

Evaluating and Negotiating Emerging Payment Options, a new physician resource published by the American Medical Association

The health care delivery system in the United States is undergoing a paradigm shift with regard to physician and other health care provider payment methodologies. In an effort to control the growth of health care costs, payment methodologies involving risk are slowly replacing fee-for-service as the predominant means through which physicians will be paid. These “pay for value” or risk-based models include pay-for-performance, withholds and risk pools, capitation, shared savings, and bundled payment arrangements.

Because the terms “value-based” or “risk-based” do not clearly describe what makes these new payment systems different from fee-for-service, we use the term “budget-based” to make the distinction clear. In all these payment systems, the primary driver of the economic result to the physician practice is the extent to which the actual cost of providing care to a patient population varies from the projected budget for those costs – physicians who come in at or under-budget prosper, while physicians who exceed the budget are penalized.

As complex as it is to manage fee-for-service payments, payments based on a “budget” raise a host of new issues that physicians must understand to successfully negotiate the evolving payment environment. Under “budget-based” payment systems, rather than being paid for each service provided, physician income is tied to the physicians’ ability to successfully predict and manage future utilization for a patient population by thoroughly understanding the past utilization for a similar patient population as well as the costs of delivering these services efficiently.

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 the health care services covered by the budget to this patient population will be equal to or less than the budgeted amount? Because of the enormous skew in the utilization of health care services depending on the patient, this is not an easy task. Fully half the population spends less than \$1000 per year on medical care. At the other end of the extreme, the top 1% of spenders use more than \$44,000 of health care services in a year. In the absence of state of the art risk adjustment systems, physicians who are lucky enough to draw panels which include large numbers of the low utilizing patients will do exceedingly well under budget-based payment systems, while those who draw the patients at the other end of the spectrum will be devastated by such systems. Contrary to every principle of medical ethics, the physicians who will be put at the greatest risk will be those who focus their practices on the poorest and sickest patients! However, with full transparency, actuarial soundness and state of the art risk adjustment systems, budget-based payment systems can be constructed to promote the more efficient treatment of everyone, rather than provide economic incentives to develop ever more creative ways of discouraging sicker patients from selecting one’s health plan or medical practice.

Thus, 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.” Physicians who are considering transitioning to one of these new payment models, whether by choice or payer request, will need practical information to enable them to evaluate the likely financial impact of these risk-based payment arrangements, negotiate the precise terms of these arrangements, if appropriate, and manage the revenue cycle associated with any new payment model to which they are ultimately subject.

Fortunately, the American Medical Association (AMA) has developed a tool to help physicians understand these concepts and position themselves to succeed under budget-based payment systems, entitled “Evaluating and Negotiating Emerging Payment Options.” [Visit www.ama-assn.org/go/payment](http://www.ama-assn.org/go/payment) to access this manual[please see if this vanity is available].

What's in the tool? Evaluating and Negotiating Emerging Payment Options is comprised of the following chapters written by expert physician consultants and advocates:

- The Introduction outlines the differences between fee-for-service and the budget-based methodologies that underlie all risk-based payment arrangements, and shows physicians how they can evaluate independently the projected utilization budgets established by the health plan;
- “Chapter One: Establishing your baseline” describes why participation in risk-based payment models will require physicians to adopt more sophisticated accounting practices than those required under fee-for-service, and gives physicians concrete guidance concerning how they can calculate their true costs of doing business, a threshold requirement for assuming risk;
- “Chapter Two: Fee-for-service” discusses the role that fee-for-service will play in the future, and how physicians can meet the continuing challenges of managing fee-for-service payments caused by unnecessary complexity and a lack of transparency;
- “Chapter Three: Pay-for-performance programs” identifies the key issues physicians should consider when evaluating a pay-for-performance opportunity, including, but not limited to, how their patient satisfaction, quality, and cost-effectiveness scores will be determined and how that determination will be used to calculate payment;
- “Chapter Four: Capitation” helps physicians evaluate, and develop the systems to succeed under, capitation arrangements—and includes guidance regarding how to transition from cash to accrual accounting, track incurred-but-not-reported liabilities, clearly define the division of financial responsibility (DOFR) between the health plan and the physician group and evaluate the actuarial soundness of proposed per member per month payments based on that DOFR, and obtain the patient enrollment data is needed to minimize the occurrence of retroactive adjustments;
- “Chapter Five: Bundled payments” helps physicians identify essential physician concerns with bundled payment proposals, including whether or not physicians will receive their portion of a bundled payment directly from the payer, how each episode of care is defined, the duration of the bundle, and how the payment will be apportioned between the participating providers;
- “Chapter Six: Shared savings arrangements” [coming in February].
- “Chapter Seven: Withholds and Risk Pools” describes the role that withholds and risk pools play in risk-based payment arrangements, and helps physicians evaluate their likely success under withholds and risk pools, by helping physicians identify their fellow risk pool participants, ascertain the extent to which physicians may independently audit risk pool status, determine how the costs of health care services will be allocated among risk pool participants, and verify the accuracy of the calculations used to determine remittances or the retention of withheld amounts;
- “Chapter Eight: Risk adjustment” describes why physicians must understand the health plan’s risk adjustment methodology, regardless of the kind of risk-based payment system involved, and identifies the essential issues physicians should consider when seeking information from the health plan about, and determining the accuracy, of that risk adjustment methodology;
- “Chapter Nine: Stop-loss insurance” outlines the reasons why physicians participating in risk-based payment arrangements are advised, and sometimes required, to obtain stop-loss insurance coverage to protect themselves against losses associated with catastrophic cases, and provides tips to help physicians when shopping for such coverage;

- “Chapter Ten: Working with actuaries” points out how obtaining the services of an actuary can help physicians assess and manage the risk associated with a budget-based payment arrangement and make cost-effective use of an actuary’s services;
- “Chapter Eleven: Negotiating the deal,” discusses issues physicians should consider prior to negotiating with a health plan over payment, such as identifying the goal of the negotiations, evaluating your negotiating position, and building your negotiating team—and also describes special issues likely to arise in connection with budget-based payment arrangements;
- “Chapter Twelve: Joint Contacting/Collective Bargaining,” briefly outlines how participating in budget-based payment arrangements may enable independent, competing physicians to “financially integrate,” thus allowing them to engage in joint price negotiations without violating the antitrust laws, and includes links to more detailed antitrust advocacy resources;
- “Chapter Thirteen: Ethical implications of risk-based payment arrangements”, discusses the ethical issues that budget-based payment arrangements may raise.

An evolving resource

The AMA will expand and update this resource to ensure that physicians are continually equipped with the information and tools they will need to evaluate and negotiate current and emerging payment arrangements. An additional chapter concerning shared savings arrangements is will be added to Evaluating and Negotiating Emerging Payment Options in early February 2012.

The AMA welcomes questions and suggestions from physicians and their advisors for new chapters or other tools to assist physicians analyze and negotiate existing and emerging payment arrangements—just e-mail Wes Cleveland at wes.cleveland@ama-assn.org.