



Physician Payment Reform

Where Do I Fit In? Dividing the Pie In New Payment Models

AMA Innovators Committee
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Executive Summary

In June 2011, the American Medical Association (AMA) formed the Innovators Committee, an advisory group of physicians with hands-on experience in the development and management of innovative health care delivery and payment models. The AMA Innovators Committee has developed resources to help physicians implement innovations that improve patient care and increase professional satisfaction and success.

Much has been said about new delivery and payment models, including episode-based bundles, accountable care organizations, and global payment bundles. Earlier Innovators Committee resources have described these models, referred to generally in this resource as Fee-for-Value (FFV) arrangements, and provided guidance to practicing physicians on the key components necessary to increase the likelihood of a successful transition to new models. These resources can be found at <http://www.ama-assn.org/go/paymentpathways>.

Missing from previous resources, developed by the AMA Innovators Committee, is how participating providers negotiate their reimbursements under these new models. Recognizing the lack of guidance in this broader area, this resource sets out to demonstrate how payments might flow to individual physicians, non-physician providers (NPPs), facilities, and payers under these new models, as well as the organizational and governing structures and the negotiating strategies that are likely to ensure payments are disbursed fairly.

The Innovators focused their attention on two distinct but related types of FFV payment arrangements: global budgets and episode-based bundles. Unlike enhanced forms of Fee-For-Service (FFS), such as care management payments, these arrangements are less well understood by physicians and, as such, engender the most concern about appropriate payments. This resource will address this concern head-on by describing and “showing” how to transition from redesigning care delivery in these types of arrangements to adopting payment innovations that reward high value care down to the individual physician-level.

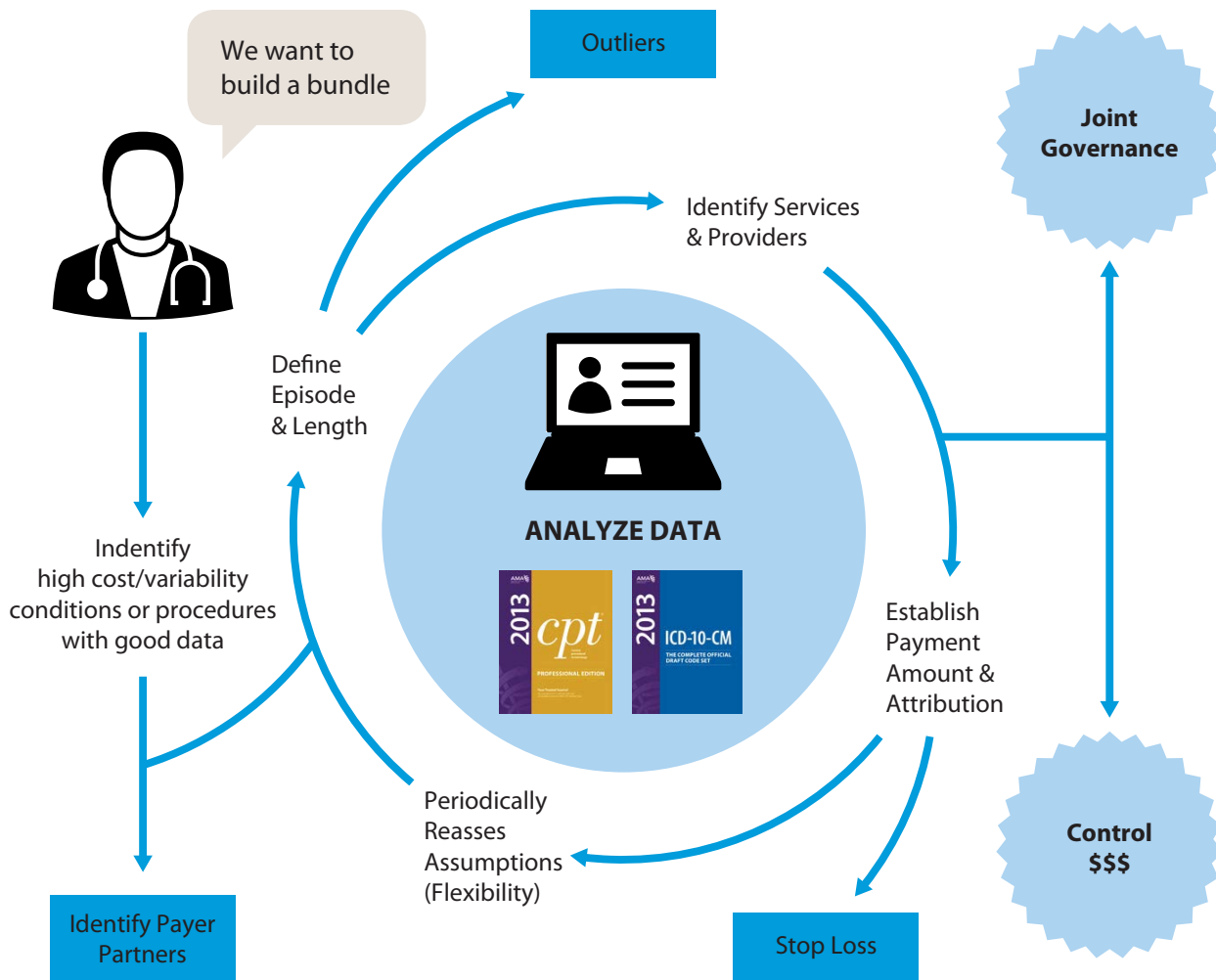
The first part of this document describes the key components of a global budget model, which adjusts FFS payments retrospectively based on predetermined spending targets. In

this regard, Tables 1-9 are included as illustrative examples of how data might be organized in this model, while the latter part of the resource describes how this data is factored into individual physicians’ final payments. The Innovators chose this model because its focus on maintaining a budget is similar to the type of financial accounting that most people use in their personal lives. In addition, the model provides enough flexibility to allow the inclusion of multiple FFV arrangements—for example, a bundled payment for a surgical episode—within the context of the overall global budget. That said, the flexibility of this model must be tempered by the fact that, as implied by the term budget, all providers must adhere to certain spending parameters as the responsible stewards of finite resources. The resource closes with series of case studies to describe situations in which episode-based bundles may be appropriate, and how payments flow to individual physicians in these constructs.

The notion that physician practices will need to align with other healthcare stakeholders to build integrated systems necessary to succeed in a FFV model is embedded throughout this resource. Alignment strategies may include partnering with other physician groups, or with a hospital, to build and manage a global budget for a population, or it may mean partnering with payers to monitor and improve performance by sharing data and leveraging their analytic capabilities. These will require important negotiations between various stakeholders, resulting in the establishment of risk-bearing entities, or alternatively in altering the relationship with a payer as well as the payment methodology. The process that physician practices must go through in order to build these partnerships, as well as the key components of a FFV contract are described in this document, in an attempt to provide physicians with a better understanding of what role they will play in the FFV eco-system, in order to alleviate concerns about reduced payments. As a result of reading this resource carefully, physicians should appreciate that most new payment models are neither designed to completely replace FFS nor to reduce payments to individual physicians and other providers. Rather, the main innovation of FFV models is a redistribution of risk such that every healthcare stakeholder will be responsible for decisions that they can be reasonably expected to influence.

Figure 1 provides a cartoon depiction of the key elements of a FFV construct. These include, but are not limited to → identifying the episode that might benefit from bundling of care and payments → identifying the components of care within the episode as well as the providers and services included in the bundle → establishing partnerships with other stakeholders, including payers → performing a thorough analysis of the clinical components and costs of care likely to be provided during the episode, including outliers, and making assumptions about these → establishing the infrastructure necessary for the analytic requirements → establishing organizational and governance structures → building off the previous steps to determine attributions and payments at the individual physician level → allowing for periodic review and adjustments to reflect changes in practice patterns and adoption of new treatment protocols and technologies.

Figure 1: Overview of FFV – Logistics and infrastructure required to build episode-based bundles, the quintessential building blocks of global and population health constructs



Note: Please use the List of Acronyms and/or Glossary of Terms for help in defining key terms that are used in the Innovators Committee resources. The information herein is not legal advice; physicians should always consult an attorney before entering into new contracts or payment arrangements.

FFV Models: Making All Healthcare Stakeholders Accountable Not Just the “Gate Keeper”

Most healthcare payers and purchasers are moving away from the point-of-service payment model, opting instead for models that assert more control over the healthcare dollar. Accountable Care Organizations, Patient-Centered Medical Homes, and Global Budgets are all variations on the premise that someone or something should monitor all healthcare delivery (at the patient and population-level) to ensure that resources are allocated to achieve high quality and lower cost care. However, unlike the managed care models in the 1990s, which relied on a single “gate keeper” to control patients’ access to healthcare, FFV models are designed so that all physicians and other healthcare stakeholders are accountable for cost and quality, and fairly rewarded for their participation in both caring for patients and organizing the system of care.

This level of accountability is made possible by recent advances in healthcare analytics that enable the aggregation and analysis of large volumes of data from multiple sources at a level and to a degree that was impossible 20 years ago. Evidence-based measures, clinical registries, and health information exchanges have already demonstrated significant improvements in care delivery. This trend will continue as new technologies evolve, and will conceivably accelerate if the predicted easing of federal regulations governing the analysis and exchange of health information occurs. The remainder of this resource turns the page to show how understanding their healthcare costs and quality data can lead physicians to → the payment model (or models) that will enable their practice to sustain high value care delivery to → alignment with like-minded practices, facilities, and payers in risk sharing arrangements to → accountable payments to the individual physician and other providers.

Healthcare Expenditures and Potential Waste: The Macro-Level View

FFV models will require physicians to understand their current healthcare expenditures as a means to begin identifying possible savings and allocating resources as effectively as possible. Data shown below reflect expenditures by a group of practices in western and central Massachusetts that use global budgets to manage the care of a patient population. Unlike most global budgets analyses, patient copays and out-of-pocket costs are included within each of the spending categories. This enables the practices to align their budgets with the benefit structures of some payers, which allow for member/beneficiary engagement and sharing surpluses. Of note for physicians, this analysis only considers their professional costs; other budget analyses may include professional costs, facility costs, and other providers' costs. Despite these noted differences and other demographic variables, practices that accept risk under a global budget or other FFV model must be able to analyze their spending by category and understand how they interrelate as a means to begin to identify possible waste (expenditures that do not improve health).

that will be essential as service lines are gradually added to the budget. Understanding the budget's limitations also will help identify analytic gaps that should be addressed in the long-term, as well as those conditions or services that should be paid for separately (for example, under an episode-based bundle).

It is important to identify and accurately describe the limitation of the budget. For example, physicians should clarify which parts of the budget are based on estimates (or targets) and which are based on historical benchmarks. This will build credibility with partner clinicians and ultimately help to ensure their support of the global payment model, support

Table 1: Healthcare Spending & Possible Waste

Plan Type	Total Costs (\$/Year)	% Possible Waste	% MD Costs	% Hospital Costs	% SNF Costs	% Rx. Costs	% Other Costs
Commercial	\$5,000	15+%	20%	22%	5%	23%	22%
Medicaid	\$6,000	20+%	15%	30%	8%	15%	23%
Medicare	\$11,000	30+%	12%	30%	12%	10%	24%

*Source: Accountable Care Associates (Springfield, Massachusetts)

The Role of Data in FFV Models: Using Historical Benchmarks to Estimate Costs and Savings

Historical financial benchmarks are typically good indicators of future financial performance and are commonly used to establish annual spending targets. Internal benchmarks indicate that the aforementioned practices in central and western Massachusetts have been able to cut wasteful spending by at least half year-over-year. The data above projects that \$4,150, or 19 percent, of total spending is wasteful. Historical data suggests that the group will achieve a \$2,075 reduction in spending. That said, in risk-based payment models, spending targets represent the number that is negotiated with payers that practices must hit in order to share savings—it is always wise to base spending targets on a more conservative set of assumptions than historical benchmarks might otherwise suggest.

Practices like the one in Massachusetts, which have identified workable practice and managed care infrastructure, have shifted their thinking about how to allocate shared savings. They first use their shared savings to reinvest in and continually improve their infrastructure so that they can maintain their competitive advantage. Reinvestments include adding staff (care managers, health coaches, for example), training existing staff to take on new responsibilities, investing in technology, redesigning practice workflow, and so on. Practices have also ensured success by retaining that a portion of the shared savings in reserve for physicians and NPPs who accepted accountability, or risk, for achieving cost and quality targets.

Data in Table 2 represent a multispecialty practice that includes 50 total physicians and NPPs. Of these, 16 are primary care physicians who have 33,000 members in their panels, 5,000 of which are managed under a global budget. Because of added quality and care coordination activities, these physicians spend more time per-patient with their managed care population. Due to the added management payments, however, Quality Value Unit (QVU) payments¹, surplus

distributions, and increased pay-for-performance (P4P), the 5,000 managed members contribute more revenue to this practice than the remaining 28,000 FFS non-globally managed members. And even when the added time (and office resources) is taken into account, the managed care members contribute five times more revenue to the practice than the FFS members..

¹ Quality Value Unit: assigns a quality value to activities that will help achieve a quality score (see page 12 for detailed explanation).

Table 2: Revenues from FFS vs. Managed Care

PCP No.	All Managed			FFS-Other			Total		
	Memb.	Total Revenue (\$/Year)	PCP (hrs) /wk.	Memb.	Total Revenue (\$/Year)	PCP (hrs) /wk.	Memb.	Total Revenue (\$/Year)	PCP (hrs) /wk.
1	380	\$ 442,793	8.2	1,824	\$ 394,975	33	2,204	\$ 837,768	43
2	262	\$ 391,947	6.2	1,654	\$ 358,163	30	1,916	\$ 750,110	38
3	282	\$ 291,894	6.6	1,985	\$ 429,839	36	2,267	\$ 721,733	45
4	166	\$ 193,629	3.4	1,497	\$ 324,166	27	1,663	\$ 517,795	32
5	314	\$ 229,893	6.3	1,562	\$ 338,241	28	1,876	\$ 568,134	36
6	444	\$ 520,919	10.4	1,926	\$ 417,063	35	2,370	\$ 937,982	47
7	486	\$ 773,490	12.2	1,784	\$ 386,314	32	2,270	\$ 1,159,804	45
8	475	\$ 716,213	12.5	1,891	\$ 409,484	34	2,366	\$ 1,125,696	48
9	197	\$ 294,394	5.3	1,300	\$ 281,507	24	1,497	\$ 575,901	30
10	440	\$ 612,747	9.9	2,229	\$ 482,675	40	2,669	\$ 1,095,423	52
11	226	\$ 195,405	4.5	1,578	\$ 341,706	29	1,804	\$ 537,111	35
12	270	\$ 196,497	5.6	1,731	\$ 374,837	31	2,001	\$ 571,334	39
13	593	\$ 472,491	11.3	1,456	\$ 315,287	26	2,049	\$ 787,778	40
14	297	\$ 344,372	6.3	1,720	\$ 372,455	31	2,017	\$ 716,827	39
15	216	\$ 146,556	4.5	1,895	\$ 410,350	34	2,111	\$ 556,905	41
16	291	\$ 215,332	5.8	1,562	\$ 338,241	28	1,853	\$ 553,573	36
Total:	5,340	\$ 6,038,573		27,594	\$ 5,975,301		32,934	\$ 12,013,874	
Ave:	356	\$ 402,572	7.9	1,840	\$ 398,353	33	2,196	\$ 800,925	41
%:	16%	50%	19%	84%	50%	81%		100%	

*Source: Accountable Care Associates (Springfield, Massachusetts)

As stated previously, some of these additional revenues are disbursed to individual physicians through QVU payments, care coordination payments, and management payments. However, a significant portion of the revenue is reinvested in the practice as a means to foster a cycle of continuous delivery innovation that enables operational and clinical improvements year over year. This has enabled the practice to reduce adverse outcomes, improve patient satisfaction, and reduce costs even as payments increase.

Identifying the Services and Providers Included in a FFV Model

Physician groups new to global budgets and other FFV models should initially focus on a limited number of conditions or episodes that have well-defined patient populations, start and end points, and evidence-based measures and treatment protocols. Clarity around these definitions will help to mitigate risk, and will enable more accurate cost and shared saving estimates. There also should be a focus on high cost conditions or episodes where there is more waste and a greater potential to earn shared savings.

Data presented in Table 3 represents cost projections from a multispecialty physician group in North Carolina (NC). This practice narrowed the scope of a budget by stratifying patients into specific categories, or populations, to reveal market specific opportunities to reduce waste and curb increasing cost trends. The NC practice stratified its patients into five patient populations: heart failure patients, oncology patients, frail or elderly patients, those patients with more than five chronic diseases (polychronics), and the dual eligible Medicaid/Medicare patients (who tend to have socio-economic issues that exacerbate underlying medical problems). The practice likely chose these patient populations because of pre-existing experience or infrastructure in these areas (for example, cardiology or oncology registries) or because of the potential to demonstrate significant cost savings.

Next, the practice developed specific care transformation models aimed at redesigning care delivery for these patient populations. Finally, the practice quantified the impact of the models on each patient population based upon the magnitude of savings estimated per model.

Disclaimer Regarding Shared Saving Assumptions: Please note that the table below represents the projections of one particular practice. The 30 percent future cost reduction estimate was based upon some historical information and will have to be tracked in real time using claims data in addition to clinical data from the payers. Tracking such data, over time, enables practices to trend the real savings and effectiveness of their delivery reform efforts. The inclusion of the 30 percent estimate in this resource does not represent AMA endorsement of the underlying assumptions made by the NC practice. Each practice seeking to build a FFV model should do so by establishing spending and shared savings targets that are based on their own historical information.

Table 3: Cost and Shared Savings Assumptions for Specific Populations

Heart Failure Population						
Future Annualized Cost Data	N	Prior Annual Cost*	Predicted Annual Cost*	Fut Cost StDev		
Cohort Sample	42	\$773,500	\$ 1,339,990			
Avg Cost per Case	1	\$17,464	\$ 31,905	\$23,420		
CHC Cohort (tot)**	181	\$3,161,036	\$ 5,774,719			
* Capitated at \$114,000	**Current 12202012					
Total Patient Population						
Assumptions			Revenue Opportunity (accrued)	12/14/2012	1/14/2012	1/15/2013
Future Cost Reductions %	30%	a)	Panel Size	181	205	334
Shared Savings %	50%	b)	Predicted Future Cost per Case	\$ 31,905	\$ 31,905	\$ 31,905
Current Navigators	1	a x b = c)	Total Pred Fututre Cost	\$ 5,774,719	\$ 6,540,427	\$ 10,656,111
Max navigator panel size***	100	d)	Adj Pred Future Cost	\$ 4,042,303	\$ 4,578,299	\$ 7,459,278
Navigator S&B	\$80,000	c - d = e)	Savings Opportunity	\$ 1,732,416	\$ 1,962,128	\$ 3,196,833
Current Physician FTEs	1	f)	Shared Savings Rev	\$ 866,208	\$ 981,064	\$ 1,598,417
Max physcian panel size	300	Direct Cost				
Physician S&B	\$300,000	g)	Navigators (N)	9	9	9
		h)	Navigators S&B	\$ 80,000	\$ 80,000	\$ 80,000
Current Dir of Care Man	1	i)	Physician FTEs	1	1	1
Director of Care Man S&B	\$100,000	j)	Physician S&B	\$ 300,000	\$ 300,000	\$ 300,000
Pt Care Nav Supervisors	0	k)	Director of care Man FTE	1	1	1
Max PCNS # PCN	15	l)	Director of care Man S&B	\$ 100,000	\$ 100,000	\$ 100,000
Pt Care Nav Supervis S&B	\$85,000	m)	Pt Care Nav Supervis FTE	0	1	1
Registered Dieticians	0.5	n)	Pt Care Nav Supervis S&B	\$ 85,000	\$ 85,000	\$ 85,000
Max Panel Size Reg Diet	250	o)	Registered Dietician FTE	1	1	1
Registered Dietician S&B	\$65,000	p)	Registered Dietician S&B	\$ 65,000	\$ 65,000	\$ 65,000
Panel Roundup Tolerance	10%	q)	Total Direct Cost	\$ 1,185,000	\$ 1,270,000	\$ 1,270,000
		f - k = l)	Contribution Margin	(\$318,792)	(\$288,936)	\$328,417

Sample breakeven analysis. The base model assumes a 30% reduction in TCOC. All highlighted boxes contain adjustable paramaters for navigator panel size. Salaries are all estimates. Patient growth in panel size is observational.

*Source: Cornerstone Healthcare

Table 4: Understanding the Assumptions behind the Shared Savings Projections

Step 1	Ttl. Predicted Future Cost \$5,774,719	X	Future Cost Reduction 30%	=	Savings Opportunity 15%
Step 2	Savings Opportunity \$1,732,416	X	Shared Savings 50%	=	Shared Savings Target \$866,208

Revenue projections, such as Shared Savings Opportunity likely depend on a series of assumptions about future expenditures and waste. For example, as Table 4 shows, the North Carolina practice projected a Shared Savings Opportunity of \$1,732,416 by assuming that waste represented 30 percent of Future Costs. It then assumed a 50 percent reduction in waste to project a Shared Savings Target of \$866,208.

Identifying the Services and Providers Excluded from the FFV Model

Physician practices considering a FFV arrangement must also be able to accurately estimate costs and measure those services that are left out of the projections (or services that are included in the projections but delivered by outside providers). Such estimates may indicate a high-cost condition that should be accounted for separately through a bundled payment, or excluded due to unpredictability.

An outside services expense report in which prior years expenses are used to estimate future costs enables practices to track these services to ensure that costs remain relatively stable year after year. Significant fluctuations in the costs of outside services may indicate a problem that needs to be resolved or it may indicate a potential opportunity for the practice. For example, significant increases in the provision of particular outside services may suggest an opportunity to develop an episode-based bundle as a means to better control their costs. Over time, this data may reveal future recruitment opportunities such that a group can deliver services within the practice that had previously been referred to outside providers. Alternatively, a practice may find that services provided within the practice could be provided more efficiently by an outside provider. However, before offloading services, it will be important to understand the competition trends in the market. Healthy competition among several outside providers is not only good for patients—it's also an insurance policy in the event that your first choice does not work out.

Drilling Down: Analyzing the Per-Capita Cost of Care

Once a practice has a big picture view of its expenditures and shared saving opportunities in the FFV model, it needs to better understand how individual physicians and NPPs are performing. This is the point when relatively new technologies that supplement the functionality of existing practice infrastructure, such as an electronic health record, will play a critical role. For example, analytic tools that drill down at the patient and clinician level, health information exchanges, tools to help identify gaps in care, registry tools, tools able to aggregate, analyze, and share data from multiple sources, and tools able to risk stratify patients and do predictive modeling regarding costs of care. Currently, most physician groups neither have the resources nor, given their relatively small patient panel sizes, would they find these technologies useful as separate (non-integrated) practices. Overcoming these challenges will require physicians to pursue partnerships or alignment strategies² with other healthcare stakeholders that preserve medical independence. Such partnerships may allow physicians to build the economies of scale that will enable optimal use of data analytic and sharing technologies to reform health care delivery and redesign payments to sustain value. While this resource focuses on the latter, the Innovators guidance on the role of technology in delivery reform can be found at <http://www.ama-assn.org/resources/doc/washington/delivery-reform-white-paper.pdf>.

Table 5 shows how one practice applied this kind of technology to predict the future cost of care for its costliest patients. Such predictive modeling is typically based on historical data and demographic variables, including age, gender, and so on. This permits healthcare teams and individual physicians to begin thinking proactively about how to redesign care delivery to better meet the medical needs of their highest cost patients. More important for reimbursement purposes, predictive modeling enables individual physician cost benchmarking and it tracks actual costs against the projections. However, this type of drilldown analysis should never be used in isolation. Such data must always be put in the context of a physician's total cost of care (for a given panel or population) before it is used FFV reimbursement formula.

Given these and other moving parts, such as the appropriate level of stop-loss insurance, practices may want to negotiate an upside only model during the initial period. This will enable practices that are new to this type of financial tracking to gain experience before accepting downside risk.

² Healthcare integration has become synonymous with a loss of practice autonomy. To avoid these negative connotations, the Innovators uses "partnership or alignment strategies" to encompass models that preserve independent medical practice.

Disclaimer Regarding Assumptions: Many analytic tools include proprietary technology that may not provide a complete picture of how certain assumptions are made.

Table 5: Estimated Costs of a Practice's Top 30 Patients

Patient Gender	Risk Months	Patient Age	Future Risk Costs	Future Risk Inpatient	Inpatient Stay Probability	Future Costs with Cap*	Prior Ttl Costs (Annualized)	Prior Rx Costs (Annualized)	Prior Ttl Cost with Cap (Ann)*	Total Mos. Enrolled	Medical Plan	PCP Name
Female	12	75	4	6.51	20.7	\$ 15,100	\$ 3,292	\$ 1,033	\$ 3,292	24	CMS	Physician 1
Male	12	79	47.49	30.79	90	\$ 179,520	\$ 144,703	\$ 0	\$ 114,000	24	CMS	Physician 2
Male	12	72	6.33	9.44	30	\$ 23,920	\$ 17,016	\$ 1,854	\$ 17,016	24	CMS	Physician 3
Male	12	50	1.72	3.43	10.9	\$ 6,500	\$ 1,437	\$ 0	\$ 1,437	24	CMS	Physician 4
Female	12	59	5.35	5.22	16.6	\$ 20,220	\$ 4,848	\$ 4,848	\$ 4,848	20	COVENTRY	Physician 5
Male	12	76	12.5	23.64	75.2	\$ 47,260	\$ 22,595	\$ 2,795	\$ 22,595	24	CMS	Physician 4
Male	12	83	3.58	5.74	18.3	\$ 13,550	\$ 2,251	\$ 0	\$ 2,251	24	CMS	Physician 6
Male	12	56	14.53	25.55	81.2	\$ 54,910	\$ 49,680	\$ 1,259	\$ 49,680	24	CMS	Physician 7
Male	12	73	7.74	10.55	33.6	\$ 29,270	\$ 8,954	\$ 0	\$ 8,954	24	CMS	Physician 8
Male	12	67	4.57	8.78	27.9	\$ 17,290	\$ 3,745	\$ 0	\$ 3,745	24	CMS	Physician 7
Male	12	78	16.44	22.76	72.4	\$ 62,160	\$ 13,296	\$ 1,598	\$ 13,296	24	CMS	Physician 9
Male	12	78	10.56	18.16	57.8	\$ 39,910	\$ 23,719	\$ 293	\$ 23,719	24	CMS	*
Female	12	76	6.91	9.71	30.9	\$ 26,110	\$ 34,686	\$ 0	\$ 34,686	24	CMS	Physician 3
Female	12	74	37.17	25.83	82.1	\$ 140,510	\$ 77,902	\$ 152	\$ 77,902	24	CMS	Physician 10
Female	12	73	4.27	3.97	12.6	\$ 16,150	\$ 1,553	\$ 771	\$ 1,553	24	CMS	Physician 7
Female	12	68	5.21	5.71	18.2	\$ 19,710	\$ 33,682	\$ 0	\$ 33,682	24	CMS	Physician 11
Male	12	89	6.9	13.3	42.3	\$ 26,080	\$ 9,396	\$ 934	\$ 9,396	24	CMS	Physician 9
Female	12	86	9.59	25.82	82.1	\$ 36,230	\$ 7,713	\$ 0	\$ 7,713	24	CMS	Physician 1
Female	12	50	2.54	1.78	5.6	\$ 9,580	\$ 4,938	\$ 2,028	\$ 4,938	22	AETNA	Physician 12
Male	12	82	9.49	19.12	60.8	\$ 35,880	\$ 21,075	\$ 0	\$ 21,075	24	CMS	Physician 4
Female	12	83	5.13	6.45	20.5	\$ 19,400	\$ 19,778	\$ 975	\$ 19,778	24	CMS	Physician 1
Male	12	61	12.13	22.4	71.2	\$ 45,850	\$ 14,535	\$ 204	\$ 14,535	24	CMS	*
Male	12	91	9.14	10.37	33	\$ 34,550	\$ 17,114	\$ 857	\$ 17,114	24	CMS	Physician 13
Female	12	78	13.03	25.46	81	\$ 49,270	\$ 15,833	\$ 0	\$ 15,833	24	CMS	Physician 9
Female	6	54	1.08	1.78	5.6	\$ 4,080	\$ 2,450	\$ 38	\$ 2,450	16	CMS	Physician 1
Female	12	71	3.23	8.82	28.1	\$ 12,220	\$ 2,002	\$ 0	\$ 2,002	24	CMS	Physician 1

*Source: Accountable Care Associates

Table 6: Actual Savings per Physician

IB-F1	IB-F2	IBNR Adjsted	Adjusted-'12 Spls/Dfct-\$	S/D-'12 \$PMPM
\$22	\$10			
\$22	\$10	\$45	\$402,346	\$314
\$22	\$10	\$33	\$134,198	\$74
\$22	\$10	\$34	\$185,581	\$87
\$22	\$10	\$39	\$225,567	\$182
		\$37	\$947,692	\$147

*Source: Accountable Care Associates

Once the technologies and practice infrastructure are in place, near real-time tracking of revenues, expenses, and expected expenses at the individual physicians panel level will enable practices to identify cost centers and fix them immediately. This capability is important in risk-based payment models, especially those that include down-side risk in which failure to meet savings targets will hurt the bottom line.

Table 6 shows actual savings for a group of four physicians, after total revenues, total expenses, and IBNR (incurred but not reported) expenses are taken into account.

Drilling Down: Analyzing the Quality of Care

The last step in the global budgeting process is to identify areas where cost targets may be achieved by improving the quality of care. Depending on the conditions and services captured by the global budget, certain care processes may need focused attention, such as how quickly patients are moving from point A to point B. For example, data in Tables 7 and 8 show how often specified patient populations are contacted by care managers. These tables also begin to show

the impact of these care processes on the quality of care by showing how many patients were discharged and how many patients were deceased (compared to the total population). As Table 8 suggests, the capability to include progress notes which could put particular data in context also may be an important functionality.

Table 7: Analyzing Quality at the Patient Panel Level

12/14/12	Fst Pt	Active Mos	FTEs	Active Pts	Death/Exit	All Pts	Tot Pt Contacts	Avg Contacts/Mo
Patient Navigator Program								
Heart Failure Clinic	7/17/12	5.2	2	108	16	124	391	
Breast Ca Nav	9/14/12	3.2	1	30	0	30		
Lung Ca Nav	11/1/12	1.6	1	13	6	19	36	
PPCP- Premier	11/20/12	1.0	1	26	0	26		
PPCP- Westchester	11/20/12	1.0	2	4		4	36	
Care Outreach	2/1/13	0.0	1	0		0		
Case Mag of VB Contracts		0	1	0		0		
Others (unknown)				69	69	69		
Totals	7/17/12	11.9	9	181	91	272	532	44.7
Patient Care Advocate Program								
Calls placed								
Calls made re Humedica							9413	
Call made re Payer metric							2367	
Calls received							2700	
Total	3/14/11	33.4	11	?	?		14,480	434

*Source: Conerstone Healthcare

Table 8: Putting Quality Data in Context

1/9/13	Total Active	New Enrollments	Total Discharged	Total Expired	Comments
Heart Function Clinic	113	5	18	8	Nearing the 6 month mark for 1st enrolled patient (January 17th). Will initiate “report card” for each patient at their 6 month mark.
Oncology - Breast Cancer	34	0	0	0	This week has marked the 1st enrolled patient transitioning from surgery/ chemotherapy phase to radiation phase. Carrier of post-mastectomy garments expressed amazement at how early our patients are fitted for the garments. “No one gets garments before their surgery!” If patients are not fitted before surgery, they must wait appx. 6 weeks to be fitted correctly.
Oncology – Lung Cancer	22	3	0	5	Lung Navigator is now being approached by HPRHS hospitalists for assistance with Lung patients.
PPCP – Westchester	4	0	0	0	Continuing to recruit patients for open appointment times. Working to open additional appointments dates in February. Documentation template revisions near completion.
PPCP – Premier	32	4	0	1	6 patients scheduled (1 cancelled, 1 no-show). Continued positive feedback from patients and strong enrollment growth. Documentation template revisions near completion.
RAD Pilot	20	3	1 (Opt-out)	0	Opt-in rate 75% this week.

*Source: Conerstone Healthcare

Finally, it will be essential to track quality of care of all the clinicians who provide patient care, including individual physicians and NPPs. This is important not only for comparative purposes but also to gain a complete picture of the cost and quality of care that will enable the care manager in a practice to identify high cost outliers before they threaten the overall budget and payments to other physicians/NPPs. For example, physicians who use high cost implants when there are lower cost alternatives or physicians who order twice as many diagnostic tests (with no change in outcome) should be flagged so that they have an opportunity to justify their outlier status.

Data in Table 9 show an individual physician’s performance on quality measures that are relevant to his patient population. A practice may find it useful to compare these quality results against the corresponding cost of care to gain a complete picture of each clinician’s performance. Since these data will ultimately be used to determine how payments flow to individual clinicians in the FFV model and, when necessary, to implement corrective actions in cases of suboptimal performance, some level of risk adjustment will need to be baked into the performance results. However, it is neither possible nor desirable to risk adjust for all variables so groups must balance the desire to ensure fair payments to individual physicians, for which risk adjustment is critically important, against efforts to improve performance at the group level.

Table 9: A Physician's Quality Dashboard

	Population				
	All Patients	Diabetics	IVD	Hypertensive	CAD
LDL-C Screening		90%	10%		86%
LDL-C Control <100 mg/dL (18-75 yrs.)		89%	10%		10%
Use of lipid lowering agent if LDL≥100		80%			92%
Blood Pressure Screening at every visit	90%				
Blood Pressure <140/90 (18-75 yrs.)		70%		60%	
Adult BMI Screening and Follow-up (18 yrs.)	88%				
Depression Screening and Follow-up Plan	70%				
Tobacco Use: Screening & Cessation (18 yrs.)	90%	90%			
Colorectal Cancer Screening	71%				
Breast Cancer Screening	84%				
Cervical Cancer Screening	91%				

*Source: Conerstone Healthcare

Most measures today, including those listed in Table 9, look at specific processes of care. There is general agreement that applying these measures in quality reporting initiatives, such as Medicare’s Physician Quality Reporting System, has not resulted in better outcomes.³ Common criticisms include the following: 1) process measures are poor proxies for true patient outcomes; 2) payment incentives are inadequate; 3) the existing measures are not applicable to “my” practice; 4) the lag time between reporting measures and receiving feedback; and 5) faulty peer groups comparisons. While these are valid criticisms, the unsustainable growth in healthcare costs means that performance measurement and efforts to link physicians’ and other providers’ payment to their quality and efficiency are almost certainly here to stay.

New data sharing technologies and episode groupers may eventually enable risk-adjusted outcomes measures. However, until we reach that point, process measures and homegrown solutions like the QVU will continue to serve as proxies for outcomes measures. Thus, the medical profession must begin to identify innovative quality measurement solutions that will move the ball forward.

The Inverse RVU: Assigning A Quality Value Unit

One possible solution is the previously mentioned Quality Value Unit (QVU), which was developed and has been used by a physician practice in Massachusetts. The QVU system reports specific behaviors as they are performed, thereby allowing payments to be made for these activities when they occur. The QVU assigns a quality value to activities (for example, a flu shot) that will help achieve a quality score. This enables payment for the activity to reflect resource use (RVU) and quality (QVU).

As a result, care coordination activities, flu shots, and other services that have low RVUs could see substantial increases in payments when factoring in their QVU. When QVU payments were layered on top of payments for process and outcomes measures, the Massachusetts practice saw improvements in all measures and increased payments for activities with higher QVUs. This approach still falls short of outcomes measures but it is a step in the right direction. *(Philip Gaziano, Accountable Care Associates)*

³ P. Betbeze. The Trouble With Pay-for-Performance. HealthLeaders Media, October 24, 2013

Alignment Options that Enable FFV Compensation

Delivery reforms will not translate into FFV payments to individual physicians in and of themselves. However, they are critical to demonstrate a reform commitment to like-minded physician groups, facilities, payers, and other healthcare stakeholders that may be necessary partners in various alignment models designed to enable more significant investments in care delivery redesign. Ultimately, the form that alignment takes and the ensuing improvements in data analytic and sharing capabilities will also be critically important in payment redesign efforts where individual physicians' compensation are at risk for their quality and cost of care.

Efforts to align with other healthcare stakeholders to pursue FFV payments require a level of trust among those at the negotiating table as well as among the clinicians and other stakeholders whom they represent. To build this trust, physicians must be willing to understand how the organization of their practice, its relationship to the health care eco-system, and the mechanisms by which they are compensated affect the way health care is delivered and bear on their professional responsibility. Equally important will be an understanding of how various alignment models – employment, vertical consolidation, clinical integration, virtual integration – are organized to increase value. As Figure 2 states, there is “no bad option” but some alignment models may not be right for you. As healthcare stakeholders align into clinically integrated models, it is critical for physicians to understand the tradeoffs of each model and make informed decisions that reflect their professional and personal goals.

For example, vertically integrated healthcare systems or hospitals, in which physicians are employees, offer the promise of a stable paycheck, flexible schedules, and possibly fewer work hours. Possible tradeoffs are loss of autonomy, less control over business and staffing decisions, an inability to quickly respond to changes in the healthcare market, and lack of influence over how your compensation is structured.

Align with Stakeholders that Share Your Desire for Payment Reform

1. Other providers: pool resources/expertise, defray infrastructure costs, share data.
2. Health Information Exchanges: build the systems that enable data sharing & comparisons

STOP

Reform care delivery & achieve consensus on FFV principles

3. Payers: identify those that are receptive to risk-based payment models
 - Build credibility by reforming care delivery. Support assertions with performance data.
 - Get an assist from other stakeholders (e.g., other providers, HIEs, and so on)
 - State your goals (e.g. FFV contract design & data sharing in support of value-based care)
 - Be persistent—you may talk to several payers before one takes a bite at the apple

Beware of the Easy Option: Alignment Takes Many Forms

- How You Align with other Stakeholders Will Have Lasting Consequences
 - Underpins efforts to improve care coordination & transitions
 - Fosters economies of scale that lower costs or anticompetitive practices that raise costs
 - Will affect your practice autonomy and future earnings potential
- Employment
- Vertical consolidation
- Clinical Integration
- Virtual Data Sharing
 - There is no bad option each type of alignment has its own risks and rewards
- Make an informed decision understand the trade offs & choose the best option for your practice
 - How much practice autonomy will I have?
 - Will my patients continue to receive high quality care?
 - How will my earnings be impacted (short term & long term)?

Cornerstone's Model: Build It So They Come

Cornerstone Healthcare built credibility with local healthcare stakeholders by putting its reform aspirations into action. It achieved NCQA recognition for its patient-centered medical home by offering weekend hours, improving patient satisfaction, and implementing an electronic health record. These delivery reforms gave Cornerstone the credibility and the analytic tools it needed to begin the process of negotiating value-based contracts. The initial focus was on smaller payers. Following positive media coverage about its model, the larger payers came to the negotiating table. Its willingness to demonstrate an ongoing commitment to reform and to publicize results was also useful. *(Grace Terrell, Cornerstone Healthcare)*

Physician practices that value their autonomy may view networks of independent providers, such as IPAs or PHOs, as better options. Interest in these models has increased as physicians have begun to look for clinical integration options that do not involve consolidation. Recent evidence demonstrating significant increases in care management activities among members in IPAs and PHOs is likely to further encourage those seeking a middle ground approach to clinical integration. Regardless of which alignment model you choose, verify that physicians are included in the governing structure and/or other leaderships positions, that the organizational culture is consistent with your professional and personal goals, and that the business model supports high value care delivery.

Alignment Options for Independent Practices

Independent Physician Associations (IPAs) and Physician Hospital Organizations (PHOs) are organizational structures that allow networks of independent physicians to maintain significant control of their practice. The ability to jointly contract with health plans and access to administrative support services and infrastructure are strong selling points of both IPAs and PHOs. The main difference between them, both of which typically include 150-300 physician members, is that the latter aligns with hospitals, as well. A recent study found IPA and PHO members were three times more likely to provide high value care management services than their non-aligned counterparts.⁴

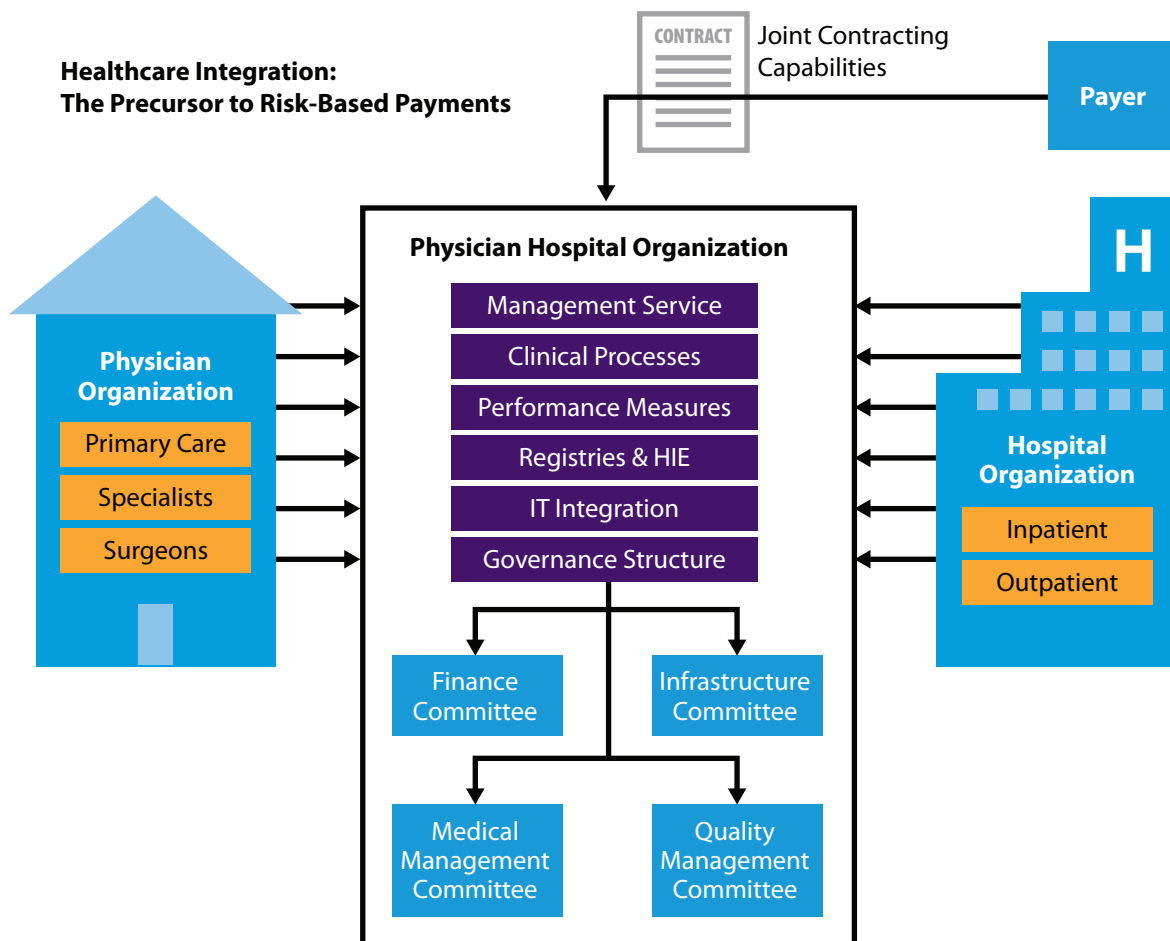
⁴ L. Casalino et al. Independent Practice Associations And Physician-Hospital Organizations Can Improve Care Management For Smaller Practicess. Health Affairs, Vol. 32, No. 8. August 2013.

Building the Alignment Model: The Governance Structure and Organizational Principles

Several rounds of negotiations with other participating physician groups, facilities, and payers, each of which may require a separate legal contract, may be necessary to operationalize a FFV arrangement. As a precursor to contract negotiations, there should be a general sense of what the physicians would like the arrangement to look like once alignment is complete, and what the physicians hope to get out of the arrangement. This not only will help you to determine the group's Best Alternative to a Negotiated Agreement) prior to negotiations with the other healthcare stakeholders but it will help to assess whether the governing structure and organizational principles (or bylaws) reflect the group's goals or whether changes should be pursued in contract negotiations.

For illustrative purposes, Figure 3 depicts the organization and governance of a clinically integrated PHO. Regardless of how your group chooses to align with other healthcare stakeholders, make sure that it is organized to enable the delivery of high value care and governed to fairly distribute (or manage) the various types of risk in a FFV model. A detailed discussion of what high value care delivery looks like—including the staffing, infrastructure, and technology requirements—can be found in an earlier Innovators Committee resource, the Case for Delivery Reform.⁵

Figure 3: Organization and Governance of intergrated PHO



⁵ Innovators Committee. The Case for Delivery Reform: Implementing Innovative Strategies in Your Practice. May 2012

The following questions and abbreviated responses are designed to help physicians build the infrastructure necessary to accept risk-based payments under a FFV arrangement. Physician groups should seek to answer these organizational questions internally prior to negotiations with hospital, payers, and other healthcare stakeholders. Unabbreviated responses to these questions can be found in [Appendix A \(Governing Principles\)](#)⁶.

1. How should the Risk Bearing Entity (and the Management Services Organization) be organized to promote value while also ensuring that individual physicians and other providers are paid fairly?

Several legal forms are available, e.g., for-profit or not-for-profit corporation, professional association, partnership, limited partnership, limited liability company. The suitability of available options may vary from state to state, given specific state requirements, and may depend on the other stakeholders (hospitals, other facilities, payers) involved in the [partnership... \(see Appendix A\)](#)

2. What governing structures for Risk Bearing Entities foster payment distribution schemes that provide value to the system while remaining fair to individual physicians and other providers?

Any bundling or global payment arrangement requires careful attention to governance. This applies regardless of whether a practice is receiving payments only for physicians' professional services or whether it is considering a more expansive global payment structure that involves non-physician partners. When physicians partner with one or more non-physician entities to create a risk-bearing entity, careful attention should be paid to governance. Since participating physicians will be assuming risk for their services, governance must be structured to ensure that physicians have a strong voice, if not control over, key [concerns... \(see Appendix A\)](#)

3. How much and what types of risk should your organization take on and who assumes responsibility for the risk of referral to outside providers?

The type and scope of risk that a payer is willing to transfer, and the risk-bearing entity's providers are willing and able to accept, will drive the costs for which the risk-bearing

entity will be responsible and the earnings potential from financial performance. Ideally, each party to the agreement will have direct control over the scope and type of risks they assume: providers will assume responsibility for performance (i.e., how efficient and effective services are delivered) while payers will assume insurance risk (i.e., how much demand there is for services due to the burden of illness of the population, the number of unforeseen events like trauma and preterm neonates). However, in some situations, it may be necessary for the entity's providers to contract with selected outside providers to deliver specialized [services... \(see Appendix A\)](#)

4. How Can You Mitigate Risk or Insure Against Too Much Episodic Risk?

Stop-loss insurance establishes a cost of care threshold beyond which the risk-bearing entity will no longer incur the full brunt of losses associated with a particular patient or patient population. This offers protection from unlimited losses resulting from catastrophic episodes, for example, in the case of an accident causing severe trauma, the risk bearing entity's financial exposure may be limited to 10 percent of incurred claims costs after the first \$100,000 ("stop-loss threshold") is [exceeded... \(see Appendix A\)](#).

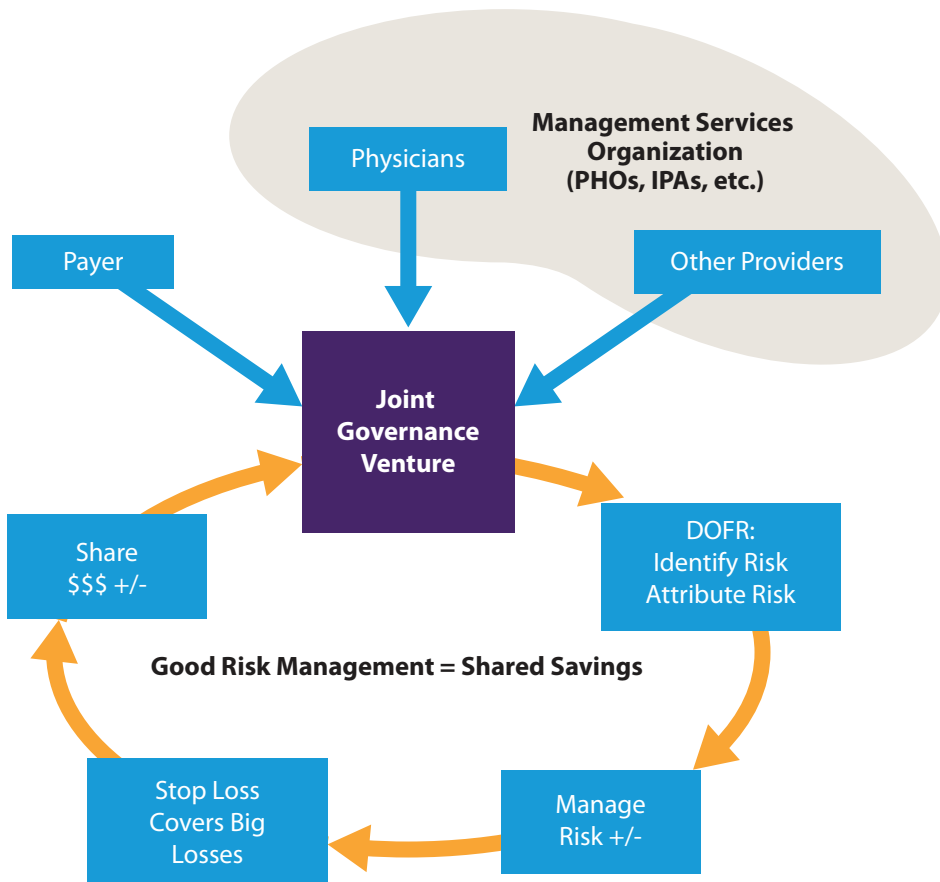
5. What is the payer's relationship with the Risk Bearing Entity—key things to keep in mind during payer negotiations?

The risk bearing entity should pay careful attention to the payer's contractual obligations, seeking to change them through negotiation when necessary. Understanding the payer's obligations up front may make potentially contentious issues, such as sharing quality and utilization data, less likely to arise and potentially easier to address, if they become an [issue... \(see Appendix A\)](#).

⁶ See Appendix A: Governing Principles to Ensure Fair Payment Under Risk-Based Payment Models

Risk-Based Payment Contracts: Establishing the Terms of a FFV Payment Model

Figure 4: Organization of the Risk Bearing Entity



As physician practices begin negotiations with healthcare facilities and payers in FFV arrangements, it is essential to understand what is really being negotiated. While appropriate compensation for high quality and cost effective care is the goal, only physicians that identify and effectively manage risk will be able to maximize their payments. Thus, under risk-based payment models, the parties are primarily negotiating over responsibility for which types of risk will be assumed and the organization of the Risk Bearing Entity (RBE) that will facilitate effective risk management for all participants. Graphic 4 illustrates the organization and basic function of an RBE, which may include physicians, healthcare facilities, other providers, employers, patients, and payers.

The [Division of Financial Responsibility \(DOFR\)](#) is the negotiated contract between the insurer and the medical providers that specifies which services are the financial obligation of each party. Put more simply, the DOFR specifies how risks are allocated among the various parties to a payment contract. The insurer components may contain incentives for controlling expenses to the insurer; a form of shared savings. The provider component may include “make-or-buy” decisions for particulars like “stop-loss insurance.” Finally, separate DOFRs may be negotiated for outpatient professional (physician) services, technical services, outpatient facilities, inpatient facilities, and so on.

It's Not Necessarily More Risk—It's Just Different Risk

What's the Risk?	Under FFS	Under Bundled Payments
What Stays the Same?	<ul style="list-style-type: none"> • How much will your practice expenses increase? • How many patients will you have? 	<ul style="list-style-type: none"> • How much will your practice expenses increase? • How many patients will you have?
What Is Different?	<ul style="list-style-type: none"> • Will your patients need enough services to cover practice expense? • Will fee levels from payers be adequate to cover costs? • What utilization controls will payers impose? • Which services that patients need won't be reimbursed by payers? • What P4P penalties will be imposed based on quality measures? • What P4P penalties will be imposed based on "efficiency" measures? 	<ul style="list-style-type: none"> • Will your patients need more services than available revenue? • Will the episode or global payment amount be adequate to cover costs? • Will risk adjustment be adequate to control for differences in need? • What unexpected services will have to be provided to meet patient need? • What portion of payments will be withheld based on quality? • How will you control the costs of other providers involved in the care?

*Source: Center for Healthcare Quality & Payment Reform

In spite of all the excitement (or concern) surrounding FFV payment models, they fundamentally do not change the amount of risk assumed by healthcare stakeholders but, as previously noted, they do rebalance the risk such that each stakeholder is responsible for the risk that they can reasonably be expected to control. As Figure 5 asserts, "It's Not Necessarily More Risk—it's Just Different Risk." FFS includes the risk that payer-imposed utilization control will not cover a particular service, whereas FFV models give providers more flexibility to develop customizable and cost effective plans for specific patients or populations. Similarly, FFS models control costs by assessing payment penalties for failure to report on specific measures, whereas FFV models use shared savings and bonuses to encourage physicians to think about their overall quality. Finally, FFS models encourage rigidly separate payment silos, that have influenced how providers think about reform, whereas FFV models break down these silos such that physicians and other providers are not only rewarded for their individual performance but also for influencing downstream quality and costs.

A Good Contract Can Reduce Risk

Examination of the payer policies and procedures associated with stem cell transplants demonstrate the importance of the contracting process between all healthcare stakeholders involved in a bundling arrangement. Providers must contract with the payer, and they may have individual contracts among providers accounting for referrals, payments, and levels of interaction particularly when the providers are not organized into one legal entity. Physicians should consult legal counsel prior to entering into such contractual arrangements to ensure compliance with federal laws that govern referral arrangements. To minimize risk, contracts define which patients are appropriate candidates for transplant therapy and specify which insurance plan enrollment is necessary before the initiation of treatment. Additionally, an appeals process for any disagreement must be agreed upon among the parties involved, including the payer, patient, and providers. Other risk adjustment mechanisms include defining the included services and the length of the episode, and using standard treatment protocols and care processes.

(Case Study 2, Michael Neuss)

FFV Payment Options: Rewarding Clinicians for Achieving Quality and Cost Benchmarks

Once your practice has the necessary infrastructure in place, and the terms of partnerships with other healthcare stakeholders have been formalized, payments can be disbursed to individual clinicians according to any number of reimbursement arrangements. However, in all likelihood, the payer will not be involved in how payments are distributed to individual clinicians. Instead, negotiations between participating providers will determine the reimbursement scheme that works best for their alignment model. This is a main reason why participating physicians should reach consensus on model design, including a representative governing structure and organizational principles (or bylaws), before negotiating with other model participants—the design of the alignment model will largely determine how much influence participating physicians and other providers have over their compensation model.

There are numerous options to fund reimbursements to individual physicians in hybrid FFV arrangements. These options may represent numerous payment models working in harmony to influence cost and quality as patients move through the system. Models that group physicians and other providers into teams will most likely require participants to reach consensus on a hierarchy of accountability, such as the tiering approach in transplant bundles, in order to determine payment flow to individual team members. A few FFV payment models are summarized below followed by examples of how these models work in the real world:

1. **Management payments** are reserved for providers who coordinate the value-added activities of the practice, thereby ensuring that care delivery aligns with quality and cost targets. Large practices often hire full-time care managers to oversee these activities but most practices will be able to identify someone internally who assumes a part-time care management role in exchange for supplemental payments (for example, a partially capitated salary) on top of FFS.
2. **Enhanced FFS payments associated with office visits** may actually increase under a FFV model. Value-based care delivery that is focused on disease prevention, monitoring, and control puts a premium on avoiding high cost and unnecessary care in the future. Under global budgets and other FFV models, practices have the option to pay participating providers more for these services than they would otherwise receive from payers.
3. **Non-face-to-face payments** may be made for value-added coordination activities. Reviewing the medical records, adjusting the care plan, documenting medical decision making, and ensuring appropriate handoffs and follow-up are all critical components of care coordination that are not compensable in a FFS model that assigns values based on resource use. To address this challenge, some groups have begun to think of new ways to value non-face-to-face activities that are critical to ensure coordination, avoid duplication, and prevent medical errors.
4. **Episode-based bundles** aggregate a group of services delivered by a team of providers into a prospective payment that is capitated or partially-capitated. Such payments are usually centered on a procedure with well-defined start and stop points. As the transplant example below reveals, this form of payment is typically reserved for high-cost episodes where another layer of specialized care management is necessary to monitor quality and cost.
5. **Global Bundles** are capitated or partially capitated payments intended to cover the full complement of care a patient received over a given time period. It typically refers to a global budget, which makes retrospective cost and quality adjustments to FFS payments. Less common are prospective global payments for care that has not yet been delivered.

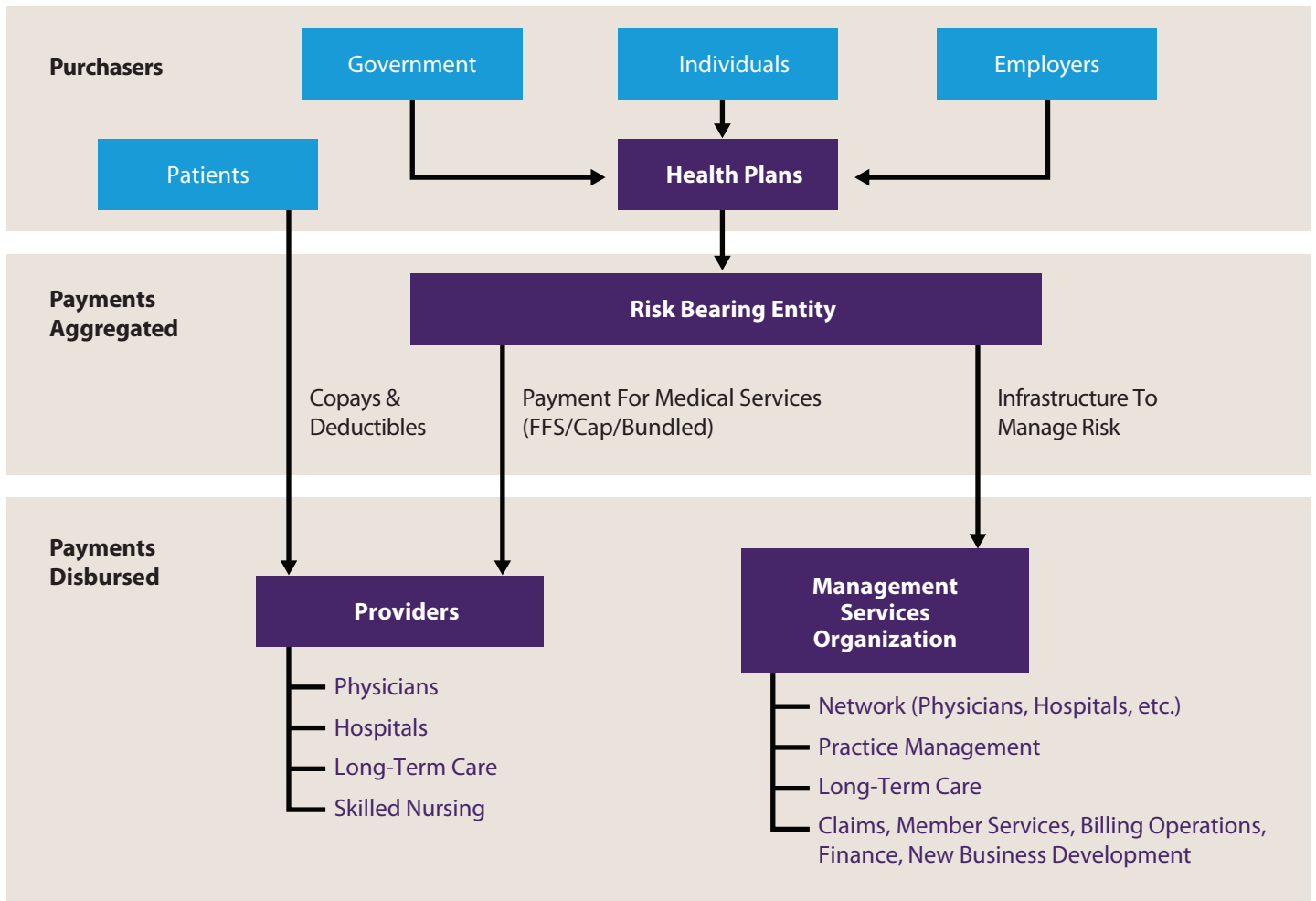
Most FFV payment options, such as those described above, are not designed to replace FFS payments but to serve as a counterweight to their volume-based incentives. In fact, many of these models continue to rely predominantly on FFS even as they redistribute risks among the participating providers and payers. These models can take the form of a global budget that adjusts FFS payments retrospectively during end-of-period reconciliation or prospectively through a FFS withhold. They can also take the form of a supplemental salary for a small subset of physicians (for example, those who perform care management and transitional activities) in addition to their FFS payments. Even under an employment model, compensation is typically a combination of productivity-based payments (RBRVS or visits or coverage windows) with performance incentives of ~20 to 25 percent that are based on success against performance measures (utilization, completion of coding, quality benchmarks, patient satisfaction, and so on).

Figure 6 summarizes how payments flow from the purchasers down to the individual providers in FFV arrangements. To recap, the key differences from the current FFS payment system are alignment models that are governed and organized to better assign and manage risk among the various stakeholders. Such models may have one or more layers of organization. For example, an individual practice may be aligned with hospitals and/or non-physician providers in a Management Services Organization that, in turn, may have partnered with one or more payers in a risk bearing entity.

Professional Capitation: Payments at Riverside Medical Center

Located in southern California, Riverside Medical Center (RMC) is a multi-specialty practice that established a bifurcated organizational structure in which all revenue is divided equally between two entities. A risk-bearing organization is responsible for all professional payments to RMC clinicians and outside contractors. A management services company is

Figure 6: Flow of Revenue & Infrastructure in an RBE



responsible for nursing, ancillary, and management staff, as well as building costs, equipment, supplies, general insurance, and legal and accounting costs.

RMC physicians receive payment through the risk-bearing organization based on RVUs by provider, a quality bonus based on internal and external benchmarking, and an equal share of the excess revenues collected. Utilization by the group determines the amount of the excess revenue; there are no separate risk pools or sub-capitation. "Overhead" expense is agreed to be 50 percent, which is paid to the management services company, and therefore providers are paid 50 percent of their RVU income as their production income. The payment is attributed to the provider regardless of insurance type, permitting RMC's risk bearing organization to take the risk for collection of the fee, and allowing the physicians to treat every patient with the same standard. Each physician is held to internal and external benchmarks for continuing employment and their quality bonus.

One important caveat of professional capitation is that it focuses only on the physician side of the equation—there is no ability to influence the downstream costs of other providers. This challenge has led RMC to explore partnerships with other providers that will allow it to influence quality and costs downstream. By breaking down the healthcare silos, RMC is betting that these partnerships will result in further cost savings that can be reinvested in the system or flow downstream to reward participating physicians and other providers.

Salaries under an Employment Model: The Mayo Way

At Mayo Clinic, all staff is compensated by a salary that is based on specialty benchmarks, typically targeting a percentile of the compensation range at a market basket of peer institutions. These benchmarks are reviewed annually. There is no productivity or other incentive payment. Thus, individual physician reimbursement is indifferent to the method by which the institution is compensated for care: fee-for-service, episode based bundles, and capitation all result in identical physician compensation. Here, the institutional goal is to optimize the care of the individual patient and the appropriate resource inputs, be those staff time, supplies, tests, or procedures. In such a system, there is no incentive to generate additional units of service in order to generate more revenue; the incentive is to optimize efficient use of the resources at hand.

Mayo's Leadership Teams: Odd Couples that Work

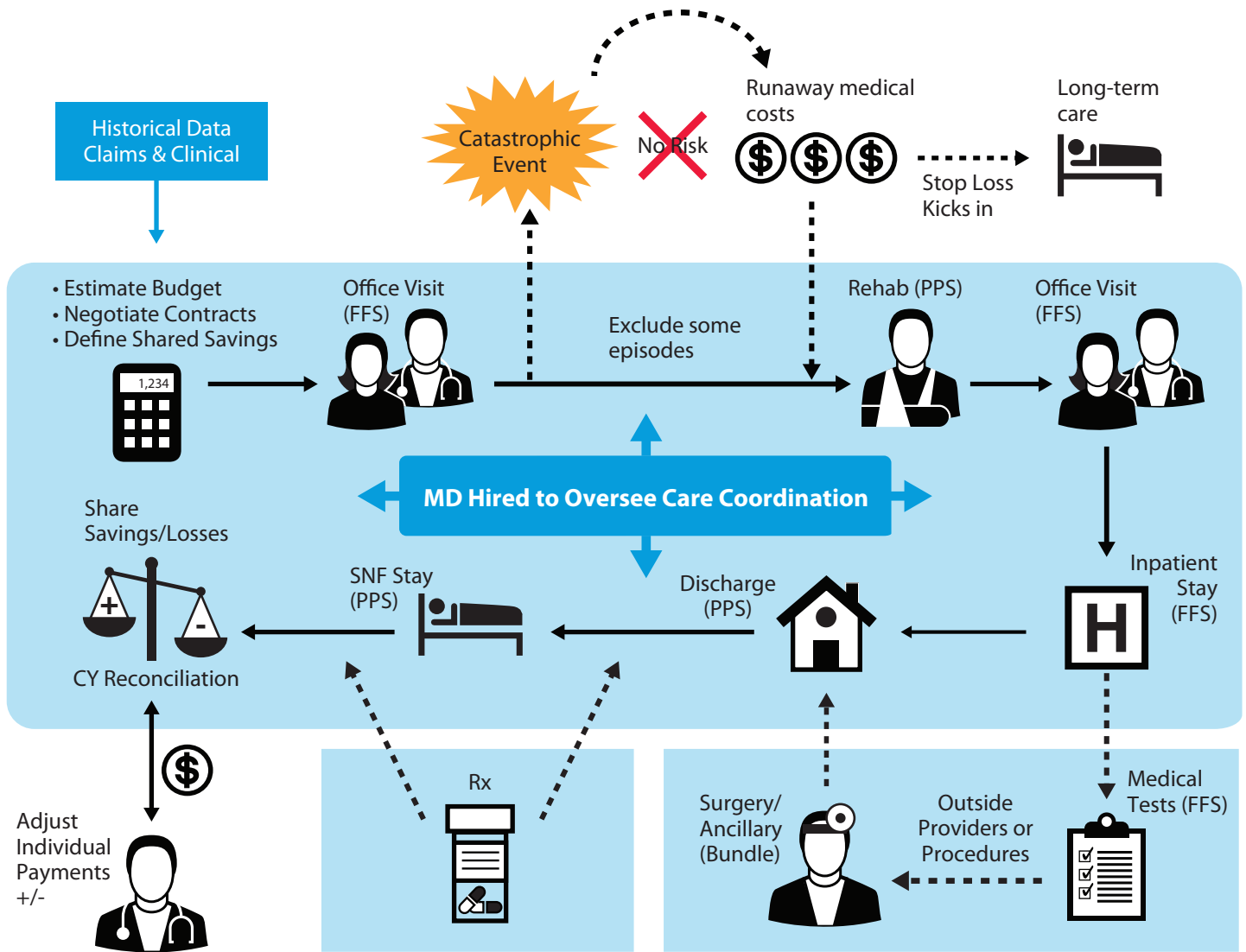
At Mayo Clinic, all leadership positions are term limited, usually to 4-8 years. Successful leaders are rewarded by promotion to other leadership roles, not by additional terms in the same role. This allows for constant refreshing of leadership ideas in a given area, as well as cross fertilization as leaders move from one responsibility to another. Leadership development programs begin for all Mayo staff when they are hired; opportunities to test skills exist in a variety of committee and other administrative roles in practice, education, and research. All physician leaders are paired with an administrative partner to form a leadership team; thus rather than have one individual with the combined skills of a MD and a MBA, Mayo partners a MD with a MBA. The administrative staff also rotates, so that, as the level of responsibility increases, the administrative pair brings an increasingly diverse background and preparation to the tasks at hand. (Peter Amadio, Mayo Clinic)

Thus, great effort is expended at Mayo in improving the quality of services, so that rework and waste are minimized. This drives down unit costs but, more importantly, by emphasizing the efficiency of the overall process, it drives down costs per episode, whether the episode is comprised of a hospital stay, a procedure, or a year of care for a chronic disease. As patient demand increases to the point where capacity is exceeded, additional resources (for example, staff and facilities) are acquired. Conversely, should demand diminish, outdated facilities are closed rather than replacing them, and replacing fewer departing staff. Additional flexibility is achieved by operating equipment for two or in some cases three shifts per day, including weekends.

Accountable Care Associates: Partial Capitation + Fee-for-Service w/ Performance Incentives:

Using a global budget and cloud-based technologies, Accountable Care Associates (ACA) has built a virtual network of several thousand independent physicians across seven states. ACA's budget-based model is, strictly speaking, a hybrid payment model which makes relatively few changes to the underlying FFS system. A small number of physicians, usually one in each practice setting, agree to serve as the

Figure 7: What Goes Into a FFV Model



care manager responsible for coordinating care for the entire practice. ACA typically offers these physicians an incentive-based payment structure—such as a partial salary with a bonus opportunity for overseeing the practices coordination activities—on top of their FFS payments for their patient care services.

Under a global budget, ACA also has the option to pay participating physician groups more for their patient care services than they would otherwise be able to negotiate with payers. It exercises this option through enhanced FFS office visits, thereby putting a premium on disease prevention, monitoring, and control that avoid high cost and unnecessary care in the future. Finally, as previously mentioned, the ACA has developed the QVU to track and reward the delivery of high value services (for example, a flu shot) that are under-reimbursed or not covered in the FFS model. As a

result, non-face-to-face care coordination activities, flu shots, and other services that have low RVUs could see substantial increases in payments when factoring in their QVU. At year end reconciliation, physicians' FFS payments are reconciled with the budget projections to assess debits for shared losses or credits for shared savings.

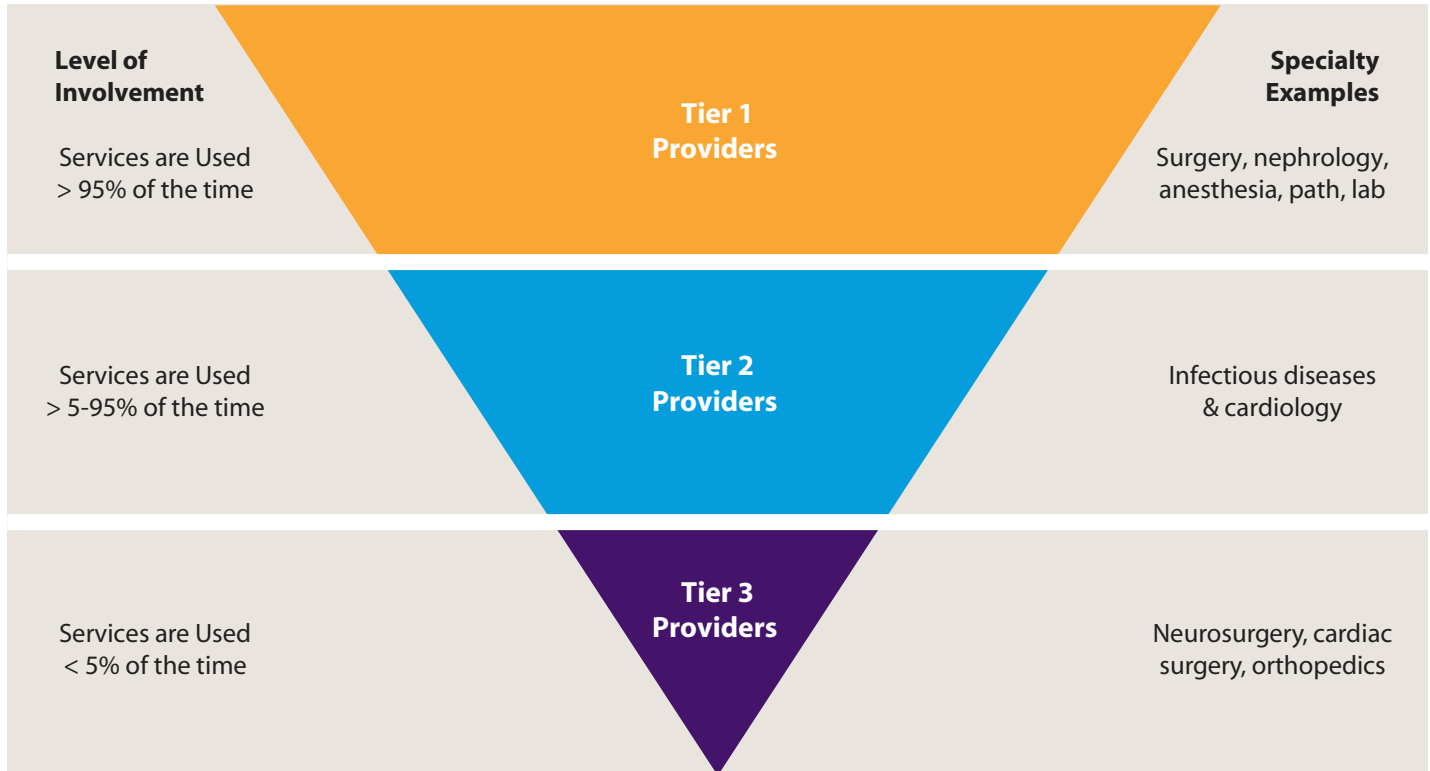
In addition to the payment levers described above, the key to the success of ACA's hybrid model is a homegrown cloud-based data sharing tool called CareScreen™. This tool aggregates and analyzes payer and practice data across ACA's entire network and provides decision support at the point of care. By doing so, Care Screen™ enables care managers and the treating physicians to address quality and cost issues before they adversely impact the global budget.

Payment Tiering: The Experience of the Transplant Community

A tiering approach to disbursing payments to individual physicians involved in an episode of care has been used in the transplant community since the 1990s. Under this model, first tier providers who are involved in every case or second tier providers receive a prospective payment that is based on some percentage of each case's total reimbursement. This is determined using historical data that may include Current Procedural Terminology® (CPT) codes and the International Classification of Diseases (ICD) codes, in addition to other data sources that are not well recognized under the FFS model. Third tier providers who are almost never involved would be paid according to a pre-negotiated rate from a "payment kitty" that is set aside to cover the costs associated with rare complications. In the vast majority of cases that do not involve third tier providers, the funds set aside for the kitty would be redistributed according to first and second tier methodologies. Graphic 8 describes in further detail how payment tiering works.

Within one or more of the tiers, high value services that are not currently recognized in the FFS system could be factored into the episode by attributing more payments (or a management fee) to physicians who deliver these services. The nephrologist, for example, could be paid extra for ensuring care coordination with other physicians involved in the episode or for ensuring that, following discharge, a patient receives appropriate care in the outpatient setting. Before divvying up the total payment bundle between tiers, transplant surgery takes an administrative percentage off the top to pay for these types of services—other specialties may do it differently. This is not unlike ACA's incentive-based payments to physicians who agree to serve as care managers in each practice.

Figure 8: Payment Tiering in Trnasplant Surgery



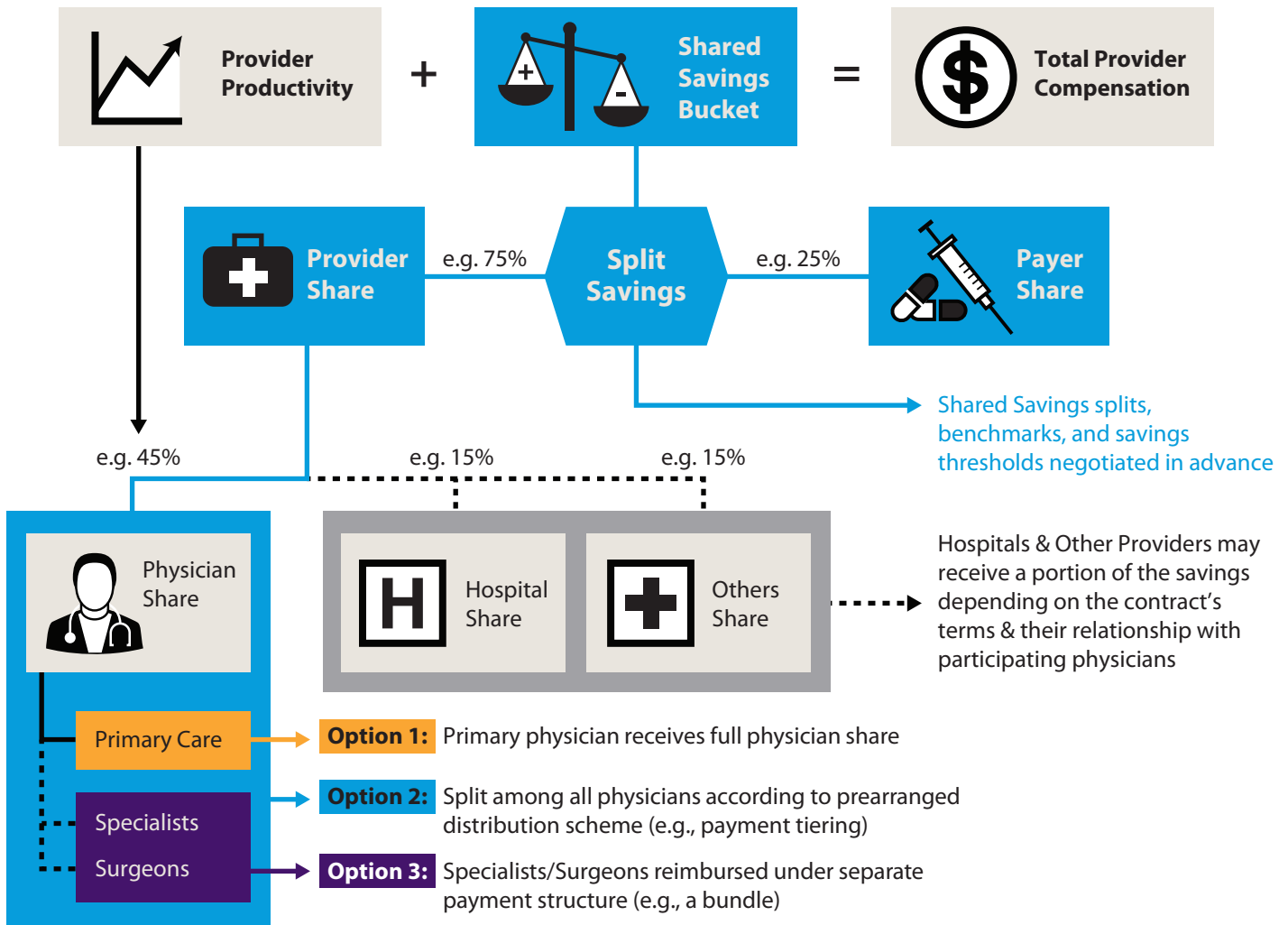
Note: Tiers 1, 2 & 3 "Specialty Examples" will change according to the condition or episode

The Happy Medium: Aligning Value and Productivity

Regardless of the specifics of the payment disbursement model, it should balance the desire to reward value-based care against the competing desire to encourage practice productivity. No new or existing payment models have proposed to completely eliminate the Resource-Based Relative Value Scale (RBRVS) and other measures of clinical productivity and it's unclear whether this would be a desirable outcomes. Without a measure of productivity to serve as a counterbalance, some FFV models may focus too heavily on reducing the cost of care with little regard to quality. The fact that most quality measures use processes of care as proxies for true patient outcomes lends some validity to this concern.

As a result, many physicians remain perplexed about what a FFV value model will mean for their payments and patients. Common questions include: Will my payments be cut or will my sick patients be discharged earlier than indicated because a facility can document that all relevant process measures were reported? For all of its limitations, the longevity of the current FFS model means that most providers understand its "rules of the road." This has resulted in a weird Twilight Zone where providers dislike the burdensome requirements (prior authorizations, utilization reviews, quality reporting, and so on) that are built into the FFS model while, fearing what lies ahead, simultaneously clinging on to FFS and unwilling to break their former habits.

Figure 9: How Do Shared Savings Flow to Groups and Individuals? It's All About Shared Savings Splits!



Thus, it is important to remember that FFV does not mean an end to FFS. In many cases, and in many locations, FFS will continue to be the primary mechanism of reimbursement to individual physicians. This includes global budgets and other FFV models that will continue to rely on FFS to pay most physicians at the time of care. Moreover, as stated at the beginning of this resource, consultations and other healthcare services, which have intrinsic value that is impossible to capture in a FFV model, may continue to be reimbursed through FFS. Finally, if FFV arrangements continue to see value in linking a portion of providers' payments to their productivity, some form of FFS will be necessary for the foreseeable future.

Figure 9 describes various options for aligning FFV payments with FFS and other productivity-based payment models. Of note, most existing FFV payment models have focused on rewarding primary care. If these models are to succeed, it will be important to co-opt all healthcare stakeholders to share accountability for cost and quality. This may mean that multiple payment models—bundled payments, management fees, pay-for-performance, gainsharing, and so on—are used in a clinically integrated FFV arrangement to insure that all members of the care team have skin in the game. Not doing so runs the risk of dooming FFV arrangements to a death by a thousand cuts as unaccountable providers follow the playbook used by opponents to managed care.

Conclusion

While it is impossible to predict precisely what the future holds, global budgets and other FFV models are being embraced as a means to avoid unnecessary care and to curb healthcare cost growth, not to reduce healthcare payments to individual physicians and other providers. This may prompt some providers to reconsider expensive capital projects that are predicated on unsustainable volume increases but, given the demographic reality presented by the aging of the baby boomers, fears that some providers will not get paid in FFV arrangements are unfounded. However, physicians, their patients, and other stakeholders will be expected to understand their role in a cost-conscious healthcare environment in which each test, treatment, procedure, or drug will have downstream effects on the availability of resources for future care delivery. Higher payments and lower premiums will be linked to efficient care delivery that prevents unnecessary care, ensures continuity of care, and improves health outcomes.

Appendix A: Governing Principles to Ensure Fair Payment Under Risk-Based Payment Models

1. How should the Risk Bearing Entity Be Organized to Promote Value while also ensuring that individual providers are paid for their work, both the work involved in directly delivering medical services and the work required to manage the care?

Several legal forms are available, e.g., for-profit or not-for-profit corporation, professional association, partnership, limited partnership, limited liability company. The suitability of available options may vary from state to state, given specific state requirements, and may depend on the other stakeholders (hospitals, other facilities, payers) involved in the partnership.

Option A:

A multi-specialty physician group practice organized as a professional association might be able to function as a risk bearing entity with respect to the professional services of its member physicians. The advantage of professional capitation is that it can limit risk to those services for which physicians are directly responsible but, by excluding hospitals and other providers, it also may limit the ability to impact the total cost and quality of care.

Option B:

Some practices may wish to partner with non-physician entities, such as hospitals or payers. Such partnerships may offer more opportunities to reduce cost and increase quality and to share in the resulting savings—the disadvantage is that there may be more exposure to downside risk, especially related to services, such as facility and technical services, which are beyond the scope of a physician's ability to control. Practices considering this option may need to organize the risk bearing entity under a separate legal structure, given that some states prohibit non-physicians from having any ownership stake in a medical practice.

Although a variety of legal structures may be available, the limited liability corporation (LLC) is an option whose

legal popularity has grown. An LLC may have greater operational flexibility than other types of organizational forms, e.g., corporations, confer liability protection on participants, and also receive favorable tax treatment other options may not enjoy.

2. What governing structures for Risk Bearing Entities foster the establishment of payment distribution schemes that provide value to the system while remaining fair to individual providers?

Any bundling or global payment arrangement requires careful attention to governance. This applies regardless of whether a practice is receiving payments only for physicians' professional services or whether it is considering a more expansive global payment structure that involves non-physician partners. The former is far simpler since the governing structure will only involve the physicians but, even among physicians, discussions of payment distribution can be contentious since most physicians are likely to value the services in their specialty greater than the services in the other specialties.

When physicians partner with one or more non-physician entities to create a risk-bearing entity, careful attention should be paid to governance. Since participating physicians will be assuming risk for their services, governance must be structured to ensure that physicians have a strong voice, if not control over, key concerns. These concerns include:

- defining payers' relationship with the risk-bearing entity;
- determining the type and amount of risk assumed by each partner;
- identifying quality and efficiency metrics used to evaluate performance;
- assessing and managing infrastructure and data analytic needs;
- specifying how patients and medical costs are attributed to the risk bearing entity;

- specifying how quality and cost of care are attributed to individual providers or teams;
- provider credentialing;
- establishing procedures for sharing and disclosing performance data (what data will be shared and what will be done with it?)

Ultimately, all of these concerns should inform the selection of both the governing structure and how payments will be allocated, not only between physicians and non-physician partners but among individual physicians. There are a number of ways that governance could be structured to facilitate physician influence or control, keeping in mind that state and federal requirements may impact the availability of some options.

Full Physician Governance – In some cases, the non-physician participant may be willing and permitted to allocate all board seats to representatives of participating physicians. This type of governing structure will require the trust of all parties.

Proportional Governance – In other cases, board seats may be allocated evenly between representatives of participating physicians and non-physician providers, and other parties involved in the arrangement.

Class Voting – Some risk-bearing entities could ensure strong physician input through class voting, in which physician directors could receive one class of votes, non-physician directors receive another class of votes, and so on. The risk-bearing entity could take no action unless a majority of the members of both classes approved the action.

Supermajority Voting – The risk-bearing entity's by-laws or operating agreement could identify issues, e.g., the selection of clinical or efficiency guidelines, of such importance to participating physicians that a supermajority, e.g., 75 percent, of all the directors would be required before the risk-bearing entity could take any action with respect to those issues.

Standing Committees – Another way to ensure physician governance and input would be to ensure that a

certain number of positions on key board committees are filled by physicians. Such committees could include, for example, the finance committee, or the risk-bearing entity's physician compensation committee, which might be charged with overseeing payment distribution methodologies.

There is no one-size-fits-all governance model that will be most advantageous to physicians participating in risk-bearing entities. And once you do find a governing structure that suits your needs, it may be necessary to periodically make adjustments to reflect practice changes. Lastly, a key point is that all of this should be codified in the risk bearing entity's bylaws or operating agreement—**a gentleman's agreement is not good enough.**

3. How much and what types of risk should your organization take on and who assumes responsibility for the risk of referral to outside providers?

The type and scope of risk that a payer is willing to transfer, and the risk-bearing entity's providers are willing and able to accept, will drive the costs for which the risk-bearing entity will be responsible and the earnings potential from financial performance. Ideally, each party to the agreement will have direct control over the scope and type of risks they assume: providers will assume responsibility for performance (how efficient and effective services are delivered) while payers will assume insurance risk (how much demand there is for services due to the burden of illness of the population, the number of unforeseen events like trauma and preterm neonates). However, in some situations, it may be necessary for the entity's providers to contract with selected outside providers to deliver specialized services.

The risk-bearing entity's participating physicians and other providers must have confidence in their ability to control or influence the quality and cost of care delivered by providers who are not part of the risk bearing entity. The contract with the payer organization(s) must clearly establish whether the risk bearing entity is able to control access to providers who are not part of the risk bearing entity, under what conditions such control may be exercised and the financial responsibility for services rendered by providers which are not part of the risk bearing entity.

Will the services rendered by providers not part of the risk bearing entity be subject to the payment provisions of the payers' network contracts? Will the risk bearing entity be financially responsible for emergency and for elective services sought by patients from providers who are not part of the risk bearing entity? How are patients informed of these rules?

4. How Can You Mitigate Risk or Insure Against Too Much Episodic Risk?

Stop-loss insurance establishes a cost of care threshold beyond which the risk-bearing entity will no longer incur the full brunt of losses associated with a particular patient or patient population. This offers protection from unlimited losses resulting from catastrophic episodes, for example, in the case of an accident causing severe trauma, the risk bearing entity's financial exposure may be limited to 10 percent of incurred claims costs after the first \$100,000 ("stop-loss threshold") is exceeded.

Often the payer will provide the risk bearing entity with stop-loss protection under the terms of the contract. Depending on the situation, risk-bearing entities may go to the market (privately purchase stop-loss insurance) for insurance, which may be cheaper than acquiring it from the health insurer or payer. This is because health insurers, especially relatively small health plans, may purchase stop-loss coverage from a stop-loss insurer and then resell it to physicians at a profit. Physicians can purchase stop-loss coverage directly from stop-loss insurers if they are (or their broker is) knowledgeable about risks, insurance policy contracts, and the administrative procedures that are required for claims payment.

The extent to which a risk-bearing entity will want to purchase stop-loss insurance depends on the type and amount of risk assumed. This, in turn, will depend on the risk-bearing entity's ability to accurately estimate risks and build them into its budgets for the year. As such, a newly-created risk-bearing entity may want to minimize the amount of downside risk it initially assumes (or even argue for an initial term of upside-only risk) with a commitment to take on more risk in subsequent terms. If, and when, the risk bearing entity does assume downside risk, then an appropriate split of shared savings might be calculated based on the amount of such risk, i.e., the greater the percentage of downside risk assumed, the greater the potential share of savings.

5. What is the payer's relationship with the Risk Bearing Entity—key things to keep in mind during payer negotiations?

The risk bearing entity should pay careful attention to the payer's contractual obligations, seeking to change them through negotiation when necessary. Understanding the payer's obligations up front may make potentially contentious issues, such as sharing quality and utilization data, less likely to arise and potentially easier to address if they become an issue. Regardless of how the payer is aligned with the risk bearing entity, participating physicians should be mindful of the following as they review the payer's contractual obligations:

- The payment methodology should be transparent and as simple as possible—otherwise the methodology's effectiveness will be hindered because physicians and other risk-bearing entity constituents will not understand the incentives involved.
- A commitment to provide the risk-bearing entity with quality and utilization performance reports on a frequent basis, e.g., at least quarterly. Such reports should contain readily understandable and actionable data that drill down to the attributable patient and provider (including outside providers).
- Provisions addressing the confidentiality and propriety of data. The payer will likely want provisions protecting the confidentiality and propriety of its data, however, it is important that such provisions are not overly broad. For example, such provisions should not interfere with the ability to share data nor should they enable the payer to claim ownership over information developed by the risk-bearing entity itself.
- A DOFR that sufficiently details all of the items and services for which the risk-bearing entity and its participating provider groups are responsible.
- Frequency of the final payment reconciliation, e.g., six months after the close of the term of the payment arrangement. While longer reconciliation periods may help ensure accuracy they also extend the period of time until the final reconciliation payment is received.
- Circumstances under which the payer may amend the contract of payment methodology. For example, does the risk bearing entity have to provide its consent for the terms to be amended or does the payer have to provide written notice to allow sufficient time for objection, appeal, and/or termination?

- An easily accessible and efficient dispute resolution process through which misunderstandings can quickly be resolved. This is particularly important for newly constituted partnerships where the payer and providers may still be testing the waters.
- Length of the agreement and rules governing termination. The initial agreement should be sufficiently long to achieve meaningful performance results—a 3-year term may be an appropriate initial term. Look for a clause that allows for early termination if any party is unable or unwilling to meet its contractual obligations.

Lastly, establishing a model that fundamentally changes how participating providers are paid will involve some growing pains and missteps. To smooth the transition, it may be wise to have experienced legal counsel review the terms of all contracts that are associated with the risk bearing entity so that mistakes are caught before they happen. Good luck!

Appendix B: Episode-Based Bundles within a Global Budget

The case studies that follow will describe episodes of care in which it may be appropriate to establish more narrowly defined payment bundles that are separate from a global budget. The episodes include bariatric surgery, cardiac surgery, hip and knee replacements, adult stem cell transplant and a chronic disease episode such as heart failure.

In some cases the costs for such services may be factored into the budget with payments reserved in a separate reinsurance pool for high cost episodes of care. In other cases, the global budget may choose to exclude certain services entirely. An important point to remember is that this tool is not designed to describe every possible scenario that a physician may encounter in designing these models but only the Innovators perspective of how these models might be structured.

Case Study 1: Orthopedic/Joint Replacement Bundle

Peter Amadio, MD & Gerald Maccioli, MD

Background/intel from a project in NC in which Orthopedic Group controls the money to all other physician parties and the hospital:

- Focus on the initiative at Triangle Orthopedic Associates, P.A. (TOA)
- Contract with BCBSNC; separate agreements with the hospital and the anesthesia group.
- TOA provides surgical and physical therapy services
- Participating providers bill under a new NPI number (this helps BCBSNC keep track of things). BCBSNC reimburses TOA, who in turn pays other providers.
- BCBSNC utilizes Prometheus data (risk adjusted data in the commercial aged population) obtained from HCi3.

Discussion Questions

1. Why would a hospital agree to this scenario? *So long as it is fair it should not matter who runs it. And giving the surgeons control may have been the only way to keep them at the table. Ultimately though the hospital and the other providers had to accept the relative assignment of dollars as being equitable. I would imagine that there would be an opportunity to revisit. And ideally the books would be open to inspection, so that there is transparency*
 - a. What guarantees would a facility need to participate? *As above, I would think the ability to review the books, and to renegotiate on some recurring basis'*
 2. Why would other physician providers agree to this scenario? *See above*
 - a. What guarantees would those physicians need to participate? *See above*
 3. How does the proposed bundle define complications or exacerbation of chronic conditions? *This is clearly an important issue*
 - a. With respect to complications, the hospital, which has negotiated a set price, gets killed. *I would imagine that there are exceptions for outliers*
 - b. How are the consulting specialists paid who are not party to the agreement but may be involved in the post-operative complication care plan? *The same issue arises with any bundle. Some specialists MAY be involved but are not routinely. Usually they are compensated by some sort of modified fee for service; occasionally on a per capita basis (i.e., whether their services are used or not).*
 - i. Does it come out of the orthopedic group pay-
- ment? I think it's a mistake to think about the money as being the orthopods, just because it goes to them first. If this bundle is going to work, all the stakeholders have to believe that it is collective money, and that one group is managing the distribution. Whether it is the orthopods, the hospital, or some other group, the basic principle should be the same. All the stakeholders have to agree. If it is a group decision, then it is much more likely to be successful*
- ii. Is the anesthesiology group protected against this situation in that they are paid a negotiated rate? *Again, see above. I would think that to work there would have to be an upfront agreement on how the payments work for each stakeholder*
 - iii. If a penalty exists for complications attributed to the anesthesiology group, what if the group disagrees to the assertion that they are responsible for the adverse outcome? *As with any bundle, all this needs to be worked out up front. Whether it is the orthopods, the hospital, anesthesia, or any other stakeholder taking the lead, the principle is the same*

Other matters to be considered vis-à-vis patients and payments

4. Do the patients have a co-share? I would think this would depend on the payer, and the arrangement that the patients have with the payer. For example, in traditional Medicare there would be a co pay. In Medicare advantage, not

5. Do any or all of the non-orthopedic participants payments get reduced for bad debt? If this is a bundle with a payer, why would there be any bad debt?
6. Do any or all of the non-orthopedic participants payments get reduced if the ortho's cannot collect on the patient co-share? OK. I see. I would think again this would need to be worked out, and pro-rated among the stakeholders some way
7. If a reduction is made how is the bad debt spread among the participants? By an equitable arrangement decided up front
18. If clinical protocols are developed, are contracted providers required to follow the protocol in order remain participating providers?
19. What is the definition of complications? If a return to the OR subsequent to the primary joint replacement surgery occurs, what is the protocol to determine if the return is a complication of the joint replacement surgery?

Administrative concern

8. Use of a separate NPI number for certain subset services for a given patient population may be difficult to manage.

Additional considerations which require discussion and recommendation

9. What products are included? e.g. Medicaid, Medicare, Wcomp, Commercial (PPO, EPO, HMO, POS, etc.), direct employer arrangements. Highly important to note different populations may have different acuity levels/utilization of services.
10. Are limitations placed on sites of service such as surgeries may only be performed at medical group owned (or joint venture) ASC?
11. What is the distribution model if shared savings are included?
12. What is the protocol to determine the distribution?
13. Who would be administering and paying the claim - the managed care plan or the contracting provider group?
14. What is the episode time period- discharge or 90 days whichever is later?
15. How do complications impact the timeline of inclusion of services?
16. So revisions extend the timeline?
17. What is the patient population? Are there age bands? Are broad categories of ICD/DRG categories excluded such a traumatic injury or cancer? If the patient's acuity is higher than average (physical status (P4+), a significant number of co-morbidities), is the patient excluded from episode of care or placed in a high acuity bundled episode (e.g., high acuity joint replacement)?

Case Study 2: Adult Stem Cell Transplantation

Michael N. Neuss, MD

Payment for medical services may be structured over a continuum from pure fee for service to total capitation for groups of individuals. In this context, bundled payment plans may be seen as providing a system which encourages a compromise balancing the incentives to provide too little care within a global model and too much care in a piece rate-payment scheme. This can only be accomplished when quality outcome measures are incorporated within the system. Those services currently subject to bundled payments currently range from straightforward inpatient hospital Medicare diagnosis related group (DRG) episodes to global payments for all services related to complex, multispecialty, care involving both inpatient and outpatient services. Many considerations relevant to any one of these bundles are relevant to most. These include the topics such as the definition of the bundle, organization of providers into a system to deliver care, quality and outcome monitoring, and the development of risk stratification to consider patient comorbidities. In oncology, bundled payment for stem cell transplantation serves as an example of these organizational, service, quality, and provider considerations.

Stem cell transplantation may provide lifesaving treatment for a variety of malignant and non-malignant but serious disorders. In 2010, over 10,000 patients underwent transplantation in the United States. Of those over 50 years of age, over 5000 patients underwent dose intensive therapy and infusion of their own stem cells: another 3000 received cells from either a family or volunteer donor. Myeloma was the most common diagnosis leading to the procedure, with other hematologic malignancies making up the great bulk of patient diagnoses in older patients. Allogeneic transplants for other cancers and non-malignant disease were much more commonly performed in younger patients, and in patients younger than 20, more complicated and toxic allogeneic transplants were performed in 2/3 of the 2261 procedures performed in 2010. (All transplant data from the Center for International Blood and Marrow Transplant Research, <http://www.cibmtr.org/ReferenceCenter/SlidesReports/SummarySlides/Pages/index.aspx>(Accessed April 27, 2013)).

Charges associated with stem cell transplants are great with estimates varying from averages of \$80K to \$250K. Using 100,000 as an “average” in round numbers, one year’s 10,000 US transplant procedures would cost an estimated \$1 Billion. And though this represents less than 0.05 percent of the 2.8 trillion dollar annual US health expenditure, it has captured the attention of commercial payers who, over the past 10 years, have almost universally adopted an episode-based bundled payment for this procedure.

The Contracting Process: Terms, Service Inclusion/Exclusion, Patient Definitions, & Appeals

Examination of the payer policies and procedures associated with this service demonstrate critical aspects of importance for all bundles. This starts with several different types of contracts, including those between the insured and insurer which may include specific transplantation riders or enhancements of benefits. The patient must be in a legal relationship to the insured which allows their coverage. Providers must contract with the payer, and they may have individual contracts among providers accounting for referrals, payments, and levels of interaction particularly when the providers are not organized into one legal entity. Obviously, contracts define which patients are appropriate candidates for transplant therapy, and verification of plan specific and appropriate plan enrollment is necessary before the initiation of treatment. Definition and standards for the provision of services included in the pre-procedure evaluation of the patient and, in the case of allogeneic transplant, the stem cell donor, definition of included services, duration of care provided within the bundle all must be specified. Additionally, an appeals process for any disagreement must be agreed upon among the parties involved, including the payer, patient, and providers. Finally, large scale payers and administrators of self-insured plans have developed certification standards for centers which perform transplants.

In response to these payment policies, providers have adopted a variety of strategies to meet payer requirements, maintain excellence in care, and control costs and while trying to

optimize volume to support but not overtax systems allowing the service to be completed. These strategies involve careful analysis of the events incorporated in the transplant, alternatives to each facet of treatment, the costs associated with each individual step, and the effect of changes in any one step on the entire procedure. Additionally, any time a change is made, analysis needs to include consideration of patient outcomes including survival, functional status, and patient experience in addition to the expense of providing care.

The Organizational Structure

Discussion of contractual relationships starts with consideration of the involved parties. Individuals cannot perform stem cell transplants. By necessity, the providers of complex procedures are by necessity complex medical organizations and subcontractors to these organizations. They must include staff and facilities for outpatient provider visits for evaluation and management as well as inpatient units for hospitalizations which may be either elective or emergent. In either location, parenteral medications and transfusion of blood products must be provided. Patients often undergo both elective and emergent surgery to provide central venous access, biopsy of skin, bone marrow, pulmonary and gastrointestinal visualization, or major general, thoracic or neurosurgical procedures. Hospitalizations may be lengthy. All parties involved in any aspect of this care must be compensated, and arrangements for this care and compensation for its delivery must be completed before the transplant begins, requiring a complex administrative structure to administer payments and monitor quality. This structure must be adequately supported. A similar organization is required when contracting for other, high expense conditions, such as, stroke, coronary artery disease, severe neonatal illness, or any condition resulting in ventilator requiring respiratory failure. Though these events occur on average to only 1 percent of private plan beneficiaries, their extraordinary costs prompt both stop-loss insurance (also termed reinsurance) and organized efforts at cost control. (<http://publications.milliman.com/research/health-rr/pdfs/benefit-designs-high-cost.pdf>) Those entities which are already organized into structures which allow provision of this care have an advantage in negotiating contracts, and the awareness of the necessity of entering into this type of contract may be responsible for the consolidation of health care delivery services and the migration of physicians from private practice to institutional employment.

The ripple effect of decisions regarding contractual compensation arrangements of care can be illustrated by considerations around non-related allogeneic transplants, where stem cells are provided by the National Marrow Donor Program (NMDP). This program locates potential donors, evaluates their suitability for donation, and arranges for obtaining marrow and processing the stem cells. A contract may include these charges as a pass through or even provide for direct payer payment to the NMDP. When payment is direct payers may feel that there is no control on pricing for this important resource. When payment is provided to the treating entity, there may be an opportunity for margin on the service. Additionally, if the procedure can't be performed because of changes in the patient health status or because a suitable donor isn't available, the fees associated with searching for a donor may not be paid for unless contracts explicitly ask for payment.

Importantly, the contracting organization also arranges for distribution of the payment for care. In highly integrated organizations, this can be done "after the fact" when one can evaluate true expenses, and by increasing the pool of services, decreasing the financial risk to the provider organization.

Bundled Services: Inclusions/Exclusions and Catastrophic Expenses

The specifics of services included for payment is critical. In an extreme example, consider the patient who falls over their IV tubing during a transfusion and breaks their hip, has a myocardial infarction due to the stress of sepsis, or even is involved in a serious automobile accident while coming for treatment. Any one of these events may seriously impact the expense of caring for the patient, and if contractually included in the bundle, may result in seriously increased expenses to provide care. Even if the bundle is created to include only specifically listed procedures to avoid this risk, the duration of care included within the bundle is generally specified, as the cost of ongoing care for serious problems, such as graft versus host disease, may be very expensive.

The providers may decide to take risk for this ongoing over-expense on themselves or purchase "stop-loss insurance" secondary insurance for a catastrophic over-expense. This is commonly done in other insurance situations, with major medical insurance for catastrophic illness as one example.

Tracking the Quality of Care

Quality monitoring is essential within any bundled payment event. Stopping treatment early (due to patient refusal for treatment or patient death) must be monitored, as stopping treatment early results in decreased provider expense and should be occurring at a rate comparable to other centers. But death during medical events is subject to random variation, and any analysis must include statistical perspective. Additionally, all patients are not equal. Age, comorbidity, and disease responsiveness vary, and consequently, survival statistics must be interpreted in context of evaluation of these factors.

In transplantation, the Foundation for the Accreditation of Cellular Therapy provides comorbidity stratified survival reports. Additionally, the United States Department of Health and Human Services (HHS) monitors patient survival through the Health Resource and Services Administration (HRSA) Transplant Registry within The C. W. Bill Young Cell Transplantation Program. Just like the bundle itself, the analysis of survival statistics discourages centers from performing procedures on patients with excessive risk.

Tracking the Cost of Care

Bundled payments encourage maintenance and promotion of increased value in included services. Because of the aggregation of services, centers must focus on the cost of providing the services and not simply the charges associated with care. Expensive stem cell stimulating drugs may decrease the costs of hospitalization or transfusion and the relative cost to provide these services must be compared. The charges for individual services, and the margin contained in each service are not always directly related to the overall effects of individual changes in global payment. Awareness of this, in the context of adjusted outcomes monitoring, promotes rapid innovation, transferring inpatient care to outpatient venues and decreasing routine care that isn't shown to influence outcomes.

This is approached in a three step process. First, all events associated with transplantation have been categorized. Next, the relative expense of certain events is catalogued. Finally, alternatives are proposed and subjected to analysis. In transplantation, the acquisition and transfusion of blood products accounts for a significant proportion of overall expense. The indications for transfusion (including symptomatic anemia or thrombocytopenic bleeding, as well as thresholds for trans-

fusion in asymptomatic patients) have clear resource utilization within this domain. Sequential analysis of thresholds has led to cost savings in this domain, without any demonstrated detrimental effect on outcomes. Similarly, the sequential addition of antibiotics to febrile patients without identified infection has led to evidence based algorithms for antibiotic treatment which have decreased the cost to provide care without adversely affecting outcomes. This iterative improvement process can be seen as a mechanism to encourage increasing value.

Conclusion

The organizational characteristics of stem cell transplant programs, and the necessity of contracting both between payers and providers and among providers, providing quality monitoring which considers patient comorbidity, while encouraging all parties to strive toward improvements to promote increasing value serve as an example of the considerations inherent in providing high quality care for complex conditions. As more and more services are included in bundled payments, systems will expand to provide continuously monitored and continuously improving care. While this may drive consolidation in health care delivery, the opportunity for improving value represents a paradigm which may control health care costs while concurrently improving patient outcomes.

Case Study 3: Bundling Chronic Conditions using Prometheus ECR's

Keith Michl

Colorado Choice Health Plan Pilot

The Colorado Choice Health Plan is using chronic Evidence-Informed Case Rates (ECRs)⁶ in a pilot developed by the Prometheus Payment system developed by the Health Care Incentives Improvement Institute (HCII). All of the 30 primary care physicians in the San Luis Valley are involved in the program with half of the physicians being employed by the hospital. Approximately 15,000 patients are in the south-central Colorado community.

Starting April 1, 2013, Colorado choice will start paying a \$4 per member per month to the physician practices for patients attributed to that practice in the following areas:

1. Diabetes
2. Hypertension
3. Asthma
4. COPD

Using an ECR Engine developed by MedAssets, physicians involved in the pilot project are able to access various areas of care of these ECR's collecting data provided by the Health Plan. The plan has an ability to integrate medical care and drug utilization data. The MedAssets engine is set up with appropriate security to allow individual physicians to see all patients attributed to them through Prometheus algorithms. Any patient that the physician is provided care for can be looked at even though the patient may be attributed to another physician. Medical directors of different practice groups can view all of the patients attributed to their individual practice or system as well as patients to whom they have provided service.

San Luis Valley health providers are enthusiastic about the ability to get real-time data on their patients. As a pilot moves forward, the thin-cap payments affords the potential for practices to clinical reengineering as the ECR project is moving forward. Even so, potential challenges include physicians finding the time and having the willingness to actually use the software portal. If claims are allocated to Potentially Avoidable Complications, it is likely that practices will have

closely scrutinize the decision. Hospitals may see a potential for lost revenue as care patterns change. The Colorado Choice Health Plan's involvement in the pilot is of interest to employer groups in that they can see a strategy that simultaneously works to reduce waste in the system while improving the quality of care for employees. Having simultaneous health plan participation and employer support of the pilot as well as having robust analytics makes this pilot a valuable example of how bundled payment initiatives might be implemented.

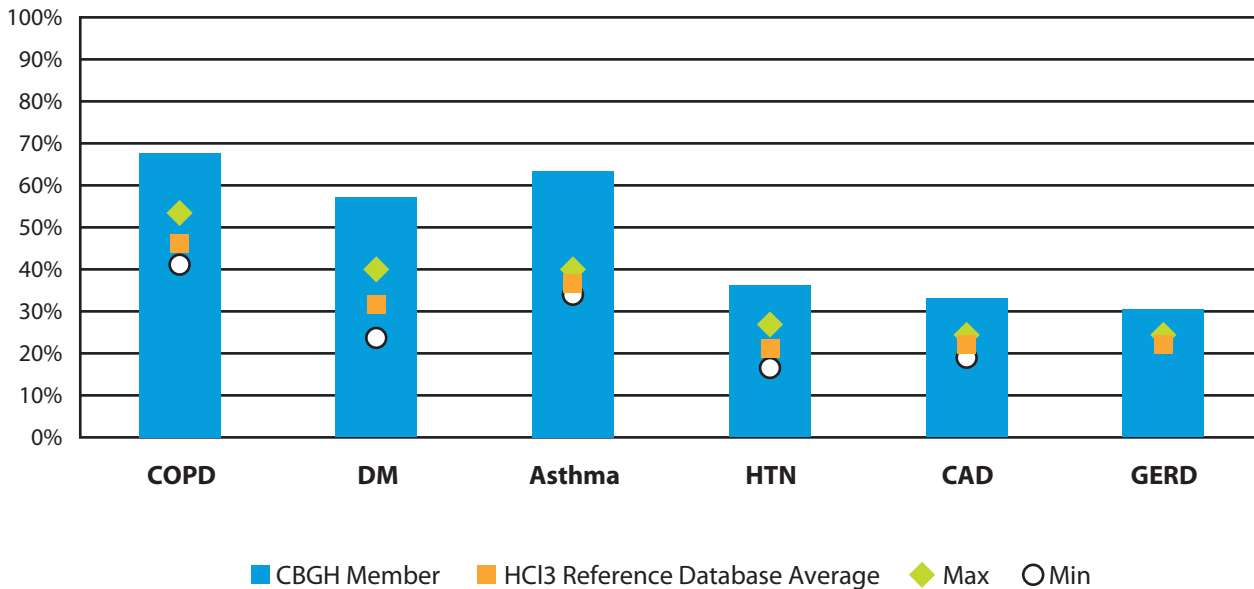
Colorado Business Group of Health Pilot

Colorado Business Group of Health (CBGH) with funding from the Colorado Health Foundation has developed an effort in the Boulder County and Colorado Springs area using Prometheus Payment methodology. Employers and provider groups have agreed on a bundled payment methodology for six chronic conditions:

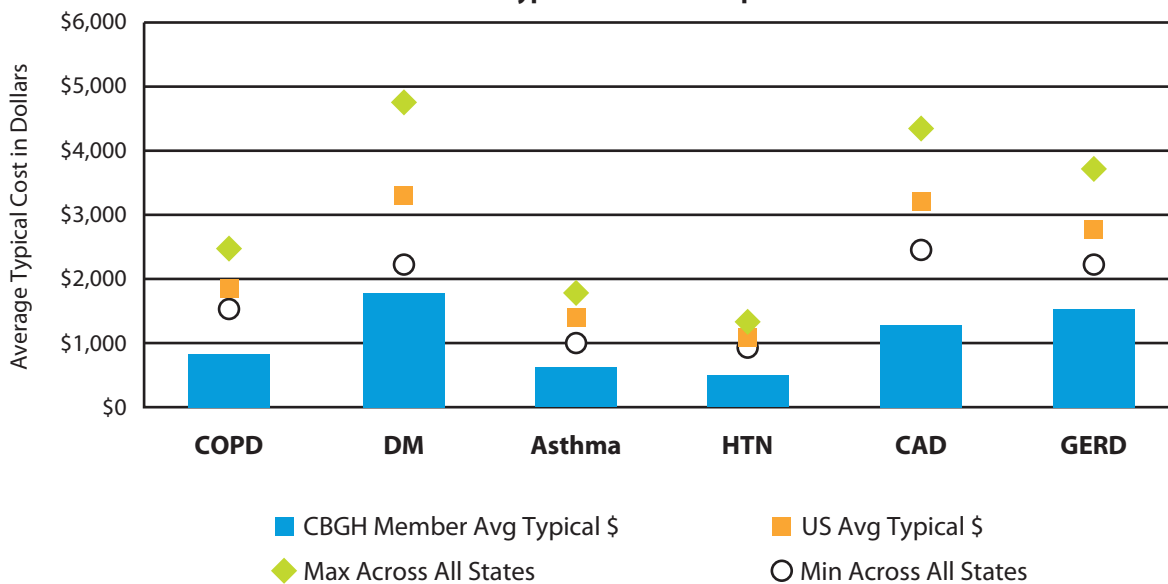
1. COPD
2. Diabetes mellitus
3. Asthma
4. Hypertension
5. Coronary Artery Disease
6. Gastroesophageal Reflux Disorder

CBGH deliberately looked at chronic conditions with multiple co-morbidities. The six conditions chosen are ones amenable to care coordination through clinical re-engineering. Cost reduction can be achieved by targeting services that are not contributing to care or may inadvertently be compromising care. Incentives are created which are based on direct improvements in patient outcomes. The six chronic ECR conditions were targeted with a high percentage of Potentially Avoidable Complications (PACs). Interestingly, CBGH member experienced low typical costs per patient but had high PAC percentages, indicating that waste was still present in the system. Despite having low unit cost, the aggregate cost remained high due to a high level of PAC.

PAC Percentages



Chronic ECRs: Comparison of Average Typical Dollars Per Episode



CBGH had the role of contracting with employers and with primary care physicians. In focusing on these two discrete communities, it is easier to project getting the participation of 85 percent of primary care physicians in the area. Participation for providers requires that practices must have data systems that are certified for Meaningful Use. The Colorado Business Group on Health is charging employer groups \$0.75 per member per month (PMPM) to set up a data repository warehouse. Because Colorado legislated an All-Payer Claims Database (APCD) for fully-insured employers, it is easier to develop episode-based care and ECR's. Analytics will be provided by SAS Analytic software and will use 2 year historical data obtained from employers. These data make it possible

for employers to know their historical PAC rate. Employers agree to set 2013 budgets equal to actual 2012 spending per condition.

Physicians that are already working on quality initiatives in their group are delighted to get real time data on their patient panels. Previously there had only been able to view data as Rates per Thousand which didn't help them develop clinical improvement initiatives. In order to participate, the practice has to have 30 or more cases in the ECR. Providers can determine the best way to reduce cost and achieved shared savings targets.

Contracting has only been done with primary care physicians. The majority of patients in the initiative are going to a minority of practices – 80 percent of the patients are assigned to large groups of 80 or more physicians. Primary care physicians will individually work with specialists in developing their own side contracts.

The initial contract began on January 1, 2013. Budgets are adjusted quarterly depending on comorbidity of the patient population. The CBGH runs the budget, does attribution to physicians/groups with validation, and allocates the budget to the practice and eventually sees if the practice beats the budget

Reserve funds are added on a quarterly basis. Physician leaders will meet with employers four times a year. At the end of the year, the shared saving reconciliation will take place.

Having an employer/provider organization puts physician groups and employers directly engaged at looking at employer data. It allows for opportunities of improving chronic care. Having ECR based bundling is felt to be superior to capitation in that it allows a smaller population size to be used.

PAC evaluation has shown that much of the care improvement is seen at reducing the need for emergency department service, hospitalizations, and readmissions. Practices are excited to see their individual practice performance data in a way that is more clinically meaningful. Episodes of care have the ability to look at price and clinical services by condition in a way that looks at typical costs and potentially avoidable costs from complications (PAC).

Among the challenges of the project has been the lack of health plan or insurer participation in the CBGH initiative. Data acquisition has been difficult in that there are inter-employer variances in formatting and aligning medical and pharmacy data. There's been a lot of reworking of databases to provide for data integrity.

Arkansas Health Care Payment Improvement Initiative

This health initiative currently has five episodes rolled out on a statewide, multi-payer basis. Over 1000 physicians and 75 hospitals are at risk for one or more episodes. Another eight episodes will be introduced this summer. The program is including upside and downside risk for providers.

Two chronic episodes are currently in progress- ADHD and Oppositional Defiant Disorder. Initially there was some thought of using chronic episodes such as chronic congestive heart failure. After studying the issue, there was a decision to blend a model where primary care providers are accountable for risk-adjusted total cost of care (TCOC). Chronic episodes like ADHD and ODD are nested inside this TCOC. For the PCP, the risk for the majority of chronic medical conditions is in the TCOC.

The ADHD episode will exclude all patients with comorbid behavioral health condition. The episode includes only patients ages age 6 to 17. Features of the ADHD episode include all ADHD-related care during a 12-month duration and includes the full range of services provides (e.g., physician visits, psychosocial therapy) as well as all medication used to treat ADHD. For patients continuing treatment after the end of the initial 12 month episode, and new episode is triggered. Each episode of ADHD includes two progressive levels of treatment. Initially, patients are assigned to level I and will remain there as long as a respondent to medical management and other first-line treatments. For patients who do not get an adequate response, providers will certify the severity or rationale in order to begin a Level II episode. Each level in the episode will have its own cost thresholds. The provider who delivers a majority of care is assigned as the Principal Accountable Provider (PAP). This designation is assigned based on the number of visits and cost of services delivered.

Providers will use a Provider Portal to certify that their assessment and treatment are delivered according to relevant clinical guidelines. Feedback reports will be sent to providers which highlight their performance on a number of cost and quality measures.

