PROVIDER REIMBURSEMENT

By:
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Provider reimbursement is a fundamental area of managed care. It is imperative that providers receive payment in a manner that offers appropriate incentives to provide quality and efficient healthcare.

The traditional methods of provider reimbursement range between the current two extremes, “fee-for-service” (FFS) and “capitation”. FFS, the traditional method of compensating healthcare providers, includes discount from billed charges, fee schedules, relative value scale, mandatory reduction in all fees, budgeted fee-for-service, sliding scale, and individual fee allowances. “Capitation”, the method most commonly associated with managed care, includes full risk and global capitation. Some other traditional and familiar methods include withhold and bonus incentives, case rate, global fee or flat rate per procedure, salary, and retainer. As the healthcare industry has changed, some of the established managed care reimbursement methods have fallen out of favor or have been disallowed by laws and regulations.

The following is a discussion of some new methods of provider reimbursement.

NEW METHODS OF PROVIDER REIMBURSEMENT

Episode-Based Global Fees. In the past, global fees were used to reimburse physicians for surgical procedures and maternity. However, global fees now focus on episodes of care as well as surgical procedures. The episode-based global fee bundles together all services related to a particular disease across the entire continuum of care.

Contact Capitation. Contact capitation modifies traditional capitation to better suit the circumstances of specialty physicians.

Contact capitation pays the specialist physician a lump sum upon the physician’s first contact with a new patient. The payment basis is the average cost of care and covers a set period (e.g., 6 or 12 months) called the contact period. The specialist is responsible for all the specialty care within that contact period. If the patient leaves the network before the specified period is over or switches to a different specialist of the same specialty in the panel, the patient is no longer counted as a contact, and the physician’s payments for managing that patient stop.

Physician DRGs. A reimbursement method whereby the physician is paid based on Diagnosis Related Groups (DRGs) in the same way that hospitals receive payment by DRG is currently under development. Physicians receive a set payment, adjusted for the severity of illness, for each DRG. If the physician provides care in a more efficient manner, the physician keeps the savings, in the same way that a hospital keeps the savings if it can reduce the length of stay.

Market Share Capitation. Market share capitation uses market share to allocate the capitation among specialty physician groups. If a specialty group sees 20% of the
patients who require that type of specialist in a year, that specialty group will receive 20% of the monthly capitation budget for that specialty.

**Direct Contracting between Physicians and Employers.** A group of large employers contracts directly with networks of providers to provide necessary care to their employees. Each network or care system consists of PCP physicians with affiliated specialty physicians and a hospital. The care system must be able to provide the continuum of medically necessary services to the enrolled population. The employer group contracts with as many care systems as fit their requirements and are willing, but a physician cannot belong to more than one care system.

**Gainsharing.** Gainsharing is an incentive arrangement between the hospital and its physicians. Receiving a share of any hospital savings gives the physicians an incentive to develop new systems and protocols for more effective care management. However, due to the restrictions on its use in federal programs, its use in non-federal programs has also been dampened. Gainsharing is strictly an incentive bonus arrangement. The program design emphasizes the improvement of quality and outcomes by insisting that certain quality and patient satisfaction measures be met.

**Reimbursement for Internet Consultations.** This program pays physicians a fixed dollar amount for online communications with patients. It allows physicians to keep updated on the health status of their chronic patients. Via email, patients can describe their current conditions (e.g., blood sugar levels in the case of diabetics), and they can ask questions. The physician responds via e-mail. The physician does not have to prescribe any medication or action to receive payment as no action may be necessary.

**Quality-Based Incentive Arrangements.** Most of the reimbursement programs using information on the quality of care are bonus programs. The basis for the bonuses is benchmarks related to the quality of care provided. Some examples of quality of care bonus criteria are:

- Preventive care measures, such as pediatric immunizations, mammograms, etc.
- Appointment access, number of patient complaints, turnover rates
- Use of practice guidelines
- Health Plan Employer Data Information Set (HEDIS) measures
- Member satisfaction surveys

**Fee Incentive Methodology.** Some health plans are using a flat fee methodology to change physician behavior. This methodology does not affect the underlying physician reimbursement, but it induces the physician to work in a manner that fits with the needs of the patient and the health plan. The following are some examples:

- If the health plan wanted to increase the use of disease management, it could pay a flat fee for each referral to a disease management program.
• To increase preventive care, a health plan could monitor HEDIS preventive care measures and pay a physician a higher fee schedule, if the physician has high performance-based HEDIS scores.
• To induce primary care physicians to follow appropriate referral patterns, a health plan could pay a flat fee for appropriate documentation of the steps taken prior to referral. Alternatively, the health plan could pay a flat fee to the PCP for tracking a patient, once referral takes place. This would help pay for the physician’s time to communicate back and forth with the specialist.
• In a capitation situation where it is hard for a health plan to get good claims information, the health plan could offer a flat fee for timely reporting of encounters with a small fee per record reported.

SUCCESES AND FAILURES

There have been successes and failures under both the managed care and non-managed care methods of provider reimbursement. Success can be defined as providing quality care while still meeting all financial obligations.

Successes. Ob/Gyn Management (OGM) is a specialty physician group in Dayton Ohio that receives capitation from its contracting health plans and then subcapitates its physicians. OGM found that 95% of its network physicians earned more under capitation than they would have under FFS, with no drop in patient satisfaction.

In Atlanta, Georgia Urology, PA, is using capitation successfully in its specialist group. It receives capitation from the health plans with which it contracts, and then subcapitates its network physicians. In six years, Georgia Urology has grown from four physicians based in two southern Atlanta offices to 34 physicians in 22 locations throughout the Atlanta area.

Raleigh Orthopedic Clinic, also a single specialty group in a managed care environment, is another reported success with capitation. The clinic has managed care penetration of approximately 50% in its practice’s payer mix.

Table 1 indicates some key elements for success and which of these were pursued by OGM, Georgia Urology, and Raleigh Orthopedic.
Table 1

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<th>OGM</th>
<th>Georgia Urology</th>
<th>Raleigh Orthopedic</th>
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<tr>
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<td>Good Relationships with Key Players</td>
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There are some common threads among these three organizations for their success. First, all three are collecting data on practice patterns, outcomes, quality of care, and other performance measures. They share this information with their physicians on a group basis and individually. They give their physicians regular and timely feedback on how they are performing in general and in comparison with their peers in the network. This has proven to be a most effective way to promote positive change among physicians.

The collection of outcomes data is also important for contract negotiations. The more information brought to the negotiating table, the better able the organization will be to negotiate fair contracts.

The second common thread involves the financial incentives provided to the physicians in the group. Both OGM and Georgia Urology subcapitate their physicians. While Raleigh Orthopedic did not reveal exactly how it reimburses its physicians, it did emphasize the importance of a fair and equitable compensation system that provides the correct types of incentives. To succeed, it is imperative to have financial incentives that induce behavior consistent with the goals of the group (i.e., quality care with little waste).

Another common thread is the use of care guidelines or pathways. Both Georgia Urology and Raleigh Orthopedic use care guidelines or pathways. The physicians in the network sign off on the guidelines and agree that they provide the most appropriate care. These guidelines allow the group to provide improved quality of care at reduced cost because the “fat”, or unnecessary steps, are removed from the process.

Finally, building close relationships with key players in the market is also critical. This includes health plans, insurance companies, and PCPs. Specialists rely on PCPs for referrals, so good relationships are vital.

One item not mentioned by any of the three organizations is the amount of risk the physicians can handle. Risk and responsibility must be balanced between the health plan and the provider.

**Failures.** Burns Clinic in Petoskey, Michigan was a multi-specialty group that attempted to embrace capitation and failed.\(^{10,11,12}\)
The failures of physician practice management companies (PPMs) have received a lot of press. A PPM is an organization that manages physicians’ practices and in most cases either owns the practices outright or has rights to purchase them in the future. Many PPMs are publicly traded. Some well-known PPM failures are MedPartners Provider Network Inc., PhyCor, and FPA Medical Management Inc. Many opinions were put forward on why these and other PPMs failed\textsuperscript{13,14,15,16}.

A reason for failure common to both Burns Clinic and the failure of the PPMs is the misalignment of financial incentives. The compensation systems were working against the goals of these organizations. They were not inducing physicians to operate more efficiently. In fact, they were doing just the opposite.

If we compare Burns Clinic with the successes, a couple of indicators emerge, aside from the misalignment of incentives described above.

First, Burns was not providing proper feedback to its physicians with respect to their performance or the operating decisions of the board of directors. With regard to the physicians’ actual performance, they were not given feedback on how they were doing either individually or compared with the whole group. Moreover, they were being rewarded for continuing to do what they were already doing.

Secondly, Burns was unable to maintain good relationships with key players. Once these relationships soured, Burns was unable to recover.

Looking at the PPMs’ compared with the successes, it seems the decision of the PPMs not to invest in the infrastructure needed to provide necessary feedback to the physicians was a key element in their failure.

Table 2 shows some of the critical elements for success and which of these elements were not addressed by Burns Clinic or the failed PPMs.

<table>
<thead>
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<th>Key Strategies Used or Not Used by Failed Specialty Groups That Used Capitation</th>
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Just as physicians are struggling with capitation, so too are hospitals. Many hospitals are now battling with health plans to renegotiate their capitation contracts. Some are even
threatening to cancel their contracts because they feel they are not receiving enough payment\textsuperscript{17}. Why are hospitals struggling under capitation?\textsuperscript{18}

- Hospitals often rush into capitation unprepared, because they fear their competitors are doing the same and they might gain an edge in market share.
- Hospitals’ capitated patients sometimes check into a competing facility, causing the hospital to pay costlier charges to the competing hospital.
- Hospitals pay regular charges instead of subcapitating outsourced tertiary services, ambulance, SNF, etc. Some hospitals also give away as much as 65% to their medical group partner.

For capitation to work for a physician group or hospital, the providers must know what they are getting into. They must also understand the risks, and know how to deal with them.

The choice of reimbursement method is not the sole reason for success or failure, however, it is a major contributing factor. If a group is financially strong, the choice of reimbursement method may not have a great impact. The same can also be said for a group that is not well funded, no one reimbursement method will solve that problem. However, for a group somewhere in the middle, the choice of reimbursement method may be what tips them towards success or failure.

**THE FUTURE**

What will provider reimbursement look like in the future? All of the methods described will continue to be used, capitation will not disappear. Neither will FFS. The reimbursement method used will be the one that best fits into the particular environment. There will also be some blending of methods as well as some new methods.

Vertical integration lends itself to the capitation method of provider reimbursement, especially global capitation. The organization receives a global capitation payment to cover the provision of all the services provided by the new organization—institutional and professional. Horizontal integration, on the other hand, lends itself more to global fees or case rates.

Reimbursement for Internet consultations is an example of using FFS, a traditional reimbursement method, to encourage a type of physician behavior necessary in the new managed care environment. We will see a lot more of this in the future. Email communication is now a major part of many people’s daily life. Most will find it more convenient than sitting waiting for the doctor to return their phone call.

We will also see the blending of reimbursement methods to fit the situations at hand. Some physician practices, especially in California, are already putting these types of reimbursement methods into operation\textsuperscript{19}. An example is paying PCPs on a capitation basis and carving out certain procedures and visits from the capitation payment and
paying these on a FFS basis. The types of services that are carved out are preventive services, such as mammograms and vaccinations, to encourage their use.

We will also see a move away from purely financial incentives for physicians and a move towards incentives based on quality of care and patient satisfaction. These types of incentives are taking on more importance as a direct result of the recent managed care backlash and increased consumer involvement in the delivery of healthcare. Employers and their employees are demanding it. Currently, the biggest hindrance to these types of reimbursement methods is how to measure quality. However, these measures are being developed (e.g., HEDIS measures), and better measures will continue to be developed, as these types of methods grow in popularity.

There will also be more risk adjustment in the provider reimbursement methods used. A physician will no longer be penalized for having sicker patients. This will help prevent the situation where physicians have an incentive to refuse very sick patients or to refer them to another doctor. These methods will become more sophisticated and more accurate in the future, as risk adjustment is performed more often and health plans and providers get more sophisticated in tracking their data.

No matter where the future takes us, one thing is certain: we can never return to a purely FFS environment. Even those health plans that choose to continue to pay on a FFS basis will incorporate some managed care components into their FFS methodology, such as care management, disease management, and centers of excellence. Some plans are already doing this. Employers will not allow healthcare expenditures to return to the level of annual increases seen in the FFS world. The new managed care plans will still demand efficiencies, but they will involve the providers more in the process, and they will be more consumer friendly.

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