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Primary Health Care: Defining, Measuring, and Strengthening: The Role of Payment Reform

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“There are many ways for paying physicians; some are good and some are bad. The three worst are fee-for-service, capitation, and salary.”

-- Jamie Robinson, Milbank Quarterly 2001

Robinson goes on to argue that adopting blended payments can mitigate serious deficiencies in the pure methods

- The NASEM Report calls for a hybrid payment model for primary care, relying on experience from various CMMI demos – CPC, CPC+, PCF.
- Some proponents would go all the way to near total primary care capitation, minimizing the concerns that arose in the '80s and '90s.
  - Perhaps the more recent adoption of risk adjustment and quality measurement can address concerns about stinting on care and risk selection, but not yet demonstrated.
- The NASEM report supports views that a hybrid offers more balanced incentives than do either pure FFS or pure clinician-level, per beneficiary per month (PBPM)
- There is a precedent within the Medicare Physician Fee Schedule (MPFS) for different forms of bundled payments including clinician-level capitation -- with mixed results -- but there remain questions about whether CMS authority permits a full-fledged, hybrid model through MPFS rule-making.
- The Medicare Shared Savings Program, which pays ACO constituent clinicians through the MPFS, offers a potential launch, likely within CMS's existing authority.

Telehealth support should promote adoption

- There is a fundamental mismatch between financing most telehealth and FFS payment.
  - High frequency, low price services should not be paid FFS because the billing costs are too high relative to payment – contributing to the current push to continue pay parity for telehealth services.
  - Coding for telehealth is fairly arbitrary and ever changing as communication technology changes and is "gameable" by providers
  - Reduced patient "time costs" and relative inconvenience of office visits likely would increase FFS volume substantially over time.
- Thus, the policy desire to support telehealth at an acceptable cost implies the need for a hybrid, FFS/PBPM method soon – "to make a virtue of necessity"
- Permanent pay parity, as many groups want, could set back prospects for alternative payment models (APMs)

Hybrid payment design features need to be resolved – they differ in CMMI demos and journal proposals

- A Commonwealth Fund supported study based at the Urban Institute is exploring a number of design choices
  - The desired mix of FFS and PBPM
  - Which services paid under which payment approach?
  - Should clinicians be accountable for total cost of care?
  - How to explicitly address disparities and promote equity
  - What risk adjustment is needed in a hybrid model?
- Despite the need to find consensus on these and other design features, a primary care hybrid model can be adopted expeditiously, given the nearly 10-year experience with CMMI demos and prior history in HMOs, as well as experience in some OECD countries.