



POLICY BRIEF

Promoting Appropriate Payments for the Value Provided by Primary Care and Care Coordination

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Payment reforms must recognize the value provided by primary care in managing the health of individuals and populations. We will not create a delivery system that is patient-centered and well-equipped to deliver high quality care while controlling costs without changing payments to recognize the value of care coordination and the management of patients, particularly those with complex chronic illnesses.

The Center for Payment Reform (CPR) believes that having an adequate primary care workforce is central to delivering high-quality, cost-effective and coordinated care. This will require improving payment to primary care physicians and other primary care providers and linking those payments to demonstrated value. We also support enhancing primary care payments in at least a budget-neutral, if not budget-positive, fashion. This means that increased payments for primary care should be funded by either the relative reduction (or reduced increase) for other specialty services and/or by the documented efficiencies and savings from other areas of the system.

Health care payment reform should both address near-term payment gaps and provide a clear pathway for a longer-term strategy to alter physician compensation such that the value of primary care services, team-based care, care coordination and cognitive medical skills are better recognized. The specific policies below address both near-term options and processes to ensure that there is a path for assuring primary and other specialty care payments are based on the value of the care provided to patients.

Near-Term Value Adjustments for Primary Care

The Center for Payment Reform supports the Senate Finance Committee's concepts that propose a combination of payment adjustments aimed at improving the payment levels and how they are calculated for primary care providers, including:

- Increasing payments for providing primary care services;
- Establishing new fee-for-service mechanisms to pay for transitional care and/or care management activities;
- Using the Center for Chronic Care Innovation to consider expansion of the medical home model upon demonstration of such programs' alignment with the *Joint Principles of the Patient Centered Medical Home*, the *Principles for Patient and Family Centered Care: The Medical Home from the Consumer Perspective*, and evidence that the model demonstrates value; and
- Expanding CMS' performance-based reporting and payment programs to foster accountability and better rewards for primary care providers for the quality, efficiency and outcomes of care they deliver.

Going beyond those elements outlined, the Center for Payment Reform believes that there is an urgent near-term need to initiate multi-year improvements to primary care payment to better

align those payments with patient value. Policies should be aggressive and include the following:

- Payments for primary care services should be increased by at least 10% in 2010 and by 5% for each of two years thereafter, so that the cumulative increase by 2013 is at least 20%. These increases should be funded from direct offsets from other areas.
- CMS should develop and implement a process – to be completed in the next two years – that would establish appropriate valuation of specific services and of overall average compensation of primary care and other specialties, which would include:
 - Restructuring of the RBRVS formula to consider not only cost inputs, but patient and societal value of services provided (see below);
 - The process proposed should be budget neutral; and
 - The process should support the goal of achieving a sustainable supply of primary care providers.

Longer-Term Value Adjustments to Physician Payments: Adding ‘Value’ Into the RBRVS Calculation

Under the current Medicare payment system – framed by the resource-based relative value scale (RBRVS) – physician payments are based primarily on the resource cost of providing a service. This approach is followed by the private sector. Current law directs CMS to determine payments based on the relative “cost” of the service or procedure from the perspective of the physician providing the service. Under the current system, payments cannot reflect a judgment of the value of a service to patients or society. As a result, providers are implicitly discouraged from delivering ‘low resource-using’ services that might be highly valuable to a patient or from a public health standpoint (e.g., counseling, care coordination, etc).

The Center for Payment Reform supports rapid movement to a physician payment system that rewards patient and societal value and resource use. The Senate Finance Committee should direct CMS to develop a new framework for payments such that provider costs are not the only factor, but instead there are also express considerations of broader value. The health reform legislation should require CMS to establish a task force to formulate a proposal – within two years – to supplement the existing cost-based approach to pricing services. The new ‘value’ factor should consider policy priorities, patient preferences, and payer and purchaser perspectives and be informed by additional considerations such as utilization patterns and geographic variation, among other factors.

The redesign of the RBRVS formula should be linked to expanding a value-based payment program for certain services and providers to reward evidence-based care. However, these rewards should not be “one size fits all.” The current physician payment mechanism does not take into account the clinical appropriateness of the services provided. Rather, it rewards growth in the volume of services: a service provided to the right patient at the right time receives the same payment as a service provided without an evidence-based justification. The CMS proposal for revising RBRVS should include mechanisms to have differential performance-based rewards that would be substantial supplements to revised RBRVS-based fee-for-service, and available only to the identified services and providers. Physicians and other ancillary providers (e.g., nurse case managers, nurse practitioners, and physician assistants) should be

eligible to receive the enhanced payments for performance in areas that are identified as having higher potential positive impact.

Reforming Medical Education to Ensure an Adequate Workforce

The Center for Payment Reform strongly supports the development of a fuller set of policies that will foster the training, education and recruitment of physicians and other providers into primary care. There is currently a shortage of primary care physicians, and that shortage and the demands on primary care physicians is expected to grow in the coming years.

While we believe that the Senate Finance Committee Policy Option of making additional residency training slots available for primary care is a step in the right direction, it is unlikely to have a significant effect. Beyond reallocating training slots, the Center for Payment Reform believes that there needs to be a fuller review and adjustment of payments for medical education that are targeted at fostering an adequate primary care physician pool. We recommend that the health reform legislation include commissioning the Institute of Medicine to formulate a National Workforce Plan with specific milestones and goals that the nation should achieve by 2025. Policies that should be considered in this plan include:

- Redistribution of the funding allotted to residency programs in different specialties to ensure adequate funding of slots for primary care;
- Loan forgiveness programs so that graduates who choose primary care have no/less debt; and
- Dramatic expansion of the National Health Service Corps to encourage greater participation.

Expand Eligibility for Enhanced Payments to Non-Physician Primary Care

The Center for Payment Reform supports efforts that acknowledge that ancillary providers, such as nurse practitioners and physicians' assistants, often perform care management and coordination services. In the face of primary care physician shortages, and while MedPAC and CMS explore options to boost the supply of physicians, Medicare should develop mechanisms to reimburse non-physician providers for care management and coordination services for patients, especially those with chronic conditions.

The Center for Payment Reform (CPR) is a coalition of consumers, purchasers, labor, physicians and other health care providers, payers and policymakers who have come together based on their shared vision that improving quality and affordability in health care requires a transformation in our payment systems.

CPR is supported by foundations and by contributions of employer, consumer, health plan, physician and other provider organizations and is an initiative of the Consumer-Purchaser Disclosure Project. Learn more about the Center for Payment Reform and the Center's Payment Reform Principles at www.centerforpaymentreform.org.