PATIENT-CENTERED PRIMARY CARE COLLABORATIVE

A NEW PHYSICIAN PAYMENT SYSTEM TO SUPPORT HIGHER QUALITY, LOWER COST CARE THROUGH A PATIENT-CENTERED MEDICAL HOME

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- Our current U.S. healthcare system is **characterized by unsustainable cost growth and the presence of significant quality gaps**. Healthcare costs are growing faster than the economy and healthcare outcomes in the United States contrast poorly with those of other industrial countries, despite the highest level of spending.

- One of the major reasons why high health care expenditures are not achieving better value is that **traditional Fee-for-Service payment rewards piecemeal work and "volume" of services rather than prevention of illness and coordination of care**. The more procedures a physician performs, and the higher the value of the procedure, the more the physician is paid.

- A better payment system is needed that aligns incentives for care that is coordinated by a personal physician through a **Patient-Centered Medical Home (PCMH),** a type of care that research shows is of higher quality and lower cost.

- A PCMH is a physician practice that has gone through a voluntary qualification process to demonstrate that it has the following characteristics and capabilities needed to effectively partner with patients to provide patient-centered care:
    - **a personal physician** who is accountable for taking care of all of a patient's health care needs;
    - **collaboration with multi-disciplinary teams of physicians, nurses, caregivers, and other health professionals,** both within a practice and through coordination of care with health professionals in the community, to assure that all of the patient's needs are met;
    - **health information technologies** to facilitate access to services and coordination and sharing of information among health professionals, care givers and sites of service;
    - **transparency and accountability** for achieving better results through reporting on evidence-based measures of care.

- A **better payment model** designed to support care provided through a PCMH would:
    - **Pay physicians for the time spent to coordinate care** with family caregivers and other health professionals that is separate from--and in addition to--the work included in a face-to-face encounter..

- **Create financial incentives for physicians to acquire and use health information technologies**—such as patient registry systems, secure email, evidence-based clinical decision support, and electronic health records--to achieve better outcomes.
- **Result in a higher payments to primary care physicians based on achieving better outcomes and reducing total health care spending** through a PCMH**. Such payments should:** recognize **the time and expenses incurred** in delivering patient-centered care through a medical home, **be sufficient to address long-standing payment inequities that undervalue primary care, recognize the potential savings** (such as preventing avoidable hospital admissions/ emergency room visits of patients with chronic illnesses) that can be achieved through effective care coordination by physicians, and **include rewards based on performance**.
- **Provide accountability and transparency** for achieving better results by linking a portion of payments to reporting on evidence-based measures of care.

- The most effective way to re-align payment incentives to support the PCMH would be to combine traditional fee-for-service for office visits with a three part model that includes:
  - **A monthly care coordination payment** ("bundled care coordination fee") for **the physician work that falls outside of a face-to-face visit** and for the **heath information technologies** needed to achieve better outcomes. Bundling of services into a monthly fee removes volume- based incentives and promotes efficiency. The prospective nature of the payment recognizes the up-front costs to maintain the required level of care. Care coordination payments **should be risk-adjusted** to ensure that there are no inherent incentives to avoid the treatment of the more complex, costly patients.
  - **A visit-based fee-for-service component that** recognizes visit-based services that are currently paid under the present fee-for-service payment system and maintains an incentive for the physician to see the patient in an office-visit when appropriate.
  - **A performance-based component that** recognizes achievement of quality and efficiency goals.

- This new PCMH payment framework will **result in better value—**defined as better outcomes at less cost—for patients and consumers and for the employers and governments that purchase health care on their behalf. It will result in better value by **recognizing the higher quality and cost-savings associated with having a primary care physician** who is accountable for a patient's whole health, by **rewarding physicians for prevention and coordination rather than volume** of services, **by facilitating the use of health information technologies** to achieve better outcomes, and by introducing **transparency and accountability** for the care provided.