CHAPTER 5

Provider Payment

CHAPTER STUDY REVIEW

1. It’s Not Reimbursement. It’s Payment.
   - Reimbursement:
     - It’s what you get when you submit your travel expenses to your employer
     - Everyone’s reimbursed the same way
     - It’s a term implying fairness and equity—righteous, good, and true
     - It’s moral
   - Payment:
     - It’s what you get when you cash your paycheck
     - Not everyone gets paid the same
     - It’s a term implying monetary motivation
     - It’s amoral (but not immoral)
   - Aside from padding, reimbursement policies do not drive behavior
   - Payment does drive behavior, though not always as you might expect

2. Physicians are not Entrepreneurs

3. The Disconnect between Health Plan Payment and Individual Physician Compensation
   - The percentage of physicians that are paid in the “traditional” way is low
   - Getting lower as physicians are increasingly being employed

4. Basic Physician Payment Methodologies used by Commercial Payers
   - Fee For Service (FFS)
     - Based on CPT-4 coding
     - Payment made after the fact, and only when care is provided
     - Criticized because of the belief that physicians will do more if they are paid more
     - Frequently more acceptable to physicians
     - Many variations of FFS used in managed care
• In plans that use coinsurance—i.e., the member pays a percentage of the cost—the coinsurance amount must be calculated based on the fee schedule, not on what the provider initially bills
• Some services such as electronic visits are not easily billed for

5. FFS—Usual, Customary, and/or Reasonable (UCR)
• Original prevailing methodology in service plans
• Supposed to be based on prevailing fees in an area, capped at the 95th percentile
• Hugely encourages fee inflation
• Had been modified using proprietary databases until NYAG case against Ingenix

6. Fee schedules
• Basis for how much an payer will pay for covered out-of-network care
• Maximum allowable fees for each CPT code set by plan
• No coverage above that amount
• Participating providers accept that as maximum collectable
• Non-par providers may bill patient for balance

7. Relative Value Scales (RVS)
• Commonly used in FFS plans
• Each procedure as defined by CPT is associated with a relative value
• Plan pays physician based on a multiplier for the RVS value

8. Resource-Based RVS (RBRVS)
• Developed for CMS (formerly the Health Care Financing Administration - HCFA)
• Relative value assigned to each CPT code by examining amount of resources actually required to provide each service

9. Case rate means a single payment for a defined episode of care

10. Facility add-on is a new fee added on top of the physician charge
• Done by hospitals that employ physicians
• Done by teaching hospitals for faculty practice plan physicians
• Payers typically negotiate that out of payment
• Payers often refuse coverage, even when reimbursing member for non-contracted provider charges

11. Basic Capitation = Prepayment for services on a per member per month (PMPM) basis, regardless of whether or not member received any medical services
• Most commonly used by HMOs for primary care (specialty capitation discussed separately)
• Payment does not vary depending on use of services
• Payment frequently adjusted for age and sex
• Payment may differ by practice type
• May be adjusted for geographic differences
- Specialty internists may be both a PCP and a specialist, but not for the same patients.
- Requires a known designation of members to physician—i.e., a panel of members, since capitation based on all members in panel, including non-users.
- Scope of covered services must be defined.
  - Contract defines the scope of covered services—what will and will not be covered under capitation.
  - Contract defines “carve outs”—what a physician may bill the plan for, e.g., vaccines, medical devices, defined procedures, etc.

12. Withholds and Risk Pools—Applicable to either FFS or capitation
  - A percentage of primary care capitation or FFS payment is withheld by HMO, or
  - A percentage of fees are withheld by HMO, for example, 20%
  - That withhold is held by the HMO and used at the end of the year to cover cost overruns in various “risk pools”—discussed next slide.
  - The remainder of the withhold is returned to the PCP.
  - Risk may be individual or may be pooled.

13. At-Risk Fee for Service in HMOs and IPAs
  - FFS with Withholds
    - Used in HMOs or IPAs that use FFS but share risk with physicians.
    - Part of fee (e.g., 20%) withheld and paid out in manner similar to risk pools under capitation (discussed shortly).
  - Mandatory fee reductions
    - Used by HMOs and IPAs where all physicians sharing risk.
    - Fees are reduced across the board if expenses exceed budget.

14. Withholds and Risk Pools (cont.)
  - Risk pools are created by actuarial determination of the total amount of money needed to cover costs.
  - Claims paid for those services and deducted from total amount in the pool.
  - May separate or combine types of risk pools.
  - Pharmacy costs may also be placed in a risk pool, but uncommon.

15. Stop-loss is a form of reinsurance to lessen impact of high cost cases on a physician’s risk pools.
  - Two forms:
    - Costs for individual members.
    - Aggregate cost protection.

16. Specialists also may be capitated by an HMO.

17. Capitation of Full Professional Risk
  - The IPA, primary medical group, MSO, or IDS receives money for all professional services—primary and specialty—but not hospital services.
18. Global capitation
- Large group, MSO, or IDS accepts capitation risk for all medical costs
- Risk of failure high except in very well run systems—They don’t call it risk for nothing

19. Federal Regulations
- Apply Only to Medicare and Medicaid, Not to Private Health Insurance
- Significant Financial Risk (SFR)
  - CMS determines whether physicians are at “significant financial risk” for medical costs
  - SFR based on a sliding scale of panel size and degree of financial risk for medical expenses
- Stop-Loss Protection
  - Must be in place to protect physicians and physician groups to whom SFR has been transferred by an MCO
  - Aggregate or per patient stop-loss can be acquired
- Disclosure and survey requirements if exceeds SFR

20. Benefits Issues that Affect Capitation
- Significant increases or decreases in benefits for which physician is at risk
- Copayment or levels
  - Can have an immediate impact on capitation rates
  - Differences in copayment amounts results in blended adjustments to capitation rates
- Point of Service (POS) Plans
  - Provide incentives for members to use gatekeeper or HMO system, but allows them to use providers outside the system
  - Difficult to accurately predict the level of in-and out-of-network use for the entire group, especially at the individual physician level
  - Capitating in POS can be so difficult that many plans capitats PCPs for pure HMO members and pay FFS for POS members, or simply switched to FFS for all products

21. Capitation Pros:
- For HMOs:
  - Brings financial incentives of capitiated provider in line with those of the HMO by putting the provider at some level of risk, or incentive for medical expenses and utilization
  - Eliminates the FFS incentive to over-utilize
22. **Capitation Cons:**
- The reward is remote in time from any actions — a physician does not immediately see a correlation between services rendered and payment received
- Decreased utilization savings may not result in savings to the plan
- **Capitation Does Not Always = Savings**

23. **Pay-for-Performance (P4P)**
- Basic idea is to better align financial incentives with the practice of evidence-based medicine
- In general, focus is more on practice behaviors than on cost savings
- P4P initiatives underway by:
  - Medicare (PQRI)
  - Employer groups
  - Individual health plans
  - Coalitions of plans, employers, and providers
- There are now nearly 150 P4P programs in place in the U.S.
- Not just the US — UK's NHS has implemented an aggressive P4P program for GPs, linked to use of a centralized national EMR
- Linking Evidence-Based Medicine to P4P

24. **Physician P4P**
- Group or grouping vs. individual physician performance
  - Geographic
  - IPA or large medical group
  - All like-specialty physicians in service area
  - If process only is measured, may measure individual physicians (CMS approach)
- Usual focus in on primary care
- Small but growing use in specialty care
- Manual vs. automated data collection and reporting

25. **Common P4P incentive approaches for physicians:**
- Common types of financial incentives:
  - Bonus payments — more common
  - Adjustments to fees using multiplier — less common
  - Incentive pools in capitated plans
- Annual more common than semi-annual or quarterly
- Commonly ranges from 5% to 10% of annual payment from the payer, but a few programs go as high as 20%
26. Does P4P Work?
   - Not all that clear
   - Proponents, including IHA, CMS, and various payers report significant improvements in adherence to evidence-based medical practice
   - Detractors, primarily providers and academic centers, report that those improvements occur anyway when clinical processes are focused on (supported by recent studies)
   - Proponents say, “So what? Why shouldn’t we preferentially reward providers for doing this even if they didn’t change to get the money?”
   - Detractors say, “It’s not about the money, it’s about the hassle and about control; it’s cookbook medicine.”

27. Depending primarily on a new payment model to result in positive change is magical thinking

28. Complexity & Distance between Event and Payment lowers the impact of any Payment Model

29. Doesn’t matter what it looks like on paper: we respond most strongly to what’s in front of us

30. Hospital and Facilities (Inpatient & Outpatient) are the Largest Percentage of Costs to Insurers and MCOS

31. Revenue Distribution does not match Bed Days
   - Hospital Price Inflation is High
   - Double Digit Hospital Charge Increases
   - Multi-Hospital Systems Grow while Non-system Hospitals Decline
   - Reality check: many large multi-hospital systems with regional hegemony
   - “Must Have” hospital system in network or at serious competitive disadvantage
   - Large and Powerful Systems Have Driven Prices Up and Huge Variations Exist

32. The Chargemaster
   - Historically, it was not the sole form of payment, per diems were
   - Early versions were more or less associated with cost
   - Typical chargemaster has 20,000 to 50,000 separate charges
   - Billing codes
     - ICD-9 CM, transitioning to ICD-10
     - HCPCS
     - DRGs and MS-DRGs

33. Payment Based on Charges
   - Usually occurs for urgent or emergency services at non-participating (non-par) hospitals
   - If service authorized or emergency, plan pays full obligation, member liable for any cost-sharing
Most plans have an administrative unit to ad hoc negotiate non-par charges.

34. Discount on regular charges usually only seen from extremely strong hospital systems for inpatient care.

35. Per Diems
   - Common method used by PPOs and HMOs
   - Fixed payment for each day in hospital, regardless of resources used
   - Shorter length of stay equates to greater savings, and vice versa
   - Commonly differentiated by service type, e.g., Labor and delivery, Surgery, Medicine, etc.
   - May be differentiated by day—first day more intense, so higher payment
   - Per diem also suited for “observation stay” (23 hr stay)

36. Sliding scales for discounts and per diems sometimes used; higher volume = greater discount.

37. DRGs and MS-DRGs
   - Diagnosis-related groups (DRGs)
     - Used in Medicare FFS program
     - Other most common form of payment used by MCOs
       - Fixed payment based on primary and secondary diagnoses
       - If case is serious and costs exceed a defined threshold, it is considered an outlier and additional payments made
       - Number of outliers has risen in last five years
   - Medicare Severity-adjusted DRGs (MS-DRGs)
     - Similar to DRGs, but takes severity adjustment into account
     - Examples include multiple chronic conditions, existing complications, etc.
     - Payments higher for sicker admissions, resulting in fewer outliers (not entirely successful)

38. Case rates
   - Single payment for all facility services based on a defined episode of care
   - Sometimes called package pricing
   - Bundled payment including all pre-op, procedure, and post-op care
   - No payments for readmission during defined time period
   - May or may not include cost of device
   - Episode Treatment Groups (ETGs)
     - Groups patients into episodes of care larger than admission
     - Not really designed for payment

39. Capitation
   - Similar to capitation for physicians by HMOs
   - Requires hospital to be full-service, or else missing service is carved out of capitation calculation
   - May be part of a larger capitation agreement with a large IDS.
40. No payment for “Never Events”

41. CMS set to not pay for avoidable readmissions

42. Outliers
   - Chargemaster used to calculate “cost” of a case
   - When “cost” exceeds a defined limit, discounted charges are paid on top of the per diem, case rate, or capitation payment
   - Chargemaster inflation a more significant driver of outliers than acuity

43. Carve outs
   - Specific service, device, or drug not included in main payment method
   - Payers seek to eliminate or reduce
   - Hospitals seek to increase
   - Use of Average Sales Price, also called Reference Pricing
   - Hospitals must rebate Medicare for warranty payments by device manufacturers, commercial payers slow to pick up on this

44. Facility Payment for Ambulatory Procedures
   - Discounts on Charges
     - Still commonly used by payers
     - Hospital or Ambulatory Surgical Center (ASC) argues that too many variables for each procedure, such as cost of implantable device
     - Result is continuing very high inflation rate for ambulatory procedures
     - Sliding scale discount may exist
   - Package Pricing or Bundled Charges
     - Plan may purchase bundled pricing calculations from third party
     - Outliers may be paid at higher rate
   - Ambulatory payment classifications (APCs)
     - Form of bundling based on patient characteristics, what’s being done
     - Used by CMS for all Medicare FFS outpatient payment
     - Commercial payer may negotiate a percentage of Medicare rate
   - Ambulatory patient groups (APGs)
     - Similar to APCs but more robust
     - Used by some commercial plans
   - Main type of modifier is the carve out, and it’s the same as for inpatient

45. Hospital P4P
   - Hospital systems usually measured individually or as a system, not grouped together with other hospitals
   - Common types of financial incentives:
- Adjust payment rate
- Multiplier on DRG
- Multiplier on per diem
- Bonus payment
- Incentives range from 1% - 5% of annual payments from the payer

- Examples of common conditions for hospital P4P (see also CMS P4P in Appendix):
  - Acute myocardial infarction (heart attack)
  - Heart failure
  - Community acquired pneumonia
  - Surgical infection prevention
  - Medication errors
  - Other patient safety measures
  - Use of electronic medical records
  - Efficiency measures (e.g., IHA)

46. Ancillary Services
- Except in emergency, it is reasonable to expect patient to travel to receive
- Ownership issues
  - Owned by hospital—may be bundled into main negotiation
  - Owned by separate company—usually will offer desirable pricing
    - Physician-Owned
      - Can be owned individually or by joint ventures or partnerships
      - Can lead to significant utilization increases in those services
- Payment methodologies
  - HMOs usually capitate
  - Non-HMOs usually pay off of a deeply discounted fee schedule or use flat rates for each type of test

47. Global Fees and Bundled Payment
- A single payment that includes all services delivered in an episode
- Bundling more often used when more than one provider is involved or to pay both the hospital and physician
- May be used to pay for non-primary care services regardless of PCP payment system
- Protects against problems of unbundling and up-coding
- Hybrid of capitation and FFS, but technically not risk-sharing, so can be used by any type of payer
- Success depends on ability to properly share the money!

48. ACA specifically requires a bundled payment pilot program for FFS Medicare
- 10 common and expensive conditions that are also associated with relatively high levels of complications and avoidable readmissions
Episode span begins at least 3 days prior to admission and extends to at least 30 days after discharge

Bundled payment applies to all care provided during the episode

**Shared Savings**

- Concept is to share some of the savings created by cost reductions
- Target costs set by condition(s)
- Costs attributed to the ACO, PCMH, or hospital by using algorithms
- No lock-in of patient, but still include costs of care provided outside of ACO/PCMH/hospital
- Some savings are shared with provider system, but not all
- Two models to begin: no risk, and risk
- Only risk-based model after first period
- Results of pilots are mixed
- Value of shared savings can never offset the loss in revenue to a facility until traditional revenue is reduced