New Reimbursement Systems and Value-Based Compensation Incentives

As mentioned in chapter 1, one of the external challenges facing medical group practices is the shifting reimbursement models from Medicare and other payers. The reimbursement systems are moving from reimbursing on a fee-for-service (FFS) basis to include incentives for quality, outcomes, improved patient experience, and reduced costs. The shift can be summarized as: Paying for value, not volume.

According to a Forbes Insights and Allscripts Healthcare Solutions survey of 204 hospital executives,

...73% agreed completely or somewhat that physicians needed to shift from volume to value immediately. Thirty-nine percent expected a quarter of total revenue to be linked to value-based purchasing within five years. Seventeen percent said it would comprise half of revenue.¹

In addition,

Physician compensation is expected to increasingly incorporate factors such as quality, outcomes and patient satisfaction. Incentive pay makes up 3% to 5% of the total compensation of employed physicians but is expected to be between 7% and 10% in the next few years, according to a survey of 424 health care organizations released Jan. 10, 2012, by Sullivan, Cotter and Associates.²

Medical practices are also starting to include value-based factors in compensation formulas without being driven by external reimbursement. Incorporating these factors can instill the organizational emphasis on the patients’ experience and health status that are frequently part of the mission, vision, and values of the practice or health system. Incorporating patient satisfaction, outcomes, and quality of care may be the most difficult of all the challenges for medical groups to incorporate in compensation plans. Although quality of care has always been a part of patient care, FFS reimbursement drove compensation models and physician behavior to emphasize volume, sometimes leading to overutilization, without factoring in quality. Value-based factors are also more difficult for administration to track and implement and for physicians to control compared to the number of procedures or collections.

Private payers have copied the Medicare models or developed their own systems. Several practices have negotiated with commercial payers showing the cost savings they’ve achieved with quality and outcomes management under Medicare. They were then able to negotiate additional reimbursement from new value-based contracts from commercial payers. State Medicaid programs have also introduced incentives, especially care management or coordination incentives.
Strategies for Value-Based Physician Compensation

Value-based reimbursement requires a shift of emphasis to ensuring that appropriate care is provided while volume is maintained. These reimbursement models require an organizational infrastructure to provide and track care in new ways but also a cultural shift to include emphasis on the new factors. Compensation plans can help with the cultural shift in providing the right incentives to adapt to the changing systems.

Although reimbursement under the new models is a small percentage of the total health system reimbursement, it is expected to increase and spread to affect more medical groups and health systems. Unfortunately, the shift is not occurring in a controlled manner. Different payers prefer different methods, placing groups and physicians in the awkward position of dealing with multiple and occasionally conflicting incentives. Medical practices must rise to the challenge and opportunity of preparing for new payment systems while continuing to function under a largely FFS environment. Unfortunately, these new payment systems bring an unavoidable added layer of complexity that conflicts with the goal of keeping the plans as simple and understandable as possible. Compensation formulas must be flexible to prepare for new reimbursement incentives while maintaining the volume that is necessary for the financial viability of the practice.

In 2013, 11 percent of reimbursement to hospitals and physicians is value-oriented, according to the Catalyst for Payment Reform (CPR), an employer coalition. Of that 11 percent, 43 percent is bonus or incentive payments and 57 percent is at-risk payments dependent on achieving quality and cost goals. Only 6 percent of physician payments is value oriented. CPR’s goal is to have 20 percent of payments be value oriented by 2020.3

History of Payer Incentive Plans

Payer incentive and rating plans from the physician provider point of view have not been without problems. Lack of transparency regarding payer methodology has led to suspicions that the plans have been one sided in favor of the health plans, at least to some degree. One problem is the data utilized by payers was primarily developed from claims submitted by providers. This data could be incomplete if patients obtain services outside the payer network. If the incentive plan or a component of the incentive plan was specific to a single metric, then this would be easier to manage and audit. If the payer was using multiple metrics with different weights, it was difficult if not impossible for the provider to understand, much less audit the results. In some cases, the payer would utilize an inadequate sample size to develop their findings.

Quality rating systems could be equally problematic. Some payers would utilize a “proprietary system” to establish a physician or practice rating without disclosure of the metrics or weighted metrics utilized. Providers were concerned there might be an over-emphasis on costs versus quality and that the plans were attempting to steer patients to low-cost providers regardless of quality. An extension of this would be when payers reduced the patient copayment for the more highly rated physicians or facilities.

Fortunately, the relationship between providers and payers has been improving over the years, and incentive plans and quality ratings are generally more transparent in their methodology. It is still recommended that providers perform their due diligence and totally understand the methodology utilized for incentives and ratings, and audit the payers’ findings.

New Reimbursement Models – What Are They?

It is important to first understand the new reimbursement systems and their measurements and incentives. After describing these systems, we’ll discuss methods of developing compensation incentives to align with the changing reimbursement methodologies. The four main models of new reimbursement systems are:

1. Value-based or pay-for-performance;
2. Medical homes and other care coordination initiatives;
3. Shared savings and accountable care organizations; and
4. Shifting financial risk.

The risk-shifting initiatives typically involve a payment mechanism that replaces FFS. The other three models maintain FFS as the basis and either modify the FFS payments or provide incentives in addition to the FFS payments. The differences create different incentives that groups must face to succeed under the different methods.

**Value-Based Reimbursement**

There are almost as many value-based payment or purchasing (VBP) models among payers as there are physician compensation models; however, the general definition is a payer or health system using reimbursement or bonus payments for the achievement of particular quality-related goals. These pay-for-performance (P4P) systems have several things in common:

- Based on metrics or measures;
- Not based on volume of services (although FFS may still underlie the whole reimbursement system);
- Frequently include efficiency or cost savings goals; and
- Include additional payment for achieving set goals or measures.

Value or performance-based contracting maintains existing FFS or capitation payment methods but ties payment increases or other incentives to providers' performance on specific measures of quality and efficiency. The purpose of VBP models is to provide incentives or payment based on quality measures with the assumption that improved quality improves health outcomes and reduces costs to the insurer. Examples of measures or metrics include patient satisfaction, chronic disease management, evidence-based care process completion, outcomes, and reduction in costs or at least a slowdown in rise of costs. For example, a payer may set benchmark or performance targets for 10 diabetes clinical quality measures or a percentage of the population having received breast or colon cancer screenings.

Payment can be in the form of bonus payments or direct incentives or reimbursement for achieving all or some of the measures. The amounts vary among the programs but are usually above the FFS reimbursement for services rendered. Some payers offer reimbursement at higher FFS levels but withhold a percentage until cost and quality targets are achieved.

Occasionally, payers will attempt to utilize a withhold from basic reimbursement until targets are achieved. The incentive is to force physicians to achieve the value-added goals prior to earning normal reimbursement. Physicians generally perceive this as a negative incentive since they have to perform additional work without additional reward.

Programs typically incorporate a physician report card to provide comparisons of the physician's and practice's performance. Data from these report cards can be used in payer physician network directories to provide additional information for patients selecting physicians.
Private Payer Initiatives

What began as P4P programs a decade ago, value-based programs continue to evolve as private payers implement different incentives, metrics, and models as they learn from earlier programs or competitors’ programs. Goals are often similar to the National Committee for Quality Assurance’s (NCQA’s) Healthcare Effectiveness Data and Information Set (HEDIS) quality metrics. Initially, the programs evaluated physicians and practices on at least two criteria:

1. Presence of infrastructure or care delivery systems to support quality care. For example, an electronic health record (EHR) is in place and used to record and analyze patient care data.

2. Providers follow treatment plans and processes that are consistent with accepted quality indicators or clinical best practices. For example, the practice consistently reminds diabetic patients to have annual foot and eye exams. This criterion emphasizes recording the completion of specific activities and was often described as “pay to report.”

More recent and sophisticated VBP programs include clinical outcome and patient experience measures, increasing the shift to pay for value. An example of an outcome measure is HbA1c < 8.0 percent for a population of diabetic patients. Programs may also incorporate cost efficiencies or utilization management, such as reduction in unnecessary tests, emergency room visits, or hospitalizations.

The following are a few examples of private-payer VBP initiatives:

- Humana’s Provider Quality Rewards program is based on nine HEDIS measures for breast, colorectal, glaucoma, and nephropathy screening, and diabetes metrics including A1c control. It engages smaller practices with less sophisticated systems using historical practice data and providing rewards for improved quality over baseline scores. In its first year (2010), nearly $10 million was distributed to physician practices as incentives and rewards. More advanced practices can participate in medical home programs under which incentive payments are based on care coordination improvements and increasing patient engagement in disease management.4

- UnitedHealthcare in Illinois reviewed historical data and graded physicians on quality and efficiency. Physicians achieving United’s goals received a 5 percent boost on their contracted rate for all services and received a star for each category in the payer’s physician directory. Value-based contracting will grow to 50–70 percent of physicians in network by 2015.5

- Blue Cross Blue Shield of Minnesota is also shifting emphasis to prevent illness rather than treating chronic and acute illnesses and including payments based on value determined by total cost of care and outcome measurement. It has shifted to longer-term contracts to build relationships with goals of lowering costs and improving quality and is working toward increasing transparency and sharing of data.6

- HealthPartners programs operating in the upper Midwest withhold 1 to 5 percent of providers’ revenue, which is returned to physicians based on achieving quality, satisfaction, and efficiency targets.7

Private Payer’s New Reimbursement Models

The Government Accountability Office found the following common themes after evaluating private payer programs that reimbursed physicians in new models: “Measuring performance and making payments at the physician-group level, rather than the individual patient level; using a standard set of metrics; tying financial incentives to benchmarks as opposed to gauging performance relative to peers; and paying incentives soon after the performance period ends.”
CMS’s Medicare Value-Based Initiatives

The Centers for Medicare & Medicaid Services (CMS) has introduced several Medicare programs to begin the shift toward paying for value. The agency's programs have followed this concept:

> The concept of value-based health care purchasing is that buyers should hold providers of health care accountable for both cost and quality of care. Value-based purchasing brings together information on the quality of health care, including patient outcomes and health status, with data on the dollar outlays going towards health. It focuses on managing the use of the health care system to reduce inappropriate care and to identify and reward the best-performing providers. This strategy can be contrasted with more limited efforts to negotiate price discounts, which reduce costs but do little to ensure that quality of care is improved.9

Many of Medicare's reimbursement demonstration programs and initiatives were introduced or required by the Patient Protection and Affordable Care Act (PPACA), but several were in place prior to the act's passage. The CMS Center for Medicare & Medicaid Innovation (CMMI) has also been the source of several specific new payment and service delivery models defined by Congress through the PPACA and other legislation. CMMI initiatives include primary care transformation, accountable care, and bundled payment demonstration programs.

“Meaningful Use”

CMS's meaningful use requirements were a first step in incentive programs requiring physicians to show implementation and use of an EHR in the practice by reporting e-prescription and medication reconciliation activity, tracking quality measures and chronic conditions, using clinical decision support tools, and recording patient vitals, diagnoses, and smoking conditions. Complying with meaningful use requirements also showed the capability to track and record various activities, processes, and data needs that become the foundation for additional CMS initiatives and requirements. For this reason, physician's compliance with meaningful use can be a first factor in physician incentive plans.

The incentive payment, after a provider has shown meaningful use of a certified EHR technology, can equal 75 percent of a physician's total Medicare allowable with annual caps. Beginning in 2015, professionals not demonstrating meaningful use of an EHR will face reductions in their Medicare fee schedule reimbursement rates. The penalty will equal 1 percent in 2015, 2 percent in 2016, and 3 percent in 2017 and each subsequent year. As of April 2013, eligible professionals (EPs) and hospitals had received nearly $13 billion from the CMS as part of the Meaningful Use EHR incentive program.10

Physician Quality Reporting System

The Physician Quality Reporting System (PQRS) is the Medicare quality reporting program for providers to track and submit their patient care data to a system that will help them evaluate and improve the quality of care they provide. Providers were initially rewarded to document and report that they had completed defined steps in quality measures for many chronic diseases and episodic care along with adoption and use of EHRs and e-prescribing. Each physician or administrator should review and understand each measure specification to identify those applicable to the practice and the means to reach the expected targets.

What began as a voluntary reporting system with incentive payments will penalize providers who don’t participate; a 1.5 percent penalty will be applied to the practice's total estimated Medicare Part B allowed charges by 2015 and a 2 percent penalty in 2016. PQRS data will also be used in Physician Compare, the Medicare
provider rating method available to beneficiaries. Physician Compare will report quality measures reported under PQRS along with assessment of care coordination, patient outcomes, patient experience, and efficiency of care.

Many private payers have implemented programs ranking physicians based on quality and cost-effectiveness. Anthem’s Blue Precision and UnitedHealthcare’s UnitedHealth Premium are just two examples. The information is used as a tool to encourage enrollees to select physicians that meet the insurer’s ideals.

**Value-Based Reimbursement Modifier**

A value-based payment modifier (VBPM) under the Medicare Physician Fee Schedule offers differential payments to physicians or groups of physicians based on the quality of care furnished compared to the cost of care. “CMS will use PQRS quality measures, total per-capita cost measures, and the per-capita cost measures for patients with four specific conditions to determine quality and cost scores under the program.” As stated in the PPACA, the VBPM must be budget-neutral, which means that any upward payment adjustments awarded for higher quality and lower costs must be balanced by downward payment adjustments for providing lower quality at higher costs.

The modifier will initially apply to physician group practices with 100 or more EPs in 2015 based on reported data from 2013. The modifier will be applied beginning in 2017 to all physicians who will bill Medicare under the Physician Fee Schedule.

Groups will receive rating of high, average, and low depending on position relative to the national mean for quality and cost scores. Upward payment adjustment to be distributed to high performers will be determined after calculating the downward payment adjustment for low performers. Groups that don’t participate in the PQRS will be penalized up to 1.5 percent of Part B payments starting January 1, 2015.11

**Patient-Centered and Primary Care Initiatives**

Many health policy analysts and healthcare leaders believe that one of the keys to driving down healthcare costs is to start with primary care. By increasing care management at the primary care provider level, the early identification and improved management of chronic diseases and increased rate of preventive care services will result in an expected drop in hospitalizations and readmissions with lower expenses.

To gain these benefits, payers are encouraging primary care providers through several initiatives and incentives. Primary care initiatives take many names and forms, from advanced primary care to patient-centered primary care and medical homes.

Primary care emphasis goes hand in hand with the concept of patient-centered care, which is defined in many ways. The Agency for Healthcare Research and Quality (AHRQ), an agency of the U.S. Department of Health and Human Services, refers to patient-centered care as a move away from disease-centered care. The AHRQ now recommends moving toward encouraging patients to “become active participants in their own care and receive services designed to focus on their individual needs and preferences, in addition to advice and counsel from health professionals.”12 A practice can become patient centered by adopting the principles without seeking formal certification.

*Patient centeredness* is defined according to activities that put the patient in the center of care:

- A process is in place to ensure that patients receive lab, radiology, and other medical results regardless of normal or abnormal outcomes;
- Patients and caregivers are involved in a formal advisory capacity (i.e., patient and family advisory council);
Strategies for Value-Based Physician Compensation

- A mission or vision statement that explicitly includes the term “patient-centered care”;
- Providers ask patients if there are external factors (i.e., nonmedical/clinical issues) that make it difficult to take care of their health needs;
- Care is coordinated for the patient instead of relying on the patient to schedule referrals, tests, and so on;
- Patients and caregivers directly participate with staff in developing mutually agreed-upon treatment plans; and
- Patient access is prioritized by offering same-day appointments or as soon as possible and additional hours of operation or e-mail and phone access.13

Care Management and Coordination

Care management or coordination is seen as an important factor in improving patient health and reducing costs by increasing patient contact and education, more intensively managing chronic conditions, and coordinating care between providers. There are several initiatives from private and public payers to encourage care management or coordination through additional reimbursement to cover additional costs related to intensive patient management. The medical home concept is one of the care management incentives.

Johns Hopkins developed a program called Guided Care that relies on nurse care coordinators and is being adopted by other healthcare entities. Cigna launched the Collaborative Accountable Care initiative in 2008 with the specific goals of increasing patient access to reduce unnecessary emergency room visits, hospital discharge coordination, and patient education and coaching to improve patient self-management. Cigna sponsored hiring nurse care coordinators to handle many of these tasks.

The CMS Comprehensive Primary Care Initiative is a multipayer initiative fostering collaboration between public and private healthcare payers to strengthen primary care. Medicare will work with commercial and state health insurance plans and offer bonus payments to primary care doctors who better coordinate care for their patients.

In addition, CMS introduced two new Transitional Care Management services codes to reimburse for care coordination in the 30 days following a Medicare beneficiary’s discharge from an inpatient hospital, skilled nursing facility, community mental health center, or outpatient hospital observation services.

Medical Homes

Medical homes are care delivery methods characterized as “a physician practice and patient partnership that provides accessible, interactive, family focused, coordinated and comprehensive care.”14 Four organizations offer practices patient-centered medical home (PCMH) status or certification: the Accreditation Association for Ambulatory Health Care, NCQA, URAC, as well as The Joint Commission. NCQA offers a widely accepted certification program for practices that want to be recognized as PCMHs. The foundations of a PCMH are:

1. “Whole-person care is patient centered with emphasis on the patient’s experience;
2. Personal clinician provides first contact, continuous, comprehensive care;
3. Care is coordinated or integrated across the health care system;
4. Team-based care.”15,16
Reimbursement Incentives for Care Coordination and Medical Homes

CMS’s Comprehensive Primary Care Initiative is intended to encourage PCMHs and practices planning to achieve certification. Medicare will work with commercial and state health insurance plans and offer monthly bonus payments to primary care physicians (PCPs) who better coordinate care for their patients.17

Several private payers and state Medicaid programs recognize and reward medical homes through care coordination fees, increased payment for evaluation and management (E&M) services, or quality and outcome bonuses. The most common method of reimbursing medical homes (Exhibit 4.1) is a care coordination fee paid as a per member per month (PMPM) amount. The care coordination fee recognizes the extra resource requirements for care coordination. The PMPM amount varies depending on level of NCQA certification and can range from $3 in a Medicaid program to an average of $20 for a Medicare program under CMS’s Comprehensive Primary Care Initiative. Other payers increase the reimbursement for physicians in medical homes by a set percentage, either for all services or just E&M and immunization services.

EXHIBIT 4.1 Medical Home Reimbursement Methods

<table>
<thead>
<tr>
<th>Method</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>FFS plus care coordination fee</td>
<td>40.7%</td>
</tr>
<tr>
<td>Full risk capitation</td>
<td>18.5%</td>
</tr>
<tr>
<td>Pay for performance (quality and clinical incentive payments)</td>
<td>26.0%</td>
</tr>
<tr>
<td>Episode of care payment</td>
<td>7.4%</td>
</tr>
</tbody>
</table>


Some payers are using a mix of reimbursement methods to split the physicians’ incentives among several factors, including quality, care management, and individual services. WellPoint’s PCMH initiatives used a mix of reimbursements such as FFS as the base payment, a PMPM care coordination fee, and a P4P incentive based on quality and cost or utilization factors. Some of WellPoint’s programs used enhanced payments for E&M services or for physicians in PCMHs achieving higher-level certification.18 WellPoint increased reimbursement to primary care providers by an average of 10 percent for practices adopting “patient-centered practice principles.”19

Capital District Physicians’ Health Plan in New York uses a payment system that is 10 percent based on FFS, 63 percent by capitation adjusted for patient severity, and 27 percent as bonus payment based on improvements in patient satisfaction, value, quality, and cost.20 CareFirst BlueCross BlueShield increased fees by 12 percent for physicians participating in care coordination and offers bonuses that could total 20 percent, based on achieving quality score measures, electronic prescribing, use of EHRs, and targets for reducing health costs.21

Shared Savings and Accountable Care Organizations

Shared savings programs allow participants to keep part of the savings realized by the payer for specific services or the total cost of care per beneficiary or population. The federal government first considered allowing gainsharing in the late 2000s, encouraging hospitals and providers to reduce costs through product and supply standardization, application of efficient treatment protocols, and improved care coordination. Shared savings
programs include incentives for physicians to unite efforts with hospitals and other service providers in order to succeed in improving value. These programs provide new incentives and rewards.

Accountable care organizations (ACOs) are frequently used by CMS and several private payers as part of their shared savings programs to encourage multiple provider organizations to unite in a single entity to share accountability and rewards. The ACOs are expected to improve their patient population’s health by coordinating inpatient and outpatient services and investing in infrastructure and redesigned care processes. The requirements to be an ACO vary by payer, but all are eligible to receive payments for shared savings after they meet quality performance and risk-adjusted standards. Services are reimbursed based on FFS, so there is no downside risk.22

Although the Medicare’s ACO program receives most of the attention, several private payers have implemented similar programs. Cigna’s Collaborative Accountable Care initiative provides financial incentives to physician groups and integrated delivery systems to improve the quality and efficiency of care for patients in commercial open-access benefit plans. The initiative is aimed at managing at-risk populations and includes incentives for hospitals to notify physicians of patient admissions to ensure transition-of-care after discharge. Cigna offers up-front payments to encourage extension of medical practice hours or purchase of information technology systems to support care coordination and e-prescribing.23

Hawaii Medical Service Association (HMSA), Hawaii’s largest insurer, entered in a shared-savings agreement with the state’s biggest health system, Hawaii Pacific Health, and “puts 50 percent of the hospital’s annual pay increases over the five-year contract term dependent on achieving both quality improvement and cost savings thresholds.” HMSA’s physician payments already factor in HEDIS scores and other quality measures.24

The keys to succeeding under shared savings incentives are understanding who the patient population is and how to achieve the quality performance benchmarks. Understanding the population includes knowing patient demographics and tracking the total services they are receiving (pharmacy, all physicians, hospitals, and ancillary services), which requires communication among the participating entity (ACO), payer, and other providers.

The CMS quality performance standards for ACOs include:

- Patient/caregiver experience (7 measures) – gathered in the CG-CAHPS (Clinician and Group Consumer Assessment of Healthcare Providers and Systems) patient survey;
- Care coordination/patient safety (6 measures) including hospital readmission rate, hospital admissions for COPD (chronic obstructive pulmonary disease) and heart failure, and EHR meaningful use and medication reconciliation;
- Preventive health (8 measures) including immunization and vaccination rates, and health screening completion; and
- At-risk population determined by quality metrics for diabetes, hypertension, ischemic vascular disease, heart failure, and coronary artery disease.25

It will be up to each ACO to determine how to distribute the shared savings payment among participating hospitals, physicians, and other providers. Even without the CMS requirement that the ACO be managed by a separate entity, many health systems have set up a separate physician–hospital organization or hired a third-party administrator to manage the payments. This separate party contributes a sense of shared governance and trust. Distribution to physicians within participating medical groups will depend on the group’s compensation plan and the incentives it includes.
Risk-Shifting Initiatives

Part of this changing reimbursement methodology is the trend toward shifting more risk onto the providers. The general theme of risk shifting is to replace FFS reimbursement (pay for volume) with a flat preset payment for a service or per enrollee. If providers’ costs are below the payment, then they keep the extra. If costs are higher, then the provider(s) absorbs the loss. Under risk agreements, providers frequently purchase stop-loss or other insurance to help minimize the risk.

Payers have tried shifting risk under capitation, which became widespread in the 1980s and early 1990s. When a backlash ensued, partially because the emphasis was solely on cost containment not quality, the frequency of capitation reimbursement declined except in a few markets. At-risk types of arrangements are back, but they are in the form of bundled payments and what are now called global payments. These payment methods now incorporate quality along with financial metrics based on utilization.

Risk-shifting initiatives have been initiated or reintroduced by public and private payers. Providers under such programs will be rewarded for cost-effectiveness while maintaining quality and experience of care or improving outcomes. Some of these programs are so new, participating entities are still struggling with how to distribute risk and reward between hospitals, physicians, and other providers involved in the included services. Physician compensation methodologies need to incorporate appropriate incentives. Examples of risk-shifting reimbursement systems, in order of increasing risk, include:

- Case rate;
- Bundled payments; and
- Capitation and global payments.

Case Rate

Case rate payments are fixed, pre-established payment for a specific case. Each case is paid the same rate regardless of complexity. The most frequent examples are for obstetric and orthopedic services. Obstetricians are paid one rate for deliveries, which includes expected pre-and postnatal care.

A new model is the Evidence-informed Case Rate (ECR®) under the Prometheus Payment model developed by the Health Care Incentives Improvement Institute. ECR is a payment budget established for all providers who will interact with the patient for a given condition, including the hospital, physicians, laboratory, pharmacy, and rehabilitation facility. The rate is based on expected costs adjusted for the patient’s age, gender, and other demographic and risk factors. For physicians, 10 percent of the case rate payment is held back in a performance contingency fund. The fund is used to reward efficient use of evidence-based treatment within the agreed-upon rate, with optimal referral and collaboration efforts. Unfortunately, the formula is complex and proprietary, making it difficult for providers to predict the expected payment amount.26

Bundled Payments

Bundled payments are single payments to cover multiple services related to an applicable episode of care. An episode of care includes a hospitalization or procedure and the related services provided prior to admission and following discharge. The goal is to encourage collaboration of inpatient or outpatient hospital services, physicians, and post-acute care and other providers to reduce costs while maintaining quality. Since payment is less than the sum of previous payments, the entities must reduce costs through standardization, managing length of stay, coordinating transfer of care, ensuring that discharge planning is followed through, or other steps.
To reduce readmissions and other adverse consequences, services are tracked for a period after hospitalization or an outpatient procedure. Bundled payments are opportunities for payers and providers to manage a patient population, coordinate information sharing and efforts, and manage costs without the complexity and amount of risk of capitated contracts. However, this payment mechanism only addresses episodic care and not the long-term and chronic disease management care that drives a large percentage of U.S. healthcare costs.

Not only are payers shifting more risk to providers, but they also shift the responsibility of how the payment is distributed among providers. Hospitals typically receive the payment since they have the responsibility of tracking the different services to complete a care episode and are more capable of distributing payments to other providers.

One of Medicare’s bundled payment demonstration programs was the Acute Care Episode program, which included cardiac and orthopedic inpatient procedures. Participating organizations needed to achieve hospital and physician quality metrics prior to receiving shared savings distribution. A more recent CMS initiative is Bundled Payments for Care Improvement, which offers four models with different requirements.

An example of a private payer’s bundled payment program is UnitedHealthcare’s pilot for treatment of breast, colon, and lung cancers. Payment was based on volume of drugs administered, revenue the group would make on drug expense margins, and a “case management fee to reflect the time and resources that the oncologist’s office spends in managing the patient relationship.” Geisinger Health System in Pennsylvania developed bundled payment programs for elective coronary artery bypass, perinatal care, bariatric surgery, and other services.

**Capitation and Global Payments**

Capitation, once in vogue in the 1980s and 1990s, is seeing a return, although in sometimes modified forms. Capitation is defined as “payment for the obligation to furnish all or part (e.g., physician professional services only) of care for a given population of patients typically paid on a per beneficiary (member) per month basis (PMPM). Payment amount is adjusted for patient demographics, including age, sex, and health status.” If costs for patient care amount to less than the payment, providers keep the difference. If, however, healthcare costs exceed the payment, doctors make up the difference out of their own pockets.

The goal of capitation or global payments is to eliminate incentives for volume and encourage utilization management. Capitation in the 1990s stumbled because there weren’t incentives for quality or patient satisfaction and medical practices did not have the data capabilities to truly manage patient population and risk. NCQA developed HEDIS to ensure that quality and satisfaction were included in how managed care organizations operated and reimbursed medical practices.

Capitation is typically only directed toward one provider/practice, but there are many types of capitation from primary care specific, specialty specific, contact capitation, and so forth. Global payments account for either all patient care or for a specific group of services delivered to a patient population, including outpatient physician, ancillary, hospital services, and prescription drugs. Since global payments cover more services than physicians provide, payments are frequently directed toward integrated health systems or ACOs.

- Other features that may be included in capitation or global payment systems include:
- Risk sharing between healthcare provider and insurance entity;
- Health status adjustments based on population risk factors;
- Enhanced integrative healthcare systems, including data sharing;
Strategies for Value-Based Physician Compensation

- Risk corridors where provider and insurance entity establish floors and ceilings to the amount of risk shared;
- Reinsurance or stop-loss options to mitigate risk margins for providers and insurers; and
- Financial incentives tied to quality performance measures.

Blue Cross Blue Shield of Massachusetts (BCBS) introduced global payments in its Alternative Quality Contract with primary care and multispecialty practices. The annual global budget is based on each participating group’s previous PMPM spending. BCBS provides quality-based performance bonuses and regular reports on spending, service use, and quality of care. Groups are paid FFS during the year and all medical care payments, both within group and out of group, are deducted against the global budget. At year end, BCBS reconciles with each group, paying any money left in global budget or “recouping” what was spent overbudget. The quality aspect uses 64 measures – 32 for inpatient and 32 for outpatient care - covering process of care, outcomes, and patient experience. Participants must receive the minimum quality score. If the highest score is achieved, the bonus can be 10 percent of total medical spending with 5 percent from ambulatory quality measures and 5 percent for inpatient quality measures.31

To succeed under bundled and global payments, providers must understand three factors:

1. Member reconciliation or patient attribution. This measure is defined as the specific patient population that the provider is responsible for. Providers must know the number of members, demographics, and risk adjustment of the population to fully understand the risk of the contract. The amount of risk will also depend on whether or not patients are explicitly assigned to the provider entity and how patients’ choice of providers and services is managed through a referral requirement.

2. Scope of services or benefits that are covered under the contract. Does it include just office visits or minor procedures and hospital visits, pharmaceutical and ancillary services? Services and benefits must be clearly defined in the contract.

3. Handling of out-of-network care. Will the patient, provider, or insurer cover out-of-network costs and under what circumstances?

Physician performance and incentive programs under these reimbursement mechanisms must emphasize population health management and cost management, including limiting the number of unnecessary referrals, procedures, and diagnostic services. Practice executives must watch for adverse patient selection or incorporate the number of higher-risk patients in incentive systems.32

Physician Compensation and Risk-Based Contracting. Medical groups that participate in risk-shifting initiatives, particularly capitation and global payments, should ensure that physician compensation incentives align with the financial realities and reimbursement incentives of the risk contracts. Capitation contracts can penalize practices with compensation formulas that encourage high productivity. New reimbursement incentives that are based on quality and value should be matched by similar compensation formulas. For example, according to a survey of 21 large, multispecialty groups participating in risk contracts, groups with more revenue from risk-based contracts had a slightly higher share of physician compensation dependent on performance measures: 5 percent for specialists and 7–12 percent for PCPs. Most of the groups expected to change their physician compensation calculation in the next two years to match the predicted shift from FFS revenue to revenue from shared savings, pay for performance, and global capitation. The responding groups received an average of 25 percent of revenue from global capitation contracts and 9 percent from partial capitation or shared risk. Most had more than 440 physicians, and many had affiliated health plans.33
Notes


23. See note 21 above.

24. See note 22 above.


26. Ibid.


29. See note 25 above.


32. See note 25 above.