

## Evaluating & negotiating payment options

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Payments based on a “forecast” of how much it will cost to treat a particular patient population raise issues that physicians must understand to negotiate the evolving payment environment. For physicians transitioning from fee-for-service payment to risk-based reimbursement, the AMA provides payment systems information based on the ability to stay within a specified budget for health care services provided to a specified population, including shared savings, bundled payments, pay-for-performance and capitation.

### Payment options manual overview

The health care system in the United States is undergoing a paradigm shift with regard to physician and other health care provider reimbursement methodologies. This manual describes the steps physicians need to take to make these payment systems work for their practices, and covers the concepts more commonly associated with health insurance than physician payment, including, “actuarial soundness,” “risk adjustment” and “risk mitigation,” the mastery of which is necessary to the successful navigation of risk-based contracting and revenue cycle management.

Download Evaluating and Negotiating Emerging Payment Options (PDF).

Physicians who are able to manage their risks are able to succeed in a budget-based payment system.

### 4 steps to evaluating a utilization budget

Step 1: Determine what services are included within the budget.

- To establish an actuarially sound budget, know the specifics of all the services which are covered by the budget. This means an exhaustive list defining each and every service which will be charged against the budget by CPT®, HCPCS, ASA, CDT and ICD-10-CM codes, and the financial impact of any applicable modifiers, as well as any facility-based services.

- Pay extra attention to these areas: Mid-contract changes to legal coverage mandates, new technologies or drugs and out-of-network and out-of-area services.
- To eliminate confusion on what services the budget covers, clarify that the budget excludes any service which is not specifically listed.

Step 2: Accurately predict the extent to which the patient population will use those services. To do this, gather key information from the health insurer, such as:

- Expected number of enrollees
- Guaranteed minimum number of patients
- Age and sex breakdown of your expected patient population
- Expected utilization profile, by CPT code
- Risk adjustment

Step 3: Determine the cost for each of the covered services. A credible “utilization projection” or forecast is not enough to determine the likely financial impact of a budget-based payment system. Know how much money has been allocated for each of the projected services.

Step 4: Determine whether the services can be provided within the budgeted amount. This will require an understanding of the practice costs and potential areas for savings. For more information on how to determine practice costs, see Chapter 1: How to Establish Your Baseline Costs.

## **Chapter 1: How to establish Your baseline costs**

Learn why participation in risk-based payment models requires physicians to adopt more sophisticated accounting practices than those required under fee-for-service. This chapter gives guidance on how physicians can calculate their true costs of doing business.

## **Chapter 2: Fee-for-service issues**

Learn about the likely role that fee-for-service will play in the future, and how physicians can meet the challenges of managing fee-for-service payments caused by unnecessary complexity and a lack of transparency.

## **Chapter 3: Pay-for-performance programs**

This section identifies the key issues physicians should consider when evaluating a pay-for-performance opportunity, including how their patient satisfaction, quality, and cost-effectiveness scores will be determined and how that determination will be used to calculate payment.

## **Chapter 4: Capitation**

Learn how to evaluate and develop systems to succeed under capitation arrangements. This chapter includes guidance regarding how to: transition from cash to accrual accounting; track incurred-but-not-reported liabilities; clearly define the division of financial responsibility between the health insurer and the physician group; evaluate the soundness of proposed per member per month payments; and obtain the patient enrollment data needed to minimize the occurrence of retroactive adjustments.

## **Chapter 5: Shared savings proposals**

Delve into practical guidance that helps physicians understand the key analytical issues associated with shared savings arrangements, including the Medicare Shared Savings Program.

## **Chapter 6: Bundled payments**

Identify physician concerns with bundled payment proposals, including whether or not physicians will receive their portion of 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 7: Withholds and risk pools**

This section describes the role that withholds and risk pools play in risk-based payment arrangements. It helps physicians evaluate their likely success by helping them 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 8: Risk adjustment**

This section describes why physicians must understand the health insurer's risk adjustment methodology, and identifies the essential issues physicians should consider when seeking information from the health insurer about, and determining the accuracy of, the insurer's risk adjustment methodology.

## **Chapter 9: Stop-loss insurance**

This chapter outlines the reasons why physicians participating in risk-based payment arrangements are advised 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 10: Working with actuaries**

This area 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 how physicians can make cost-effective use of an actuary's services.

## **Chapter 11: Negotiating the deal**

This chapter discusses issues physicians should consider prior to negotiating payment-related issues with a health insurer, such as identifying the goal of the negotiations, evaluating a negotiating position and building a negotiating team; it also describes special issues likely to arise when negotiating budget-based payment arrangements.

## **Chapter 12: Joint contracting/collective bargaining**

This chapter outlines how participating in budget-based payment arrangements may enable independent, competing physicians to "financially integrate," allowing them to engage in joint price negotiations with health insurers and other payers without violating the antitrust laws, and includes links to more detailed antitrust advocacy resources.

## **Chapter 13: Ethical implications**

This chapter discusses the ethical issues that budget-based payment arrangements may raise.

## **Chapter 14: Evolving compensation methodologies**

This section discusses new compensation methodologies for employed physicians that align with value-based payment models.

## **Contact us**

For additional questions, please contact Wes Cleveland, JD, senior attorney: [wes.cleveland@ama-assn.org](mailto:wes.cleveland@ama-assn.org).