

Prospective Payment for Primary Care: Lessons for Future Models

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Abstract

Realizing a vision for advanced primary care in the United States will require adopting new payment strategies. The predominant payment scheme under which primary care practices operate—and their primary source of revenue—is fee-for-service payment. However, fee-for-service is not structured to support or sustain a comprehensive primary care system. Prospective payment for primary care is an alternative payment model that can facilitate care delivery transformations to better manage population health. It offers practices a predictable source of revenue, independent of the units of traditionally billable services, and the flexibility to manage care within a budget to optimize outcomes for a population of patients. Earlier primary care prospective payment models, such as those commonly employed in the 1990s, offer lessons and insights for designing a prospective payment for primary care that will facilitate the delivery of comprehensive, coordinated, and patient-centered primary care.

Introduction

Primary care is essential to achieving better health outcomes, managing the health of populations, and lowering health care costs. It has historically been reimbursed on a fee-for-service basis, requiring primary care practices to generate office visits to ensure revenue.¹ The reduction in face-to-face visits brought on by COVID-19 has further exposed the limitations of the fee-for-service payment model, creating financial hardship for primary care practices during the pandemic.²

There is widespread recognition that fee-for-service payment, the principal payment mechanism used for primary care in the United States, is incompatible with achieving the goal of accessible, patient-centered, high-quality care.⁵ It is a particularly ill-suited model for realizing an advanced primary care system that manages care for patient populations and improves health outcomes. Many federal and state purchasers and insurers, several primary care specialty societies, and others are advocating for or experimenting with prospective payment models for primary care to align payment with the vision for an advanced primary care system.⁶

Reduced office visits and patient encounters during the pandemic have left primary care practices without their main source of revenue, creating a financial crisis that has forced practices to furlough staff and/or temporarily close down, and has caused significant disruptions in access to care during a public health emergency.^{3,4}

This brief examines prospective, per-patient payment for primary care services as an alternative to fee-for-service payment and is intended to inform and advance conversations among primary care practices, state policymakers, and health care payers and purchasers about primary care payment reform and sustainability. “Population-based payments,” “primary care capitation,” and “global budgets for primary care” are terms used to identify

prospective payment models, each paying a fixed, per-patient amount for a defined set of primary care services.

The brief focuses attention on the *manner* in which primary care services are reimbursed, not the *level* of overall investment in primary care. Prospective, per-patient payment models hold the potential to strengthen primary care by providing flexibility for primary care practices and greater revenue certainty, thereby facilitating and sustaining system transformation. Compared to fee-for-service payments, prospective payments also offer practices a predictable revenue stream, one that promotes a sustainable primary care system.

Better Today Than Yesterday

Paying for primary care services using a prospective payment arrangement is not new. Health insurers in California have been administering primary care per-patient payments prospectively for decades; yet nationally it remains a model under which relatively few primary care practices operate. According to an analysis of the 2016 National Ambulatory Medical Care Survey (NAMCS) performed by the Robert Graham Center, 88% of primary care providers reported that less than 25% of their revenue comes from prospective payment and 85% of visits to primary care physicians were to practices that reported less than 25% of revenue from capitation.⁷

Experience with prospective primary care payment in the 1990s offers lessons for structuring prospective payments for primary care that can support a sustainable, comprehensive, and coordinated primary care model, a hallmark of a high-functioning health care system.^{8,9,10} Such arrangements with primary care physicians increased in the 1990s with the rise of enrollment in health maintenance organizations (HMOs). HMOs used prospective primary care payment as a means of controlling health care costs but also imposed utilization management requirements, including referral requirements, and determinations of medical necessity on primary care physicians, effectively transferring both financial risk and traditional insurer obligations to physicians. This led to a backlash among patients and physicians, resulting in a decline in capitated arrangements in most parts of the United States.

Importantly, those early prospective primary care payment models did not feature many of the design components that are now widely acknowledged as needed to make it a more attractive and viable payment model for practices.^{11,12,13} Key distinctions between earlier models and those that are gaining attention today include the following:

- Earlier models were not risk-adjusted beyond age and sex, and therefore did not accurately account for increased costs associated with patients with more complex health needs. This created an incentive for primary care physicians to favor healthier patients over sicker patients. (Risk adjustment moderates this incentive to some extent.)
- Services included in earlier models extended beyond some practices' clinical capacity, thereby transferring financial risk for care that practices could not manage.

- Mechanisms to mitigate incentives to withhold care, such as quality and performance incentives, were typically not included in earlier models.

Emerging models are, in large part, structured to address the deficiencies and concomitant consequences of earlier models. In addition, practices today have many advantages that did not exist in the 1990s:

- Primary care transformation efforts over the past 10+ years, including the Centers for Medicare and Medicaid Services (CMS's) Comprehensive Primary Care (CPC) and Comprehensive Primary Care Plus (CPC+) initiatives and other patient-centered medical home (PCMH) programs, have been helping practices redesign care delivery and position themselves to effectively manage population health under prospective
- Insurers have often provided financial support for infrastructure investment in practices, and sometimes have continued doing so for care management and care coordination functions on an ongoing basis.
- Today, practices possess electronic medical records, telehealth capability, and analytic tools for managing population health. They also receive data and reports from insurers, such as notifications of emergency department visits and hospital discharges, high-risk patient lists, spending reports, and quality gap reports, as well as information from state and regional health information exchanges, that they previously did not.
- Finally, advanced, team-based care is more prevalent now, and practices are therefore in a better position to make use of a complementary practice team to support patient care.

Supporting and Sustaining Primary Care Transformation with Prospective Payment

Under a prospective payment arrangement, primary care practices are prepaid a fixed amount for each patient for a set of covered services over a defined period of time. It is a budget-based model, in contrast to fee-for-service, which is production-based. The amount paid is based on the practice's panel of patients, and is independent of the covered services provided. Payment is typically administered on a monthly basis, and the amount of the payment may sometimes include an overall adjustment to support transition to the new payment model.

Rhode Island: Over the last decade, Rhode Island's Office of the Health Insurance Commissioner (OHIC) has leveraged its regulatory authority to promote and require investments in primary care. Early efforts focused on supporting practice transformation activities to create an advanced primary care system and requiring commercial insurers to increase the share of total spending allocated to primary care. The state is now directing commercial health insurers to implement prospective payments with primary care practices beginning in 2021. Insurers must increase the percentage of attributed lives for which the insurer is making prospective payments from at least 20% of insured members in 2021 to at least 60% by 2023.¹⁴

A prospective payment model affords practices greater financial predictability and control. It allows for flexibility in allocating resources to communicate with and care for patients using the modalities that are most responsive. These may include video or telephone visits, email, or electronic messaging. Practices can invest in technology and systems to optimize workflow and/or expand their staff for an extended, multidisciplinary care team. More sophisticated health IT tools enable practices to stratify patient populations and identify those patients for whom care coordination or disease prevention programs could yield better outcomes, and to support the staff to deliver these interventions. With a more certain flow of cash and a payment scheme untethered from the production incentives of fee-for-service, practices are better positioned to manage the health of their patient populations and deliver patient-centered care.

Primary care practices operating under prospective payment arrangements assume a level of financial risk to manage the care needs of patients within the budgeted amount. However, the financial risk is *only* for primary care services, and not for other service needs their patients may have. Primary care practices therefore are only financially accountable for the services they deliver, a shift from earlier capitated models. In contrast to fee-for-service payment, there is no longer a financial imperative to generate patient visits in order to generate income. This represents a substantial change in the way a practice operates, with implications that are described further below.

Prospective payments for primary care also align with emerging and evolving payment models that establish a budget or cost target for managing and improving the health of a population of patients across all health-related services, such as the arrangements used with accountable care organizations (ACOs). Primary care practices receiving prospective payment can more easily adopt a population-focused approach to care delivery, consistent with ACO objectives.

Case example: A practice uses prospective payment to enhance care for patients with diabetes. Patients receive support and education from a practice-based nutritionist and a certified diabetes educator, both of whom provide tools and information to assist patients in managing their diabetes. Care provided by these providers is coordinated by a practice-based care coordinator.

The practice has invested in a population health management tool that connects with its electronic health record and maintains a registry of its patients with diabetes. The registry is used to track patients' responses to dietary interventions discussed with the practice's nutritionist and to diabetes medications. In addition, it captures and tracks lab values over time and alerts a patient's care team when an annual eye and foot exam and other preventive health screenings are due. Care coordinators then contact the patient by phone to schedule screenings, instead of relying on an office visit for scheduling and referral.

Evidence-based clinical guidelines are embedded in the practice's medical records system to ensure adherence to best practices. Operating with more predictability in cash flow and leveraging the flexibility of the capitated payment model, the practice is able to be more proactive and patient-centered, and to deliver team-based and coordinated care. Together, those activities support patients in managing their diabetes.

Payment Design Considerations

Emerging prospective payment models consider several design components and features, including the following.

Primary Care Provider Types

Implementing a prospective payment model with primary care practices requires payers to identify those provider types eligible for receiving a capitated payment. In general, the provider types include family practice physicians, internal medicine physicians, pediatricians, and geriatricians. Nurse practitioners and physician assistants may provide primary care services but typically do so as part of a care team. To a limited extent, some payers may categorize certain medical specialists (e.g., OB/GYN or HIV specialists) as primary care providers for the purpose of a prospective payment.

Attribution

A per-patient payment necessarily relies on a methodology for attributing a patient to a primary care practice. That is, determining which patients “belong” to the practice, or are part of the practice’s panel. (Attribution models are also used to measure provider quality performance.) Some payers may set a minimum panel size for the primary care practices to which they administer prospective payment because of the associated administrative costs, but for primary care practices, the critical issue is the percentage of their patients that are paid for in this manner. One analysis found that capitated revenue needed to be “sufficiently high” (more than 63% of practice payments) both to make it financially sustainable for practices and to support investment in infrastructure changes and changes in clinical workflows.¹⁵

There are different methods for attributing patients to a primary care provider, including:

- a patient identifies a primary care clinician (preferred method because it reflects patient choice);
- a payer attributes a patient to a practice on the basis of prior care-seeking patterns;¹⁶
- a payer assigns a patient to a practice, with or without application of an algorithm identifying prior care patterns.

The last option typically requires notifying patients that they are part of a certain practice’s panel, and is employed in HMO insurance products to ensure that every enrollee has an identified primary care practice relationship. It is commonly used by Medicaid managed care programs.

Payers typically complete a patient attribution process on a monthly basis to account for any changes to the practice’s panel, due, for example, to patient health plan disenrollment. Since payment is made prospectively, frequent attribution updates are required to align patients with payment. Additional information on patient attribution can be found in [Accelerating and Aligning Population-Based Payment Models: Patient Attribution](#), published by the Health Care Payment and Learning Action Network (HCP-LAN), and in a [fact sheet](#) developed by CMS.

Risk Adjustment

Current models of prospective payment are increasingly risk-adjusted. Risk adjustment is a method used to account for the health status of a population of patients. When applied to prospective payment, it is intended to align financial resources with the expected intensity of care needs. Payment may be adjusted based on the age and sex distribution of the panel or may include more sophisticated methodologies that reflect the clinical profile of the patient population.¹⁷ Clinical risk adjustment is more effective in explaining variation in primary care costs than adjusting for age and sex alone. There are, however, few validated risk-adjustment models designed specifically for primary care services.¹⁸ Methodologies to further adjust payment to account for patients' social risk profile are evolving, but have not yet been developed for use with primary care prospective payment.¹⁹

Risk adjustment partially mitigates the financial incentive for providers to avoid serving the sickest, costliest, and perhaps most attention-requiring patients, or to underserve those patients. Widely acknowledged as a valuable and necessary mechanism for predicting cost, risk adjustment is nonetheless imperfect. Risk-adjustment methodologies rely on individual demographic, utilization, and diagnostic data to estimate costs. Lower utilization due to barriers to accessing care (e.g., income, geography) may underestimate the cost of caring for individuals in a population and result in payment that is inadequate to meet their needs. This phenomenon has been shown to introduce racial bias in widely used commercial risk algorithms, demonstrating the limitations of such models in accurately and equitably calculating risk.²⁰ In addition, accommodations may need to be made in risk adjustment for primary care practices specializing in high-risk populations.

Services Included in the Prospective Payment

Designing the prospective payment model requires identifying the services that are included in the payment. Services to be covered may include provision or coordination of all recommended Grade A and B U.S. Preventive Services Task Force (USPSTF) preventive services, provided either during an office visit or virtually (as appropriate), as well as sick visits, administration of vaccines, care coordination, patient navigation services, and specified tests and procedures.²¹

Advanced primary care practices—for example, those with fully integrated behavioral health care and/or oral health care, pharmacists, or nurse care management—could have a more robust set of services included in the payment.²² These additional services might include care management for physical and/or behavioral health needs, including referrals to community-based

Direct Primary Care (DPC): A fixed, prospective, per-patient payment is not exclusive to insurer-provider contracts. Under a DPC model, individual patients or employers enter into agreements directly with physicians or practices to pay a flat amount for a defined set of primary care services. This offers a predictable payment stream that supports primary care sustainability and reduces the administrative time associated with insurance billing requirements.²³

social services, prescribing consultation, and therapy provided by a practice-based behavioral health clinician. Payment to primary care practices that are making progress in integrating behavioral health, but do not have co-located and integrated behavioral health care, might cover a smaller scope of behavioral health-related services, such as assessment, brief intervention, and referral to treatment.

For advanced primary care practices with the capacity to deliver a more robust set of services and integrated care, the prospective payment may be enhanced or there may be a supplemental prospective payment. For example, in the case of complex care management, the enhanced or supplemental payment would support hiring and maintaining a care manager, typically a nurse or social worker, who is embedded in the practice.

Quality Performance Incentives

A prospective payment model gives practices flexibility and budget predictability, but on its own is insufficient to ensure accessible, high-quality care and efficient use of resources.²⁴ As a result, prospective primary care payments are often paired with a separate financial incentive or disincentive that is tied to performance on quality measures. This may take the form of a performance-based financial bonus or penalty incentivizing practices to achieve certain quality targets, accessibility standards, and/or other practice transformation milestones. Quality metrics for comprehensive or advanced primary care may include screening for depression, controlling high blood pressure, cancer screenings, and diabetes care, among others. Incentives to promote advanced primary care or behavioral health integration, or to screen for and address social determinants of health, may support practices in achieving transformation milestones. One important consideration for payers and purchasers in designing such incentive programs is that alignment of performance measures and methodologies across payers is critical to ensuring that practices are able to focus their efforts and achieve desired objectives.²⁵

Hawaii Medical Service Association (HMSA) – Blue Cross Blue Shield (BCBS) of Hawaii: In 2016, HMSA introduced Population-based Payments for Primary Care, a primary care capitation payment system with multipayer support. The model design is similar for members across different lines of business, for example, members enrolled in a Medicare Advantage plan, a Medicaid plan, or commercial HMO and non-HMO plans. HMSA solicited feedback from clinicians to inform the design of the model and found that a primary goal for clinicians was “reducing the pressure for a high number of office visits to generate revenue, to allow greater flexibility for primary care practices (PCPs) to deliver care aimed at population health and quality, not number of visits.” Practices receive a risk-adjusted per-member per-month (PMPM) payment and are eligible to earn additional revenue through a pay-for-quality bonus and shared savings opportunity. The health plan may also impose a financial penalty on practices for failing to meet certain standards, including same-day appointments, 24/7 access to care, and engaging in a review of performance data. An evaluation of the first year of the new payment model found small improvements in overall quality after implementation, but not all measures improved uniformly, and there was no significant difference in the total cost of care between practices that were operating under the new payment approach and those that were not.

Implementation Considerations

Transitioning from fee-for-service to prospective payment is a significant change for practices and insurers and is not without challenges. There are a variety of steps that can facilitate the change.

- **Adopt a hybrid payment model:** An incremental transition may encourage primary care practices that are reluctant to shift from fee-for-service to a prospective payment model. In fact, preliminary results from a Massachusetts Health Policy Commission survey of physician practices administered during the COVID-19 pandemic found that primary care providers were highly interested in payment models that blended fee-for-service and prospective payment.²⁷ Adoption of a hybrid payment model may help to alleviate concerns and enable primary care practices to gain experience with a budget-based model and make infrastructure investments to operate under such a model. Under a hybrid approach, practices continue to be paid fee-for-service, albeit at a discounted rate, while separately receiving prospective payment, also at a discounted rate. A hybrid model can be utilized on a transitional basis or as an ongoing payment model, should an insurer and practice agree to do so. [The CPC+ initiative](#), a multipayer demonstration project developed by the Center for Medicare and Medicaid Innovation (CMMI), is an example of a hybrid approach.
- **Phase in payment model features:** It is possible to phase in prospective payment model attributes. Here are two examples:
 1. Risk-adjustment methods can start with age and gender and phase in more sophisticated clinical risk-adjustment and social risk-adjustment methods over time, especially if the payer is unable to implement the more sophisticated methods initially. This also gives time to the primary care practice to gain experience with risk adjustment before moving to more advanced methods.
 2. Including payment for integrated behavioral health services can be added as both practices and payers gain experience with the clinical model.
- **Support practice operational and financial transition:** Fee-for-service payments are administered based on financial management systems organized around coding and claims. Shifting operations to a prospective payment model requires practices to change their payment management system from claims-based reporting to “encounter” (proxy claim) reporting and to adopt accounting and revenue management practices tied to population-based payments and financial risk at the practice level. Payers must be prepared to assist primary care practices in developing operational capabilities to adapt to a new payment model. Financial and/or technical resources for training and consultation paired with monthly membership and payment reporting, including reconciliation of attributed members with prospective payments from payers, can support the transition. Technical support can also help to assess whether a practice is ready to move to a different payment model and what type of assistance it may need.²⁸

- **Align across payers:** Multipayer alignment can advance the adoption of prospective payment models. Moving to prospective payment for a small number of patients in a practice panel is not financially or operationally viable for practices. Without alignment of payment model design, practices are left operating under different schemes, managing different revenue streams, and utilizing different administrative processes for financial management, all of which is untenable for many practices. Greater consistency across payers may increase the likelihood that providers will consider prospective payment models. CMMI seeks to align payment across multiple payers through the CPC+ and newer Primary Care First initiatives, citing the need for support across multiple insurers to change care delivery for the entire panel of patients. In addition, the Washington State Health Care Authority²⁹ and Oregon Health Authority³⁰ are pursuing multipayer strategies to implement payment reforms for primary care services, including boosting overall investment in primary care.

There is a body of literature that assesses the impact of prospective payment for primary care, but most studies are of earlier models that differ from the payment model described in this brief. The limited evaluation of the prospective payment model as it is used now makes it difficult to draw any conclusions; however, here are some examples of findings from recent literature.

- One review, which included a scan of the literature and an assessment of expert opinion, found limited or no data to demonstrate any effect of a comprehensive, prospective payment for primary care on health outcomes, patient experience, or health care costs. The review found evidence of decreased hospital utilization and poor patient satisfaction resulting from traditional capitation payments (i.e., capitated payments that are adjusted for age and sex, are built on fee-for-service costs, and include services beyond primary care.)³²
- An analysis of compensation arrangements in Medicare found that PCPs with at least 35% of revenue in

Maryland launched a multipayer advanced primary care program in January 2019 as part of the state's Total Cost of Care All-Payer Model contract with CMS. The [Maryland Primary Care Program \(MDPCP\)](#) aims to advance comprehensive primary care throughout the state through payment reform and practice support. Informed by CMS's CPC and CPC+ models, MDPCP represents a hybrid approach to the transitioning of practices to a prospective payment model.

Practices must apply in order to participate, and can elect to begin on one of two model tracks. Those on Track 1 continue to receive Medicare fee-for-service payments with the expectation that, over time, they will transition to Track 2. On Track 2, practices receive a portion of their payment prospectively on a quarterly basis along with reduced fee-for-service payments. Track 2 participants are required to increase over time the proportion of payment received prospectively. Participating practices also receive a care management fee and can earn additional revenue through a performance-based incentive program.

MDPCP also acknowledges the need to assist practices in transforming the way they deliver care in order to achieve the goals of advanced primary care. The program offers coaching, organization redesign assistance, and assistance with enhancing electronic medical records. Practices also receive support in meeting the requirement to participate in the state's health information exchange.³¹

capitated payments delivered the same or higher-quality care compared to those in other payment models.³³

- In a separate analysis using the same data, researchers found that PCPs with at least 35% of revenue in capitated arrangements had the lowest risk-adjusted spending per Medicare beneficiary.³⁴

Lessons learned over time from capitated arrangements—and from the advantages and limitations of other payment models—are largely influencing the manner in which prospective payment models are designed today.

Mitigation of Unintended Consequences

Like any payment model, prospective payment for primary care is not without limitations. Transferring financial risk to providers in the form of a budget-based model, even if only for primary care services, remains a concern among payers, policymakers, and providers. Prospective payment requires physicians to manage utilization of care differently to maximize the potential benefits of the model for patients and practices, and to ensure practices' financial stability. While fee-for-service payment creates many constraints and undesirable incentives, including physician-focused care and unnecessary visits, prospective payment creates an incentive for withholding care, making too many specialty referrals, and accepting patient panels of excessive size. If practices are not confident in the adequacy of the payment or the risk-adjustment methodology, they may avoid sicker patients with a need for more intensive services. Diagnosis "upcoding" or other actions that influence risk-adjustment methodologies and lead to higher payment are among payer concerns in a population-based payment model.³⁵

Payers can guard against the financial incentives and inherent risks through rigorous oversight and the adoption of standards of quality, access, and other performance aspects. Payers may consider an array of options³⁶ to detect and protect against adverse consequences including those found in Table 1.

Capital District Physicians' Health Plan (CDPHP): Operating in upstate New York, CDPHP's medical home model, the Enhanced Primary Care (EPC) Program, features a prospective payment model for primary care services. Providers are also eligible for a performance-based incentive, which is structured largely to mitigate some of the weaknesses of a capitated model. For example, the health plan has incorporated metrics of performance tied to a financial bonus to guard against shifting care that could be provided by a primary care practice to a different setting, such as an urgent care center or emergency department. An internal evaluation found that the program reduced total costs by \$19.6 million (2012–2015) and that PCPs spent more time with at-risk members; increased engagement with PCPs was attributed to reduced utilization of services, including lab, radiology, and prescription services.³⁸

Table 1: Steps to Mitigate the Risks of Prospective Payments for Primary Care

Risk Identification	Mitigation Steps
<p>Adopting metrics to ensure that patients are still receiving all of the primary care services, treatment, and care needed from the primary care practice, and to monitor whether care is being shifted to other parts of the health care system. The metrics should be stratified by race, ethnicity, language, age, and disability status, where appropriate and feasible, in case impact varies by subpopulation.</p>	<ul style="list-style-type: none"> • Practice panel-level risk scores • Encounter rates for PCP visits • Wait time for new, follow-up, and urgent appointments • Urgent care visit rates • Emergency room visit rates • Specialist referral rates • Preventive health measure performance (e.g., immunizations, well-child visits, cervical cancer screening) • Chronic disease management measure performance (e.g., HbA1c control, blood pressure control) • Evaluation of patient experience through the Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG CAHPS) or other similar surveys • Ambulatory care-sensitive condition admission rates • After-hours access
<p>Establishing standards for encounter data submission</p>	<ul style="list-style-type: none"> • Identifying the inputs required for submission of encounter data • Establishing time frames for submission of encounter data
<p>Performing monthly attribution processes</p>	<ul style="list-style-type: none"> • Frequent attribution to guard against “leakage” (i.e., the provision of capitated services by a clinician to whom the patient is not attributed, and who therefore is not the recipient of the prospective payment). Through frequent attribution, a payer can identify where a patient is receiving primary care.³⁷
<p>Implementing processes to identify an increase in delivery of excluded services by the primary care practice receiving the prospective payment—for example, sending patients to an urgent care center in which the provider has a financial stake</p>	<ul style="list-style-type: none"> • Monitoring specialty referral rates • Monitoring rates of delivery of excluded services

In addition to procedures for detection, payers and practices might consider processes for reviewing, and, if necessary, sanctioning improper behavior should it occur, as well as direct financial disincentives. Finally, payers should assess performance across primary care practices to analyze trends and monitor outcomes for their full populations; states can also do this across their payers. These analyses support an evaluation of potential program-wide adverse consequences.

Conclusion

Shifting primary care payment away from fee-for-service to a prospective payment model has the potential to support transformation of primary care delivery to improve outcomes for patients. Prospective payment provides the flexibility for practices to offer more comprehensive, coordinated, patient-centered, and continuous care, consistent with the vision for an advanced primary care system. Practices can engage patients in care in different ways, such as through electronic communication, team-based delivery of care, and other modes that do not require an in-person office visit. Applying lessons learned from early prospective payment models can inform the design and structure of a new prospective payment model to encourage wider adoption, creating a more sustainable and modern primary health care system.

While the right design will contribute to prospective payment models that are easier to implement and more effective, practices need to clearly recognize the different associated administrative requirements before entering into these arrangements, in order to help ensure a smooth transition and good results. Rigorous post-implementation monitoring and adoption of specific metrics can detect undesirable behavior and promote the integrity of the payment structure.

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- ¹⁶ There are different approaches to attributing patients based on care-seeking patterns. For example, the Primary Care First model, a CMS initiative, attributes patients who have not selected a primary care physician based on where they had their most recent (within the last 24 months) Annual Wellness or Welcome to Medicare visit. In the event that patients did not have an Annual Wellness or Welcome to Medicare visit within the last 24 months, CMS will attribute a patient to the practice that has billed the plurality of primary care visits within the last 24 months. For more information on the Primary Care First attribution methodology, see <https://innovation.cms.gov/innovation-models/primary-care-first-model-options>.
- ¹⁷ Rosen AK, Reid R, Broemeling AM, Rakovski CC. Applying a risk-adjustment framework to primary care: can we improve on existing measures? *Ann Fam Med*. 2003;1(1):44-51. doi:10.1370/afm.6.
- ¹⁸ One example is PCAL (Primary Care Activity Levels), which aims to predict primary care needs based on age, sex, and diagnoses recorded in claims data. (See Ash AS, Ellis RP. Risk-adjusted Payment and Performance Assessment for Primary Care. *Medical Care*. 2012;50(8):643-653. doi:10.1097/mlr.0b013e3182549c74.) Commonly used diagnosis-driven risk-adjustment models, such as the Johns Hopkins ACG System, 3M Clinical Risk Groups (CRGs), and the Chronic Illness and Disability Payment System (CDPS) were developed to adjust for the total cost of patient care, not just primary care.
- ¹⁹ Breslin E, Lambertino A, Heaphy D, Dreyfus T. Medicaid and social determinants of health: adjusting payment and measuring health outcomes. https://www.shvs.org/wp-content/uploads/2017/07/SHVS_SocialDeterminants_HMA_July2017.pdf. Published July 2017. Accessed July 6, 2020.
- ²⁰ Obermeyer Z, Powers B, Vogeli C, Mullainathan S. Dissecting racial bias in an algorithm used to manage the health of populations. *Science*. 2019;366(6464):447-453. doi:10.1126/science.aax2342.
- ²¹ Prospective payment to larger practices with some experience under such a model often includes lab services. Labs and imaging may be excluded from the prospective payment for practices with less experience; however, the capitated payment would include identifying the need for a screening, ordering tests, and delivering follow-up care based on results.
- ²² Meyers D, LeRoy L, Bailit M, Schaefer J, Wagner E, Zhan C. Workforce configurations to provide high-quality, comprehensive primary care: a mixed-method exploration of staffing for four types of primary care practices. *J Gen Intern Med*. 2018;33(10):1774-1779. doi:10.1007/s11606-018-4530-7.

- ²³ Direct Primary Care. AAFP Home. <https://www.aafp.org/about/policies/all/direct-primary.html>. Published January 4, 2018. Accessed July 6, 2020.
- ²⁴ While resource-use measures such as inpatient and emergency department utilization are often employed, the significant random variation in the use of these services makes them unreliable at the practice level, particularly for smaller practices because of concerns over statistical validity due to small sample size. If employed at all, they should be risk-adjusted.
- ²⁵ Castellucci M. Getting quality measures in alignment a difficult task. *Modern Healthcare*. <https://www.modernhealthcare.com/patients/getting-quality-measures-alignment-difficult-task>. Published June 26, 2019. Accessed July 6, 2020.
- ²⁶ Navathe AS, Emanuel EJ, Bond A, et al. Association between the implementation of a population-based primary care payment system and achievement on quality measures in Hawaii. *JAMA*. 2019;322(1):57-68. doi:10.1001/jama.2019.8113.
- ²⁷ The Massachusetts Health Policy Commission (HPC). HPC Board Meetings June 10, 2020, meeting materials. <https://www.mass.gov/doc/presentation-board-meeting-june-10-2020/download>. Accessed July 31, 2020.
- ²⁸ Payers can assess primary care practices' capabilities and structure technical assistance to meet identified needs—for example, sharing best practices, providing data analytics expertise, and collaborating with practices to ensure that the information being shared is meaningful and actionable.
- ²⁹ Washington State Health Care Authority. The Multi-payer Primary Care Transformation Model website. <https://www.hca.wa.gov/about-hca/multi-payer-primary-care-transformation-model>. Published July 13, 2020. Accessed July 22, 2020.
- ³⁰ Oregon Health Authority. The Oregon Health Authority Transformation Center Primary Care Payment Reform Collaborative website. <https://www.oregon.gov/oha/HPA/dsi-tc/Pages/SB231-Primary-Care-Payment-Reform-Collaborative.aspx>. Accessed July 22, 2020.
- ³¹ Perman C, Patterson R., Haft H. Maryland's innovative primary care program: Building a foundation for health and well-being. Milbank Memorial Fund Issue Brief. <https://www.milbank.org/publications/marylands-innovative-primary-care-program-building-a-foundation-for-health-and-well-being/>. Accessed July 31, 2020.
- ³² Park B, Gold SB, Bazemore A, Liaw W. How evolving United States payment models influence primary care and its impact on the quadruple aim. *J Am Board Fam Med*. 2018;31:588-604.
- ³³ Landon BE, O'Malley AJ, McKellar R, Reschovsky JD, Hadley J. Physician compensation strategies and quality of care for Medicare beneficiaries. *Am J Manag Care*. 2014;20(10):804-811.
- ³⁴ Landon BE, Reschovsky JD, O'Malley AJ, Pham HH, Hadley J. The Relationship between Physician Compensation Strategies and the Intensity of Care Delivered to Medicare Beneficiaries. *Health Services Research*. 2011;46(6pt1):1863-1882. doi:10.1111/j.1475-6773.2011.01294.x.
- ³⁵ Notably, the practice of upcoding diagnoses concerns state and federal purchasers that contract with health care plans to manage care for a population of patients under capitated payment models.

³⁶ Options presented are not mutually exclusive and are most effective when used in combination to promote high-quality clinical care and improve patient outcomes.

³⁷ Some payers may choose to reduce the amount of a future payment to the primary care practice receiving the capitated payment to avoid paying a different provider for an included service, but doing so is administratively complex. Monitoring, frequent attribution, and communication with physicians are steps payers can take to avoid this necessity.

³⁸ The Capital District Physicians' Health Plan. Enhanced Primary Care. Practice and Payment Reform. Year Four Program Review. <https://academyhealth.confex.com/academyhealth/2017arm/mediafile/Presentation/Paper18451/Academy%20Health%202017%20%28Pickreign%29%20Final.pdf>. Published 2017. Accessed July 6, 2020.

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