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Primary Care Physician Payment

Primary care physicians (PCP) are the Hippocratic guarantors of the high-quality care every patient hopes to receive., They are also, potentially, the decision makers on many aspects of the rising costs of health care services. This issue brief focuses on policy options to increase the supply of primary care health professionals via through financial mechanisms. Fee-for-service is, by all accounts, not working. The insurance system is broken with respect to primary care. In addition, consolidation in the health care industry has resulted in dramatically increasing the numbers of PCPs who are on salary.

In brief with more detail below, the financial mechanisms include the following three (combinations of the below are possible):

1. Direct primary care;
2. Capitation and/or salary;
3. Combination of either 1. and 2 together with additional sums that are given based on quality of care and/ or utilization metrics risk pool.

Direct primary care (DPC) and capitation (a per member per month payment) are very similar. The main differences is who pays (the insurance company vs. the individual patient) and how much is paid (direct primary care is pegged at a higher level). We are at an early stage of DPC implementation. One could imagine a future scenario in which insurance companies pay make the DPC payment directly to the individual enrollee.

The administrative benefits of DPC are clear; it avoids any dealings with insurance companies. The challenge is in obtaining individuals willing to sign up and the difficulties in obtaining information typically obtained from claims data. This information can be useful particularly in assessing the clinical risk burden of patients thus providing information to the PCP on both outcomes and the risk burden (and clinical intensity) of the PCP panel of patients.

Direct Primary Care (DPC).

DPC represents a flat-rate payment, typically on a per-member per-month basis (pmpm), paid to a practitioner for providing specified services as frequently as is necessary to enrolled members. DPC is intended to cover services that the PCP ordinarily provides in the office. In contrast, capitation of PCP services in the United States rarely involves solely physician care. and It usually includes certain basic tests or procedures that are low cost and are performed in the office setting.

Capitation or DPC payment means that the physician takes on a form of risk. A PCP can assume two types of risks: service risk and financial risk. Service risk refers to the risk a physician assumes for providing as many needed services as specified under the contract in return for a fixed payment. In economic terms, a physician's time can also be viewed as a marginal cost, whereas an x-ray constitutes a direct cost. The PCP is at total service risk for what is included in the DPC. This service risk pertains to the services the PCP would routinely provide to the patient in the office. Under this arrangement, the typical one for primary care capitation or DPC, the PCP bears service risk but no direct financial risk, in that the PCP is guaranteed the agreed-upon pmpm payment.

Group versus Individual Physician Capitation – The Salaried Health Professional

Particularly on the West Coast, group capitation is more important than individual capitation. This reflects the fact that increasing numbers of physicians and other health professionals are have become salaried workers in a large group and/or hospital. Salary, in essence, is a form of capitation.

Often a medical group will be capitated for services to an enrolled population. In this situation, the group practice can pay individual PCPs in the group using a variety of methods, including salary or discounted fee for service. Alternatively, the group practice may elect to reimburse its physicians using capitation. There is no empirical literature on group capitation as it compares with capitation of individual physicians. Capitation of a group may provide more actuarially precise reimbursement than could be provided to an individual physician in independent practice. A large number of Managed Care Organizations (MCOs) contract with medical group practices only on a capitated basis. On the other hand, individual physician capitation may provide for more direct feedback and communication between the MCO and a specific physician.

Withhold

"Withholding" of a percentage of a PCP's capitation is a still utilized tool in capitation but is irrelevant for DPC.

Bonus

A "bonus" payment represents a monetary reward for meeting performance standards. A bonus or supplementary payment can have a significant financial impact on the PCP's overall income. Bonuses could apply to both DPC and capitation

Risk-Based Payment

This section only applies to capitation. Risk pools or other funds are sums of money set aside by an MCO to distribute to a physician or group practice. Risk pools specifically oriented toward cost containment have become less common as MCOs have become more actuarially familiar with the development and maintenance of capitation payments that do not place the MCO at undue risk.

When fund distributions based on quality are made, they may be tied to performance on the physician's other risk pools. If the PCP performs poorly on hospital, ancillary, and specialist funds, for example, no payment is made, irrespective of the physician's performance on the QA standards.

Stop-loss

Stop-loss is only relevant for capitation. "Stop-loss," "risk-limiting protection," and "reinsurance" are terms used to describe financial arrangements whereby the MCO provides financial protection to a capitated provider or protects the reasonableness of a risk pool arrangement against the effects of extraordinarily costly cases. Different levels of stop-loss provide varying degrees of protection to the provider (typically a group practice, although it can be an individual physician), assuming financial risk-sharing with the MCO. For example, stop-loss insurance is purchased so that one hospitalization or one sick patient does not deplete a group practice's hospital or outpatient (e.g., ancillary and referral) risk fund. No empirical data document the impact of stop-loss on practice behavior.

A provider's desire to cover catastrophic loss may indicate that stop-loss coverage should be established at a low dollar level. In contrast, a medical group may want to assume increased risk, generating increased profit, and thus establish the stop-loss coverage at a relatively high dollar level. The extent of risk most medical groups assume typically depends on two factors: the number of enrollees for which the medical group is assuming risk and whether the services placed at risk are under direct management supervision by the group.

Because outside referrals are under the control of the medical group, most providers are willing to place themselves at risk for specialty referrals. In contrast, medical groups have less influence over hospital services and therefore are often less willing to assume significant risk for these services unless they have very large enrollee bases. Typical stop-loss policies range from $1,000 to $9,000 for outpatient referral services and $10,000 to $100,000 for hospital services based on the number of claims per member per year. Medical groups tend to assume risk at the lower end of the range for hospital services, while MCOs with substantial enrollment assume a larger stop-loss risk for hospital services.

Ancillary Service Capitation

Capitating ancillary services, such as laboratory and pharmacy, enable the MCO to know its expenses in advance. It also is important for reasons of physician feedback. Capitation of laboratory services is made possible by the low marginal cost of incremental laboratory tests. From a financial perspective, laboratory companies may be interested in capitating this service because it provides a marketing entree to physicians covered under the contract. On the other hand, capitation of pharmacy services is made possible by discretionary dispensing behavior (e.g., generic versus brand name) and the ability to obtain bulk discounts, both of which can be

influenced by pharmacists. No published research studies examine the impact of capitation of ancillary services on physician behavior.

Concluding Comments

The decreasing number of primary care physicians and the difficulty in attracting PCPs to the profession demonstrate that the payment system for PCPs is broken. Capitation, placing PCPs at both service and financial risk, has been tried and found wanting. Direct primary care or DPC consists only of service risk and, at this point, requires direct payment of a monthly payment by the individual enrollee or patient to the PCP. It is unclear whether the DPC model will take hold as is, or change into a system that more directly involves payment by insurance companies to patients who in turn reimburse their PCPs. It is important for PCPs to be engaged in this process both through their association and with their elected representatives.