

Family Physicians Should Be Paid for Managing

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Your ability to manage care wisely is invaluable to payers and patients alike. But are you reimbursed in a way that encourages you to manage?

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Appropriate care management, whether in preventing unnecessary care or in ensuring the delivery of necessary care, is of clear value both to the patient and to society. Since family physicians and other primary care physicians are in the best position to manage a patient's care, it follows that they should be encouraged to manage wisely and that they should be well compensated for good management. It is a sad fact that they are not and a sad consequence that, in many instances, they do not really manage. Sometimes this function is performed, with variable success, by the front-office staff. When a patient calls to request a referral, the request may be granted by the office staff with little or no awareness on the physician's part. The physician manager should have input concerning not only the necessity of the referral, but also the choice of a referral specialist.

Management takes time, skill, judgment, expertise and tact. Consider, for instance, the patient who transfers to a new physician from a physician who still gives an annual chest X-ray with an annual physical. All of these qualities are needed to gain the patient's confidence and to get him or her to understand why an annual physical may not be necessary and why an annual chest X-ray is not desirable. The physician who may be reimbursed for performing an unnecessary chest X-ray is paid nothing for avoiding one. Surely it is time to change how physicians are paid.

Management is more than gatekeeping

In the development of managed care, the primary care physician has tended to be valued as a resource for cost-containment — for preventing unnecessary services. Hence the term *gatekeeper*. As more and more managed care organizations (MCOs) are coming to realize, however, care management involves much more than blocking care. The family physician's responsibilities

as a manager involve delivering or ensuring the delivery of necessary services as well as blocking unnecessary ones. Care management aims to maximize cost-effectiveness, not cost-containment. The care manager works to make sure the patient gets all the care he or she needs without wasting a dollar of the MCO's money or subjecting the patient to a single unnecessary test. Here are examples of good managers at work:

- The physician who avoids hospitalization by treating a low-risk patient with community-acquired pneumonia at home.
- The physician who fields telephone calls from an anxious mother who, along with her baby, has gone home within 24 hours of delivery.
- The physician who sees a patient in the office after hours instead of in the emergency department.
- The physician who appeals an adverse precertification decision to ensure that a patient receives necessary treatment.
- The physician who takes the time to explain why a high-tech procedure may not be necessary for a patient with a given set of symptoms.
- The physician who refers a patient and then personally calls the referred physician to make sure the urgency of the referral is appreciated.

Under the current system of medical reimbursement, none of these management services are adequately compensated.

Many patients use the emergency department as their entrance into the health care system. Managed care and the proactive care manager try to control this practice not just because ED care is expensive but because the ED is *inefficient* in providing routine care. ED physicians typically do not know the patient, and they recognize that the situation gives them perhaps only one opportunity to make a diagnosis. One result is likely to be unnecessary testing. A primary care physician who knows a patient and will have opportunity for follow-up can safely order fewer tests for the same illness.

Generally, care management falls into three categories:

- Treating illness or disease
- Functioning as

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▶ Preventive services may not be managed appropriately today because they are unquestioningly assumed to be valuable.

▶ Fee-for-service reimbursement encourages overuse rather than careful management.

▶ Capitation can encourage limitation of care rather than careful management.

▶ Paying a separate management fee puts the financial incentive where it belongs: on optimal use of resources.

an educator and case manager

- Providing the preventive services needed to preserve health

The realm where the importance of cost-consciousness is perhaps least appreciated now is preventive services. Prevention is so often spoken of as a way to reduce both morbidity and expense that we may tend not to manage preventive services actively enough. For instance, the 50-year-old woman who needs an annual mammogram does not need an annual CBC, EKG, chest X-ray, etc. Why are so many services that are necessary coupled with so many that are not?

The *Guide to Clinical Preventive Services* published by the U.S. Preventive Services Task Force looks at 169 interventions and assesses their effectiveness as screening tools.¹ The stark fact is that the vast majority of these services could not be recommended for routine screening purposes (see Table 1 for some examples). Prevention needs to be tailored to individual patients and their risk factors.

How should management be rewarded?

To pay for care management is to pay, not for providing services or for withholding services, but for providing necessary services and withholding unnecessary ones. The challenge of designing financial incentives appropriate to this model has not yet led to the ideal solution. In many managed care systems, family physicians are paid a significantly discounted fee for service with a withhold. Discounted fee for service is also the payment mechanism for Medicare and Medicaid. This payment system does have several advantages:

- It ties payment to services actually performed. Since family physicians generally perform a wide variety of services, this tends to be a fair payment mechanism.
- It automatically adjusts reimbursement to reflect unpredictable instances of high utilization that would not be picked up by age- and sex-adjusted capitation.
- It provides a built-in reward for hard work.

The most egregious difficulty with capitation is that the fee is usually too low.

These advantages, however, are outweighed by one disadvantage: Discounted fee-for-service care, like undiscounted fee-for-service care, incorporates a perverse incentive for physicians not to prioritize — *not* to manage care — and to do more than may be necessary. In fact, this seems to be the main weakness of the fee-for-service system. Given the continuing inequity in payment for cognitive and procedural services, the problem is frequently compounded when

the physician performs ancillary services such as X-rays. A family physician who actually manages patients is not well served by agreeing to discounted fee-for-service payments, especially if he or she is spending time with patients to meet their real and perceived needs.

In theory, capitation should be a good way to compensate family physicians. Paying so much per member per month (PMPM) takes away the incentive to perform services that are not medically necessary. Another theoretical advantage of a capitated system is that it could obviate billing. However good this may sound in theory, though, capitation is problematic in application. The theoretical advantage in billing reduction tends to evaporate in practice, since most HMOs that capitate still require billing data to use in reporting and profiling. Capitation can also cause difficulty if the capitated MCO does not have enough patients per physician to spread the risk effectively. The physician with only a few capitated patients can lose money if even one or two of them are very sick.

Another problem with capitation is the difficulty of adjusting risk to the makeup of the patient population. Basing rates on age and sex provides only a gross adjustment, and while more sophisticated arrangements have been explored, they are not normally used. A patient who was treated for an emotional problem last year is more likely to require treatment this year. A doctor whose expertise in treating diabetes attracts many diabetic patients will not do well on an age- and sex-adjusted capi-

tation. The examples of potential problems go on and on.

The most egregious difficulty with capitation is that the capitation fee is usually too low. While the low reimbursement encourages *limitation* of care, it does nothing to encourage proactive *management* of care. Without some provision to compensate the primary care physician for wise management, it errs in the direction of encouraging undertreatment, just as fee-for-service payment errs in the opposite direction.

Worse, in many managed care systems, family physicians and other primary care physicians are capitated while specialists continue to be paid a discounted fee for service. This provides a matched pair of perverse incentives, since it encourages primary care physicians to refer patients instead of taking care of them and at the same time gives referral specialists no encouragement to contain costs.

Management fee

What a family physician's services are worth depends, of course, on the physician's clinical skill, scope of practice and ability as a care manager. But the importance of that last factor is such that good care management merits generous, independent compensation. This compensation should recognize the staff costs and other extraordinary overhead expenses that come with primary care. Moreover, it should

be enough to redress the reimbursement imbalance of cognitive and procedural services. After all, wise management is probably the ultimate cognitive service in terms of its value to the MCO and the patient.

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While no payment system yet devised seems able to reward management perfectly, one system that seems able to accommodate this sort of compensation — a system I have had some experience with — is to pay the

primary care physician a discounted fee for service *and* a generous per-member-per-month case management fee. (I believe capitation with a generous case management component and some correction for adverse selection would work equally well, although I don't have experience with this type of system.) Such a system does not encourage overtreatment,

Table 1

Unnecessary Preventive Services

Here is what the U.S. Preventive Services Task Force had to say about five common screening practices:

Routine EKG: “. . . Secondary prevention of CAD (screening) by performing routine electrocardiograms to screen asymptomatic persons is not recommended . . .”

Screening for peripheral arterial disease: “Routine screening for peripheral arterial disease in asymptomatic persons is not recommended . . .”

Routine chest X-ray: “Screening asymptomatic persons for lung cancer by performing routine chest radiography or sputum cytology is not recommended.”

Screening for ovarian cancer: “Screening of asymptomatic women for ovarian cancer is not recommended. It is prudent to examine the uterine adnexa when performing gynecologic examinations for other reasons.”

Screening for diabetes: “. . . Routine screening for diabetes in asymptomatic non-pregnant adult patients, using plasma glucose measurement or urinalysis, is not recommended for the general population, but it may be appropriate in selected high-risk groups . . .”

Source: *Guide to Clinical Preventive Services: An Assessment of the Effectiveness of 169 Interventions*. Report of the U.S. Preventive Services Task Force. Williams and Wilkins, 1989.

SPEEDBAR

► A substantial management fee paid to primary care physicians could be funded by the resultant savings.

► Tying a physician's management fee to his or her ability as a care manager would encourage management education.

► The quality of care management can be measured indirectly in terms of the physician's adjusted PMPM cost for ambulatory care.

because the fee-for-service component is significantly discounted. At the same time, however, it does take into account the fact that the physician is performing many services that are not billable. In such a system, performance feedback is essential to distinguish primary care physicians who manage from those who don't.

In my experience with discounted fee for service and a case management fee, the case management component was set at \$4 PMPM. For a physician with 500 patients from a given HMO, this represents \$2,000 a month — and remember that this is new income; in a sense, it represents income after expenses, because it goes directly to the physician's bottom line. A good physician manager will save this amount many times over by the type of management I have described, so such a management fee can be funded by savings from other areas of health care delivery.

Obviously, the management fee would not achieve its purpose if, when added to the capitation or discounted fee for service, the total compensation did not increase. In a fully capitated system, primary care physicians are now typically paid \$10 to \$13 PMPM, while the aggregate of other specialists receive about \$18 PMPM. An added \$4 PMPM management fee would increase the primary care payment by 30 to 40 percent — enough to have the desired effect.

One problem with a universal PMPM case management fee as a way of compensating proactive management is that it rewards all primary care physicians equally, whether they manage well or not. Physicians who don't manage should not, of course, receive a management fee. On the other hand, given the importance of management to good primary care, and given the difficulty of providing management services when management is not remunerated, I think the fee should be paid as a rule and taken away from a physician only on clear evidence that the physician fails to

manage and only after educational intervention involving physician peers.

Physicians need management education, whether it's to learn the importance of management or to refine already well-developed management skills. Tying part of their income to management services would facilitate this education. Clearly, an adequate management fee, whether part of a discounted fee-for-service system or a capitated system, will be very important to the primary care physician.

It also makes an important statement: that the whole of what a family physician does is greater than the sum of the parts. This philosophy must be emphasized in all practice settings, but particularly at the level of physician training.

My experience indicates that the best rough index of a primary care physician's performance as a manager in a gatekeeper-model system is the age- and sex-adjusted PMPM ambulatory expense for the care of patients signed up by that physician. I would not include hospital costs, because they are more difficult to control and more subject to adverse selection. If a given physician's PMPM ambulatory expenses are high, an experienced physician reviewing the data should be able to determine with relative ease whether this is due to adverse selection or poor management.

Whatever the payment system, managed care must be efficient and cost-effective to succeed. It depends on family physicians and other primary care physicians for coordination and management. If optimal management is to occur, primary care physicians must devote the necessary time and resources to it. Not to encourage that management and enhance the effectiveness of primary care physicians through payment mechanisms is short-sighted and foolish. **FPM**

1. *Guide to Clinical Preventive Services: An Assessment of the Effectiveness of 169 Interventions.* Report of the U.S. Preventive Services Task Force. Baltimore: Williams and Wilkins, 1989.

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