

Physician Payment Reform:

REWARDING VALUE OVER VOLUME

Due to the evolving landscape of health care delivery and payment, physicians and physicians-in-training alike often struggle to understand the nuances of how they will be paid for the care they provide to patients under various payment models (see reverse side). The overall increase in health care costs in the U.S. has slowed recently; however, there is still an overwhelming consensus that the cost of health care in this country is unsustainable and more must be done to improve the quality of care. In response to this growing crisis, public and private payers have launched scores of innovative health care delivery and payment models designed to reward the value of health care services, instead of the volume of service.

Family physicians will continue to lead the way toward a reformed payment system that allows physicians to provide the right care, at the right place, and at the right time to their patients—striving toward the triple aim of health care, delivering **better quality care**, achieving **better health outcomes** for patients, all at a **lower cost to patients** and to the system.

As future family physicians, it is important to understand the ways in which the different payment models incentivize particular aspects of care delivery. The underlying incentive systems inherent to each payment model ultimately drive disparate physician behaviors, clinical outcomes, and organizational overhead requirements. Understanding the advantages and disadvantages of each model will help physicians and physicians-in-training alike determine the type of practice they are interested in pursuing.

A reliable payment system should:

- Have as its primary goals: quality care, access to care, positive health outcomes.
- Preserve doctor/patient relationship.
- Be based on continuing, comprehensive care.
- Encourage ambulatory treatment and minimize institutional treatment.
- Value and incentivize prevention, health maintenance, early diagnosis, and treatment.
- Compensate appropriately for cognitive physician services.
- Compensate physicians only for services for which they have documented training and/or experience, demonstrated abilities, and current competence.
- Involve physicians in determining the values for services.
- Be flexible to variation in medical encounters (site of service, number of patients, health status, complications, severity, etc.)
- Allow physicians to set their own charges for their services and, in doing so, to allow for consideration of skill, special training, time spent, risk, economic considerations for disadvantaged populations, supplies and equipment, the use of ancillary personnel and services, facility costs, and complexity.
- Provide that the medical profession will assure quality and appropriate utilization of services through peer review mechanisms at a local level, involving all specialties.
- Include provisions for regular re-evaluation.
- Appropriately pay for care management services.
- Take into account the unique practice expenses and professional liability costs of primary care physicians, and use a single conversion factor for all physician services.
- Recognize, and not limit by plan design, the role and payment of family physicians in the delivery of mental health services.
- Pay for periodic preventative services when performed in the same anniversary month as they were last performed.
- Pay for non-face-to-face services.
- Not discriminate physician payment in any form (equal pay for equal work).

PHYSICIAN PAYMENT MODELS	ADVANTAGES	DISADVANTAGES
<p>Fee-for-service: Physicians, and other health care professionals, are retroactively compensated for each distinct service provided during discrete episodes of care.</p>	<p>Rewards productivity and industriousness; implicitly does case-mix adjustment; commonly used and readily understood by payers and physicians.</p>	<p>Does not address quality of care or value (to the patient or the health system) of services provided; fragments care delivery into silos; high administrative and transaction costs; services that are compensated may be marginalized; complexity makes it susceptible to gaming and fraud; can result in the provision of clinically inappropriate, duplicative, or otherwise unnecessary services.</p>
<p>Bundled Payment: Consolidates payment for multiple providers or provider types (e.g., physicians, the hospital, and other health care services) into a single predetermined amount to appropriately cover all patient care services provided for a predefined set of related care episodes, or for a specific condition over a defined period of time.</p>	<p>Encourages greater cooperation and coordination of care among multiple providers/provider types involved in the patient's care; encourages a more comprehensive approach to patient care management.</p>	<p>Sets up potential conflicts among providers and institution with respect to the appropriate division of bundled payment; encourages volume of bundles; may not address quality of care provided; primary care services are more difficult to parse into bundles; creates a one-size-fits-all treatment plan, with the potential to disregard a patient's unique condition.</p>
<p>Global Payment (Capitation): Physicians and care providers receive a predetermined payment for each patient in their panel on a periodic basis (monthly, annually, etc.) to cover the provision of care. Global payment can be comprehensive, (i.e., covering all services provided to the patient across the entire spectrum of care) or more specifically cover only a selected subset of services (e.g. primary care services).</p>	<p>Focuses physicians on population health rather than volume of services; encourages cost-efficiency within the cap; incentivizes providers to deliver clinically appropriate care; captures the value for the provision of ongoing care management and services via asynchronous or telemedicine.</p>	<p>Can result in providers or institutions attempting to limit the provision of clinically appropriate services or patient care; can incentivize cherry-picking of patients for panel, especially if not risk-adjusted or tempered by quality reporting systems; management of global payment contracts can require physicians and providers to take on increasing amounts of both financial and clinical risk.</p>
<p>Pay-for-Performance (P4P)/Shared Savings: Typically implemented as a complimentary payment used in conjunction with another base payment methodology. Both models are generally tailored to incentivize very specific outcomes, including the delivery of certain services (e.g., preventive services or care management), achieving improved clinical outcomes, or enhancing patient satisfaction.</p>	<p>Can help mitigate drawbacks of other payment models when used in conjunction with them; tends to incentive and reward quality of care.</p>	<p>May lead physicians to overly focus on only those things that are being measured and rewarded; quality measurement is imperfect; shared savings have diminishing returns, depending on how they are structured.</p>
<p>Blended Payment: A payment model that blends various methods of paying for health care services; for example, the Centers for Medicaid and Medicare Services' (CMS) Comprehensive Primary Care initiative combines fee-for-service with a per-patient, per-month care coordination fee and the opportunity for shared savings.</p>	<p>Ideally combines the best of multiple, individual payment models while mitigating their respective drawbacks.</p>	<p>Potentially more complicated to understand and administer than a single payment model.</p>
<p>Salary: A payment model in which a physician is paid more or less a set amount for his or her collective services over a period of time (e.g., a year). A straight salary does not vary based on number of patients or services. However, salaries often have productivity or performance thresholds included to insure a certain level of work on the part of the physician, and they may also include pay-for-performance incentives. The physician's employer, however, may still be receiving its reimbursement through one of the models above, therefore exposing the physician to the incentives associated with that model.</p>	<p>Avoids drawbacks of fee-for-service and capitation; rewards physician for all work done during period covered by salary; values physician time regardless of activity.</p>	<p>Does not incentivize productivity, per se; does not address quality of work done.</p>