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# *In the Literature*

## FUNDAMENTAL REFORM OF PAYMENT FOR ADULT PRIMARY CARE: COMPREHENSIVE PAYMENT FOR COMPREHENSIVE CARE

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There is mounting evidence that primary care can promote good health and control costs. But few medical school graduates are choosing to enter the field, put off in part by a dysfunctional system of reimbursement. Under a new proposal, the encounter-based reimbursement system currently in use would be replaced by per-patient payments, and new incentives would be created for physicians to provide effective and efficient care.

In "Fundamental Reform of Payment for Adult Primary Care: Comprehensive Payment for Comprehensive Care" (*Journal of General Internal Medicine*, Mar. 2007), a team of physicians led by Alan H. Goroll, M.D., of Massachusetts General Hospital, and including Stephen C. Schoenbaum, M.D., of The Commonwealth Fund, explain how their proposed system would avoid the problems of previous capitation systems, which merely bundled together inadequate fee-for-service payments. The authors call for a new social contract: substantially increasing payments for primary care in return for greater accessibility, quality, safety, and efficiency.

### Health Care Teams, Information Systems, and Performance Benchmarks

Under the authors' new model, practices would receive monthly payments for each patient under their care, with adjustments made according to the patient's needs and risks. Over two-thirds of the payments would be designated to pay for multidisciplinary health care teams (e.g., nurse practitioners, nutritionists, and social workers) and for information systems to monitor safety and quality, including interoperable electronic health records. Fifteen to 25 percent of payments would be linked to performance in meeting benchmarks of cost-effectiveness, efficiency, health outcomes, and patient-centered care.

Payments for hospital and specialist services, laboratory tests, imaging studies, and other ancillary services would remain unchanged and continue to be paid under the resource-based relative-value scale system. Appropriate use of such services would be promoted through reliance on evidence-based guidelines and performance incentives linked to efficiency.

### Advantages over Existing Systems

The proposed system would move away from payment based solely on discrete face-to-face encounters. Instead, practices would be paid comprehensively for providing coordinated, well-organized primary care—which in turn would lead to a healthier, more productive population and reduced need for hospitalizations and other costly services.

Comprehensive payments differ from the capitation systems attempted in the past decade in three important ways: 1) the payments would be adjusted according to patients' levels of risk and need; 2) outcome and patient satisfaction measures would ensure that health services would not be underused; and 3) funds would be provided to support health care teams and infrastructure. The authors argue that these features would avoid the pitfalls of earlier capitation systems, which had the effect of erecting barriers to necessary care and encouraging providers to avoid complex patients.

All payers, including Medicare, would be asked to take part in testing and evaluating this new model, the authors say. Such all-payer trials would be needed to enable true practice and payment reform. Should these trials show promise, more widespread practice reform could follow.

### Comprehensive Payments Could Reduce Waste, Improve Care

Under one possible scenario, practices would receive an average of $800 per patient per year. This would increase total health care spending for this population by 2 to 3 percent. While in the short run it would represent a net investment in primary care, in the longer term it should generate sufficient reductions in waste and improvements to more than pay for itself, say the authors.

In addition, the comprehensive payment system would free up time that primary care practices now devote to claims billing, coding, and other administrative tasks embedded in the current system. By separating income from volume of patient visits, the new system would enable practices to tailor care to the particular needs of patients—from customized office visits with members of the health care team to e-mail and Web-based communications, group visits, and even visits in patients' homes.

The authors acknowledge that the system holds the potential for abuse, necessitating certain safeguards. They suggest disbursement guidelines could ensure the appropriate use of funds targeted for health care team salaries and systems. Objective, validated measures of risk and need as well as independent audits could prevent "gaming" of the risk-adjustment process. And, to prevent practices from "dumping" patients onto specialists, the per-capita payments could follow patients when specialists assume most of the responsibility for their care.

"Primary care in the United States stands at a crossroads," the authors conclude. "We believe taking the road to recovery requires fundamental reform. It is urgent that new models of payment and practice be developed, tested, and implemented."

**Sample Allocation Formula for Comprehensive Payment System**

| | | |
|---|---|---|
| 25% | Physician reimbursement: $250,000 before bonus and fringe | |
| 60% | Staff, fringe, rent, office expense (assumes hiring of multidisciplinary office team charged with timely delivery of personalized comprehensive care): $600,000 | |
| | nurse practitioner $100,000 | medical assistant $50,000 |
| | nurse $90,000 | rent $40,000 |
| | .5 FTE nutritionist $35,000 | office expenses $50,000 |
| | .5 FTE social worker $35,000 | insurance $50,000 |
| | receptionist $60,000 | physician fringe $75,000–$90,000 |
| 10% | Information technology/patient safety/quality monitoring: $100,000 | |
| | purchase/lease/setup of electronic health record and quality monitoring system $35,000, data manager $35,000 | |
| 5% | Performance bonus, annual meeting mutually established goals: $50,000 | |

Note: Example assumes an average comprehensive payment of $800/year/patient, an average panel size of 1,250 patients/full time primary care physician and team, 30 percent fringe benefit unless otherwise specified, and gross revenue of $1 million/full time equivalent primary care physician and team.

Source: A. H. Goroll, R. A. Berenson, S. C. Schoenbaum et al., "Fundamental Reform of Payment for Adult Primary Care: Comprehensive Payment for Comprehensive Care," *Journal of General Internal Medicine*, March 2007 22(3):410–15.