

PATIENT-CENTERED PAYMENT FOR PRIMARY CARE

The Problems With Current Approaches to Primary Care Payment

High-quality primary care is an essential component of a high-value healthcare system. Unfortunately, the fee-for-service payment systems currently used by Medicare and most health insurance plans do not support high-quality primary care:

- There are no fees at all for many important primary care services, particularly services needed for proactive patient care rather than merely reactive care.
- Many of the fees that do exist are less than what it costs to deliver high-quality care.
- There is no assurance that the service delivered for a fee is appropriate or high-quality.
- The primary care practice is penalized financially if it succeeds in keeping its patients healthy.

None of the approaches that have been used or proposed as alternatives to standard fee-for-service payments – including pay-for-performance, medical home payments, and population-based payments – solves these problems, and some can make it even less likely that patients will receive high-quality care.

A Patient-Centered Payment System for Primary Care

A different approach is needed, one that will actually solve the problems of the current fee-for-service payment system for both primary care practices and patients without causing new problems for either. A successful, *patient-centered* payment system for primary care should have four characteristics:

1. The payment for each patient should be based on the services that patient needs and wants to receive.
2. The payment for each patient should ensure that patient receives high-quality care in the most efficient way.
3. The payment amounts should be adequate to support the cost of delivering services to each patient in a high-quality manner.
4. The payments should be affordable for patients with and without insurance.

A Patient-Centered Primary Care Payment system with these characteristics is described below.

A. Separate Payments for Each Type of Primary Care Service

Every primary care practice delivers three important types of services to its patients: (1) wellness care,

(2) chronic condition management, and (3) non-emergency acute care. In addition, (4) it would be desirable for every primary care practice to offer integrated behavioral health services. Patient-Centered Primary Care Payment would have separate payments for each of these types of services in order to ensure that each patient can receive the combination of services they need and want, and also to ensure that primary care practices with different types of patients can be paid adequately for the specific types of services they need to provide.

1. **Monthly Payments for Wellness Care.** The most important role of primary care is to help patients stay healthy. Maintaining and improving health is a continuous process that occurs throughout the year, not simply through occasional office visits. Consequently, the primary care practice should receive a monthly payment for each patient who enrolls with the practice to receive wellness care. The monthly payment would support wellness care *management*; service-specific fees should continue to be paid for any specific procedures, tests, or treatments the patient needs as part of their wellness plan, such as immunizations, mammograms, colonoscopies, etc.
2. **Monthly Payments for Chronic Condition Management.** Some patients will have one or more chronic conditions, such as asthma, diabetes, or hypertension. If the patient wants the primary care practice to help manage those conditions (rather than a specialist), the practice should receive an additional monthly payment for that patient in order to deliver chronic condition management services. Since continuous, proactive care is needed to reduce the severity of symptoms and prevent exacerbations of the condition, a monthly payment is necessary to support this.
 - ◆ **Higher payments for patients with a newly diagnosed or treated chronic condition.** A higher monthly payment will be needed during the initial month following diagnosis or enrollment in order to develop the most effective treatment plan and to ensure it is effective.
 - ◆ **Higher payments for patients with a complex condition.** A higher monthly payment will be needed for a patient with combination of chronic conditions or other characteristics that require significantly more time and assistance.
3. **A Fee for Diagnosis and Treatment of a Non-Emergency Acute Event.** Some patients who are receiving good preventive care and chronic disease management will have accidental injuries, acute illnesses, or problematic symptoms that will require additional services from the primary care practice. Since these events will occur unpredictably, and different patients may be more susceptible to these problems than others, the primary care practice should receive an Acute Care Visit Fee when it pro-

vides diagnosis and treatment services for a new acute event. The practice should be permitted to deliver the services in whatever way is most appropriate in the circumstances, including by telephone, telehealth, or an in-person visit with the physician or other practice staff. The Acute Care Visit Fee would not be paid for care of a patient experiencing an exacerbation of a chronic disease, however, since the cost of that kind of care would already be covered by the monthly payment for chronic condition management.

4. Monthly Payments for Integrated Behavioral Healthcare.

In order to deliver behavioral health services, a primary care practice needs to have one or more staff with training in helping patients with behavioral health needs. It is problematic to pay for integrated behavioral health care using fees for counseling sessions, or to pay only for patients who have been formally diagnosed with a behavioral health condition. Instead, the practice should receive an additional monthly payment for each patient who has enrolled to receive wellness care from the practice.

5. Fees for Individual Procedures and Tests.

In addition to the four core services, many primary care practices perform procedures such as an immunization, injection, or excision and/or perform basic laboratory tests. It is beneficial for patients to be able to receive these procedures and tests from the practice, rather than needing to make a separate trip to another physician or facility. Since only a subset of patients will need these procedures and tests, and since the cost of performing each of them will differ, the primary care practice should receive an additional fee when it performs a procedure or test that is adequate to cover the cost.

6. Fees for New Patients and Services Delivered to Non-Enrolled Patients.

The practice will only receive monthly payments for wellness care and chronic condition management for patients who explicitly enroll with the practice to receive those services. Most new patients will need one or more initial visits with the practice before enrollment occurs, and the practice can continue to be paid current fees for these initial visits. In addition, if patients who are unwilling to enroll want to receive occasional services from the practice, and if the practice wants to provide those services, the practice should be paid standard visit fees in those cases.

The primary care practice should only be paid for proactive wellness care and chronic condition management services if a patient wants to receive them. Not every patient may want wellness care assistance, and some patients with a chronic disease may need or want to receive support from another practice that specializes in the patient's condition(s). Consequently, the primary care practice should only receive the monthly payments for these services for a patient who explicitly enrolls with the practice to receive them. The patient would enroll with the primary care practice, not with the patient's health insurance company. No patient should be "attributed" to a practice by a health insurance company without the knowledge and consent of both the patient and the primary care practice.

In order to allow the new payments to be easily implemented within the existing billing and claims payment systems used by primary care practices and health plans, new CPT codes would be created for each of the new wellness care, acute care, chronic condition management, and behavioral health care payments . For each patient who had enrolled for wellness care and/or chronic condition management, the primary care practice would submit the appropriate CPT codes each month to the patient's health insurance plan. If the practice had addressed a new acute problem for an enrolled patient, the practice would also submit the appropriate code for an Acute Care Visit Fee. The health plan would then pay the practice the amounts assigned to each of those codes.

B. Accountability for Quality and Utilization

Current approaches to performance-based payment and utilization management have been ineffective in improving quality and reducing unnecessary services, burdensome for primary care practices, and harmful to many patients. Quality measures do not assure that each patient has received high-quality care, and they can penalize a primary care practice that is providing the most appropriate care for individual patients. Prior authorization systems harm patients by delaying diagnosis and the delivery of appropriate treatment and by reducing the time primary care practices can spend delivering high-quality care. These approaches need to be abandoned and replaced by a patient-centered method of assuring the quality and appropriateness of services.

In Patient-Centered Primary Care Payment, a primary care practice would only bill and be paid for a Monthly Wellness Care Payment, Monthly Integrated Behavioral Healthcare Payment, Monthly Chronic Condition Management Payment, or Acute Care Visit Fee if:

- the practice had delivered all appropriate services to the patient during the month or acute care visit that are consistent with applicable, evidence-based Clinical Practice Guidelines (CPGs), Clinical Pathways, or a Standardized Clinical Assessment and Management Plan (SCAMP), or the practice had documented the reasons for deviation from those guidelines in the patient's clinical record; and
- the practice is using a Standardized Assessment, Information, and Networking Technology (SAINT) to identify and prioritize any problems the patient is experiencing and to determine whether the practice's services are effectively addressing the patient's needs.

Evidence-based Clinical Practice Guidelines are available for most of the acute problems and chronic conditions commonly addressed by primary care practices, such as acute back pain, upper respiratory illness, asthma, depression, diabetes, and heart disease, and also for many less-common conditions. If a primary care practice does not deliver a specific type of service (i.e., wellness care, behavioral healthcare, chronic condition management, or acute care) in a way that is consistent with the best-available medical evidence and the patient's own needs and preferences, the practice would not submit a bill for that service and it would not be paid for that service.

In contrast to current quality measures and prior authorization systems, this assures that every patient receives high-quality care and that patients *only* receive appropriate, evidence-based services. There would be no administrative burden for the practice beyond documenting in the clinical record what is done for the patient and why. If a health plan has reason to be concerned that a particular primary care practice is delivering or ordering services without utilizing a CPG/SCAMP or that it is deviating from the CPG/SCAMP excessively without good reasons, it could request documentation from that practice and recoup any payments that were made inappropriately. This is the same as what is done today in fee-for-service payment systems if there is concern that a practice has been billing for services that were not delivered.

There is not clear evidence in all cases about what services are best for patients who have multiple health problems or complex needs, and some patients are unable or unwilling to use the services that evidence indicates are likely to be most effective for them. Under Patient-Centered Primary Care Payment, the primary care practice would have the flexibility to modify its services in response to patients' needs and preferences, in contrast to current quality measurement and prior authorization systems that can penalize practices for customizing care. **Whenever possible, the primary care practice would be using a Standardized Clinical Assessment and Management Plan (SCAMP).** A SCAMP is a form of clinical practice guideline/pathway that also has a mechanism for collecting information about deviations from the guidelines and the outcomes of those choices in order to improve the guidelines.

In order to provide timely and effective care, a primary care practice needs actionable information about any physical and emotional problems each of its patients may be having and also about whether the services the practice is providing to the patient are addressing the issues that are of most concern to that patient. A SAINT is a system for providing a primary care practice with this patient-reported information. To be effective, a SAINT should: (1) be easy to use and affordable for the primary care practice; (2) provide timely, actionable information to guide care; and (3) enable and encourage patient participation. *How's Your Health* is a SAINT specifically designed for primary care that has all of these characteristics, is free of charge, and is already being used by many primary care practices.

C. Adequacy of Payments

No matter what *method* is used to pay the primary care practice, if the *amount* of payment is not sufficient to cover the cost of delivering high-quality services, the practice will be forced to deliver low-quality care or go out of business altogether. While it is clear that the current fees health insurance plans pay for primary care services are inadequate, there is little information available on what it actually costs to deliver high-quality primary care, since it is impossible for practices to deliver high-quality care without adequate revenues to do.

The cost of delivering high-quality primary care will be significantly higher than it is today for two reasons:

- **Primary care physicians need to spend much more time with each patient than they can today.** One set

of analyses found that in order to deliver all of the evidence-based preventive care, acute care, and chronic care services needed by the 2,500 patients managed by a typical primary care physician, the physician would need to spend an average of 23 hours per day on every working day of the year.

- **A primary care practice needs to employ an adequate team of staff to support the physician.** A primary care physician can delegate a portion of the services patients need to receive, but only if the practice employs enough staff with appropriate skills to enable the physician to do so.

Even if they have sufficient staff with the necessary skills, most primary care physicians will need to be managing the care of far fewer patients than they do today, and the payments they receive for services to those patients will need to generate sufficient revenue to cover the costs of operating the practice, including paying both the physician and the staff adequately. The following amounts of payment are estimated to be adequate to cover the minimum costs for a small primary care practice to deliver high-quality care:

- **a \$7.40 Monthly Wellness Care Payment for each patient;**
- **an additional \$4.25 Monthly Integrated Behavioral Healthcare Payment for each patient if the practice offers integrated behavioral health services;**
- **an additional \$24.60 Monthly Chronic Condition Management Payment for each patient with a chronic condition (or a \$54.60 Monthly Complex Condition Management Payment if the patient has a complex condition);**
- **a \$141 Acute Visit Fee, paid each time a patient has a new, non-emergency acute problem.**

These payment amounts would be adequate to cover the cost of operating a primary care practice with a single physician, a nurse who serves as both a chronic condition care manager and a behavioral health services care manager, a Medical Assistant, a receptionist, and a part-time billing clerk or service.

However, the primary care practice should not be *required* to have any particular staffing arrangement in order to receive Patient-Centered Primary Care Payment. The practice should have the flexibility to use different types and numbers of staff depending on the needs of the specific set of patients it is caring for. It would also have responsibility for ensuring that it did not accept more patients, or more high-need patients, than it could deliver high-quality care to with the number and type of staff that it has.

There is no need to "risk adjust" these payments. Because there are separate payments for wellness care, acute care, and chronic condition management, the primary care practice's revenues will automatically increase if it cares for patients with more acute or chronic conditions without having to change the fees for any of the individual components.

Higher payment amounts will be necessary for primary care practices that are located in communities with a high cost of living and communities where it is difficult to

Patient-Centered Primary Care Payment						
Type of Service	Billing Code	Eligible Patients	Frequency of Payment	Accountability for Quality	Estimated Amount	Patient Share
Wellness and Preventive Care	XX010 Wellness Care	A patient who enrolls for proactive wellness care	Monthly	Follow evidence-based preventive care guidelines (CPG/SCAMP) and use a SAINT to monitor patient needs	\$7.40 per patient per month	\$0
	XX011 Transitional Care	A patient who was hospitalized or had a serious illness	Month after hospital discharge or serious illness	Follow evidence-based guidelines (CPG/SCAMP) and use a SAINT to monitor patient needs	\$14.80 for the month (instead of \$7.40)	\$0
	XX012 Integrated Behavioral Healthcare	A patient who enrolls for proactive wellness care if the practice has integrated behavioral health services	Monthly in addition to Wellness Care Payment	Follow evidence-based guidelines (CPG/SCAMP) for behavioral health and use a SAINT to monitor patient needs	\$4.25 per patient per month (in addition to \$7.40)	\$0
Non-Emergency Acute Care	XX020 Acute Care Visit	A patient enrolled for wellness care who experiences a new acute symptom or injury that does not require emergency care	For each new acute event	Diagnosis and treatment plan based on evidence-based guidelines (CPG/SCAMP) for the symptom/condition and use of SAINT to monitor outcomes.	\$141 per visit (\$282 for visit requiring more than 45 minutes)	\$25
Chronic Condition Care	XX030 Initial Management of a Chronic Condition	A patient with a newly diagnosed or newly treated chronic disease	Following diagnosis or initial treatment	Follow evidence-based guidelines (CPG/SCAMP) for management of the chronic condition and use a SAINT to monitor patient needs	\$54.60 per patient for the initial month	\$0
	XX031 Chronic Condition Management	A patient with a chronic condition	Monthly	Follow evidence-based guidelines (CPG/SCAMP) for management of the chronic condition and use a SAINT to monitor patient needs	\$24.60 per patient per month after the first month	\$0
	XX032 Management of a Complex Condition	A patient with a complex condition	Monthly	Follow evidence-based guidelines (CPG/SCAMP) for management of the complex condition(s) and use a SAINT to monitor patient needs	\$54.60 per patient per month	\$0
Procedures & Tests	Standard code for procedure or test	A patient receiving a procedure or test	When procedure or test is performed	Follow evidence-based guidelines in ordering test or performing procedure	Payment based on cost of procedure or test	Amount varies
New Patient	99201-99205	Any patient	When patient is first seen by physician	Follow evidence-based guidelines in evaluating patient needs	Current fee schedule	Current benefits

attract an appropriate staff team. If a payer and primary care practice agree that a primary care practice should deliver additional services to patients, higher payments will be needed to support the additional staff needed to do that.

Once primary care practices begin receiving the payments and are thereby able to restructure and improve primary care delivery, data can be gathered on how much time is actually needed to deliver high-quality care, and the payment amounts can be refined using those data. This process of refinement is similar to what is done in the current fee-for-service payment system.

D. Affordability for Patients

Patients can only benefit from high-quality primary care if they use it, and they will only use it if they can afford to do so. Moreover, a primary practice will only receive sufficient revenue to deliver high-quality care if patients actually enroll in the primary care practice and use its services, and patients will be unlikely to do that if they feel that services from other providers would provide similar benefits at a lower cost.

For patients with insurance, cost-sharing amounts should be established that encourage patients to use the primary care practice:

- **A Modest Co-Payment for Acute Care Visits.** The copayment amount should be low enough that patients do not avoid contacting the practice when they have an acute issue that should receive attention. Moreover, the copayment to receive care from a primary care practice should be significantly less than the copayment or coinsurance required for an urgent care visit or an emergency department visit.
- **No Cost-Sharing for Wellness Care.** Since health insurance plans are not permitted to charge patients for recommended preventive care services, it will be best to require no cost-sharing for the monthly Wellness Care Payments.
- **No Cost-Sharing for Chronic Condition Management.** The goal of these services is to prevent chronic condition exacerbations from occurring, and since the savings from not having to treat the exacerbations will likely exceed the cost of the monthly condition management services, it would be undesirable to create cost barriers that could discourage patients from enrolling to receive these services.

Patients who have no insurance will have to pay the full amount for any services they receive from a primary care practice. In addition, patients on many high-deductible health plans will also have to pay the full amount for some or all primary care visits except for required preventive care services. The structure of Patient-Centered Primary Care Payment helps to make primary care as affordable as possible for these patients:

- separate payments for wellness care, acute care, and chronic condition management ensure that the patient is not paying for services they do not need or want;
- the payments for wellness care and chronic condition management are spread out over the course of the

year, rather than requiring large, lump sum payments when a visit is needed. The monthly payments for wellness care would total \$87 over the course of the year, which is less than the fee the patient would likely have to pay for a single office visit today.

- the patient would not be charged any fee for a visit, for a month of wellness care, or for a month of chronic condition management if the patient did not receive the appropriate evidence-based services they needed during the visit or during the month. No similar assurance of quality is available from any alternative source of care.

Comparison to Other Payment Methods

There is no perfect payment system for primary care or any other aspect of healthcare services. However, Patient-Centered Primary Care Payment System is superior to the current fee-for-service payment system, to population-based payment and capitation systems, to pay-for-performance systems, to medical home payment models, to shared savings, and to global payments in terms of enabling and assuring delivery of high-quality care to each patient, and providing adequate financial support for primary care practices.

Predictability of Revenues for Primary Care Practices

It might appear that a single population-based payment would provide a more predictable revenue stream for primary care practices and do a better job of avoiding the kinds of financial problems that occurred during the coronavirus pandemic. However, in reality, population-based payment systems are not as predictable as they seem because they use complex attribution systems, leakage penalties, problematic risk adjustment methodologies, and performance-based adjustments.

In contrast, under Patient-Centered Primary Care Payment, the practice would know exactly how much revenue it would receive from the monthly Wellness Care Payments and Chronic Condition Management Payments because it would know how many patients it had enrolled. Moreover, the Acute Care Visit Fees would not be restricted to in-person visits with the physician, so the practice would have the flexibility to address acute care problems through telehealth or other methods that are feasible for the practice to safely deliver to patients during a pandemic or natural disaster.

Ensuring Equitable Access to Care for Disadvantaged Populations

Patient-Centered Primary Care Payment would improve access to quality care for disadvantaged patients in three ways:

- **Higher Payments for Patients with Multiple Acute Problems.** For patients who experience frequent acute care problems, the primary care practice would be paid an additional fee for addressing each of those problems. In addition, the payment would be high enough to allow the practice to spend adequate time with the patient, and the payment would be flexible

Comparison of Alternative Payment Methods on Desirable Characteristics of Primary Care Payment							
Desirable Characteristics of a Payment System	Patient-Centered Primary Care Payment	Current Fee-for-Service Payment	Population-Based Payment / Capitation	Pay for Performance on Quality Measures	Medical Home Payment Models	Shared Savings ACOs	Global Payment / Direct Contracting
The primary care practice is paid for delivering proactive care and non-visit-based services as well as in-person office visits with a physician	YES	NO	YES	NO	YES	NO	YES
The payment amounts are set at levels expected to be adequate to cover the costs of delivering high-quality care	YES	NO	NO	NO	NO	NO	NO
Each patient is assured of receiving appropriate, high-quality care in return for payment	YES	NO	NO	NO	NO	NO	NO
The primary care practice receives additional resources and flexibility to help patients who have higher-than-average needs or face barriers in accessing services.	YES	NO	NO	NO	YES	NO	NO

Comparison of Alternative Payment Methods on Undesirable Characteristics of Primary Care Payment							
Undesirable Characteristics of a Payment System	Patient-Centered Primary Care Payment	Current Fee-for-Service Payment	Population-Based Payment / Capitation	Pay for Performance on Quality Measures	Medical Home Payment Models	Shared Savings ACOs	Global Payment / Direct Contracting
Financial penalty for keeping patients healthy	NO	YES	NO	NO	YES	YES	NO
Financial penalty for delivering or ordering all services that patients need	NO	NO	YES	NO	YES	YES	YES
Financial reward for withholding needed services	NO	NO	YES	NO	YES	YES	YES
Financial penalty if spending increases or a patient experiences a poor outcome for reasons beyond the control of the primary care practice	NO	NO	YES	YES	YES	YES	YES

enough to allow the practice to address the patient's needs in whatever way will work most effectively, whether by telephone, telehealth, or a face-to-face visit.

- **Higher Payments for Patients with Complex Conditions.** The practice will receive a higher monthly payment for those patients who have characteristics that require the practice to spend significantly more time managing care of a chronic condition. The higher payment is not based on how many diseases the patient has been diagnosed with, but based on the complexity of providing appropriate care for the patient.
- **Accountability and Flexibility to Deliver the Most Appropriate Care for Each Patient.** In return for receiving adequate payments, the primary care practice would be accountable for delivering (or at least attempting to deliver) the care to each patient that is most appropriate for that specific patient. The practice would have the flexibility to deliver different services if they are necessary or appropriate given a patient's unique needs, and the practice would not be penalized if a patient is unable or unwilling to use the recommended services.

In contrast, other approaches to paying for primary care can reduce access to quality care for disadvantaged patients. For example, population-based payments do not provide higher payments for patients who have new health problems, who have multiple acute health problems, or who require more time or services due to non-medical factors, and performance-based payments can penalize primary care practices that provide care to disadvantaged patients.

Benefits and Costs of Patient-Centered Primary Care Payment

A. Improvements in Care Delivery

The current fee-for-service payment system not only fails to pay adequately for many services, it does not pay at all for many types of services and for methods of delivering services that may be more effective for individual patients than the services that are paid for. By correcting both of these problems, Patient-Centered Primary Care Payment will allow primary care practices to significantly redesign the way they deliver services to patients.

B. Impacts on Primary Care Spending

Most payers are currently spending less than is needed to support high-quality primary care for the patients they insure, so most payers will likely have to spend more on primary care services to implement Patient-Centered Primary Care Payment. The increase in spending for a payer will depend on how much it is paying for services today and the characteristics of the patients it insures. Spending on primary care services might change very little or even decrease for a health plan that currently pays significantly more than Medicare rates and encourages its members to use primary care services frequently. On the other hand, spending on primary care services could more than double for a health plan that cur-

rently pays less than Medicare rates or if it has cost-sharing requirements that discourage patients from using primary care services.

It is inappropriate to set targets for the percentage of total healthcare spending that primary care practices should receive. No matter what target amount is used, it may be too low or too high depending on the characteristics of the patient population and the community where they are receiving care. Spending on primary care will only be adequate if the amounts paid for primary care services are sufficient to allow primary care practices to spend adequate time with patients and hire the appropriate staff to deliver services.

C. Impacts on Total Healthcare Spending

The goal of primary care is to *improve patients' health*, not to *reduce healthcare spending*. Since many patients currently receive poor quality primary care, unnecessary specialty services, and unnecessarily expensive treatments, improving the quality of primary care will likely result in some reduction in spending on other kinds of services for many groups of patients. However, one cannot assume that these savings will completely offset the increase in spending needed to provide adequate support for primary care.

If total healthcare spending increases when primary care practices are paid adequately and are delivering high quality care, this does not mean the payments to primary care are too high or that there is not enough "incentive" for the primary care practices to reduce healthcare spending. Moreover, the calculations of "savings" used in evaluations and shared savings models implicitly assume that total spending will remain the same if spending on primary care does *not* increase. If inadequate payments for primary care continue and access to primary care is reduced, it is likely that spending on other services will increase, both in the short run and the long run.

D. The Economic Value of Better Health and More Patient-Centered Service Delivery

Too little attention has been given to the beneficial impacts effective primary care can have on worker productivity. For many types of common health problems, the cost of lost productivity from both absenteeism and presenteeism is much greater than the amount spent on healthcare services to treat them. These problems can be effectively treated or managed by primary care practices if they have the time and resources to do so. If workers stay healthy and if they can have their health issues addressed effectively without having to make multiple visits to different physicians, they will have to spend less time away from work and be more productive when they are working. The monetary benefits of higher productivity may well offset any net cost of higher primary care, but the benefits of higher productivity will accrue to the employer and employees, not to the employees' health insurance plan.

Implementing Patient-Centered Primary Care Payment

Three sets of actions will be needed to implement Patient-Centered Primary Care Payment:

- The mechanism for billing and payment of primary care practices must be created.
- The clinical guidelines and related tools must be available to ensure that appropriate, high-quality care is delivered.
- Payers must implement the changes in payments for primary care practices and changes in cost-sharing requirements for patients.

A. Operationalizing Billing and Payment

The following actions will be needed in order to enable primary care practices to bill and be paid for primary care services under a Patient-Centered Primary Care Payment system:

- The American Medical Association's CPT Editorial Panel should establish a formal definition for each of the patient-centered primary care services (e.g., a month of Wellness Care Management) and assign a specific CPT code to that definition.
- The American Medical Association/Specialty Society RVS Update Committee (RUC) should assign appropriate RVU amounts for each of the new CPT codes for the Patient-Centered Primary Care Payments.
- Medicare and health insurance plans should use appropriate Conversion Factors to convert the RVUs into adequate payments for participating primary care practices. Analyses should be carried out by the RUC or an organization such as the Patient-Centered Primary Care Collaborative or the Medical Group Management Association in order to determine an appropriate conversion factor for Patient-Centered Primary Care Payment CPT codes.

B. Operationalizing Accountability for Quality and Utilization

In order to bill for one of the services in Patient-Centered Primary Care Payment, the primary care practice would need to deliver services to the patient consistent with a Clinical Practice Guideline (CPG), Clinical Pathway, or Standardized Clinical Assessment and Management Plan (SCAMP) that is appropriate for the patient or document the reasons for deviation. In addition, the primary care practice would need to use a Standardized Assessment, Information, and Networking Technology (SAINT) to identify and prioritize any problems the patient was experiencing in order to take actions to address those problems consistent with a CPG, Pathway, or SCAMP.

Clinical Practice Guidelines already exist for most of the symptoms and diseases that are commonly addressed by primary care practices and also for many less-common conditions. However, it is expensive for medical specialty societies and multi-stakeholder groups to maintain these guidelines. Moreover, because the guidelines are inherently complex and come from many

different sources, actions will be needed to facilitate the use of the guidelines by primary care practices.

- Government agencies (such as the Agency for Healthcare Research and Quality and the Centers for Medicare and Medicaid Services) and charitable foundations should provide funding to medical specialty societies and multi-stakeholder collaboratives to support development and maintenance of clinical practice guidelines that are free of commercial influence.
- Guideline developers should work together to create a mechanism for enabling primary care practices to easily access all of the guidelines that they would commonly use and to resolve any conflicts among different guidelines.
- The certification requirements for Electronic Health Record systems should be modified to require that the "clinical decision support" component of the EHR be based on all of the most current guidelines and that this component be easy for clinicians to use.

A Standardized Clinical Assessment and Management Plan (SCAMP) is a clinical practice guideline that also includes a mechanism for improving the guideline by gathering information about the situations where deviations from the guideline are needed. An essential tool for collecting and analyzing data for a SCAMP from multiple physician practices is a Clinical Data Registry (CDR), but using and maintaining such a registry is expensive.

- Government agencies (such as the Agency for Healthcare Research and Quality and the Patient-Centered Outcomes Research Institute) and charitable foundations should provide funding to support the development of SCAMPs and the use of Clinical Data Registries.
- Patient-Centered Primary Care Payment amounts should be large enough to ensure that primary care physicians have the resources needed to participate in CDRs and the time needed to document the reasons for deviations from guidelines.

How's Your Health is a SAINT that can be used immediately by primary care practices that participate in Patient-Centered Primary Care Payment.

- Government agencies (such as the Agency for Healthcare Research and Quality and the Patient-Centered Outcomes Research Institute) and charitable foundations should provide funding to support enhancements to the *How's Your Health* system.
- Patient-Centered Primary Care Payment amounts should be adequate to allow primary care practices to pay modest subscription fees to support the continued operation of the *How's Your Health* system.

C. Making Patient-Centered Primary Care Payment Available to Primary Care Practices

Every payer – every commercial insurance plan, every Medicare Advantage plan, every Medicaid Managed Care Organization, every state Medicaid agency, and Original (fee-for-service) Medicare – should make Patient-Centered Primary Care Payment available to any primary care practice providing services to the patients insured by that payer so that all patients have the opportunity to receive high-quality primary care. However, primary care practices should not be required to participate if they do not wish to.

1. Changes in Payments From Private Insurance Plans

Unfortunately, it is unlikely that most private insurance companies will implement Patient-Centered Primary Care Payment without significant pressure from businesses and citizens.

- Self-insured purchasers should use health plans that implement Patient-Centered Primary Care Payment.
- Businesses should work together through purchaser coalitions to select health plans that implement Patient-Centered Primary Care Payment.
- Purchasers should ensure that health plans implement Patient-Centered Primary Care Payment fully and correctly. This means:
 - ◆ Making payments for all of the new billing codes.
 - ◆ Paying adequate amounts for all new billing codes.
 - ◆ Eliminating pay-for-performance programs.
 - ◆ Eliminating prior authorization requirements.
 - ◆ Setting appropriate patient cost-sharing amounts.
- If residents of the community have choices about which health insurance plan to use, primary care practices can refuse to contract with plans that do not use Patient-Centered Primary Care Payment.

2. Changes in Medicare Payments

- Congress should create a Patient-Centered Primary Care Payment program for Original Medicare beneficiaries with the following characteristics:
 - ◆ All primary care practices should be able to voluntarily enroll, but no primary care practice should be forced to participate;
 - ◆ CMS should implement all of the new billing codes for Patient-Centered Primary Care Payment and assign payment amounts to the codes that are adequate to support high-quality primary care services.
 - ◆ The program should exempt participating primary care practices from the current Merit-Based Incentive Payment System (MIPS), and instead should base accountability for quality and utilization on the utilization of clinical practice guidelines and SCAMPs.
 - ◆ Any net increase in spending on primary care should be exempt from budget neutrality calculations.

- Medicare beneficiaries who have chosen to enroll in a Medicare Advantage plan should choose a plan that makes Patient-Centered Primary Care Payment available to primary care practices. In addition, primary care practices can refuse to contract with Medicare Advantage plans that do not use Patient-Centered Primary Care Payment.

3. Changes in Medicaid Payments

- CMS should establish a policy indicating that approval will automatically be given to states that want to require Medicaid Managed Care Organizations (MCOs) to use Patient-Centered Primary Care Payment.
- In states that use Medicaid MCOs, the state Medicaid agency should require MCOs to use Patient-Centered Primary Care Payment for primary care practices that wish to participate.
- In states that do not use Medicaid MCOs, the state Medicaid agency should begin using Patient-Centered Primary Care Payment to pay primary care practices that wish to participate.

Accelerating Payment Reform for Primary Care

It is time to stop making small changes to the current payment system and expecting significant results. Current approaches have failed to address the serious problems facing primary care, and there is no reason to expect the same approaches will achieve better results in the future.

Patient-Centered Primary Care Payment will address the problems in the current primary care payment system and provide primary care practices with the support they need to deliver high quality care to all patients, including those with complex needs. The details of the payment system can be adjusted over time after the payment system is operational, since it will be impossible to determine what payment amounts or service definitions are exactly right until primary care practices are actually able to deliver care differently. Delaying implementation of a patient-centered payment system until consensus is reached on an ideal approach will prevent patients from receiving the better-quality care they need right now, and it will likely result in additional losses of primary care practices in the interim.

The leadership for reform will need to come from primary care physicians, employers, and citizens. They are directly affected by the problems in the current payment system, and they will receive the benefits in terms of better health and higher productivity, not health insurance plans. The future of primary care will depend on whether purchasers, patients, and primary care practices work together to take the actions necessary to implement a truly patient-centered primary care payment system.

Actions Needed to Implement Patient-Centered Primary Care Payment

Operationalizing Billing and Payment

- The CPT Editorial Panel should establish a formal definition for each of the patient-centered primary care services and assign a specific CPT code to that definition.
- The RVS Update Committee (RUC) should assign appropriate RVU amounts for each of the new CPT codes.
- Medicare and health insurance plans should use appropriate Conversion Factors to convert the RVUs into adequate payments for participating primary care practices. Analyses should be carried out by the RUC or an organization such as the Patient-Centered Primary Care Collaborative or the Medical Group Management Association in order to determine an appropriate conversion factor for Patient-Centered Primary Care Payment CPT codes.

Operationalizing Accountability for Quality and Utilization

- Government agencies and charitable foundations should provide funding to medical specialty societies and multi-stakeholder collaboratives to support development and maintenance of clinical practice guidelines that are free of commercial influence.
- Guideline developers should work together to create a mechanism for enabling primary care practices to easily access all of the guidelines that they would commonly use and to resolve any conflicts among different guidelines.
- The certification requirements for Electronic Health Record systems should be modified to require that the “clinical decision support” component of the EHR be based on all of the most current guidelines and that this component be easy for clinicians to use.
- Government agencies and charitable foundations should provide funding to support the development of SCAMPs and the use of Clinical Data Registries (CDRs).
- Patient-Centered Primary Care Payment amounts should be large enough to ensure that primary care physicians have the resources needed to participate in CDRs and the time needed to document the reasons for deviations from guidelines.
- Government agencies and charitable foundations should provide funding to support enhancements to the *How's Your Health* system.
- Patient-Centered Primary Care Payment amounts should be adequate to allow primary care practices to pay modest subscription fees to support the continued operation of the *How's Your Health* system.

Making Patient-Centered Primary Care Payment Available to Primary Care Practices

Every payer – every commercial insurance plan, every Medicare Advantage plan, every Medicaid Managed Care Organization, every state Medicaid agency, and Original (fee-for-service) Medicare – should make Patient-Centered Primary Care Payment *available* to any primary care practice providing services to the patients insured by that payer so that all patients have the opportunity to receive high-quality primary care. However, primary care practices should not be required to participate if they do not wish to.

Changes in Payments From Private Insurance Plans

- Self-insured purchasers should use health plans that implement Patient-Centered Primary Care Payment.
- Businesses should work together through purchaser coalitions to select health plans using Patient-Centered Primary Care Payment.
- Purchasers should ensure that health plans implement Patient-Centered Primary Care Payment fully and correctly. This means:
 - ◆ Payments must be made for all of the new billing codes.
 - ◆ The payments for all new billing codes must be adequate.
 - ◆ Pay-for-performance programs must be eliminated.
 - ◆ Prior authorization requirements must be eliminated.
 - ◆ Patient cost-sharing requirements must be changed appropriately.
- If residents of the community have choices about which health insurance plan to use, primary care practices can refuse to contract with plans that do not use Patient-Centered Primary Care Payment.

Changes in Medicare Payments

- Congress should create a Patient-Centered Primary Care Payment program for Original Medicare beneficiaries structured as follows:
 - ◆ All primary care practices should be able to voluntarily enroll, but no primary care practice should be forced to participate;
 - ◆ CMS should implement all of the new billing codes for Patient-Centered Primary Care Payment and assign payment amounts to the codes that are adequate to support high-quality primary care services.
 - ◆ The program should exempt participating primary care practices from the current Merit-Based Incentive Payment System (MIPS), and instead should base accountability for quality and utilization on the utilization of clinical practice guidelines and SCAMPs.
 - ◆ Any net increase in spending on primary care should be exempt from budget neutrality calculations.
- Medicare beneficiaries who have chosen to enroll in a Medicare Advantage plan should choose a plan that makes Patient-Centered Primary Care Payment available to primary care practices. In addition, primary care practices can refuse to contract with Medicare Advantage plans that do not use Patient-Centered Primary Care Payment.

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