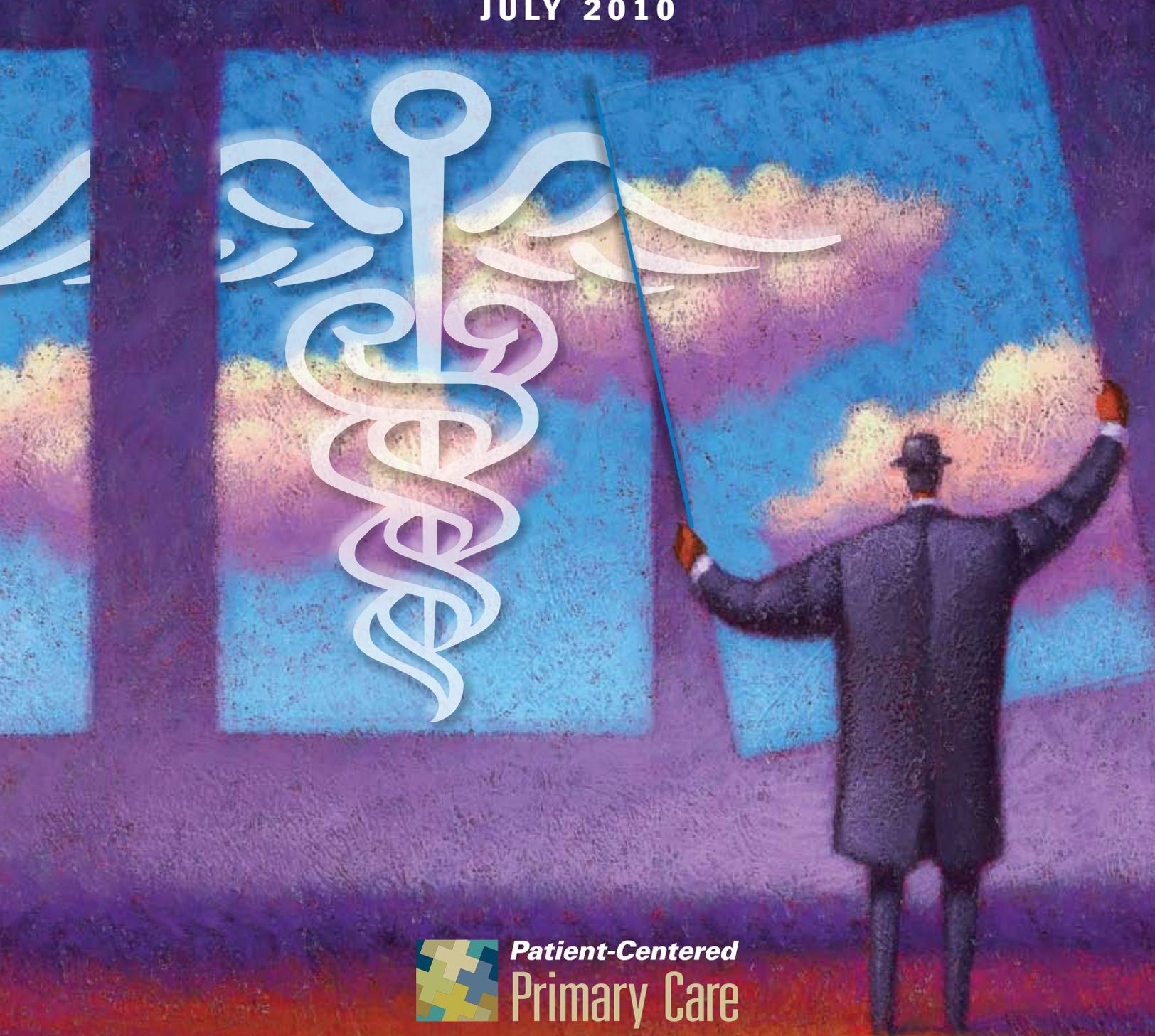


Payment Reform to Support High-Performing Practice

Report of the Payment Reform Task Force

JULY 2010



Patient-Centered
Primary Care

COLLABORATIVE

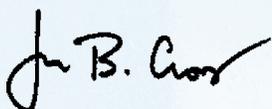
Dear Colleagues:

The Patient-Centered Primary Care Collaborative (PCPCC) was born of a realization among large employers that U.S. health care fails to deliver comprehensive primary care because of the way primary care is financed. Primary care is the only entity charged with the longitudinal care of the whole patient, and it is the primary care relationship that has the most profound effect on health care outcomes. The idea was shaped further when the term “patient-centered medical home” was coined and took root with a number of large employers and primary care physician organizations. Thus, the PCPCC was established to (1) facilitate improvements in patient-physician relations, and (2) create a more effective and efficient model of health care delivery. To achieve these goals, the PCPCC has become one of the major developers and advocates of the patient centered medical home (PCMH) model in America.

Dozens of PCMH demonstration projects across the country are exploring ways to implement better care coordination, meaningful use of health information technology, better communication access between patients and providers and a team approach to care. But efforts to transform health care delivery depend heavily on introducing sustainable new models to finance the PCMH. Without changing the way health care is purchased, providers will have no incentive to move away from a system that promotes health care volume to one that rewards health care value.

This report by the PCPCC’s Payment Reform Task Force reviews the spectrum of payment models currently being used to support PCMH implementation. By focusing on payment reform, its goal is to help guide those interested in financially sustaining the PCMH model. The Task Force examined representative payment reform models and, in doing so, also derived a set of basic payment principles and guidelines. This is yeoman’s work, and we are indebted to the efforts of this task force and the expertise they brought to the project.

It is important to note that this work is not final; like the PCMH itself, payment models are still in the development stage and evaluations of their effectiveness will likely shed more light on the topic. Our hope is that this report will shed significant light on the payment reform proposals in current use and on the horizon, and that readers will find the evaluations and recommendations valuable to their pursuit of patient-centered, high-value care for all.



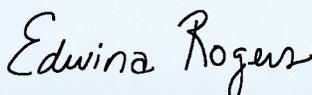
John Crosby, Esq.

PCPCC Chair and Executive Director of the American Osteopathic Association



Paul Grundy, MD

Global Director of Healthcare Transformation, IBM and PCPCC President



Edwina Rogers, Esq.

Executive Director, PCPCC

Acknowledgments

This report represents the work of the PCPCC Payment Reform Task Force, a diverse group of PCPCC stakeholders and collaborators interested in exploring payment reform as a means of supporting the PCMH and transforming primary care in the United States. The PCPCC would like to thank the following authors for their contributions:

Allan H. Goroll, MD, Chair

SECTION CONTRIBUTORS:

Bruce Bagley, MD,

Marjorie Harbrecht, MD

Neil Kirschner, PhD

Nandan Kenkeremath, JD

This work represents the devoted efforts of a large number of people who participated over six months in weekly conference calls, e-mails, and telephone conversations to make important contributions to the PCPCC Payment Reform Task Force's discussions and deliberations.

PCPCC would like to gratefully acknowledge the contributions of the following individuals:

Arlene Ash, Ph.D., University of Massachusetts

Bruce Bagley, MD, American Academy of Family Physicians

Michael Barr, MD, MBA, FACP, American College of Physicians

Sally Bleeks, RN, Blue Cross Blue Shield of America

Francois DeBrantes, MS, MBA, Prometheus

Robert Doherty, American College of Physicians

Marjorie Harbrecht, MD, Colorado Guidelines Collaborative

Katherine Capps, Health2 Resources

Nandan Kenkeremath, JD, Leading Edge Policy & Strategy, Cogon Strategy, Policy, and Relations

Neil Kirschner, Ph.D., American College of Physicians

Donald Liss, MD, FACP, Aetna

Thomas Long, MD, American Academy of Pediatrics

Meredith Rosenthal, Ph.D., Harvard School of Public Health

Dana Safran, Sc.D, Blue Cross Blue Shield of Massachusetts

Karen Sanders, American Psychiatric Association

Foong-Khwan Sieu, Ph.D., MBA, Collaborative Care Solutions

Louis Terranova, MHA, American Academy of Pediatrics

Thanks go to **Relja Ugrinic** of the PCPCC for outstanding administrative support of the task force.

Contents

Acknowledgments 2

Executive Summary 4

Introduction..... 6

Methodology 7

Consultation on Piloting of Payment Reform 7

Criteria for Evaluating Payment Reform Proposals 8

Reviews of Specific Payment Reform Proposals 9

 Fee-for-Service + Management Fee + Pay-for-Performance Model 9

 Prometheus Evidence-Informed Case Rate Model..... 11

 Risk-Adjusted Comprehensive Payment and Bonus Model..... 15

 Accountable Care Organization Model..... 18

Selecting a Payment System for the PCMH: Principles and Guidelines..... 22

Future Task Force Work and Unaddressed Issues 24

References and Resources 24



Executive Summary

Charges to the Task Force

1. Provide policy guidance to the Patient-Centered Primary Care Collaborative Board of Directors on promoting payment reform in support of the patient-centered medical home (PCMH).
2. Provide guidance and recommendations to stakeholders on payment reforms to support their PCMH implementation efforts.

Recommendations on Promoting PCMH Payment Reform

- ❖ Many different payment reform models for the PCMH should be piloted and evaluated.
- ❖ PCMH payment piloting efforts in a primary care practice should include as many payers and patients as possible because the PCMH is intended for all patients.
- ❖ Medicare and Medicaid should participate in multipayer piloting efforts to help promote the payment reform effort through public-private partnerships.
- ❖ Fast-track piloting should be undertaken rather than demonstrations.

Guiding Principles and Recommendations on PCMH Payment Reform

- ❖ Payment reform is essential to the establishment and sustained operation of the PCMH, especially practice transformation and desired outcomes in patient experience, cost, quality, efficiency, patient safety, and professional satisfaction.
- ❖ No one payment system is universally best for the PCMH. One's choice of a payment reform approach should be based on assessment of its ability to foster key PCMH objectives and outcomes, taking into account the local patient population, practice environment and culture, financial needs, and commitment to change.
- ❖ A blended strategy to payment reform can help minimize the shortcomings associated with any single-method approach.
- ❖ Pay-for-performance and bundled or global approaches to payment should be risk adjusted to minimize actuarial risk and the shunning of complex or difficult patients; risk adjustment should incorporate psychosocial as well as biomedical factors.
- ❖ Pay-for-performance should, to the extent possible, be based on evidence and focused on outcomes, complemented by carefully chosen and thoughtfully applied process and system measures, especially in the early phases of implementation. Payment for desired outcomes and processes of care should foster accountability and transparency in cost, quality, and patient experience.
- ❖ Bonus payments funded from cost savings, as with many models that rely on shared savings, have the risk of ratcheting down over time as wasteful and avoidable spending decreases. A portion of shared savings and bonus payments should be folded into the base payment over time to avoid reductions in total pay.

- ❖ PCMH sustainability is proportional to the penetration of payment reform in the practice and its ability to fund the initial building and maintenance of the PCMH infrastructure and services. A substantial majority of the practice population needs to be covered by the payment reform for the PCMH to be sustained, often necessitating multipayer participation.
- ❖ Payment reform should correct existing imbalances and distortions in physician payment and take into account value created by primary care, especially in the areas of cost, quality, care coordination, access, and patient centeredness.
- ❖ Payment reform should improve the practice environment and enhance the professional satisfaction and attractiveness of a career in primary care.
- ❖ Payment reform should encourage patient-centered, coordinated care by all providers, not just those inside the PCMH.
- ❖ Payment reform models and proposals should be widely piloted, systematically evaluated, and, for those shown to be effective, rapidly promulgated.
- ❖ Administrative practicality is desirable, if not essential (although the transition may require considerable effort).
- ❖ Payment models that achieve validation through piloting should be offered to practices by all payers, allowing each practice, group, or network to choose a single approach to payment that works best. This would greatly simplify administrative burdens, provide a consistent set of incentives, and allow concentration of effort on achieving universally desired outcomes.



Introduction

At the heart of the U.S. crisis in primary care sits a dysfunctional payment system for health care services.¹ It richly rewards expensive procedures and grossly underpays for evaluation and management (E&M) services. It incents high volumes of high-cost care and largely ignores considerations of value. Although designed more than two decades ago to correct the imbalances in reimbursement between procedures and E&M services, it has come to exacerbate them. Causes for this paradoxical outcome include the exponential growth of medical technologies (especially in imaging and interventional procedures) and the growing influence and market power of procedural specialties. Physicians who earn a living by taking a history, performing a physical examination, formulating a differential diagnosis, designing a plan of testing and treatment, counseling, educating, and coordinating care (be they primary care physicians or nonprocedural specialists) find themselves at the bottom of the medical food chain, unable to afford the teams and information management infrastructure that define modern, high-performance practice. Instead they work in a “hamster-wheel” practice environment, trying to make up what they lose on each patient by increasing the volume of patients they see. The consequences include demoralized physicians and staffs, unhappy patients, and a shunning of careers in primary care by the current generation of young physicians and other health care professionals. Access to high-quality primary care is becoming increasingly problematic in many parts of the country.

Ironically, this sorry state of affairs is occurring at the very time there is growing recognition of the value of primary care, a field increasingly recognized as essential to the successful functioning of a modern health care delivery system. Available data show that when primary care is available, per capita health care expenditures are lower, health outcomes are better, and disparities in care are fewer.² This recognition has triggered a nascent renaissance in primary care, stimulating new ideas about the organization and delivery of primary care and culminating in a national redesign effort often referred to as the patient-centered medical home (PCMH).³

Despite garnering considerable enthusiasm from a wide spectrum of health care stakeholders, the PCMH transformation has gotten off to a relatively slow start, impeded in part by the lack of funding available to transform primary care practices. Even demonstrations and piloting efforts have been modest. In an environment in which most health care purchasers believe they already spend too much for health care and cannot fathom paying still more, finding the dollars to support the necessary net investment in primary care continues to be problematic and progress toward large-scale implementation remains modest. Despite initial data from piloting efforts that suggest major cost savings and quality improvements are achievable,⁴ there are no obvious sources of new funds under the current system that dominates health care payment in the United States.

The recognition that the existing payment system cannot adequately support primary care yet engenders wasteful spending on unnecessary procedures (estimates run as high as 30 percent⁵) has stimulated national interest in major payment reform for medical services. The Payment Reform Task Force of the Patient-Centered Primary Care Collaborative (PCPCC) was established to provide information and guidance to the PCPCC Board or Directors and the stakeholder community on payment reform and its impact on support of the PCMH.

This report represents the work of the PCPCC Payment Reform Task Force, a diverse group of PCPCC stakeholders and collaborators interested in exploring payment reform as a means of supporting the PCMH and transforming primary care in the United States. Many other organizations are examining payment reform proposals; the PCPCC task force is focusing on them from the unique perspective of their impact on the PCMH. As in politics, all health care is local, so the task force’s goal was not to identify the best payment reform proposal, but rather to point out the strengths and shortcomings of various approaches to payment reform so that PCMH advocates could choose the type of model that best suits their needs and circumstances. A subset of available models, representing the spectrum of approaches from fee-for-service to global capitation, was chosen for review.

Methodology

Membership in the task force was open to all PCPCC stakeholders, with a core group composed of PCPCC Center leadership. Weekly conference calls were held from October 2009 to March 2010. Average participation was about 20 people. At the outset, the task force provided a consultation to the PCPCC board on its recommended position on piloting the PCMH and payment mechanisms to support it.

The authors of each payment reform model chosen for review (representing the spectrum of available approaches) were invited to the task force's weekly calls to present their ideas. The group then established a set of criteria for reviewing these payment reform proposals, with an emphasis on how each proposal addressed and supported the PCMH goals. Using these criteria, members reviewed each model under consideration, often contacting the authors and participants involved in piloting their models. Finally, the group established a set of working payment reform principles designed to help stakeholders in their implementation and sustained operation of the PCMH.

Consultation on Piloting of Payment Reform

At the outset of the group's work, the issue of piloting payment reform came to the fore because of its consideration in federal health system reform legislation. The task force discussed the issue and released a consensus recommendation to the PCPCC board. It contained the following key elements:

- ❖ Many different payment reform models should be piloted and evaluated for the PCMH.
- ❖ PCMH payment piloting efforts in a primary care practice should include as many payers and patients as possible because the PCMH is intended for all patients.
- ❖ Medicare and Medicaid should participate in multipayer piloting efforts to help promote the payment reform effort.
- ❖ Fast-track piloting should be undertaken rather than demonstrations.

The recommendations were adopted and incorporated into PCPCC advocacy efforts.



Criteria for Evaluating Payment Reform Proposals

Criteria were established by consensus to provide a systematic approach to reviewing payment reform proposals, with particular emphasis on how they relate to implementing and sustaining the PCMH. These included the following:

1. How well does the proposal encourage and reward high-value, patient-centered care?
 - a. Incent quality and enhance patient safety?
 - b. Foster efficiency and cost-effectiveness (e.g., through use of evidence-based medicine and decision support tools)?
 - c. Improve access (e.g., through establishment of new portals for care, improved scheduling, and provision of necessary support to enable taking on new patients without regard to medical complexity or psychosocial determinants of health)?
 - d. Engage patients and families as partners in care (e.g., through formulation of care plans, use of shared decision making, and implementation of self-management approaches)?
 - e. Provide for comprehensiveness of care (including resources for behavioral health)?
2. How well does it foster coordination and continuity by the PCMH?
3. How well does it support practice innovation and transformation (e.g., to establish teams and implement health information technology)?
4. How well does it ensure sustainability of the PCMH over the long term?
5. How well does it improve the practice environment and reward primary care physicians proportionately for the value they create (reducing current payment disparities)?
6. How practical and implementable is the proposal (including for health plans and small practices)?
7. How acceptable and valid are the payment and reporting systems to stakeholders?
 - a. Physicians and other health professionals?
 - b. Payers?
 - c. Purchasers?
 - d. Patients and families?
8. How well does the proposal incent cooperation, coordination, and cost-effectiveness among all providers, including specialists and hospitals?
9. What are the challenges to implementing this model?

Reviews of Specific Payment Reform Proposals

■ Fee-for-Service + Management Fee + Pay for Performance Model^{1,6}

Description

This blended-payment model has three components: 1) fee-for-service based on Medicare's resource-based relative-value scale (RBRVS); 2) a care management fee, often adjusted for panel severity and level of medical home services provided; and 3) performance-based payment, commonly referred to as pay-for-performance (P4P). Its implementation is typified by the Colorado Multipayer, Multistate Patient-Centered Medical Home Pilot, which served as the basis for this review (although some elements, such as severity adjustment and elements of P4P, have not yet been fully implemented). The pilot retains the participating provider's existing fee-for-service contract and adds to it a per-member-per-month (PMPM) care management fee, paid by each participating plan for its insured patients in the practice. The management fee was determined by estimating the cost of establishing a PCMH, which in turn was informed by actuarial analysis and a look at other national pilots. The care management fee is intended to proactively help practices build their infrastructure and transform. It includes payment for coordination services not covered in the usual office visit fee, such as nonvisit time spent on coordinating care with family caregivers and other clinicians, as well as other PCMH activities not addressed under the RBRVS.

(NOTE: the American Medical Association's RBRVS Update Committee constructed a recommended risk-adjusted PMPM patient management fee for one of Medicare's PCMH demonstrations that also adjusts for meaningful use of key health information technology).

The Colorado P4P component has not been finalized, but it is expected to be based on nationally validated consensus measures of process and outcome (e.g., Healthcare Effectiveness Data and Information Set (HEDIS) measures, plus others pertinent to the PCMH) along with results from patient satisfaction surveys. It is estimated that the amounts paid under P4P will be less than the management fees. To participate in this pilot and receive PMPM payments, practices must be recognized by the National Committee for Quality Assurance (NCQA) Physician Practice Connections–Patient-Centered Medical Home™ program for at least Level 1. To receive P4P payments, practices must reach specific targets for process and outcome measures in cost and quality.

Evaluation

Overview

The blended approach used in this model has the potential to moderate the adverse effects of pure fee-for-service payment by supplementing it with a management fee and P4P to support provision of PCMH services and encourage achievement of desired outcomes in cost, quality, and patient experience. However, to have the intended beneficial effects, these additional elements need to be of sufficient magnitude compared to the fee-for-service component. Improvements in quality, patient safety, coordination, and other positive activities and outcomes might still occur without substantial P4P (especially if participating practitioners are highly motivated). However, it is hard to see how this commitment to outcomes will be sustained unless the standards for receiving the management fee are very high or P4P is made a substantial part of total payment. In many pilots, like in the Colorado demonstration, practices receive the PMPM management fee after meeting certain medical home operational standards (such as those specified by NCQA), which can be a major factor in driving quality, safety, and coordination.

Beyond piloting, the need for substantial monies for the management fee and P4P begs the question of their funding. In an environment where new monies are scarce, these funds ultimately will have to come from sharing in the savings that derive from the PCMH implementation. Up-front funding of the initial practice transformation will need to be based on expected savings, which should be provided by data from pilots such as the Colorado initiative.

One advantage of this model is its evolutionary nature, maintaining systems that are in place and adding only a management fee plus enhanced P4P. This practical advantage is also its potential downfall, because it maintains the very RBRVS-based fee-for-service system that has been blamed for the current demise of primary care. Whether the tempering features of this blended model will be enough to overcome the adverse effects of fee-for-service remains to be determined.

Criteria-Based Review*

1. How well does the proposal encourage and reward high-value, patient-centered care?

- a. **Incent quality and enhance patient safety?** It depends on P4P, participation standards, and adequacy of the management fee.
- b. **Foster efficiency and cost-effectiveness** (e.g., through use of evidence-based medicine and decision support tools)? It depends on the amount of P4P and participation standards; the management fee may provide for funding of the necessary information technology.
- c. **Improve access** (e.g., through establishment of new portals for care, improved scheduling, and provision of necessary support to enable taking on new patients without regard to medical complexity or psychosocial determinants of health)? It depends on the magnitude of the management fee and the robustness of its risk adjustment.
- d. **Engage patients and families as partners in care** (e.g., through formulation of care plans and use of shared decision making)? It depends on how adequate the care management payment is and whether P4P rewards such activities.
- e. **Provide for comprehensiveness of care** (including resources for behavioral health)? This is unclear; it still depends on RBRVS, which is deficient, perhaps aided by the management fee.

2. How well does it foster coordination and continuity by the PCMH? Potentially, it does it quite well by specifically providing a management fee for care coordination, especially if it is adequately risk adjusted.

3. How well does it support practice innovation and transformation (e.g., to establish teams and implement health information technology)? Potentially, it does it well through the management fee, particularly when supplemented by practices joining in learning collaboratives and taking advantage of on-site quality improvement coaching.

4. How well does it ensure sustainability of the PCMH over the long term? This is unclear; it depends on how much cost savings emerge to share as well as the sustained adequacy of the management fee and P4P payments.

5. How well does it improve the practice environment and reward primary care physicians proportionately for the value they create (reducing current payment disparities)? It does not do it particularly well if, by retaining current RBRVS fee-for-service payment as the core component of compensation, the emphasis on volume persists, but the environment could improve with a substantial risk-adjusted care management fee and financially meaningful P4P.

6. How practical and implementable is the proposal (including for small practices)? It is very practical because it is simply added to the current payment system, but its preservation of the problematic and administratively burdensome RBRVS system maintains many of its disadvantages.

*Based on qualitative review and comments from participants in the Colorado PCMH demonstration

7. How acceptable and valid are the payment and reporting systems to stakeholders?

- a. **Physicians and other health professionals?** It depends on their knowledge and attitudes about fee-for-service, performance-based compensation, the cost structure of their practice, and the relative percentages of the different components of this blended package.
- b. **Payers?** It is probably acceptable as the most easily adopted of blended models, but it is not as simple as enhancing a fee-for-service payment schedule.
- c. **Purchasers?** It depends on its ability to produce cost savings.
- d. **Patients and families?** It depends on its ability to improve the care experience. If fee-for-service remains the main source of revenue, there may be little improvement, but if the management fee is substantial and P4P is large enough, the care experience may improve.

8. How well does the proposal incent cooperation, coordination, and cost-effectiveness among all providers, including specialists and hospitals?

There is no impact per se; it requires use in combination with another payment mechanism that incepts such behavior.

9. What are the challenges to implementing this model?

The greatest challenges are developing and implementing validated, risk-adjusted care management fees and performance-based payments; both are essential to providing adequate monies for practice transformation and support of the PCMH team and infrastructure. If they are insufficient, there will be little to counter the volume imperative that now predominates in primary care practice and little incentive to improve outcomes.

■ Prometheus Evidence-Informed Case Rate Model⁷

Description

This payment model, developed by the nonprofit Prometheus Inc., establishes payment or case rates for the treatment of specific conditions based on the cost of all services, pharmaceuticals, tests, equipment, etc., needed to treat the condition following agreed-on evidence-based clinical practice guidelines (where available) or expert opinion. The cost of avoidable complications is also built into the model. The developers of this payment method establish the case rates through review of claims data, best evidence in the scientific literature, and expert consultation.

The evidence-informed case rate (ECR) designates payment by diagnosis for an episode of care, or the ECR takes the form of a yearly rate for chronic conditions. The cost accounting for the case rates is developed from claims data and takes into account resource use, reflecting the minimum level of service for typical care, regional variation, and the inclusion of a reasonable profit margin (e.g., 10 percent) for the provider. The ECR also includes a severity adjustment and a margin for potentially avoidable complications (PACs), costs that are under the professional's control and could be avoided through the use of best practices. It has been estimated that 40 percent of the costs related to six common chronic medical conditions fall into this PAC category. Current pilots include 50 percent of the PAC costs in the ECR budget.

Typically, the amounts included in these ECR budgets are significantly higher than a physician's current claim billings because the ECR rate includes the PAC component. Practices that can minimize the occurrence of PACs through better care and care coordination are eligible for a bonus based on the difference between the derived, budgeted ECR rate and the actual cost of care (fee-for-service claims billed) for the episode. The amount of the bonus the practice receives also depends on its performance on a quality scorecard containing recognized structural, process, and outcome measures (e.g., such as those identified by the Centers for Medicare & Medicaid Services (CMS) Physician Quality Reporting program, National Quality Forum, and AQA Alliance).

The case rate is not limited to the cost of care delivered by ambulatory providers, but also includes cost contributions from all aspects of the health care system (e.g., primary care provider, specialists, hospital care). The Prometheus model allocates costs as required. The resultant savings through reduced occurrence of PACs can be distributed to all providers involved in the care episode, based on either an agreed-on formula or a function of the provider’s involvement in the care (e.g., percentage of E&M claims).

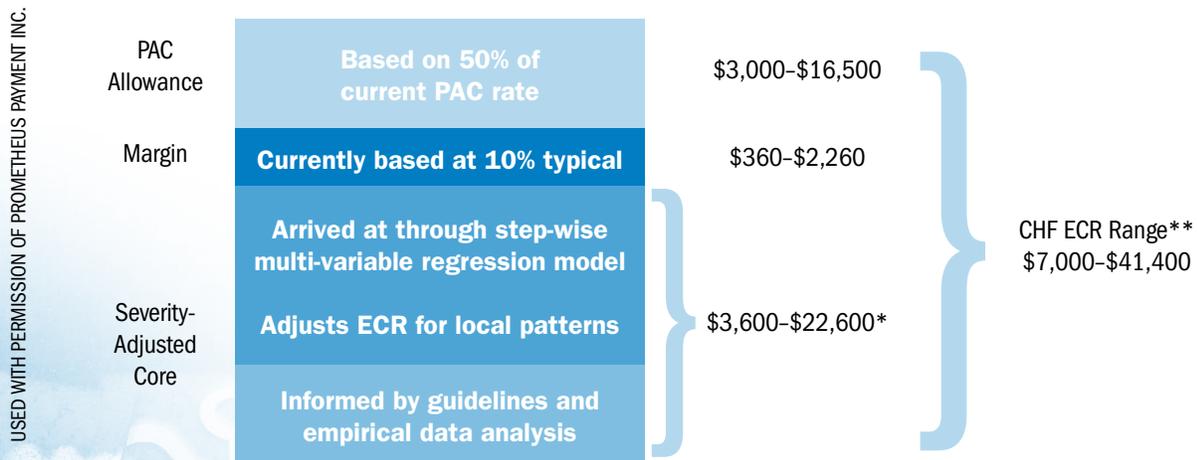
ECRs have been developed for the following conditions:

- ❖ **Chronic medical conditions:** diabetes, asthma, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), coronary artery disease (CAD), hypertension, and gastroesophageal reflux disease (GERD)
- ❖ **Acute medical conditions:** acute myocardial infarction (AMI), stroke, and pneumonia
- ❖ **Inpatient procedures:** hip replacement, knee replacement, coronary artery bypass graft (CABG), and bariatric surgery

An additional 50 to 60 ECRs are scheduled for development over the next three years. The Prometheus developers estimate that ECRs eventually can be developed to cover from one-half to two-thirds of health care expenditures. Pilot demonstrations involving the initial set of conditions for which case rates have been developed are being implemented in Rockford, Illinois; Minneapolis, Minnesota; Grand Rapids, Michigan; and southeastern Pennsylvania.

This payment model has been adapted to help transform primary care practices into medical homes by concentrating on case rates for chronic conditions, requiring participation by primary care practices only, and providing an advance against future expected savings. Under it, practices continue to bill on a fee-for-service basis, but at the end of the year a retrospective reconciliation process occurs that entails the following components:

Total ECR Price = Type of Services x Frequency x Price per Service



*\$2,300 was added to the base set of claims-based/observed services to create a right-sized evidence-informed set of services.
 **The upper range can be greater than the amount stated depending on the severity of the patient.

PAC = potentially avoidable complication **ECR** = evidence-informed case rate **CHF** = congestive heart failure

Figure 1. Example of the determination of an evidence-informed case rate.

- ❖ **Fee-for-service component:** This is only for those services related to routine prevention; nonemergent, nonchronic sick care; and care for conditions for which ECRs have not been established.
- ❖ **ECR-related bonus:** Claims for all services covered by an ECR will be accumulated and compared to the amount that would be paid under an ECR payment budget. The practice becomes eligible for a bonus to the extent that claim payments are less than the budgeted ECR amount. Generally, this bonus is a result of reduced avoidable complications, but it also may include savings derived from providing the evidence-informed care in an efficient manner. The amount of the bonus actually received is also a function of quality performance.
- ❖ **Advance against future reductions in PACs:** A PMPM payment would be advanced against future bonuses obtainable through the year-end reconciliation process. These advances are negotiated between the payer and the practices and generally reflect the practice's claims history. The monthly payments could assist practices, especially small practices, in making necessary practice transformations. Practices would not be liable for payback of any negotiated advance payments if their earned bonus does not cover the advances for a given year, decreasing practice risk while providing an incentive for the payer to support and encourage practice quality and efficiency efforts.

Evaluation

Overview

This model, grounded on evidence-based care, attempts to move toward a system of value-based payment. Its proposal to provide primary care practices with a no-risk prospective payment for anticipated savings provides a potentially important source of funds for practice transformation (a type of prospective shared savings). The broader application of the model to all providers has the potential to engage all in the value-creating effort. Its preservation of fee-for-service billing helps minimize administrative disruptions, but it also preserves some of the incentive to maximize volume. The use of risk adjustment is an important component in determining potentially avoidable complications. The emphasis on reducing avoidable complications and the inclusion of a quality link to the bonus should help improve quality and safety.

The Prometheus system also entails some Promethean challenges. A principal challenge is the cost and complexity of specifying and keeping current the case rates, because the evidence for best practices is a continuously moving target and many diagnoses must be addressed. Moreover, most older patients present with multiple diagnoses, which further complicates the analytic task. Defining best practices for a single diagnosis or problem can be daunting; doing so when there are several active problems that can interact with one another multiplies the degree of difficulty. Risk adjustment can be similarly complicated (see the comments on risk adjustment in the next model), and accurate coding of diagnoses becomes extremely important.

Another challenge is the no-risk prospective payment as an initial source of funds for primary care practice transformation. As now structured, it is unclear how much payers will be willing to risk in providing an initial no-risk prospective payment to practices. In at least one demonstration project (Rockford, Illinois), the participating primary care practices receive no prospective payments. In theory, because the ECR budget is typically much higher than the level of claims most practices now generate, most practices should be able to qualify for at least some initial prospective payment negotiated with the payer to help transform the practice, but how this plays out in actual, everyday contracting remains to be seen. Also, as with many models that rely essentially on shared savings, the risk is that the bonus would ratchet down over time as the expected complication rate falls.

As noted, maintaining fee-for-service can help minimize the stress of culture change in the practice, but doing so sustains the incentive to maximize visit volume with its litany of potentially adverse consequences. How this will be modulated by the model is unclear.

Criteria-Based Review

1. **How well does the proposal encourage and reward high-value, patient-centered care?**
 - a. **Incent quality and enhance patient safety?** Theoretically, it does it very well by its emphasis on best practices and limiting avoidable complications. Also, quality is directly driven by linking a significant bonus to the practice's performance on a set of structural, process, and outcome quality measures.
 - b. **Foster efficiency and cost-effectiveness** (e.g., through use of evidence-based medicine and decision support tools)? It does it very well by its focus on best practices and associated cost savings and by holding all providers accountable.
 - c. **Improve access** (e.g., through establishment of new portals for care, improved scheduling, and provision of necessary support to enable taking on new patients without regard to medical complexity or psychosocial determinants of health)? This is unclear; certainly retention of fee-for-service encourages visit volume, and the bonus may provide for enhanced services but no specific ensuring of improved access.
 - d. **Engage patients and families as partners in care** (e.g., through formulation of care plans and use of shared decision making)? This is not specifically addressed, but it may be indirectly incentivized by the model's provision for incentive bonuses for patient-centered care.
 - e. **Provide for comprehensiveness of care** (including resources for behavioral health)? This is unclear; it still depends on RBRVS, but is helped by the bonus and advance payment.
2. **How well does it foster coordination and continuity by the PCMH?** Potentially, it does it very well by strongly incenting coordination among all providers.
3. **How well does it support practice innovation and transformation** (e.g., to establish teams and implement health information technology)? Potentially, it does it well, but it depends on the model's ability to provide initial practice transformation funds through the prospective payment component.
4. **How well does it ensure sustainability of the PCMH over the long term?** Potentially, it does it well, especially in the early years, but there is a risk the bonus will ratchet down over time.
5. **How well does it improve the practice environment and reward primary care physicians proportionately for the value they create** (reducing current payment disparities)? This is unclear, especially since fee-for-service payment remains a core component of compensation, but it could improve the environment by increased payment through access to a substantial bonus (including a prospective component) based on the savings compared to the ECR budgets.
6. **How practical and implementable is the proposal** (including for small practices)? On one level, it is very practical because it involves no change in billing practices, but coding needs to be improved and the system is very complex and potentially expensive to implement and sustain.
7. **How acceptable and valid are the payment and reporting systems to stakeholders?**
 - a. **Physicians and other health professionals?** It depends on what they think of continuing under fee-for-service payment and their experience with qualifying for the bonus; the no-risk prospective bonus payment will be much appreciated.
 - b. **Payers?** This is unclear; some elements are very simple to implement, while others are potentially very expensive.
 - c. **Purchasers?** It depends on its ability to produce cost savings; the emphasis on paying for best practices and reductions in avoidable complications should be appealing.
 - d. **Patients and families?** It depends on its ability to improve the care experience; the emphasis on efforts to reduce avoidable complications and the inclusion of a quality link to the bonus have the potential to improve the patient and family experience.

8. **How well does the proposal incent cooperation, coordination, and cost-effectiveness among all providers, including specialists and hospitals?** It does it extremely well; it is a major strength of the system's episode-based component and potentially for chronic care as well.
9. **What are the challenges to implementing this model?** As discussed earlier, the main challenges are related to determining the ECR price for each condition because it entails identifying best practices and continuously updating the determination for a large number of conditions. This can be both expensive and time consuming. Another challenge is to get all providers sharing in the payment to agree to its rules and rationale, especially rules assigning responsibility for care and share of payment.

■ Risk-Adjusted Comprehensive Payment and Bonus Model⁸

Description

This model seeks to better align payment with desired outcomes by providing a risk-adjusted comprehensive payment in return for provision of comprehensive, coordinated, personalized care. More specifically, it replaces volume-based, fee-for-service reimbursement with a yearly per-patient risk-adjusted comprehensive payment paid monthly for all physician and team services. The attempt is to counter the prevalent “hamster-wheel” environment of underfunded fee-for-service primary care practice with a payment model that removes volume from the payment equation and includes new monies for transforming and enhancing patient-centered care (e.g., for a multidisciplinary team and robust application of information technology). It rewards desired outcomes with a substantial (up to 25 percent) risk-adjusted bonus for achievements in quality, cost, and patient experience. The risk-adjustment and bonus components serve to counter the tendencies under capitation to cherry-pick patients and underutilize services. As with all of these payment reform models, participation requires commitment to practice transformation and ultimate PCMH recognition.

Practices receive a monthly risk-adjusted comprehensive payment for each patient (PMPM) under their care. The risk-adjustment methodology uses a validated actuarial model that predicts a patient's need for primary care services and provides a relative risk score based on demographics and billing diagnoses. It takes into account both medical and psychosocial factors and is updated periodically. Initial iterations have been based on billing diagnoses, but later versions will be based on the problem list obtained from the electronic medical record.

Over two-thirds of the practice's payments go to support its multidisciplinary team and information technology infrastructure (Table 1, see next page). The bonus is paid periodically, also on a risk-adjusted basis, and is added to the comprehensive payment for meeting mutually agreed-on, evidence-based performance benchmarks in cost, quality, and patient-centered care. Payments for hospital and specialist services, medications, laboratory tests, imaging studies, and other ancillary services continue to be paid as before, but appropriate ordering of such services by the primary care practice is promoted through evidence-based efficiency/effectiveness and quality targets for cost and quality bonuses.

In this model, practices and payers negotiate the PMPM. The risk-adjustment and bonus components help rightsize the practice's panel and staffing. If practices intentionally understate their expected resource needs, they risk their performance bonus by not having enough staff and other resources in place to improve care. If they overestimate, they may not get the contract because their expenses seem too high. Practices that are most cost-efficient in achieving the desired outcomes will do best. Small practices just starting the transformation process might need expert assistance to help them determine staffing and infrastructure needs.

Table 1. Sample allocation formula for risk-adjusted comprehensive payment and bonus model. *

25%	Physician payment for all primary care physician services rendered, including inpatient, outpatient, home, and extended care facility (payment is risk- and needs-adjusted to properly compensate for estimated work load)																
60%	Staff, fringe, rent, and office expense (assumes hiring of multidisciplinary office team charged with timely delivery of personalized comprehensive care and payment is risk- and needs-adjusted to ensure proper team size): <table border="0" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">nurse practitioner/physician's assistant</td> <td style="width: 50%;">rent</td> </tr> <tr> <td>nurse/care coordinator</td> <td>office expenses</td> </tr> <tr> <td>medical assistant</td> <td>insurance</td> </tr> <tr> <td>receptionist/secretary</td> <td>fringe</td> </tr> <tr> <td>.25 full-time equivalent nutritionist</td> <td></td> </tr> <tr> <td>.25 full-time equivalent social worker</td> <td></td> </tr> <tr> <td>.25 full-time equivalent physical therapist</td> <td></td> </tr> <tr> <td>.25 full-time equivalent pharmacist</td> <td></td> </tr> </table>	nurse practitioner/physician's assistant	rent	nurse/care coordinator	office expenses	medical assistant	insurance	receptionist/secretary	fringe	.25 full-time equivalent nutritionist		.25 full-time equivalent social worker		.25 full-time equivalent physical therapist		.25 full-time equivalent pharmacist	
nurse practitioner/physician's assistant	rent																
nurse/care coordinator	office expenses																
medical assistant	insurance																
receptionist/secretary	fringe																
.25 full-time equivalent nutritionist																	
.25 full-time equivalent social worker																	
.25 full-time equivalent physical therapist																	
.25 full-time equivalent pharmacist																	
10%	Practice/data manager Business management of the practice; purchase, lease, and setup of electronic health record and quality monitoring system																
5%	Performance bonus (up to 25% of physician payment); risk-adjusted for achievement of desired outcomes in cost, quality, and patient experience																
*Assumes panel size of 1,250 to 1,500 adult patients per full-time primary care physician																	

Evaluation

Overview

Shortcomings of this blended model include its focus on only primary care practice and the radical shift it represents from the current fee-for-service. It does little to change the behavior of other providers except enhance the coordinating capacity of the primary care practice and incent evidence-based care through the bonus. Combining this model with one that addresses systemwide payment and practice reform beyond the primary care practice (e.g., the risk-adjusted global payment method of accountable care organizations or the Prometheus model) could encourage wider-scale change in behavior by providers outside the medical home while ensuring adequate payment to PCMH primary care practices. Primary care practices that find the jump to comprehensive payment too much of a culture change while they are transforming to a PCMH might prefer to be paid along the lines of the blended fee-for-service model until they feel confident enough to handle a more capitated approach to payment. Payers heavily invested in the fee-for-service, claims-processing model might have a hard time transitioning, but the overall simplifications offered by PMPM billing and payment have the potential to greatly lower administrative costs. Most new costs would be related to risk adjustment and tracking of outcomes, higher-value expenditures that help ensure good care.

Criteria-Based Review*

1. How well does the proposal encourage and reward high-value, patient-centered care?

- a. **Incent quality and enhance patient safety?** It rewards them directly with a meaningfully large bonus (up to 25 percent). In Albany, physicians must meet quality measures and score at a certain level on the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Patient Satisfaction Survey, then they must meet efficiency measures to qualify for an outcomes/performance bonus. In Boston, physicians can earn extra for meeting selected measures for clinical outcomes, patient experience (through surveys based mostly on access), and efficiency (ambulatory sensitive emergency room visits and hospital admissions).
- b. **Foster efficiency and cost-effectiveness** (e.g., through use of evidence-based medicine and decision support tools)? It does it through the bonus and by providing the necessary team and information technology support.

*Based on qualitative review and interviews with Boston area and Albany pilot sites

- c. **Improve access** (e.g., through establishment of new portals for care, improved scheduling, and provision of additional support to enable taking on of new patients without regard to medical complexity or psychosocial determinants of health)? It does it seemingly well; anecdotal reports from office staff indicate that access is improving. For example, patients who would have been sent to the emergency room under fee-for-service systems are now being seen in the office.
- d. **Engage patients as partners in care** (e.g., through use of shared decision making)? There is nothing inherent, but the patient satisfaction bonus will help. In Albany, the plan is to add questions in this area to measure outcomes.
2. **How well does it foster coordination and continuity by the PCMH?** It does so by funding necessary staff and health information technology and by rewarding these aspects through the patient-centered and cost/efficiency components of the bonus, although not yet specified. However, as noted earlier, it does not specifically control care by other providers.
3. **How well does it support practice innovation and transformation** (e.g., to establish teams and implement health information technology)? It does it by providing a guaranteed monthly payment that covers building of infrastructure and basic staff salaries; it eliminates compensation as a worry, so less energy needs to be spent on payment issues and more can be spent on innovation and practice redesign (with support from outside sources) to determine the best way to deliver care to patients.
4. **How well does it ensure sustainability of the PCMH over the long term?** Ultimately, it requires efficiency and cost savings to pay for the increases in payment to practices. By paying explicitly up front to build the infrastructure needed to promote savings and quality, it is designed for this.
5. **How well does it improve the practice environment and reward primary care physicians proportionately for the value they create (reducing current payment disparities)?** Initial informal responses appear strongly positive. It appears to have reinvigorated many participants; some had stopped taking medical students and are now resuming. By adding risk adjustment and panel size to base salary, it is helping reduce payment disparities. Some expressed caution about the bonus; most participants recommend sharing the bonus with the entire practice team and not limiting it to the physician.
6. **How practical and implementable is the proposal** (including for small practices)? It requires a major culture change to move from fee-for-service to a capitated payment with strong incentives for desired outcomes. It is doable for small practices because it provides the financial resources to transform, but transformation and accountability pose major challenges and they need assistance.
7. **How acceptable and valid are the payment and reporting systems to stakeholders?**
- a. **Physicians?** A key requirement is willingness to assume increased care management responsibility and overcome previous reservations about capitated payment. Once physicians realize the model meaningfully rewards good patient care and provides the resources needed for improved practice performance and a more satisfying practice experience, they appear quite eager to participate.
- b. **Payers?** Some, skeptical about primary care practices' ability to transform, are reluctant to provide the enhanced up-front comprehensive payment called for by the model; they fear an inadequate return on investment. Such payers prefer to wait until practices transform and show they can save money before considering this payment reform. Piloting payers such as Albany's Capital District Physicians' Health Plan (CDPHP) view the model as a means of energizing and transforming their participating primary care practices. For them, it is about improving the effectiveness and efficiency of care. CDPHP estimates that if it can save 2 percent of its total costs, it will cover up-front costs of supporting the program; preliminary results from their participating practices are very encouraging.
- c. **Purchasers?** It has the potential to reduce costs; the focus on value-added care is appealing.
- d. **Patients?** Patients should find much more advocacy and personalized care under this form of capitation than under previous iterations, which did not risk adjust, pay for teams, or reward desired outcomes in quality and patient experience.

8. **How well does the proposal incent cooperation, coordination, and cost-effectiveness among all providers, including specialists and hospitals? And behavioral health?** As noted above, payment under this model does not automatically extend to the “medical neighborhood” (i.e., specialists, hospitals, behavioral health). It might be necessary to establish a gain-sharing agreement or combine this model with another that engages all providers (e.g., the accountable care organization model). Nonetheless, some practices are starting to address this issue as they proceed with redesign, believing that the model does empower them to encourage other providers to change behavior as well.
9. **What are the challenges to implementing the model?**
- Getting all participants to accept the culture change from fee-for-service to comprehensive payment.
 - Validating risk adjustment and identifying what metrics really capture differences in care and outcomes. Research is ongoing and some validation is completed.
 - Getting payers to make the up-front investment and fundamentally change their basis for payment.
 - Establishing measures of patient centeredness. Validated outcome parameters are needed.

■ Accountable Care Organization Model^{9,10}

Description

Payment reform limited to primary care misses the opportunity to engage other providers in delivery of value-based care. Even if primary care practices are empowered to coordinate and manage care, their impact on cost and quality is likely to be limited if other providers are not motivated to provide the same kind of cost-effective, evidence-based, patient-centered care that is the hallmark of the PCMH. One approach to enlisting the participation of a more extended group of providers is the accountable care organization (ACO) model. In this model, several providers join together, agreeing to take responsibility for delivering value-based comprehensive care to a population of patients. ACOs may range in size from groups of providers to fully integrated delivery systems, but all share the commitment to manage the care of a population in a value-oriented fashion and to accept a single negotiated global payment that is divided among its members.

In the implementation example considered here—the Blue Cross Blue Shield of Massachusetts (BCBSMA) alternative quality contract (AQC)—a yearly risk- and inflation-adjusted global payment is established and made to the ACO based on the total dollars spent the prior year and is supplemented by bonuses of up to 10 percent for improvements in quality, safety, and patient experience (see Figure 2). The overarching success metric is “value added to patients.” How the payment is distributed among the providers participating in the ACO is left to the ACO’s members and usually is not specified in the contract between the payer and the ACO. Because many of the bonus parameters involve primary care outcomes and processes, it behooves the ACO to strongly support primary care, but the AQC does not require or specify it.

Any cost savings are retained by the ACO, incenting cost-effective delivery. Allocating the global payment to participating practices and providers is left to the group’s discretion. For the enterprise to be sustained, the payment must be apportioned to the ACO’s members on the basis of the value added, requiring the ACO to focus on the value added at each level of health care delivery. Without a change in internal payment incentives, providers who have thrived in the current fee-for-service payment system by performing highly paid procedures irrespective of the value added may have difficulty functioning in an ACO environment.

Key components of the alternative contract model

UNIQUE CONTRACT MODEL:

- Physicians & hospital contracted together as a “system”—accountable for cost & quality across full care continuum
- Long-term (5-years)

CONTROLS COST GROWTH:

- Global payment for care across the continuum
- Annual inflation tied to CPI
- Incentive to eliminate clinically wasteful care (“overuse”)

IMPROVED QUALITY, SAFETY AND OUTCOMES:

- Robust performance measure set creates accountability for quality, safety and outcomes across continuum
- Substantial financial incentives for high performance (up to 10% upside)

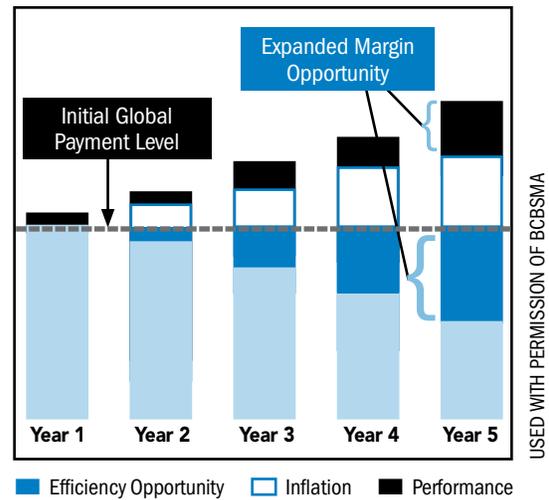


Figure 2. Example of a risk-adjusted global payment model for the accountable care organization: Massachusetts Blue Cross Blue Shield Alternative Quality Contract.

Since the ACO model does not specify how a particular organization might maximize value for patients at every level, it offers the opportunity for a wide range of approaches. Most observers appear to agree that the essential elements are a strong primary care base, excellent care coordination, and judicious use of high-cost interventions. Many of the quality metrics are primary care-centric. The AQC model supports the PCMH by requiring that the organization have a primary care focus and highly functioning office practice environment to be successful. The first two organizations to contract with BCBSMA under the AQC were large, primary care-oriented HMO practices. Measures of patient outcomes are more heavily weighted than process measures.

Evaluation

Overview

For purposes of the review, the task force used the AQC example because it is one of the best developed of the ACO models. However, given the broad nature and lack of specificity of the ACO concept, individual organizations are free to implement and innovate without detailed guidance. As a result, matching the model against the review criteria is more about the likelihood that the ACO model can be adapted to support the PCMH than actual practice.

Criteria-Based Review*

1. How well does the proposal encourage and reward high-value, patient-centered care?

- Incent quality and enhance patient safety?** Potentially, it does it well through the bonus program that includes major primary care quality measures. Payments and incentives in the AQC play off of a list of quality measures that focus one-half on primary care, one-third on hospital care, and the rest on specific special conditions or procedures.

*Based on qualitative review and limited discussion with piloting participants

- b. Foster efficiency and cost-effectiveness** (e.g., through use of evidence-based medicine and decision support tools)? Potentially, it does it well through the incentive of allowing the ACO to keep most of the cost savings, but it includes no specific allocations for health information technology.
- c. Improve access** (e.g., through establishment of new portals for care, improved scheduling, and provision of additional support to enable taking on of new patients without regard to medical complexity or psychosocial determinants of health)? This is not specifically addressed.
- d. Engage patients as partners in care** (e.g., through use of shared decision making)? This is not specifically addressed, but it could be through the quality bonus program.
- 2. How well does it foster coordination and continuity by the PCMH?** The ACO model does not specifically reward continuity and care coordination, two key features of the PCMH, but these are viewed as essential to reducing system costs. In the AQC program, continuity is supported by basing the budgeted population on those who belong to a primary care practice, and BCBSMA makes it clear that resources will be wasted if the ACO does not coordinate care in a proactive way. It has set experimental measures that affect payment, such as ability to follow up on the 40 percent of patients who are discharged from the hospital with pending labs or tests scheduled after discharge.
- 3. How well does it support practice innovation and transformation** (e.g., to establish teams and implement health information technology)? Again, there is no specific support for these elements in the model, but the incentives are such that primary care practices in the ACO with health information technology (e.g., registries, e-prescribing) and care coordinators in their teams are likely to help their ACO do better. Organizations that have not been primary care-oriented in the past have asked for help and are given data that support the need for a strong set of PCMH capabilities to make this work.
- 4. How well does it ensure sustainability of the PCMH over the long term?** An important feature of the AQC is a contract term of five years, making it difficult to succeed without substantial change and assignment of proper value and resources to primary care.
- 5. How well does it improve the practice environment and reward primary care physicians proportionately for the value they create** (reducing current payment disparities)? There is no mandate that primary care physicians or their practices must be paid more, but the bonus program provides clear incentives to support infrastructure, health information technology, and care coordination. An organization that does not allocate sufficient resources to primary care will not do well over time on the primary care-oriented measures that drive ACO revenue.
- 6. How practical and implementable is the proposal (including for small practices)?** This is difficult to answer because the model favors system integration rather than individual practices. Organizations working under the AQC will find that fortifying primary care capability will be essential, which could lead to recruiting both large and small practices.
- 7. How acceptable and valid are the payment and reporting systems to stakeholders?**
- Physicians?** The AQC does not dictate internal incentives or how resources might be distributed among all who contribute to value generation; how this is determined is left to each ACO to work out and will likely drive individual physician acceptance.
 - Payers?** This is a payer-initiated plan. The payer's goal in this example is to hold health care cost inflation to the rate of inflation in the general economy.
 - Purchasers?** Purchasers should be happy to participate in any plan that slows cost inflation or at least stabilizes costs so they can be more predictable while incenting quality.
 - Patients?** The AQC's evaluation of patient experience and the use of primary care-oriented outcome measures should improve their care experience and outcomes.
- 8. How well does the proposal incent cooperation, coordination, and cost-effectiveness among all providers, including specialists and hospitals?** Potentially, it does it well by holding all participants financially accountable. Organizations that achieve high levels of cooperation and coordination will do better financially.

9. What are the challenges to implementing the model? For primary care practices, the main challenges will be ensuring that the monies needed for transformation and the rewards for value creation will be forthcoming from the ACO. One possible way to do so would be to pair the ACO model with one of the other primary care payment reform models discussed in this report. Historically, primary care practices have fared poorly in hospital- and specialty-dominated systems; having a specific payment mechanism in place that prescribes payment in support of the primary care PCMH might facilitate transformation and participation of previously independent primary care practices. Other challenges include maintaining the willingness of members to share financial accountability and work in a coordinated fashion, keeping the cost-savings and bonus components financially meaningful and avoiding their shrinking over time as performance improves, establishing fair and workable internal rules of payment distribution for all participants, and applying effective risk adjustment for the global payment.



Selecting a Payment System for the PCMH: Principles and Guidelines

While transformation to the patient-centered medical home cannot occur without payment reform, there is no single best payment model for implementing and sustaining the PCMH. Like politics, all medical practice is local. Each individual, group, and network considering the PCMH needs to take into account its own culture, practice environment, patient population, financial resources, desired outcomes, and commitment to change when choosing the model or combination of models that will work best. The models examined here, which represent the spectrum of payment reforms now undergoing field trials, are only a few examples of the many permutations and combinations possible. Data from these trials will further elucidate their strengths and weaknesses. Nonetheless, a number of principles and guidelines emerge from the task force's review that might be helpful to those embarking on a PCMH initiative:

- ❖ Payment reform is essential to establishment and sustained operation of the PCMH, ensuring key practice transformations and desired PCMH outcomes. Current reimbursements under the terms of RBRVS-based fee-for-service payment are insufficient to support the necessary multidisciplinary teams and health information technologies that are central to practice transformation and improving outcomes for patients.
- ❖ No one payment system is universally best for the PCMH; the choice of a payment reform approach should be based on a careful assessment of its ability to foster key PCMH objectives and outcomes in a specific practice setting.
- ❖ A blended strategy to payment reform can help minimize the shortcomings associated with any single-method approach. Fee-for-service encourages overutilization; capitation, underutilization; salary, excessive loyalty to the organization; and P4P, cherry-picking of patients and clinically illogical care. Thoughtful combinations of approaches, as typified by the models reviewed in this report, seek to maximize benefits and minimize limitations. Combining two complementary blended models (e.g., ACO and risk-adjusted comprehensive payment; see Table 2) might further enhance the payment reform effort.
- ❖ Risk adjustment, incorporating both biomedical and psychosocial factors, is key to protecting practices from actuarial risk and reducing the incentive to shun complex or difficult patients, especially in pay-for-performance and bundled or global approaches to payment. It should include techniques to identify patients at high risk for uncoordinated care. Risk adjustment methods for primary care have been developed and are undergoing validation; they are essential to payment reform.
- ❖ To the extent possible, P4P should be based on evidence, focused on outcomes, and complemented by carefully chosen and thoughtfully applied process measures, especially in the early phases of implementation. Although basing P4P payment on outcomes would be ideal, measurement of outcomes remains problematic in many instances. Carefully considered application of validated process measures that correlate with outcomes (e.g., screening for cervical cancer) provides a near-term P4P alternative that is much easier to implement and reward; process measures can complement outcome measures in the longer term.
- ❖ PCMH sustainability is proportional to the penetration of payment reform in the practice and its ability to fund PCMH services. Participation by only some payers and carveouts of selected subgroups, while helpful in directing resources to targeted populations, may not be sufficient to transform an entire practice to the PCMH, which is intended for all patients.
- ❖ Payment reform should correct existing imbalances and distortions in physician payment and take into account value created. Payment by measures of value created should help redress the gross underpayment for primary care and raise primary physician income. Work on such measures is urgently needed, and P4P is a step in this direction. Meanwhile, funding the necessary resources for the PCMH, while not necessarily raising physician pay, can improve job satisfaction and the attractiveness of primary care as a career.
- ❖ Payment reform should improve the practice environment and enhance professional satisfaction. Simply increasing current fee-for-service physician payments is unlikely to suffice. Anything that shuts down the

“hamster wheel” and limits the productivity imperative will be welcome. In some settings, this objective will entail supplementing fee-for-service with a substantial management fee and P4P bonus. In others, it may lead to choosing a more comprehensive payment approach. Many piloting practices are improving their practice environment by targeting new monies toward their teams and health information technology.

- ❖ Payment reform should encourage patient-centered, coordinated care by all providers, not just those inside the PCMH. Systemwide payment reform is needed. Approaches that engage all providers are welcome and essential, but it is important that they not leave payment for the PCMH to chance or the political process because chronic underfunding of primary care has rendered primary care practices relatively weak at the negotiating table. Effective systemwide payment reform needs to ensure adequate financial support for the PCMH, either by specifying it directly or by melding with one of the PCMH payment models outlined in this report that does so.
- ❖ Administrative practicality is desirable, if not essential, although the transition to a new system can be challenging. The current payment system is dysfunctional, costly, and administratively complex, yet many stakeholders are reluctant to change it because they have figured out the rules of the game and the transition is likely to be disruptive. Nonetheless, if a simpler, more functional payment system can be identified that better supports the desired outcomes of the PCMH, it should be seriously considered and moved toward. The ambitiousness of the reform effort and the speed of transition will need to take into account the local practice culture and the group’s commitment to change.
- ❖ Payment reform models and proposals should be piloted and subjected to systematic evaluation and review. The models presented here are based on a considerable body of knowledge and experience, but they remain largely untested. They require expedited and extensive field testing complemented by careful evaluation. Fast-track, wide-scale piloting of the full spectrum of payment models is needed to elucidate the strengths and shortcomings of each model, especially the unintended consequences, followed by rapid dissemination of those that prove most effective.
- ❖ Those payment models that achieve validation through piloting should be offered to practices by all payers, allowing each practice, group, or network to choose a single approach to payment that is likely to work best for them. This would greatly simplify administrative burdens, provide a consistent set of incentives, and allow concentration of effort on achieving universally desired outcomes.

Table 2. Particular strengths of major payment reform models for the PCMH.

	RBRVS + Management Fee + P4P	Prometheus	Risk-Adjusted Comprehensive Payment and Bonus	Accountable Care Organization
Supports transformation	++++	++++	++++	
Sustains PCMH	++++	++++	++++	
Emphasizes value over volume		++++	++++	++++
Amply rewards outcomes	++++	++++	++++	++++
Reduces pay disparities	++++	++++	++++	
Eases transition	++++	++++		
Simplifies payment			++++	++++
Engages all providers		++++		++++
Engages all-payer interest	++++	++++		++++

NOTE: These are crude estimates only, based on qualitative review of each model’s features and early anecdotal experience from field trials. These estimates will need to be revised as more experience with these models is reported. For now, these ratings assume successful implementation of the model and adequate size of care management and comprehensive payments and bonuses.

PCMH = Patient-Centered Medical Home **RBRVS** = Resource-Based Relative Value Scale (Medicare’s fee-for-service payment system)

P4P = Pay for Performance **Prometheus** = Evidence-Informed Case Rates

Future Task Force Work and Unaddressed Issues

The task force focused on generating general principles and examined a representative subset of available payment models to do so. New ones and melded or revised versions of existing ones are almost certain to emerge and will deserve future consideration as the iterative process of payment reform moves forward.

The task force did not have time to address a number of specific issues in its first scope of work. Most important are the special payment considerations for the care of children. For example, primary care practices need to be assured of vaccine benefits as soon as the Centers for Disease Control and Prevention and the American Academy of Pediatrics have provided endorsement for the continual evolution of vaccine materials; this continuing benefit cannot be presumed. Children with special needs are different from adults; the additional care requirements for such children need to be recognized, especially in risk-adjustment formulas. Responsibility for neonates also needs to be addressed, as does the evolving importance of personalized care, perhaps best evidenced by the newly available genetic studies.

References and Resources

1. American College of Physicians. A system in need of change: restructuring payment policies to support patient-centered care. Oct. 2006. Available at www.acponline.org/advocacy/where_we_stand/policy/change.pdf.
2. Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. *Milbank Q*. 2005;83:457-502.
3. American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, American Osteopathic Association. Joint principles of the patient-centered medical home. March 2007. Available at: www.medicalhomeinfo.org/joint%20Statement.pdf.
4. Reid RJ, Fishman PA, Yu O, et al. Patient-centered medical home demonstration: a prospective, quasi-experimental, before and after evaluation. *Am J Manag Care*. 2009;15:e71-e87.
5. Fisher ES, Wennberg DS, Stukel TA, et al. The implications of regional variations in Medicare spending, Parts 1 and 2. *Ann Intern Med*. 2003;138:273-98.
6. Rosenthal MB, Dudley RA. Pay-for-performance: will the latest payment trend improve care? *JAMA*. 2007;297:740-743.
7. Prometheus payment. Available at www.prometheuspayout.org/.
8. Goroll AH, Berenson RB, Schoenbaum SC, Gardner LA. Fundamental reform of payment for adult primary care: comprehensive payment for comprehensive care. *J Gen Intern Med*. 2007;22:410-415.
9. Fisher ES, Staiger DO, Bynum JPW, et al. Creating accountable care organizations: the extended hospital medical staff: a new approach to organizing care and ensuring accountability. *Health Affairs*. 2007;26:w44-w57.
10. Blue Cross Blue Shield of Massachusetts. The alternative quality contract. March 2009. Available at: <http://www.qualityaffordability.com/pdf/alternative-quality-contract.pdf>.



Patient-Centered Primary Care Collaborative
The Homer Building • 601 Thirteenth Street, N.W. • Suite 400 • Washington, D.C.
Phone: 202/724-3332 • Fax: 202/393-6148 • www.pcpc.net

©2010 PATIENT-CENTERED PRIMARY CARE COLLABORATIVE