



# Paying Healthcare Providers

## The Impact of Provider Reimbursement on Overall Cost of Care and Treatment Decisions

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### Introduction

How providers are paid is one of the often-discussed and often-reformed aspects of the American healthcare system. Are doctors being paid too much? Is how they are being paid incenting them to perform unnecessary services or to not give enough attention to their patients? Why can't we just pay them salaries like most of the rest of us receive? Why does provider reimbursement have to be so complicated?

In an ideal world, healthcare providers would always make the most cost-effective course of care decisions for their patients. However, provider-payment discussions aside, there are not always clear-cut decisions in healthcare. For example, if a patient comes into a physician's office with vague symptoms, there are any number of courses of action a physician could recommend, ranging from a "wait and see" approach to a "run every test we've got" approach. The right decision for any individual patient should be made through an open and honest discussion with their physician, covering their options, the patient's medical history, and any cost/benefit trade-offs. The goal of an effective provider reimbursement structure would be, most simply, to not stand in the way of a physician and a patient making the "right" healthcare decision for them in a given situation.

This article intends to discuss various reimbursement methodologies, both traditional approaches and emerging approaches, in order to highlight some of the complexities of the healthcare system that need to be considered as we work through a reform environment.

## Traditional Reimbursement Models

Traditionally, there have been three main forms of reimbursement in the healthcare marketplace: Fee for Service (FFS), Capitation, and Bundled Payments / Episode-Based Payments. The structure of these reimbursement approaches, along with potential unintended consequences, are described below.

### Fee for Service (FFS)

Under FFS reimbursement, a physician's revenue is based solely on what procedures they perform. Each individual "service" a patient receives would have a corresponding code with a price attached. For example, a 15-minute office consult, a tetanus shot, a urinalysis, a basic metabolic panel, all have separate codes and prices attached to them.

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Additionally, what a healthcare provider gets paid for a particular service varies depending on the insurance of the patient receiving the care. When dealing with Medicare or Medicaid the prices per code are decided by Centers for Medicare and Medicaid Services (CMS). Commercial (or private) insurance often sets its prices per code as a percent of the Medicare price. Medicaid prices are the lowest, then Medicare, then Commercial. And so, a physician might get paid three times as much to provide the exact same care to a privately insured patient than they would for a patient covered under Medicaid.

FFS reimbursement approaches are referred to as "volume-based" reimbursement, because the primary way for a provider to increase their revenue is to increase the number of services they perform. To be reimbursed, a provider needs to show that the procedures provided are justifiable to the diagnoses

that are present. There is a potential misalignment of incentives here, where doctors can justifiably do more (and therefore make more revenue) even when the additional services might not be necessary or appropriate for the patient.

## Capitation

Capitation in its simplest form is a payment a provider receives to cover all services for a specified population over a period of time. For example, a doctor's office has 100 patients, and they get paid \$25 per month for each patient to cover all costs associated with those patients for the month. The amount of payment has no direct connection to the amount of services provided – one patient might incur \$0 in services and another might incur \$5,000, but the provider will still receive \$25.

There are many different forms of capitation. Some capitation payments only cover professional fees (i.e., costs of going to a primary care doctor or specialist), while others cover all costs patients incur (hospital inpatient, outpatient, and pharmacy costs).

Additionally, there are many adjustments that can be made to the capitation payment to try to make the compensation more “fair”. For example, it would not be appropriate for a doctor who services primarily Medicare patients (who are older and sicker on average) to receive the same \$25 per patient a doctor who primarily services young adults would receive. This situation would create an incentive for doctors to only care for younger and healthier patients.

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Adjustments to the capitation payment can be made based on many factors, including patient demographics (age/gender), where the patients live (service costs can vary by zip code), and the patient's health status (chronic conditions). Effectively and fully adjusting capitation payments for varying health status is a challenge, however. Typically, the compensation for the sickest patients is never enough to cover their full costs.

Different than the volume-based reimbursement structures, capitation (or fixed) reimbursement approaches allow providers to increase their revenue through an increased number of patients. If a physician gets paid \$X per patient no matter what services he renders, his incentive is to get as many patients as possible into his practice, which can often infringe on the quality of care and amount of time spent with each patient.

Salaried physicians are a form of fixed compensation as well. With doctors being paid salaries, there is neither an incentive to perform as many services as possible or to get as many patients as possible, but



there is still a disconnect to the payment received (fixed salary) and the services provided. Similar to the example noted above for capitation, providers serving older/sicker populations will be paid the same to do more work. Additionally, how should salaries be adjusted year over year if the number of patients serviced or services rendered changes dramatically?

## **Bundled Payments / Episode-Based Payments**

Bundled payments, also known as episode-based payments, are the reimbursement of health care providers on the basis of expected costs for clinically-defined episodes of care. These episodes cover a wide range of conditions from maternity care, to hip replacements, to cancer, to organ transplants. So, for example, if the expected cost for an uncomplicated hip replacement is \$10,000, then a provider would be reimbursed \$10,000 for every hip replacement he performs, even though some individual surgeries will be more and some will be less.

Bundled payments can be looked at as a combination of fee for service reimbursement and capitation. Providers are getting reimbursed for the various individual procedures required as a part of the entire episode of care, but only for what is expected to be required. If a provider has a more severe situation than is considered in the pricing of the episode, they will be underpaid for the episode of care. And so, as with capitation, it is important to consider various severity levels of episodes in the pricing. If severity is effectively captured in the pricing, the bundled payment approach promotes efficient care, because providers are able to increase their revenue by lowering their costs.

Bundled payments have grown in popularity throughout the implementation of ACA. They have been used as a strategy for reducing health care costs through efficiency of care. Both Medicare and Commercial payers have shown interest in bundled payments in order to reduce costs. However, there are challenges in using this reimbursement structure effectively. The development of appropriate expected costs per episode is not a simple exercise, particularly for types of conditions with wide variation in severity and cost, like cancer. Similar to the health status adjustment discussed in the capitation section, getting the cost differences right for various severities of an episode is extremely challenging. Additionally, not all care patients receive cleanly falls into a “bundle”. And, episode-based reimbursement can be more challenging to administer compared to the simpler FFS and capitation models.

## **Value Based Reimbursement Models**

As the healthcare system continues to evolve from the more traditional payment approaches, payers are asking providers to change the way they do business to focus more on value, where value can be thought of as the intersection between cost and quality.

Value Based Reimbursement (VBR) models are intended to encourage healthcare providers to deliver the best care at the lowest cost. VBR takes the best parts of the three traditional reimbursement methods and combines them into an approach that financially rewards doctors for performing better than expected and, in some cases, punishes them for not achieving expectations.

There are two main types of VBR. A one-sided model (Gain Share) rewards providers for performing well, and a two-sided model (Risk Share) both rewards and punishes providers depending on their outcomes. Most VBR models today are Gain Share arrangements. In the simplest form, a payer would estimate how much a population of patients should cost as a target for the providers to achieve. If the average cost per patient is less than the target, the provider gets to share in the savings with the payer – for example, the provider may get 30% of the amount below the target. In a Risk Share, there is the additional element of sharing in the loss – for example, the provider may have to pay back 30% of the amount above the target. Sometimes there are quality metrics that must be met as well, in order to share in profits.

Now, in an ideal world, physicians are effectively managing their patients, even long before they develop a chronic condition or end up in the hospital. Physicians should be focused on wellness and preventive care in addition to providing the most efficient treatment options once their patients become ill. In reality, though, there are many barriers to physicians managing their patients' health optimally (including lack of motivation, lack of know-how, lack of resources, lack of information, etc.). VBR aims both to provide incentives to motivate providers and to combine resources of the provider and payer to help improve the knowledge and data aspects. Ultimately, VBR approaches are attempting to change the way provider groups do business to both lower cost of care and improve patient care management. Not every provider group can administer and/or be successful under these arrangements, though. There is a certain level of technological and clinical sophistication required as well as an openness to a new way of approaching patient care and payer collaboration.

## Conclusion

The types of reimbursement outlined above are defined here in their simplest forms – there are many variations on and combinations of each that result in unique reimbursement approaches by payer, by facility/doctor, and sometimes by patient. Thinking about that dynamic from the provider's perspective, if a physician group services 100 members, they might have some patients covered by Medicaid who reimburse FFS, some under a capitation contract, others that pay a combination of bundled rates and FFS, and others still that are on a more whole-patient VBR approach. The system is complicated, both to understand and to administer.

Payers have been focused on reforming provider reimbursement to encourage doctors to make the most efficient choices for their patients (low cost / high quality). And while it is absolutely beneficial to seek reimbursement approaches that eliminate misaligned financial incentives and support providers in managing their patients' health, there is no silver bullet that will steer doctors to make the "right" choices all the time. Partly because, in healthcare, there often aren't clear "right" answers in terms of treatment. But, also because there are other elements of optimal healthcare that need to be addressed alongside provider reimbursement in order to improve America's overall health status and care costs.

### **About the Author:**

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