Laboratory panels, for example, are commonly bundled together where several independent but related laboratory tests are performed for a single fee.

Maternal care, consisting of a normal vaginal delivery of a baby, is another example of a common bundled payment methodology. The flat fee payment may include months of pre-delivery care, including ultrasounds, laboratory work and pelvic examinations, followed by the labor and delivery, and brief follow-up care. Many obstetricians bundle such services.

Medicare’s prospective payment system is a form of bundled payment, reimbursing a single provider (the hospital) for all services provided in a particular patient stay with a single payment amount.

Other bundled payment programs involve specific surgical procedures, and include the range of providers involved in that episode of care. A bundled payment for a hip replacement, for example, might cover pre-surgical preparation and diagnostic tests, anesthesiology, the surgical procedure, operating room fees, the hip implant, intra- and post-operative radiological examinations, laboratory tests, and rehabilitation.

Bundled payments must be adjusted for the quality of care and health status to ensure that providers will not be incentivized to skimp on care or avoid high-risk patients.

B. How do bundled payments differ from capitation payments?

Bundled payments are sometimes described as a hybrid of fee-for-service payments and capitation payments; and they do fall between those extremes. Fee-for-service payment programs leave all the risk with the payer, while capitation agreements shift almost all of that risk to the provider. There is little middle ground. Bundled payment programs, however, involve shared risk. They typically will target specifically defined, known health care procedures or diseases. Thus, providers who participate in bundled payment programs usually incur the “performance risk” only, that is, the risk that the procedure will be more difficult than usual, or the patient will experience excessive complications or require a greater intensity of services. Those risks are inherent in any medical procedure, of course, but combining many different providers and services in the “bundle” increases the performance risk that something unexpected may occur. Unlike capitation, however, in a bundled payment program there is no insurance risk as to whether or how often the patient will need the service. The providers will get paid each time an agreed, bundled episode of care is provided, but the bundled payment usually is less than could be obtained by itemizing each service in the bundle. That, of course, is the advantage and selling point to the patient or third-party payer. The appeal of bundled payments is that these result in a sharing of the risk of care between the payer and the provider, and a cost savings to the payers.

C. How do you evaluate the budget?

Fundamental to the concept of bundled payment programs is that if the costs of care during the episode of care or agreed timeframe are less than the bundled payment amount, the providers keep and share the difference. By the same token, costs exceeding the bundled amount result in a shared loss among all bundled payment participants. Essential to that determination, then, is an accurate and sophisticated analysis of costs. Unless the participants have access to detailed payment and claims information, it is difficult to accurately predict the appropriate costs and payment for a bundled service.

The first step is the clinical step. The participants should identify the specialties of physicians and ancillary providers who will be involved in the proposed care episodes. Next, the diagnosis-related groups (DRGs) or specific disease conditions or procedures must be identified and analyzed. Physicians should focus on those particular procedures or disease states where they and their potential partners have expertise and are recognized as community leaders. Maternal care? Total joint replacement? Disease management? From this analysis, patient care plans are developed that target areas of cost within that episode that can be reduced or eliminated. It’s not sufficient to simply bundle all providers into a global fee, and then reduce it by 10%. Rather, improved and coordinated care plans—identifying critical metrics and clinical protocols to be adopted—will form the basis of the budgets which are used in the development of the bundled pricing proposal.

A key, related consideration is identifying those physicians and health care providers that will participate in the arrangement. For example, if a physician is approached to participate in a bundled payment arrangement, the physician should determine the extent to which the other physicians or providers who will be providing services included in the bundle payment are physicians and providers with whom the physician has worked well in the past or with whom the physician is at least familiar. These participating partners should have a reputation for providing quality services efficiently, particularly the provider, e.g., a hospital that will be the main cost driver in the arrangement.

An important consideration in that process is evaluating and assigning provider responsibility for care. In some episodes, hip replacement for example, duties and assigned tasks are readily predictable. The surgeon should have primary accountability for the patient. Physical therapy aggressively administered can dramatically affect outcomes. In other disease conditions, however, it is more difficult to predict critical tasks. A hip fracture might involve three or four facilities and prolonged treatment by numerous

providers.¹⁷ Age and weight affect outcomes, and co morbidities are less predictable. A successful bundled payment program will have well-defined and predictable episodes of care, carefully delineated as to provider responsibility and involvement. This will enable participants to know exactly what will be required of them in order to produce the successful outcomes that the bundled payment arrangement will be expected to produce. Careful delineation of provider responsibility will also be essential toward ensuring that providers who produce quality services efficiently will not be held responsible for the services of other participants who might not produce commensurate results. Having a means of ensuring that any measures used to determine provider responsibility will be as objective as possible will also help assure participants that their performance will be based on considerations that are within their control.

Evaluating catastrophic costs is a necessary ingredient of an accurate bundled payment budget. It may be easy to analyze the average costs of a knee replacement, but few cases are average. How can one analyze outliers? Variations in length of stay and the probability of infections or serious complications are key components of that analysis. Your organization may wish to fund such outliers through stop-loss coverage. See chapter nine, “**Stop-loss insurance**” for further information. Also, because payments due the physician under a bundled payment arrangement may involve a situation in which an intermediary receives the bundled payment directly from the payer and then, in turn, pays the physician, the physician may find that payments may not always readily “flow downhill” from the payer to the physician. For example, the administrator may experience administrative or financial difficulties that may significantly delay the physician’s receipt of his or her portion of the bundled payment. To protect against the contingency of payment delays, the physician may wish to establish sufficient credit or acquire other financial resources to ensure practice financial viability if the bundled payment arrangement is likely to constitute a significant portion of total practice revenue.

Developing the budget is a joint effort involving sophisticated claims data analysis, which requires trained financial assistance, along with implementing clinical best practices that will identify and improve particular critical areas of the care plan.

D. Who holds and administers the bundled payments?

A central organization should hold and administer bundled payments and claims. It may be an existing hospital financial department, an Independent Practice Association (IPA), or third-party administrator. It’s not the lead surgeon’s office manager! That administrative entity should be capable of receiving, storing, and transmitting information on pricing of cases, payments, types of providers, contracts, master codes for cases, packages, bundles or episodes, bundling rules, and length of stay data. The organization may carry out some or all of the following steps:

- receiving and storing information about a bundled case episode;
- generating a unique case ID for the bundled case episode;
- receiving claims for services which are generated by providers, both facility and professional;
- identifying a specific claim with procedural and diagnosis codes that triggers a specific case rate or bundle price (previously set up) and then automatically matching all other claims (as either inclusive to or excluded from the bundle) to the case ID of the identified bundled case;
- matching each claim associated with the bundled episode or case to determine whether it is inclusive or exclusive of the length of stay (LOS) for the bundled case rate; and
- determining whether the case exceeds the fixed LOS for the identified bundle.

This same organization also calculates accounts payable to providers on the case, calculates net margin per case prior to potential risk pool claims; submits the single, repriced bundled claim to a third-party payer and/or other responsible party; and automatically provides claim status to each provider on the case, including whether the claim is billed, in process, denied for more information required, or paid. The

¹⁷ Bundled Payment, American Hospital Association Committee on Research, May 2012.

organization should also be responsive to all participating physicians and providers, for example, by providing regular communications with, and prompt feedback to, those physicians and providers.

The level of sophistication required varies with the type of episodes of care. An OB/GYN may be very capable of calculating the costs and resources used in a pregnancy. A coronary bypass artery graft (CABG), on the other hand, requires the services of a cardiologist, an anesthesiologist, a pathologist, a radiologist, a general surgeon, infectious disease and neurology consultations, pulmonary and critical care, hospital services, and laboratory and perfusion services. The data elements required to adequately assess a realistic payment level for such complicated care are massive.

II. The necessity of transparency

Transparency is an essential component to physician success under bundled payment arrangements, just as it is under any of the other types of reimbursement models discussed in other chapters of this guidance. As the discussion above illustrates, although some bundled payment methodologies may be relatively simple and familiar to physicians, others may be very complex, involving many different physicians, individual health care providers, and health care facilities. The more complex the arrangement, the more challenging it will be not only for the party administering the arrangement, but for participating physicians who will have to be sufficiently sophisticated to understand the arrangement, evaluate the amount of risk they are likely to assume under the arrangement, and manage that risk over the course of their participation. Thus, in addition to being able to establish their baselines as described more fully in chapter one, “**How to establish your baseline costs**,” and being able to understand how to transition successfully from fee-for-service to a budget-based payment methodology, as discussed in the introduction, physicians will need to be given complete, accurate and transparent information concerning key items of information specific to the bundled payment arrangement.

The following are some of the essential elements of any bundled payment methodology with respect to which physicians must have complete, accurate and transparent information:

- whether or not the payer will pay a single entity or use virtual bundling;
- if payment will be made to a single entity, e.g., a hospital, when the physician can expect to receive payment from that entity;
- how each episode of care or condition is defined, including but not limited to, each item or service included in the bundle, identified by CPT®, HCPCS, ASA, and ICD-9-CM codes, and any applicable modifiers;
- the duration of the bundle, including the extent to which the risk window may be increased to enhance payer and patient satisfaction;
- how the basic bundled payment is calculated;
- whether the physician will be given information sufficient to enable the physician to calculate independently bundled payment amounts and determine whether or not those amounts are appropriate given the enrollees the physician is responsible for treating;
- how responsibility for items and services will be assigned to the physician;
- how the payment will be apportioned between the participating providers;
- the percentage that the payment amount received by the physician represents of the entire bundled payment made to all bundled payment participants;
- the identities of each physician or provider that is involved in the bundling arrangement; and
- the methodology’s use of cost and quality benchmarks, risk adjustment and other mechanisms—the kind of considerations that are common to the other risk arrangements discussed in this resource.

III. Control and administration of bundled payments

A central consideration for every physician in the bundled payment context concerns the avenue through which the physician will receive his or her portion of the bundled payment. As section **1.D.** discusses, a central organization will hold and administer bundled payments and claims. In many if not most cases, bundled payment arrangements will combine hospital and physician services. In its negotiations with physicians, and in cases where the payer is not utilizing virtual bundling, the hospital will likely see its role as the central organization that will receive the bundled payment from the payer, and then apportion that payment between itself, and participating physicians and health care providers.

Not every physician may feel comfortable with the hospital partner receiving and apportioning the bundled payment. In communities where a good working relationship exists between the hospital and physicians, and open communications exist between the hospital and physicians, physicians may have sufficient trust in the hospital as a business partner that allowing the hospital to receive and distribute the bundled payments may be acceptable. But in many communities, good working relationships are lacking, and physicians may be very wary of the hospital assuming such a role. At the same time, the hospital may not be willing to negotiate with respect to its expectation that it will function as the central organization.

In situations where relationships between physicians and hospitals are not conducive to trust, it is imperative that physicians not only be given the kind of transparent information described in Section II, but physicians must also play a role in administrating the bundled payment arrangement. This means, for example, that physicians should have real input into decisions that are made with respect to the arrangement's structure and operation. There are a number of ways in which physicians may be given a voice in these types of decisions. For example, a joint physician-hospital finance or bundled-payment committee could be created. This committee could be charged specifically with overseeing the entire provider role in a bundled payment arrangement. Members of the committee could be apportioned between representatives of the hospital and representatives from the physicians participating in the arrangement, with such physician representatives being elected or appointed by the physicians. A hospital's unwillingness or even reluctance to be forthcoming with all information concerning the bundled payment arrangement, e.g., the amount of payment received, when claims are submitted to the payer, regular claims status reports to all participants, when payments will be received, how each participant's portion of the bundled payment will be determined, etc., will be a red flag to any physician who is considering entering into a bundled payment arrangement with the hospital.

In some cases, a physician may be asked to participate in a virtual bundling arrangement. In so-called "virtual" bundling, the payer may pay the participating physicians and health care providers, e.g., a hospital, independently, but adjust each payment according to negotiated, pre-defined rules in order to ensure that the total payments to all of the providers for all of the defined services do not exceed the total bundled payment amount. In such cases, the concerns previously addressed with regard to a hospital serving as the central organization would more properly be directed to the payer itself.

IV. Provider-driven bundled payment programs

Providers have not simply waited for the government to initiate payment reform. Some organizations pioneered the use of bundled payment methodologies and have successfully provided such care for decades. **Appendix two** provides examples of successful bundled payment strategies initiated by private organizations. Please also see the discussion concerning Prometheus Payment Inc., in chapter ten, "**Working with actuaries**" for further information concerning a private, provider-driven bundled payment initiative.

V. Limitations on bundled payments due to existing restrictions on gainsharing

Bundled payment arrangements which include the cost of hospital services involve what is sometimes referred to as "gainsharing." Different from, but a close cousin to bundled payments, gainsharing

“typically refers to an arrangement in which a hospital gives physicians a percentage share of any reduction in the hospital's costs for patient care attributable in part to the physicians' efforts.”¹⁸

Gainsharing has the potential to align hospital and physician incentives to realize cost savings. For example, gainsharing arrangements can encourage more appropriate use of imaging and testing services, more careful choice among available generic and brand name drugs, reductions in medication errors, use of outpatient rather than inpatient services, use of disease management services to preclude the need for hospital admission, and reduction of avoidable readmissions. Currently a federal law, frequently referred to as the Civil Monetary Penalty statute¹⁹, this law imposes financial penalties on hospitals that make payments to physicians as an inducement to reduce or limit services to Medicare or Medicaid beneficiaries. The Office of the Inspector General (OIG) of the U.S. Department of Health and Human Services has interpreted the Civil Monetary Penalty statute as prohibiting such payments even if the services being reduced are not medically necessary or appropriate.²⁰ Consequently, gainsharing programs that are designed to reward physicians for reducing unnecessary services or unnecessary elements of services may be determined by the OIG to violate the Civil Monetary Penalty statute and may in some circumstances implicate the federal Anti-Kickback statute.²¹

Notwithstanding its general prohibition concerning gainsharing arrangements, since early 2005, a number of gainsharing arrangements have been reviewed and favorably approved by OIG in a series of advisory opinions. These approved arrangements have used cost-reduction mechanisms such as limits on use of certain supplies; product standardization; and using certain supplies and services only on an "as needed" basis, in order to curtail waste. While the gainsharing arrangements reviewed by OIG vary, it appears that features common to the permitted arrangements include:

- specific, identifiable, and transparent cost-saving actions and verifiable cost savings from those actions;
- a ceiling on how much of the realized savings participating physicians could receive;
- arrangements of fixed duration;
- a floor on the minimum permissible use of certain services and materials, set in accordance with objective evidence;
- provisions for participating physicians to make a patient-by-patient determination of necessary care and other patient care safeguards;
- disclosures to patients about hospital and physician participation in cost-saving efforts;
- equal distribution of cost savings among all participating physicians; and
- reliance on third parties to develop and monitor the gainsharing arrangement.

While the advisory opinions have shed light on OIG's analysis of gainsharing arrangements and what is likely to raise concerns, persons who are not a party to the advisory opinions are unable to rely upon them. Consequently, the current process may create substantial barriers to consideration, development and implementation of such arrangements. The American Medical Association continues to advocate for flexibility under the Civil Monetary Penalties statute so that physicians may engage in the development of innovating delivery models.

¹⁸ See the July 1999 DHHS-OIG Special Advisory Bulletin, Gainsharing Arrangements and CMPs for Hospital Payments to Physicians to Reduce or Limit Services to Beneficiaries, which may be accessed at <http://oig.hhs.gov/fraud/docs/alertsandbulletins/gainsh.htm>

¹⁹ Ibid.

²⁰ Ibid.

²¹ Ibid. For additional information, see the American Medical Association comprehensive white paper entitled “Pathways for physician success under healthcare payment and delivery reforms,” which is accessible at www.ama-assn.org/go/paymentpathways.

VI. Summary

Should you participate in a bundled payment arrangement? Bundled payment arrangements carry inherent risk but have significant upside potential, both for reimbursement and increasing market share. Successfully analyzing and assessing the top ten risk areas will mitigate those risks and better enable the participants to demonstrate efficient and economical health care delivery, while still realizing a reasonable profit. Take this Top Ten quiz.

Top Ten questions for bundled payments:

- 1. Are you affiliated with an organization that has sufficient infrastructure to administer successfully a bundled payment arrangement or try to build one from scratch?**

Note: Success in bundled payment systems depends upon having sufficient infrastructure and administrative expertise to manage the bundled payment arrangement. In some cases, physicians may benefit from partnering with an institution or larger physician organization that has the requisite administrative expertise, as physicians may find it challenging to create that expertise from scratch. When looking for a partner, however, a physician should ensure that the partner and the physician have common goals and that the partner has recognized physician leadership and administrative expertise.

- 2. To what clinical conditions or procedures should bundled payments be applied?**

Note: Are there obvious common and predictable procedures to start with?

- 3. Are you already a community leader in a particular procedure or disease state?**

Note: Go with your strengths. What are you known for? What do you do the most of?

- 4. Do you have sufficient historical clinical and financial data to assess the risk?**

Note: Anecdotal evidence is not sufficient. Access to adequate and sophisticated historical data, and the resulting due diligence, is critical to ensure success.

- 5. Which providers and services should be included in the arrangement?**

Note: Who is essential for the success of the procedure or the treatment? Who do you routinely communicate with in that course of treatment? Who do you wish you could communicate with? Who drives costs?

- 6. How can provider accountability be measured and ensured?**

Note: What role does each provider play? What can they contribute to a successful outcome, and more importantly, what problems can they create? Can those be objectively measured?

- 7. What should be the timeframe of a bundled payment?**

Note: Surgeries typically have a 90 day surgical window. Can increasing the risk window be reasonably done to enhance payer and patient satisfaction?

- 8. What administrative capabilities are needed to administer a bundled payment?**

Note: Do you have a staff and infrastructure capable of administering the program, or do you have to build it from the ground up? How will you provide feedback and communication among participants?

- 9. What financial and cash flow backing is available?**

Note: Payments do not always readily flow downhill. If the arrangement will be a significant portion of your business, have you credit and other resources to ensure success?

- 10. How should payments be set and allocated among participants?**

Note: Once the overall rate is determined, transparency and equity among participants is key. And achievable financial incentives built into the arrangement will help foster a cooperative work ethic.

Bundled payment programs are not for the faint of heart. Accurately answering these questions will determine whether a bundled payment program should even be entered into, and if the answer is yes, whether it is likely to be successful.

Chapter 6 Appendix 1: Congressional activity

Congress has authorized a number of initiatives designed to test the possibilities of bundled payment arrangements. For example, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 authorized the creation of the Acute Care Episode (ACE) Demonstration. The ACE Demonstration, which is being overseen by the Centers for Medicare and Medicaid Services (CMS), is a three-year project that tests the use of a global payment for an episode of care covering all hospital and physician services associated with a patient's inpatient stay. The ACE Demonstration is limited to physician-hospital organizations (PHOs) with at least one physician group and at least one hospital and that routinely provide care for at least one group of selected orthopedic or cardiac procedures, namely: (1) hip/knee replacement or revision surgery; and/or (2) coronary artery bypass graft (CABG) surgery or cardiac intervention procedure (pacemaker and stent placement). Under the ACE Demonstration project, the Medicare program pays a single amount to the PHO to cover both hospital and physician services for the specified cardiac and orthopedic procedures, and then the PHO divides the payment between the hospital and the physicians. The demonstration design allows the hospital, physicians and patients to share in any savings that the PHO is able to achieve. Evaluation of the ACE Demonstration will reveal whether the use of a bundled payment system will produce savings for Medicare for episodes of care involving the included DRGs. In addition to cost savings, the evaluation will assess changes to quality of care at the demonstration sites, whether or not the payment system creates better collaboration between physicians and facilities leading to higher quality patient care. Congressional authorization allows CMS to waive restrictions on gainsharing, so hospitals can share internal savings with physicians (see below). Demonstrations are being conducted in Texas, Oklahoma, New Mexico, or Colorado. The first ACE site began its program in May 2009.

In the 2010 health reform legislation, Congress accelerated the use of bundled payment systems under both the Medicaid and Medicare programs. Section 2704 of the Patient Protection and Affordable Care Act (PPACA) instruct the Secretary of Health and Human Services to develop by January 1, 2012 a demonstration project involving up to eight (8) states “to evaluate the use of bundled payments for the provision of integrated care for a Medicaid beneficiary...with respect to an episode of care that includes a hospitalization; and...for concurrent physicians services provided during a hospitalization.”²² Congress' goal is for the demonstration projects to focus on “lower[ing] costs under the Medicaid program while improving care for Medicaid beneficiaries.”²³ Any State selected to participate in the demonstration project must specify the one (1) or more episodes of care which the State proposes to address in its project, the services to be included in the bundled payments, and the rationale for the selection of those episodes of care and services. And in an interesting example of Congressional clinical micromanagement, hospitals participating in the demonstrations must “have or establish robust discharge planning programs to ensure that Medicaid beneficiaries requiring post-acute care are appropriately placed in, or have ready access to, post-acute care settings.”²⁴

Section 3023 of the PPACA provides similar authority under the Medicare program. No later than January 1, 2013, the Secretary must “establish a pilot program for integrated care during an episode of care provided to an applicable beneficiary around a hospitalization in order to improve the coordination,

²² Patient Protection and Affordable Care Act, Section 2704, Pub. L. 111-148 (March 23, 2010).

²³ *Id.*

²⁴ *Id.*, at § 2704(b)(5)

quality and efficiency of health care services under [Medicare].”²⁵ The Secretary has flexibility to determine payment methodologies under the pilot, but such methods may include bundled payments. Importantly, however, the program must be budget neutral. Total payments for the demonstration project may not exceed payments that would have been made for those beneficiaries without the demonstration as estimated by the Secretary.²⁶

Medicare Bundled Payment for Care Improvement Initiative

Pursuant to the Section 3023 mandate, CMS has implemented a Medicare Bundled Payments program through the newly created Center for Medicare and Medicaid Innovation. The Bundled Payments for Care Improvement initiative seeks to improve patient care through payment innovation that fosters improved coordination and quality through a patient-centered approach.²⁷ Medicare currently makes separate payments to providers for the services they furnish to beneficiaries for a single illness or course of treatment, which leads to fragmented care with minimal coordination across providers and health care settings. As CMS explains, current Medicare payments are based on how much a provider does, not how well the provider does in treating the patient. Under the Medicare Bundled Payment initiative, introduced August 23, 2011, CMS would link payments for multiple services patients receive during an episode of care. Instead of a surgical procedure generating multiple claims from multiple providers, the entire team is compensated with a “bundled” payment that provides incentives to deliver health care services more efficiently while maintaining or improving quality of care. Providers will have flexibility to determine which episodes of care and which services would be bundled together.

In the four proposed models, CMS and providers would agree to a target payment amount for a defined episode of care. Applicants would propose the target price, which would be set by applying a discount to total costs for a similar episode of care as determined from historical data. Participants in these models would be paid for their services under the original Medicare fee-for-service (FFS) system, but at a negotiated discount. At the end of the episode, the total payments would be compared with the target price. Participating providers may then be able to share in those savings.²⁸

In Model 1, the episode of care is an inpatient stay in a general acute care hospital. Medicare pays the hospital a discounted amount based on the payment rates established under the Inpatient Prospective Payment System (IPPS). Medicare then will pay physicians separately for their services under the Medicare Physician Fee Schedule. Finally, hospitals and physicians will be permitted to share gains arising from better coordination of care. Although straightforward conceptually, one might question why a hospital would agree under Model 1 to receive a discounted DRG which applies to inpatient stays only, when it could receive the entire DRG payment.

In Model 2, the episode of care includes the inpatient stay and post-acute care and would end, at the applicant’s option, either a minimum of 30 or 90 days after discharge. Providers negotiate a discounted fee-for-service rate with CMS and have the opportunity to retrospectively share in any “savings” from a projected target amount.

Model 3 focuses on post-discharge follow-up care. The episode of care begins at discharge from the inpatient stay and would end no sooner than 30 days after discharge. The “bundle” includes physician services, care by post-acute providers, related readmissions, and other services like laboratory and diagnostic imaging.

Model 4 applies to inpatient stays only and presents the most “risk” to providers. Under Model 4, CMS would make a single, prospectively determined bundled payment to the hospital that would encompass all services furnished during the inpatient stay by the hospital, physicians and other practitioners, including

²⁵ Patient Protection and Affordable Care Act, Section 3203, Pub. L. 111-148 (March 23, 2010).

²⁶ 42 U.S.C. 1395cc-4(c)(3)(A)(ii).

²⁷ <http://innovations.cms.gov/initiatives/bundled-payments/index.html>

²⁸ <http://innovations.cms.gov/documents/pdf/Fact-Sheet-Bundled-Payment-FINAL82311.pdf>

related readmissions. Only by close coordination of care can the providers realize a profit under this model, and physicians must be especially vigilant to understand the cost assumptions behind the model.

Applications for Model 1 closed November 18, 2011. Applications for Models 2-4 must be received by CMS by March 15, 2012.²⁹

²⁹ <http://innovations.cms.gov/initiatives/bundled-payments/index.html>

Chapter 6 Appendix 2: Provider-driven bundled payment programs

Providers have not simply waited for the government to initiate reform, however. Some organizations pioneered the use of bundled payment methodologies and have successfully provided such care for decades.

Cardio Vascular Care Providers

In 1984, world renowned heart surgeon Dr. Denton Cooley founded CardioVascular Care Providers, Inc. (“CVCP”) in Houston, Texas. CVCP was formed as a financially and clinically integrated network of physicians (before those terms were popular) offering cardiovascular services under global case rates or packaged pricing arrangements. Dr. Cooley’s concept was that CVCP members could share financial risk among all of the participating physicians and thus incentivize the network physicians to cooperate in controlling costs and improving quality by managing the provision of their services. His goal was, “To make the highest quality cardiovascular services more accessible and affordable.”³⁰ The bundled package of services then was made available to insurance companies, self-insured employers, and other payers.

Nothing was left to chance. The development of package rates required careful analysis of the population to be covered and was facilitated by the extensive patient database maintained at the Texas Heart Institute (THI). The database contained information on more than 160,000 cardiovascular patients and procedures, dating from the time of the first coronary artery bypass in the late 1960s. For every cardiovascular operation performed at THI, the patient’s diagnosis, surgical procedure, postoperative course and other medical information, as well as personal demographic data, are recorded. In addition, long-term follow-up studies are conducted.³¹

CVCP’s model has worked successfully for 27 years. The company initially developed a specialty-specific all-inclusive payment package for certain cardiac services, covering 16 select cardiovascular surgical procedures, such as coronary bypass and cardiac catheterization. Today, CVCP provides 49 separate packages in its service array, ranging from initial office visits to heart transplants, mostly provided at the renowned Texas Heart Institute, St. Luke’s Episcopal Hospital, and Methodist Hospital in Houston, Texas.

Under the CVCP model, the participating employer incentivizes its employees to select the CVCP “Center of Excellence” programs by covering all patient co-pays, deductibles, co-insurance and other covered expenses at 100%, resulting in no out-of-pocket costs for plan participants. Enrollment in the program is entirely voluntary for the employees, and the program is typically open with no pre-qualifying criteria to any active employee of the company. CVCP contracts with the employer or other payer for a flat bundled payment for any of the 49 separate cardiovascular packages. There are no surprises and no hidden costs.

By sharing the financial risks and coordinating the clinical delivery of care, the CVCP results have been clinically and financially impressive. Compared to the marketplace experience of one of the largest insurers in the greater Houston area, CVCP has demonstrated:

- a 30-40% cost savings of all coronary artery bypass graft surgeries;

³⁰ <http://www.cvcpdoes.com/about-cvcp/>

³¹ Cooley, Denton A. and John W. Adams, Jr. “Package Pricing at the Texas Heart Institute.” *Consumer-Driven Health Care: Implications for Providers, Payers, and Policymakers*. Regina E. Herzlinger. San Francisco, CA: Jossey-Bass, 2004. 612-619.

- a 10-20% cost savings for all cardiac catheterization;
- 0% mortality in the patient group studied, even though it was high risk subgroup of patients; and
- 0% of patients with additional bypass surgeries within 12 months of the initial bypass surgery.

On the basis of its early success, CVCP in late 1985 proposed that the office of Research and Demonstrations in the Healthcare Financing Administration (HCFA) investigate the feasibility of a similar plan for Medicare patients who were to undergo coronary artery bypass graft (CABG) surgery. At the time, the combined facility and physician fee for CABG under the CVCP plan was \$13,800, in contrast to the national average Medicare payment of \$24,588.³² In a 1987 study, the Inspector General of the U.S. Department of Health and Human Services, Richard P. Kusserow, showed that HCFA could decrease its annual bill for CABG by more than \$192 million if it paid THI's price for the surgery. Citing THI as one of the nation's best and least expensive centers for CABG, Kusserow pointed out the irony of the fact that CVCP patients received the very best care at such a low price.³³

HCFA agreed with the proposal and began soliciting participants in 1988. In July 1991 (almost six years after CVCP's initial proposal), HCFA selected four sites for the project, adding three more sites in 1993. The demonstration was a success, and at the seven involved centers, the demonstration project continued beyond the planned five-year period, extending until December 31, 1998.³⁴ The only sour notes sounded involved billing and reimbursement difficulties, problems that the bundled payment payer should resolve.

Geisinger

Other providers around the country have enjoyed similar success. Geisinger Health Plan in Danville, Pennsylvania, in 2006 instituted its own bundled payment program, called ProvenCare. Founded in 1915, Geisinger is a physician-led health care system including several hospitals and outpatient centers and nearly 60 community practice locations in central and northeastern Pennsylvania. Geisinger thus is an integrated health system that historically has provided team-oriented and coordinated care.

Geisinger in 2006 instituted a bundled care and payment program for coronary bypass surgeries. According to Geisinger, their patient care teams spent countless hours reassessing how they perform specific procedures. They examined patient care records, and also researched "best treatment" recommendations from national experts, professional associations and databanks. Through its research, the Geisinger team identified critical steps that greatly improved the chances of a successful procedure and recovery. Based on leading-edge medical data, Geisinger documented the best practices for its ProvenCare procedures and now requires its doctors to follow these guidelines. A system of checks and balances holds various members of the surgical team responsible for elements of the patient's care. These checks are built into the patient's Electronic Health Record and ensure that the steps are documented and cross-referenced. CABG procedures alone have forty (40) benchmarking steps in the process.³⁵

The bundled care and payment model charges one fee for the entire surgical episode of care, including pre-op and post-op care. Based on its success with the initial coronary bypass procedure, ProvenCare expanded the program to additional procedures, including total joint replacements, bariatric surgery, cataract surgery, back pain and perinatal care. The ProvenCare system lives up to its name, as Geisinger has documented reduced hospital lengths of stay, reduced complications, and reduced additional surgeries, all of which benefit the patient and save costs. Popular news media refers to it as the "surgery with a warranty."³⁶

³² Edmonds and Hallman, "CardioVascular Care Providers."

³³ Cooley, Denton A. and John W. Adams, Jr. "Package Pricing at the Texas Heart Institute." *Consumer-Driven Health Care: Implications for Providers, Payers, and Policymakers*. Regina E. Herzlinger. San Francisco, CA: Jossey-Bass, 2004. 612-619.

³⁴ *Id.*

³⁵ <http://www.geisinger.org/provencare/benchmarks.html>

³⁶ "Quality, not Quantity," *The Economist*, June 16, 2011.

By all accounts, the results of the ProvenCare system have been remarkable. Based on a sampling of the initial coronary bypass procedure first implemented in 2006, the ProvenCare program has achieved the following results:³⁷

ProvenCare: Coronary Artery Bypass	Before	After	% Reduction
30-day readmission rate	6.9%	3.8%	44%
Any Complications	38%	30%	21%
Blood products used	23%	18%	22%
Re-operation for bleeding	3.8%	1.7%	55%
Average LOS	6.2	5.7	9%

³⁷ <http://www.geisinger.org/provencare/numbers.html>

Chapter 7: Withholds and risk pools

Wes Cleveland

I. Introduction

Payment withholds are a long-standing type of risk arrangement. Under a withhold arrangement, the health plan retains or withholds a portion of the payments that are contractually due you. These withheld amounts are then placed in one or more risk pool funds held by the health plan. The health plan may also contribute funds to the risk pool.

Whether or not you or any other physicians participating in the withhold arrangement will receive all, or a portion of, the withheld monies will depend on the extent to which you and those physicians achieve specific, predetermined quality and/or cost-efficiency targets. For example, a withhold arrangement might involve the health plan withholding 20% of fee-for-service or capitation payments due you and other physician risk pool participants. These withheld payments will fund 50% of a risk pool that will be used to pay for certain specialty services. The health plan will contribute the other 50%. Whether or not you and the other physicians will receive all, or a portion, of your 20% withheld payments depends on how you and your fellow physician risk pool participants perform with respect to a predetermined utilization budget set by the health plan. This budget will generally be based on past claims data concerning the enrollee population that will be subject to the risk pool arrangement. If at the end of the contract term the cost of the specialty services utilized by the enrollee population is less than the budgeted amount, a risk pool surplus is created. This surplus will then be allocated between the health plan and the physicians, e.g., 50% to the health plan and 50% to the risk pool physicians as a whole. Withheld amounts remitted to you will be paid out of this latter 50%, and whether or not you receive your entire withheld payments will depend on the size of the surplus. However, if the cost of the specialist services exceeds the health plan's cost budget, this creates a risk pool deficit for which the health plan and physicians are responsible, e.g., on a 50%-50% basis. Your withheld payments will be used to help offset that part of the risk pool deficit that is allocated to the participating physicians.³⁸

Although the preceding example only references use of a cost-of-care budget, physician performance with respect to quality benchmarks or targets can also be used to determine the extent to which withheld payments will ultimately be remitted to you. For more information concerning how quality and cost-effectiveness targets are developed and their role in risk-based compensation, see chapter three, "[Pay-for-performance](#)."

Withholds were used extensively during the heyday of managed care risk contracting. Although withhold arrangements have not been as prevalent recently as they were in the 1990s, payers and employers are now revisiting the use of withholds as a means of slowing the growth of health care costs. If, as expected, risk-based reimbursement methodologies will replace conventional fee-for-service as the predominant means of physician compensation, it is very likely that health plans will be offering you withhold contracts. This is because withholds and risk pools can be used in conjunction with any reimbursement methodology. A health plan might retain a portion of fee-for-service payments otherwise due you.

³⁸ The American Medical Association's (AMA) comprehensive white paper "Pathways for Physician Success Under Healthcare Payment and Delivery Reforms," contains additional information describing withhold/risk pool arrangements. This resource is accessible to AMA members at <http://www.ama-assn.org/resources/doc/washington/x-ama/payment-pathways.pdf>.

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Alternatively, a withhold arrangement might involve the health plan retaining a percentage of payments that might otherwise be owed to you under a risk arrangement. For example, a health plan might withhold a percentage of your per-member-per-month payments under a capitation arrangement.

Because withholds may be used in conjunction with a broad range of reimbursement methodologies, you should look for withhold provisions in every managed care contract offered to you. Past physician experience suggests that you should carefully analyze any proposed withhold arrangements. In the 1990s, few physicians who entered into withhold contracts ever received withheld amounts, regardless of how well those physicians performed. Until contemporary physician experience proves otherwise, your analysis should take into account the possible effect that failure to receive withheld amounts will have on the financial viability of your practice.

II. Possible advantages of withhold arrangements

Although you should approach withhold arrangements with caution, there are at least a couple reasons why you may find participation in such arrangements attractive. First, participation in withhold arrangements may help improve your market position. Health plans, employers and other purchasers of health care services are increasingly basing their purchasing decisions on physicians' ability to provide high quality health care services in a cost-effective manner. Withhold arrangements are perhaps currently the most readily-available type of risk arrangement through which physicians may demonstrate a commitment to responding to purchasers' priorities.

Second, participating in physician networks engaged in withhold contracting may be attractive because of protections that may be available under state and antitrust laws. Federal and state antitrust laws dictate the extent to which independent, competing physicians may collectively negotiate contract price terms or refuse to deal (i.e., engage in group boycotts). The antitrust laws that prohibit independent competing physicians from engaging in collective price negotiations or group boycotts typically do not preclude those activities when undertaken by physicians who have financially integrated their practices according to guidance issued by the U.S. Department of Justice (DOJ) and the Federal Trade Commission (FTC). In their 1996 Statements of Antitrust Enforcement Policy in Health Care ("Statements"),³⁹ the DOJ and FTC described the kinds of physician financial integration that enables physicians to receive favorable antitrust review of conduct constituting collective price negotiation and/or a group boycott. Withhold arrangements are one of the types of financial integration that the Statements discuss. More specifically, under the Statements, favorable antitrust review is available to physician networks where a significant portion of fee-for-service payments are withheld and placed in risk pools. The Statements do not specify how large the withhold or risk pool must be in order for the physician network to qualify for favorable treatment. However, FTC advisory letters suggest that a 15 percent withhold may not be sufficient⁴⁰ to justify the joint price negotiations, while a pool within a 15 to 20 percent range suffice.⁴¹ How large the withhold will need to be to constitute financial integration sufficient to qualify for favorable antitrust review will likely depend on a case-by-case analysis and be contingent on factors such as how important membership in the network is to participating physicians, and how many of patients will be subject to the withhold arrangement.

III. Key considerations

A. General risk arrangement considerations. Although this chapter focuses on issues specific to withholds and risk pools, a withhold/risk pool arrangement is a type of risk-based payment methodology. Consequently, your analysis of a contract containing a withhold arrangement must take into account the

³⁹ The Statements may be accessed at www.ftc.gov/bc/healthcare/industryguide/policy/hlth3s.pdf.

⁴⁰ Letter from FTC to Paul W. McVay, President, ACMG, Inc. (July 5, 1994), available at <http://www.ftc.gov/bc/adops/007.shtm>

⁴¹ Letter from FTC to David V. Meany, Esq., on behalf of Yellowstone Physicians, L.L.C., (May 14, 1997), available at <http://www.ftc.gov/bc/adops/yelltone.shtm>

core physician concerns common to all risk-based payment methodologies. These concerns include, but are not limited to:

- identifying the specific items and services that will be subject to the arrangement, as well as those services that will be carved out;
- identifying the utilization budgets and quality benchmarks that will be used to measure your performance;
- determining the actuarial soundness of your utilization budgets and quality benchmarks;
- predicting enrollee utilization;
- the extent to which a reliable risk adjustment methodology will be used to establish your utilization budgets and quality benchmarks, and to evaluate your performance with respect to those budgets and benchmarks;
- use of a Division of Financial Responsibility matrix;
- tracking your own utilization and quality performance during the term of the arrangement so that you can compare your practice data with utilization and quality data that you receive from the health plan;
- verification of enrollee eligibility;
- accrual accounting;
- working with actuaries;
- stop-loss insurance; and
- sharing sufficient risk to qualify for favorable treatment of certain types of joint conduct under state and federal antitrust laws.

You will, of course, also have to establish your practice baseline. Further information concerning these core issues may be found in other chapters in this guidance, e.g., the chapters discussing how to establish your baseline costs, the differences between fee-for-service and budget-based payment systems, pay-for-performance, capitation, risk adjustment, stop-loss insurance, working with actuaries, and joint contracting/collective bargaining.

B. How much of payments otherwise due you will be withheld?

1. Identify the precise amount of the withhold. Obviously, a crucial consideration is the withhold's size. The larger the withhold, the greater your risk of loss and the more you must endeavor to obtain as much information as you can concerning the data and methodology used to structure the withhold arrangement. The best approach is for the health plan to tell you what the withhold will be in terms of a precise dollar amount. It is more likely, however, that the health plan will describe your withhold amount in terms of a specific percentage. If the health plan gives you a percentage, insist that the health plan also provides you with information sufficient to identify the specific payment amounts to which the percentage withhold will apply—otherwise you will not be able to precisely determine withheld amounts. Thus, for example, if the withhold will be applied to fee-for-service payments, you should insist that the health plan provide you with all of the information described in chapter two, "Fee-for-service issues."

2. Federal and state regulations. Your consideration of any proposed withhold's size should take into account potentially applicable federal and/or state risk-sharing requirements. For example, certain federal Medicare Advantage requirements apply when a Medicare Advantage plan's managed care agreements transfer so-called "substantial financial risk" to contracted physicians. One of the ways in which a Medicare Advantage plan can transfer substantial financial risk to a physician is through the use of withholds and risk pools, where the withhold exceeds a specific percentage threshold. For example, a Medicare Advantage plan transfers substantial financial risk to a physician if the plan places the physician at risk for referral services at amounts beyond a twenty-five (25%) percent threshold, that is, if more than twenty-five (25%) percent of potential payments are at risk. "Referral services" are defined as "any

specialty, inpatient, outpatient, or laboratory services that a physician . . . orders or arranges, but does not furnish directly."⁴² Ancillary services are not considered to be "referral services" if the physician practice performs the ancillary services. If, however, your practice refers patients to other providers (including contractors of your practice for ancillary services, then the services are referral services.

C. Risk pools. Risk pools are a central component of withhold arrangements and can vary widely in complexity. The following are key issues that you will need to consider with respect to risk pools.

1. In what type of risk pool or pools will you be involved? Your risk pool involvement can vary widely from one withhold arrangement to another. Depending on how the health plan structures the arrangement, you may be involved in one risk pool or in multiple risk pools. Risk pools might also vary with respect to the number and types of physicians and institution health care providers involved. Risk pools may also vary in terms of the items and services that risk pool monies will fund. The following are just a few ways that risk pools may be structured in withhold arrangements that may be offered to you.

- a. **A single risk pool for your patients.** Your withheld payments might be used to fund a risk pool that applies only to the health care items and services that you provide to patients who have been assigned to, or who have selected, you. This type of withhold arrangement can place you at significant risk because risk is spread across a limited number of enrollees and you do not share risk with other physicians. This withhold arrangement can also have significant ethical and legal implications. See section **IV** below and chapter 13, "**Ethical implications of financial incentives in Managed Care Contracts.**"
- b. **Risk pools with other physicians.** It is likely that withhold arrangements offered to you will require you to participate in risk pools with other physicians. These risk pools will often be structured around physician specialties. For example, a withhold arrangement might involve two physician risk pools—one for primary care physicians (PCPs) and another for all other specialists to whom PCPs refer. But risk pools may be further divided along specialty lines. For example, rather than having one risk pool for all non-PCP specialists, there may be separate risk pools for all physicians within a particular specialty, e.g., radiology. It is even possible that risk pools may be structured for particular sub-specialties.
- c. **Types of services that risk pool monies will fund.** It is also vital for you to understand precisely the items and services that will be funded by risk pool monies. Physician risk pools will, of course, be used to help pay for services that physicians provide, e.g., specialty procedures, physical examinations, etc., which physicians provide in their practices. But withheld payments might also be used to help fund other types of services. You might be asked to participate in risk pools which will place you at risk for inpatient and/or outpatient hospital services. For example, a health plan may fund a hospital risk pool that may be used to incentivize both physicians and hospitals to reach certain targets regarding the utilization of hospital services, e.g., reduction of readmissions or hospital-acquired conditions. You may also be asked to participate in risk pools in which you will accept risk for utilization costs for pharmaceuticals, laboratory services, durable medical equipment and other ancillary items or services.
- d. **Whose services will be funded by risk pool monies?** In addition to understanding the types of services that will be funded by risk pool monies, you will also need to understand the extent to which your risk pool withholds will be used to pay for the services of particular types of providers. For example, will services from out-of-network providers be paid from risk pool funds? If so, will you have sufficient control over out-of-network utilization? Has the health plan developed an adequate network so that it is likely that enrollees will be able to access all of the services they need in-network? If you are a PCP, will the services you refer to specialists have to be funded from the risk pool?

⁴² 42 C.F.R. §417.479(c)

2. Who will be your fellow participants in your risk pool? Once you have identified the risk pools that your withholds will help fund, you should ask the health plan to identify all the other physicians and providers that are participating in those risk pools. Since your share in any risk pool surpluses or obligations for risk pool deficits will depend on how well you and your fellow participants perform with respect to quality and/or cost-efficiency targets, identifying those other physicians and providers may help you assess the likelihood of your sharing in such surpluses or liability for deficits. For example, if the other physicians and/or providers have a reputation for quality and cost-efficiency in your community, the more likely it is that you will have some, or all, of your withheld amounts remitted to you out of any risk pool surplus (assuming that the applicable quality and/or cost-effectiveness targets are actuarially sound). But if the other participants do not enjoy such reputations, this may signal that a cautious approach with respect to your participation is warranted. So find out as much as you can regarding whether or not your fellow risk pool participants share your commitment to achieving mutual quality and cost-efficiency goals.

3. Over how many participants will your risk be spread? A crucial issue in your risk analysis is the extent to which your risk will be shared by other physicians and providers. The more your risk is shared, the less likely it is that a catastrophic occurrence involving one of your patients or otherwise unexpected utilization by your patient population will, by themselves, cause risk pool deficits. But if risk is spread across a small number of participants, a single catastrophic occurrence can result in risk pool deficits for which you may be liable.

4. How many enrollees will be included in each risk pool? You also need to determine the number of enrollees who are included within each risk pool. The more enrollees involved in your risk pools, the more risk can be spread across that patient population and, the less likely it is that a catastrophic case or unexpected utilization will result in risk pool deficits.

5. What will be the payer mix of your enrollees? You should insist that the health plan provide you with specific information concerning the payer mix of the enrollees that will be assigned to, or select, your practice. The health plan may combine in your risk pools patients whose health care services are financed by a broad array of payers: traditional Medicare; Medicare Advantage; Medicaid; Medicaid managed care; commercial health plans; etc. Such information will aid your evaluation of the risks and benefits associated with a withhold arrangement by helping you predict expected utilization and payment adequacy.

6. Account information and ongoing audit capability. Because it is your withheld money that will help fund your respective risk pools, you should insist that the health plan allows you to access risk pool account information on a continual basis until the withhold arrangement is terminated and all payment reconciliation activity has concluded. The health plan should, for example, tell you the name of the institution holding the risk pool funds, and provide you with any account numbers and other information necessary to specifically identify available risk pool fund amounts. You should also determine the extent to which you will be able to audit those risk pool accounts as a means of verifying other information that you receive from the health plan concerning the risk pool.

7. In what type of account will the risk pool monies be held--interest considerations? You should determine whether or not risk pool monies will be held in an account that earns a competitive rate of interest, and the extent to which that interest accrues to you or to the health plan. Since at least part of the risk pool will be funded by payments withheld from you, you should insist that any interest on such withheld monies accrue to you.

8. What happens if risk pool monies are insufficient to cover expense obligations? A paramount consideration is the extent to which you may be liable for any risk pool deficits. For example, will your liability be limited to your total withheld amounts, or will the health plan be able to impose additional withholds in order to cover risk pool deficits? Will the health plan have recourse against you for previously made payments to offset liabilities that exceed risk pool amounts? Unless you obtain specific answers to these types of questions, you cannot accurately assess your risk under any prospective

withhold arrangement. Note that state regulations may limit the amount of risk of loss that you may be contractually obligated to assume.

9. Who is funding the risk pool and how much is being funded? The risk pool may be funded from several sources. For example, a risk pool might be funded by contributions from a health plan, and withholds from payments due a hospital, physician network like an independent practice association (IPA), primary care physicians, and/or specialists. You should know who is contributing what percentage of funds to the risk pool, as this is likely to help you identify the parties that may exert the most influence on management of the risk pool, and how any risk pool surplus or deficit will be allocated to the different participants.

10. Will risk pool surpluses or deficits be carried over? You should determine whether or not any risk pool deficits or surpluses can be carried over from one contract term to the next. You should resist any attempts to carry over deficits or surpluses. Assuming that your contract is for a term of one year, subject to renewal, deficits and surpluses should be reconciled at the end of each contract term, so that you can be sure to obtain any remittances due you or discharge any obligation for risk pool deficits. This will enable you to start out each contract term with a clean slate. The possibility that deficits that can be carried over from one year to the next may significantly compromise your ability to assess your risk accurately, since it is often more difficult to estimate risk exposure over longer time periods vis-à-vis shorter periods of time.

11. Can a surplus in one or more of your risk pools be used to offset a deficit in other risk pools? It is also vital that you determine the extent to which the health plan can use a surplus in one risk pool to offset a deficit in another risk pool. For example, even if you and your fellow risk pool participants come in under a risk pool's medical expense target, can the health plan use the resulting surplus to offset deficits in another risk pool rather than remitting withheld amounts to you out of that surplus? If a health plan can offset risk pool deficits in this manner, it will reduce the likelihood that you will receive any withhold monies.

D. Methodology and data. You will need to obtain clear and complete information concerning the methodology and data that the health plan used to structure all aspects of the withhold arrangement in order to determine whether or not you can successfully manage the risk you will have to assume should you enter into that arrangement. You may need the assistance of an actuary to help you make this determination. For further information, see chapter ten, "Working with actuaries." You will also need to be given regular reports to help you track your performance and successfully manage your risk during the term of the withhold arrangement. It will be particularly important for you to have sufficient information to determine how any risk pool surpluses and/or deficits will be allocated to you.

1. Allocation of risk pool surpluses and deficits. You should insist that the health plan provide you with information sufficient to enable you to understand and independently verify how any risk pool surpluses and deficits were allocated to you. For example, will you share equally in all surpluses or deficits with all of physicians in your risk pool, or will your portion of any surplus or deficit obligation be contingent on how you performed compared to other risk pool physicians with respect to quality benchmarks and/or cost-effectiveness budgets? If PCPs and specialists participate in the same risk pool, will risk pool surpluses and deficits be allocated between PCPs and specialists in a manner that is mutually agreeable? What will be the health plan's share? Will you have sufficient information to verify independently the manner in which the health plan has determined its allocations?

E. Verification of income and expense allocation. In order to succeed under the withhold/risk pool arrangement, you must be able to regularly verify how expenses and income are being allocated among the various participants in the risk pools in which you are participating. To do this, you must be able to reconcile any payments, remittances, and/or deficits received or allocated to your practice on a frequent basis during the term of the contract, as well as subsequent to the conclusion of each contract term. To perform this allocation verification and reconciliation, you should insist on receiving quarterly reports from the health plan that contain sufficient detail to allow verification and reconciliation, as well as a

comprehensive year-end report that will enable you to: (1) verify the health plan's final allocation of income and expenses; and (2) perform a final payment/deficit reconciliation.

F. Timing of remitted withhold amounts. Be certain that the contract indicates when any withheld amounts will be remitted to you. The health plan may want to make disbursements on an annual basis. However, it is more beneficial to receive remittances with great frequency, e.g., on a quarterly basis, to help your practice avoid cash-flow problems.

IV. State and federal requirements concerning physician financial incentives.

States may have statutes or regulations prohibiting the use of financial incentives in managed care agreements. For example, California law prohibits managed care arrangements (including medical group and IPA arrangements) that include specific payments as an inducement to deny, reduce, limit or delay specific, medically necessary covered services to particular enrollees or groups of enrollees. The prohibition does not extend to capitation payments, shared risk agreements or other general payments that are not tied to specific medical decisions involving specific enrollees or groups of enrollees with similar medical conditions.⁴³ Similarly, federal Medicare Advantage regulations state that a Medicare Advantage plan is prohibited from making a specific payment, either directly or indirectly, to a physician or a physician group as an inducement to reduce or limit medically necessary services furnished to any particular enrollee.⁴⁴ Requirements such as these may influence how withhold agreements in your state may be structured.

V. Conclusion

Given the likelihood that withhold mechanisms will play a significant role in future contracts offered to you, developing the capacity to evaluate and negotiate such arrangements will be worth your time and effort. This chapter provides you with the essential factors you will have to consider in order to successfully manage your risk under the wide variety of withhold arrangements that health plans will inevitably offer you.

⁴³ See Business & Professions Code §511; Health & Safety Code §1348.6; Insurance Code §10175.5.

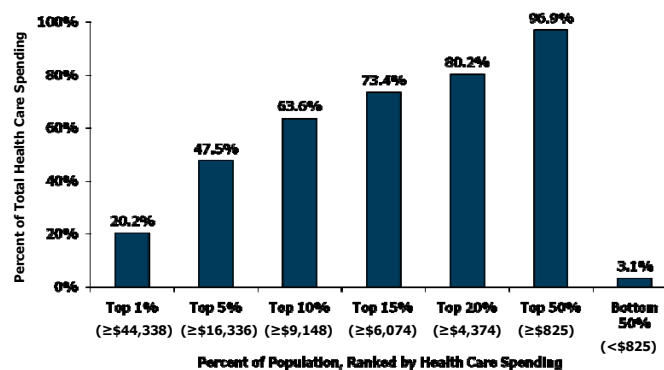
⁴⁴ 42 CFR § 422.208(c)(1)

Chapter 8: Risk adjustment

Catherine I. Hanson

It is well established that patients use wildly different amounts of health care services. The following chart from the Kaiser Family Foundation graphically demonstrates the magnitude of this skew:

Concentration of Health Care Spending in the U.S. Population, 2008



Note: Dollar amounts in parentheses are the annual expenses per person in each percentile. Population is the civilian non-institutionalized population, including those without any health care spending. Health care spending is total payments from all sources (including direct payments from individuals, private insurance, Medicare, Medicaid, and miscellaneous other sources) to hospitals, physicians, other providers (including dental care), and pharmacies; health insurance premiums are not included.
Source: Kaiser Family Foundation calculations using data from U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey (MEPS), 2008.



As this chart shows, half of the population uses very few health care services in any particular year — less than \$825 worth in 2008. At the other end of the spectrum, the 5% of the population which uses the most health care services utilizes nearly 50% of all health care services provided in any one year. Thus, unless we intend to perversely disincentivize physicians from treating sicker patients, any payment system which bases what is paid to physicians on the extent to which these physicians have provided health care services to their assigned patient populations on a projected budget must adjust that budget to reflect the increased costs which sicker patients will necessarily generate.

Here is a more concrete example of the importance of risk adjustment. The chart below demonstrates the huge variation in cost likely to be encountered by physician groups managing patients with diabetes, depending on their medical status.

While the “average” cost of managing this patient population was \$556, the range was from \$28 - \$5,111. Clearly, a practice which received a utilization budget of \$556 for managing diabetes patients would be quickly driven out of business if its patient population were largely comprised of the sickest, stage 3 patients, while a practice that drew a panel of healthy, stage 1 diabetics would make a fortune. Subspecialists or other physicians who generally treat sicker patient populations should be particularly vigilant with respect to the projected utilization budget and associated risk adjustment system to ensure they will be able to manage the risk they assume.

Note that this chart also demonstrates the importance of having more patients to obtain an actuarially sound result. The very small sample sizes used to generate the projections for stage 3 patients is likely responsible for the anomalously low costs associated with healthier, stage 3 patients, and may similarly understate or overstate the cost of sicker, stage 3 patients.

Cost of Chronic Diabetes Patient Risk (DCGs)

Stage	# of Episodes	Episode Cost	DCG Risk Score	DCG Risk Score				
				Healthier.....			Sicker
				0	1	2	5	10
1	7,972	\$354	3.01	2,856	1,900	1,969	962	485
				\$132	\$308	\$389	\$536	\$527
2	2,707	\$1,133	5.32	587	599	776	371	374
				\$248	\$562	\$862	\$1,815	\$2,224
3	44	\$1,604	9.62	15	10	5	1	13
				\$28	\$113	\$171	\$1,726	\$5,111
Overall	10,723	\$556	3.62					

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Here is another chart that demonstrates the critical importance of risk adjustment for physicians who are to be paid based on a budget, this time from the Centers for Medicare and Medicaid Services in its February 2010 report entitled “Challenges in the Risk Adjustment of Episode Cost” by MaCurdy et. al. As you can see, the variation in cost for the most costly Medicare episodes is far greater than for the population of diabetic patients shown above. To take the most extreme examples, the variation of the cost of handling Acute Myocardial Infarction ranged from \$209 for the cheapest cases to over \$32,000 for the most expensive episodes. With respect to chronic care, the range for handling lung, bronchi or mediastinum cancer was from \$190 for the cheapest cases to over \$34,000 for the most expensive episodes.

Table 3.5: Episode Costs for Top-Aggregate-Cost MEGs

#	MEG: Description	# of Episodes	Total Cost	Summary Statistics								Mean	Std Dev	Fraction of Cost in Bottom 50% of Episodes	Fraction of Cost in Top 5% of Episodes
				10%	25%	50%	75%	90%	95%						
Top 10 Acute MEGs by Cost															
1	Acute Myocardial Infarction	3,956	\$42,298,039	\$209	\$2,213	\$7,451	\$14,820	\$26,148	\$32,039	\$10,692	\$11,866	14%	21%		
2	Pneumonia: Bacterial	11,454	\$41,728,983	\$41	\$91	\$520	\$4,817	\$9,235	\$15,201	\$3,643	\$6,698	2%	34%		
3	Cerebrovascular Disease with Stroke	8,624	\$37,988,500	\$38	\$77	\$452	\$5,349	\$13,021	\$21,753	\$4,405	\$9,465	1%	40%		
4	Fracture: Femur, Head or Neck	2,558	\$29,025,913	\$77	\$1,640	\$10,659	\$17,401	\$23,533	\$27,472	\$11,347	\$9,677	17%	15%		
5	Complications of Surgical and Medical Care	6,064	\$25,990,797	\$50	\$117	\$640	\$5,172	\$11,872	\$18,371	\$4,286	\$9,105	2%	38%		
6	Cataract	50,999	\$24,518,390	\$38	\$60	\$74	\$581	\$1,480	\$2,125	\$481	\$794	6%	30%		
7	Arrhythmias	22,915	\$22,716,514	\$36	\$60	\$159	\$571	\$2,322	\$4,918	\$991	\$2,740	3%	55%		
8	Urinary Tract Infections	14,701	\$12,213,571	\$31	\$46	\$94	\$339	\$2,530	\$4,656	\$831	\$2,364	3%	55%		
9	Diverticular Disease	7,814	\$11,631,790	\$58	\$162	\$405	\$630	\$3,511	\$5,960	\$1,489	\$4,386	6%	57%		
10	Cholecystitis and Cholelithiasis	2,158	\$10,783,445	\$124	\$553	\$2,457	\$8,213	\$12,318	\$16,440	\$4,997	\$6,406	9%	24%		
Top 5 Chronic MEGs by Cost															
1	Osteoarthritis	26,586	\$57,193,928	\$47	\$105	\$313	\$1,120	\$10,056	\$12,843	\$2,151	\$4,804	3%	43%		
2	Angina Pectoris, Chronic Maintenance	23,128	\$51,477,727	\$46	\$95	\$258	\$1,323	\$5,313	\$12,535	\$2,226	\$5,885	2%	53%		
3	Chronic Obstructive Pulmonary Disease	13,168	\$27,570,454	\$43	\$105	\$418	\$2,393	\$5,458	\$8,763	\$2,094	\$4,217	3%	39%		
4	Neoplasm, Malignant: Lungs, Bronchi, or Mediastinum	2,097	\$22,153,051	\$190	\$865	\$6,865	\$17,086	\$27,393	\$34,357	\$10,564	\$11,795	9%	20%		
5	Essential Hypertension, Chronic Maintenance	66,244	\$21,908,869	\$38	\$65	\$120	\$219	\$408	\$717	\$331	\$1,280	10%	57%		

I. What is risk adjustment?⁴⁵

"Risk adjustment" is the term used to describe the methodology for determining whether patient characteristics will necessitate higher utilization of medical services. Variations in patient populations will likely substantially affect the financial impact on a physician practice of any payment arrangement where the economic results depend on the variation between projected and actual experience. Payment models which are based on such "budgets" include capitation, shared savings, bundled payments and most pay-for-performance systems.

Risk adjustment is different from the actuarial processes used to account for "systemic risks," such as accidents or pandemics that are spread across the entire system. Rather than dealing with system-wide risks, the purpose of risk adjustment is to "level the playing field" for all physician groups participating in the same budget-based payment system by aligning payments with the relative health status and compliance of different patient cohorts.

II. Why is risk adjustment important?

Failure to adjust the budget for the risk of the population may lead to a payment which is not high enough to cover the true medical needs of the patients covered by the budget-based payment system. Moreover, a system without risk adjustment could result in quality physicians who attract very sick patients being unable to practice in the health care delivery system covered by the budget-based payment system, and/or in very sick patients being unable to obtain care because there are no physicians who can afford to have them in their "case mix." In this regard, proper risk adjustment is necessary to ensure quality of care.

⁴⁵ The following discussion borrows heavily from the excellent resources on risk adjustment for physicians developed by Rong Yi, PhD, Senior Consultant with Milliman, for the Massachusetts Medical Society and from the work Elaine Kirshenbaum, MPH, Vice President Policy, Planning and Member Services, Massachusetts Medical Society.

Risk adjustment systems recognize that certain patient characteristics contribute to utilization. Typically, projected health care cost budgets are adjusted for age, sex and type of benefit plan. However, there are many other factors that are likely to influence the utilization of health care services, including: acute clinical stability; principal diagnosis; severity of principal diagnosis; extent and severity of co-morbidities; physical functional status; psychological, cognitive, and psychosocial functioning; non-clinical attributes such as socioeconomic status, race, substance abuse, and culture; health status and quality of life; previous status as insured or uninsured; and patient attributes and preferences.

Although adjustment for age and sex alone is not sufficient, it can be significant. The variation in capitated amounts due to age/sex differences may be as much as five hundred (500%) percent, such as the difference in actuarially sound rates between children from 0-2 and children between 5-19 years old.

III. How is risk adjustment done?

Risk adjustment has two steps:

- Risk assessment, where the relative morbidity level of the population is evaluated and the individuals in the population are assigned “relative risk scores,” and
- Risk payment, where payments are made to participating entities in the risk adjustment program based on the relative risk scores.

Risk assessment is typically based on claims data, and particularly the diagnosis codes. Based on the evaluation of historical data, various “episodes” or other clinically homogeneous groupings have been created that generate reasonably predictive cost estimates. Further analysis has resulted in algorithms for predicting costs in cases where an individual has more than one medical condition, such as diabetes and cardiovascular disease. These risk assessment tools are then applied to individual patients to create individual risk scores. See the example below using the Milliman Advanced Risk Adjuster (MARA) prospective DxAdjuster illustrating how a patient with hypertension, COPD and other arthropathies is projected to cost approximately 2.12 times as much as the average patient:

Risk Scoring



Sample Patient
Age: 55
Sex: M

- Hypertension
- COPD
- Other Arthropathies

Relative Risk Score: 2.23

Risk Adjustment Model Example - 55 yo male patient -

Service From Date	Service Thru Date	Claim Paid Date	ICD-9-CM	
1/9/2009	1/9/2009	1/22/2009	401.1	essential hypertension
7/14/2009	7/14/2009	8/6/2009	496	Chronic airway obstruction
8/14/2009	8/14/2009	8/27/2009	496	Chronic airway obstruction
9/9/2009	9/9/2009	12/24/2009	716.99	Arthropathy, unspecified, multiple sites
10/9/2009	10/9/2009	12/24/2009	716.99	Arthropathy, unspecified, multiple sites
11/6/2009	11/6/2009	12/24/2009	716.99	Arthropathy, unspecified, multiple sites
12/4/2009	12/4/2009	12/24/2009	496	Chronic airway obstruction

Risk payments are then based on comparing the individual risk scores of the patients assigned to the various groups and equalizing payments based on those scores. This can be done prospectively by varying the prospective budget, or retrospectively by paying a bonus or withholding funds as appropriate.

IV. What different types of risk adjustment systems are there?

There are four major areas in which risk adjustment models vary: 1) concurrent vs. prospective; 2) diagnosis based vs. pharmacy based; 3) the outcomes predicted; and 4) population to which the model applies (Medicare, Medicaid or commercial).

Concurrent vs. prospective

Concurrent models seek to explain the variation that actually occurs during a year, while a prospective model seeks to predict the variation for the coming year. Not surprisingly, concurrent models tend to have a much higher predictive accuracy (more than 50% of the cost variation can be attributed to the variations in risk scores) than predictive models (approximately 20% of the cost variation can be predicted based on risk scores). Because of their higher accuracy, physicians are generally better off with concurrent models. However, the government is proposing prospective models due to concerns that only prospective models properly incentivize preventive care and aggressive medical management.

Diagnosis vs. pharmacy-based systems

Most risk adjustment systems are based on the ICD-9 diagnoses coded on claims. Clearly, increased accuracy in the coding of diagnoses will be critical to physician groups that are receiving payment based on any of the budget-based payment systems. The new electronic claim transaction standard which took effect on January 1, 2012, the ASC X-12 5010 837, should help in this regard, as it will now require the inclusion of the primary diagnosis code as a condition of a clean claim. However, to ensure appropriate risk scores, and thus fair payment, physicians will need to ensure that they code all relevant diagnoses, not just the primary diagnosis, and that they code them in order of importance, not randomly, or by alphabetical order as some physicians have professed doing.

There are risk adjustment systems based on pharmacy data, or on both diagnosis and pharmacy data. Some people are concerned that systems based on pharmacy data are too sensitive to treatment and prescription patterns. However, physicians may wish to look at the results under both types of systems to maximize the accuracy of the risk adjustment system for their patient population, particularly as the transition from ICD-9 to ICD-10 occurs.

Outcome predictions

Physician groups should look for systems that maximize the amount of information that is generated. Systems that report the segment costs by different service categories (e.g. inpatient, outpatient, pharmacy and other professional costs in addition to total health care costs) are much more useful to physician groups who are trying to increase their practice efficiency. Reports that go into even greater detail on factors that the physician group may be able to influence, such as hospital readmissions and use of advanced imaging tests, may be even more helpful.

Population type

Current risk adjustment systems are specific to specific populations. Physician groups should ensure that the appropriate system is being applied to each line of business – Medicare, Medicaid and commercial.

V. Key issues for physicians

A. Which risk adjustment system should be used?

The most important issue is the risk adjustment system's predictive accuracy. Using the language of actuaries, a risk adjustment system that perfectly predicted the costs each patient would generate would have an "R-Squared value of 1.0," and a risk adjustment system that was useless at predicting a patient's costs would have an "R-Squared value of 0." Physicians should seek the risk adjustment system that will have the highest R-Squared value for their patient population. At this point, the best prospective risk adjustment systems for commercial populations have an R-Squared value between .15 and .30, and the best concurrent systems have an R-Squared value of .60. Because the predictive value of concurrent systems is so much higher, physicians will generally prefer these to prospective systems.

Physicians must also understand that all risk adjustment tools are developed based on "average" patient populations and cover the total cost of care. Particularly where a physician group has a smaller population that may have unique characteristics, or if certain services have been "carved out" of the arrangement, it may be advisable to have the risk management system vendor perform an evaluation of that population and modify the "off-the-shelf" system as appropriate, or at least build in "look-back" and "true-up" provisions so that physicians are not financially devastated by unavoidably higher costs generated by

more needy patients. It is possible to do a retrospective evaluation and determine the predictive ratio that was actually achieved between the cost predicted by the risk adjustment system, and the cost which the population actually incurred. Physicians may want to require that such an analysis be done so that retrospective adjustments can be made if the system failed to achieve appropriate results.

Finally, physicians should obtain as much information as possible about the risk adjustment system. At a minimum, physicians need to know the vendor of the risk adjustment system, as well as the specific model and version that will be used so they can validate the results. Ideally, the vendor will agree to complete transparency with the physician group, and provide detailed reports to the risk contribution level of individual patients.

B. How important is diagnosis coding to accurate risk adjustment?

In the world of risk adjustment, diagnosis coding is as important as procedure coding. Physicians who are considering the assumption of risk and the move to budget-based payment systems must implement a program for training and monitoring the physician and billing staff's diagnosis coding practices. Ideally, every claim will have both the principal and secondary diagnoses, coded pursuant to the content and sequencing rules established by the ICD-9-CM Coding Guidelines. Where this requires more than two diagnoses, these should be coded even though the payer may disregard anything after the second diagnosis code for payment purposes. Similarly, to the extent the physician group uses a clearinghouse to submit claims that will be used for risk adjustment purposes, the physician group must ensure that the clearinghouse is not eliminating or truncating diagnosis codes.

Physician groups should also take into consideration the impending transition to ICD-10 coding, and the impact this may have on risk adjustment, at least until there has been enough experience with ICD-10 coding for the risk adjustment systems to have been recalibrated. Physicians may wish to consider moving to or at least adding a pharmacy-based system or other failsafe during this transition period.

C. How are patient attribution and partial eligibility handled?

Except in cases where the physician group is acting as the gatekeeper for all the patients in the population for which the risk payment is being made, in which case the matter is relatively straightforward⁴⁶, patient attribution rules may vary. In such cases, physicians need to ensure that the particular rules being applied correctly attribute patients to the physicians who are most responsible for their care, and that these rules are being applied consistently for quality and efficiency evaluations and for payment. Again, physicians may want to require that a retrospective evaluation of the patient attribution system be performed to validate the results.

These issues become more complex to the extent patients are moving between health plans or physician groups mid-year. Different payers have different rules as to when they will start using risk-adjusted data for a patient, as opposed to merely adjusting for age and gender. Physicians will typically prefer systems that apply full risk adjustment to every patient for whom it is possible to do so.

D. How frequently should the risk adjustment model be updated and risk payments be made?

Because the accuracy of risk adjustment systems continues to improve, it is generally in the interest of physician groups to require regular incorporation of system enhancements. Because patient populations, medical technologies and other treatment patterns and benefit designs continue to change, reasonably frequent recalibration of the risk adjustment system to account for these changes is also preferred.

Similarly, physicians will typically prefer more frequent payment of risk monies, particularly to the extent they have higher-cost patients. One possible approach is to receive regular data reports from the health plan sufficient to enable the practice to verify the accuracy of risk payments, followed up by a final, comprehensive report issued subsequent to the conclusion of the contract year. For example, in

⁴⁶ See the chapter on capitation for the issues involving payment from the inception of patient eligibility as well as retroactive additions and deletions to eligibility rosters.

California, the health plan must, on a quarterly basis, provide the physician practice with a detailed description of each and every amount of expense and income allocated to the physician practice and health plan, respectively. The identification of each expense or income must include the relevant member identification number, date of service, description of service by claim codes, net payment, and date of payment. Then, no later than 180 days after the close of the contract year, the health plan provides the practice with a final payment reconciliation report that is accompanied by a final payment covering services provided by the practice during the preceding contract year.

E. What other strategies should physicians employ to mitigate the risk of attracting sicker, and thus more costly, patients?

Physician groups are generally best advised to obtain stop-loss insurance to protect themselves against losses associated with catastrophic cases, in addition to the protection afforded by a risk adjustment system. Stop-loss insurance establishes a maximum threshold amount beyond which a physician group is no longer financially responsible for treatment. Its purpose is to protect physicians from unlimited losses associated with catastrophic cases, e.g., transplants, severe trauma, neonatal intensive care. For more information, see chapter nine, “**Stop-loss insurance.**”

Another potential risk-mitigation strategy is a “risk corridor.” Essentially, a risk corridor applies to limit both the upside and downside risk of the risk arrangement. Physicians who are considering contracts with risk corridors should work closely with an actuary to ensure the risk corridor makes sense given the patient population and other factors specific to the payment arrangement.

VI. Conclusion

For more information on risk adjustment, physicians are encouraged to review the excellent resources on risk adjustment developed by Milliman and available from the Massachusetts Medical Society, including **Risk Adjustment: Important Considerations for Global Payments to Providers** , **Risk Adjustment and its Applications in Global Payments to Providers** , and **Risk Adjustment Checklist for Physicians Entering into Risk-based Global Payment Contracts.**

Additional information on risk adjustment, including software designed to risk adjust different patient populations, is available from several vendors, for example, *see* MARA DXAdjuster, RxAdjuster, CxAdjuster at **www.milliman.com**, **Verisk HealthCare, Inc.** ; **Johns Hopkins Ambulatory Cost Groups**; **3M Health Information Systems (Clinical Risk Groups)**, and **Optum risk adjustment solution.** This software is increasingly valuable not only to ensure adequate capitation payments, but also to identify patients for whom case management services are likely to be beneficial from both a cost and quality perspective.

Chapter 9: Stop-loss insurance

Tom Handley

Stop-loss insurance establishes a maximum threshold amount beyond which a physician group is no longer financially responsible for the health care services a patient needs, even though the group has agreed to assume the financial risk for that patient's care. Its purpose is to protect the physicians who have entered into risk-based payment agreements from unlimited losses associated with catastrophic cases, e.g., transplants, severe trauma, neonatal intensive care.

Threshold amounts (deductibles) vary according to the plan contract (if the stop-loss insurance is obtained through the plan) or insurance policy (if the insurance is obtained through a stop-loss insurer). For example, if the stop-loss deductible is \$7,500, at the point in the year when the physician group has provided services worth \$7,500 to an individual patient, the stop-loss amount would trigger and the plan would pay the group on a fee-for-service basis for that patient's services for the rest of the year. Usually the coverage applies "per subscriber per year."

Stop-loss insurance is usually necessary for groups of physicians at risk for referral services, and may be necessary for other physicians as well, such as those participating in shared-risk pools with a potential for significant down-side risk. Generally speaking, the larger the group, the higher the deductible. Some large groups self-insure. Many medical groups are now going to the open market to purchase stop-loss insurance, which is usually cheaper than purchasing it from the health insurer. This is because health insurers generally purchase stop-loss coverage from a stop-loss insurer, and then pass the cost on to the physicians, with a surcharge. Physicians can purchase stop-loss coverage directly from insurers if they are (or their broker is) knowledgeable about risks, insurance policy clauses, and the administrative procedures that are required for claims payment.

I. Determining whether you need stop-loss insurance

An important step in the decision process is determining whether you even need stop-loss insurance. The answer to that question will depend on whether the contract has any risk and if so, what kind of risk. The examples below will help with evaluating your situation.

- **Primary Care Capitation** – For a typical primary care capitation contract, the risk is minimal. The per unit cost of services is low and the level of fluctuation for the number of services is not great. A patient with chronic health problems will use a high number of services but there is a chance that many of these services will fall outside the scope of the primary care capitation payment.
- **Physician Services Capitation (Primary and Specialty)** – There is a risk potential with this type of contract. With surgery, the per-unit cost can be high and thus the concomitant potential for significant financial risk, and because a broad range of services is included, the fluctuation risk is also high. Persons with chronic conditions will be your greatest source of risk. The deductible should be at lower levels (possibly as low as \$5,000) to capture the excess cost of the high frequency user.
- **Full Service Capitation** – This definitely has a risk potential since hospital services are included. This assumes that the physician group is partnering in some fashion with a hospital or hospital system. Obviously, there is a significant financial risk for large claims from the inpatient care as well as for some outpatient services. The deductible (stop-loss amount) will depend on how much cash and reserves the hospital partner has. There are some general recommendations in the discussion below.

- Bundled Payment Contracts – This will probably include physician and hospital services but for a specific condition. The risk element here is the range of services to be provided. The payment amount should recognize the severity of illness but if the providers of care are not efficient or follow a different treatment methodology, then there can be adverse consequences. There should not be a great need for stop-loss insurance. If the providers of care are not comfortable with the prescribed treatment methodology, they should not accept the contract.
- Carve-outs – There could be some situations where the physician group is better off carving out some conditions or services rather than purchasing stop-loss coverage or allowing the costs to flow into the stop-loss coverage. These situations should be those that the physician group knows will be high cost, and it simply does not make economic sense to assume this risk. This could involve specific conditions, or easily definable or specific surgeries. Examples could be cardiac surgeries, premature babies, certain cancers, transplants, dialysis, etc.

II. Determining how much stop-loss insurance you need

Once you decide that you need stop-loss insurance, the next important decision to be made is how much stop-loss coverage does your group need? The level of coverage is dependent on the number of members covered and the services covered. If you are at risk for hospital services, especially inpatient, then you will need protection for larger claims. If hospital services are not part of the capitation, then large claim risk is minimized but large claims can still occur. A general rule of thumb that combines number of members and range of services is to tie the stop-loss deductible to a multiple of your projected annual capitation revenue. A reasonable amount might be 2% - 5% of the revenue. If your organization has sufficient funds in a reserve, then you could select the higher percentages. Lower deductibles do mean higher stop-loss premiums so you will need to evaluate your net stop-loss cost. Your net stop-loss cost equals what you paid in stop-loss premiums less expected claim recoveries. The net should be approximately 25% of the stop-loss premium. If the net is greater than that, then the premium is too high.

III. What to find out about stop-loss insurance

Whether your group elects to obtain stop-loss insurance from a stop-loss insurer, or from the health insurer directly, physicians should find out at least the following information from the carrier or health insurer, respectively (much of the information below should be stated in the stop-loss policy):

- When contracting directly with a stop-loss carrier, what are the carrier's stop-loss insurance applications like? You should not have to fill out long and onerous application forms.
- What is the premium cost and what is the deductible amount?
- What services will be included and excluded in determining when the deductible is reached—all the services covered under the capitation payment? Some carriers will offer a lower premium but exclude many services in calculating when the threshold is met.
- How is the calculation made concerning when the physician reaches the deductible? Is a fee-for-service payment amount ascribed to each capitated service provided? If so, what fee schedule is used? Is some other formula used? *Physicians will have to keep detailed expense records on each patient in order to prove that the stop-loss level has been reached, and to prove the amount of payment due after the level is met.* However, physicians will want to track this data in any event, to determine if the capitation rate is adequate.
- If the physician never reaches the stop-loss deductible or has very few cases which reach the threshold, will the carrier offer a rebate on the premium? (Such premiums generally are not rebated where the deductible is high and the premium is low.)
- What will constitute the policy year for purposes of medical groups reaching their threshold? Will the threshold apply per patient, or in the aggregate? Say a threshold of \$5,000 (per case) must be reached before the calendar year is up on December 31. What if on December 31 a group has one or more patients for which the group has provided \$4,000 in services? In such cases, the carrier should

extend the stop-loss year to thirteen (13) or fourteen (14) months. Or, if a catastrophic case (illness or injury) began late in the year, the policy year should be extended. It is not fair for physicians to have many catastrophic cases that fall just below the threshold amount. Moreover, the policy must allow claims incurred in the previous calendar year to be submitted for at least sixty to ninety (60-90) days into the following year. The best contract would be one that covers claims incurred in the year and paid in the year and the three or six months following. These are generally referred to as 12-15 or 12-18 contracts.

- How are physicians paid after the deductible is met? What services are covered—only the services covered under the capitation arrangement? What fee schedule is used to pay the physicians after the threshold is met?
- Are properly submitted claims paid in less than thirty (30) days? Do you begin to receive payment as soon as the deductible is met?
- Are there clauses in the insurance policy that absolve the insurance company from paying certain types of claims? Are there escape clauses such as pre-existing conditions exclusions? Are hospital inpatients or disabled members covered on the effective date?
- Does the stop-loss contract permit the insurer to terminate the policy with thirty (30) days' notice? *Negotiate this out of the policy!* This allows insurers to "jump ship" as they see catastrophic claims building.
- Will all of the above be guaranteed in writing?

Medical groups should be careful about purchasing stop loss coverage from unknown insurance companies in exchange for a low premium. You may wish to avoid insurers that are "off-shore." Check insurance rating guides to make sure coverage is being provided by a reputable company. You may wish to deal exclusively with properly registered "A" or higher rated insurers. Also, check with the relevant state insurance regulator to see whether the company meets state requirements and whether it has had any complaints against it.

Chapter 10: Working with actuaries

Tom Handley

Many of the “value based” payment models that payers are seeking to use to augment or replace fee-for-service payments are designed to reward physicians who can successfully provide health care services for less money than the amounts the payer has projected based on historical experience and projected inflation. Capitation, shared savings and bundled payments are all examples of such payment alternatives.

Payment options that depend on the development of a “budget” projected to cover the costs of providing services to a group of patients are best evaluated by someone with the expertise to determine whether the budget is a fair estimation of what the health care costs of the covered population are likely to be. The people who have this expertise are health care actuaries.

What is an actuary?

Actuaries put a price tag on risk. They are the leading professionals who specialize in finding ways to manage risk, and are experts in:

- Evaluating the likelihood of future events—using numbers, not crystal balls
- Reducing the impact of undesirable events
- Designing creative ways to reduce the likelihood of undesirable events

Actuaries apply their mathematical expertise, statistical knowledge, economic and financial analyses, and problem-solving skills to a wide range of business problems. They help organizations evaluate the long-term financial implications of their decisions; they develop new ways to manage risk; and they estimate the costs of uncertain future events, ranging from tornadoes, hurricanes, and automobile accidents with crippling injuries, to changes in life expectancy.

Actuaries work in all sectors of the economy, though they are more heavily represented in the financial services sector. Their work is the analytical backbone of the nation's financial security programs, including all forms of insurance, Social Security, Medicaid and Medicare.

Some actuaries have degrees in actuarial science, while others have degrees in business, economics, math, or the liberal arts. To join the profession in the United States, prospective actuaries must pass a series of exams given by the Society of Actuaries (SOA), the Casualty Actuarial Society (CAS), or the American Society of Pension Professionals and Actuaries (ASPPA). The exam process usually takes several years.

Actuaries manage risk

The future is uncertain and full of risk. In that respect, health care is no different from any other class of services. Risk is the chance that an undesirable event will occur, but risk is also opportunity. That is where actuaries come in.

It takes a combination of strong analytical skills, business knowledge and understanding of human behavior to manage today's complex risks facing physicians as they decide what type of payment model will work for them. Actuaries can be an invaluable resource to physicians who are considering the transition from fee-for-service to shared savings, bundled payments, capitation or any other type of payment system which, unlike fee-for-service, ensures payment only when the total cost of the health care services provided to a specific patient population does not exceed the projected budget for those services.

How do actuaries manage the risk?

Risk comes in many forms. Everybody and every organization face risk. As experts in measuring and managing risk, actuaries fill a significant need for organizations. With respect to health insurance, actuaries are best known for determining how much an insurance company should charge for health insurance, taking into account the area, demographic characteristics, costs or contract reimbursement levels in the area, expected rates of utilization of services and levels of deductible, coinsurance or co-pay.

The sections that follow identify some specific situations where an actuary can be useful to physicians and how they can help physicians succeed under any type of payment arrangement.

Evaluating fee-for-service (FFS) schedules

Many of the FFS schedules today are expressed as a multiple of the Medicare Resource-based Relative Value Scale (RBRVS) schedule.

What can an actuary do to help you assess if the schedule is fair and reasonable?

Actuaries can:

- compare the current schedule to the proposed schedule;
- compare the proposed schedule to your budget (budget assumes that the historical distribution and number of procedure codes can be provided so a projected revenue can be compared to your projected office costs);
- test the impact of changes in procedure code mix by comparing your procedure code mix to the procedure code mix of other client procedure distribution, information which is particularly helpful to physician groups considering adding or removing different specialties;
- test the impact of different RBRVS multipliers on the eventual payout; and
- test using one multiplier for one set of procedures and a different multiplier for another set of procedures.

You would need to provide the following information to the actuary to aid in the evaluation:

- A copy of the current fee schedule.
- A copy of the proposed fee schedule.
- Your proposed budget, i.e., physician and other practice staff salary costs and practice overhead (rent, business and professional liability insurance, etc.) for the year the fee schedule would apply.
- The distribution of procedure codes utilized (billed) in the past year or for whatever period you have the data.
- What percent of your practice revenues (10%, 25%, 50%) have in the past resulted from your business relationship with payer that is proposing the schedule?

If you have not been furnished with the complete fee schedule, if you can provide the RBRVS schedule and the multiplier specified in the contract, then the actuary should be able to duplicate the full schedule. If there are some exceptions – certain procedures paid at a different multiplier – then those should be identified as well.

The end product might be a table displaying results of the evaluations, for example:

Schedule being evaluated	Expected dollar payout
Current schedule (130% RBRVS)	\$1,125,000
Proposed schedule (125% RBRVS)	\$1,050,000
Budget adjusted to carrier %	\$1,100,000
Proposed with different mix	\$1,115,000

These results can lead to additional scenarios to be tested or provide you with some leverage during negotiations with the payer.

Evaluating capitation payment

Capitation payment can be applied to a number of different classifications of services. What is capitation? Where's the risk?

Capitation is an actuarial rate that transfers insurance risk from payers to providers by taking a very broad-based assumption of cost of care across a wide population. Capitation imputes that cost as an average cost for any provider being reimbursed by the capitated rate.

Providers take the risk that they may have a sicker patient panel than average or that their condition or disease mix can be more unfavorable in terms of resource use per patient than the average.

Capitation is based on average costs and patient risk. Should the FFS equivalent cost vary or the patient risk vary, then capitation may be less than the actual cost. To make this risk manageable, the capitation payment must apply to a population large enough to limit fluctuations or be limited to a list of services that is more predictable (services that have high frequency and low cost per unit), or there should be limits on the ultimate exposure to the provider group for low frequency, high cost per unit services.

The Blue Cross Blue Shield of Massachusetts Alternative Quality Contract

One example of the current use of capitation is the Alternative Quality Contract (AQC) implemented by Blue Cross Blue Shield of Massachusetts in 2009. Under the AQC, Blue Cross Blue Shield of Massachusetts makes a fixed payment to a healthcare provider for each patient to cover all care services delivered to the patient (including hospital care, physician services, pharmacy costs, etc.), with the payment amount adjusted by the health status of the patients. The provider can earn up to a 10% bonus payment for achieving high performance on clinical process, outcome and patient experience measures. The amount of the payment is based on historical costs for caring for a similar population of patients and is increased annually based on inflation. Outlier payments are made for patients with unusually high needs and expenses, and limits are placed on the total amount of financial risk the providers accept. Further information concerning the AQC can be found in the comprehensive AMA white paper entitled "[Pathways for Physician Success Under Healthcare Payment and Delivery Reforms](#)", which is available to AMA members.

What can the actuary do to help limit and/or manage the risk?

An actuary can do all of the following:

- Review the contract and list of capitated services and identify those that are high risk or lead to fluctuations in utilization.
- Compare actual costs (FFS equivalents) of the physician group or broader provider organization to proposed revenue using the payer's proposed capitation rate. If the actuary has sufficient detail on the physician practice's distribution of service types and procedures, the actuary can also identify services or types of services where FFS equivalent costs are high or low versus norms (averages).
- Test the impact of changes in utilization and/or reimbursement to projected provider costs versus payer capitation payments.
- Compare the proposed capitation rate to industry based norms (from actuarial models) adjusted by age, gender, plan and any other variables used in the capitation rate.
- Recommend appropriate levels of stop-loss coverage that would limit risk at the high end.
- Respond to proposed changes in capitation rates and other payment variables from the payer and show how these changes will impact the physician group.
- Evaluate the impact of the types of patients that have or could enroll with the physician group or physician-hospital group, and the relative risk of those patients compared to the "average

patient.” Does the nature of the physician or broader provider group attract patients that pose a higher risk that their health care costs will exceed those of the “average patient?”

- Evaluate the payer’s proposed risk adjustment system, and the extent to which it will mitigate the risk the physician group attracts sicker or otherwise more costly patients.

You would need to provide the following information to the actuary to aid in the evaluation:

- Copy of the current capitation schedule.
- Copy of the FFS equivalent schedule used to evaluate the capitation agreement or proposal.
- Copy of the capitation contract and the complete list of services included.
- Copy of the proposed capitation schedule and applicable list of services.
- Data files or experience reports of utilization for past 12 months under current contract; should include distribution of enrollment by age, gender and any other variables used as well as utilization of services by CPT and HCPCS code, diagnosis code(s) and FFS equivalent values.
- Current and proposed budget values for the portion of total physician group revenue generated by the capitation contract.
- If there is a hospital or other health facility involved, then the actuary will need a copy of the hospital and other health facility reimbursement schedules, both current and proposed.
- If there are any other health care professionals involved, then the actuary will need a copy of the reimbursement schedules for those professionals, both current and proposed.
- If there are any incentive or bonus arrangements that are part of any sub-contracts between the physician group and other health care providers that the physician group will be responsible for paying out of the capitation revenue, the actuary will need copies of these arrangements.

If the physician organization is part of a global capitation contract with a hospital, then the data will need to include costs and services associated with the hospital. Analysis of a global capitation contract can also depend on the incentives offered to physicians to help manage and limit the ultimate cost.

A sample of what the actuary might provide after the analysis could look like the following.

Description	Revenue	FFS equivalent cost	Gain(loss)
Current Contract	\$2,450,000	\$2,425,000	\$25,000
Proposed Contract	\$2,550,000	\$2,570,000 ¹	(\$20,000)
Using Norm Values	\$2,550,000	\$2,400,000 ²	\$150,000
Using Norm Utilization Values	\$2,550,000	\$2,450,000 ³	\$100,000

1 – applies a trend to current period costs of 6%

2 – applies actuarial model norms to projected period utilization and reimbursement

3 – applies actuarial model norms to projected period utilization only

Evaluation of capitation contracts requires working with significant amounts of data. The physician group has much more at risk, and thus should invest much more effort than is typically invested in evaluating a fee schedule for a fee-for-service arrangement. The physicians need to work with persons familiar with health care data. How much data do they need? Is the data accurate? Is the data relevant to the population which the capitation schedule will apply? Is the amount of data credible, reasonable and appropriate? Actuaries are familiar with and routinely work with health care data and data issues and, if they have access to relevant historical data and a willingness to work with physician groups as well as payers, can serve as invaluable partners to physicians considering capitation contracts.

Data analysis and monitoring of the physician group's experience under a capitation contract should be done more frequently than once a year. Monitoring of results on a quarterly basis will allow the physician group to adapt practice as needed to improve financial results. The actuary could provide comparisons throughout the year of actual results to capitation revenue and to benchmark or norm values (from actuarial models adjusted to demographics). Comparison to benchmarks will identify areas where performance can be improved.

Evaluating bundled payments

Bundled payments are a more recent method of packaging payments and services for health care when compared to capitation. There are two different systems currently being used or tested. Each system has different implications to the provider(s) of care (bundled payment methods generally combine physician and hospital services), especially in regards to the level of risk and corresponding financial reimbursement. We will briefly describe each system before addressing the nature of the risk to the providers.

Geisinger System - ProvenCare

The first system was developed by the Geisinger Health System and is called "ProvenCare" (see <http://www.geisinger.org/provencare/>). This method calculates all costs associated with a standard of care, and then adds 50% of the average historical claim costs for care related to complications. To develop a "bundle" following the ProvenCare model, the following process is required:

1. Expert review of best practices – treatment protocols;
2. Definition of critical steps;
3. Building the process into a workflow;
4. Measuring the outcomes both clinically and financially along the way;
5. Defining the conditions that qualify for the bundled payment category; and
6. Determining what services are included in the bundle—hospital, physician, acute care and post-acute care.

This process aligns reimbursement with success and outcomes. The provider accepts the risk and receives a global payment for services and no payment for related complications. The actuary will look at procedures performed as part of the treatment protocol and assess the ranges of variations that can occur for a particular condition. This could require some conversations with practicing physicians to completely outline and describe the potential variations.

The provider is fully at risk since services and charges in excess of the global payment are not reimbursed.

PROMETHEUS Payment

In 2006, Prometheus Payment Inc., a nonprofit group, began testing its payment model, which features fee-for-service payments to physicians and non-physician providers of care within the constraints of a condition specific payment budget, commonly referred to as a "bundled payment." There is also a shared-savings component, which will be morphed into a pay for performance program as the model progresses. Prometheus is an acronym for **P**rovider payment **R**eform for **O**utcomes, **M**argins, **E**vidence, **T**ransparency, **H**assle-reduction, **E**xcellence, **U**nderstandability, and **S**ustainability. The declared goals of the Prometheus Payment approach include improved health care quality, reduced health care costs, lowered administrative burden, increased collaborative care among providers, and reimbursement that is based on the amount and proportion of services that are provided to specific episodes of care. The model's codes, algorithms, and the results of data modeling are publicly available on the Prometheus Payment website at www.prometheuspagement.org; however, the model is complex. The purpose of this educational document is to present the basic components of Prometheus Payment in a logical manner and not to advocate for or against the Prometheus Payment model or other episode-based payment systems. Although this is an extremely complex payment system, Prometheus can grant pilot sites permission to use only selected parts of the model.

Prometheus Payment model

At the heart of the Prometheus Payment model is the process of creating a bundled payment for a set of services that makes sense from a medical perspective. This process includes identifying the appropriate health care services associated with treating a select acute or chronic condition, calculating the estimated cost of providing those services, and then comparing those projected services and costs with the actual services and costs of a specific patient's episode of care. The episode of care is defined as all of the services a patient receives associated with a particular illness or condition over a specific period of time.

The Prometheus Payment system takes patient treatment data from CMS 1500s and UB-94s and allocates them to specific episodes of care. The data from the episode are then divided into two buckets: those services that are typical to providing care according to clinical practice guidelines (CPGs); and those associated with potentially avoidable complications (PACs). The CPG services and their associated costs are combined and increased to account for PAC, severity and margin to create evidence-informed case rates (ECRs). Each ECR is also customized in an attempt to account for the severity and complexity of each patient's clinical condition. The ECR could be considered the financial target or budget for treating an individual patient's condition. Physicians, other health care professionals and hospitals, or other health facilities are then paid a contracted fee for their services out of the allocated ECR. A portion of the payment is also withheld to be used for shared savings or pay for performance-based incentive payments. A more detailed description of the steps taken to build the Prometheus Payment model follows.

1. *Construct clinical practice guidelines (CPGs) to determine standards of care*
Focusing on structure (e.g., health information technology infrastructure and use of registries), process, and outcomes, Prometheus leverages existing efforts in quality measurement such as the Joint Commission's ORYX program, Leapfrog and CMS hospital measures, and Bridges to Excellence (BTE) measures for physicians, which include NCQA, CMS and Physician Consortium for Performance Improvement (PQRI) measures. Prometheus deconstructs these measures to construct CPGs to determine which specific services (e.g., visits, diagnostic tests, treatments, procedures, drugs, etc.) are necessary to deliver the standard of care for specific conditions. In instances where evidence-based measures are lacking, expert opinion of the standard of care is used.
2. *Separate the costs attributable to patient-related factors from potentially avoidable complications (PACs)*
Taking into account all of the providers associated with the patient's treatment, the model uses a system to separate claims into either a "standard of care" or a PAC category. In the Prometheus model, PACs are recognized as complications of care that could be prevented through proactive care. Using Prometheus' logic, re-admission of a patient recently discharged after cardiac bypass surgery for treatment of an infection of the surgical wound is considered a PAC.
3. *Establish evidence-based case rates (ECR)*
The Prometheus model covers payment for physicians, other healthcare professionals, and hospitals or other health facilities across multiple settings (e.g., hospital, physician, pharmacy, laboratory, and rehabilitation facilities) which provide patient services for specific episodes of care. For acute conditions, the episode of care typically begins when the patient is first evaluated for the condition and ends when that care has been completed. For chronic diseases, which have no defined end point, the episode of care is set at one complete calendar year. ECRs set a budget for an episode and start with a base rate, which encompasses the estimated costs of the patient services that need to be provided to meet Prometheus' recommended treatment guidelines. A percentage (generally 50%) of the cost of expected services attributed to PACs is added to the cost of the base rate. Above the base and PAC costs, Prometheus applies its severity adjustment in an attempt to account for a higher intensity of services needed to treat sicker patients, and a margin, to give physicians a financial incentive to provide all of the services comprising the standard of care. Prometheus' risk adjustment methodology is based on the following patient and treatment factors: demographics, co-morbid conditions, severity of

illness, evidence-informed procedures performed and evidence-informed pharmacy used. The following provider characteristics also factor into the risk adjustment: hospital location (rural vs. urban); hospital type (teaching vs. non-teaching); hospital size (number of beds and specializations); and physician specialty type (primary care vs. specialist). Prometheus Payment has developed ECRs for a number of conditions and inpatient procedures, including: acute myocardial infarction, hip and knee replacement, diabetes, asthma, congestive heart failure, and hypertension.

4. *Payment for services and the elimination of PACs*

Under Prometheus Payment, physicians and non-physician health care providers are paid using a fee for service model within the constraints of the ECR budget. The incentive for providers to act on and reduce PACs comes directly from the savings found in the reduction of them. The allowance for a PAC is calculated for and included in each ECR and a portion of the budget is withheld. Should complications occur, this portion of the budget serves to offset the actual costs of the corrective treatment. However, if providers can reduce or eliminate PACs, they may retain the allowance as a bonus and significantly improve their margins per patient.

5. *Create a scorecard to report and pay for quality and cost-efficiency*

As Prometheus evolves, the system will strive to incentivize physicians and non-physician providers, not only for reducing PACs, but also for the provision of exemplary quality of care, efficiency and service. This will be accomplished by having Bridges To Excellence establish physician and other health care professional and facility scorecards based on a variety of metrics that track and evaluate care across the scope of treatment, including the overall cost of care and each provider's performance in meeting the CPGs, positive patient outcomes, the avoidance of preventable complications, and the patient's satisfaction with care received. To create an incentive for clinical collaboration, the final scores will depend on a percentage of the individual provider's performance on treating the patient and on a percentage of the performance of other providers treating that patient for that condition. The results of these scorecards will determine if additional payments are to be made and their size.

Prometheus pilots

Through the support of the Robert Wood Johnson Foundation, the Prometheus model is currently being piloted with health care systems in four sites: Minnesota with HealthPartners; the Employers' Coalition on Health is working with local physicians and hospitals in Rockford, Illinois; Grand Rapids, Michigan with Spectrum Health and Priority Health; and in southeastern Pennsylvania with Crozer Keystone Health System and Independence Blue Cross. These pilots vary tremendously, and may not encompass the entire Prometheus payment system. Prometheus Payment is monitoring them for compliance with the model's principles and execution to learn from these experiments.

What can an actuary do to help limit and/or manage the risk within bundled payments?

- Compare the current and proposed contracts in terms of the services included in each "bundle" and the associated payment rates.
- Review the definitions of episode of care with the physicians. Are the episodes relatively homogeneous with a reasonable level of variation in their costs? The actuary can quantify the variation potential for each proposed bundle.
- Work with the physicians in the group to identify for an episode of care the appropriate treatment protocols, procedures to be performed and fees for the procedures. Identify complications that can occur and services to quantify the impact of variations. What care is necessary and what is not necessary?
- Develop models that use frequency of procedure, fee schedule amounts and probabilities of complications to develop an independent fee for an episode of care. This would use data available from the providers as well as payer data and the actuary's own available data resources. Should there be different levels of payment based on severity of condition?

- Test various assumptions within the model structure to quantify the range of financial risk.
- Identify the type of information needed to manage and monitor the program, especially from a financial perspective.
- Provide guidance on the definition of the episodes of care to be included in the bundled payment arrangement, and how payments should be distributed between physicians and hospitals.

Physician groups would need to provide the following information to the actuary to aid in the evaluation:

- Copy of current and proposed contracts.
- Copy of FFS equivalent schedule used to determine payment.
- Definitions of the bundles of services or episodes of care included in the contract.
- Treatment protocols and guidelines describing services, procedures and diagnosis codes applicable. This should include identification of different severity levels and how they could result in a different episode of care class.
- Data files or experience reports of utilization for past 12 months under current contract.
- Data from physician practice records showing procedures done, frequency of procedure and diagnosis used.
- Description of how physician group will coordinate with hospital on care provided, services used and identification of unnecessary care.

A sample of what the actuary might provide after the analysis could look like the following.

Description	ECR*	FFS equivalent cost	Recommended protocol
CABG	\$25,000	\$28,000	\$21,000
COPD	\$14,000	\$17,000	\$15,000
Diabetes	\$30,000	\$34,000	\$28,000

*ECR – Evidence-informed Case Rate

The FFS equivalent represents the amounts that would have been paid to the physician group on an FFS basis if the physician group had been paid pursuant to the contracted fee schedule. The actual report would include the results for the services actually provided as well as the projected results if the physician group’s recommended protocol had been followed. These results can then be used to identify changes to protocols or as a basis for negotiating different payment levels with the payer or hospital partner.

Evaluation of data (capitation and bundled payment)

An important component of evaluating both capitation contracts and bundled payment contracts is the data used by the actuary for the payer. The payer is using its own data or some other outside source to develop the rates being proposed. An important step in evaluation of the contract for the physician group is an evaluation of the payer data by the actuary hired by the physician group. This step is a common practice used by departments of insurance when reviewing the rates being proposed by an insurance company. Departments of insurance hire independent actuaries to review the data and methodology used to develop the rates. A physician group should follow this same practice. This is in addition to the other steps referenced in either chapter four, “Capitation,” or chapter six, “Bundled payments.”

How do you find an actuary?

You can search for actuaries on a number of websites:

- Society of Actuaries — <http://www.soa.org/>
- American Academy of Actuaries — <http://www.actuary.org/>

These two websites have directories that include actuaries with backgrounds and expertise in health care. You will want to look for consulting actuaries and actuaries in the health benefit systems primary area of practice or an additional area of practice such as managed care.

There are a number of professional designations to consider:

- **Associate, Society of Actuaries (ASA).** An Associate has demonstrated knowledge of the fundamental concepts and techniques for modeling and managing risk. Associates have passed a series of four comprehensive exams, four college level courses and a professionalism course.
- **Fellow, Society of Actuaries (FSA).** A Fellow has demonstrated knowledge of the business environments within which financial decisions concerning health insurance are made. This includes the application of mathematical concepts and other techniques to various areas. A Fellow has completed all the educational requirements of an Associate plus two other exams, four additional modules and a Fellowship Admissions Course.
- **Member, American Academy of Actuaries (MAAA).** A member has to have attained ASA or FSA status and demonstrated good moral character and professional integrity.

Choosing an actuary:

- Is location important? Do you want personal meetings with your actuary or will email and conference calls be enough contact? Is the actuary familiar with how health care is provided in the area and who the key players and providers are?
- What is your budget? Billing rates vary by type of professional accreditation, size of the firm, and region of the firm. Actual fees are typically determined by one of the following three methods:
 - Hourly billing rates
 - Project rates
 - Fixed-fee not to exceed
- Conflicts of interest – has the actuary worked for a possible competitor in your area?
- Prior experience and qualifications – have they worked in an insurance company before? Have they worked with provider-based groups before? Will the senior actuaries be involved or will the project be handed off to staff at lower levels?
- Is the actuary's data or model consistent with practice patterns for the area in which the physician group practices or just part of a standard guideline or model?
- Is the actuary familiar with provider contracts, setting provider reimbursement rates and managing the risk of provider-payer contracts?

Conclusion

You can be certain that third-party payers will have taken advantage of an actuary's expertise in determining what payment proposals will be offered to you. Accordingly, it would be prudent to similarly engage an actuary's services to help you determine how to respond to a payer's proposals. The emerging value or budget-based payment offerings are different in kind from the fee-for-service proposals of which you may be most familiar. While you can prosper under these emerging payment models, your odds of success will be much greater if you can avail yourself of the actuarial expertise necessary to understand and manage the risk you will assume under these models.

Chapter 11: Negotiating the deal

David W. Hilgers

After reading the previous chapters of this publication, the physician will have an excellent understanding of the growing variety of payment modalities evolving for medical compensation. Unfortunately, understanding the details of these options is not enough. Physicians live in the real world and, in order to survive and, hopefully, thrive, they must interact with a real-life payer, hospital or other opponent and negotiate a complicated contract. Negotiation is a subject in and of itself, and the medical group should expend as much time in planning for that process as it does understanding the details of the payment options. Without that planning, all of the knowledge about payment options may be wasted.

Anyone trying to discuss the “art” of negotiation must confess that if you have seen one negotiation you have seen one negotiation. Every “deal” has its own logic, its own rhythms and its own personalities. There are twists and turns within discussions that cannot necessarily be anticipated. Instead, the team participating in the bargaining must be adaptable and respond to the various arguments, ploys and techniques used by the opposition. However, the fact that deal-making is unpredictable and variable does not negate the need for planning and preparation by the physicians as they enter into discussions with the potential payer. Preparation is not a guarantee that the physicians will be successful, but the lack of it will very likely assure that they will not be. All too often, physician groups negotiating with hospitals or insurance companies have a brief pre-negotiation meeting among themselves and then immediately jump into the discussions with the opponent. Instead, the physicians need to take a careful look at the circumstances surrounding the potential transaction and plan a strategy to achieve their negotiating goals.

I. Evaluating the Negotiating Position of the Group

A. How valuable is the group? The physician group must do a very candid and objective evaluation regarding the negotiating leverage of the parties in the discussions. Each market is different. For example, a large medical group in a mid-size town of one hundred thousand will likely have substantial bargaining power over any possible opponent. A hospital will be very concerned about losing referrals; while a health plan will need the group in order to be attractive to the town population. On the other hand, if the group is a small pulmonary medicine practice in a large city, it is unlikely to have much bargaining power in a negotiation against any possible payer. The hospital, health plan or accountable care organization (ACO) will have a number of competitors to choose from and can, therefore, be somewhat cavalier in their discussions with the pulmonologists.

However, there are other factors that can impact negotiating leverage than the size of the group or market. If a five person primary care group is negotiating with an ACO, it may be in a better position than would be apparent from its size. The ACO’s membership is determined by the number of patients attributed to the primary care physicians participating in the ACO. Also, primary care physicians are exclusive to one ACO. Consequently, even a single primary care physician with a substantial number of Medicare patients may be in high demand for any ACO. This means that the primary care group can carefully consider its choices among available ACOs and also demand some premium for its participation.

Another interesting example of unusual physician leverage is the small rural community. Particularly in negotiations with the local hospital, the physician is largely in the driver’s seat. The hospital cannot function without a physician, and it is difficult to recruit one to the community. However, the rural physician negotiating with a health plan may not be in the same position. The health plan may be able to

utilize physicians in the surrounding communities as a substitute and, therefore, take a harder position than the hospital.

B. Who is the competition? Another factor to evaluate is what alternatives are available to the negotiating opponent. Obviously, if there are numerous similar specialists available in a community, the bargaining power of one group is small. Less obvious, however, is the situation of the large anesthesiology group in a mid-size town. Yes, the group is important to the hospital and the health plan and there are few apparent alternatives. However, if the hospital is pushed too far, it may resort to one of the national anesthesiology practice management companies. This would not be an easy choice and would create difficulties for the hospital but is a possibility. Another similar concern for large medical groups negotiating with hospitals is the possibility of the hospital building its own competing group. Many hospitals are already caught up in the practice-building frenzy. Difficult negotiations might be a factor in pushing hospitals further toward that option. Consequently, even if the medical group seems to be in a good bargaining position at the moment, it is important to consider what options may be available to the opponent in the future.

If the group is negotiating with a health plan, the threat of the plan building a new group is not usually significant. However, some health plans have recently acquired medical groups in significant markets and the possibility cannot be totally ignored. Also the insurance companies have been known to encourage hospitals or other competing groups to expand their medical groups in reaction to what they perceive as unreasonable demands from a group.

C. What negotiating power is held by the opponent? What if the group is unable to achieve a satisfactory contract? What are its options? For example, if negotiating with an ACO, is there a competitor for the group to consider? The same question can be asked of a hospital opponent. Is there another hospital in the market that is a threat to the medical group's opponent? If there is a viable alternative, the opponent is going to be in a weaker position. On the other hand, in some markets there is virtually only one health plan. This gives the plan substantial market power in its negotiations with even the largest group. It is crucial for any negotiating group to evaluate this question. A failure to correctly access this issue can be seriously detrimental to any negotiation planning. However, simply because the opponent has serious market power does not necessarily mean that the group is out of luck.

D. What strategic alternatives are available? If we assume that the opponent is a health plan with dominant market power in the group's area, the negotiator will have fewer options. However, it may be a strategic possibility for the group to reject a contract and go out-of-network with the plan. This is not a pleasant option for the medical group and must be planned for carefully. Patients must be notified and the problem explained carefully. However, if done effectively, the patients can bring pressure on the plan through their employers and by personal appeals to the plan. This pressure can be even greater if the health plan is merely administering an employer-sponsored health plan. Employees going to their employer's human relations department complaining of the plan's refusal to contract with the physicians can be a powerful motivation to restart negotiations.

There are other possible strategic moves that might be considered. A medical group of cardiologists or other procedure-based groups negotiating with a hospital might consider utilizing another hospital for some of its patients. This option is limited somewhat by the problems this might create for the hospital from a Stark Law or anti-kickback perspective. Because the hospital cannot contract with the group in order to generate referrals from the group, if a contract is achieved after this movement of referrals, it might be deemed consideration for referrals. Thus, this strategic option must be used carefully. Nevertheless, the medical group needs to consider what actions it might take if the opponent appears to be difficult to persuade and whether the group is willing to use them.

E. Does the group have allies? As described above, it may become necessary with health plans to go out-of-network in order to overcome a recalcitrant opponent. In that case, it is much better to have a friendly hospital. Will the hospital tolerate the complaints from patients when the medical group goes out-of-network? As part of any plan to become a non-participating provider, it is important to determine the hospital's reaction. Can it be counted on?

F. What is the personality of the negotiating opponent? What is the medical group's relationship with the opponent? Has it been a long-standing relationship where the group and the opponent have worked together over the years? If there has been a history of a successful relationship with the hospital or health plan, it will necessarily impact the group's approach to the bargaining. It will be very hard to change what have been cordial or, at least, civil discussions into confrontational discussions without generating a very hostile reaction. On the other hand, the group cannot be afraid to firmly state its position despite the potential negative reaction.

Is the medical group planning to work with this organization, despite what happens in this negotiation? If so, the group must keep in mind the need to not create acrimony that will undermine ongoing relationships after the contract is approved. This type of imperative can require the group to take a more compromising position than it would if the ongoing relationship were not so important. If this is the case, the medical group needs to understand the reality and try to use it to generate compromise from the opponent. Also, the group may need to decide that if the opponent is not demonstrating the appropriate demeanor commensurate with the long-term relationship, it may need to change its negotiating posture and take on a more confrontational aspect.

What type of reputation does this organization have in negotiations? Is it considered very hardnosed and contentious, or is it reputed to be more reasonable and conciliatory? If the opponent is known as a very hard bargainer, it will impact the group's approach to the bargaining. Certainly, the group's first offer must be significantly more aggressive if there is reason to believe the opponent will be difficult. The physicians will want to take a much more demanding opening position, because they know that the opponent will be likely to be unreasonable at the beginning of negotiations.

G. What is the strength of the medical group? As a part of the negotiation planning, it will be important to look at cohesion and joint commitment of the physicians in the group. Is the group on sound financial ground and able to withstand a long and arduous negotiation? Is the group cohesive? Does it have able leadership that the physicians are willing to support through difficult discussions? At what stage are the group members in their careers? Is the group largely populated with young physicians, older physicians, or both? Is this going to impact the ability to negotiate as one? Physicians later in their career may not have the same drive to carry on a long and difficult negotiation as the younger physicians. The group needs to avoid internal dissension as the negotiations proceed. It is not uncommon to have negotiation opponents, such as hospitals, appeal to the more susceptible members of the group during a negotiation to try to create disagreement within the group. Equally, it is not uncommon for disgruntled members of a group to contact the opponent and attempt to split the group. This is very frustrating, but the potential for lack of group cohesion must be candidly evaluated. If there is some weakness in the group, it may color the group's approach to the bargaining.

II. Who is on your negotiating team?

Another important aspect of planning is choosing the negotiating team. Depending on the group's history with the opponent, it may be important to have someone on the team who has had long-standing relationships in interactions with the payer. Clearly, it is important to have someone on the negotiating team with knowledge about the issues. Most likely, the group should also have someone who is credible to the group and to the opponent. Another important option that should not be overlooked is the need for personalities that can effectively act as a good cop and a bad cop. If the group has a possible candidate for the negotiating team a person who is somewhat conciliatory, it may be wise to include him/her as a possible good cop. If, on the other hand, there is someone available who tends to be more contentious, he/she can serve as a bad cop. The advantage of having these two roles played by separate people is that it often can keep the opponent guessing. The payer may wonder which of the two has the upper hand internally within the group. Also, it gives the payer someone they feel who is more sympathetic that they can talk to and perhaps can approach about compromises or solutions that they would not give to the more contentious person. Realizing that sometimes groups do not have the luxury of multiple options for the team, it is still useful to discuss who will be negotiating and what the roles will be in the negotiations. Finally, it is very crucial that the members of the group not on the negotiating team avoid interaction with the opponent on a casual basis. Sometimes there is truly a role for a non-involved party to initiate or

respond to overtures from the opponent. Starting communications between parties not directly involved in the bargaining can allow for the exchange of proposals that would not be possible otherwise because of the posture of the negotiators who are in the heat of discussions. It is sometimes useful to identify this alternate go-between so that he/she can be kept up with the discussions in the event a new face is needed. However, this should never be done by a physician before discussing it with the negotiating team and determining what should be said and what role the intermediary might have.

III. Determining the group's aspirational goals

Once the group has evaluated itself and its opponent and chosen its negotiating team, another essential planning step is to determine the best-case goals for the negotiation. What are the terms that are absolutely necessary? The negotiators need to fully consider all of the elements that might go into this agreement. Are there side issues that the group might want to use to sweeten the contract? Is it possible to get some benefits that are ancillary to the main negotiation along with a good price? The group cannot go into a negotiation without a clear picture of what it hopes to achieve. This picture should not include just the large issues, but the negotiation team should understand all of the details and minor goals as well.

Just as important, however, is the determination of whether or not your expectations are realistic. To the degree that you can find out what the market price is for services, it is very useful to do so. For example, knowing MGMA's compensation schedule for the group's specialty is valuable. If your local market value can be determined, you can use it along with your analysis of your group's leverage to come up with a realistic number.⁴⁷

At an absolute minimum, you must understand your practice costs and the realistic economic impact of any "value-based" payment arrangement you are considering. Various other chapters in this manual can provide invaluable guidance in this regard, including chapter one, "**How to establish your baseline costs**," which discusses how to determine what it actually costs you to provide services, chapter ten, "**Working with actuaries**," which discusses the potential value of including an actuary on your negotiating team, and the various chapters dealing with the issues specific to various emerging payment options.

After determining the group's bottom line aspirational goals, it is important to determine what is going to be the initial offer. This beginning proposal can be impacted by the relationship with the opponent. If the group has a long-term relationship with the opposition and will need to have a continued relationship with it, the opening offer may be more reasonable. However, more often than not, it is better to start with a number or terms that are substantially greater than the group expects to obtain. Typically, the payers will always start low unless there are special circumstances giving the group substantial leverage. Many times, physicians are afraid that they will alienate or anger their opponent by asking for too much. That concern needs to be taken into account. However, most of the payers are more sophisticated. They may feign anger or disgust but rarely refuse to continue negotiating. Another important aspect of a negotiation plan is not settling on one issue at a time. If you can present an overall proposal that captures all of the issues that you desire to resolve, it keeps you from giving too much in one issue and not being able to counterpunch by demanding more in another area. Negotiating each separate issue one by one limits your flexibility on how the group can react to your opponent's proposals.

IV. Special issues for negotiations regarding risk payments

As is discussed in the Introduction, negotiations involving risk payment systems require preparation and knowledge beyond what has been discussed in the first three sections of this chapter. Negotiating these contracts is akin to a building contractor setting a fixed price for the construction of a house but is even more complicated. In order to make a reasonable calculation, the physician group will have to understand its own costs, the health status of the population it will be serving and the services to be delivered. Often

⁴⁷ Any effort to determine what the market value in your area is for these services needs to keep in mind that any collusion between provider groups or sharing of information regarding pricing could be a violation of the antitrust laws. Consequently, it is important to confine your efforts to find pricing from sources other than your competitors.

it is not possible to accurately gauge the risks of an agreement without obtaining critical information from the payer regarding the plan participants. Consequently, before entering into negotiations, it is absolutely necessary to secure from the insurance company as much data as you possibly can regarding the demographics and health care status of the patient population involved. Additionally, the medical group will have to have a clear understanding of the services to be provided. Because of the need for this knowledge, it is appropriate to enter into discussions with the payer about a risk contract by first asking it to provide you with sufficient information so that you can independently determine whether or not you can succeed financially under the contract. This may entail something of a pre-negotiation in which you may dicker with the payer about the information to be provided. It is possible that you either have, or may be able to gather, information that can be used to fill in some of the holes in the information provided you by the payer, because the insurance companies are not always forthcoming with sufficient data. A number of chapters in this book, e.g., chapter one, “**How to establish your baseline costs,**” will help you fill in some of these holes. However, it is not wise to move into negotiations of the actual terms of the risk contract without securing adequate information. An additional concern is to make sure that the contract with the payer obligates it to give the medical group regular data on the makeup and behavior of the patient population so that the medical group can identify changes that impact cost and quality. Several chapters in this book, e.g., “**Introduction,**” and chapter four, “**Capitation,**” will help you identify the kinds of patient population data that the payer will need to provide you on a regular basis.

Because many of these risk contract negotiations involve insurance companies with preexisting contracts and protocols, it is important to secure from the payer information about its standard contracts and operational practices. For example, in a capitated contract, one of the hidden issues is participant terminations from the plan. If the physician group treats the patient because the patient is listed as a participant in the health plan, but in reality the employee was terminated one month earlier, this can result in a loss to the physician group. What is the normal practice of the payer as to informing the medical group of health plan participant terminations, and who bears the risk if the physician treats the patient who is incorrectly listed as a participant of the health plan? Another policy issue that would be useful to know is the grounds for terminating a problem patient. Oftentimes, it is necessary for the medical group to be able to terminate a patient who is noncompliant. What are the terms of the policy of the payer governing that termination? Unfortunately, many of these issues that are crucial for the physician group to know are often buried in policies and procedures that are not part of the contract. Consequently, it is important for the physician group to understand and identify the issues of concern, as well as obtain from the insurance company whatever policies and procedures it may have that are written on this point. In the negotiations, if those policies and procedures are subject to change without permission of the medical group, it may be important to negotiate a provision that requires approval before these policies and procedures are changed or to put these in the terms of the contract itself so they cannot be changed without the medical group’s permission.

Other peculiar issues are raised by risk contracts involving shared savings. An ACO is going to have a standard affiliation agreement as well as standard bylaws of the organization. It is often very difficult to change those bylaws or affiliation agreements after they have been established. Consequently, before spending a great deal of time in negotiating these terms, it would be very important to gather information to find out what the bylaws say and whether or not there is a reasonable possibility of modifying them. For example, in an ACO with a shared savings program, who benefits from savings that the medical group produces from its patients? Are those savings shared with other physicians affiliated with the ACO, even though their own results were poor? How are the shared savings to be distributed? Are they distributed based on efficiency, quality or both? What types of withholds are there in the bonus pool? Often this information is readily available from the payer, and it can help the medical group determine its negotiation strategy by studying this information carefully. Further information concerning how to evaluate withholds and risk pools is provided in chapter seven, “**Withholds and risk pools.**”

Capitation, shared savings, withholds/risk-pools, pay-for-performance, bundled payment and other types of risk payment structures require a great deal of education of the medical group, as well as information gathering prior to the initiation of negotiations with the payer. However, if you gather that information

and understand the nuances of the payer's plans, this will give you a much better likelihood of success as you move forward in the negotiations.

V. In the negotiations

Even after all of the planning, the actual negotiations can be completely unpredictable. The possible scenarios are almost infinite in number, but there are some situations that commonly arise. We will try to outline some of these in an effort to give a feel for what issues might interrupt the smooth and successful bargaining the physicians would like to achieve.

A. Valuators. Because of the restrictions of the Stark and anti-kickback laws and regulations, almost any negotiations with hospitals will involve a valuator who will have ultimate say over the price that the parties negotiate. In order to maintain compliance with these laws, the hospitals and physicians must be able to prove that the payments from the hospital are fair market value. Though a valuation is not always required by the hospital, it should be expected in most hospital-physician negotiations. This raises a number of problems for the physicians.

The first question is how to determine the identity of the valuator. If possible, the best option is to reach an agreement between the parties on the valuator. Often, many of the big hospital systems will have a list of approved valutors from which the physicians can choose. These valutors are not often trusted by the physicians, because they regularly do work for the hospital system and, thus, their credibility is questioned. Sometimes it is possible for the physicians to suggest other credible and respected valutors as alternatives and have the hospital choose from their list. However, this is often a sticking point and the hospital refuses to use a valuator not on their list. The outcome of this disagreement will often depend on the leverage of the physicians. If the hospital prevails and refuses to go outside its list, the value of having an independent valuator for the physicians is limited. It can serve to reassure the physicians that the valuation reached by the hospital is reasonable. However, if there is a substantial difference between the physicians' valuation and the hospital's, it is unlikely that the hospital will agree to the physicians' valuation. The only alternative for the physicians in that situation is most often to refuse to contract with the hospital.

The medical groups should understand that, most of the time, the valuations of the different valutors are rarely far apart. The methodologies of valutors have become fairly uniform and there is not much room for disagreement. Thus, the likelihood that the physicians' valuation will be substantially greater than the hospital's appraisal is unlikely. That being said, it is possible that two valutors comparing their results can agree on some changes that could be helpful to the physicians. The chance of achieving a better result will have to be contrasted with the cost for these appraisals, which can be significant.

Another sleeper problem that can significantly impact a negotiation is the time-limited nature of the valuations. Many times negotiations with a hospital can be quite protracted. If a valuation is obtained early in the negotiations, it can expire in approximately twelve months if the negotiations are not concluded. This is not a happy situation for either the hospital or the physicians, as the valuation can be substantially different from year to year. Everyone should be aware of this potential difficulty.

Another potential problem involving valuations is the hospital's need to have a method to confirm the productivity of the physicians. Often the valuations are built upon assumptions of physician productivity. Consequently, the valutors will require the demonstration of a minimum productivity in order to justify the compensation. This can be measured in relative value units or time. This requirement is often a shock to physicians who are certainly not used to meeting requirements to keep time. When faced with this mandated productivity, it is possible to negotiate dollars such that a reduction in relative value units or hours in one year will not impact compensation or, if it does, the impact will only occur in subsequent years. Also, it is important to assure that greater production than required can result in higher compensation. For the negotiators it is important to understand the nuances of these valuations and productivity mandates and be prepared to respond to the problems created by them. It is very difficult to negotiate away some of these compliance requirements. Instead, the physicians' negotiators need to be prepared to negotiate provisions that will mitigate the impact of the compliance requirements.

B. Time issues. As mentioned earlier, negotiation of some contracts can take substantial amounts of time. Many negotiations with health plans can be completed fairly quickly, but contracts for larger groups with substantial market power can be complicated and lengthy. Similarly, negotiations with hospitals or ACOs can also take substantial periods of time. The physicians need to be prepared for this possibility.

It should be an early issue in the negotiations to set a schedule for negotiations. How often are the negotiators going to meet? In complicated negotiations it is often best to set a series of meetings with topics for discussion at each meeting early on in the negotiation process. Otherwise inertia can set in and the discussions can be delayed interminably as neither side is ever forced to deal with the transaction problems.

C. Oh, you can't do that! As anyone participating in the health care industry over the last fifteen years knows, there significant compliance restrictions imposed on transactions involving physicians and hospitals, and even physicians in health plans. One of the common issues faced by physicians in these negotiations is a legal response by the opponent that a proposal is impossible because it is illegal. This can oftentimes occur after the opponent has tentatively agreed to a proposal but has run it by legal counsel who has opined that the proposal is not possible under federal or state law. This is a very difficult option for most physicians to overcome without retaining serious legal consultants. First, if there is credible legal counsel representing the physicians, the opponent's legal staff will be less cavalier about preparing an opinion that declares a proposal illegal. Second, oftentimes knowledgeable legal counsel make small changes or adjustments that will enable the physicians to achieve their goals without running afoul of the law. This obviously creates more cost for the physicians, but this is such a common occurrence that legal counsel is often a very valuable ally in negotiations.

D. Trying to avoid the issue by issue negotiation. In most negotiations, there are a number of significant points that need to be hammered out between parties. If it is at all possible, a physician should not acquiesce or come to an agreement on each issue one at a time. Instead, it is a better practice to withhold final agreement on any one issue until all concerns have been addressed. All too often, the group may have to compromise on one position, but can acquire an advantage by trading off that compromise for another goal on another issue. If you reach final agreement on one item, it is more difficult to return to that item and secure a modification as a quid pro quo for a compromise you made on another late topic. In reality, this is a difficult strategy to work since it is natural to deal with one issue at a time. However, perhaps the best technique is to simply state that as to one issue the group has gone as far as it can go and will look at the whole package once it is complete.

E. Techniques for breaking stalemates. At times the parties can reach a point in the negotiations where no progress is being made. There are some techniques that can be used to break through the stalemate.

1. **Change the subject.** Often times the parties get locked up over one issue. Even though it may be an essential issue, it may be useful to drop the issue momentarily and move on to other points. This allows the participants to get off of the divisive topic and move on to easier subjects. This change of topic can give everyone a chance to reduce the posturing and act cooperatively. When the parties return to the crucial issue, the parties may be able to get a fresh start.
2. **Introduce a new participant.** Sometimes the parties in the negotiations can get stale and contentious. Bringing in a new participant with a fresh perspective can be helpful. Usually this personality needs to be a more conciliatory person that can break the repetitive debates that are bogging down the talks.
3. **Try a side door.** When the negotiating team is making no headway, it is common to try to contact someone else in the opponent's hierarchy. This can often be done with a person who is not a part of the negotiating team. This allows for the new negotiator to talk to the person from the opponent and suggest that the negotiators for both sides are missing some important opportunities for solutions. However, this should be done only with the understanding of the

negotiating team for the physicians. Independent overtures by physicians can be very destructive of the group's negotiating position.

4. **Mediation.** Another option in a stalemate situation is to suggest the use of a mediator to resolve a difficult issue. The mediation is not binding, but it is amazing how often an independent third party can assist two sides that seem to be entrenched in opposite positions.
5. **Good cop/bad cop.** Earlier, we mentioned the possibility of setting up a good cop/bad cop scenario. It may sound like something from a bad television cop show, however, it can be quite effective to avoid stalemates. The bad cop can take positions that help create a strong negotiating position. The opponent can focus its ire on that person. Meanwhile the good cop can be in a position to suggest compromise solutions as a seemingly independent voice. The bad cop can even reject the proposals by the good cop, but it allows for some discussion of the possibilities for a solution.

VI. Conclusion

In the changing health care world today, physicians will have to learn new skills, and one of the most important is negotiation. Their success in the coming years will depend to a great degree on what types of deals they can construct with the other players like health plans, ACOs and hospitals. This means that physicians will have to spend as much time preparing and planning for these negotiations as they do on other aspects of their business. The discussion above has emphasized the need to enter negotiations prepared in every aspect of the bargaining process. As mentioned, planning is absolutely essential; the physicians must have a clear-headed understanding of their goals and their leverage in the market. A failure to appropriately understand the goals of the group and its power in the discussions will result in unhappy results. It is hard and not often much fun, but the process is fundamental to the practice of medicine.

Chapter 12: Joint contracting/Collective bargaining

Wes Cleveland

I. Introduction

For physicians to create and successfully participate in the kinds of innovative health care delivery models that are essential to controlling costs and improving health care, they must be able to collaborate. The ability of independent, competing physicians to jointly contract with health insurers and other payers is often the key to ensuring the achievement of their mutual quality and cost goals. Joint contracting—i.e., allowing independent, competing physicians to collaborate and negotiate with payers as a single unit—is often essential, because it ensures each physician’s commitment to, and accountability for, the collaboration’s cost and quality improvement goals, and it ensures that the payer is committed to the delivery system as a whole.

II. Favorable antitrust treatment for physicians who are financially integrated

Federal and state antitrust laws dictate the extent to which independent, competing physicians may collectively negotiate contract price terms. The antitrust laws that prohibit independent, competing physicians from engaging in collective price negotiations typically do not preclude those activities when undertaken by physicians who have financially integrated their practices according to guidance issued by the U.S. Department of Justice (DOJ) and the Federal Trade Commission (FTC). In their 1996 Statements of Antitrust Enforcement Policy in Health Care (“Statements”),⁴⁸ the DOJ and FTC described the kinds of physician financial integration that enables physicians to receive favorable antitrust review of conduct constituting collective price negotiations. Financial integration occurs under the Statements when physicians share “substantial financial risk” for the costs of health care services.⁴⁹

Many of the kinds of risk arrangements described in the preceding chapters are likely to satisfy the FTC’s and DOJ’s requirements for financial integration, because physicians participating in those arrangements typically will be sharing substantial financial risk. For example, the Statements recognize that withhold arrangements are one of the ways in which physicians may financially integrate. More specifically, favorable antitrust review is available to physician networks where a significant portion of fee-for-service payments are withheld and placed in one or more risk pools.⁵⁰ The Statements do not specify the size of the withhold or risk pool. However, FTC advisory letters suggest that a 15 percent withhold may not be sufficient⁵¹ to justify the joint price negotiations, while a withhold within a 15 to 20 percent range may be sufficient.⁵² How large the withhold will need to be to constitute financial integration sufficient to qualify for favorable antitrust review will likely depend on a case-by-case analysis and depend on factors such as how important membership in the network is to participating physicians, and how many patients will be subject to the withhold arrangement.

⁴⁸ The Statements may be accessed at www.ftc.gov/bc/healthcare/industryguide/policy/hlth3s.pdf.

⁴⁹ See Statement 8, concerning physician network joint ventures.

⁵⁰ Id

⁵¹ Letter from FTC to Paul W. McVay, President, ACMG, Inc. (July 5, 1994), available at <http://www.ftc.gov/bc/adops/007.shtm>

⁵² Letter from FTC to David V. Meany, Esq., on behalf of Yellowstone Physicians, L.L.C., (May 14, 1997), available at <http://www.ftc.gov/bc/adops/yelltone.shtm>

The Statements explicitly recognize other types of financial integration. In addition to substantial withholds/risk pools, Statement 8 concerning physician network joint ventures states that independent, competing physicians may share substantial financial risk by agreeing with a health plan to provide services under a capitated payment. Statement 8 also recognizes that physician participation in global or case-rate payment methodologies are another means by which independent, competing physicians may financially integrate. Other means of sharing substantial financial risk that the Statements recognize include agreements whereby participating physicians are compensated based on a predetermined percentage of health plan premium or revenue, or where significant financial rewards or penalties are used to motivate physicians to achieve specified cost-containment budgets or targets.

It is important to note, however, that the Statements' list of substantial risk-sharing arrangements is not exclusive. Statement 8 states that, "The Agencies recognize that new types of risk-sharing arrangements may develop. The preceding examples do not foreclose consideration of other arrangements through which the participants in a physician network joint venture may share substantial financial risk..." Accordingly, even the types of risk arrangements discussed in this resource which are not cited in the Statements, such as bundled payments or shared savings programs, may nevertheless be appropriate vehicles through which independent, competing physicians may share substantial financial risk. For further information concerning how physicians may achieve financial integration, see "[Competing in the Marketplace: How physicians can improve quality and increase their value in the health care market through medical practice integration, second edition,](#)" which may be accessed on the AMA website. Further information concerning integration and antitrust can be accessed on the [AMA's Payment Models Resources](#) website.

III. Clinical integration is another means of obtaining favorable antitrust review of joint price negotiations

The sharing of substantial financial risk is not the only avenue through which independent, competing physicians may obtain favorable antitrust review with respect to joint price negotiations. Clinical integration is another means by which such physicians may obtain favorable review. So, even if collaborating physicians do not share sufficient risk to constitute the type of financial integration described in the Statements, e.g., if the physicians integrated only with an eye to developing infrastructure that would enable them to collectively report practice data and thereby obtain a "pay-for-reporting" bonus, clinical integration may still be an avenue for more lenient review of collective price negotiations. Under Statement 8, physicians can evidence the requisite clinical integration by implementing an active and ongoing program to evaluate and modify practice patterns by the physician participants and by creating a high degree of interdependence and cooperation among the physicians to control costs and ensure quality. Such a program may include: (1) establishing mechanisms to monitor and control utilization of health care services that are designed to control costs and assure quality of care; (2) selectively choosing network physicians who are likely to further these efficiency objectives; and (3) the significant investment of capital, both monetary and human, in the necessary infrastructure and capability to realize the claimed efficiencies. As in the case of financial integration, both the DOJ and FTC in Statement 8 indicate that (1) through (3) above are not the only kinds of indicia evidencing sufficient clinical integration. For a much more detailed discussion concerning how physicians may evidence the type of clinical integration that will result in the application of favorable antitrust review to participating physicians' joint negotiating activity, see "Competing in the Marketplace" and Payment Models Resources at the websites listed above.

III. Market power considerations may limit the size of the physician network

The ability of financially or clinically integrated physicians to engage in collective price negotiations is not without limits. More specifically, although a financially or clinically integrated network of independent, competing physicians may otherwise be able to jointly negotiate price-related information with health insurers, those physicians will only be able to do so as long as their network does not possess market power. Determining the extent to which a physician network possesses market power typically requires a complicated analysis. For further information regarding this issue, please see "[Competing in the Marketplace.](#)"

Chapter 13: Ethical implications of financial incentives in Managed Care Contracts

Wes Cleveland

Physicians who enter into contracts with managed care organizations that include financial incentives should consider the ethical concerns raised by such arrangements. The American Medical Association Council on Ethical and Judicial Affairs has addressed the ethical implications of participating in a variety of payment mechanisms, which include financial incentives that may influence a physician's clinical decision making. These ethical opinions are set forth below.

Ethical Opinion 8.051: Conflicts of Interest under Capitation

The application of capitation to physicians' practices can result in the provision of cost-effective, quality medical care. It is important to note, however, that the potential for conflict exists under such systems. Physicians who contract with health care plans should attempt to minimize these conflicts and ensure that capitation is applied in a manner consistent with patients' interests.

1. Physicians have an obligation to evaluate a health plan's capitation payments prior to contracting with that plan to ensure that the quality of patient care is not threatened by inadequate rates of capitation. Physicians should advocate that capitation payments be calculated primarily on the basis of relevant medical factors, available outcomes data, the costs associated with involved providers, and consensus-oriented standards of necessary care. Furthermore, the predictable costs resulting from existing conditions of enrolled patients should be considered when determining the rate of capitation. Different populations of patients have different medical needs, and the costs associated with those needs should be reflected in the per-member-per-month payment. Physicians should seek agreements with plans that provide sufficient financial resources for all care that is the physician's obligation to deliver and should refuse to sign agreements that fail in this regard.
2. Physicians must not assume inordinate levels of financial risk and should therefore consider a number of factors when deciding whether or not to sign a provider agreement. The size of the plan and the time period over which the rate is figured should be considered by physicians evaluating a plan, as well as in determinations of the per-member per-month payment. The capitation rate for large plans can be calculated more accurately than for smaller plans because of the mitigating influence of probability and the behavior of large systems. Similarly, length of time will influence the predictability of the cost of care. Therefore, physicians should advocate for capitation rates calculated for large plans over an extended period of time.
3. Stop-loss plans can prevent the potential of catastrophic expenses from influencing physician behavior. Physicians should ensure that such arrangements are finalized prior to signing an agreement to provide services in a health plan.
4. Physicians must be prepared to discuss with patients any financial arrangements which could impact patient care. Physicians should avoid reimbursement systems that, if disclosed to patients, could negatively affect the patient-physician relationship.

Ethical Opinion 8.054: Financial Incentives and the Practice of Medicine

In order to achieve the necessary goals of patient care and to protect the role of physicians as advocates for individual patients, the following statement is offered for the guidance of physicians:

1. Although physicians have an obligation to consider the needs of broader patient populations within the context of the physician-patient relationship, their first duty must be to the individual patient. This obligation must override considerations of the reimbursement mechanism or specific financial incentives applied to a physician's clinical practice.
2. Physicians, individually or through their representatives, should evaluate the financial incentives associated with participation in a health plan before contracting with that plan. The purpose of the evaluation is to ensure that quality of patient care is not compromised by unrealistic expectations for utilization or by placing that physician's payments for care at excessive risk. In the process of making judgments about the ethical propriety of such reimbursement systems, physicians should refer to the following general guidelines:
 - a. Monetary incentives may be judged in part on the basis of their size. Large incentives may create conflicts of interest that can in turn compromise clinical objectivity. While an obligation has been established to resolve financial conflicts of interest to the benefit of patients, it is important to recognize that sufficiently large incentives can create an untenable position for physicians.
 - b. The proximity of large financial incentives to individual treatment decisions should be limited in order to prevent physicians' personal financial concerns from creating a conflict with their role as individual patient advocates. When the proximity of incentives cannot be mitigated, as in the case of fee-for-service payments, physicians must behave in accordance with prior Council recommendations limiting the potential for abuse. This includes the Council's prohibitions on fee-splitting arrangements, the provision of unnecessary services, unreasonable fees, and self-referral. For incentives that can be distanced from clinical decisions, physicians should consider the following factors in order to evaluate the correlation between individual act and monetary reward or penalty.
 - i. In general, physicians should favor incentives that are applied across broad physician groups. This dilutes the effect any one physician can have on his or her financial situation through clinical recommendations, thus allowing physicians to provide those services they feel are necessary in each case. Simultaneously, however, physicians are encouraged by the incentive to practice efficiently.
 - ii. The size of the patient pool considered in calculations of incentive payments will affect the proximity of financial motivations to individual treatment decisions. The laws of probability dictate that in large populations of patients, the overall level of utilization remains relatively stable and predictable. Physicians practicing in plans with large numbers of patients in a risk pool therefore have greater freedom to provide the care they feel is necessary, based on the likelihood that the needs of other plan patients will balance out decisions to provide extensive care.
 - iii. Physicians should advocate for the time period over which incentives are determined to be long enough to accommodate fluctuations in utilization resulting from the random distribution of patients and illnesses. For example, basing incentive payments on an annual analysis of resource utilization is preferable to basing them on monthly review.
 - iv. Financial rewards or penalties that are triggered by specific points of utilization may create enormous incentives as a physician's practice approaches the established level. Therefore, physicians should advocate that incentives be

calculated on a continuum of utilization rather than a bracketed system with tiers of widely varied bonuses or penalties.

- v. Physicians should ascertain that a stop-loss plan is in place to prevent the costs associated with unusual outliers from significantly impacting the reward or penalty offered to a physician.
3. Physicians should also advocate for incentives that promote efficient practice but are not designed to realize cost savings beyond those attainable through efficiency. As a counterbalance to the focus on utilization reduction, physicians also advocate for incentives based on quality of care and patient satisfaction.
4. Patients must be informed of financial incentives that could impact the level or type of care they receive. Although this responsibility should be assumed by the health plan, physicians, individually or through their representatives, must be prepared to discuss with patients any financial arrangements that could impact patient care. Physicians should avoid reimbursement systems that, if disclosed to patients, could negatively affect the physician-patient relationship.

Ethical Opinion 8.056: Physician Pay-for-Performance Programs

Physician pay-for-performance (PFP) compensation arrangements should be designed to improve health care quality and patient safety by linking remuneration to measures of individual, group or organizational performance. To uphold their ethical obligations, physicians who are involved with PFP programs must take appropriate measures to promote patients' well-being.

1. Physicians who are involved in the design or implementation of PFP programs should advocate for:
 - a. incentives that are intended to promote health care quality and patient safety, and are not primarily intended to contain costs;
 - b. program flexibility that allows physicians to accommodate the varying needs of individual patients;
 - c. adjustment of performance measures by risk and case-mix in order to avoid discouraging the treatment of high-risk individuals and populations;
 - d. processes to make practice guidelines and explanations of their intended purposes and the clinical findings upon which they are based available to participating physicians.
2. Practicing physicians who participate in PFP programs while providing medical services to patients should:
 - a. maintain primary responsibility to their patients and provide competent medical care, regardless of financial incentives;
 - b. support access to care for all people and avoid selectively treating healthier patients for the purpose of bolstering their individual or group performance outcomes;
 - c. be aware of evidence-based practice guidelines and the findings upon which they are based;
 - d. always provide care that considers patients' individual needs and preferences, even if that care conflicts with applicable practice guidelines;
 - e. not participate in PFP programs that incorporate incentives that conflict with physicians' professional values or otherwise compromise physicians' abilities to advocate for the interests of individual patients.

Ethical Opinion 8.132: Referral of Patients: Disclosure of Financial Limitations

Physicians should always make referral decisions based on the best interests of their patients, regardless of the financing and delivery mechanisms or contractual agreements between patients, health care practitioners and institutions, and third-party payers. When physicians agree to provide treatment, they assume an ethical obligation to treat their patients to the best of their ability. If a physician knows that a patient's health care plan or other agreement does not cover referral to a non-contracting medical specialist or to a facility that the physician believes to be in the patient's best interest, the physician should so inform the patient to permit the patient to decide whether to accept the outside referral.

Physicians must not deny their patients access to appropriate medical services based upon the promise of personal financial reward or the avoidance of financial penalties. Because patients must have the necessary information to make informed decisions about their care, physicians have an obligation to assure the disclosure of medically appropriate treatment alternatives, regardless of cost.

Physicians must assure disclosure of any financial inducements that may tend to limit the diagnostic and therapeutic alternatives that are offered to patients or that may tend to limit patients' overall access to care. Physicians may satisfy this obligation by assuring that the managed care plan makes adequate disclosure to patients enrolled in the plan. Physicians should also promote an effective program of peer review to monitor and evaluate the quality of the patient care services within their practice setting

Chapter 14: Evolving compensation methodologies for employed physicians in an era of changing clinical practice, reimbursement and health reform

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I. Introduction

In an attempt to achieve the triple aim of lower costs, higher quality and better health, payers, especially the Centers for Medicare and Medicaid Services (CMS), have been introducing additional financial incentives, quality reporting and care coordination approaches into their reimbursement models. While physician employers, whether physicians practices, hospitals or health systems, are still mostly paid based on fee-for-service and capitated risk payer methodologies, increasingly hospital, health system and physician group reimbursement has elements which include:

- financial incentives that tie to achievement of specific quality or performance measures;⁵³
- incentives for managing total cost of care or increased use of generics;
- bundled payments to achieve more cooperation between stakeholders to achieve outcomes;
- global capitation for professional services, institutional services and/or pharmaceuticals;
- a global reimbursement for episodes of care;
- penalties or lower reimbursement for preventable hospitalizations; and
- additional payments to patient-centered medical homes.

This article explores new individual physician compensation models that will enable integrated delivery systems, accountable care organizations (ACOs), and physician practice organizations to better align compensation with these payer incentives. These incentives typically address management of costs associated with a patient or episode of care or provide disincentives for events which result from poor quality. We will discuss changing reimbursement methodologies and care delivery models and suggest ways to modify the prevailing compensation models for employed physicians to create meaningful incentives and alignment suggested by these trends.

The first mover opportunity for physicians is to increase their income from earning financial incentives for their demonstrable quality, outcomes and population and patient health and disease management. All these are attempts to pay for outcomes rather than activity. Each will have levels of risk for physicians depending on whether the parent organization is capable of managing risk, if the risk resides within the confines of the physician practice, or if some or all of the risk is borne by the physician as a withhold.

⁵³ An overview of international reviews evaluating the effectiveness of financial incentives in changing healthcare professional behaviors and patient outcomes found little conclusive evidence that introducing quality incentives change healthcare professionals' practice." An overview of reviews evaluating the effectiveness of financial incentives in changing healthcare professional behaviors outcomes." *Cochrane Database of Systematic Reviews* 7. 2011: *Web of Knowledge*. Web. 31 June 2012.

II. How are most employed physicians currently compensated?

A. Fee-for-service. The physician compensation methodologies adopted by various health systems and group practices in markets dominated by fee-for-service have heretofore prioritized different incentives both as to the nature of the incentive and the specific measurement. These physician compensation systems generally measure physician productivity on an individual or departmental basis and from a fee-for-service standpoint. Payments based on satisfaction of quality measures typically are in addition to the usual fee-for-service payments and do not necessarily focus on cost reduction, and quality-based incentives typically focus on patient encounters and surveys, process measures, not outcomes or population health management⁵⁴. Accordingly, generally 80% to 100% of a physician's compensation, if not a straight fixed salary, is tied to individual "productivity" and the non-financial incentives typically address citizenship, quality, achieving system goals, or program compliance, with little incentive for care co-ordination. See [Appendix one](#).

In the rash of physician integration transactions over the past four years, compensation methods have been less about alignment and more about how to get the deal done and to provide security to the physicians in an environment where fee-for-service payment amounts are either flat or declining. In order to make these transactions commercially reasonable, the compensation incentives have been designed to assure a stream of revenue from physician's fee-for-service productivity. This has often been supported by achieving higher reimbursement from transferring group practice ancillaries to outpatient departments of hospitals to support that compensation. Worse yet, the incentives have been structured as a withhold, and physician receipt of 100% of scheduled compensation has been conditioned upon achieving all the redirects or quality measures.

1. Historic methods for measuring physician productivity. Most physicians employment agreements measure productivity either from a "top line" perspective by tying physician compensation to that physician's measured fee-for-service production (in capitated environments it might also be expressed as panel size based upon lines of business, quality measures, and coding accuracy) or from a "bottom line" or net margin approach by matching physician allocated revenue to attributed expenses in producing that revenue. Under the top line approach, expense and resource utilization are employer-controlled. In contrast, the "bottom line" approach often allows the physician (or in the context of a physician services agreement the physician group) greater latitude and corresponding accountability for managing operating expenses, revenue cycles, and patient intake practices.

Health systems generally have paid individual physician salaries, many with little incentive for production or outcomes. When productivity incentives or accountability are measured, typically the measurement is top line via work relative value units (wRVUs). These wRVU-based payment systems use personally performed physician services, but may include incident to ancillary or physician extender services (subject to Stark limitations). The objective of this approach is to remove payer mix from the equation and to produce productivity data that hospitals and not-for-profit payers can use for required fair market value appraisals. More enlightened contracts extracted a higher fee-for-service multiple if contracted providers controlled the overall cost of care more efficiently.

Health system compensation often supplements productivity measures with bonuses/withholds for meeting quality metrics, patient satisfaction scores, participation in administrative duties, and chart completion. Generally "citizenship" is expected, but not separately compensated. Finally, there is little uniformity among health systems as to the role of productivity in determining physician compensation as many prefer straight salary arrangements rather than tying physician compensation to unit of service productivity.

⁵⁴ Physician Quality Reporting System eligibility and means of participation are available at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PORS/index.html?redirect=pqrs>

Certain specialties such as hospitalists and pediatrics often use departmental productivity metrics to assure coverage and avoid payer mix anomalies. These can be applied to the group, but many times not to the individual. Incentives can be structured as "bonuses," "floor productivity requirements," or "withholds." At present, there is little uniformity among health systems as to the role of productivity in determining physician compensation, as many prefer straight salary arrangements rather than tying physician compensation to unit of service productivity.

In contrast, physician groups often look to bottom line methods by crediting physicians with revenues and allocating expenses. Depending on the specific payment methodology, these can be allocated at the physician, office site, or department level. There are three general approaches to measuring productivity: (1) production-only calculated as attributed revenue minus allocated expense; (2) production with sharing of overhead evenly or by an equal percentage; and finally, (3) a portion of reimbursement based upon the physician group's (or a department within the physician group) achieving pre-determined non-financial goals of the health system (implementation of protocols, use of electronic medical records [EMR], patient satisfaction, patient outreach/education, etc). Group practices often carry the "net profit" concepts to ancillary services within the group practice (subject to Stark limitations) by allocating a portion of all of such ancillary margins to offset (or, if negative, to increase) individual physician allocated expenses.

2. Practical challenges of the current fee-for-service model. Compensation based on individual physician services almost inevitably results in a creation of silos and makes it very difficult to implement team-based care initiatives. RVU models do not take into account payer mix, group objectives and outcomes and uneven distribution of payer mix by individual physicians. These approaches also do not hold physicians accountable either for practice expenses or for revenue cycle management through improved realization via timely and complete intake and billing and fewer claim denials and expensive resubmission for missing data. These models also present legal issues in assuring a Stark "group practice" exception with respect to division of ancillary revenue profits or in compensating physicians for "incident to" services based on the employer of the clinician. This is because absent a specific exception under Stark, physicians are prohibited for having a financial interest in entities to which they make referrals of designated health services.

These productivity measures also do not incent behaviors which might produce performance bonuses from governmental or private payers.⁵⁵ Now that health systems are facing lower margins, penalties for certain never events, and payers and employers are insisting on accountability for rising per capita expenditures, there are compelling reasons to change. For most practices, the change will be evolutionary and driven by new payer incentives, cost of care by individual physician decisions, and group mandates for quality or meaningful use of electronic health records (EHR).

B. The current state of capitation. Mature groups with capabilities to manage cost, quality, and networks have capitated with the payer. This allows them more control of their destiny. Capitation at the group level means they are receiving a monthly check based upon number of assigned or attributable lives, age-sex mix and in some cases the illness burden. This is defined as a risk-adjusted factor. This payment is in the form of per member per month (PMPM).

The types of capabilities an organization may need to manage capitation are found in the following departments: legal, contracting, network management, finance, analytic, actuary, claims, and medical management. The above can be complicated, but usually when a group takes risk it is delegated many functions a health plan would otherwise perform. The above departments will allow the organization to carry out the delegated functions and manage quality and cost. Medical management would include discharge planning from the hospitals, complex case management, disease management, concurrent

⁵⁵ A study conducted in the United States on improvement incentives in relation to measures of high-quality ambulatory care concluded that an inconsistent relationship exists between the two factors. Bishop, Tara F., Federman, Alex D., Ross, Joseph S. "Association between physician quality improvement incentives and ambulatory quality measures." *The American Journal of Managed Care* 18.4 01 April 2012: 126-34. *Web of Knowledge*. Web. 31 May 2012.

review in the hospital, managing hospitalists and more. For more information on capitation, see chapter four, **Capitation**.

Once a contract with the health plan is capitated, the organization has many options to align incentives with its physicians and other health care providers. Assuming the contract capitates services for primary care provider (PCP) and high-volume specialists, the PCP may be paid for the assigned panel of patients on a PMPM basis just like the organization, although individual capitation is very challenging due to the potential lack of adequate panel size and the limitations of current risk-adjustment systems, and should not be undertaken without significant thought and provision for risk mitigation, such as stop-loss insurance with a relatively low attachment point. Again, see chapter four, **Capitation**, for further information. Other payment types are made using fee-for-service with a bonus, case rates for time periods, a certain payment amount per patient seen for a period of time no matter the services, contact capitation, or case rate based upon an episode of care (certain payment per patient referred through the entire episode of care). For PCPs and specialists, this requires knowledge of the cost of care both by the practitioner and for all referred or prescribed treatments, tests, consults, pharmaceuticals, therapies, and rehabilitation services, as well as patient self-referred health services. Entering into these types of agreements has a great deal of positives,⁵⁶ but unless there is good and complete data, knowledge of how to analyze the data, scale, and adequate protection from adverse selection including appropriate risk adjustment and cost effective re-insurance, the financial consequences can be dire. Again, see chapter four, **Capitation**, for a more detailed discussion.

C. Bonuses. Regardless of the type of base payment, many times there is a bonus based on financial cost projections, but paid based upon quality, service and administrative measures. This assures that there are funds there to pay, while limiting any incentive to shrink, reduce or delay necessary care or necessary but expensive treatment.

III. The current transformation in payment and health care service delivery

A. New payer incentives/expectations generally. To address the challenges of the fee-for-service model and to direct resources towards population health, increased patient access to primary care services, and team-based medicine, a number of new payer incentives/expectations have been introduced and focused on demonstrable improvement in or achievement of:

- programs and methods for patient engagement to improve their health and comply with necessary monitoring and regimens;
- improved care coordination, especially in transitions of care, which reduces cost or prevents readmissions and manage post-discharge medications;
- use of evidence-based medicine;
- cost containment, both as to assigned populations and specific episodes of care;
- population health and disease management programs which reduce hospital admissions and demand for acute interventions;
- improved quality of patient encounters and demonstrable outcomes; and
- avoidance of preventable readmission, in-hospital medication errors, hospital acquired conditions, never events and disease management, National Committee for Quality Assurance (NCQA) recognition⁵⁷ and “meaningful use” of electronic health records (EHR).

⁵⁶ A study conducted in the United States suggested physicians in highly capitated practices had the lowest total costs and intensity of care. Landon, Bruce E., Reschovsky, James D., O'Malley, A. James, Pham, Hoangmai H., Hadley, Jack. "The Relationship between Physician Compensation Strategies and the Intensity of Care Delivered to Medicare Beneficiaries." *Health Services Research* 46.6 Dec 2011: 1863-1882. *Web of Knowledge*. Web. 01 June 2012.

⁵⁷ Criteria and standards for each level of NCQA's PCMH recognition are available at: <http://www.NCQA.org/tabid/631/default.aspx>

These, and other, new payer expectations, and their roles in much-discussed emerging payment and delivery models such as ACOs, bundled payment arrangements, and patient centered medical homes (PCMHs) are extensively discussed in “ACOs, CO-OPs, and other options: A ‘how to’ manual for physicians navigating a post-health reform world 2nd edition.” For ease of comparison a brief comparison of these models is attached as Appendix two.

B. CMS’ development of the Medicare Shared Savings Program and the impact of Medicare Advantage programs

In many respects, Medicare Advantage under a full risk provider agreement through an Independent Practice Association (IPA) or staff model and Medicare Shared Savings Program (MSSP) ACOs share a similar set of incentives-the principal difference being Medicare Advantage's (MA) prospective patient assignment and greater in-network control, versus the ACO's retrospective patient assignment coupled with unrestricted patient choice in the selection and geographic location of the Medicare provider. The financial risks are greater in MA programs since there is no fee-for-service component equivalent to that paid to ACO participants. Both programs, however, incent improved and increased access to primary care services and care coordination in the transitions of care as core clinical attributes to enable the cost savings and quality benchmarks to be achieved.

Physician groups and health care delivery systems alike will need significant capabilities in order to manage the risk. In addition, each individual physician participating in the arrangement must also realize the utilization patterns, his or her own cost of care and how illness burden can affect the overall cost of care. By understanding these patterns, contracts can be set up that will control cost, improve quality, lower utilization and advantage the practicing physician monetarily.⁵⁸

C. Private payer and employer-based strategies. Increasingly, private insurers are experimenting with incentives for team-based care, quality or cost containment. In Colorado, for example, a consortium of insurers, self-insured employers, and primary care providers entered into a three-year pilot project in which PCPs were paid both fee-for-service and paid a PMPM fee based upon a commitment to progress to level 3 NCQA Patient-Centered Medical Home (PCMH) recognition. Numerous managed care agreements provide incentives for increased use of generics, quality reporting, reductions in certain costs or treatments, bundled payments for physician and hospital services or even tied to reductions in the projected total cost of care for assigned populations. In addition, insurers have been willing to pay facility fees for certain invasive procedures in physician offices whose surgical suites have been accredited in an attempt to lower costs of care.

We are starting to see payers implementing many initiatives using CMS demos, such as the Physician Group Practice Demonstration as the justification. In many ways, the private sector is trying creative experiments much faster than CMS, by, for example:

- Paying higher fee-for-service payments for practices that have PCMH certification;
- Paying physician practices a care management fee for being a certified PCMH;
- Paying gain sharing opportunities for lowering costs in PCMHs on PPO products;
- Payers buying physician groups-it is not just a hospital game anymore; and
- Payers starting physician group practices, and even independent physician associations.

No matter the strategy, the key elements for physician success are legal knowledge, contracting knowledge, care coordinated work flows in physician offices, and EHR use, preferably in conjunction

⁵⁸ A study conducted in the United States suggested physicians in highly capitated practices had the lowest total costs and intensity of care. Landon, Bruce E., Reschovsky, James D., O'Malley, A. James, Pham, Hoangmai H., Hadley, Jack. "The Relationship between Physician Compensation Strategies and the Intensity of Care Delivered to Medicare Beneficiaries." *Health Services Research* 46.6 Dec 2011: 1863-1882. *Web of Knowledge*. Web. 01 June 2012.

with participation in a health insurance exchange (HIE). Physicians should also know their outcomes so that information can be used for financial negotiations with the payers.

D. Fractionated payment methodologies often create the same challenges as fractionate delivery.

The above-referenced payer initiatives are generally payer and program specific. Accordingly, absent pilots or programs where multiple payers adopt the same payer metrics or markets where a single payer dominates the private insurance market, it may become more difficult to tie physician bonuses and incentives to a particular payer's incentive. Accordingly, any payer-driven model designed to reduce hospitalizations through better care coordination, use of PCMHs, or by assuring patients greater access to primary care services and specialty consultations will need to represent a significant portion of the physician employer's revenue or would need to drive market share to that hospital or health system employer to compensate for the reduced admissions and other health care service utilization that these payment methodologies often produce.

E. New clinical delivery models are driving change

1. Team-based care and care management. Tremendous pressure is being exerted in both public and private sectors to create a health care delivery system that is founded on a team-based approach. Physicians and health care providers that gear their work-flows and personnel to maximize care coordination for their patients will be rewarded. Prioritizing care coordination will require physicians to accept new responsibilities within the care coordination process and many physician practices to: retain care coordinators; create new job descriptions for office staff; and develop the ability to track multiple types of care transitions from various locations and all care ordered for, and specialists used by, the practice's patient population.

In addition, connections to your organization's care coordination team (if viable), or the payer's care coordination team, is vital in this team-based health care delivery transformation. (For further information regarding care coordination, please see section **II.D.2** of chapter nine **“Retaining independence while embracing accountability: Care coordination and integration strategies for small physician practices,”** which is part of the AMA publication entitled “ACOs, CO-OPs, and other options: A ‘how-to’ manual for physicians navigating a post-health reform world 2nd edition.” This ‘how-to’ manual may be accessed at www.ama-assn.org/go/aco). Such connection would include disease management coordinators, social workers, complex case managers, discharge planners at the hospitals, hospitalists, and care coordinators who can track the universe of transitions that may affect your patients, e.g., not simply transitions from hospital to home, but transitions to and from the hospital emergency department, skilled nursing facility, and long-term care facility, as well as inter-hospital transfers, changes with respect to insurance, changes in residence (e.g., relocation to another state), etc. Connecting the key clinical data sets with the appropriate, coordinated interventions is the key to improving quality and lowering cost. This is why a functioning health information exchange is important. An EHR will help coordinate care in your own office, but the HIE will coordinate care externally. As different reimbursement models emerge that reward administrative function as well as financial and clinical outcomes, this transition will become easier to perform.

2. Service line co-management and professional service agreements. An increasing number of hospitals are entering into departmental or service line co-management agreements or using professional service agreements with their physicians. The objective of these agreements is to create significant efficiencies and physician engagement in achieving per unit cost savings through equipment and supplies standardization, and to innovate care delivery to improve patient care quality and efficiency. These agreements typically provide incentives for quality improvements through the development and implementation of clinical care guidelines. Another cost containment objective is achieved through efficiency improvements both as to staff, utilization and coordinated and timely discharge assessments, instructions and post-discharge monitoring, and care coordination. Patient and staff satisfaction are typically measured. Finally, these service line agreements attempt to improve disease management, population health programs, and coordination at the transitions of care. While typically these service line agreements focus on specialists and inpatient quality measures, they can and should be structured to involve primary care physicians in the transition of care and to assure timely access to specialist care both

clinically and as part of patient education and engagement. An example of service line quality metrics for orthopedics is attached as [Appendix three](#).

III. How changes in health care delivery and payment will alter the way in which employed physicians are paid, and how you can adapt to those changes

A. Your payment will be based on measurable performance

1. Performance metrics as a foundational element in payment methodology. In this new health care delivery and payment environment, employed physicians' payment will increasingly depend on physicians' performance, as measured by a broad spectrum of metrics. Health systems and large physician groups have identified a number of metrics more closely aligned with health reform's triple aim that are not directly production based in terms of unit of service. These metrics include:

- Patient access via extended hours and appointment availability (effective only if tied to demonstrable reduction in ED use and admits which exceed the higher costs of primary care);
- Panel size generally deployed for providers receiving integrated or fully capitated reimbursement (typically contemplates a commercial/senior mix of 2,000 patients where seniors are weighted 3:1);
- Effective mid-level provider management and supervision since the pressure to coordinate care and have PCPs manage is high, but the numbers of PCPs is low; and
- Disease management (this is best if combined with a case management/care coordination program).

2. Metrics to consider for primary care. With respect to PCPs, payers are experimenting with supplements to fee-for-service compensation by incenting improved patient access to primary care services via supplemental payments. These supplemental payments physician employer to provide PCPs with shift differentials for evening and weekend office hours and help offset the cost of establishing and managing secure email communications with patients as to scheduling, assessment, medical records, reports, follow-through, and monitoring and the lost revenue from such uncompensated patient management services. Others compensate PCPs for the extent of their mid-level provider supervision and panel size, or pass through to the physician some meaningful use and e-prescribe benefits, or reward PCPs for NCQA achievement levels. Finally, other incentives are targeted around the establishment and improvement of disease management programs. Health systems also have tied incentives to participation in and development of community outreach and education programs intended to serve their core missions and expand their market reach for tertiary services while providing needed access to primary care. A number of payers publically offer either incentive-based or value-based programs for physicians or physician groups to adopt and use care guidelines, driving the quality of treatment their patients' receive.⁵⁹ Typical quality metrics would include the following pay-for-performance measures: Healthcare Effectiveness Data and Information Set (HEDIS) criteria, coding accuracy, ED rates as an indication of access, readmits rate to acute care facilities, meeting attendance, cost of care, generic usage, EHR adoption, etc.

⁵⁹ Many health insurers have announced primary care quality incentives, patient healthy lifestyle incentives or ACO incentives. For example, Anthem Blue Cross and Blue Shield has a primary care quality incentive program for primary care providers that includes a combination of chronic disease and preventive measures, both process and outcome based, as well as measures focused on technology and pharmacy utilization. The more detailed description of the program is at:

http://www.anthem.com/provider/noapplication/f5/s2/t0/pw_b155821.pdf?refer=ahpprovider&state=me

Aetna's incentive program also consists of incentives that impact its beneficiaries or its user's health care spending such as premium reductions through participating in programs such as Aetna Healthy Actions Program, See [Guidelines](#).

http://www.aetna.com/employer/commaterials/Roadmap_to_Wellness/incentiveprograms.html

United Healthcare is [introducing](#) a variety of value-based contracting approaches with greater emphasis on shared risk and accountability for improved outcomes. See also,

<http://www.uhc.com/live/uhc.com/Assets/Documents/ViewpointACO.pdf>. Other care programs can be found at: http://www.uhc.com/physicians/care_programs.htm.

3. Metrics for specialist. For specialists, payers seek to improve care coordination, and may do so by improving timely consults as measured by surveys or specific time frames, or by requiring a minimum number of unallocated scheduling slots. Other initiatives focus on transitions of care, creating expectations and rewards for specialist involvement and communication with respect to timely discharge assessments, approval and communication to PCPs of discharge plans and post-discharge medical reconciliation. To support these initiatives, some physician employers are compensating specialists for improving their timely consults and/or for open scheduling. Through the use of service line co-management services or properly structured gain sharing arrangements, specialists are being rewarded for on-time surgical starts, management of implant and other supply costs, and oversight of pre-admission and post-admission care coordination. Finally, specialists might be provided incentives for participating in improved patient access through medical neighborhoods. Some other metrics include: compliance of preferred drugs, readmits, cost of episode, availability in hospital, meeting attendance, surveys by PCP, and HEDIS-specific scores.

4. Measuring quality. For PCPs, quality metrics generally focus on preventive measures, patient satisfaction, citizen metrics, and system alignment. Examples are summarized in [Appendix four](#). Specialists are increasingly being asked to proactively improve and participate in care coordination. Similarly, metrics are being developed to address post-acute care, medication reconciliation, and discharge planning with the goal of reducing readmissions and of assuring that both PCPs and specialists have real time information regarding discharge, discharge notes and patient medications and post-acute therapies. An example of a payer medical home benchmarking chart is attached as [Appendix five](#) and a quality report against NCQA standards is attached as [Appendix six](#).

B. Payment may in large part also depend on the physician employer's ability to successfully manage financial risk

Many of the organizations that will be employing physicians will receive a substantial amount of their revenue within the context of risk arrangements. For example, more and more such organizations will want to acquire the ability to successfully engage in partial or global capitation arrangements, and a number of private and public initiatives are incentivizing organizations to move in this direction. See, e.g., the CMS Pioneer ACO Program. In those organizations receiving a substantial portion of their fees on a capitated basis, physician compensation will generally include a base salary coupled with bonuses based upon both individual and group achievement via sharing of payer withholds or bonuses. Productivity is generally determined based upon size of panel, office visits or patient encounters. Quality incentives focus on patient satisfaction, waiting times, and specific measures in the capitation agreements, as well as performance as determined by the types of metrics discussed in [III.A](#), above. See, for example, the Blue Cross and Blue Shield of Massachusetts Alternative Quality Contract.

It is very important to remember that in a capitated payment model, physicians are not rewarded for activity per se. Longer visits and administrative focus may actually prove more effective at reducing total health care costs, and thus reward the physician more than the traditional 10-15 minute visits. If reimbursement is tied to lowering cost and improving quality, then paying attention to these factors makes fiscal sense.

C. Adapting to changes in employed physician compensation

1. Commonality of all the care models and payment methodologies. Although this chapter has discussed a number changes that will take place with respect to payer-driven care models and payer reimbursement methodologies that will alter the way in which employed physicians are paid, all of these care models and reimbursement methodologies will require the following common capacities and characteristics:

- Contracting;
- Analytics;
- Outcome tracking and reconciliation;
- Physician and/or group accountability; and

- Some basis for quality and utilization review.

Where they differ is as to the risk assumed, the openness of the provider network, the degree of patient choice, and the specific financial and quality metrics being employed.

As the future becomes the present, each practice should consider changing to a care coordination model. In so doing, the practice's physicians can position themselves to anticipate, and take advantage of, changes in employment compensation. The care coordination model has been described previously, but more information can be attained at the [NCOA website](#) and further [resources](#) concerning care coordination can be accessed on the AMA website. As this transition happens, the practice should institute a disease registry (DR) to track all patients and whether the practice is complying with nationally recognized guidelines for preventive care and treatment of common diseases. All these can be embedded in the practice. The DR and associated review processes will ensure better results and improve compliance. Analytics need to be implemented which will track this and any other metrics that are embedded in the payment system to be sure the practice is properly rewarded for this activity.

2. Positioning your practice and simplifying complex decisions. We have found that physicians tend to do better when there are a series of small decisions rather than a large one. A large decision is whether to sell the practice to the local hospital, how to do it, for how much, and what should the employment agreement look like. If you look at what CMS is doing through payments or demonstration projects, several conclusions can be made. CMS is pushing for:

- EHR adoption;
- HIE connection so clinical information is available at the point of service;
- Care coordination;
- Tracking of outcomes and adherence to evidence-based guidelines; and
- Team approach so care is improved through the whole continuum.

This, in turn, will require that a physician be prepared to do all of the following:

- Purchase and implement an EHR, or EHR capability, e.g., cloud computing, after obtaining the appropriate assistance in making the choice and performing the implementation;
- Implement a disease registry and track your outcomes;
- Change the office workflows to maximize care coordination – acquiring a PCMH certification is at least 100 hours of work and \$1,000 in fees; and
- Obtain expertise from medical associations, hospitals, and larger physician groups. This would include contracting knowledge so as to leverage your outcomes for more reimbursement.

When the time comes for a big decision, then all the little ones will be done so the practice is prepared and of more value.

D. Anticipate and prepare for evolving salary agreements

Changes in existing compensation formulas generally will be driven by the needs of the physician's employer. Those health systems that currently use fixed-salary models may shift towards productivity models while maintaining quality standards. In contrast, those physician employers with pure productivity models may shift emphasis from productivity towards more team-based care and quality incentives. Still others will blend approaches.

Productivity, however measured (panel size, patient encounters, wRVUs, revenue minus expenses, call availability, office hours etc.), will likely continue to comprise between 85% to 95% of a physician's base compensation. Given the adage that "you are what you measure," physicians should be wary of compensation incentives that are triggered by new metrics which have not historically been tracked and addressed. Best alignment occurs when the process for developing the quality initiatives is led by physicians and the financial implications are introduced after a minimum of a year's operation in which

the measures are tracked. With the introduction of pay-for-performance at the hospital level, it is reasonable to assume that hospitals and health systems will seek to create incentives for the care coordination necessary to reduce readmissions within 30 days of discharge and physician efforts to help prevent "never events" and help achieve nationally recognized quality benchmarks.

The challenge in the pure physician employment context is that physicians lack the clinical control over many of the clinical and other services being performed at the various practice settings outside their offices or other site of their personally performed services. Accordingly, physicians should continue to advocate for professional services agreements and service line co-management agreements where they can more effectively impact the algorithms, care coordination, vendor selection, practice setting, and staff coordination necessary to meaningfully improve patient satisfaction, cost effectiveness and outcomes.

In addition to the above, more evolutionary changes, in those markets where major payers are shifting towards lower fee-for-service in exchange for group performance bonuses under a variety of care coordination, quality or cost effectiveness incentives, physicians can maximize both alignment and compensation by understanding the revenue drivers and identifying those components which they should manage and then share in the value produced.

E. The transparency imperative: what types of compensation information will the individual physician need, both prior, and often subsequent, to entering into an employment relationship?

As already discussed, just as practice revenue will increasingly be based on the practice's meeting applicable quality measures and successfully managing risk, so to will the employed physician's compensation depends on the employer's evaluation of the physician's quality performance and health care resource utilization. Accordingly, a physician offered an employment opportunity will be incapable of evaluating properly the appropriateness of the applicable compensation formulae or predicting *actual* payment amounts unless the physician receives accurate and complete information concerning:

- the specific quality and resource utilization metrics or standards that will be used to evaluate the physician's performance (or better yet, is able to help define those metrics);
- the employer's overall compensation methodology;
- the data that that methodology will use to determine both ultimate performance results and actual payment amounts; and
- the appraisal methodology being used to set (and perhaps cap) physician income.

Transparency with respect to compensation should also be present over the entire course of employment. In other words, agreements should be structured such that the employer, on an ongoing basis, provides the physician with accurate and complete performance and other financial and quality data to enable the physician to contemporaneously predict payment amounts and make practice adjustments, where necessary, to achieve reasonably expected compensation. Transparency with respect to those listed above will also enable the employed physician on the back end to evaluate the extent to which actual payments received adhere to the compensation formulae specified in the employment agreement. For further information on tracking quality and utilization, see chapter three, **Pay-for-performance programs**.

Transparency with respect to those listed above is unlikely by itself to produce a complete picture of all the factors that may affect compensation, and that the employed physician will therefore want to know. For example, it will not only be important for the physician to know *what* metrics the employer will be using to evaluate quality performance, but the physician will also need to know the extent to which those metrics are clinically appropriate for the physician's specialty and patient population. Again, see chapter three, **Pay-for-performance programs** for further information. Also, if the employer is involved in a risk arrangement, and if individual physician compensation will be based in part on the physician's meeting or beating a utilization budgets, then it is imperative that the physician understand whether the employer will adequately risk-adjust the physician's performance with respect to those budgets. See chapter eight, **Risk adjustment**, for additional information.

The physician also needs to understand up-front the extent to which the employer will support the physician's practice via health information technology and other infrastructure essential to: coordinate care internally and externally; manage patients (particularly those with chronic conditions); monitor patient compliance; and educate and otherwise remediate cases of patient noncompliance. In the most successful programs, physicians receive "coaches" who help them transform their practices to enable them to achieve the quality metrics being measured and to obtain the patient engagement and to utilize physician extender resources to maximum advantage.

As previously discussed, compensation can depend significantly on hours worked or wRVU production. In such cases, it may be crucial that the potential employer provide the physician with a reliable estimate concerning the amount of income the physician can expect to receive, given factors such as the employer's current patient population and patient demand.

For additional information concerning key physician employment issues where transparency is essential, e.g., appeal rights, covenants-not-to-compete, etc., please see the [**Annotated Model Physician-Group Practice Employment Agreement**](#). For additional information concerning the key issues that must be made transparent for physicians in the hospital employment context, see chapter eight, [**Hospital physician employment agreements**](#), which is part of the AMA publication entitled "[**ACOs, CO-OPs, and other options: A 'how to' manual for physicians navigating a post-health reform world 2nd edition**](#)."

Although it may appear from this discussion that employer transparency obligations primarily benefit the employed or prospectively employed physician, as opposed to the employer, this is not the case. For many physician practice employers, particularly the small or solo practices in which most of the physicians in the United States still practice, entering into an employment relationship with a physician is a very serious matter that involves a significant commitment of resources and is not without significant risk. Accordingly, once such a practice enters into an employment arrangement, the practice will be heavily invested in the arrangement's long-term success. Full transparency is key to maximizing the communication, alignment and trust which are essential to both ongoing physician satisfaction and practice transformation.

IV. Final tips

For the most part, healthcare markets are local or regional so there will not be a one-size-fits-all solution to your next agreement.

- Employed physicians and their hospital or health system employers may do better with dedicated administrators and areas of additional clinical responsibility including incident to services and management of ancillary services that enable values physicians the control necessary to be accountable for productivity, quality, patient outcomes and satisfaction.
- Quality incentives and other changing benchmarks or incentives should be developed under a process which is patient-centered and clinically sound, by also physician-led and physician-driven.
- Compensation plans vary significantly as to whether the value of excess wRVUs are recognized at a higher dollar per wRVU level (since fixed overhead is absorbed, as in tiered compensation plans) or at a lower dollar per wRVU (based upon appraiser data suggesting that the higher compensated physicians in the aggregate earn less per wRVU than their lower performing counterparts).
- As physician extenders become the norm, physicians should propose ways to be recognized for the clinical production of those clinicians. Thus, many agreements provide for "mid level provider" eligible wRVUs of nurse practitioners and physician assistants to be included in measuring the productivity of their supervising physician.
- Physicians should be prepared to discuss all compensation elements from quality incentives (Are they aspirational, tiered or reasonably achievable?), stipends/other compensation for selected administrative activities, call coverage and approved non-wRVU generating services (such as independent medical exams and other medical-legal, non-expert witness assessments).

- For most hospital and health system employers, even where productivity incentives are in place, most agreements will place aggregate compensation limits on maximum physician compensation. Physicians should understand the basis for these limits, and to the extent they are intended to reflect reasonable market-value, ensure that the current specialty-specific data is accurately reflected.
- For a physician who is entering the job market for the first time, or who is not bringing an existing patient base, it will be essential to understand the extent to which the employer will offer an income guarantee while the physician builds his or her practice, and the specific amount and duration of such a guarantee. Such physicians will also need to know what, if any, efforts the employer will take to help the physician develop a patient base, e.g., by advertising.
- Many factors will define physician compensation after the initial term and physicians should request:
 - i. protection against non-market rate renewal offers;
 - ii. exclusions from a non-compete clause which would force relocation outside of the area;
 - iii. adequate time from the renewal offer to assess options or address challenges;
 - iv. governance rights that ensure the employer's decision making has appropriate physician input;
 - v. transparency in future appraisals and ability to provide independent data or use of an agreed data set;
 - vi. adequate capital and administrative resources to support the practice; and
 - vii. a significant role in recruitment of new physicians to assure a culture that would be patient-centered, collaborative, accountable and clinically effective.

V. Conclusion

As payers move from fee-for-service payment methodologies to methodologies focused on population health, outcomes measures and efficient health care delivery, so should employed physicians expect that the compensation systems used by employers to pay those physicians will also change. While the data are less than clear as to what specific incentives and other changes in physician compensation will produce measurable differences in the achieved quality, patient engagement and cost effectiveness that payers seek, experimentation in physician compensation models and incentives will continue until a general consensus is reached concerning the successful alternatives to, or variations of, the models that were utilized in the traditional fee-for-service payment environment. Increasingly, larger physician organizations and health systems are making their case by publically reporting the "value" they create via nationally recognized benchmarks and internally developed initiatives.⁶⁰ This presents an opportunity for physicians to gain control over the health care dollars spent in their communities, and to obtain transparency over insurers' current costs, so that wellness and savings can be achieved other than through continued discounting of physician services and other caps on reimbursement. Hopefully, this chapter will help individual physicians understand the key issues at play as they evaluate, and then attempt to succeed under, employment arrangements utilizing new and evolving compensation methodologies.

⁶⁰ An example of published quality metrics used for market share development and for payer incentives, covering the entire range of quality, care coordination, inpatient, preventative health, disease management, wellness, and efficiency metrics, see Advocate Physician Partners Value Report:

<http://www.advocatehealth.com/2012valuereport>

Chapter 14 Appendix 1: Incentives embedded in prevailing fee-for-service physician reimbursement models

Until recently, the predominant physician reimbursement models were either fee-for-service or total or partial risk sharing via full or partial capitation or withholds.

Fee-for-service/DRG reimbursement incentives in the group practice setting

The traditional fee-for-service model reimbursed physician and outpatient services based upon specific services associated with patient encounters with reimbursement levels set by governmental payers or negotiated with third party payers. For a significant number of physicians, the fee-for-service payment is a percentage of Medicare Reimbursement for the same service. Historically a physician group's profitability was dependent principally upon the volume and reimbursement levels for services performed, the gross margin and utilization rates for ancillaries and diagnostics captured in the group practice setting, and the efficiency of operations from a staffing and facility utilization standpoint. Physician compensation in the group practice setting rewarded "productivity" either based on collections or where payer mix was disregarded, on an RVU basis. Physician efficiency was addressed via specific overhead allocations or credits based upon ancillary margins. While the formulas differed greatly from highly specific cost and revenue allocations to percentage-based formulas, most formulas and methods distributed 100% of profits via an allocation of revenue and expense. Quality was managed via normal payer QA/UR reviews. Thus, the physician compensation generally increased with greater numbers of procedures, office visits and reimbursable activities and increased use of compensable ancillaries. Uncompensated patient directed activities were generally ignored and there was little accountability for utilization or efficiency with respect to inpatient care, third party referrals or pharmaceuticals.

Fee-for-service reimbursement incentives in the hospital employed or professional service agreement practice settings

Typically, physician compensation plans sponsored by health systems, whether direct employment or through foundations or professional services agreements, either compensate physicians on a salary plus bonus (often tied to minimum wRVUs) or on a wRVU basis. These agreements may also compensate physicians for documented administrative time and contain other bonuses tied to achieving certain quality or efficiency metrics (either established in advance or mutually developed post integration). Again the incentives are focused on compensable activities of physicians and quality metrics often tie to inpatient initiatives of the health system.

Chapter 14 Appendix 2: Comparison of payment reform model

	MSSP Accountable Care Organization	Patient Centered Medical Homes	Bundled Payments
Triple Aim Strengths	Makes providers accountable for total patient costs and preserves patient choice. Requires transparency and quality reporting.	Supports PCP effort to better manage population health and provide greater resources for patient engagement. Extended hours and management of chronic conditions can avoid expensive ED visits and hospitalizations.	Promotes efficiency and care coordination as to specific episodes. Limits unnecessary re-admits. Requires quality reporting and transparency.
Triple Aim Weaknesses	Retrospective allocation undermines accountability/requires substantial infrastructure investment, which may have large health systems or insurers driving the organization versus physicians.	Requires significant training and multiple payer buy-in to be meaningful to PCPs and specialists.	Does not address chronic conditions or total cost of care.
Affect on Primary Care	Provides flexibility and potential source to drive primary care participants to medical home model. No clear source of funding for required infrastructure investment.	Redefines office visits and drives PCPs to team-based care model. Requires use of allied professionals. To be successful must complement fee-for-service with PMPM payments to provide proactive support and expanded access.	Can be structured to compensate PCPs for management of post-discharge medications throughout all transitions of care. Requires a culture of coordination of care and trust to meaningfully affect primary care.
Rewarding Improved Care Coordination Among Providers	Significant incentive on both quality and cost side for care coordination. May provide safe harbor funding for same. Includes as quality measures EHR infrastructure to facilitate coordination of care.	Yes if combined with medical neighborhood in which patients have more immediate access to specialty consults. Yes if PMPM payments are available to support communication and coordination.	Will drive care coordination for bundled payment programs which cover substantial periods post-discharge. Limited effect as to inpatient-only bundles. Generally will address only a portion of all admitting diagnoses. No incentive to coordinate to avoid inpatient admissions.

	MSSP Accountable Care Organization	Patient Centered Medical Homes	Bundled Payments
Financial Impact on Volume and More Expensive Interventions	Rewards greater primary care services. Continues fee-for-service to individual providers. Outside providers have no accountability for costs.	Objective is to expand primary care offerings beyond services that are currently reimbursable. In combination with open access scheduling, longer office hours, and patient monitoring and coaching should reduce ED visits and some acute episodes in fragile populations.	Might reduce certain inpatient services and shift volume to lower cost providers or settings post-discharge. No incentive to avoid hospitalization as commences with inpatient admission based on DRG.
Quality Incentives	Requirement for significant quality reporting and financial payments conditioned on exceeding minimum benchmarks.	Absent payer collaboration, difficult to coordinate among payers. No financial accountability but possible material impact on managing total patient cost.	Isolated to the episode with no population health component. Should minimize inpatient infection rates and medication errors and post discharge adverse events.
Required Infrastructure	Significant for ACOs, especially in EHR, patient engagement processes in quality reporting, and other compliance aspects.	Yes as to EHR, expanded human resources, and physician training and quality reporting.	Common or interoperable EHR would help. Development of care coordination and discharge protocols among providers.
Patient Choice/Ability to Steer	Unrestricted patient choice/ACOs must demonstrate value of in-network providers. Risk that due to site of injury, location of adult children, or marketing by centers of excellence that higher cost procedures will be performed outside the ACO.	Generally patients will remain with PCMH based on the proactive monitoring and engagement. Use of PMPM should offer greater sense of connection to PCMH and need not be contractually steered. When successful employers may reinforce.	Generally physicians and hospitals can steer patients through the transitions of care—more likely if participants are in a normal referral pattern.

Chapter 14 Appendix 3: Sample orthopedic service line co-management measures quality

Improvement and reporting on applicable Physician Quality Reporting Initiative Measures

- Venous Thrombosis Complication Rate
- Post operative wound infection rates
- Surgical Care Improvement Project Measures
- Order Entry, Medication Reconciliation, PCP notification
- Patient Satisfaction

CMS Core Measures/Infection Prevention

- Pre-Surgical Antibiotic Administration
- Post-Surgical Discontinuance of Antibiotic

Operational Improvement

- On Time First Case
- Reduced Operating Room Turnover Times
- Inpatient and Outpatient Cost Per Case
- Achieving Operational Budget
- Unallocated Scheduling Slots

Chapter 14 Appendix 4: Prevention management, outcomes and other quality measures

Preventative measures

- Well Child Visits, Adolescents Well Care Visits
- Age, gender and patient appropriate cancer screenings and tests
- Vaccinations
- Cholesterol, blood pressure screenings, LDL-C test, osteoporosis
- Eye (glaucoma) and foot exams
- Completed Health Risk Assessments, Depression Screening

Patient and Population Health Management Measures

- Timely follow-up and recordation of blood pressures, blood sugar, or cholesterol
- Active monitoring of certain drugs for potential side effects
- Coaching and information regarding lifestyle changes
- Conduct of individual or a group coaching
- Medication reconciliations

Objective Outcome/Process/Infrastructure Measures - Improvement on Inpatient Surgical Care Improvement Project (SCIP) and Core Measures

- Eligibility of Patient Quality Reporting System (PQRS) and e-prescribe payments, Electronic Prescription (e-Rx), Electronic Disease/Patient-Registry, use of Anthem Quality Insights Web Portal
- Level of Achievement with respect to NCQA Certifications (for example, with respect to diabetes, a one control and cholesterol control or blood pressure control).
- Attainment of Meaningful Use of EHR

Qualitative Measures - Improvement or minimum levels on

- Patient satisfaction
- Peer reviews
- Staff reviews
- Phone surveys

Good Citizenship Measures - Often mandated and only occasionally compensated

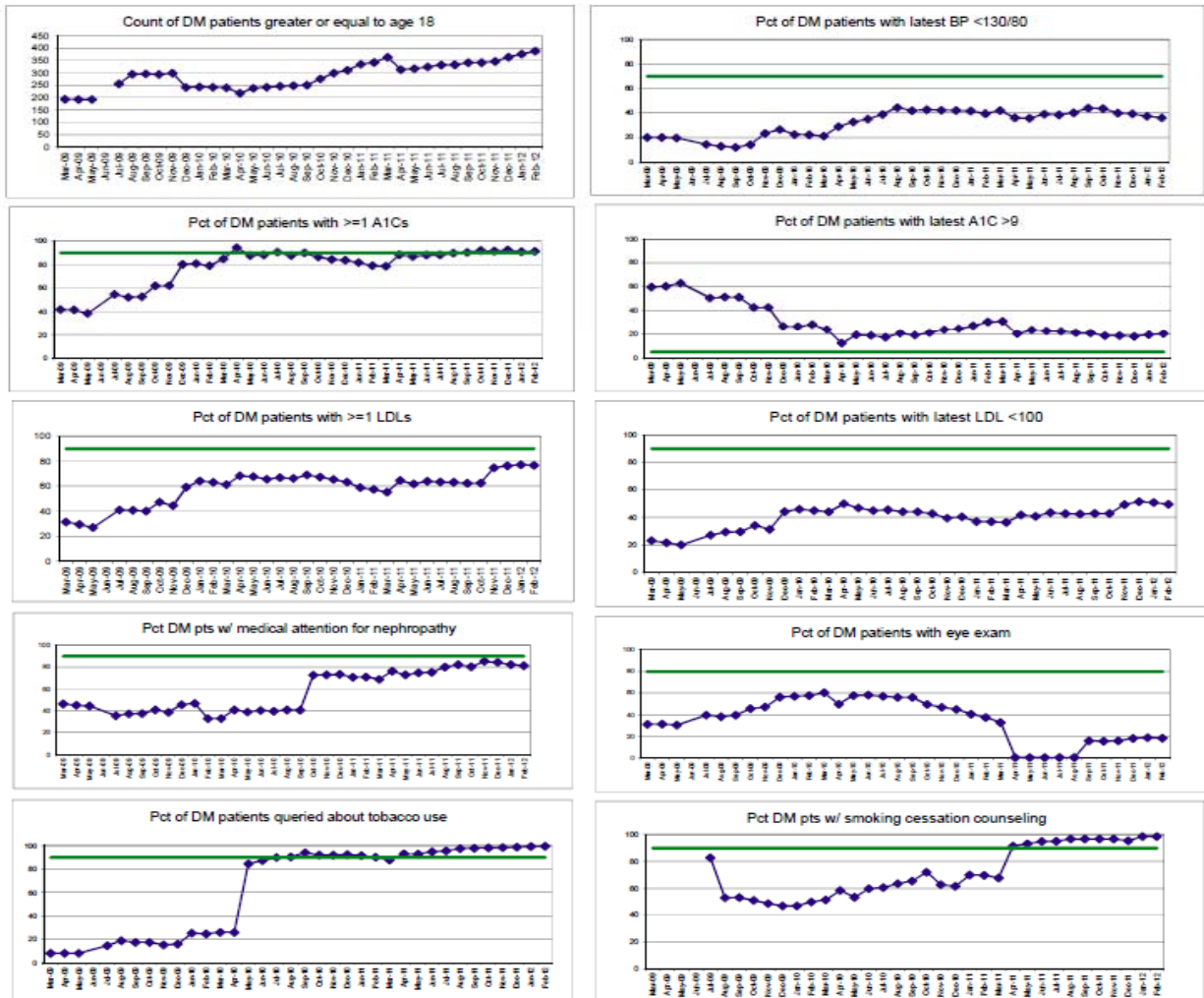
- Meeting Attendance
- Risk Management Education
- Community Outreach
- Seniority
- Protocol Development
- Research
- Administrative/Leadership
- Teaching

Chapter 14 Appendix 5: Clinical measure benchmarking example

Clinical Measures	Base Threshold for P4P (80% Target)	Target for P4P	Baseline Denominator Practice	Baseline Numerator Practice	Baseline Rate for Practice	Post Denominator Practice	Post Numerator Practice	Post Rate for Practice	Attainment Score	Improvement Score	Best Score
1.HgA1c>9 (DM)	18%	15%	294	126	42.9%	347	65	18.7%	0.0	0.9	0.9
2.BP < 130/80 (DM)	20%	25%	294	42	14.3%	347	139	40.1%	1.0	1.0	1.0
3.LDL <100 (DM)	29%	36%	294	101	34.4%	347	172	49.6%	1.0	1.0	1.0
4.Tobacco Counseling (DM)	64%	80%	45	23	51.1%	60	58	96.7%	1.0	1.0	1.0
5.Depression Screening (DM) (10/20/10)	32%	40%	276	162	58.7%	347	285	82.1%	1.0	1.0	1.0
6.LDL <100 (CV) (1/2010)	40%	50%	116	64	55.2%	252	116	46.0%	0.6	0.0	0.6
7.BP <149/90 (CV) (1/2010)	60%	75%	116	73	62.9%	252	196	77.8%	1.0	1.0	1.0
8.Tobacco Counseling (CV) (1/20/10)	64%	80%	9	7	77.8%	29	28	96.6%	1.0	1.0	1.0
9.Depression Screening (CV) (9/2010)	32%	40%	255	162	63.5%	252	174	69.0%	1.0	1.0	1.0
Cost Measures									Total - Actual		8.5
Inpatient*									Total - Possible		9.0
ER Visits*									Final Bonus Rate		94%
*Health Plans											

Chapter 14 Appendix 6: Sample medical home performance

	Feb-12	Goal		Feb-12	Goal
Count of DM patients greater or equal to age 18	388		Count of DM patients 40+ yo	364	
Pct of DM patients with >=1 A1Cs	90	91	Pct of DM patients with latest A1C >9	5	20
Pct of DM patients with >=1 LDLs	90	77	Pct of DM patients with latest LDL <100	90	50
Pct DM pts w/ medical attention for nephropathy	90	81	Pct of DM patients with eye exam	80	19
Pct of DM patients queried about tobacco use	90	99	Pct DM pts w/ smoking cessation counseling	90	99
Pct of DM patients aged 40-75 on aspirin	85	55	Pct of DM pts prescribed a statin	60	70
Pct of DM patients with latest BP <130/80	70	36	Pct of DM patients with current flu vaccination	75	59
Pct DM pts screened for depression	40	85	Pct of DM pts reassessed w/severity scale in 3 mos	60	
Pct DM pts Screened - Positive	50	0	Pct of DM pts w/6 mo assessment decreased 50%	60	
Count of DM patients 55-75	45	0	Pct DM patients with latest BP <140/90	47	0
Pct DM patients with latest LDL <130	50	0	Pct DM patients with foot exam	52	0
Pct DM patients with SM Goal	55	0	Pct DM pts 55-75 taking ACE/ARB	57	0
Pct DM pts with pneumo vacc	60	0	Pct DM patients referred for eye exam	62	0



Questions or concerns about practice management issues?

AMA members and their practice staff may e-mail the AMA Practice Management Center at [**practicemanagementcenter@ama-assn.org**](mailto:practicemanagementcenter@ama-assn.org) for assistance.

For additional information and resources, there are three easy ways to contact the AMA Practice Management Center:

- Call **(800) 621-8335** and ask for the AMA Practice Management Center.
- Fax information to **(312) 464-5541**.
- Visit [**www.ama-assn.org/go/pmc**](http://www.ama-assn.org/go/pmc) to access the AMA Practice Management Center Web site.

Physicians and their practice staff can also visit [**www.ama-assn.org/go/pmalerts**](http://www.ama-assn.org/go/pmalerts) to sign up for free Practice Management Alerts from the AMA Practice Management Center.

The Practice Management Center is a resource of the AMA Private Sector Advocacy unit.