



HEALTH ACTUARIES & CONSULTANTS

Inspire



Population Based Reimbursement: Building an Effective Reimbursement System

David Axene, FSA, FCA, CERA, MAAA

Introduction

As more and more health systems consider population based reimbursement, pursue the development of ACOs, and consider value based reimbursement methods, they are faced with the age-old question of “how do we distribute the funds to providers?”. As the old scripture proverb states “History merely repeats itself. It has all been done before. Nothing under the sun is truly new.” This is truly the case with provider reimbursement and the task of distributing funds among the various stakeholders.

The Challenge

As financial risk is transferred from the payer/ administrator to individual health care providers, the provider payment process becomes increasingly complicated and requires innovation to assure appropriate financial outcomes. Under the traditional fee-for-service system, providers are paid or reimbursed only when they provide a service. However, as provider payments are based on alternate reimbursement methods different payment and allocation approaches must be deployed. The question becomes what method should be used? What method works the best? What method will achieve the best results?

A Generic Approach

I usually recommend a rather simple approach based upon a generic framework that can achieve the desired results for almost any configuration of health care providers. This is based upon very simple and straightforward principles familiar to most observers.

What are the basic categories of care? They consist of:

- Primary care services
- Specialty care services
- Ancillaries
- Institutional services
- Prescription drugs

Organizing the reimbursement system around these five categories provides a consistent framework that is highly adaptable to various provider structures. For example, if the reimbursement is focused on a group of primary care providers, the primary care segment can be used to craft the desirable approach. When it is focused on a multi-specialty medical group, both physician categories can be combined to develop the desired approach for entire physician segment. If it is a broader Clinically Integrated Network (i.e., CIN) or ACO, perhaps the entire group of categories are combined in some fashion.

“ As categories are grouped into broader categories, basic principles of reimbursement for the individual categories can be preserved.”

As the individual categories are grouped to determine overall reimbursement levels, basic principles of reimbursement within each of the five categories can be preserved within the broader structure to achieve the optimal reimbursement approach.

Primary Care Services

Once primary care services are clearly defined, preferably in terms of CPT codes, the reimbursement methodology can be selected. Personal preference leans towards primary care capitation, although capitation is clearly not required. As long as the assigned member panel is large enough for statistical reliability, capitation works well. With the advent of reliable risk adjusters in the marketplace, risk adjustment solves most of the earlier concerns by primary care providers. I usually recommend both demographic and risk adjustment. I prefer both withholds and gain sharing of referral services. I recommend a variable withhold model that decreases the withhold (i.e., required risk margin) for those providers consistently

earning incentive payments and increases the withhold for those generating losses or consistently using their withholds for higher than expected payment levels.

Specialty Care Services

Since few specialists have direct assignment to individual patients, they don't explicitly control referral patterns or demand for their services. As a result, they oftentimes experience volatility from one time period to another and it is usually inappropriate to utilize specialty capitation. As a result, traditional fee-for-service reimbursement is most common. For those specialists willing to accept a withhold, some gain sharing is possible and reasonable. Most institutional care and the use of ancillary services are driven by the specialists so it is reasonable to include some type of incentive based upon the appropriateness of institutional and ancillary utilization or performance.

“ Usually inappropriate to use specialty capitation.”

The selection of the individual specialist is usually the direct choice of the primary care provider (i.e., the PCP's referral pattern), so it is always reasonable to include the primary care doctor in the performance analysis.

Ancillary Services

The use of ancillary services is directly tied to referrals by specialists and some primary care providers. Ancillary providers “do what they are told to do”, should be held accountable for doing it right the first time, and have little to do with the overall performance. They are not able to do much to impact performance, perhaps with the exception of refusing to perform a medically inappropriate referral. They function as vendors in the health care system, very important vendors, yet not controlling much of the cost of the health care system. Most ancillary services are performed on a fee-for-service basis although some (e.g., lab services) have agreed to various forms of capitation.

Institutional Services

Institutional services are often viewed as the most critical category of services since these are the ones where care management efforts potentially achieve the greatest savings. Our consulting assignments show that two-thirds of what can be saved is often associated with inpatient care. In care management parlance, the greatest opportunity for changes in cost are in shortening and eliminating potentially avoidable inpatient stays. Different approaches have been used to reimburse institutional services with the most current

and most popular approach being DRG case rates for inpatient and APC related for outpatient services.

“ Important to incorporate acuity/ severity in payment mechanism to match payments with required resources.”

Experience suggests that DRG case rates may provide long term savings but do not provide immediate or short term savings from length of stay reduction. Traditional per diem methodologies provide the greatest savings but market trends have clearly gravitated to DRG case rates. The integrated delivery system models (i.e., ACO and CIN) also utilize forms of capitation although usually incorporate some cost reconciliation at the end of the reporting period.

I recommend an approach that incorporates acuity severity if using a DRG case rate approach (i.e., APR-DRGs or MS-DRGs). Recognizing acuity and severity in the reimbursement methodology better matches the consumption of resources with the reimbursement reducing the concerns of the institutions.

Most of the incentive mechanisms compare budgeted institutional services with those provided including the savings or cost reductions in the incentive program with providers.

Prescription Drugs

Prescription drug costs are an increasingly importance cost category especially as drug costs now increase at a much higher rate than other services. Specialty drugs have become a more important category with the introduction of very expensive drugs (i.e., Hep-C drugs, HIV drugs, etc.). Pharmacy management programs are increasing in effectiveness through the use of sophisticated formulary management practices and benefit design enhancements.

Some incentive plans transfer much of the risk to providers and in turn their incentive programs, while other approaches delegate much of the management of that to contracted PBMs. Capitation programs are popular in some markets.

Basic Incentive Design Considerations

As the strategist begins to design the system it is helpful to categorize and quantify the impact of various risk transfer efforts. The chart below is one organization’s attempt to quantify risk for various reimbursement methods (i.e., red is high risk, blue is low risk).

Risk Level to the Contracting Organization

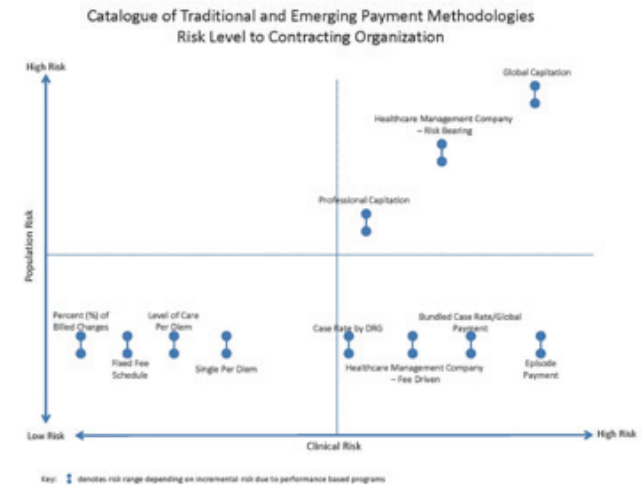
| Section 1: Base Payment Methods (non performance based) | Payment per Svc./Event/ Population | Type of Entity (Hosp./Phys) | Traditional/ Emerging | Level of Risk to Provider | | |
|--|------------------------------------|-----------------------------|-----------------------|---------------------------|-----------------|-------------------|
| | | | | Clinical Risk | Population Risk | Total Risk |
| % of Billed Charges | Svc | Hosp or Phys | Traditional | Very Low | Very Low | Very Low |
| Fixed Fee Schedule (no bundling) | Svc | Hosp or Phys | Traditional | Very Low | Very Low | Very Low |
| Level of Care Per Diem | Svc | Hosp | Traditional | Low | Very Low | Very Low |
| Single Per diem | Svc | Hosp | Traditional | Low | Very Low | Low |
| Case rate by DRG | Svc/Event | Hosp | Traditional | Med | Very Low | Low |
| Bundled Case Rate - Acute Care Hospital Stay Only | Event | Hosp & Phys | Emerging | Med to High | Very Low | Low to Med |
| Episode Bundled Payment | Event | Hosp & Phys | Emerging | Med to Very High | Very Low | Low to Med |
| Partial Capitation: Only for svcs provided by org, risk adjusted | Population | Hosp or Phys | Emerging | Med | Low | Low to Med |
| Partial Capitation: Only for svcs provided by org, risk adjusted | Population | Hosp or Phys | Emerging | Med | Med | Med |
| Full Capitation: For all services for a population, risk adj. | Population | Hosp & Phys | Emerging | Very High | High | High to Very High |
| Full Capitation: For all services for a population, risk adj. | Population | Hosp & Phys | Traditional | Very High | Very High | Very High |

| Section 2: Non-Provider Organization entities | Payment per Svc./Event/ Population | Type of Entity (Hosp./Phys) | Traditional/ Emerging | Level of Risk to Organization | | |
|--|------------------------------------|-----------------------------|-----------------------|-------------------------------|------------------|------------------|
| | | | | Clinical Risk | Population Risk | Total Risk |
| Specialty Healthcare Management Company - Fee Driven | Svc/Event | Non-Provider | Both | Med to High | Very Low to Low | Med |
| Specialty Healthcare Management Company - Risk Bearing | Population | Non-Provider | Both | Med to Very High | Med to Very High | Med to Very High |

| Section 2: Performance Based Payment Methods | Payment per Svc./Event/ Population | Type of Entity (Hosp./Phys) | Traditional/ Emerging | Incremental Risk to Base Payment Method | | |
|--|------------------------------------|-----------------------------|-----------------------|---|-----------------|---------------|
| | | | | Clinical Risk | Population Risk | Total Risk |
| Price payments, upside only | Any | Hosp or Phys | Both | No Change | No Change | No Change |
| Risk arrangements, upside and downside | Any | Hosp or Phys | Both | 1 to 2 Levels | 1 to 2 Levels | 1 to 2 Levels |

1)Capitation: Payment made to provider regardless of patient utilizing svcs
 2)Fee for Svc (FFS): Payment made to provider contingent upon patient utilizing svcs. Definition of svc can vary from the most granular itemization of svcs to a full event.
 3)Clinical Risk: Risk within a given medical event.
 4)Population Risk: Risk of events occurring for a given population.
 5)Total Risk: Combined clinical and population risk.

This same organization graphically presented the risk transfer showing population risk on the vertical axis and clinical risk on the horizontal axis.



As this last chart shows, global capitation transfers the greatest risk to the provider entity (i.e., high population risk and high clinical risk).

The key considerations of an effective reimbursement and incentive system are:

- **Population:** Clear understanding of who the population is so that prior experience can be reviewed and compared to proposed reimbursement levels
- **Demographic Adjustment:** Prior to the development of appropriate risk adjustment methodologies, one of the most effective adjustments available in the marketplace were

demographic or age/gender adjustments. Utilization and costs tend to increase as the person ages. Female costs tends to be higher than male costs. As the population mix changes costs can vary significantly. For pediatric populations the gender difference is much smaller than for other populations.

- **Risk adjustment:** Providers must be protected from shifts in the population mix, especially shifts in underlying morbidity/health status. As morbidity/health status changes, anticipated health costs and burden of illness change which must be reflected in the health care budgets.

“ There are several key considerations to develop an effective reimbursement and incentive system.”

- **Reimbursement levels:** The historical data is based upon some negotiated reimbursement level. If there is no assumed change in reimbursement levels, then no adjustment is necessary. If there is a change, especially a reduction, then it needs to be reconciled to be sure the budgets are reasonable
- **Care Management Effectiveness:** The historical data is based upon the prior care management. To the extent that the care management process changes or is improved, the impact to the budgets needs to be understood. From the provider's perspective, one of the reasons it is willing to assume the additional risk is the opportunity to benefit from any improvements in care management they are able to implement.
- **Trend and Inflationary Adjustments:** To the extent that some inflationary trend has occurred and or an inflation adjustment is necessary, the budget needs to reflect that adjustment. Without appropriate adjustments the budgets can quickly become unreasonable.
- **Division of Financial Responsibility (DOFR):** The DOFR is used to identify what is included in the budget and who is responsible for it. This is a document that clearly defines what the capitation payment covers. This is critical to understand. This often includes a description of any carve-out or stop-loss protection that the health plan is offering the risk bearing organization.
- **Potential Incentive Payments:** The budget assessment requires a good understanding of what potential incentive payments might exist and how they would work. This is most important when only a portion of the health care dollar is capitated. If global capitation then this is not as critical.

Risk Pools

A frequently recommended incentive model is built around the concept of risk pools. The simplest such approach has been called the HARP Fund (i.e., Hospital and Risk Pool). The scope and size of the HARP fund varies depending upon what services are included.

The simplest approach is:

- Primary Care Services
- HARP Fund

In this situation, primary care services might be capitated with primary care doctors sharing a portion of the savings from all other services. In this case the HARP Fund would include specialty services, ancillary services, hospital inpatient and outpatient services and pharmacy.

In a situation where Medical Group capitation was considered, it could be modified to:

- Professional services (i.e., Medical Group capitation)
- HARP Fund

In the case of global capitation, it could be modified to:

- All services (i.e., global capitation)
- Empty HARP fund

This highly flexible approach enables the planners to develop what is best for their own organization and structure. It is highly flexible.

Quality Adjustment

Any incentive payments from the above approaches should always be adjusted by quality performance. One frequently used approach adjusted using three specific performance components which are weighted as follows:

- Quality Measures: 25%
- Customer Satisfaction Measures: 25%
- Cost Measures: 50%

Separate measures would be developed for each type of provider with actual payments based upon provider specific scoring in each of these areas. Some recommended measures for the first year are included in the table below by type of provider. Actual metrics, measures and goals would be set collaboratively and updated on an annual basis.

Illustrative Quality Performance Measures

| Measures | Primary Care | Specialty Care | Ancillary | Hospital |
|-----------------------|--|--|--|---|
| Quality | Immunization rates and other HEDIS score | pathway compliance | first time appropriateness | pathway compliance and re-admission rates |
| Customer Satisfaction | Standardized patient satisfaction survey | Standardized patient satisfaction survey | Standardized patient satisfaction survey | Standardized patient satisfaction survey |
| Cost | cost compared to last year | cost compared to last year | cost compared to last year | cost compared to last year |

The overall intent is to pay 100% of the allocated risk incentive amount for excellent performance across the above metrics. We assume that no payment would be made if there is unacceptable performance, even if funds were available. A 50% payment would be appropriate for moderate or average performance. The goal is to maximize the performance so all providers are getting 100% of what they have earned.

The previous table shows suggested performance measures. These should be collaboratively determined and agreed to in advance. It is critical that measures are administratively easy to obtain and reliable.

The performance on each measure would correspond to a specific set of points ranging from 0% to 25% for Quality, 0% to 25% for Customer Satisfaction, and 0% to 50% for Cost Measures. The total of the three scores would determine an overall score determining the percentage of the incentive payments that would be paid to the provider. For example, a quality score of 20%, a customer satisfaction score of 15%, and a 40% cost score would total to 75%. A provider with this score would be paid 75% of their earned incentive payment.

Any unpaid amount could be added to pool for future payments to providers.

Key Success Factors

The following table presents key success factors in achieving long-term success with provider reimbursement and incentives:

| Success Factor | Description |
|-------------------------|---|
| Administratively simple | No method will succeed over the long run unless it can be easily and consistently administered without significant cost burdens. This has to match both the provider's needs and capabilities with the payer/network. |

| | |
|---|---|
| Adequate, but not excessive payment level | Provider overhead costs have escalated to the point it is sometimes hard to cover fixed costs. Deep discounts resulting in payment levels below operating costs make it impossible for providers to provide the high quality, cost effective care the patient expects. |
| Consistent with actual or desired resource requirements | As much as is possible, the reimbursement methodology should compensate providers for resources consumed, required services and technology, etc. A high prevalence of both overpayments and underpayments on various procedures and services creates unnecessary financial risk for providers. |
| Reflect case-mix/acuity/severity mix of population | For any contractual arrangement to succeed over the long term, the methodology needs to protect providers from adverse implications of swings in case-mix/acuity/severity mix. This may require explicit risk adjusters where reimbursement is based upon a budget or capitation. |
| In synch with medical management strategies | Many methods are at cross-purposes with medical management strategies. Method must be consistent with overriding objectives and create a win-win situation for both the network and the provider. |
| Consistent across different payers | Without negatively impacting innovation, networks need to be sure reimbursement and risk sharing methodologies are consistent across all payers to keep administrative expenses to a minimum and pool risk. |
| Clinically acceptable method | Since the physician is the key manager of the health care system, it is important that the selected methodology is clinically acceptable. Some methodologies make little sense clinically and can unnecessarily increase health costs. |
| Reflect exceptional provider performance to the greatest extent possible | If a segment of the provider panel performs at or above expectations, the reimbursement system can be used as an individual motivator/incentive to continue desirable performance. This is most closely related to provider incentives, which are oftentimes beyond the scope of a reimbursement mechanism. |
| Consistent with provider management and oversight tools and resources | Methodology should incorporate all performance and assessment results to maximize the influence on provider behavior. |
| Maintain health care affordability, quality of care, and provider access | The method must enhance the long-term viability of the health care system. |

Adaptations of Model

The above model is designed to be a convenient management tool to use when operating as a risk bearing organization. It can be adapted in a variety of ways to meet the unique requirements of any health plan or payer. For example, in an environment where an organization would take global capitation for a broad set of members, we would recommend that the organization internally manage the distribution of revenues using this approach even though receiving a global payment rate for all services. If in another situation the organization agreed to a professional capitation from a health plan or payer, we would recommend managing the professional capitation in total the way the primary care, specialty and super-specialty area was described above.

This provides a useful approach to manage almost any type of reimbursement arrangement. It also provides a framework that the organization can use to negotiate an arrangement with a particular health plan and provides guidance as to how to share risk with a health plan. Health plans can also use this approach to maximize the consistency of its proposals to providers.

The same underlying methodology can serve as the framework for arrangements made on a primary capitation only basis, a professional capitation basis and also a global capitation basis. We encourage organizations to consider this as a framework to use in its negotiations with health plans and payers.

Summary

Provider reimbursement and incentive systems can be complex, challenging to develop, and somewhat temperamental as different objectives or goals are introduced into the process. The above template provides a generic format that can be used to simplify the process.

1 Ecclesiastes 1:9 NLT.

2 Somewhat arbitrary allocation of importance. Goal was to have no less than half based upon quality and customer satisfaction.

About the Author:

David Axene, FSA, FCA, CERA, MAAA, is the President and Founding Partner of Axene Health Partners, LLC and is based in AHP's Murrieta, CA office. Dave can be reached at (951) 294-0841 or david.axene@axenehp.com.

©Axene Health Partners, LLC 2016