Connecticut Health Policy Project

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Health reform financial models -- Downside risk explainer

Connecticut's Health Care Cabinet is now considering a Strawman proposal drafted by consultants for state health reform. A prominent and controversial feature of the consultants' proposal is to place our state Medicaid and state employee coverage plans into a downside financial risk model. There've been a lot of questions and misinformation about what that model is and how it relates to other options. The following compares financial models in savings potential, risks of harm, likelihood of improving the quality of care, and feasibility of implementation. We also include the history of each in Connecticut and examples of how they work.

Broadly, there are five categories of financial risk models in health care.

Fee-for-Service is the traditional model for health care services. Providers are paid a separate fee for each service they provide. Rates vary between coverage plans; private insurance plans typically pay the most for services and Medicaid pays the least. Medicare is in between with rates that are set to equal the costs of delivering care.
Pros: Ensures we get what we are paying for, and there are no financial incentives to deny needed care (also called "stinting" on care).
Cons: Could encourage providers to over-treat people except when they are being paid less than their costs or, in the case of scarce treatments such as primary care, less than other plans are willing to pay. Also provides no incentive to improve the quality of care, to prevent health problems, or to reduce costly duplicative services.

Fee-for-service with performance bonuses is very common and is how Connecticut's current successful Medicaid program is structured. In this model providers are paid for each service they provide, as in fee-for-service, but can earn extra bonuses for better performance. Those bonuses vary between plans and over time to address concerns and improve the value of care. Typical bonuses include monthly per-member payments to certified patient-centered medical homes for care coordination, and bonuses for better quality care and

outcomes such as reductions in hemoglobin A1c for diabetic patients and improved patient satisfaction scores. The model can also include penalties for poor outcomes, such as pressure sores or catheter-associated infections for hospital patients.
Pros: Fee-for-service targets quality improvement toward identified problems. It rewards providers for investing in quality. The model reduces costs if bonuses reward avoiding expensive, poor quality outcomes. This model creates no incentive to stint on care. Incentives can be structured to reduce unnecessary duplication of services.
Cons: This model does not directly support providers' flexibility to improve quality in other ways that are not rewarded. Historically, bonuses have been small, limiting their impact.

Shared savings or upside-only risk models are relatively new. In these arrangements, networks of providers that care for patients are paid for each service they provide, as in fee-for-service, but if at the end of a year, the total cost of care for their patients is lower than expected, they receive part of those savings, typically half. Savings benchmarks can be risk adjusted for patient's level of need to limit incentives to avoid or "cherry pick" costly patients. Risk adjustment is a new and evolving science. Savings payments are also typically dependent on achieving a limited set of quality standards. The lists of quality standards are often quite short and performance expectations are often very low, so the application of these standards may not act as a protection against stinting on care. Monitoring systems for stinting on care are rare.
Pros: Shared savings/upside-only risk encourages cost savings, early treatment, and preventing health problems. The model supports investment in innovations that promote value in health care.
Cons: Can reward stinting on care or cherry picking more lucrative patients. Low quality benchmarks undermine quality improvement incentives and offer little protection to consumers. Different methodologies for determining the total cost of care and shared savings payments give variable results, potentially denying payments to deserving providers and over-paying others.

Capitation was common in the 1990's but has fallen out of favor. In capitation, provider networks are paid a pre-set, flat fee to cover all the costs of care for their members. If the total cost of care is less than the fee, the network keeps the extra. Conversely, if the total cost of care is more, the network loses money. Capitation rates are also usually risk adjusted. Risk adjustment is an evolving science and current methodologies do not account for social determinants, undiagnosed needs (i.e. behavioral, oral health needs), non-English speaking patients, geographic access to care, or other member characteristics that require provider resources. Medicaid in Connecticut has moved away from this model. Since then, Connecticut's Medicaid program has enjoyed improved access to care, higher quality of care, and both per-person and total state costs have dropped.
Pros: As payments are consistent and certain, and providers have extensive data on their patients' needs, resource planning is far easier than in other models. Upfront payments support investment and innovation. Payers also benefit from certainty of risk.

Cons: Capitation includes strong incentives to reduce the level of care, both needed and unnecessary care. Data on utilization trends are difficult to get, as claims are no longer needed for payment, making accountability very difficult. Monitoring for inappropriate underservice is nonexistent. Quality and performance standards are low and rarely enforced, as payments have already been made. Moving members from their plan is administratively burdensome and there may not be a better alternative as markets consolidate.

Shared risk or downside risk is very new and experimental. It builds on capitation and is not implemented anywhere in Connecticut currently. As in shared savings/upside-only risk, networks of providers that care for patients are paid for each service they provide, as in fee-for-service, and if, at the end of a year, the total cost of care for their patients is lower than expected, they receive part of those savings, typically a bit more than half. However, under shared risk/downside risk, if the total cost of care for their patients is higher than expected, they also share a part of the losses, requiring a claw back payment to the payer at a later date. In Medicare nationally, provider networks have been very reluctant to accept downside risk arrangements, despite strong pressure, and the majority of first-adopters have dropped out of the program.
Pros: Proponents note loss aversion theory, extrapolated from psychology and financial markets, provides a much stronger incentive to control costs in this model.
Cons: Incentives to deny needed care are stronger as disincentives and penalties grow. As in shared savings/upside-only risk, total cost of care benchmarks are risk adjusted; the same problems in methodology apply here as they do to other models. Quality standards are similarly weak and monitoring for underservice is nonexistent. Loss aversion, inherent uncertainty, and the long delay between behaviors and rewards in this model chill incentives for upfront investments in promising innovations that could improve value or prevent health problems.

	Fee for Service	Fee for Service + PCMH, quality bonuses	Shared savings/Upside-only risk	Capitation	Shared risk/Downside risk
History in CT	Ubiquitous	Current HUSKY program, many others	Very new	1990's Medicaid and private insurance	Not yet in CT, very experimental in other states
Success in CT	Depends	Yes -- quality and access up, costs down	Too soon to say -- mixed results elsewhere	"Failed spectacularly"	No idea -- not popular elsewhere
Drives quality improvement?	No	Yes	Not usually	No	Not likely
Volume incentive?	Only for plans that pay more than cost, not Medicaid	Only for plans that pay more than cost, not Medicaid	Depends	No	Depends
Drives underservice?	No	No	Yes	Yes	Strong Yes
Saves money?	No	Yes	Too soon to say, but generally not saving money in the Medicare program	No	????
Incentive to invest in promising innovations?	Only if they are billable	Yes	Yes	Yes	Maybe, if the expected return is very high and very certain
Incentive to prevent health problems?	No	Yes, if quality bonuses support	Yes	Yes	Maybe, depends on the investment required