Most population-based healthcare systems involve a provider-based contracting organization receiving payment from a payer (e.g., government, commercial, self-insured employer) in the form of a per-member per month (PMPM) capitation payment, from which it will compensate the individual providers who provide services to the patients. Developing these payment methods and gaining acceptance among providers is a critical and complex task.

Most healthcare providers are accustomed to being compensated by methods that have some relationship to their costs (for institutional providers) or the time required to deliver the service (for individual providers). This paradigm is different from those used by investment bankers, for example, who incorporate a risk factor into their compensation and who therefore may be compensated disproportionately higher or lower than their efforts would normally recognize. Because capitation payment is not related to provider costs or efforts, an individual provider’s acceptance of a capitation payment implies the provider’s acceptance of a measure of risk in his or her compensation. This acceptance is often difficult to obtain.

**Alternatives for Payment**

Several alternatives are available for payment of providers.

**Fee for service (FFS).** Under these arrangements providers are paid directly for performing services to patients. Specific fee schedules are used, with payment rates for services established to roughly correlate with the amount of time or resources required to provide that service. Under pure FFS payment, providers have a financial incentive to deliver more services to the patient. This incentive is contrary to the financial incentive under capitation, and is therefore generally discouraged by capitated contracting organizations.

**Capitation.** Capitation can be implemented only on providers having members, as described in the related article “The Return of Capitation: Preparing for Population-Based Health Care,” published in the July 2012 issue of *hfm*. Under capitation arrangements, the providers receive a fixed amount per member, generally on a monthly basis, resulting in a PMPM payment. This amount may be severity-adjusted to reflect medical conditions of the patients. Under pure capitation payment, providers have a financial incentive to perform fewer services for patients, because their revenue is unrelated to the services provided; however, their costs generally increase as service levels rise.

**Salary.** Many physicians are employees of a hospital and are paid a salary, a portion of which may be tied to physician productivity. The fixed component of this compensation provides similar incentives to capitation in that compensation is not related to volume of services, while the productivity component provides the same incentives as FFS payment.

**Episode of care.** Under these arrangements, a provider is paid a fixed amount for providing care to a patient for a specific procedure or having a specific set of conditions. This approach differs from capitation in that the provider does not assume the “incidence” risk that a member of the population will become a patient; however, the provider does assume the “utilization” risk that the patient will
consume a higher or lower amount of cost or time. Bundled payment programs that pay a fixed fee for a specific DRG or group of diagnoses fall into this category.

Quality-based payment. Some provider payment systems incorporate a quality-based component that requires providers to meet certain quality targets to receive full compensation. Generally, these quality targets are binary (either “met” or “not met”), so the targets themselves cannot be the only factor used to determine compensation. In addition, the state of development of quality metrics is evolving, and some recent studies have indicated a lack of correlation between some payment metrics and patient mortality, which is the ultimate “quality metric” (see, for example, www.nejm.org/doi/full/10.1056/NEJMsa1112351). Nonetheless, current trends indicate an increase in use of these metrics as a factor in payment.

Hybrid models. Many payment systems are combinations of some of the alternatives shown above. They may incorporate a fee-for-service component that withholds a certain portion of the payment making it subject to meeting quality score requirements, for example.

Pushing Risk Down the Healthcare Food Chain

As noted in the July 2012 hfm article, there are several different types of risk associated with healthcare services. There’s payment rate risk, which is the risk that provider payment rates per unit of service will increase or decrease. There’s utilization risk, which is associated with the quantity of services that a patient will require. And finally, there’s incidence risk, which is the risk that a member of the population will become a patient and require services.

Providers have always been subject to payment rate risk, in which their payment rates may not fully compensate them at the rate that they believe is appropriate to their services. In some instances, providers have accepted utilization risk, which occurs in DRG-based payment in which the hospital accepts length-of-stay and service-intensity risk, and also in episode-based payments in which a physician accepts a fixed payment amount for a specific type of surgical or obstetric service. It also occurs in bundled payment systems in which the providers receive a fixed payment regardless of the services provided to the patients. Incidence risk, however, has generally remained with insurers and other payers.

In FFS or episode-based payment, the payment is always related to a patient receiving services. Under capitation payment systems, the provider assumes incidence risk as well as the other risks, since the payment received under capitation does not vary based on whether the population member receives services. This risk is generally larger and more difficult to quantify than utilization or payment risk, and is therefore more difficult to persuade providers to assume. But many payers and governments are attempting to offload this risk onto providers who are willing to accept it in the form of capitation-based payments.

Matching Business Models for Revenue and Expense

An additional complication for the contracting organization occurs when the basis for the revenue doesn’t match the basis for the expenses.

For example, in a restaurant, revenues and expenses are generally related to the number of customers served, with both categories varying in relation to business volume. This limits the possibility of large profits or losses. Alternatively, in web companies such as Google the revenue stream from advertising is unrelated to the expenses of personnel and computers, which creates the possibility of significant profits or losses for companies with this type of business model.
The latter situation could occur for contracting organizations that are paid on a capitated basis, but that compensate providers on a FFS basis. Aligning the revenue and expense payment methods limits risk, and some contracting organizations may wish to capitate as many providers as possible to align the revenue and expense models. The same principle applies to other payment methods such as bundled payment, in which the contracting organization (which is usually a hospital) will probably attempt to induce physicians to accept a case-based payment themselves in lieu of the FFS payments that they have historically received. This pushes the utilization risk from the contracting organization to the providers. Finally, a contracting organization that accepts capitation payments from the payer may attempt to offload this risk to its constituent providers by capitating those providers and thereby aligning its revenue and expense models.

In addition, using the same payment methods for the contracting organization and providers creates aligned financial incentives, which is important in creating provider behavior that meets the contracting organization’s goals. When the contracting organization is capitated but providers are paid on a FFS basis, those goals are misaligned because the provider has a financial incentive to increase utilization while the contracting organization has an incentive to reduce it.

**Being Inside or Outside of the Deal**

In the current environment, payment system reform is focused on reducing utilization levels. In ACOs and some bundled payment models (with the notable exception of the Medicare Bundled Payment for Care Improvement initiative), “shared savings” accrue to providers from decreases in overall provider payments that occur through reductions in some provider’s utilization. But if overall provider payment declines, how does any provider benefit? It depends on whether that provider is “inside” or “outside” of the contracting organization’s shared savings deal.

Consider an ACO composed solely of primary care physicians that receives a capitated payment from a payer for a specified population. By developing an effective medical management model, the physicians reduce admissions at hospitals, resulting in a decrease in payments to the hospitals and the physicians who would have cared for those inpatients. The primary care physicians’ payments probably haven’t decreased, because they wouldn’t have provided a large portion of that inpatient care. But the ACO, being inside of the deal, will accrue shared savings from avoided payments to the hospital and other physicians who were outside of the deal. Those shared savings can be allocated among the ACO’s members. The hospital’s and other physicians’ payments will be reduced because of the decrease in admissions, with no shared savings gain to offset that loss.

Often providers that can affect the services of other providers through referrals or providing alternate services (i.e., care management services designed to reduce readmissions) are insiders, and specialists are outside. As noted above, this situation can be problematic for the specialists, who have less control over their own utilization than other providers. Generally, therefore, it’s better to be inside of the deal than outside of it.

**Putting It All Together**

Unfortunately there’s no “one size fits all” provider payment model that fits all situations. Each model is fact-dependent, with the following factors affecting the final outcome:

- The relative bargaining strength of each of the parties (physicians, hospital, and payer)
Additional funding over the historical FFS payment rates that may be made available to providers under a non-FFS model (perhaps from meeting quality targets), which may provide an incentive for participation

The existing provider infrastructure for managing episode or capitation-based payment, which may facilitate adoption of those payment models

Most payment systems end up being a combination of the above payment methods, and push the risks throughout the contracting organization’s participants at varying levels. Physicians who are part of a mature care management organization may be comfortable in having their personal compensation based on a per-member population-based payment, whereas freestanding physicians may be uncomfortable with any system other than FFS.

ABOUT SINGLETRACK ANALYTICS

Singletrack Analytics is a healthcare consulting firm providing financial and analytical expertise to assist healthcare providers and purchasers achieve to success through better use of data and analytic techniques. Our 30+ years of experience and unique combination of financial and data-related credentials make us a cost-effective partner for healthcare organizations looking for cutting-edge, data-driven strategies to meet today's financial and regulatory challenges.

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