VIEWPOINT

Designing a Successful Primary Care Physician Capitation Model

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In recent years, public and private payers have been experimenting with new payment methods to drive better care at lower costs, including primary care services. The urgency has been compounded by COVID-19. Over the past 12 months, the pandemic has revealed major weaknesses in a health system built on fee-for-service (FFS) payment tied to face-to-face patient encounters. According to a 2020 survey, more than 80% of 736 primary care physicians (PCPs) surveyed reported finding problems with payment based on volume and extensive documentation.[1] This has left many physicians desiring more financial stability.

As the country progresses past the immediate urgency of COVID-19, the problems of affordability, coverage, patient experience, and quality in the US health system that preceded the pandemic will remain. The question is: Is there an effective and feasible solution?

According to a 1996 definition from the Institute of Medicine, primary care is "the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community."[2] Depending on how they are categorized, PCPs and other primary care clinicians provide more than 40% of all office visits. If redesigned correctly, delivery of effective primary care services should be an effective way of reducing spending. Primary care constitutes less than 10% of total spending[3]; however, it has an important influence on referrals for specialist care, emergency department use, and hospitalization, and a small portion of the cost savings in other parts of the health care system could be used to augment primary care payment.

Primary care capitation is increasingly viewed as a fundamental component of the answer.[4] The Center for Medicare and Medicaid Innovation is rolling out a Primary Care First model that includes monthly per-patient payments, and several health plans have proposed a shift to primary care capitated payments in the wake of the COVID-19 pandemic.[5]

A major challenge to widespread adoption of this shift in payment model are the concerns of many PCPs based on memories of managed care in the 1990s. Physicians were unhappy because capitation was more complicated than FFS, did not give them clinical autonomy, and seemed to reduce their revenue. Many PCPs were thrust into total capitation models but lacked information on spending and patient management processes, which forced some practices out of business, and exacerbated physicians' distrust of payers. Capitation often seemed like another way for payers to reduce payments to PCPs. Payers were unhappy because they perceived physicians responded to capitation by shifting care to specialists, thereby increasing total costs.

Today, primary care capitation constitutes only a small portion of overall payment in specific regions (such as Florida and California) and market segments (Medicare Advantage). But the abrupt decline in revenue induced by COVID-19 has made the benefits of predictable revenue more salient. Based on pandemic experience, 75% of 765 clinicians polled in a March 2021 survey do not believe FFS should account for the majority of primary care payment.[6] Accelerating adoption of capitation will require addressing physicians' legitimate concerns while also allaying payers' concerns that PCPs will reduce access to services without being accountable for outcomes.

Seven Design Elements

One essential feature of payment reform is broad, multipayer participation. Otherwise, not enough of a practice's revenues will be based on the alternative payment, thereby undermining incentives to change workflows and other practices. Seven additional design elements may be important for a successful PCP capitation initiative.[7] To date, no prior PCP capitation initiatives incorporated all of these elements.

First, capitation should increase primary care payments and not be a surreptitious mechanism to reduce payment to PCPs. The base capitated payments should reflect the previous 3 years excluding the COVID-19 period. There should be an increase in payments to reflect the need for PCPs to invest in changing their office practice workflow. The baseline capitation rate may not increase over the contract, but higher PCP payment could be possible through greater bonuses related to improving value through total cost of care and quality.

Similarly, physicians leaving hospital employment to become independent should not see their revenue decline by participating in PCP capitation. The baseline for newly independent PCPs would naturally be higher than network average in the marketplace without creating fee schedule distortions. This should be a gain for PCPs and a gain for payers because it reduces the ability of health systems to use these employment arrangements to lock in referrals for higher-priced specialty and ancillary care.

Second, capitation contracts should be long-term. PCP practices have finely honed their office workflows to FFS payment. To be successful in capitation, PCPs will need to reengineer their workflows to focus on getting patients the care they need without the constraints of FFS billing and documentation. These could include routine telemedicine visits and telephone check-ins; more nurse visits, group visits, and home visits; identification and care management of high-risk patients; and integration of mental health services. Implementing these changes requires substantial investments of time and administrative efforts and may require new staff. These investments will be worthwhile only if PCPs can be assured that they are "the new normal" and not an evanescent demonstration project. Five-year capitation contracts provide that kind of assurance.

Third, PCP capitation should not apply to every service but be used primarily for the most common evaluation and management codes, such as code 99213, for mid-level outpatient office visits for established patients.

Fourth, FFS payments should be maintained for a small number of specific services that are proven to improve quality, access, and costs. Thus, PCPs should be paid FFS for services that achieve these aims, such as immunizations, referral management, patient visits within 7 days of an emergency department visit or hospital discharge, systematic medication holidays to reduce unnecessary polypharmacy, and services that they are qualified to perform, but could be referred at higher cost, such as joint aspiration. In FFS, many of these services are either not paid for or paid very modestly. Paying for these services FFS will help ensure they are performed, but will keep FFS a small portion of PCPs' total revenue.

Fifth, to align the interests of payers and PCPs, capitation should be linked to substantial incentives to improve value by restraining total cost of care and improving quality. Substantial research suggests these incentives need to be salient and timely, constituting at least 20% of total compensation and paid every quarter. More important, the incentives should not be folded in to baseline capitation but be paid separately so physicians "see" how much they have earned by their efforts to restrain costs and improve quality.[8] To make these incentives meaningful, payers will need to share timely and actionable data with PCPs so they can properly manage care and have transparency into the measures for which they are accountable. Physicians in practices with too few patients for reliable cost trending could receive these incentives by participating in an accountable care organization with other practices.

Sixth, PCPs need incentives to engage patients to be assigned to their patient care panels. Capitation changes how physicians "count" patients. Having patients included on a panel even when those patients are not seen in the office still generates payments. This is new for PCPs. They need to be confident that the right patients are attributed to them. This will require that PCPs have visibility and input into the attribution model used; that patient attribution to panels is prospective, not retrospective; that panels are updated monthly or quarterly; and that the PCPs have a mechanism and incentives to enroll patients so they can influence who is attributed to their panel. They also need a mechanism to notify payers if they determine a patient has been erroneously attributed to them.

Seventh, financial considerations should not be the only factor in redefining the payer-PCP relationship. Most PCPs are driven by intrinsic motivations to deliver excellent care and help their patients live healthy lives. Balanced office finances are necessary but not an ultimate goal. PCPs also want respect for their expertise, autonomy to practice the way they think is best, and flexibility over their time. PCP capitation has to fulfill these goals not just in rhetoric, but in action. Capitation will not be able to eliminate coding and claims until quality and utilization reports can be extracted from electronic health records. But PCPs' quality of life and satisfaction with primary care practice can be improved in other ways. PCP capitation can eliminate many aspects of utilization management, such as for imaging studies and referral to specialist care, because PCPs will be financially incentivized to manage these services. Another change might be to eliminate any audits of zero-dollar claims, ie, claims that are not paid but filed for tracking quality and utilization.

Conclusions

COVID-19 has highlighted the problems with the current FFS payment, especially for primary care. At the same time, the pandemic has reinforced the need to move more rapidly to a health system that rewards high-value care. A model that combines primary care capitation with accountability for total cost of care and higher quality could help correct many of the inadequacies of FFS, build on the lessons of earlier experiments in primary care capitation, and accelerate the recent move to value-based payment. The model must overcome 2 major barriers: hesitancy by physicians who are concerned that change will reduce their payment and the substantial effort needed to transform practice workflows. Adopting these 7 design elements could be a path forward to help ensure development of a feasible and successful PCP capitation model.

ARTICLE INFORMATION

Published Online: May 12, 2021. doi:10.1001/jama.2021.5133

Conflict of Interest Disclosures: Dr Emanuel reported receiving personal fees, nonfinancial support, or both from companies, organizations, and professional health care meetings. Dr Emanuel is also a venture partner at Oak HC/FT, a partner at Embedded Healthcare LLC, ReCovery Partners LLC, and COVID-19 Recovery Consulting and an unpaid board member of Village MD and Oncology Analytics. Dr Mostashari reported being CEO of Aledade Inc. Dr Navathe reported receiving grants from Humana, Hawaii Medical Service Association, Anthem Public Policy Institute, Commonwealth Fund, Oscar Health, Cigna Corporation, Robert Wood Johnson Foundation, Donaghue Foundation, Pennsylvania Department of Health, Ochsner Health System, United Healthcare, and Blue Cross Blue Shield of NC, Blue Shield of California; personal fees from Navvis Healthcare, Agathos Inc, Navahealth, YNHHSC/CORE, Maine Health Accountable Care Organization, Maine Department of Health and Human Services, National University Health System-Singapore, Ministry of Health-Singapore, Elsevier Press, Medicare Payment Advisory Commission, Cleveland Clinic, and The Analysis Group; equity from Embedded Healthcare; and other from Integrated Services Inc.

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