Sustainable provider payment arrangements: What are the key elements conceptually?

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Managed care faced a significant backlash in the late 1990s as many providers that accepted risk experienced financial difficulty, if not ruin. Furthermore, consumers resented, and ultimately left, plans where limits were placed on access and choice, leading to a perception of medical care rationing. This resulted in a widespread return to fee-for-service reimbursement with corresponding escalation in medical utilization and costs. Consequently, insurers and their employer clients are again looking for ways to shift some financial risk back to providers as a way to encourage the alignment of incentives to achieve better care delivery. In this paper we take a brief look at the shortcomings of provider payment during the 1990s and consider features about payment arrangements that may make provider risk sharing sustainable in the future.

PHYSICIAN CAPITATION UNDER 1990S-STYLE MANAGED CARE

One factor underlying the pushback against HMOs in the late 1990s was physician capitation. The standard arrangement was a per-member-per-month amount that physicians were paid for patients in their panel. Physicians would then provide the care needed, which could vary widely between patients. This, in effect, placed insurance risk on physicians; some patients would cost less to manage than the reimbursements paid, and others would cost more. Inexperience in understanding the care management implications under this arrangement caused many physician practice failures. This arrangement fundamentally changed the financial incentives for providers. While prior to managed care and capitation the doctor was fiscally rewarded for providing more services, under the revised arrangement many practices risked financial ruin if behavior was not modified. The physician and her practice could only achieve adequate revenue if the aggregate cost of services provided was equal to or less than the total of all capitation payments. This resulted in a system where a physician was financially incentivized to provide fewer services, even if they were medically necessary.

PROVIDER RISK-SHARING: BALANCING THE INCENTIVES

While most providers and patients are wary of total capitation, the ever-escalating costs associated with the standard fee-for-service reimbursement system have demonstrated that fee-for-service reimbursement is unsustainable in the long term.

The table on page 2 briefly summarizes some of the salient effects of both fee-for-service and capitation. It is important to note that these effects are generalizations, and there are instances of very well-functioning capitated systems as well as fee-for-service arrangements that do not result in spiraling costs. Most physicians and hospitals are truly committed to providing patients with the best possible care regardless of payment arrangement. That being said, hospitals and physicians are also businesses.

Designing a reimbursement system that avoids the pitfalls of both fee-for-service and capitation is one of the largest challenges facing the healthcare industry today. Most healthcare stakeholders would probably agree that such an arrangement should have the following goals:

- Provide medically appropriate care to the patient
- Compensate providers adequately to ensure financial health, and in a way that rewards high-quality care
- Restrain growth in healthcare costs

Anyone with a stake in the healthcare industry knows that meeting these goals is not an easy task. There are many competing interests, creating a high degree of complexity that makes tackling the problem tricky.

FIGURE 1: REIMBURSEMENT SYSTEM EFFECTS

	FEE-FOR-SERVICE	FULL CAPITATION
PATIENT SERVICES	FREQUENTLY, PATIENTS ARE ABLE TO ACCESS ANY SERVICE THEY WOULD LIKE, WHETHER OR NOT IT IS MEDICALLY NECESSARY.	SOME SERVICES ARE OFTEN NOT AVAILABLE TO PATIENTS. IN SOME CASES, THE RESTRICTED SERVICES MAY BE MEDICALLY NECESSARY.
PROVIDER RESPONSE	PROVIDE MORE SERVICES TO INCREASE COMPENSATION.	PROVIDE FEWER SERVICES TO INCREASE COMPENSATION.
COST OF COVERAGE	DEMONSTRATED TO ESCALATE OVER TIME.	COSTS OF CARE PLATEAUED IN THE 1990S FOR A WHILE. THERE IS DEBATE OVER WHETHER THIS WOULD HAVE CONTINUED, OR IF IT WAS A ONE-TIME EFFICIENCY GAIN.

MANAGING RISK: FEATURES OF AN IMPROVED REIMBURSEMENT SYSTEM

From an actuarial perspective, a key factor in the decision making of both businesses and individuals is risk. How we respond to the world is largely a reaction to the possible risks and outcomes associated with an action. Informally, we can categorize risk in the following way.

- **Controllable risk**: Risk associated with an action and outcome over which an organization has some degree of control
- **Uncontrollable risk**: Risk that is out of an organization's control

Health insurers are experienced at taking risk in environments over which other stakeholders have no control. A key element of this is that insurers work to prevent moral hazard, which is where insureds are incentivized to use services more by virtue of them being insured. For example, cost sharing is a benefit design feature that requires insureds to share in the cost of covered services, so they are less likely to use services excessively or frivolously.

For insurers, uncontrollable risks include individuals who are (or become) very expensive due to severe diseases such as cancer, major accidents, or those with expensive end-of-life care. The frequency of these medical cases in the covered population is the uncontrollable risk. In many ways, covering these risks is the traditional role of health insurers. Insurance is meant to protect any one individual from the catastrophic financial consequences of a major health event. The insurer manages this risk for the covered population by pooling many thousands of individuals, and by purchasing reinsurance.

One additional uncontrollable risk over which insurers have limited control in a pure fee-for-service system is physician behavior. Physician recommendations and treatments of patients may be redundant and not medically necessary, creating additional liability for the insurer. It is the intensity or severity of the treatment that is the uncontrollable risk for an insurer (at least in part). Health insurance presents an unusual misalignment of financial responsibility and decision making: Physicians (and patients) have the most influence on the costs borne by the insurer, and yet have minimal financial downside for doing so. It's a bit like spending someone else's money, with the associated "why not?" attitude, which is a classic example of a moral hazard.

In the 1990s, the insurers sought to remove the moral hazard associated with provider behavior by shifting the entire medical risk (controllable and uncontrollable) to providers by means of capitation. This was not always a reasonable arrangement, and it caused many providers to fail. Consider maternity services as an example. Is it reasonable to expect providers to accept the financial risk for an increased incidence of pregnancies among their patients? There is little to nothing that providers can do to manage the incidence of this and many other medical conditions. Physicians can, however, manage the care provided to patients once a condition is present, and hence control the severity of treatment cost.

From an actuarial perspective, an improved reimbursement system would limit uncontrollable risk for all parties involved and maximize the taking on of controllable risk, creating incentives to innovate and provide proper care.

- **Increase controllable risk.** Risk of the care management and outcomes associated with a well-defined course of treatment can be shifted from the insurer to the provider. While there is still risk involved, the outcome is directly associated with provider behavior (the type and effectiveness of treatment delivered). An example would be a physician group accepting prospective

(i.e., paid in advance) bundled case rates for treating diabetic patients. In a well-designed arrangement, the patient benefits by receiving quality and appropriate care, the physician benefits financially by focusing energies on the most cost-effective activities for managing the condition, and the insurer transfers what is an uncontrollable financial risk for the insurer to the provider, where that risk is controllable.

- **Avoid transfer of uncontrollable risk.** Providers should avoid the transfer of risk over which the physician or hospital has no control. This would be the frequency risk associated with occurrences of high-cost encounters, particularly those that are high-cost but infrequent. An extreme example for illustration would be a surgeon accepting a capitated payment for services that include transplant surgeries. It's unlikely that groups of surgeons would have enough volume to absorb the cost for such a case into a typical revenue stream.

By careful consideration of what risks should be transferred to the provider, all stakeholders stand to benefit. By leveraging each party's strengths—physicians are experts at managing patient care, and insurers are experts at spreading the condition incidence risk—through an appropriate financial incentive, the healthcare system would begin its move from McAllen, Texas, to Grand Junction, Colorado.[1] After all, to paraphrase George Bernard Shaw's "The Doctor's Dilemma," if you pay a man to cut off your leg, he will.

1 The Cost Conundrum. What a Texas town can teach us about health care. *The New Yorker*. Atul Gawande, June 1, 2009. Available at http://www.newyorker.com/reporting/2009/06/01/090601fa_fact_gawande

IDENTIFYING RISKS TO TRANSFER TO PROVIDERS

Alternative provider payment arrangements will have to be carefully constructed on a case-by-case basis, after evaluating a physician's or hospital's ability to successfully manage risk and provide quality patient care. Providers entering into such arrangements must use claim experience to "do their homework" and understand the impact on revenues, given the uncertainty of future claim experience.

We recommend that hospitals and health plans start by bundling payments for standard treatments already provided by the hospital. This will insulate the hospital from taking on uncontrollable risk in terms of care management accomplished outside of the hospital as well as the frequency of cases treated, and would allow the hospital the opportunity to maximize the outcomes from the controllable risk it assumes.

Alternative payment arrangements could take a variety of forms, including rewarding physicians and hospitals for avoiding repeat procedures or for improved coordination to reduce hospital readmissions. Whatever the program, providers and payers need to carefully assess the nature of the risk passed along so that the arrangement is sustainable in the long term.

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