

Money

Understanding the new payment models

Alternatives to fee-for-service reimbursement may benefit your practice—if you know how they work

by ALICE G. GOSFIELD, JD

HIGHLIGHTS

01 Before going to an alternative payment model, be sure to understand all the qualifying conditions and details of how your practice will be paid for the care it provides.

02 Unlike the capitation payment model, today's episode rate models take into account the services patients require for defined clinical conditions, thereby lessening the financial risk to physicians.

As if attempting to qualify for meaningful use payments and Physician Quality Reporting System bonuses weren't enough, the proliferation of new payment models is leaving many primary care physicians (PCPs) confused. ▶▶

▶▶ **THIS ARTICLE** seeks to clarify concepts about which there is considerable misunderstanding among doctors and other medical professionals. It will also touch on some of the contractual issues that these models can generate—from the least complex model, the Patient-Centered Medical Home (PCMH), to the most complex, accountable care organizations (ACOs).

PCMH is a care delivery concept that is intended to produce greater engagement between the physician practice and its patients, particularly around chronic diseases. PCMH seeks to meet the goal of increased value by keeping patients out of the hospital through better management of their chronic condi-

tions. Most PCMH programs sponsored by commercial insurers pay an enhanced per-member, per-month payment to PCPs. Some pay a care management fee per patient. It is important to bear in mind, however, that PCMH is a care delivery model rather than a payment concept.

Where payers make enhanced payments available to PCMH practices, they typically do so on a "take it or leave it" basis. Sometimes there is not even a contract amendment. The health plan merely says, "If you are National Council for Quality Assurance-certified, you are eligible for additional payments."

The issues to pay attention to in such a contract are the qualifying conditions for

payment and ensuring that failure to meet the conditions does not affect your basic right to participate with a plan without PCMH payments.

BUNDLED PAYMENTS

“Bundled payment” is a term describing payments that put multiple providers together in the same financial risk pool. Typically, the term describes payments where disparate providers who are paid under different payment methodologies—e.g., hospitals paid on diagnostic-related groups and physicians paid fee-for-service—are at risk together for the same budget or pool of funds.

Some bundled payment programs make one payment to a single entity, traditionally a hospital, which then allocates the money among the participants. In Medicare’s Bundled Payment for Care Initiative (BPCI), however, many of the more than 450 participants are physician entities. Payment may be bundled around a single admission, which was the model for the Medicare coronary artery bypass graft demonstration in the late 1990s.

Today, references to bundled payment usually also entail “episode rates.” Episode rates are budgets designed around a continuum of care for a specific patient for a specific condition. Episode payments are also referred to as “case rates.” To establish the payment amount, boundaries in terms of time and the range of services to be included must be defined. For example, an episode of care around an acute myocardial infarction would include the admission and subsequent cardiac rehabilitation and other services until 30 or even 180 days after discharge. Some episode rates reach back and include the diagnostic services that established the condition. Episodes in chronic care, such as diabetes, congestive heart failure, or asthma typically extend for a full year to coincide with annual health insurance premiums.

Episode payments or case rates need not entail bundling. A physician group by itself could be paid for its services on a case rate. In today’s parlance, however, episode rates are often combined with bundled payments so that the in-

AT A GLANCE

New payment models

Patient-Centered Medical Homes

While it is a care delivery model designed to increase greater engagement by practices and patients and improve the coordination of care among specialists, most programs

sponsored by commercial payers make an enhanced per-member, per-month payment to primary care physicians. Some also pay a care management fee per patient.

ISSUES TO WATCH: Monitor closely qualifying conditions for payment. Make certain it does not impact participation with plans without PCMH payments.

Bundled payments

This model puts multiple providers together in a shared risk pool. A budgeted amount is paid for the care of the patient. Typically one entity, traditionally a hospital,

allocates the money among the participants. Bundled payments also include episode rates, which are budgets designed around a continuum of care.

ISSUES TO WATCH: Look closely at what services are bundled, what triggers a bundle and when do bundled payments end.

Accountable Care Organizations (ACO)

The term is really about organizational structure and includes a wide array of payment arrangements. Most commercial ACOs use some form of bundled payments, others

use a form of retrospective payment reconciliation. Payment measures typically include quality of performance, efficiency, and patient satisfaction.

ISSUES TO WATCH: Closely evaluate language around bundled contracts, governance of the ACO, payment appeal rights, and dispute resolution.

Capitation

An actuarially assigned payment to provider per covered person regardless of whether or not that person actually uses healthcare services.

ISSUES TO WATCH: If the actuarial predictions for healthcare coverage are too conservative, physicians are at risk for inadequate funding.

ISSUES TO WATCH

12 Recommendations on payment reform

1. Over time, payers should largely eliminate stand-alone fee-for-service payment to medical practices because of its inherent inefficiencies and problematic financial incentives.
2. The transition to an approach based on quality and value should start with the testing of new models of care over a 5-year time period, incorporating them into increasing numbers of practices, with the goal of broad adoption by the end of the decade.
3. Because fee-for-service will remain an important mode of payment into the future, even as the nation shifts toward fixed-payment models, it will be necessary to continue recalibrating fee-for-service payments to encourage behavior that improves quality and cost-effectiveness and penalize behavior that misuses or overuses care.
4. For both Medicare and private insurers, annual updates should be increased for evaluation and management codes, which are currently undervalued. Updates for procedural diagnosis codes should be frozen for a period of 3 years, except for those that are demonstrated to be currently undervalued.
5. Higher payment for facility-based services that can be performed in a lower-cost setting should be eliminated.
6. Fee-for-service contracts should always incorporate quality metrics into the negotiated reimbursement rates.
7. Fee-for-service reimbursement should encourage small practices (those having fewer than five providers) to form virtual relationships and thereby share resources to achieve higher quality care.
8. Fixed payments should initially focus on areas where significant potential exists for cost savings and higher quality, such as care for people with multiple chronic conditions and in-hospital procedures and their follow-up.
9. Measures to safeguard access to high-quality care, assess the adequacy of risk-adjustment indicators, and promote strong physician commitment to patients should be put into place for fixed payment models.
10. The Sustainable Growth Rate (SGR) should be eliminated.
11. Repeal of the SGR should be paid for with cost-savings from the Medicare program as a whole, including both cuts to physician payments and reductions in inappropriate utilization of Medicare services.
12. The Relative Value Scale Update Committee (RUC) should make decision-making more transparent and diversify its membership so that it is more representative of the medical profession as a whole. At the same time, CMS should develop alternative open, evidence-based, and expert processes to validate the data and methods it uses to establish and update relative values.

Source: National Commission on Physician Payment Reform

centives of the participants are aligned with the goals of improved quality and efficiency. Most bundled payment programs today are focused on procedures such as hip and knee replacements. This is primarily because these are relatively delimited conditions and therefore easier to use as a starting point to learn how to manage these new payment and delivery approaches.

Most experts on episode rates and bundled payments agree, however, that the real potential for improved value will be found in chronic care. Episode-based payments and bundled payments will be increasingly important to PCPs and specialists such as cardiologists, endocrinologists, pulmonologists, and allergy and asthma specialists who treat a high volume of chronic care patients.

Bundled payment or episode rates often come with numerous potential contracting pitfalls. The most critical issues for physicians are clarity regarding what services are included in the bundle, what triggers a bundle (usually a service identified by a current procedural terminology or an international classification of diseases code) and when the bundle ends. When the bundle includes disparate providers, such as hospitals and physicians, or physicians with home health agencies and rehabilitation, the contractual concerns include how disputes will be handled, which payment decisions are subject to challenge, and which are not.

ACCOUNTABLE CARE ORGANIZATIONS

Probably the most confusing term used today is "ACO." People use this term to describe a wide range of payment arrangements, yet the term really pertains to organizational structures. The Medicare Shared Savings ACO program has very specific features. Foremost among them is that any entity that chooses to be a Medicare ACO must be able to accept Medicare Part A and Part B payments to the extent that any dollars will be available at the end of the 3 years of the program to pay the participating providers. In the Medicare program, physicians and other participating providers are paid in the ordinary course of business with a reconciliation → 49

→ 46 and payout if savings are available to be shared at the end of 3 years.

Commercial ACOs are quite variable. Most use some form of retrospective payment reconciliation after paying physicians in the ordinary course. Virtually all ACOs entail some form of bundled payment, and measurement of results, in terms of quality, performance, efficiency, and patient satisfaction. The form of payment from the health plan to the provider entity—the ACO itself—can vary from a percent of premium to global capitation, episode of care payments, or payment in the ordinary course with bonuses for meeting targets. Some commercial ACOs encompass all patients insured by the health plan treated by the participating providers. Others use the term ACO to describe a specific service line, bundled payment, or quality performance bonus mechanism.

PCMH can be part of an ACO, as can bundled payments and episode rates. The ACO is the organizational structure with processes deployed in it to enhance quality, improve value and score well. The payer enters into an agreement with the ACO to pay the amount they negotiate.

Below the level of that agreement, however, a web of contractual arrangements must be created when the participants are not part of a single entity. There are contracts with physicians if the ACO is hospital-owned, with hospitals if it is physician-owned, among the hospitals and physicians if it is jointly operated, and with all the other providers rendering the full continuum of care for which the ACO is accountable. Without detailing all of the contractual issues in these arrangements, they include all of the issues associated with bundled payment as well as issues in the governance of the ACO, appeal rights regarding payment issues, and dispute resolution.^[1]

CONTRAST WITH CAPITATION

Some people confuse bundled payment with capitation. Capitation is not a bundled payment model. Capitation is an actuarially determined payment per assigned covered person who may or may not use the physician's services or any other services. Primary care capitation typically pays only for the physician services.

The distinction between capitation and any of the new models described above is that capitation pays the same amount regardless of what the patient needs clinically or receives as services. There are broader types of capitation

which may include services beyond physician services, such as physical rehabilitation or pharmacy.

The calculation of the capitation amount derives from actuarial principles of insurance. The big risk in capitation is incidence risk. The actuaries determine what the payment rate will be based on historical utilization of resources—whether of stellar or mediocre quality of value. They project these utilization patterns and the associated clinical conditions into the future to determine a dollar amount that will cover these services with some profit.

If the population to whom the insurance plan is sold does not conform with the actuarial assumptions, then physicians accepting capitation are at risk for inadequate funding. This risk increases as the physicians become responsible for the costs of other providers, too. For example, where actuaries calculate the rates based on typical assumptions and the health plan sells its health insurance to the local cigarette manufacturer or primary employer in an area of a cancer cluster, the incidence risk is much higher.

By contrast, well-constructed episode rates consider the services patients need for the defined clinical condition and that defines the budget. This is one of the fundamental principles of the PROMETHEUS Payment® model.^[2]

Episode rates expose physicians to medical management risk; in other words, the physicians are financially at risk for managing care within the budget.

There are a variety of concepts and programs being implemented to change the cost and quality of healthcare. Physicians are critical to all of them. But many of these concepts and programs are not well understood by most physicians. Many offer promise, depending on how they are implemented. Physicians should be vigilant about understanding what is available and offered to them. ■

REFERENCE

1. Gosfield, "Avoiding Food Fights: The Value of Good Drafting to ACO Physician Participants", AHLA Physician Practice Group (June 2012) pp. 10-12 <http://gosfield.com/PDF/PhysOrg.Avoiding%20Food%20Fights.June%202012.pdf>
2. de Brantes, Rosenthal, Painter, "Building A Bridge From Fragmentation to Accountability – The PROMETHUES Payment Model," NEJM, 2009, p. 361: 1033-1036 (Sept. 10, 2009).