Forms of Reimbursement and Risk Sharing

The health care system encompasses a range of ways in which physicians are paid. The payment continuum includes models that have evolved over time and that still exist today.

Health Care Payment Continuum

PHYSICIAN PAYMENT	Traditional Fee-for-Service (FFS)	Discounted Fee-for-Service	Discounted FFS within a budget, with withholds and bonuses	Capitation for defined set of services	Global Capitation	Salary
INSURANCE COVERAGE	Indemnity	Preferred Provider Organization	Managed Care: IPA Model HMO	Group / Network / IPA Model Managed Care		Staff Model HMO
			Prepaid Plans			

To the left are arrangements where physicians are paid fees for providing units of service to patients. These arrangements occur when patients have traditional indemnity insurance or no insurance. They may also exist within insurance plans that some call "managed care," such as Preferred Provider Organizations (PPOs) or some loosely structured Health Maintenance Organizations (HMOs). These plans may have some elements of managed care, but physicians in these arrangements are only minimally involved in truly managing care in the sense of providing high quality and cost-effective care for populations.

The most effective managed care occurs when the boundary between insurance and service delivery is blurred, and insurers and providers share in the financial risk inherent in meeting the health needs of a population. Physicians, usually through some group structure, assume responsibility for providing care within a global budget. These are the arrangements located to the right of the continuum shown above. When this happens, managed care is no longer an overlay of cost considerations onto the "pure" system of healthcare delivery, but rather a melding, an integration of the two. For managed care to exist and function at its full potential, all the key players, most especially physicians, must be invested in its success.

Risk sharing between the health plan and its participating physicians takes three general forms: **salary, modified fee-for-service, or capitation**. Then there are variations within these categories.

Salary as a means of reimbursing physicians is restricted to staff-model HMOs. The health plan may also offer bonuses for meeting certain targets related to costs, utilization, and/or

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quality. Also the HMO's employed physicians may be eligible for profit-sharing.

In **modified fee-for-service** arrangements, physicians typically are paid for each service they provide according to a fee schedule, but in addition there are financial incentives to control utilization, claims, and costs. The HMO sets target budgets for its providers and services, and distributes some or all of the surpluses at defined points during the year. One version features withholds. That is, when the physicians provide a service, they bill the HMO. The HMO pays out the designated fee for each service, but it withholds a certain percentage of the payment. At the end of the year, if total reimbursements are below the target budget, then the HMO returns some or all of the withheld amounts. If not, the physicians forfeit the withhold. Since the withhold might be only 10% of payments, the risk to the physicians is not very significant, but it starts the physicians thinking about how they provide care and where they can eliminate unnecessary services or substitute less expensive ones.

The specifics of which physicians are eligible for what distributions vary by plan. Some distributions may be limited to individual or groups of physicians based on their own billings, while other distributions may apply to the entire panel of participating physicians based on the HMO's overall performance. Primary care physicians may be eligible for year-end distributions reflecting actual costs for specialty care, and all physicians may share in rewards for keeping hospital costs under-budget. Individuals and groups of physicians may also receive bonus payments for items like high member satisfaction scores, or high rates of immunizations or other preventive services.

Fee schedules by which providers are paid apply to units of service, but there can also be fees for cases or episodes-of-care. The fee is an aggregate rate reflecting the combined costs of all the relevant services and expenses. The providers know how much they will be paid, and they can organize the specific units of service as they wish to best serve the patient. For hospitals, aggregated rates of payment include per diem rates, case rates, and payments according to the admissions' Diagnostic Related Groups (DRGs).

Capitation is a more extreme form of risk-sharing. The HMO pre-pays a specified amount per patient-or, per capita-to its providers to deliver a specific package of services over a set period of time. The payment is usually stated as a per member per month or PMPM rate. Capitation rates are derived from projections of services and costs, based on historical claims data. The total payments to providers vary to reflect the total number of members covered and, typically, characteristics of these members such as age and sex. The key is that payment does not vary based on the actual services provided to each member. In addition to the capitation payments, physicians can collect co-payments from members for office visits. Co-payments are defined in the plan's benefits agreement, usually around $5-10 per visit.

Capitation payments can be set for different levels of services, for example:

Global capitation: A single capitation amount to cover virtually all medical services

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related to member care, including hospitalizations, specialist care and ancillary services.

Primary care capitation: A capitation paid to primary care physicians and practices for service provided directly by the primary care physicians and, depending on the contract, a set of ancillary and other services ordered by these physicians.

Subcapitation: An arrangement whereby a physician group receives a capitation payment and, in turn, subcontracts with another physician or institutional entity and pays it on a capitated basis for the provision of designated services (e.g., specialty care, ancillary services, etc.).

Contact capitation: A method of paying specialists a predetermined lump sum per patient upon referral to manage and provide care during the episode of illness. This arrangement, also known as "case rate capitation" is a hybrid of capitation and fee-for-service reimbursement.

Reverse capitation: An arrangement in which the specialists are paid by capitation and the primary care physicians are paid on a fee-for-service basis. The intention is to control overall costs by structuring incentives to provide treatment in primary care settings instead of more expensive specialty settings.

Carve-out: Services separately designed and contracted to an exclusive, independent provider by a managed care plan. For example, an HMO may "carve out" the mental health benefit and select a specialized vendor to provide these services on a stand-alone basis.

Associated with capitation is risk adjustment, a methodology to set differentiated rates based on the characteristics of the enrollees in each provider panel. The most common risk adjustment factors are age and sex. For example, the global capitation rate for Medicare enrollees is 3-4 times higher than the rate for adults under age 65. Other factors can include sociodemographic items, health status, geographic residence, and prior health care utilization. The objective is to compensate providers more fairly given the expected costs incurred by their enrollees.

These new financing arrangements are changing medical practice fundamentally. Under the traditional system, physicians concentrated on the services they provided or recommended, without regard for the costs. If they provided a service and billed for it, they were reimbursed out of someone else's funds. There was no reason to limit how much care was provided or to think about less intensive ways of doing things. Capitation turns the incentives around so that it pays to care for patients as efficiently as possible. The focus shifts from piecemeal production-i.e., providing individual patients with units of service-to a process function-i.e., serving these enrollees with this amount of resources. It's also advantageous to keep members as healthy as possible so they don't develop avoidable conditions or complications. These have been the goals of the health plan, and now the

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providers share the same goals and incentives, instead of having conflicting or misaligned incentives as in the past.

Another change is in how practices are organized. Risk-sharing rarely takes place at the level of the individual physician, whose ability to accept risk is limited. The patient base is small, so there is too high a possibility that a small number of high cost cases could overwhelm the prepaid budget. Also, a single physician is unlikely to hold much sway over how care is organized outside of his or her own office. This defeats the purpose of using risk-sharing as a vehicle for enabling physicians to improve the efficiency and effectiveness of healthcare delivery. By contrast, larger physician entities can pool their resources to develop information systems, hire case managers, and build other infrastructure supports. Capitation arrangements require physicians to organize into groups or networks in a significant way, as has been happening in the medical marketplace.

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