

How to Pay for Primary Care

There is almost universal agreement that the current fee-for-service payment system does a poor job of supporting high-quality primary care, but what should replace it? Is “population-based payment” the best way to pay for primary care, as many people have proposed?

Payments Must Support Three Different Primary Care Services

A good payment system should enable a primary care practice to deliver care to all types of patients in the most effective way. Primary care consists of three distinct types of services: (1) wellness care, (2) acute care, and (3) chronic condition care. To achieve the best outcomes for patients, each of these services must be delivered in the right way by the most appropriate members of the primary care team:

- Wellness Care** must be *proactive*; the goal is to prevent health problems from occurring in the first place or to identify them in early stages when they can be treated more successfully. Good wellness care involves far more than delivering immunizations and arranging screening tests. The primary care physician should develop an appropriate plan for each patient’s wellness care, but most of the education and assistance the patient needs can and should be delivered by other staff in the primary care practice, such as a nurse or medical assistant.
- Acute Care** is inherently *reactive*; the goal is to promptly diagnose and treat a patient when they have a new acute problem. The primary care physician plays the central role in acute care by accurately diagnosing the patient’s condition and by providing or referring the patient for appropriate treatment, with other staff in the primary care practice assisting the patient in obtaining appropriate diagnostic testing and treatment.
- Chronic Condition Care** must be *both proactive and reactive*. The goals should be to prevent patients from experiencing exacerbations of their condition and also to promptly treat exacerbations when they occur. All members of the primary care team play significant roles in delivering good chronic condition care. The physician ensures the condition is diagnosed accurately and an appropriate plan of treatment is developed, and responds promptly when exacerbations or other problems occur. Other staff in the primary care practice ensure the patient understands how to effectively manage the condition and they proactively monitor how the patient is doing in order to identify problems as early as possible.

Key Primary Care Services and Care Team Roles			
Service	Goal	Physician Role	Other Care Team Member Roles
Wellness Care	Proactive: Prevent health problems from occurring	Developing and overseeing preventive care plan	Providing immunizations, helping patients get screenings & tests, and educating/assisting patients about healthy lifestyle
Acute Care	Reactive: Prompt treatment when new acute problems occur	Prompt, accurate diagnosis and effective treatment (or referral)	Assisting patient with treatment, coordinating services, and monitoring progress
Chronic Condition Care	Proactive + Reactive: Prevent exacerbations & promptly treat exacerbations that occur	Accurate diagnosis and appropriate treatment plan; Prompt response when problems occur in order to avoid ED visit or hospitalization	Patient education and assistance with treatment & self-management; Monitoring to identify & resolve problems early

The primary care *payment system* must enable each of these three primary care services to be delivered in a high-quality way to the patients who need them.

Paying for Wellness Care

Fee-for-Service Payment does a poor job of supporting wellness care because it is designed to pay primarily for office visits with physicians, even though most wellness and preventive care services can and should be delivered by other members of the primary care team. Moreover, fee-for-service payment penalizes the practice financially for keeping the patient healthy, because payments are tied to office visits and healthy patients don’t need as many visits.

Under a **Population-Based Payment** system (also known as **capitation**), the primary care practice receives a fixed amount of money for each patient every month regardless of how many services the patient actually receives during the month.

- In contrast to fees for office visits, the monthly population-based payment allows team members other than the physician to deliver wellness care services, and the practice's revenue will not decrease if patients stay healthy.
- However, in contrast to fee-for-service payment, the practice receives a monthly population-based payment even if it provides no wellness care services to a patient at all. In addition, there is no additional payment for patients who require many preventive care services or who need extra help in obtaining those services (e.g., due to financial barriers or lack of transportation). These weaknesses could reduce, rather than improve, access to wellness care.

There is a third alternative that has the strengths of both fee-for-service and population-based payment while avoiding their weaknesses. Under **Patient-Centered Payment**, the primary care practice would receive a monthly *Wellness Care Payment* for each patient to support a team-based approach to wellness and preventive care, and it would receive a higher payment for those patients who have more preventive care needs or who require more assistance in receiving wellness care services. Unlike fee-for-service payment, the practice would not be paid less if patients stay healthy, but in contrast to population-based payment, the practice would not receive the Wellness Care Payment unless the patient actually *received* wellness care.

Paying for Acute Care

Fee-for-Service Payment is much more closely matched to what is needed to support effective acute care for non-emergency conditions. The fees support the most important aspect of care – the physician seeing the patient to diagnose and treat their condition. If a patient has multiple acute problems during the course of a year, the physician is paid more to address each of those problems. Physicians are now also paid to “see” the patient in quicker and more convenient ways since telehealth restrictions were removed during the pandemic. A key weakness of fee-for-service payment is that it encourages scheduling multiple visits with a patient for the same acute problem even if the patient’s needs could be addressed in fewer visits.

In contrast, **Population-Based Payment** is poorly designed to support effective acute care. The primary care practice receives the same payment regardless of how many acute problems the patient has during the year, and it is paid even if a patient with an acute problem can’t get a timely appointment and has to go to an urgent care center or hospital emergency department.

A **Patient-Centered Payment** preserves the strengths of fee-for-service payment while correcting its weaknesses. When a patient has a new acute problem, the practice would receive an *Acute Care Fee* that enables the physician to spend adequate time diagnosing and treating that problem, and if the patient has multiple acute problems during the year, the practice would receive additional Acute Care Fees to address them. The Acute Care Fee would be paid when the patient has a new acute problem, not simply because the patient makes additional office visits, so there would be no reason to schedule unnecessary visits.

Strengths and Weaknesses of Alternative Ways of Paying for Wellness Care			
Service	Payment System	Strengths	Weaknesses
Wellness Care (proactive)	Fee-for-Service: Fee for each office visit with physician	<ul style="list-style-type: none"> • Supports preventive care (e.g., physical) delivered in person by PCP 	<ul style="list-style-type: none"> • No payment for services delivered by practice staff • Lower revenue if patient stays healthy
	Population-Based Payment (Capitation): Fixed amount per patient per month for all services	<ul style="list-style-type: none"> • Supports services by both physician & staff • No loss of revenue if patient stays healthy 	<ul style="list-style-type: none"> • May not be adequate for patients who face barriers to obtaining preventive care • Payment made even if no care is delivered
	Patient-Centered Payment: Monthly Wellness Care Payment with higher amount for new & complex patients	<ul style="list-style-type: none"> • Supports services by both PCP & other primary care practice staff • No loss of revenue if patient stays healthy • Higher payments for patients with barriers to care • No payment unless wellness care is provided 	

Strengths and Weaknesses of Alternative Ways of Paying for Acute Care			
Service	Payment System	Strengths	Weaknesses
Acute Care (reactive)	Fee-for-Service: Fee for each office visit with physician	<ul style="list-style-type: none"> • Supports physician time with patient to diagnose & treat each problem that occurs 	<ul style="list-style-type: none"> • No payment for help provided without a physician office visit • Higher revenue for unnecessary repeat visits
	Population-Based Payment (Capitation): Fixed amount per patient per month for all services	<ul style="list-style-type: none"> • Allows flexibility to deliver care in different ways • No additional payment for unnecessary visits 	<ul style="list-style-type: none"> • No additional payment for patient with multiple acute problems • Payment is made even if no care is provided at all
	Patient-Centered Payment: Acute Care Fee for diagnosis & treatment of a new acute problem	<ul style="list-style-type: none"> • Flexibility to deliver care in different ways • Supports additional time needed to address multiple acute problems • No payment for unneeded return visits • No payment unless acute care is provided 	

Paying for Chronic Condition Care

Neither Fee-for-Service Payment nor Population-Based Payment does a good job of supporting the combination of proactive and reactive services required for good care of patients with chronic conditions.

- **Fee-for-Service Payment** helps ensure patients with exacerbations are treated promptly and it pays a physician more for additional time spent treating complex patients. However, typical fees provide only limited support for other members of the care team to deliver proactive care management services, and the practice receives less revenue if the patient's care can be managed without frequent office visits.
- **Population-Based Payment** provides greater flexibility for the entire care team to deliver proactive care than fee-for-service payment. In addition, the practice does not lose revenue if it helps a patient avoid exacerbations. However, the practice is paid the same amount even if it fails to effectively manage the patient's chronic condition, and it is paid the same amount for a patient who has complex needs as for a patient who requires less time and attention.

A **Patient-Centered Payment** incorporates the strengths of both fee-for-service and population-based payment while avoiding their weaknesses. The primary care practice would receive a monthly *Chronic Condition Care Payment* that enables all of the members of the primary care team to deliver both proactive and reactive care to a patient with one or more chronic conditions, i.e., to prevent exacerbations from occurring and also to treat them if they do occur. Since the payment would be dedicated to care for the patient's chronic condition(s), the practice would not receive the payment if the patient did not receive appropriate chronic condition care. In contrast to population-based payment, the monthly Chronic Condition Care Payment would be higher if the patient had more complex needs (not just more chronic diseases), but unlike fee-for-service payment, the practice would not be paid more to treat exacerbations that should have been prevented by good chronic condition care.

Strengths and Weaknesses of Alternative Ways of Paying for Chronic Condition Care			
Service	Payment System	Strengths	Weaknesses
Chronic Condition Care (proactive + reactive)	Fee-for-Service: Fee for each office visit with physician	<ul style="list-style-type: none"> • Supports physician time for diagnosis & care planning • Supports physician time with patient when exacerbations occur 	<ul style="list-style-type: none"> • No payment for education & proactive monitoring by staff • Lower revenue if patient has fewer exacerbations
	Population-Based Payment (Capitation): Fixed amount per patient per month for all services	<ul style="list-style-type: none"> • Supports proactive & reactive services by physician & staff • No loss of revenue if patient has fewer exacerbations 	<ul style="list-style-type: none"> • No additional payment for extra time needed by complex patients • Payment is made even if no care is provided at all
	Patient-Centered Payment: Monthly Chronic Condition Care Payment with higher amount for patients with complex needs	<ul style="list-style-type: none"> • Supports proactive & reactive services by both physician & staff • No loss of revenue if patient has fewer exacerbations • Higher payment for complex patients • No payment unless chronic condition care is provided 	

Assuring Access to Care and Appropriate Utilization of Services

Fee-for-Service Payment is routinely criticized for rewarding "volume over value," i.e., encouraging delivery of unnecessary services. However, **Population-Based Payment** has the opposite problem – it can reduce access to care and encourage stinting on services, since the primary care practice receives the same payment regardless of how much care a patient needs or whether the patient's needs are met.

In addition, Population-Based Payment can make it difficult for patients with complex needs to obtain primary care, because a primary care practice will not receive any additional payment to compensate for the additional time such patients require. Risk-adjusting the monthly payments does not address this, because typical risk adjustment systems only increase the monthly payment if a patient has multiple chronic diseases, not if they have a more severe condition, if they face non-medical challenges in managing their chronic condition(s) such as poverty or lack of transportation, or if they have frequent acute problems. This could increase disparities in health outcomes.

These problems would not exist under **Patient-Centered Payment** because the payments for each patient would be based on the specific kinds of services that *individual* patient needs. This would preserve and improve access to care for all types of patients, without creating problematic incentives to either over-treat or undertreat them.

Impacts of Alternative Payment Methods on Access to Care and Utilization of Services		
Payment System	Access to Care	Utilization of Services
Fee-for-Service: Fee for each office visit with physician	<ul style="list-style-type: none"> • Discourages enrolling and managing healthy patients (who don't need many services) 	<ul style="list-style-type: none"> • Encourages delivery of unnecessary visits (which provide extra payment for a limited amount of extra work)
Population-Based Payment (Capitation): Fixed amount per patient per month for all services	<ul style="list-style-type: none"> • Discourages enrolling and managing complex patients (who require extra time and services with no additional payment) 	<ul style="list-style-type: none"> • Encourages avoiding or delaying necessary visits (which require extra work for no additional payment)
Patient-Centered Payment: Monthly payments for wellness care; Fees for diagnosis & treatment of acute problems; Monthly payments for chronic care	<ul style="list-style-type: none"> • Requires delivery of wellness care to healthy patients • Requires delivery of acute & chronic care to patients with health problems 	<ul style="list-style-type: none"> • Encourages addressing new acute problems in a timely, efficient way • Encourages preventing exacerbations of chronic conditions

Patient-Centered Payment is Not Just a “Hybrid” Payment System

Patient-Centered Payment provides three different types of payments to support three different types of primary care services. Monthly payments are used to pay for wellness care and chronic condition care because those are proactive services designed to prevent problems from occurring. Fees are used to pay for acute care because some patients have more acute problems during the year than others, and the primary care practice will need to deliver additional services promptly when each new acute problem occurs.

This is very different from the “hybrid” payments that have been created by the Center for Medicare and Medicaid Innovation and other payers as part of their primary care payment programs. These programs continue to pay fees for every type of primary care service, but the amounts are much lower than current fee levels. The practice also receives a small monthly payment for each patient regardless of what services the patient needs or receives.

This hybrid approach to payment not only fails to eliminate the weaknesses of fee-for-service for wellness care and chronic condition care, it adds the weaknesses of capitation to acute care and the other services.

Patient-Centered Payment is Not Merely a “Hybrid” Payment			
Service	Patient-Centered Payment	“Hybrid” Payment	Weaknesses of Hybrid Payment
Wellness Care (proactive)	Monthly Wellness Care Payment with higher amount for new & complex patients	Small fees for office visits + Small monthly payments	<ul style="list-style-type: none"> Loss of revenue if patient does not have physician visits Monthly payments too small to support effective wellness care for many types of patients
Acute Care (reactive)	Acute Care Fee for diagnosis & treatment of a new acute problem	Small fees for office visits + Small monthly payments	<ul style="list-style-type: none"> Visit fees are inadequate for the time needed for diagnosis Small visit fees encourage unnecessary return visits Small difference in payment for multiple acute problems
Chronic Condition Care (proactive + reactive)	Monthly Chronic Condition Care Payment with higher amount for patients with complex needs	Small fees for office visits + Small monthly payments	<ul style="list-style-type: none"> Loss of visit revenue if patient has fewer exacerbations Monthly payments adjusted only for the number of chronic conditions, not for the severity of conditions or the complexity of patient needs

Payment Amounts Must Be Adequate to Support the Time Needed for Quality Care

Patient-Centered Payment is a better way of paying for primary care than either Fee-for-Service Payment or Population-Based Payment. However, it is not enough to have a good *method* of payment for primary care. The *amount* of payment must also be *adequate* to support the time that primary care teams will have to spend delivering the services that patients need. Yet another weakness of most Population-Based Payment systems is that the amounts of the monthly payments are not based on how much time it actually takes to deliver high-quality primary care, but rather on the average amount the payer had been spending under fee-for-service, even though the fee-for-service payments were inadequate to support high-quality primary care.

Because each of the three components of Patient-Centered Payment is designed to enable delivery of a particular type of service, adequate payment amounts can be established by:

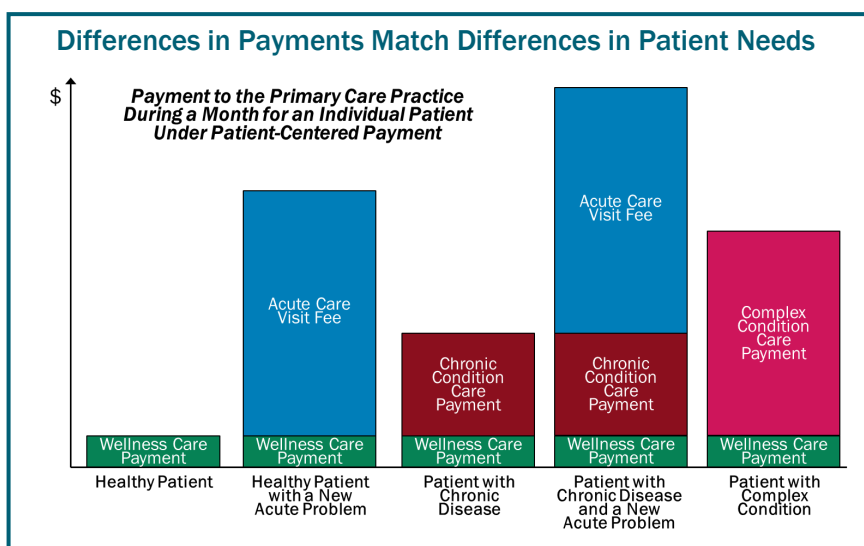
- (1) estimating the amount of time that will be needed to deliver each of those services in a high-quality way,
- (2) identifying which members of the primary care team will likely be involved in delivering the services, and then
- (3) translating those times into costs based on the team members’ wage rates and the overhead cost of the primary care practice.

(A detailed discussion of how to determine appropriate payment amounts for primary care services is available in the Center for Healthcare Quality and Payment Reform’s report [Patient-Centered Payment for Primary Care](#).)

Defining Adequate Payment Amounts to Support the Cost of Primary Care Team Members’ Time				
Service	Patient-Centered Payment	Time Needed	Team Skills Needed	Payment Needed
Wellness Care (proactive)	Monthly Wellness Care Payment with higher amount for new & complex patients	~0.75 hours per year ~1.5+ hours per year (complex patient)	~40% physician ~60% nurse/staff	\$8 per month per patient \$16 per month per patient (complex patient)
Acute Care (reactive)	Acute Care Fee for diagnosis & treatment of a new acute problem	~35-40 minutes per acute event	~90% physician ~10% nurse/staff	\$141 per acute event
Chronic Condition Care (proactive + reactive)	Monthly Chronic Condition Care Payment with higher amount for patients with complex needs	~2.1 hours per year ~4.2 hours per year (complex patient)	~60% physician ~40% nurse/staff	\$29 per month per patient \$58 per month per patient (complex patient)

This approach automatically “risk-adjusts” the total payment the practice receives for each patient during a month based on the relative amount of time the practice will need to spend addressing that individual patient’s needs.

- The practice will receive the smallest payment during the month for a healthy patient with no acute problems, because that patient will need the fewest services. However, the practice will still receive a payment each month for that patient, because the patient should be receiving proactive wellness care every month.
- The practice will receive the highest payment during the month for a patient who has an acute problem, because the primary care physician will need to spend adequate time with that patient to diagnose and treat the problem.
- The practice will receive a higher amount each month for a patient with a chronic condition than for a patient without a chronic condition, and it will receive an even higher amount for a patient with a complex condition, since those patients will require more proactive care from the practice than a healthy patient as well as be more likely to have exacerbations that require prompt treatment.



A primary care practice can also deliver integrated behavioral health services to its patients if the Wellness Care Payments and Chronic Condition Care Payments are set at levels high enough to cover the additional cost of employing behavioral health staff in the primary care practice.

Patient Cost-Sharing for Primary Care

It does little good to pay the primary care practice adequately to deliver high-quality care if cost-sharing discourages or prevents patients from receiving that care, as current requirements often do. Under **Patient-Centered Payment**:

- there should be *no cost-sharing for wellness care*, so there is no barrier to spending the time needed to help the patient prevent health problems from occurring or to identify problems at an early stage when they can be treated more successfully and at lower cost.
- There should be a *small co-payment for acute care*. 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, but large enough to discourage truly unnecessary visits. Moreover, the copayment should be significantly less than the copayment or coinsurance required for an urgent care visit or an emergency department visit.
- There should be *no cost-sharing for chronic condition care*. Good chronic condition care will prevent exacerbations that require expensive treatment, so there should be no cost barriers that discourage patients from receiving proactive chronic condition care.

Affordable Cost-Sharing for the Patient as Well as Adequate Payment for the Primary Care Practice				
Service	Patient-Centered Payment	Payment Needed	Patient Cost-Sharing	Rationale
Wellness Care (proactive)	Monthly Wellness Care Payment with higher amount for new & complex patients	\$8 per month per patient \$16 per month per patient (complex patient)	No cost share	Encourages wellness care to avoid need to treat preventable problems
Acute Care (reactive)	Acute Care Fee for diagnosis & treatment of a new acute problem	\$141 per acute event	Affordable copayment for acute visit	Encourages primary care visit instead of more expensive ED visit
Chronic Condition Care (proactive + reactive)	Monthly Chronic Condition Care Payment with higher amount for patients with complex needs	\$29 per month per patient \$58 per month per patient (complex patient)	No cost share	Encourages proactive care of chronic condition to prevent need for ED visits and hospitalizations

Assuring Patients Receive High Quality Care

Neither Fee-for-Service Payment nor Population-Based Payment assures that a patient will receive the services they need to achieve the best health outcomes. In an effort to address this, Medicare and other payers have created complex pay-for-performance structures using dozens of different quality measures. However, the quality measures don't actually measure the quality of care and they can penalize primary care practices that care for higher-need patients. (These problems are explained in more detail in CHQPR's report [Why Quality Measures Don't Measure Quality](#).)

In **Patient-Centered Payment**, a primary care practice would not bill or be paid for a monthly Wellness Care Payment, an Acute Care Fee, or a monthly Chronic Condition Care Payment for an individual patient unless (1) the practice had delivered services to the patient consistent with applicable, evidence-based Clinical Practice Guidelines (CPGs) during the month or acute care visit, or (2) the practice deviated from the guidelines for patient-specific reasons and had documented those reasons in the patient's clinical record. In addition, in order to receive Wellness Care Payments or Chronic Condition Care Payments for a patient, the primary care practice would need to contact the patient regularly to assess the status of their health problems.

This approach assures that each *individual* patient is receiving the most appropriate, high-quality care for *their individual needs*.

Paying for High-Quality Care Without Burdensome Administration or Financial Risk

Not only is Patient-Centered Payment better than Population-Based Payment in supporting high-quality primary care for all types of patients, it can be implemented with far less administrative burden. Payers' existing claims payment systems and primary care practices' current billing systems can be used for billing and payment by creating a small set of new billing codes. There is no need for the complex "attribution" systems that are used in Population-Based Payment systems to (inaccurately) determine which patients a primary care practice is accountable for, and there is no need for the burdensome data submissions currently required to support calculations of risk adjustment factors and quality scores. The patient-specific quality standards would eliminate the need for problematic prior authorization systems that delay care and waste physicians' time. There is also no need for primary care practices to take financial risk for services and spending they cannot control. This enables small primary care practices to participate in Patient-Centered Payment, not just large medical groups or health systems.

No Payment for a Patient Unless Quality Care is Delivered			
Service	Patient-Centered Payment	Patient-Centered Standard of Quality	Assurance of Quality
Wellness Care (proactive)	Monthly Wellness Care Payment with higher amount for new & complex patients	<ul style="list-style-type: none"> Deliver or order all evidence-based preventive care services unless the patient is unwilling or unable to receive the services Contact the patient regularly to assess the status of their health problems and the patient's confidence in managing their health needs 	No payment for the month for the patient unless the standard of care is met for <i>that</i> patient
Acute Care (reactive)	Acute Care Fee for diagnosis & treatment of a new acute problem	<ul style="list-style-type: none"> Follow evidence-based clinical practice guidelines to diagnose and treat the problem in a timely way Deviations from guidelines should be based on patient-specific needs, resources, and preferences that are documented in the clinical record 	No payment for the acute event unless the standard of care is met for <i>that</i> patient
Chronic Condition Care (proactive + reactive)	Monthly Chronic Condition Care Payment with higher amount for patients with complex needs	<ul style="list-style-type: none"> Follow evidence-based clinical practice guidelines to diagnose, treat, and manage the chronic condition(s) effectively, with deviations based on patient-specific needs, resources, and preferences Contact the patient regularly to identify problems and address them as quickly as possible 	No payment for the month for the patient unless the standard of care is met for <i>that</i> patient

Accelerating Primary Care Payment Reform

It's time to stop debating whether fee-for-service payment or population-based payment is better, since both have serious weaknesses. **Patient-Centered Payment** is the best way to support primary care. *Every payer* should make Patient-Centered Payment available to all primary care practices, so that *every patient* has the opportunity to receive high-quality primary care.

Patient-Centered Payment is Best for All Primary Care Services		
Service	Patient-Centered Payment	Strengths
Wellness Care (proactive)	Monthly Wellness Care Payment with higher amount for new & complex patients	<ul style="list-style-type: none"> Supports services delivered by both PCP & staff No loss of revenue if patient stays healthy Higher payment for patients with complex needs No payment unless wellness care is provided
Acute Care (reactive)	Acute Care Fee for diagnosis & treatment of a new acute problem	<ul style="list-style-type: none"> Flexibility to deliver care in different ways Supports additional time needed to address multiple acute problems No extra payment for unnecessary return visits No payment unless acute care is provided
Chronic Condition Care (proactive + reactive)	Monthly Chronic Condition Care Payment with higher amount for patients with complex needs	<ul style="list-style-type: none"> Supports proactive & reactive services by both physician and practice staff No loss of revenue if patient avoids exacerbations Higher payment for patients with complex needs No payment unless chronic condition care is provided