

# **Understanding the Shifting Models of Payer Contracts**

An Exploratory Paper

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## **Introduction**

This paper's objective is to give the ambulatory practice manager a better understanding of trends in payer contracting. It attempts to (1) explain payer contracts and (2) describe the shifting trends away from the Fee-For-Service (FFS) payer contract payment model and toward risk-based global payment models with pay for performance and other features included. When practice managers can clearly see the coming wave of change, they can better prepare their practices for success.

The research methodology of the proposed paper will be a comprehensive literature review of peer-reviewed journal articles, non-peer reviewed articles, relevant books, and white papers. The scope of this paper encompasses the USA healthcare system contracts of government and private insurance payers to healthcare provider organizations, focusing most on the larger organizations (IDS), which are employing ever larger numbers of practice managers. The goal was to provide an overview for practice managers, while providing more detail in the appendices for those practice managers who may be tasked with payer contract negotiation and want to delve more deeply into this complex, evolving topic. All Acronyms are defined in the Appendices.

## **Background**

Since the publishing of *Crossing the Quality Chasm* by the Institute of Medicine in 2001, legislation and organizations have been striving to reach the triple aim of improving access, quality, and cost. With Fee-For-Service dominating as the provider compensation method in the USA, the country's payers and provider organizations are talking about the triple aim, while physician work with patients is still generally being driven by volume. Payer compensation to provider organizations is the foundation of the financial incentive system, which drives much of the behavior in our health care system, regardless of the espoused ideals and goals. Payers and legislators are striving for the triple aim, driving changes in payer contracts, and with it will come change to practice compensation.

Pure Fee-For-Service (FFS) and Pure Capitation payer\* contracts have been tried in the past and present, yielding mediocre quality and outcomes, while generating higher than desired costs. Small additions of Pay-For-Performance (P4P) features did not significantly improve the results. Future models will include features of global payments, shared risk contracts, bundles, pathways, value networks, pay for performance, employer self-pay, and retainer (concierge). The risk-based feature of these contracts is the most difficult to manage and is the most dangerous to future revenue streams.

\*Health Insurance carrier (private or government) or self-insured insurance sponsor, eg., employer or union

## **Part 1: Payer Contracts**

With FFS dominating as the provider compensation method in the USA, the country's payers and provider organizations are talking about the triple aim, while physician work with patients is still generally being driven by volume. Payer compensation to provider organizations is the foundation of the financial incentive system, which drives much of the behavior in our health care system, regardless of the espoused ideals and goals.

### **Problems with Current Payer Contracts**

The goal is to design and implement a payer compensation system, which enables the healthcare provider organization and payer to reach the triple aim goals of population health, improved patient experience, and lower per capita health care costs. Existing payer compensation models to healthcare provider organizations are not yielding satisfactory results. Beyond simply not achieving the goal, our system is eroding one of its most important resources, the primary care doctor, who is often feeling burned-out, leading to primary care doctor shortages and decreasing access to primary care. The central problem with most current payer – provider organization payment models today is that they incentivize non-value-adding behaviors by stakeholders.

There are numerous resulting problems with the current payer compensation models. There is a heavy administrative cost in both time and money at both the payer and provider organization, and, worst of all, this cascades down to the physician and mid-level providers, who spend precious time entering data into EHR's, rather than examining, diagnosing, and treating patients. Most provider organizations enter into payer contracts with multiple payers, whose contracts may include features which create opposite incentive forces on the provider organizations. What may be the greatest impediment to achieving the triple aim is the failure of the provider organization to create provider compensation which aligns the providers' financial incentives with the provider organization's financial incentives. Data integrity issues often appear when EHR data does not match up with billing data and accounting data, giving rise to a lack of confidence in the payer compensation systems, which have become heavily dependent upon accurate data. An overwhelming quantity of different metrics from the payers creates a situation where providers are feeling overwhelmed and have understandable difficulty connecting their decisions and behaviors to the metrics.

## **Payer Contract Basics**

The language of the formal provider – payer relationship is spelled out in a contract from private insurance payers and in regulation from government insurance payers.

Payer contracts vary by size of the provider organization. Often an IPA or PHO will negotiate with the payer on behalf of its member private practices, and then separately contract with the private practice regarding the shared risk/savings and P4P features of the contract.

Payer contract, as used in this paper, refers to the contract between a payer and a health care provider organization. It is important to distinguish between the relationship of payer - provider organization and the relationship of provider organization – individual provider (or independent practice). The two relationships interact and influence each other significantly.

One example of a payer - provider organization regulation is an agreement between Medicare (government insurance) and a physician hospital organization (PHO) or independent physician association (IPA), which, for their affiliated and employed primary care physicians (PCPs), utilizes the organization structure of an accountable care organization (ACO), created by the 2010 landmark federal Patient Protection and Affordable Care Act (PPACA). This agreement would include a foundation payer model type of fee for service (FFS), supplemented with a shared risk/savings component, and supplemented with a pay for performance (P4P) bonus.

One example of a provider organization – individual provider (or independent practice) contract is a physician hospital organization (PHO) or independent physician association (IPA) contract with a private practice primary care provider (PCP), which includes a foundation payer model type of fee for service (FFS), supplemented with a relative value unit (RVU) volume bonus, and supplemented with pay for performance (P4P) bonus. A common component of contracts between provider organizations and providers are volume bonuses based upon RVU benchmarks, often supplied by the Medical Group Management Association (MGMA) in the outpatient context. This paper will focus on the contracts between payers and provider organizations, and will mention, but not focus on, the contracts between the provider organizations and the providers.

## **Stakeholders of Payer Contracts**

Doctors take the Hippocratic Oath, promising to care for patients and do no harm. Congressional representatives take an oath of office, promising to represent the rights of the citizens in their state or district. Legal organizations, whether they be for-profit or nonprofit, typically draft mission statements with high ideals. The financial incentive system drives much of the behavior in our health care system, regardless of espoused ideals and goals. This is not cynical; it merely reflects human behavior. The table below shows how the incentives of the payer and provider organizations are financially opposed to one another.

Key stakeholder behaviors that impact healthcare triple aim are the following:

- Patient: lifestyle behaviors, demands of health care service/products
- Provider: decisions regarding testing and treatment orders, hours worked and time spent with patient
- Payer: reimbursement activities, such as delays, approvals/denials, audits, documentation demands

See Appendix: Stakeholder definitions and general motivations

## **Payment Models of Payer Contracts**

### Foundation Models

Foundation payer models can stand on their own.

#### 1. Pure Fee-For-Service (FFS)

The predominant foundational model for payment from payer to healthcare provider organization.

The provider organization is paid a set rate per service provided. The service provided is most often defined by a CPT (Current Procedural Terminology) code, based on the Medicare fee schedule multiplied by a multiplier negotiated between the payer and the provider organization. The CPT code is matched against the ICD (International Classification of Disease) diagnosis code by the payer. The claim is submitted by the provider to the payer, payer adjudicates claim, requests and responses for additional documentation are made, denial or approval and payment is made. This process typically takes 30 to 60 days. The incentive impacts toward reaching the triple aim:

- Negative: no motivation to improve healthcare outcomes

- Positive: providers motivated to be productive
- Unintended: providers motivated to perform unnecessary services and order unnecessary products, increasing TME

Advantage: existing, detailed system that can track services performed and diagnoses assessed

Disadvantage: results in excessive costs and mediocre health outcomes

## 2. Pure Capitation

The fixed payment from the payer to the provider organization is made per month, per quarter, or per year. Attribution rules determine how much capitation payment goes to specific providers. This is relatively simple for primary care providers, yet becomes more complicated for specialist and subspecialists. The fixed payment is based upon population TME risk and sometimes individual risk.

The incentive impacts toward reaching the triple aim:

- Negative: no motivation for provider productivity; cost dominates decisions, rather than health outcomes
- Positive: providers motivated to be contain costs
- Unintended: providers work less, access to care is reduced, patients with borderline conditions may be denied optimum care

Advantage: healthcare costs are contained

Disadvantage: poor access, mediocre health outcomes

## 3. Global Capitation (Global Payments)

This model is often a blended form of the foundational models of capitation and FFS with model features of shared risk/savings and P4P, with one new feature of global TME responsibility. It shifts risk even further from the payer to the provider organization. A large provider organization, typically an integrated delivery system (IDS) is held accountable for the total medical expense for a patient, regardless of where the medical service was provided.

There is significant risk to provider, who cannot control the consumer choice of specialist or hospital, while being held financially accountable for this choice. Usage of services can be inside or outside of network of providers, while payer policies often allow patients to choose providers outside of provider network with little or no negative

consequence to the patient. This causes a disconnection between responsibility and authority, since the provider is financially responsible, while the payer gives the patient the authority to decide. For example, if the patient chooses to get a colonoscopy at a colonoscopy specialty practice outside the network, the provider network is responsible for the cost incurred at the year-end budget accounting with resulting risk penalty, while the colonoscopy specialty provider outside of the network gained the revenue from the service. Most provider organizations carry this risk, withholding from physician practices or employed physicians a year-end bonus (shared savings feature), if goals are not met. The practices or individual physicians typically never have to write a year-end check.

The incentive impacts toward reaching the triple aim:

- Negative: complexity and administrative cost can reduce effectiveness
- Positive: theoretical motivation of provider organization is to contain costs (capitation component) and increase quality and health outcomes (P4P component)
- Unintended: expensive and risky for providers, who feel forced to join larger IDS and IPA organizations, causing consolidation and reduced competition, with the economic result of higher cost than in a more competitive environment

Advantage: healthcare costs are contained

Disadvantage: poor access, mediocre health outcomes

Capitation structure with goal: reduce cost

Pay for Performance features with goal: increase quality and access

#### 4. Episode-based payments (bundling services)

This is a fixed payment for a specific type of medical episode. There can be complexity adjustments, yet the risk of complexity and increased medical expense is generally held by the provider organization, not the payer. The payer, Medicare, uses this method more than any other payer. Medicare calls this the system of Diagnosis Related Groups (DRGs). One example would be an episode of prenatal, birth, post birth to discharge care. Another example would be a global surgery package for a hip replacement, which covers preoperative, operative, and postoperative care.

The incentive impacts toward reaching the triple aim:

- Negative: within the episode, decrease procedures, services, and products, even when performance would be medically optimal
- Positive: providers motivated to be contain costs
- Unintended: access to care is reduced, patients with borderline conditions may be denied care, eg., new mother and baby discharged 1 day earlier than optimum for the health of the baby. Administrative complexity of payment coordination among all providers in the episode can be challenging.

Advantage: healthcare costs are contained

Disadvantage: poor access, mediocre health outcomes

### Model Features

Model Features can be combined with a foundational model.

#### 1. Care Management Fee

PCMH is a primary example of how the payer rewards the provider organization with a PMPM fee for managing the care of patients.

#### 2. Pay-for-Performance (P4P)

Incentive payments, typically paid quarterly or annually, are paid to the provider organization for performance in any area of the business, eg. Medicare Meaningful Use

#### 3. Shared Savings / Risk

Risk is the financial risk of a monetary loss when the patient or defined patient population utilizes more health care services (incurs more health care costs) than are allotted in the contract. Savings is the opposite.

#### 4. Pathways<sup>i</sup>

Care pathways are procedures, designed from results of research evidence, with measurement, assessment, and treatment protocols.

#### 5. Value Networks<sup>ii</sup>

Payers rate providers on quality and cost, and then promote the highest rated providers who deliver lower cost care.



## 6. Employer self-pay

Most self-paid employer health plans are administered by private insurance companies, who use existing methods and the bank account of the employer to pay claims.

## 7. Retainer-based (subscriber, concierge)

Variation on capitation, where the patient, rather than the payer, pays the provider directly on per month or per year basis.

## 8. Consumer-Driven

In this model, risk is largely taken by the patient, who pays a high deductible.

### Combining Models

It is very rare for a payer contract to contain only one type of payer model. For example, a Patient Centered Medical Home will usually contain a foundation payer model type, such as FFS or capitation, often supplemented with a care management fee, usually paid per patient per month, a P4P payment at the end of the year for meeting quality goals, and a shared risk/savings payment for meeting goals related to total medical expense of their attributed patients.

A common model uses FFS for weekly or monthly reimbursement payments, with a retrospective annual capitation feature, which incorporates the shared risk/savings component.

SEE Appendix: Model Features

### **Payer Contract Impacts on Delivery System Organizational Models**

The alignment of healthcare delivery system organization structure (including entire chain of payer to provider) to payment model affects how well the system performs to the triple aim. Organizational structure change is one of the most significant results of the shift in payment models, as will be discussed in the next section, Drivers of Change, Primary and Secondary. Below, some existing organizational structures are mentioned to give the reader a sense of organizational structures that have evolved to align with the payer model. The payment model is the driver, and the organization is following behind, trying its best to align, to ensure its financial nourishment and survival.

Payer Organizational Structure: Managed Care

FFS drives the payer organization to create Managed Care, necessary to decrease costs. This balances the incentive of the provider organization to increase costs. See Appendix: Stakeholder definitions and general motivations, Figure 3. Most plans have managed care features, in which the health plan controls when, where, what, and who (provider) the patient

receives care. More than half of Medicaid beneficiaries nationwide are enrolled in managed care organizations, most of which rely heavily on capitated rates, shifting a large part of the financial burden onto providers. Twenty-three states plan to grow their Medicaid managed care portfolios in 2015. <sup>iii</sup>

#### Provider Organizational Structure: Accountable Care Organization (ACO)

Risk contracts with P4P features can lead to the creation of ACOs. This is a network of providers who share with the payer (US and state governments: Medicare/Medicaid) risk and reward for health care service costs used by large defined patient populations. Payments are billed FFS, with holdback payments tied to cost and quality metrics. The variance of metric from benchmark determines shared financial gain or loss. Some people use the term ACO to refer to an integrated care network, which is the private payer version of the Medicare ACO, in which a defined population, attributed to an integrated care network, is associated with a capitated budget of TME.

#### Provider Organizational Structure: Patient-Centered Medical Home (PCMH)<sup>iv</sup>

FFS with PCMH metric-based incentive payments, a form of P4P, can lead to the formation of a PCMH. A PCMH is a highly-coordinated team of primary care providers, often “led” by the NP including the following: MD, NP, Nurse, MA, RD, Psychologist, and Specialist. This model saves costs, since a clinically trained NP guides the patient through the provider system, carefully utilizing services, tests, and coordinating care to reduce cost, increase access, increase quality, increase patient outcomes. The PCMH receives extra per patient add-on revenue from the payer or government grants. The model provides extra care management to chronic or high-risk patients, with the aim of reducing complications and ER visits.

#### Other Delivery System Models

1. Medicaid Managed Care
2. Primary Care Case Management (PCCM)
3. Risk-Based Managed Care/Managed Care Organization (RBMC/MCO)
4. Prepaid Health Plan (PHP)
5. Managed Long-Term Services and Supports (MLTSS)
6. Health Home (HH)

## **Part 2: Shift in Payment Models**

### **Primary Drivers of Shifting Payer Contract Payment Models**

1. Excessive national health care costs
2. Downward pressures on costs from payers and fund sources
3. Entry of risk and quality into the payer-provider organization contracts.
4. Legislation
  - a. PPACA
  - b. MACRA
  - c. HITECH ACT
  - d. Pioneer ACO is sun setting at end of 2016
5. Regulation
6. Increasing expectation and accessibility of information (cost, quality, access) to all stakeholders, most importantly, the patients
7. Primary care provider burnout

MACRA repeals SGR formula for Medicare reimbursement and creates a new P4P system using modified versions of existing quality programs.

Risk is entering PPO and POS type health plans, when historically, it has been limited to HMO plans. Medicare in Medicaid are both heading toward risk-based contracts, with current plans containing some shared risk/savings elements.

### **Secondary Drivers**

1. Move away from FFS as a payment model
2. Consolidation of health insurance companies
3. Consolidation of health care networks
4. Academic medical centers buying or affiliating with hospitals, clinics, and IPAs
5. Private physician practices becoming employed by hospitals
6. Private physician practices joining larger physician practices or IPAs
7. Vertical growth in the service chain with provider organizations becoming payers, resulting in a pure capitation model<sup>v</sup>
8. Transition from business to business (payer to employer) health insurance models to business to consumer (payer to consumer, via PPACA connector websites) models
9. Innovation
10. Shift of medical risk: PPACA requirements make some medical risk appear to be uninsurable, and payers desire to shift some of this risk to providers

Recognition that the current healthcare payment system rewards volume of services, rather than value and quality has led to an environment of payment model reform, shifting away from the norm of FFS. Physicians are increasingly choosing to be employed by IDS, due to the increased capital, risk, regulatory, administrative demands, revenue cycle management requirements of coding & billing.

Innovation is beginning to occur, in response to the changing landscape of healthcare. Iora Health is developing a capitation model for PCPs in a very limited market of self-insured employers. IDS organizations are creating their own medical management tools to help with medical decision making, driven by the need to improve on quality and cost. These provider organization tools could someday be the replacement for the payers' managed care tools. For example, Mass General hospital has developed PROE, a proprietary medical management system, to manage surgical care decisions<sup>vi</sup>.

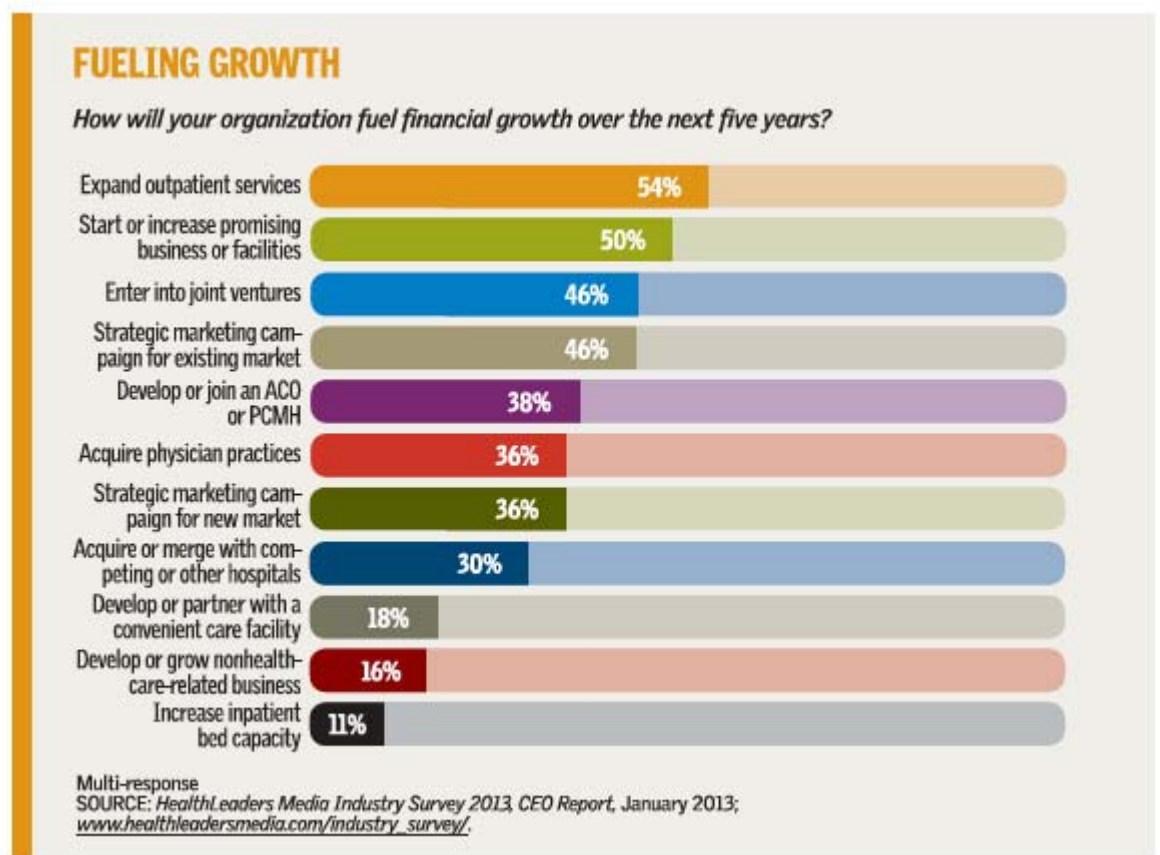


Figure 1: Health Care CEO's 2013 financial strategies

Source: HealthLeaders Media Industry Survey 2013, CEO Report, January 2013

## **Potential Major Industry Transformations Resulting from Primary/Secondary Drivers**

If provider organizations predominantly become payers (secondary driver 7. above), the healthcare landscape of the USA will change dramatically, resulting in a pure capitation model, where the IDS revenue is equal to the premium received monthly. The most widely known model is the Kaiser Permanente payer-provider system. Another potentially dramatic shift could happen if the country shifts predominantly from business (payer) - business (employer) health insurance models to business (payer) - consumer, via PPACA connector websites (secondary driver 8. above).

## **Shifts away from Payer Contract Payment Models with These Characteristics**

11. Pure FFS
12. Indemnity FFS
13. Pure Capitation

## **Shifts toward Payer Contract Payment Models with These Characteristics**

14. Global Payments
15. Shared Risk Contracts
16. Bundles
17. Pathways
18. Value networks
19. Pay for performance (P4P)
20. Employer Self-pay
21. Retainer-based

For example, the Retainer-based compensation model, also known as the Concierge compensation model, are becoming increasingly popular among primary care providers in communities with affluent patients, exacerbating the PCP shortage. PCPs are finding that they improve their quality of life by reducing their patient panel from 2000 to 500 patients, while reducing their administrative overhead, hours worked, and stress of dealing with payer problems.

## **Payer Contracts Strategic Elements**

Beyond model types, the following strategic elements that have begun to appear or may appear in future payment models:

1. Combine Global Capitation with other payment methods to achieve the triple aim  
Global capitation, with shared risk, aligns the incentives of the fund sources (government and employers), the payers, and the providers. Current risk contracts typically phase-in provider organization risk with a target of approximately 88% risk to provider organizations and 12% to

payer.<sup>vii</sup> Future contracts may combine methods to reduce cost (such as global capitation, episode-based payments) and P4P methods to increase value and access. For example, a new mother and baby would be impacted by the episode-based payment structure to minimize hospital days and TME, while the P4P payment structure would incentivize the hospital to discharge only if there is a minute risk of complication and readmission.

## 2. Align IDS – provider compensation with payer – IDS payment contracts

Until the incentive features of the payer – provider organization contract/regulation are passed through via provider compensation agreements (currently dominated by FFS), there may be little change in provider behavior. Nonfinancial incentives have not been shown to overcome financial ones, when there is a conflict. Future contracts may implement this change, using best practices of change management, including engagement up front with question and answer sessions for employees; more training; more support before, during, and after implementation; and coaching from experienced physicians, who have successfully implemented.<sup>viii</sup>

## 3. Psychology of Motivation

Future contracts may include mechanisms utilizing research conclusions in the fields of psychology of motivation and behavioral economics, both individually and organizationally, will increase the efficacy of the contract itself.<sup>ix</sup> Payment models, even at the highest levels, impact front line health care provider and patient behaviors. Financial pressures eventually find their way to the front line, even when it is acknowledged that this can be detrimental to the purpose and vision. For example, a provider's attention can be distracted from the patient's needs, narrowing the focus to a rewarded metric at the expense of the larger creative perspective needed to perform an assessment of a complex patient and determine the best course of treatment under multiple constraints and trade-offs.<sup>x</sup>

## 4. Simplicity

Future contracts may be made more simple, acknowledging the tradeoff between payment models with higher complexity-increased fairness-higher costs and those with lower complexity-higher motivation effectiveness-lower costs. Simplicity of payer contracts reduces the administrative burden of time and cost, increases visible association between service and payment, increasing the likelihood of being a more potent motivator of behavior.<sup>xi</sup>

## 5. Transparency

Future contracts may provide for more transparency of metrics to meet the increasing expectation and accessibility of information (cost, quality, access) to all stakeholders (patients,

employers, and payers, governments) who have asked for much more detail about the care that is being provided. Implementation of the EHR and the analysis of the resulting data is making it much easier to be transparent and share data. There is a natural reluctance to share pricing and quality data, for fear that it will be used against the one sharing, yet it is the most effective way to lead.<sup>xii</sup> Many physician leaders believe that the best place to influence this movement is from the front.<sup>xiii</sup>

6. Match authority with accountability

In the future, risk sharing and savings sharing between payer and provider may not be based upon patient behavior, as many are now, but instead may be based upon provider decisions and recommendations. Risk sharing between payer and patient may be based upon patient behavior, as in the case of consumer driven plans with high deductibles. For example, in the case of a patient who demands a MRI for a sprained ankle, the payment model would shift medical expense risk, using higher copayments or cash payments from the patient, when they demand services above the standard of care.

7. Appropriately utilize and compensate service providers for value added

CMS, driven by the federal government, may break the procedural specialist's lock on the Medicare fee schedule, which has existed since the relative value system was created. Our nation's PCP shortage and its underlying causes are well documented. PCPs, population health experts, business analysts, and procedural specialists (eg. surgeons), and cognitive specialists (eg. cardiologist) may, in the future, be more appropriately compensated by the Medicare fee schedule framework. Current work is being done on a new attribution model by CMS through PCORI.<sup>xiv</sup>

Provider activities which add value, such as care coordination, telephone follow-up, and taking extra time to coach healthy patient behaviors are not rewarded in FFS nor even in many P4P contracts.<sup>xv</sup> Future payer contracts may motivate provider organizations to deliver excellent patient value, where value equals the health outcomes achieved per dollar of cost compared to peers. This payment model feature will drive organizations to restructure and develop/market centers of excellence, rather than trying to capture all services (the result of the global capitation incentives).<sup>xvi</sup>

If a medical assistant or care coordinator is adding significant value, they would be compensated in a significant way. The supply – demand free market of human resources puts a premium on medical degrees and undervalues the medical assistant, who may be adding more emotional value than anyone else in the service experience. Increasing the compensation of medical assistants, nurses, care managers, mid-level providers, and asking them to perform at the

top of their license, adds value in a systemic way. Global capitation risk sharing contracts, mentioned in the above (SEE 1.) will encourage this change.

8. Preserve data collection of ICD and CPT codes

Regardless of the decision to keep or discard FFS, the data collection generated by usage of the CPT and ICD coding documentation is a treasure for population health analytics and will likely be preserved. In fact, this was the original purpose of the ICD code set. With the results of the HITECH Act bearing the fruit of EHR implementation across the nation, the data can now be largely generated in a semi-automated way from the EHR systems.

9. Align the payment model to the provider organization capabilities

Future contracts may make allowances for provider organization capability. The capabilities of provider organizations vary immensely. For example, holding an IDS accountable for the global TME PMPM, when it does not own a post-acute care facility for rehabilitation or psychiatric care is not reasonable. Figure 2 shows that a fully-integrated IDS can handle a global capitation payment contract, while unrelated hospitals (independent, likely community hospital) would be unable to handle the risk of this contract and would be more appropriately served by the blended FFS and episode-based payment contract, with some element of P4P.

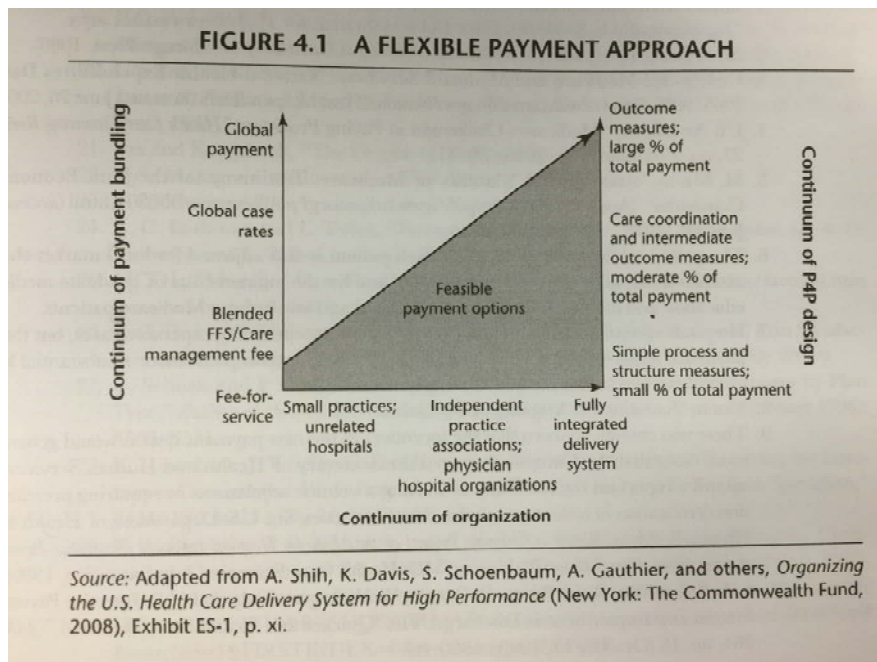


Figure 2: Alignment of Payment Model to IDS Capability

Source: Crosson, Francis, Laura Tollen, Partners in Health: How Physicians and Hospitals Can Be Accountable Together, Kaiser Institute for Health Policy, Jossey-Bass, 2010 p89



10. Reduce the FFS payment portion of contracted reimbursement below marginal cost

When FFS is utilized, the proportion of FFS will likely be reduced in future contracts, such that the FFS is significantly below marginal cost and the P4P is large enough to cover the difference plus necessary profit margin for the practice. Most contracts today between the IDS and the practice physicians include a blend of FFS and P4P. FFS dominates the compensation model and thereby the behavior. This change will create a more balanced provider behavior, which is more likely to reach the triple aim.<sup>xvii</sup>

**Conclusion**

Part 1 explained current payer contracts:

- Foundational Models: FFS, capitation, global capitation, Episode-based payments
- Model Features: Care Management Fee, P4P, Shared Savings / Risk Arrangements, Pathways, Value Networks, Employer self-pay, Retainer-based, Consumer-Driven

Part 2 described change drivers and the resulting shifts in payment models away from Pure FFS, Indemnity FFS, and Pure Capitation, while moving toward payment models of risk-based global payment, combined with features of P4P, bundling and others. Beyond model types, there are strategic elements that have begun to appear or may appear in future payment models:

1. Combine Global Capitation with other payment methods to achieve the triple aim
2. Align IDS – provider compensation with payer – IDS payment contracts
3. Psychology of Motivation
4. Simplicity
5. Transparency
6. Match authority with accountability
7. Appropriately utilize and compensate service providers for value added
8. Preserve data collection of ICD and CPT codes
9. Align the payment model to the provider organization capabilities
10. Reduce the FFS payment portion of contracted reimbursement below marginal cost

When practice managers can understand payer contracts and clearly see the current and potential future trends in payer contracting, they are better equipped to prepare their practices for success.

## Appendix: Acronyms and Abbreviations

|          |  |
|----------|--|
| ACO      | Accountable Care Organization  |
| AMA      | American Medical Association   |
| CMS      | Centers for Medicare & Medicaid Services   |
| CPT      | Current Procedural Terminology code  |
| DRG      | Diagnosis Related Group  |
| EHR      | Electronic health record   |
| FFS      | Fee for service  |
| HEDIS    | Healthcare Effectiveness Data and Information Set                                |
| HH       | Health Home  |
| HITECH   | Health Information Technology for Economic and Clinical Health                   |
| ICD      | International Classification of Disease diagnosis code                           |
| IDS      | Integrated delivery system   |
| IPA      | Independent physician association  |
| IPF      | Internal Performance Network (Partners Healthcare internal risk sharing)         |
| IT       | Information Technology   |
| MACRA    | Medicare Access and CHIP Reauthorization Act                                     |
| MGMA     | Medical Group Management Association   |
| MLTSS    | Managed Long-Term Services and Supports  |
| P4P      | Pay for performance, sometimes written, “PFP”                                    |
| PCCM     | Primary Care Case Management   |
| PCMH     | Patient Centered Medical Home  |
| PCP      | Primary care provider  |
| PHO      | Physician hospital organization  |
| PHP      | Prepaid Health Plan  |
| PMPM     | Per Member per Month (capitation payment or TME)                                 |
| PPACA    | Patient Protection and Affordable Care Act                                       |
| PQRS     | Medicare’s Physician Quality Reporting System                                    |
| PVBPM    | Physician Value-Based Payment Modifier   |
| RBMC/MCO | Risk-Based Managed Care/Managed Care Organization                                |
| RVU      | Relative value unit  |
| RSO      | Regional Service Organization  |
| SGR      | Sustainable growth rate (context: legislation-Medicare fee schedule adjustments) |
| TME      | Total medical expense  |

## Appendix: Stakeholder definitions and general motivations

| Stakeholder                      | Definition*   | Incentive from Payment System**  |
|----------------------------------|---|--|
|                                  |   | General Motivation   |
| Federal Government               | Manager of Medicare, contributor to Medicaid  | 1. Increase population health<br>2. decrease health care costs<br>3. sustainable federal and Medicare budget                   |
| State Government                 | Manager of Medicaid   | Increase population health, decrease health care costs, sustainable state budget   |
| Employer                         | Main customer of payer in US health care system, contracts with payer and typically pays 50% or more of monthly premium     | 1. Attract and retain quality employees<br>2. decrease healthcare costs<br>3. increase employees productive days/year          |
| Payer                            | Private: Insurance Organization, <i>purchaser</i> of service<br>Public: Medicare/Medicaid/Tricare                           | Increase revenue, decrease costs ( <i>decrease claims paid</i> ), decrease risk of paid claims higher than forecasted          |
| Provider Organization (IDS)      | Integrated Delivery System, a network of academic medical centers, community hospitals, and physicians, includes IPAs, PHOs | Increase revenue ( <i>increase claims paid</i> ), decrease costs   |
| Provider Organization (practice) | Group of providers bound together in a legal entity, such as professional corporation                                       | Increase revenue ( <i>increase claims paid</i> ), decrease costs   |
| Provider                         | Doctor, Nurse Practitioner, Physician Assistant   | Improve patient outcomes and satisfaction, <i>increase compensation</i>  |
| Supplier                         | Supplies products and nonmedical services   | Increase revenue, decrease costs   |
| Patient                          | Recipient of service or product; purchaser of service, in form of premiums, copays and deductibles                          | <i>Increase perceived health outcomes</i> and access (convenience), decrease cost of monthly premiums, copays, and deductibles |

Figure 3

\* Definition within context of typical private Managed Care Model or Medicare/Medicaid

\*\* Order of stakeholder priority, highest at top

Appendix Framework Source: MedPAC, Exploring Alternative Approaches to Valuing Physician Services, 2011, Christianson, et al

| Stakeholder   | FFS  | Capitation  | Episode-Based   | P4P   |
|---|--|---|---|---|
| Federal Government  | 1. Increase population health<br>2. decrease health care costs<br>3. sustainable federal and Medicare budget   | 1. Decrease health care costs<br>2. Sustainable federal and Medicare budget<br>3. Increase population health where it reduces systemic costs  |   |   |
| State Government  | Increase population health, decrease health care costs, sustainable state budget   | 1234 Sharon Rex.Snape's scope on  |   |   |
| Employer  | 1. Attract and retain quality employees<br>2. decrease healthcare costs<br>3.increase employees productive days/year   | 1. Decrease health care costs<br>2. increase employees productive days/year<br>3. Attract and retain quality employees  |   |   |
| Payer   | 1. decrease claims paid<br>2. decrease risk of paid claims higher than forecasted  | 1. Decrease number of attributed lives to provider<br>2. Deny complexity exceptions which enable paid claims outside of capitation, due to risk corridors                                     | 1. Deny qualification for episode ***<br>2. Deny complexity exceptions which enable higher than normal episode paid   | Reduce performance payments to nonperforming provider organization  |
| Provider Organization (IDS)   | 1. Increase volume of services provided<br>2. Increase procedures with higher payment/time of service<br>3. Increase days of hospital admission  | 1. Decrease volume of services provided<br>2. Decrease procedures, services, and products<br>3. Decrease days of hospital admission   | 1. Increase volume of episodes provided<br>2. Within the episode, decrease procedures, services, and products<br>3. Decrease days of hospital admission       | 1. Decrease services and products that are measured to be outside the standard of care<br>2. Increase services and behaviors rewarded by contract<br>3. Implement EHR****, data analytics, population health management   |
| Provider Organization (practice)  | 1. Increase volume of services provided<br>2. Increase procedures with higher payment/time of service  | 1. Become employed by IDS or larger practice network<br>2. Decrease volume of services provided<br>3. Decrease procedures, services, and products   | 1. Increase volume of episodes provided<br>2. Within the episode, decrease procedures, services, and products   | 1. Become employed by IDS or larger practice network<br>2. Decrease services and products that are measured to be outside the standard of care<br>3. Increase services and behaviors rewarded by contract<br>4. Implement EHR****, data analytics, population health management |
| Provider  | 1. Increase volume of services provided<br>2. Increase procedures with higher payment/time of service, eg., those with higher RVU<br>3. Improve patient outcomes and satisfaction                                    | 1. Decrease volume of services provided<br>2. Decrease procedures, services, and products<br>3. Improve patient outcomes and satisfaction   | 1. Increase volume of episodes provided<br>2. Within the episode, decrease procedures, services, and products<br>3. Improve patient outcomes and satisfaction | 1. Increase services and behaviors rewarded by employer contract with provider<br>2. Spend more time documenting per requirements   |
| Supplier  | 1. Sell products that enable providers to increase volume<br>2. Market directly to consumers, who will demand perceived highest performing product and find little resistance from provider to ordering this product | 1. Sell products that enable providers to reduce costs  | 1. Sell products that enable providers to reduce costs  | 1. Sell products that enable providers to reduce costs  |
| Patient   | 1. Utilize unlimited services, with little regard to costs<br>2. threaten to leave PCP if do not receive desired referral<br>3. threaten to leave doctor if do not receive desired treatment                         | 1. leave or threaten to leave employer or insurance company, if do not receive desired access or treatment<br>2. leave or threaten to leave PCP if do not receive desired access or treatment | 1. Request to be treated as complex patient to receive extra services   | 1. Request to be treated as complex patient to receive extra services   |
| * Definition within context of typical private Managed Care Model or Medicare/Medicaid  |  |   |   |   |
| ** Order of stakeholder priority, highest at top  |  |   |   |   |
| *** Example: Episode based payment for stay in rehabilitation hospital/clinic is denied, based on lack of prior hospital admission or lack of complexity  |  |   |   |   |
| **** Example: Medicare/CMS implemented Meaningful Use, as part of the HITECH Act, motivating provider organizations to implement EHR systems  |  |   |   |   |
| ***** Outside of Network costs penalize the shared risk capitated provider organization by increasing the TME of the patient, which increases the average TME/capitated covered life, which reduces retrospective capitated shared risk/savings revenue from the payer or even forces a check to be |  |   |   |   |

Figure 4

| Stakeholder   | Shared Risk/Savings   | Value Network   | PCMH  | Pathways  | Retainer (conterge)   |
|---|---|---|---|---|---|
| Federal Government  | <ol style="list-style-type: none"> <li>1. Decrease health care costs</li> <li>2. Sustainable federal and Medicare budget</li> <li>3. Increase population health where it reduces systemic costs</li> <li>4. Maintain population health</li> </ol> |   |   |   | Not Applicable  |
| State Government  | <ol style="list-style-type: none"> <li>1. Decrease health care costs</li> <li>2. Sustainable state budget</li> <li>3. Increase population health where it reduces systemic costs</li> </ol>   |   |   |   | Not Applicable  |
| Employer  | <ol style="list-style-type: none"> <li>1. Decrease health care costs</li> <li>2. Increase employees productive days/year</li> <li>3. Attract and retain quality employees</li> </ol>  |   |   |   | Not Applicable  |
| Payer   | <ol style="list-style-type: none"> <li>1. Measure cost and quality metrics, which lead to maximum revenue and minimum expense</li> </ol>  | Drive patients to utilize lower cost providers  | Drive patients to utilize lower cost services, such as midlevel providers, instead of high cost ER                            | Drive providers to utilize lowest cost methods  | Not Applicable  |
| Provider Organization (IDS)   | <ol style="list-style-type: none"> <li>1. Decrease services to patients outside the network*****</li> <li>2. Decrease TME</li> </ol>  | <ol style="list-style-type: none"> <li>1. Increase services and behaviors recognized and rewarded by contract, typically by reducing TME</li> </ol>                   | <ol style="list-style-type: none"> <li>1. Increase number of midlevel providers, care coordinators</li> </ol>                 | Utilize lowest cost methods for episodes of care  | Not Applicable  |
| Provider Organization (practice)  | <ol style="list-style-type: none"> <li>1. Become employed by IDS or larger practice network</li> <li>2. Decrease services to patients outside the network*****</li> <li>3. Decrease TME</li> </ol>  | <ol style="list-style-type: none"> <li>1. Increase services and behaviors recognized and rewarded by employer provider contract, typically by reducing TME</li> </ol> | <ol style="list-style-type: none"> <li>1. Increase number of midlevel providers, care coordinators</li> </ol>                 | Utilize lowest cost methods for episodes of care  | <ol style="list-style-type: none"> <li>1. Discontinue servicing patients who prefer to pay for services with insurance</li> <li>2. Market to affluent, low-risk patients</li> <li>3. reduce panel size significantly</li> </ol>   |
| Provider  | <ol style="list-style-type: none"> <li>1. Decrease out of network referrals</li> </ol>  | <ol style="list-style-type: none"> <li>1. Increase services and behaviors recognized and rewarded by employer provider contract, typically by reducing TME</li> </ol> | <ol style="list-style-type: none"> <li>1. Direct patient's care, rather than treat patient as a customer</li> </ol>           | <ol style="list-style-type: none"> <li>1. Follow procedures, sometimes even when deviation would be best for patient</li> </ol> | <ol style="list-style-type: none"> <li>1. spend more time with patients during a visit</li> <li>2. work rotating oncall to increase access time for patients</li> </ol>   |
| Supplier  | <ol style="list-style-type: none"> <li>1. Sell products that enable providers to reduce costs</li> </ol>  | <ol style="list-style-type: none"> <li>1. Sell products that enable providers to reduce costs</li> </ol>  | <ol style="list-style-type: none"> <li>1. Sell products that enable providers to reduce costs</li> </ol>                      | <ol style="list-style-type: none"> <li>1. Sell products that enable providers to reduce costs</li> </ol>                        | <ol style="list-style-type: none"> <li>1. Sell products that enable providers to attract affluent patients</li> </ol>   |
| Patient   | <ol style="list-style-type: none"> <li>1. Request to be treated as complex patient to receive extra services</li> </ol>   | <ol style="list-style-type: none"> <li>Choose PCP, specialist, and hospital that are highest ranked and have lowest associated copay</li> </ol>                       | <ol style="list-style-type: none"> <li>Choose PCP with best customer service, highest access to midlevel providers</li> </ol> | <ol style="list-style-type: none"> <li>1. Request to be treated as complex patient to receive extra services</li> </ol>         | <ol style="list-style-type: none"> <li>1. Utilize unlimited services, with little regard to costs</li> <li>2. request/demand access at times convenient to patient - weekends, evenings, mobile phone calls to doctors</li> </ol> |
| ** Order of stakeholder priority, highest at top  |   |   |   |   |   |
| *** Example: Episode based payment for stay in rehabilitation hospital/clinic is denied, based on lack of prior hospital admission or lack of complexity  |   |   |   |   |   |
| **** Example: Medicare/CMS implemented Meaningful Use, as part of the HITECH Act, motivating provider organizations to implement EHR systems  |   |   |   |   |   |
| ***** Outside of Network costs penalize the shared risk capitated provider organization by increasing the TME of the patient, which increases the average TME/capitated covered life, which reduces retrospective capitated shared risk/savings revenue from the payer or even forces a check to be |   |   |   |   |   |

Figure 5

## Appendix: Model Features

Model Features can be combined with a foundational model.

### 1. Care Management Fee

PCMH is a primary example of how the payer rewards the provider organization with a PMPM fee for managing the care of patients, utilizing coordinators and midlevel providers to reduce ER visits and TME, while improving health outcomes. Typically, this payment is a small supplement to a foundational payment model, most commonly FFS. The incentive impacts toward reaching the triple aim:

- Negative: requires coordination among providers, and often across organizations
- Positive: increased health outcomes, decreased TME for chronically ill
- Unintended: significant administrative time and expense to implement

Advantage: increased quality, decreased cost

Disadvantage: not feasible for all care within existing healthcare organizations, for example this model is designed more for outpatient PCPs, and not for inpatient admissions.

### 2. Pay-for-Performance (P4P)

Incentive payments, typically paid quarterly or annually, are paid to the provider organization for performance in any area of the business. Some examples that have been implemented are Medicare's Meaningful Use program to incentivize implementation of EMR/EHR systems, private insurance incentives linked to Healthcare Effectiveness Data and Information Set (HEDIS) clinical quality measures, Medicare's Physician Quality Reporting System (PQRS), and Medicare's Physician Value-Based Payment Modifier (PVBPM). The incentive impacts toward reaching the triple aim:

- Negative: potentially increased TME, increased administrative expense, increased provider time spent documenting and performing to metrics that have not all been proven to improve health outcomes
- Positive: increased health outcomes
- Unintended: huge expense for information technology infrastructure to implement data collection and analysis, required to implement P4P

Advantage: increased quality

Disadvantage: increased cost, increased provider time spent documenting

### 3. Shared Savings (Gain-Sharing) / Risk (Cost) Arrangements

Within the context of payer contracts, risk is the financial risk of a monetary loss when the patient or defined patient population utilizes more health care services (incurs health care costs) than are allotted in the contract. Savings is the financial savings of a monetary gain when the patient or patient population utilizes less health care services (incurs health care costs) than are allotted in the contract. Risk is the stick, while the savings is the carrot, and either/both can be shared between payers and providers.

Many corporate leaders say “risk”, when they really mean “risk and savings”. This may seem like a small thing, however it shows that risk draws the most attention of corporate leaders, which is not surprising, when one considers the numerous bankruptcies of provider networks who took on capitation and its inherent risk in the 1990s.<sup>xviii</sup> This contract feature typically is combined with two global capitation foundational payment models, for example, a Medicare Pioneer ACO or private insurance retrospective annual capitation payment model, alongside a rolling (claims submission, denial/approval, payment) payment FFS model. This sounds complicated and many do not understand it. This is how it works:

1. The FFS model functions as usual, with the payer reimbursing the provider organization on a rolling basis. The provider organization then reimburses the provider practices, and the provider practices compensate the individual providers.
2. The population has a budgeted TME, agreed upon between payer and provider organization.
3. At year end, if the TME budget was exceeded by actual TME, the provider organization writes a check to the payer. If the actual TME was less than budget, the payer may write a check to the provider organization or enter a credit toward the account.

Currently, most individual providers and provider practices are shielded from risk by their parent provider organization (their employer, IPA, PHO, or similar organization that negotiates payer contracts on their behalf). Figure 6 shows an example of how Partners Healthcare shares risk with its payers and, in a limited way, with its affiliated practices and individual providers.

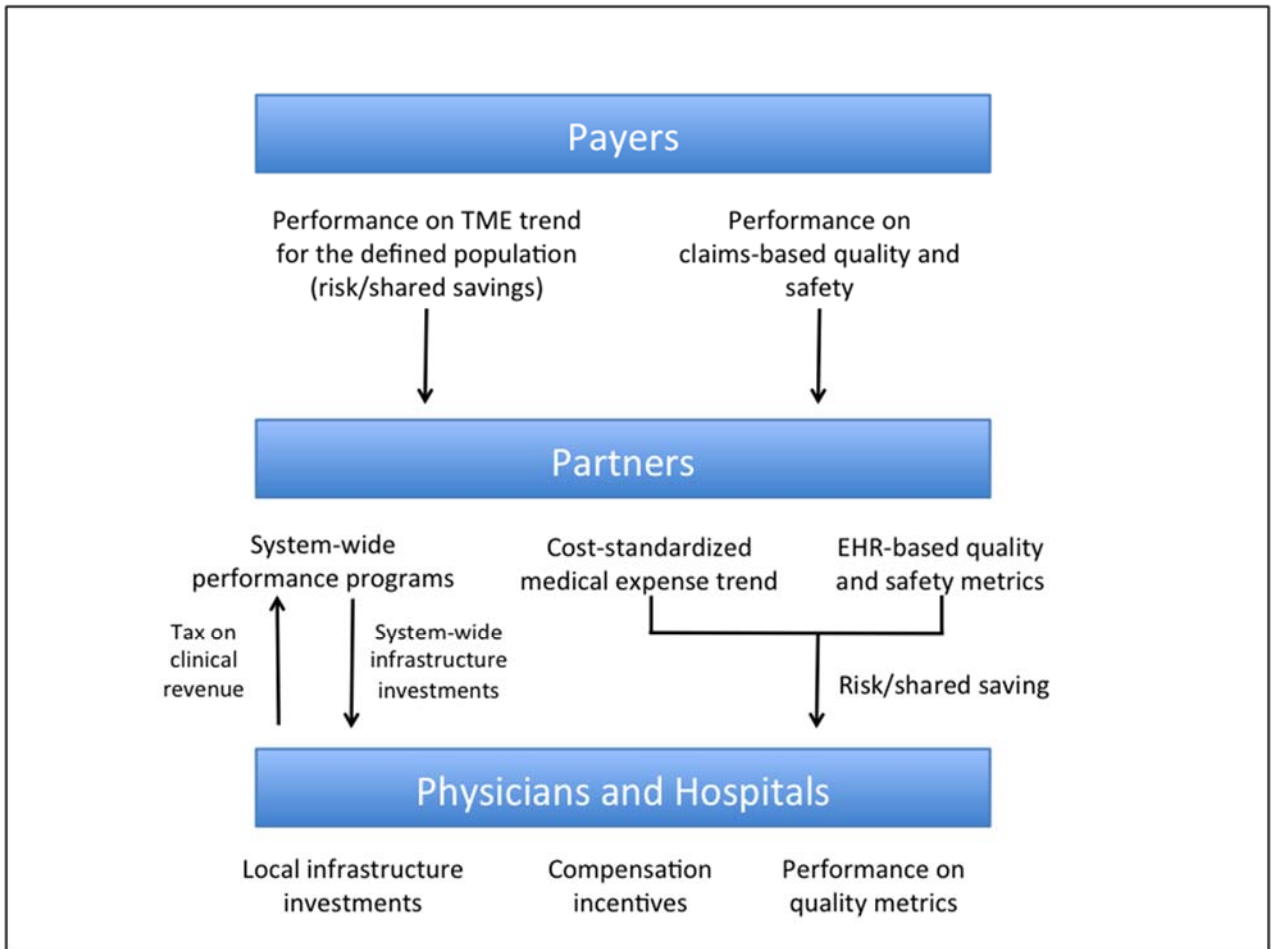


Figure 6: Partners Internal Performance Framework (IPF)

(Source: How Partners HealthCare is Managing Costs in the Emerging At-Risk Environment, Health Catalyst<sup>xix</sup>)

In 2016, parent provider organizations are generally in the process of implementing EHR, analytics, and organization structures to support the measurement and incentive system, with the intention that shared risk/savings will later be implemented top to bottom in the provider organization, in ways that are motivational and appropriate. The provider organization may create discrete incentives that align with the risk/savings contract component, however, practices typically do not have to write a check at the end of the year, if their average TME/attributed life is too high. “Any organization involved in multiple performance-based risk contracts faces the challenge of organizing the tactics and metrics for their providers. We developed the Internal Performance Network (IPF) to address this problem. It establishes a single set of performance targets and aligns incentives across all participating providers.”<sup>xx</sup>

The incentive impacts toward reaching the triple aim:

- Negative: cost dominates decisions, rather than health outcomes
- Positive: providers motivated to be contain costs



- Unintended: access to care is reduced, patients with borderline conditions may be denied optimum care

Advantage: healthcare costs are contained

Disadvantage: poor access, mediocre health outcomes

#### 4. Pathways<sup>xxi</sup>

Care pathways are procedures, designed from results of research evidence, with measurement, assessment, and treatment protocols. The aim is to reduce unwanted variation in care, reduce TME, and improve health outcomes. By standardizing, significant savings can result from negotiations with suppliers, and guidelines around treatment and days in hospital give providers a framework to ease the communication with patients. The provider organization typically receives extra per patient add-on revenue from the payer if the organization agrees to follow the care pathway guidelines. The model is most commonly used in oncology. The incentive impacts toward reaching the triple aim:

- Negative: variations in medical needs may not be acknowledged
- Positive: providers motivated to be contain costs and improve health outcomes, systemic improvement using proven quality techniques
- Unintended: access to care is reduced, patients with borderline conditions may be denied optimum care

Advantage: healthcare costs are contained, health outcomes improved

Disadvantage: potential reduced access, not feasible for most medical situations

#### 5. Value Networks<sup>xxii</sup>

Payers rate providers on quality and cost, and then promote the highest rated providers who deliver lower cost care. The rating system is questionable, since the motivation of the payer is first to make profit and only secondarily to encourage quality health care. The promotion can be required or incentivized through lower patient copayments and/or lower monthly insurance premiums for the higher ranked providers. The incentive impacts toward reaching the triple aim:

- Negative: health outcomes, access are low priority
- Positive: providers and patients motivated to be contain costs
- Unintended: patients feel access is limited, may seek different employment/insurance options

Advantage: healthcare costs are contained

Disadvantage: health outcomes, access are lower priority

#### 6. Employer self-pay

Most self-paid employer health plans are administered by private insurance companies, who use existing methods and the bank account of the employer to pay claims. There are exceptions. For example, Iora Health Care uses a PCMH-type model, which exclusively works with self-pay employers and solves the shared risk conflict of responsibility without authority over choice by reducing patient choice to be exclusively within network, unless approved by network. Iora has received high reviews from employers, providers, and patients. The incentive impacts toward reaching the triple aim:

- Negative: Varies depending upon payment model used
- Positive: Varies depending upon payment model used

Advantage: potential to tailor health plans to unique populations

Disadvantage: not feasible for American general population and all employers

#### 7. Retainer-based (subscriber, concierge)

Variation on capitation, where the patient, rather than the payer, pays the provider directly on per month or per year basis. Retainer-based models do sometimes stand on their own for affluent patients. This model is only financially feasible for Americans, in the general population, if it is supplemental to another foundational model, most commonly FFS. The incentive impacts toward reaching the triple aim:

- Negative: cost to patient increased
- Positive: access increased, health outcomes potentially increased

Advantage: reduces influence of payer over provider treatment

Disadvantage: not feasible for American general population

#### 8. Consumer-Driven

In this model, risk is largely taken by the patient, who pays a high deductible. Risk can be decreased by risk limits set in the plan with risk transferred to the employer and/or health plan.

The incentive impacts toward reaching the triple aim:

- Negative: initial cost to patient increased; patients may avoid treatment, incurring longer term TME

- Positive: patient accountable and motivated to limit medical costs

Advantage: reduces cost

Disadvantage: not currently feasible for large segment of American general population who do not manage cash flow and savings in a way that aligns with this plan

### Combining Models

It is very rare for a payer contract to contain only one type of payer model. For example, a Patient Centered Medical Home will usually contain a foundation payer model type, such as FFS or capitation, often supplemented with a care management fee, usually paid per patient per month, a P4P payment at the end of the year for meeting quality goals, and a shared risk/savings payment for meeting goals related to total medical expense of their attributed patients.

A common private payer contract in New England includes the following payment models: Shared Risk/Savings, FFS, Capitation, P4P, care pathways, and bundled services. Shared risk/savings is usually part of a capitated feature of the payer contract. Currently, a common method of implementation is utilizing FFS for payment ongoing, with a retrospective capitation feature, which incorporates the shared risk/savings component. The savings payment can be restricted to the case when both TME is below budgeted and the P4P goals are met that year, retrospectively. This contract feature stems from the idea that performing fewer services must not harm the patient in any measurable way. Care pathways are used for specific medical conditions, such as cancer treatment. Bundled services are included in the CPT coding manual as global surgery, birthing episodes, and other episodic medical procedures/services.

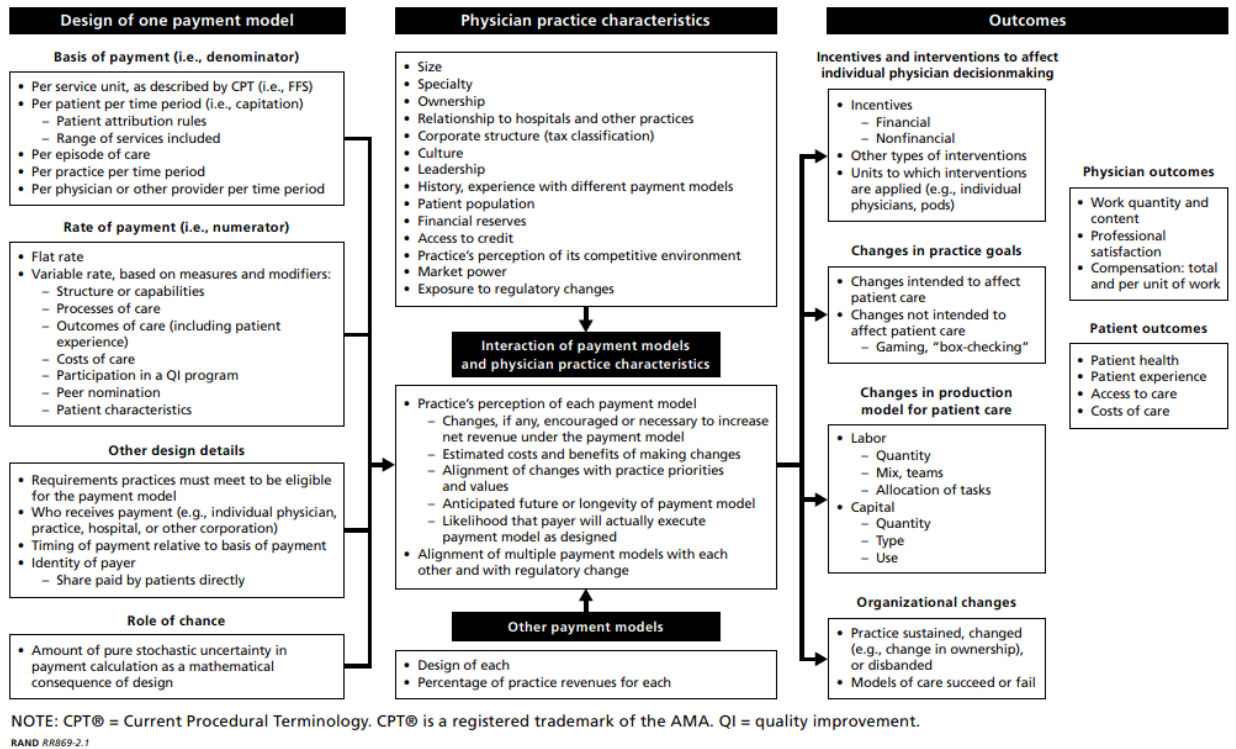


Figure 7: Conceptual model of payment model characteristics and outcomes.

Source: Effects of Health Care Payment Models on Physician Practice in the United States, 2015, RAND Corp, AMA

## Bibliography

Anonymous, "Payer Contracts: the Key to Practice Revenue", Health Management Technology, February 2006

\*Berenson, Robert A., Eugene C. Rich, "US Approaches to Physician Payment: The Deconstruction of Primary Care", Journal of Gen. Internal Medicine, 25(6):613–8, June 2010

Betbeze, Philip "Embracing Nontraditional Models," HealthLeaders, February 2013  
[http://www.healthleadersmagazinedigital.com/healthleadersmagazine/january\\_february\\_2013?pg=32#pg32](http://www.healthleadersmagazinedigital.com/healthleadersmagazine/january_february_2013?pg=32#pg32)

Blomqvist, Åke, Colin Busby, "Paying Hospital-Based Doctors: Fee for Whose Service?", C.D. HOWE Institute Commentary NO. 392, October 2013

\*Brunt, Christopher S., Gail A. Jensen, "Medicare payment generosity and access to care", Journal of Regulatory Economics, (2013) 44:215–236

Christianson, Jon B., Daniel Zismer, Katie M. White, Jessica Zeglin "Exploring Alternative Approaches to Valuing Physician Services", University of Minnesota School of Public Health, Division of Health Policy and Management for the Medicare Payment Advisory Commission (MedPAC), June 2011

\*Cimasi, Robert, Anne Sharamitaro, "Valuing Physician and Executive Compensation Agreements: Fair Compensation and Reasonableness", Valuation Strategies, March 2010

\*Citerone, Bernie, Bill Phillips, "Two Number You Need to Know", Healthcare Financial Management, September 2004

\*Cohn, Kenneth, David Harlow, "Field-tested Strategies for Physician Recruitment and Contracting", Journal of Healthcare Management, May 2009

Crosson, Francis, Laura Tollen, Partners in Health: How Physicians and Hospitals Can Be Accountable Together, Kaiser Institute for Health Policy, Jossey-Bass, 2010

Delbanco, Suzanne, "The Payment Reform Landscape: Overview," Health Affairs Blog, February 2014  
<http://healthaffairs.org/blog/2014/02/06/the-payment-reform-landscape-overview/>

\*Downey, Lavonne, Leslie S. Zun, Trena Burke, Tangula Jefferson, "Who Pays? How Reimbursement Impacts The Emergency Department", Journal of Health and Human Services Administration, Spring 2014

\*Edmondson, William, "The Per Capita Payment Model", Journal of Healthcare Management, January 2015

Friedberg, Mark, et al, "Effects of Health Care Payment Models on Physician Practice in the United States", 2015, RAND Corporation, American Medical Association

\*Galloway, Ian, "Using Pay for Success to Increase Investment in the Nonmedical Determinants of Health", Health Affairs, November 2014

Gans, David N, "A Comparison of the National Patient Centered Medical Home Accreditation and Recognition Programs", Medical Group Management Association, January 2014

Gibbons, Robert; Roberts, John; The Handbook of Organizational Economics , Princeton University Press, December 2012

Gosfield , Alice, “Understanding Risk-Based Payer Contracts”, Medical Economics, March 2015

Grimshaw, Heather, “Changing Course”, Medical Group Management Association, Executive View magazine, June 2015

Health Analyst, “How Partners HealthCare is Managing Costs in the Emerging At-Risk Environment”

[https://www.healthcatalyst.com/success\\_stories/risk-based-contracting-partners-healthcare](https://www.healthcatalyst.com/success_stories/risk-based-contracting-partners-healthcare)

Herman, Bob, “More health systems launch insurance plans despite caveats,” Modern Healthcare, April 2015

\*Johnson, Daryl, “Valuing Physician on-Call Compensation”, Compensation and Benefits Review, March 2004

\*Kerr, Steven, “On the folly of rewarding A, while hoping for B,” Academy of Management Journal, 1975, Volume 18, Number 4, pp. 769–83.

Kraft, Jeffrey G., “Direct Contracting with Employers Doesn’t Need to Be Complicated”, Modern Healthcare, November 30, 1992

Kurunthottal, Raju, “Strategies for Proactive Payer Contract Negotiations”, Medical Economics, January 10, 2015

\*Laugesen, Miriam, George France, “Integration: the firm and the health care sector”, Health Economics, Policy and Law (2014), 9, 295–312

Letourneau, Rene, “Transitioning to Bundled Payments,” HealthLeaders Media, June 2014  
<http://www.healthleadersmedia.com/finance/transitioning-bundled-payments>

Levy, Paul, Goal Play!: Leadership lessons from the soccer field, 2012

\*Lewis, Valerie A., Carrie H. Colla, William L. Schpero, Stephen M. Shortell, Elliott S. Fisher, “ACO Contracting With Private and Public Payers: A Baseline Comparative Analysis”, The American Journal of Managed Care, December 2014

\*Mahjoub, Reza, Fredrik Odegaard and Gregory S Zaric, “Health-based pharmaceutical pay-for-performance risk-sharing agreements”, Journal of the Operational Research Society (2014) 65, 588–604

Marbury, Donna, “9 points to consider when negotiating with payers”, Medical Economics, August 25, 2013

Marbury, Donna, “Soft Reimbursements May Call for Harder Negotiation with Payers”, Medical Economics, August 2013

Marcus, Leonard, Barry Dorn, Eric McNulty, “Renegotiating Health Care: Resolving Conflict to Build Collaboration”, Chapter: Designing a More Cohesive, Better-Linked Health System

McKesson Health Solutions, “The State of Value-Based Reimbursement and the Transition from Volume to Value in 2014,”

<http://mptrms.mckesson.com/rs/MckessonPT/images/Transitionfromvolumetovaluein2014.pdf>

Miller, Harold, “Ten Barriers to Healthcare Payment Reform and How to Overcome Them,” Center for Healthcare Quality & Payment Reform, December 2012

<http://www.chqpr.org/downloads/overcomingbarrierstopaymentreform.pdf>

Christopher Moriates, Vineet Arora, Neil Shah, Understanding Value-based Healthcare, McGraw-Hill 2015

Porter, Michael, Elizabeth Tiesberg, Redefining Health Care: Creating Value Based Competition on Results, Harvard Business School Press 2006

Raflery, Erin, “MedPAC Weighs New Competitive Bidding Models In Medicare”, [www.OutsideHealthPolicy.com](http://www.OutsideHealthPolicy.com) Inside Health Reform 8.11 (Mar 16, 2016)

Rice, Thomas, Lynn Y Unruh, Pauline Rosenau, Andrew J Barnes, Richard B Saltman, Ewout van Ginneken, “Challenges Facing the United States of America in Implementing Universal Coverage”, Bull World Health Organization 2014;92:894–902,

<http://dx.doi.org/10.2471/BLT.14.141762>

\*Richard, Frank, Thomas McGuire, Joseph Newhouse, “Risk Contracts in Managed Mental Health Care”, Health Affairs, Fall 1985

Ridgely, M. Susan, David de Vries, Kevin J. Bozic, and Peter S. Hussey, “Bundled Payment Fails to Gain a Foothold in California: The Experience of the IHA Bundled Payment Demonstration”, Health Affairs, August 2014

Rifkinson-Mann, Stephanie, “The Impact of Managed Care Payer Contracts on the Subspecialty Medical Provider: Policy Implications That Impact on the Care of Disabled Children”, Fordham Urban Law Journal 2001

Sanghavi, Darshak, Kate Samuels, Meaghan George and Rio Hart, “The Beginner’s Guide to New Health Care Payment Models,” Brookings.edu, July 2014

<http://www.brookings.edu/blogs/health360/posts/2014/07/23-alternative-health-care-payment-model-beginner-guide>

Saunders, Robert, “5 ways physician practices can more effectively manage payer contracts”, Healthcare Financial Management, September 2014

Shore, David, “Forces of change : new strategies for the evolving health care marketplace”, Jossey-Bass 2012

Sloan, Frank, Herschel Casper, Physician Fees and Behavior: Implications for Structuring a Fee Schedule, Incentives and Choice in Healthcare, MIT Press, 2008’s

Stodolak, Frederick, Henry Gutierrez, “Avoiding Revenue Loss Due To ‘Lesser of ‘Contract Clauses ’”, Healthcare Financial Management, August 2014

\*Zismer, Daniel, “Physician Compensation in a World of Health System Consolidation and Integration”, Journal of Healthcare Management, March 2013

Zismer, Daniel K., Jessica L. Zeglin, Sam A. Balukoff, “Collecting Data on Physician Services and Hours Worked”, University of Minnesota School of Public Health, Division of Health Policy and Management for the Medicare Payment Advisory Commission (MedPAC), August 2012

**\* Peer Reviewed Journal Article**



## References

- <sup>i</sup> Aston, Geri, “Service-line Management: A Behind the Scenes Road to Value,” – Hospitals and Health Networks, January 2015  
<http://www.hhnmag.com/articles/3757-service-line-management-a-behind-the-scenes-road-to-value>
- <sup>ii</sup> Knott, David, Tom Latkovic, David Nuzum, Jessica Ogden, and Shubham Singhal, “Maximizing Value in High-Performance Networks,” McKinsey & Company 2013
- <sup>iii</sup> Kaiser Family Foundation, “Mapping Medicaid Delivery System and Payment Reform”, 2016  
<http://kff.org/interactive/delivery-system-and-payment-reform/>
- <sup>iv</sup> Sanghavi, Darshak, Kate Samuels, Meaghan George and Rio Hart, “The Beginner’s Guide to New Health Care Payment Models,” Brookings.edu, July 2014  
<http://www.brookings.edu/blogs/health360/posts/2014/07/23-alternative-health-care-payment-model-beginner-guide>
- <sup>v</sup> Herman, Bob, “More health systems launch insurance plans despite caveats,” Modern Healthcare, April 2015
- <sup>vi</sup> Integration of Predictive Models to Support Clinical Decision Making in the Routine Care of Patients Undergoing Percutaneous Coronary Intervention, Mass General hospital  
<http://www.massgeneral.org/medicine/MIP-interview-PROE.aspx>
- <sup>vii</sup> Murphy, Jeff, Interview, Executive Director, Newton Wellesley PHO, Vice President Newton Wellesley Hospital RSO Provider Network Performance [Partners Healthcare], June 28, 2016
- <sup>viii</sup> Basford, Tara, Bill Schaninger, “The 4 Building Blocks of Change,” McKinsey Quarterly April 2016
- <sup>ix</sup> \*Kerr, Steven, “On the folly of rewarding A, while hoping for B,” Academy of Management Journal, 1975, Volume 18, Number 4, pp. 769–83.
- <sup>x</sup> \*Ariely, Dan, Uri Gneezy, George Loewenstein, Nina Mazar. 2009. “Large Stakes and Big Mistakes.” Review of Economic Studies, 76(2): 451–69
- <sup>xi</sup> \*Uri Gneezy, Stephan Meier, and Pedro Rey-Biel, “When and Why Incentives (Don’t) Work” to Modify Behavior, Journal of Economic Perspectives—Volume 25, Number 4—Fall 2011—Pages 191–210
- <sup>xii</sup> Levy, Paul, *Goal Play!: Leadership lessons from the soccer field*, 2012
- <sup>xiii</sup> Crosson, Francis, Laura Tollen, *Partners in Health: How Physicians and Hospitals Can Be Accountable Together*, Kaiser Institute for Health Policy, Jossey-Bass, 2010, P 221
- <sup>xiv</sup> Restuccia, Joseph, Boston University Professor of Health Care and Operations Management and Dean’s Research Fellow in Department of Operations and Technology Management, Research Scientist at the Veterans Health Administration’s Center for Organization
- <sup>xv</sup> \* Eisenberg J., Williams S., “Cost containment and changing physicians practice behavior. Can the fox learn to guard the chicken coop?” JAMA, 1980 1246 (19)
- <sup>xvi</sup> Porter, Michael, Elizabeth Tiesberg, *Redefining Health Care: Creating Value Based Competition on Results*, Harvard Business School Press 2006, p 149-162
- <sup>xvii</sup> McGuire, Thomas, *Physician Fees and Behavior: Implications for Structuring a Fee Schedule, Incentives and Choice in Healthcare*, ed. by Frank Sloan and Herschel Casper, MIT Press, 2008 p 263-285
- <sup>xviii</sup> Fountain, Douglas, Joy Grossman, Roger Taylor, Effie Gournis, Claudia Williams, “Market in Turmoil As Physician Organizations Stumble: Orange County, California,” Center for studying health system change, community report 10, Spring 1999
- <sup>xix</sup> Health Analyst, “How Partners HealthCare is Managing Costs in the Emerging At-Risk Environment”  
[https://www.healthcatalyst.com/success\\_stories/risk-based-contracting-partners-healthcare](https://www.healthcatalyst.com/success_stories/risk-based-contracting-partners-healthcare)
- <sup>xx</sup> Sree Chaguturu, VP Population Health Management, Partners Healthcare, Health Analyst, “How Partners HealthCare is Managing Costs in the Emerging At-Risk Environment”  
[https://www.healthcatalyst.com/success\\_stories/risk-based-contracting-partners-healthcare](https://www.healthcatalyst.com/success_stories/risk-based-contracting-partners-healthcare)
- <sup>xxi</sup> Aston, Geri, “Service-line Management: A Behind the Scenes Road to Value,” – Hospitals and Health Networks, January 2015  
<http://www.hhnmag.com/articles/3757-service-line-management-a-behind-the-scenes-road-to-value>
- <sup>xxii</sup> Knott, David, Tom Latkovic, David Nuzum, Jessica Ogden, and Shubham Singhal, “Maximizing Value in High-Performance Networks,” McKinsey & Company 2013