QUALIS HEALTH

Financing Advanced Primary Care

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KEY POINTS:

- There is no one "best" financing model for advancing primary healthcare. Each model has trade-offs.
- Many primary healthcare delivery systems are designed to accommodate pre-existing financing mechanisms, rather than the financing systems being designed to support primary care delivery.
- Providers are highly responsive to financial incentives, and in the U.S. those operating under the traditional fee-for-service payment system operate near revenue-maximizing levels of staffing and service delivery.
- Modest per-member-per-month-based funding may support some transformation, but achieving the goals of advanced primary care in the U.S. will require more radical payment reforms that specifically target the delivery of desired services, and promotion of population health as the end outcome.

The way in which primary care is paid for has a profound impact on the way in which it is delivered. However, there is no single "best method" for financing primary care, as each of the many available approaches requires certain trade-offs. Dr. Bitton provided an overview of different types of financing mechanisms for advanced primary care.

Dr. Bitton observed that delivery systems in many developed countries have often been designed to succeed under existing financing mechanisms, in contrast to an approach whereby financing mechanisms are intentionally designed to support achievement of specific system and population outcomes from primary care.

Financing approaches can be viewed along a spectrum that is bounded on one end by fee-for-service payments for point in time transactions such as face-to-face visits, and on the other by capitation or even global budgets for a population. In between, there are pay-for-performance schemes, "per-member-per-month (PMPM)" payments to supplement fee-for-service, the addition of shared savings incentives, and bundled payments for defined episodes of care.

As the financing mechanisms change, incentives, trade-offs, and risks change as well. For instance, on the fee-for-service end of the spectrum, incentives favor productivity and volume of service rather than efficiency in achieving desired outcomes. Under bundled payment approaches that are not adequately tied to achievement of desired quality outcomes, there is a risk that needed care may be withheld to assure profit.

Dr. Bitton reviewed four examples of primary care financing mechanisms that moved beyond the predominant fee-for-service model that has been used in the U.S.

In 2004, the United Kingdom implemented a pay-for-performance program that linked up to 25% of income for family doctors to achievement of various technical quality targets for 136 indicators. Initial substantial improvements on measures related to chronic conditions such as asthma and diabetes were not sustained over time. Further, among the unintended consequences were reductions in the quality of care processes not linked to performance incentives. Pay-for-performance programs in other advanced economies have similarly found that initial progress has been difficult to sustain, and have resulted in unintended consequences, especially around patients' experience of care.

Dr. Bitton reviewed a number of U.S. patient-centered medical home (PCMH) payment pilots that incorporate a variety of hybrid models that remain based on fee-for-service, but include supplemental PMPM payments and occasionally shared savings.

Iora Health is a private provider entity that contracts with employers or insurers to provide primary care. In effect, the model represents a bundled payment for a year-long "episode" of primary care. Consumers receive wrap-around insurance for specialty and inpatient care. Early results are still in process, but the care and payment model may be promising.

Comprehensive Primary Care Plus (CPC+) is a large, 14-state multipayer payment model implemented by the federal Centers for Medicare & Medicaid Services. CPC+ has two tracks with different proportions of fee-for-service, per beneficiary per month care management fees, and performance-based incentive payments. One of the tracks provides an opportunity for physicians to receive a significant proportion of compensation in the form of per beneficiary capitation.

Dr. Bitton described a microsimulation approach that modeled the effects of various combinations of fee-for-service, PMPM, and pay-for-performance bonuses on primary care practice finances. He and his colleagues found that clinics are highly responsive to financial incentives and that on average U.S. primary care practices operate at over 95% efficiency under the fee-for-service model. Modest PMPM-based funding may support some initial practice transformation, but achieving the goals of PCMH will likely require more radical payment reforms that specifically target the delivery of desired services. Models suggest that delivery of coordinated, team-based care that conforms to the PCMH approach is incentivized when the proportion of financing under capitation models is above approximately 65% of total revenue.

VIDEO: Financing Primary Care
SLIDES: Financing Primary Care