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Patient-Centered Payment Needed to Preserve Primary Care

Many patients will lose access to essential healthcare services unless radical reforms are made to the ways Medicare and health insurance plans pay for primary care.

Lebanon NH (August 5, 2021) – Throughout the United States, patients have been receiving notices from primary care clinicians that "the practice is closing" or "payment no longer allows us to provide the services our patients need, therefore we will be charging a monthly fee." In a new article in *JAMA* (the *Journal of the American Medical Association*), "Aligning Payments, Services, and Quality in Primary Care," Dartmouth Emeritus Professors of Medicine John Wasson and Harold Sox and Center for Healthcare Quality and Payment Reform CEO Harold Miller recommend a radical but realistic patient-centered approach to payment and quality assurance that can reverse the threats to the nation's primary care system.

"Everyone agrees that the methods Medicare and health insurance plans currently use to pay for primary care aren't working," said Wasson. "Inadequate payments, administrative burdens, and simplistic performance standards are making it more and more difficult for patients to receive the help they need to successfully manage their health problems. To solve this, we've proposed a patient-centered approach that will align payments with the types and intensity and services patients need, and that will take a big step toward assuring that each patient receives the evidence-based care appropriate for their needs."

Earlier this year, a report on primary care from the National Academies of Sciences, Engineering, and Medicine (NASEM) suggested a reconfigured reimbursement model for primary care, but it stopped short of defining the specifics. The new JAMA article describes the specifics: (1) monthly payments for patients who enroll with the primary care practice for wellness care and chronic disease management, and (2) fees for diagnosis and treatment of new acute problems. "Monthly payments will enable a primary care practice to support a team to deliver wellness and chronic care to patients with much less administrative burden. Payment scaled to the differing needs of patients with acute illness will help to ensure that everyone gets the care they require," said Sox.

NASEM also reported that current methods to measure quality of care are extremely inefficient and largely irrelevant. Wasson recommends the substitution of well-tested methods for quality assurance that put what matters to patients front and center. "Free technologies, like Dartmouth's HowsYourHealth.org, enable primary care practices to regularly ask each patient about the health problems that are of greatest concern to them. The clinician can then use evidence-based guidelines to help deliver services that are most appropriate for that patient, and the patient

would be asked whether the services are addressing their needs. For all practices to improve outcomes while reducing avoidable use of expensive healthcare services, primary care practices would share their approaches to care delivery and patient outcomes with each other."

"Primary care is in deep trouble. We hope that all payers will begin using this approach as quickly as possible," Sox added. "With currently available technology, they could start tomorrow."

About the Authors:

For more than four decades, **John H. Wasson, MD** was a practicing internist and geriatrician. Dr. Wasson has led many programs devoted to the delivery and improvement of primary care including outpatient services at the Veterans Administration, Dartmouth's Centers for Health and Aging, the Dartmouth - Northern New England Primary Care Research Network, and Idealized Office Practices at the Institute for HealthCare Improvement. He received a unique award as the "pioneer for practice-based research" from the Agency for HealthCare Quality and Research. A recent publication summarizes the results of primary care research to assure high quality care for each patient and populations of patients. He oversees the free distribution of www.HowsYourHealth.org for easily placing the mechanisms for the assurance of quality care into routine primary care practice.

Harold C. Sox, MD is a retired general internist, Editor Emeritus of *Annals of Internal Medicine*, and Director of Peer Review at The Patient-Centered Outcomes Research Institute (PCORI). Dr. Sox spent most of his professional life at Stanford University and Geisel School of Medicine at Dartmouth, the latter as chair of the Department of Medicine. He chaired the U.S. Preventive Services Task Force, the Medicare Coverage Advisory Committee, and four Institute of Medicine Study Committees. He was President of the American College of Physicians and is a member of the National Academy of Medicine. His books include *Medical Decision Making*, a standard textbook in this field.

Harold D. Miller is the President and CEO of the Center for Healthcare Quality and Payment Reform (CHQPR), a national policy center. Miller also serves as Adjunct Professor of Public Policy and Management at Carnegie Mellon University. Miller is a nationally-recognized expert and author of over a dozen widely-used reports on health care payment and delivery reform, including *Patient-Centered Payment for Primary Care*. He has given invited testimony to Congress on how to reform healthcare payment, and he has worked in more than 40 states and several foreign countries to help physicians, hospitals, employers, health plans, and government agencies design and implement payment and delivery system reforms. He served for four years as one of the initial members of the federal Physician-Focused Payment Model Technical Advisory Committee that was created by Congress to advise the Secretary of Health and Human Services on the creation of alternative payment models.

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Comparison of Patient-Centered Primary Care Payment to Fee-For-Service, Population-Based Payment (Capitation), and Current "Hybrid" Payment Systems for Primary Care

DIFFERENCE IN PAYMENT AMOUNTS FOR PATIENTS WITH GREATER NEEDS
Patient-Centered Payment vs. Fee-for-Service and Population-Based Payment

Patient Characteristics	Patient-Centered Primary Care Payment	Standard Fee-for-Service (FFS)	Population-Based Payment
Multiple new problems during the year	Higher Payment	Higher Payment	No Change
New chronic condition	Higher Payment	Higher Payment	No Change
Existing chronic condition	Higher Payment	Higher Payment	Higher Payment
Social risk factors affecting health	Higher Payment	No Change	No Change

DIFFERENCE IN PAYMENT AMOUNTS FOR PATIENTS WITH GREATER NEEDS
Patient-Centered Payment vs. CMMI Hybrid Payment Models

Type of Patient Health Problem	Patient-Centered Primary Care Payment	CMMI Comprehensive Primary Care Plus (CPC+)	CMMI Primary Care First
New acute problem	A visit fee is paid; Fee is higher than in current FFS systems; Fee is paid regardless of method used to deliver care. Result: Payment is adequate to support time needed for accurate diagnosis and provides flexibility to customize services based on patient needs.	A visit fee is paid; Fee is the same amount as current FFS; Fee may not be paid unless there is an office visit with a clinician. Result: Practice may not have flexibility to help the patient by phone or by a member of the practice other than a physician or other clinician.	A visit fee is paid; Fee is smaller than current FFS; Fee may not be paid unless there is an office visit with a clinician. Result: Practice may not have adequate time to address a new acute problem or the flexibility to customize services based on needs.
Exacerbation of existing chronic condition	No visit fee is paid; the practice only receives a monthly payment for the patient. Result: No reduction in practice revenue due to effective chronic condition care.	The standard visit fee is paid in addition to a monthly payment. Result: Practice revenue decreases if chronic diseases are managed well.	A small visit fee is paid in addition to a monthly payment. Result: Practice revenue decreases if chronic diseases are managed well.
Newly diagnosed chronic condition	A visit fee is paid to diagnose the problem and the practice begins receiving a new or higher monthly payment immediately. Result: Adequate payment to support proactive management of a new chronic condition.	A visit fee may be paid, but there is no new or higher monthly payment until the following year. Result: Inadequate payment to support proactive management of a new chronic condition	A small visit fee may be paid, but there is no new or higher monthly payment until the following year. Result: Inadequate payment to support proactive management of a new chronic condition

ASSURANCE OF HIGH-QUALITY CARE FOR EACH PATIENT Patient-Centered Payment vs. CMMI Hybrid Payment Models			
Characteristics of High Quality Care	Patient-Centered Primary Care Payment	CMMI Comprehensive Primary Care Plus (CPC+)	CMMI Primary Care First
Proactive identification of patient health problems	The primary care practice is required to contact each enrolled patient regularly to identify whether they are having health problems.	There is no requirement for the primary care practice to proactively contact patients other than those with complex needs.	There is no requirement for the primary care practice to proactively contact patients to identify their needs.
Delivery of evidence-based services	The primary care practice is required to use evidence-based clinical practice guidelines in order to be paid for services to a patient.	There is no requirement for a practice to use evidence-based guidelines in order to be paid for a service; Payments are reduced by a small amount if average performance on a small number of evidence-based quality measures is low.	There is no requirement for a practice to use evidence-based guidelines in order to be paid for a service; Payments are reduced by a small amount if average performance on a very small number of evidence-based quality measures is low.
Ability to customize care to individual patient needs	The primary care clinician can deviate from guidelines when appropriate as long as the reasons are documented in the clinical record.	Quality measures do not allow exceptions, so the primary care practice can be penalized when exceptions to guidelines are appropriate for an individual patient.	Quality measures do not allow exceptions, so the primary care practice can be penalized when exceptions to guidelines are appropriate for an individual patient.
Monitoring outcomes of patient care	The primary care practice is required to contact each enrolled patient regularly to determine whether services are meeting their needs.	There is no requirement for a primary care practice to monitor patient outcomes. Payments may be reduced by a small amount if the practice receives low ratings from those patients who respond to an externally administered patient experience survey.	There is no requirement for a primary care practice to monitor patient outcomes. Payments may be reduced by a small amount if the practice receives low ratings from those patients who respond to an externally administered patient experience survey.

DETAILS OF PAYMENT METHODOLOGY Patient-Centered Payment vs. CMMI Hybrid Payment Models			
Component of Payment Methodology	**Patient-Centered Primary Care Payment**	**CMMI Comprehensive Primary Care Plus (CPC+)**	**CMMI Primary Care First**
Structure of Payment	Combination of monthly payments and fees.	Combination of monthly payments, fees, and performance-based payments.	Combination of monthly payments, fees, and performance-based payments.
Purpose of Monthly Payments	Used to support wellness care and chronic disease management, not acute care.	Used to support all types of evaluation & management services delivered by the practice.	Used to support all types of evaluation & management services delivered by the practice.
Patients Qualifying for Monthly Payments	Patients who enroll with the practice to receive wellness care and chronic condition management.	Patients who are attributed to the practice based on making more office visits to the practice than to other practices.	Patients who are attributed to the practice based on making more office visits to the practice than to other practices.
Adjustment of Monthly Payments Based on Differences in Patient Needs	Higher monthly payment for a patient who has a new or pre-existing chronic condition. Higher monthly payment for a patient with social risk factors.	Higher monthly payment only for a patient who had a chronic condition during the previous year, not for a patient with a newly diagnosed chronic condition. No adjustment in payment based on social risk factors.	Same monthly payment for each patient regardless of the patient's characteristics; higher payments for all patients if the average number of chronic conditions among all attributed patients is higher than average. Monthly payment is reduced if patients make visits to other primary care practices.
Fees for Patient Visits	A fee is paid for diagnosis and treatment of new acute problems. The fee is paid if the service is delivered in the office, by telehealth, or by telephone. The fee amount is higher than current fees in order to pay adequately to address a new problem.	Fees are paid for any office visit, including a visit for an avoidable exacerbation of a chronic disease. There may not be a fee for telehealth services after the end of the public health emergency. Fee amounts are the same as current office visit fees (in Track 1) or 35%-60% of current fees (in Track 2).	A single fee is paid for any office visit, including a visit for an avoidable exacerbation of a chronic disease. There may not be a fee for telehealth services after the end of the public health emergency. The fee amount is much lower than current office visit fees.
Performance-Based Payment	The practice can only receive monthly payments or acute care visit fees for a patient if the practice has delivered evidence-based care to the patient and assessed patient needs and outcomes.	The practice is paid monthly amounts and fees for a patient regardless of the quality of care delivered to that patient. The practice receives a small additional monthly payment if its average performance on a small number of quality measures in the previous year was higher than average for primary care practices.	The practice is paid monthly amounts and fees for a patient regardless of the quality of care delivered to that patient. The practice receives an increase in the monthly payments if its attributed patients are hospitalized at a below-average rate; monthly payments are reduced if the hospitalization rate is high.