



Transition to new payment models: Start here

The health care delivery system in the United States is undergoing a paradigm shift with regard to physician and other health care provider reimbursement methodologies. In an effort to control the growth of health care costs, risk-based payments are slowly replacing fee-for-service (FFS) as the main way physicians and providers will be paid.

This resource helps physicians who are considering transitioning to risk-based payments, whether by choice or payer request, by providing the nuts and bolts information they will need to evaluate the proposal, negotiate an agreement, if appropriate, and manage the revenue cycle associated with any new payment model to which they are ultimately subject. This resource will help you figure out the likely economic consequences of the different payment proposals you may face, e.g. whether you can afford the bundled payment you are being offered by a payer that has traditionally paid you FFS, whether you would actually get a bonus if you participated in another payer's shared savings program.

Fee-for-service

Physicians understand FFS. Generally speaking, the higher the fee and the higher the volume, the more money the physician receives. Of course, the reality is much more confusing, as physicians typically have challenges with every single step of the process, from figuring out which fee schedule will apply, to getting a copy of that fee schedule, to deciphering which claim edits and payment rules will be applied to determine the final payment. Indeed, under the current system, a physician could negotiate a \$20 fee for a particular Current Procedural Terminology (CPT®) code, only to get

remittance advices indicating that the physician was paid \$0, because that CPT Code is “never allowed!”

FFS issues typically do not go away even with under new payment models, whether that model involves capitation, bundled payments, shared savings or pay-for-performance. Fee schedules, their edits and payment rules are still critical:

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

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

Risk or “budget-based” payment systems

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

certain cost targets or outcomes, rather than on simply reporting whether certain activities were done.

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

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

Evaluating a utilization budget

The evaluation of a utilization budget requires 4 steps:

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

4. determine whether the services covered by the budget can be provided within the budgeted allowance.

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

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

As a threshold matter, always ask the health plan for the data on which it based the utilization budget which underlies the payment proposal, along with a copy of a certification from the health plan’s actuary that the utilization projection is actuarially sound. Generally speaking, this should be the same data that the health plan used to set the health insurance premium rates for the population to be covered by the budget-based payment model. You should also have the health plan’s actuary certify that this is so, or if not, provide a complete explanation of any ways in which the utilization projection being used to calculate the utilization budget for the payment proposal you are being offered differs from that used to calculate the premium. Because you will need to understand the difference between actuarial analyses on the health insurer’s population versus what you will attract as a subset of that population, you will generally be best advised to seek assistance from a professional actuary. An actuary can help you evaluate certain safeguards to protect yourself from adverse selection issues or the “law of small numbers.” Although retaining an actuary will involve some up-front expense, the more favorable utilization budgets and associated payment terms resulting from that assistance should more than compensate you for that expense. See the chapter entitled, “Working with actuaries” for further information regarding how best to use an actuary’s services.

Step one: Determine what services are included within the budget

To establish an actuarially sound utilization budget, you must first know with the greatest degree of specificity ALL of the services which are to be covered by the budget. This means that you must have an exhaustive list defining each and every service which will be charged against the budget by CPT, HCPCS, ASA, CDT and ICD-10-CM codes, and the financial impact of any applicable modifiers, as well as any facility-based services. Areas deserving careful consideration include mid-contract changes to legal coverage mandates, new technologies or drugs, and out-of-network and out-of-area services. To eliminate any confusion as to what

services the utilization budget covers, you should clarify that the budget expressly excludes any service which is not specifically included.

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

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

1. **Expected number of enrollees.** The health plan should provide you with information that will enable you to estimate the number of patients who will either be assigned to, or select your practice, over the term of the contract.
 - A. **Guaranteed minimum number of patients.** The number of patients assigned to you is a significant risk factor under budget-based payment arrangements. In general, you should attempt to secure large patient populations, because they offer some protection from the financial impact of catastrophic cases. A high-use patient can have a large impact on your utilization budget if you have a small number of patients covered by that budget.
2. **Age and sex breakdown of your expected patient population.** No matter what your specialty, you should know what age and sex groups are most likely to use your services, as certain age and sex groupings can have a significant impact on the utilization of specific specialty services. For example, women ages 20 to 35 are most likely to seek OB services. Children ages 0-5 will take up most of a pediatrician's time. So insist that the health plan provide you with the expected age/sex breakdown of your expected patient population so that you can ensure that your utilization budget is appropriately sex and age adjusted.
3. **Expected utilization profile, by CPT code.** You should ask the health plan to tell you the average number of the services covered by your utilization budget you can be expected to provide, per patient for your specialty, by CPT code. This information will help you continually monitor current utilization against projections, and thereby manage your risk during the course of the contract.
4. **Demographic considerations.** Demographic considerations can also significantly affect the amount and type of services that your expected patient population will utilize. For example, if a significant number of your expected enrollees will come from high-crime, high-violence areas, this will impact your utilization budget and thus may function as a basis to negotiate for a budget increase. Similarly, patients who are likely to have significant problems travelling to their appointments or otherwise complying with their physicians' instructions will, at least in the long run, likely use more, potentially higher-cost services than those who do not face such challenges.
5. **List of employer groups enrolled.** There is some evidence that professionals and white-collar workers are higher utilizers. For example, workers in the medical field—hospital workers, doctors, dentists, etc., may utilize more services than others, simply due to their occupational experience. Also, certain employees may have dangerous jobs which require them to seek more care, e.g., stunt people, police officers, fire fighters, and chemical plant workers. Again, if your patients have high-risk jobs which are likely to affect utilization in your specialty, this may be a basis for negotiating for an increase in your utilization budget, unless these claims will likely be covered by workers' compensation, outside the budget-based payment system.
6. **Marketing information.** You need to find out how the health plan will be marketed, and to whom, and negotiate for a utilization budget that will reflect the cost of serving that population. Is the health plan marketed to employees without previous insurance, or who have not had insurance for a long time? These employees may need more care to make up for a lack of care in the past. Is the health plan marketed as if it is an indemnity, open-access product? If so, it may attract patients inclined toward multiple, potentially unnecessary visits.
7. **Copayment information.** Copayments need to be set high enough to discourage unnecessary utilization but low enough to ensure that patients seek care when medically necessary.
8. **Transition costs.** Take into account the possible increases in utilization that may result from transitioning from FFS to a budget-based payment arrangement.
 - A. **Primary care.** If the budget-based payment arrangement makes you a gatekeeper, you may

be seeing a different mix of patients than had been the case under your FFS arrangements. This difference may be a direct result of the health plan prohibiting direct access to specialists. Thus, patients that formerly went directly to allergists, dermatologists, orthopedic surgeons, rheumatologists, etc., may be treated first by you, thus increasing your utilization rates. In such systems, only those requiring specialty care as determined by you may subsequently be referred.

B. Specialty care. Specialists' utilization budgets are based, in part, on the expected frequency of utilization of the particular specialty services. These determinations are generally based upon data reflecting frequency of the utilization of services by specialists paid on a FFS basis. However, referrals from primary care providers (PCPs) may increase in payment systems where there is no financial risk to the PCP for making the referral to the specialist. For example, minor urinary infections may be referred to a capitated urologist, although historically such infections would have been treated by the PCP.

C. Optimizing care delivery. Ongoing discussion between the PCPs and specialists over referral and consultation practices is critical to developing optimal working relationships and efficient care delivery. All physicians and their patients benefit when PCPs handle all matters within their capability and refer all matters for which specialty care is appropriate, and specialists provide full reports back to PCPs on a timely basis. By carefully tracking actual utilization patterns against projected utilization budgets, peer norms and outcomes, utilization budgets and associated payment arrangements can be refined as appropriate to optimize the distribution of the workload.

9. Risk adjustment. Finally, you should insist that the health plan provide you with all factors used to risk-adjust your utilization budget. These factors should include age and sex (as described above) and benefit plan type and design, including copayment or deductible levels, as well as: localized geographic area; acute clinical stability; principal diagnosis; severity of principal diagnosis; extent and severity of co-morbidities; physical functional status; psychological, cognitive, and psychosocial functioning; non-clinical attributes, such as socioeconomic status, race, substance abuse,

and culture; health status and quality of life; and patient attributes and preferences. Unless your utilization budget is adjusted to take into account factors that can significantly increase utilization, that budget will not likely be actuarially sound and your corresponding budget-based payment will be inadequate. Again, an actuary can provide invaluable assistance in evaluating the accuracy of the health plan's risk adjustment methodology. For further information concerning risk adjustment, see the chapter entitled, "Risk adjustment."

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

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

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

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

Clearly, where the imputed fee schedule is less than what you would have received on a FFS basis, the agreement may only make economic sense to you if

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

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