Stanford MEDICINE

Stanford | Center for Health Education

INTRO TO HEALTHCARE STUDY GUIDE

MODULE 2- PHYSICIANS, PHYSICIAN PRACTICES, AND PHYSICIAN PAYMENT

LEARNING OBJECTIVES

1. Describe the role of physicians and physician practices, ways that physician practices vary, and ways physicians and practices relate to intermediaries
2. Describe the basic operations of fee-for-service physician payment systems
3. Describe the basic operations of capitation-based physician payment systems
4. Describe some other approaches to physician payment, including salary models and episode-based payments
5. Describe how physician payment systems affect financial risk faced by physician practices, and incentives created by payment systems

PHYSICIAN PRACTICES

Physician practices are organizations in which physicians work, independent entities that are privately owned and operated.

- Solo practice contains one physician who is the owner and manager of the staff (one specialty)
- Group practices can contain 2-3 doctors in a partnership or up to 100's of physicians and can be called medical groups or physician organizations.
- Larger groups are much like corporations where doctors are hired as employees and do none or less of the management of the staff.

Physicians get paid through intermediaries that determine eligibility for care, process the insurance claims and pay the claims to the doctor's practices

Physician Network: a group of physicians or practices with whom the insurer works, and which the members covered by the insurer are required or encouraged to use

- In-network: If a payer (insurance company) and a practice agree on a payment arrangement, then we say the physicians in the practice will be "in-network" for the payer, and the payer covers all or contributes to the costs of their care.
- Out-of-network: Any doctors or groups not a part of network are called 'out-of-network' and patients will need to get prior authorization to see one of those doctors or pay out of pocket.

For larger groups, the management does all the work and negotiations with the insurer.

Network Organizer: do what larger practices can do except it is for multiple small practices

- **IPA (an Independent Practice Association)** – Most common network organizer.
- IPA collects physician groups and then goes to the insurance company on behalf of all of its members.
- The IPA members are considered 'in-network'. The IPA gets paid by the insurer who then pays the practices.
- Individual practices can mix and match a bit when it comes to working with IPAs.

PHYSICIAN PAYMENT

FEE FOR SERVICE

Fee for Service (FFS): The doctor bills and is paid for each service that he/she provides whether that be in the office or hospital.

Pay for volume: The more volume of services, the higher the pay.

Fee schedule: List of services with listed payment amounts

Allowed amounts: Also called negotiated rates. The agreed upon amounts an intermediary would pay a practice

Retrospective payment system: the amount of the payment is set after the services are delivered and responds to the services

The fee billed by the doctors' offices is listed on the 'charge-master', but the amount paid by the insurer is often lower.

Procedure Codes:

- CPT- Current Procedure Terminology

- HCPCS – Health Care Common Procedure Coding System
- ICD-10PCS - International Classification of Diseases, 10th revision, Procedure Coding system

Diagnoses Codes:

- ICD-10 - International Classification of Diseases

MEDICARE

Medicare: The US government payer that provides coverage for people over age 65, and some others

The Medicare fee schedule is based around the HCPCS system. at the core of that is the CPT listing of physician services.

A central idea in the Medicare Fee Schedule is that each service there should be assigned a weight that reflects the amount of work involved in doing it, what expenses a practice might incur to provide it, the amount of malpractice risk associated with it.

RVU (Relative Value Units): A weight assigned to service which allows a specific dollar amount to be paid for each service.

One service might have 2 RVUs assigned to it. 4 RVUs means that the latter should get twice as much weight in terms of the amount of work, practice expense, and malpractice risk involved.

Medicare fee schedule has all these enumerated services and the number of RVUs associated with each one. Then there is a conversion factor that converts RVUs for payment.

TOTAL RVU*	X	CONVERSION FACTOR	=	FEE SCHEDULE ALLOWED AMOUNT
2 RVUs		$35		$70
4 RVUs		$35		$140

*Note: In the Medicare Fee Schedule, Total RVUs reflect work, practice expenses, and malpractice risk, and are adjusted for geographic variations

Medicare's fee schedule is made by the government and is available to the public online.

CAPITATION

Capitation: Payment per person, per unit of time

Capitation payment model:

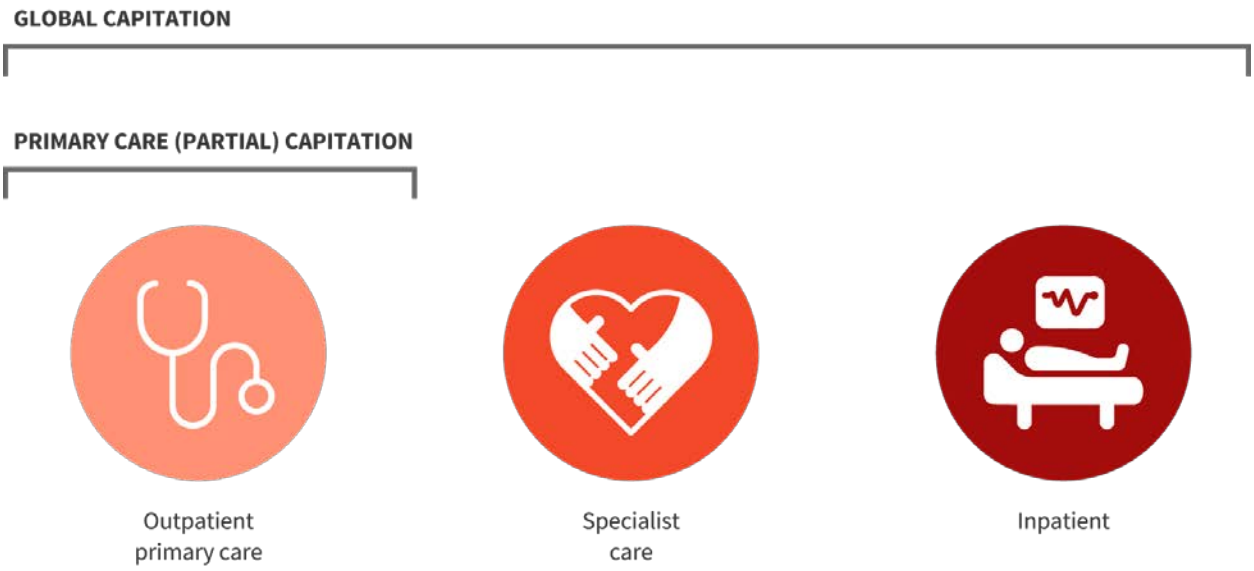
1. Identify panel of patients
2. Define scope of services
3. Practice and the intermediary agree on a fixed payment amount (called the PMPM amount, the per member per month amount)

NUMBER OF PATIENTS	X	PMPM AMOUNT	=	PAYMENT TO PRACTICE
1000 patients		$25		$25,000

If the patient needs services outside the scope of the agreement, like they need to be hospitalized or see a specialist, then the intermediary would pay for that separately.

We sometimes say capitation is the opposite of a fee-for-service system

Prospective payment: Payment amount is determined before any services are provided, and does not change depending on the services.



The scope of capitation can be primary care or can be broader. At the broadest, we have what we call global capitation. Any medical care by any provider or place of service would be covered for that panel of patients.

The capitation rate or the PMPM amount depends on the scope. The PMPM for a broad arrangement like global capitation would be much higher than the amount for narrower, say primary care only, capitation. There is more risk so it is usually only done by larger healthcare organizations

PHYSICIAN PAYMENT MODELS

1. Episode Based Payments
    - Clinical dimension - the set of services or the medical conditions to be included, like fee for service
    - Time dimension - defines the beginning and the end of the episode
    - Each episode means one patient, one medical condition, and one period of time.
2. Salary Model
    - A fixed amount for working for some period of time, a month or a year, and carrying out agreed-upon duties during the time period

RISK IN PHYSICIAN PAYMENT AND MULTI-LAYERED PHYSCIAN PAYMENT ARRANGEMENTS

Physician payment and risk:

- When an intermediary pays a physician practice using capitation, even partial capitation, it can transfer risk from the intermediary to the provider.

- Physician group got a fixed amount of money and have to deal with it, even if they need to deliver a lot of care – which would be a risk.
- In large practices, predicting needs is easier statistically so the risk is less with capitation.

Multi-layered physician payment arrangements:

- **Example 1**: Consider the easiest case of a small practice contracting directly with an intermediary. The intermediary pays the practice directly, probably fee-for-service. Then the physicians in the practice, commonly the owners, would be paid based on the profits of the practice with some method they would devise for sharing those profits among the physicians.
- **Example 2:** Consider a larger group practice. The practice group administration may arrange for payment from the intermediary based on all the collective work of the physicians. This may be fee-for-service, or it may be some sort of capitation arrangement. Then, the group administrators may make separate and different arrangements to pay the individual doctors via salary plus bonuses or based on RVUs.
- **Example 3:** Consider the case of smaller practices that have joined an IPA. The IPA makes a deal with the payer for being paid based on the collective work of all of the participating practices. This might be a capitation arrangement or fee for service. Then once the IPA is paid, it in turn pays the practices according to arrangements between the IPA and the practice. This is probably fee-for-service if they are small practices. The practices then work out how the individual physicians will be compensated, perhaps based on the profits of the practice.

INCENTIVES

Payments based on fee-for-service will tend to create an incentive to do more services or more expensive ones. This ensures all of the things being done are what the patients need. People worry that fee-for-service might create incentives that lead to overuse of care and higher healthcare costs.

Capitation on the other hand goes the other way. Physicians have an incentive to do less for each patient. They have received a fixed payment and will do better financially if they incur fewer costs by providing less care. This might be good – it might incentivize them to seek more cost-effective ways of providing care that they might ignore under fee-for-service.

One might think that salaries are a solution to the fee for service model. Salary models really only work well when physicians are employees in a larger practice.

LESSONS FOR AI AND DATA

- Patients may see a physician in different practices resulting in multiple systems
    - Records and data systems at one practice will not contain a complete record of the care provided to the patient
- Payment systems are a valuable source of data, especially in fee-for-service model
- Different AI tools are needed depending on the size and structure of a physician practice