

Health Affairs **Blog**

Creating Value-Based Incentives For Primary Care

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In a remarkable recent interview [1], Donald Berwick MD, Administrator of the Centers for Medicare and Medicaid Services (CMS), eloquently described his vision of value-based health care.

Paying for value is an incentive...The underlying idea of improvement is that American health care, historically built in fragments, often cannot achieve for patients what it really wants to achieve...Health delivery system reform refers to really reconfiguring care into much more seamless coordinated-care operations so that people, especially those with chronic illnesses, experience continuity of care over time and space.

So when patients come home from the hospital, there is a smooth handoff, and all the necessary information follows them. When they are seeing a specialist, that specialist is coordinating care with their primary care doctor.

This description probably resonates with most health care professionals as a better approach than the current paradigm's fragmentation and lack of continuity of care. But as with many things in health care, it won't be easy getting to a value-based health care approach in Medicare and Medicaid. Despite wide acknowledgement that fee-for-service perpetuates our health system's most undesirable characteristics, the mainstream of American health care seems stuck. One wonders whether CMS can rise above the special interest lobbying, get beyond the interminable pilots and decisively act on payment reform with the conviction required to help save health care from itself.

Still, the idea of value-based reimbursement begs questions. What payment methodology will incentivize the best quality and most efficient care? What path can take us there?

Primary care should be at the heart of this discussion. While much of specialty care has been overvalued [2] over recent decades, the undervaluing of primary care [3] has weakened its moderating influence over downstream services, with dramatic cost growth [4] that now threatens all health care and the nation.

Let's recount what we know about primary care and its impact on specialty services.

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More primary care in a market lowers overall health care cost [5].

Primary care physicians (PCPs) who aren't rushed with patients tend to develop stronger patient relationships and handle problems immediately, making fewer (unnecessary) specialty

referrals [6]. By contrast, volume-based primary care reimbursements that incentivize shorter established office visits increase cost.

Fee-for-service reimbursement encourages more services, independent of appropriateness, and so is antithetical to medical homes that focus on ensuring appropriate care [7] throughout the continuum.

Over the past 20 years, a specialist-dominated political process has driven an enormous disparity between primary and specialty care reimbursement [8]. Low primary care reimbursement has resulted in a primary care labor crisis [9].

When referrals are made, an open line of communication creates greater specialist accountability to the PCP, moderating unnecessary services. This approach appreciates PCPs as full-continuum patient advocates and guides rather than as “gatekeepers.”

The lessons above constitute a basis for a revised approach to primary care payment. The goal here should not be to simply pay primary care physicians more for the same work, but to change medical management in a way that increases efficiency throughout the continuum.

Here are guidelines that should be reflected in any new primary care payment scheme:

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Separate Valuation Mechanisms. The work of primary and specialty care physicians can be very different and must be evaluated differently, through separate mechanisms.

Valuation Absent Financial Conflict. Specialty physicians have a financial interest in how primary care physicians practice, so should not dominate the determination of primary care reimbursement.

Financial Parity. To rebuild our primary care workforce, generalist physician income should be on par with average specialist income.

Incentivize Appropriateness. Payment should incentivize appropriate care and, unlike straight fee-for-service or capitation, avoid encouraging the delivery of unnecessary care or the denial of necessary care.

Incentivize Teamwork. Payment should reward population-level health improvements that can only be achieved through more primary-specialty collaboration and accountability. Of course, this assumes that physicians have better access to comprehensive patient information.

A Focus on Value. Payment should be based not only on a service’s “inputs” – both inside and outside the patient encounter – required to accomplish care, but on its value. Care valuation should include patients, purchasers and health economists as well as clinical practitioners.

Encourage Investments for Better Performance. Payment should encourage investment in technologies and programs demonstrated to improve quality or safety at lower cost.

Payment that reflects these elements would liberate primary care, organically reducing unnecessary specialty care, and saving money without reducing payment for individual specialty procedures.

Fixing primary care reimbursement is a critical first step toward healing primary care and the larger American health system. For this reason, CMS should consider these design criteria within the frame of Dr. Berwick’s vision, and move with all speed to change the way it pays for primary care.

URLs in this post:

[1] interview: <http://www.aafp.org/online/en/home/publications/news/news-now/government-medicine/20110518berwick-qanda.html>

[2] specialty care has been overvalued : <http://careandcost.com/2011/03/18/rep-jim-mcdermott-questions-medpac-chair-glen-hackbarth-about-the-rvs-update-committee-ruc/>

[3] the undervaluing of primary care: <http://careandcost.com/2011/04/26/a-modest-proposal-what-if-all-specialty-procedures-were-coded-with-four-cpt-codes/>

[4] dramatic cost growth:

http://insight.milliman.com/article.php?cntid=7628?&utm_campaign=Milliman%20Homepage&utm_source=milliman&utm_medium=web&utm_term=home%20banner&utm_content=MMI

[5] More primary care in a market lowers overall health care cost:

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[7] medical homes that focus on ensuring appropriate care:

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[8] enormous disparity between primary and specialty care reimbursement:

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[9] primary care labor crisis:

<http://journals.gmu.edu/index.php/newvoices/article/viewFile/258/159>