Evaluating and Negotiating Emerging Payment Options

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Disclosure

In order to assure the highest quality of CME programming, the AMA requires that all faculty and planning committee members disclose any relationships or affiliations with commercial companies whose products or services are discussed in educational presentations.

My disclosure is as follows:

– I have nothing to disclose.

Catherine I. Hanson

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It’s a brave new world…

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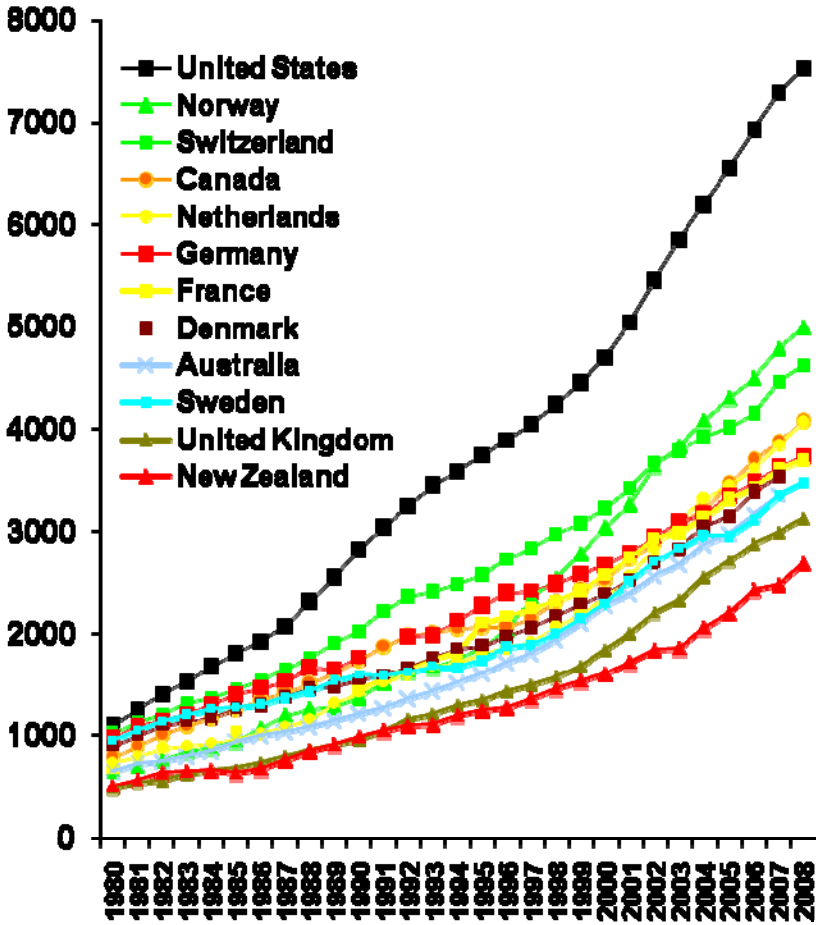
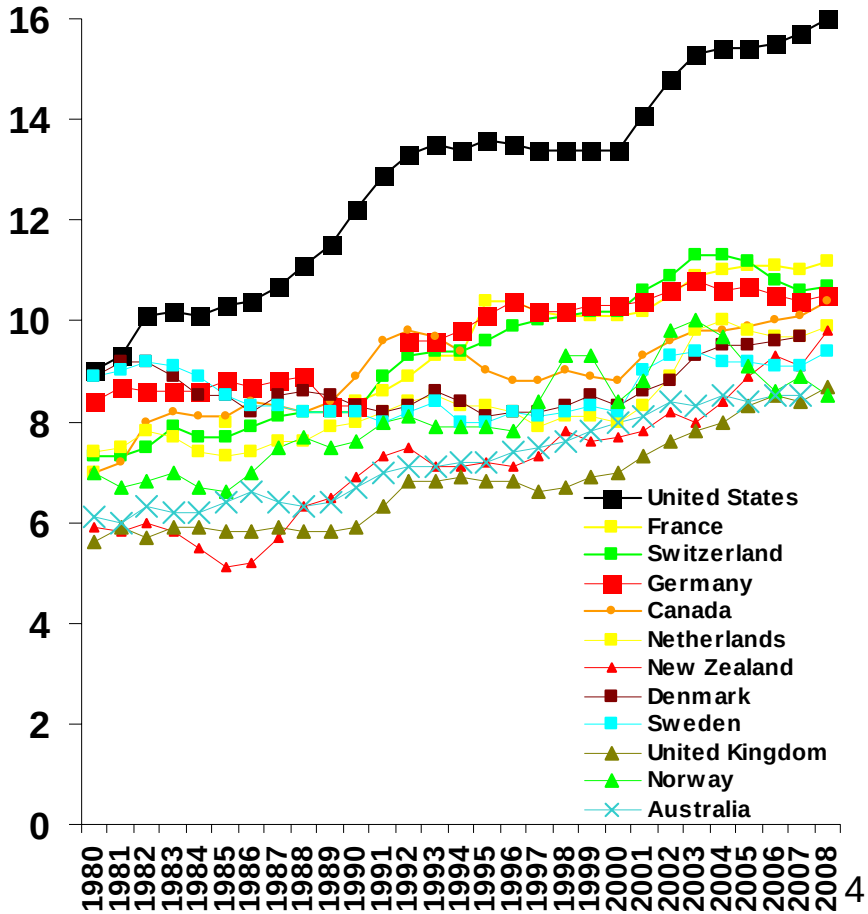
International comparison of spending on health (1980–2008)

Average spending on health per capita ($US PPP)



Total expenditures on health as percent of GDP



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Source: OECD Health Data 2010 (June 2010).

But physician income keeps going down?

- Physician average incomes adjusted for inflation fell 7% from 1995-2003
- Increases in practices expenses now outpace increases in reimbursement by 2 to 1
- **Physicians control 87% of all personal health spending**

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Solution: National Quality Strategy (higher quality, lower cost, better health)

- Coordinated care
  - Health information systems
  - Team-based care
- Patient engagement
  - Cell phone apps, etc.
  - Value-based benefit design
- Efficient delivery
  - Outpatient and home-based care
  - Elimination of medical error
- ***Value-based payment systems***

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Transition from fee-for-service (FFS) to value-based purchasing, i.e., risk-based payment

- Risk-based payment arrangements will likely supplement, if not replace, FFS as the predominate means by which physicians will be paid.
- Mechanisms in place: Medicare Shared Savings Program; Medicare Advantage; Prometheus Payment, pay-for-performance programs; gainsharing arrangements; BCBS of Massachusetts Alternative Quality Contract.

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Budget-based payment systems

- Capitated or other fixed, periodic payment arrangements;
- Shared savings arrangements;
- Bundled payment arrangements; and
- Any other payment arrangements where economic results depend on variation between *projected and actual experience*

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Budget-based payment systems are different in kind

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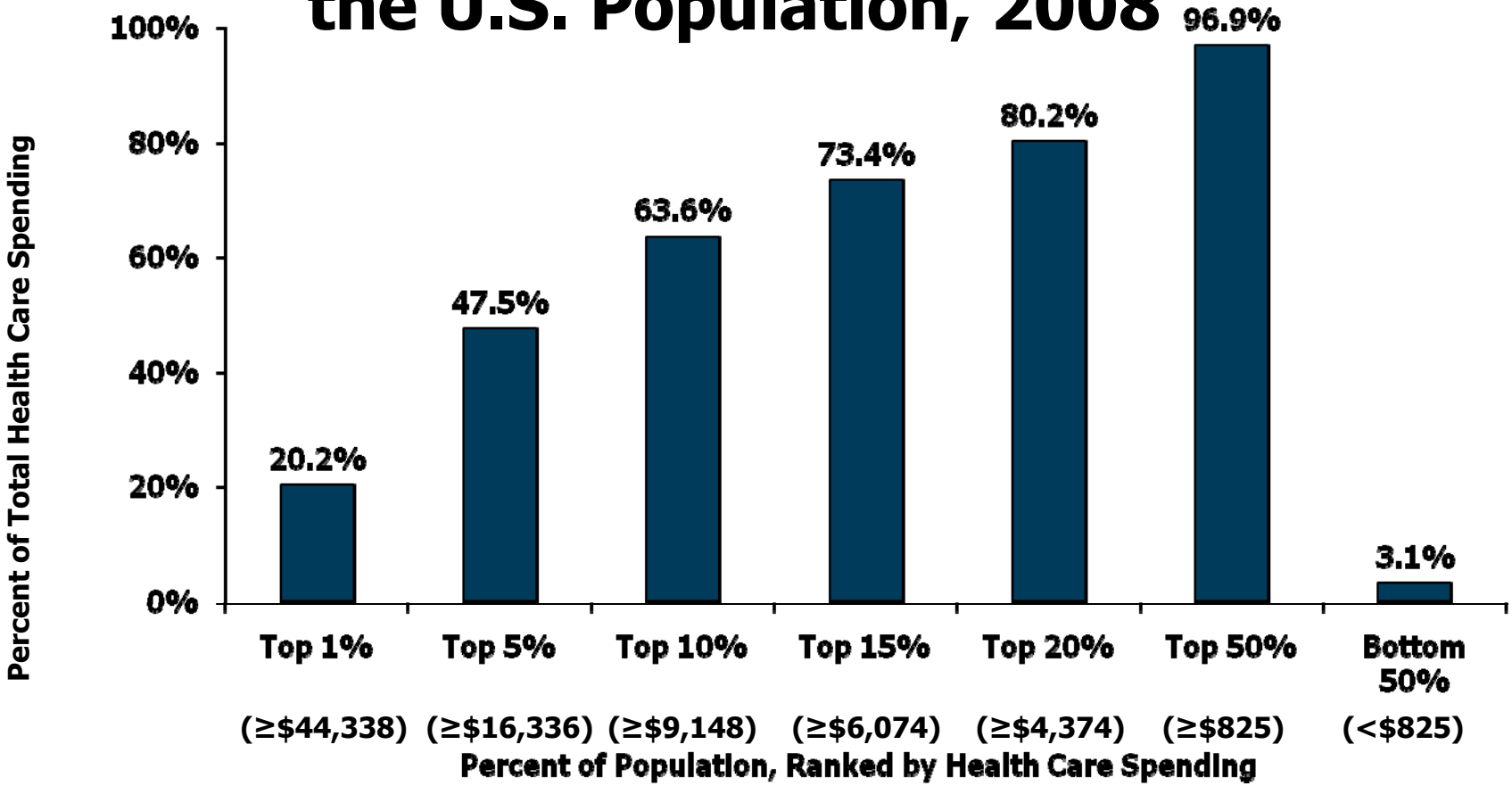
Concentration of Health Care Spending in the U.S. Population, 2008



Note: Dollar amounts in parentheses are the annual expenses per person in each percentile. Population is the civilian non-institutionalized population, including those without any health care spending. Health care spending is total payments from all sources (including direct payments from individuals, private insurance, Medicare, Medicaid, and miscellaneous other sources) to hospitals, physicians, other providers (including dental care), and pharmacies; health insurance premiums are not included.

Source: Kaiser Family Foundation calculations using data from U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey (MEPS), 2008.

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Why risk adjustment matters

- Eliminates incentive for cherry-picking patients
  - 50% of population uses less than $1000 in health care resources ea. Year
  - Top 1% uses more than $44,000
- Goal: Economic incentives that promote the more efficient treatment of everyone, NOT development of creative ways to discourage sicker patients from selecting ones health plan or medical practice

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Cost of diabetes vs. patient's overall health status

Stage	# of Episodes	Episode Cost	Risk Score	Healthier..... Sicker 0	1	2	5	10
1	7,972	$354	3.01	2,856	1,900	1,969	962	485
				$132	$308	$389	$536	$527
2	2,707	$1,133	5.32	587	599	776	371	374
				$248	$562	$862	$1,815	$2,224
3	44	$1,604	9.62	15	10	5	1	13
				$28	$113	$171	$1,726	$5,111
All	10,723	$556	3.62					

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Table 3.5: Episode Costs for Top-Aggregate-Cost MEGs

#	MEG: Description	# of Episodes	Total Cost	Summary Statistics								Fraction of Cost in Bottom 50% of Episodes	Fraction of Cost in Top 5% of Episodes
				10%	25%	50%	75%	90%	95%	Mean	Std Dev		
	Top 10 Acute MEGs by Cost												
1	Acute Myocardial Infarction	3,956	$42,298,039	$209	$2,213	$7,451	$14,820	$26,148	$32,039	$10,692	$11,866	14%	21%
2	Pneumonia: Bacterial	11,454	$41,728,983	$41	$91	$520	$4,817	$9,235	$15,201	$3,643	$6,698	2%	34%
3	Cerebrovascular Disease with Stroke	8,624	$37,988,500	$38	$77	$452	$5,349	$13,021	$21,753	$4,405	$9,465	1%	40%
4	Fracture: Femur, Head or Neck	2,558	$29,025,913	$77	$1,640	$10,659	$17,401	$23,533	$27,472	$11,347	$9,677	17%	15%
5	Complications of Surgical and Medical Care	6,064	$25,990,797	$50	$117	$640	$5,172	$11,872	$18,371	$4,286	$9,105	2%	38%
6	Cataract	50,999	$24,518,390	$38	$60	$74	$581	$1,480	$2,125	$481	$794	6%	30%
7	Arrhythmias	22,915	$22,716,514	$36	$60	$159	$571	$2,322	$4,918	$991	$2,740	3%	55%
8	Urinary Tract Infections	14,701	$12,213,571	$31	$46	$94	$339	$2,530	$4,656	$831	$2,364	3%	55%
9	Diverticular Disease	7,814	$11,631,790	$58	$162	$405	$630	$3,511	$5,960	$1,489	$4,386	6%	57%
10	Cholecystitis and Cholelithiasis	2,158	$10,783,445	$124	$553	$2,457	$8,213	$12,318	$16,440	$4,997	$6,406	9%	24%
	Top 5 Chronic MEGs by Cost												
1	Osteoarthritis	26,586	$57,193,928	$47	$105	$313	$1,120	$10,056	$12,843	$2,151	$4,804	3%	43%
2	Angina Pectoris, Chronic Maintenance	23,128	$51,477,727	$46	$95	$258	$1,323	$5,313	$12,535	$2,226	$5,885	2%	53%
3	Chronic Obstructive Pulmonary Disease	13,168	$27,570,454	$43	$105	$418	$2,393	$5,458	$8,763	$2,094	$4,217	3%	39%
4	Neoplasm, Malignant: Lungs, Bronchi, or Mediastinum	2,097	$22,153,051	$190	$865	$6,865	$17,086	$27,393	$34,357	$10,564	$11,795	9%	20%
5	Essential Hypertension, Chronic Maintenance	66,244	$21,908,869	$38	$65	$120	$219	$408	$717	$331	$1,280	10%	57%

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Evaluating and Negotiating Emerging Payment Options Manual

- New AMA resource to help physicians navigate new payment models

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Purpose of Evaluating and Negotiating Emerging Payment Options how-to manual

- Protect physicians considering transitioning from FFS, payment for volume systems, to risk-based, payment for "value" methodologies from disaster.
  - Describes the specific steps physicians must take to be successful under risk/budget-based payment arrangements.
  - Describes concepts associated more with health insurance than physician payment, including, "actuarial soundness," "risk adjustment" and "risk mitigation," the mastery of which is necessary to the successful navigation of risk-based contracting and revenue cycle management.

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Evaluating and Negotiating Emerging Payment Options: Composition

- Introduction
- Chapter 1: How to establish your baseline costs
- Chapter 2: Fee-for-service issues

Issues specific to each different budget-based payment model

- Chapter 3: Pay-for-performance programs
- Chapter 4: Capitation
- Chapter 5: Shared savings proposals
- Chapter 6: Bundled payments

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Evaluating and Negotiating Emerging Payment Options: Issues applicable to all risk arrangements

- Chapter 7: Withholds and risk pools
- Chapter 8: Risk adjustment
- Chapter 9: Stop-loss insurance
- Chapter 10: Working with actuaries
- Chapter 11: Negotiating the deal
- Chapter 12: Joint contracting/Collective bargaining
- Chapter 13: Ethical implications of financial incentives in Managed Care Contracts

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“Transparent payment to ensure access to care act”

- AMA model bill requires all payers adopting budget-based payment systems to provide:
  - Transparency regarding methodology and data
  - Accurate actuarial projections
  - State of the art risk adjustment mechanisms
  - Timely, accurate, and comprehensive information needed to reconcile payments and manage any risk assumed under the contract

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AMA Payment Resources

- Send us the questions you want answered
- Let us know if we can help
- Catherine.Hanson@ama-assn.org
- Wes.Cleveland@ama-assn.org

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AMA Toolkit
Defensible Fee Schedule Toolkit

- Physician's fee schedule – based on true cost of providing a service
- Physicians must understand their practice costs.
- Access AMA toolkit at:

  www.ama-assn.org/go/pmc

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AMA/COA/CMA California Workers' Compensation eBilling Physician Practice Engagement Campaign

- Campaign kick off in May
- Payer mandate to receive electronic claims October 18, 2012
- Access AMA eBilling resources at www.ama-assn.org/go/workerscomp

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