Health Affairs Scholar, 2023, **1(2)**, 1–6
https://doi.org/10.1093/haschl/qxad024
Advance access publication: July 3, 2023
Review Article

Health Affairs Scholar
EMERGING & GLOBAL HEALTH POLICY
OXFORD

Beyond demonstrations: implementing a primary care hybrid payment model in Medicare

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Abstract

The National Academies of Sciences, Engineering, and Medicine's (NASEM's) 2021 report on primary care called for a hybrid payment approach—a mix of fee-for-service and population-based payment—with performance accountability to strike the proper balance for desired practice transformation and to support primary care's important and expanding role. The NASEM report also proposed substantial increases to primary care payment and reforms to the Medicare Physician Fee Schedule. This paper addresses pragmatic ways to implement these recommendations, describing and proposing solutions to the main implementation challenges. The urgent need for primary care payment reform calls for adopting a hybrid model within the Medicare fee schedule rather than engaging in another round of demonstrations, despite legal and practical obstacles to adoption. The paper explores reasons for adopting a roughly 50:50 blend of fee-for-service and population-based payment and addresses other design features, presenting reasons why spending accountability should rely on utilization measures under primary care control rather than performance on total cost of care, and proposes a fresh approach to quality, emphasizing that quality measures should be parsimonious, focused on important outcomes with demonstrated quality improvement.

Key words: Medicare Physician Payment; Primary Care Payment Reform.

The urgent call to implement a hybrid primary care payment model in Medicare

Primary care faces a currently unsustainable environment with payment challenges, provider burnout, and workforce shortages that hamper the country's ability to address the crises in mental health and plateauing life expectancy,[1–3] highlighting the urgency of primary care payment reform. In addition, there is an urgent need to make independent practices financially sustainable so that primary care practices can resist being swallowed up by corporate entities that are seeking profits while raising costs for patients, employers, and taxpayers.[4]

The Center for Medicare and Medicaid Innovation (CMMI) recently announced a new demonstration of primary care payment for voluntary participants in 8 states that would take place over 10.5 years, starting in 2024.[5] Ignoring for now our concerns about some of the design features of the proposed model, another demonstration would be "too little, too late." The health system cannot wait more than a decade for the results from 8 states, especially because an alternative can be implemented for most primary care practices within a couple of years. In this paper we propose immediate remedial action to save primary care.

The National Academy of Sciences, Engineering, and Medicine's (NASEM's) 2021 report promoting high-quality primary care recommended shifting primary care payment toward hybrid models—part fee-for-service (FFS) payment, part population-based payment (PBP)—as the primary method for paying for primary care.[6] It also recommended substantially increasing the compensation for primary care clinicians, with the objectives of alleviating workforce shortages, facilitating the adoption of team-based primary care and new expectations to address health equity, behavioral health, and other health concerns. As part of primary care payment reform, the NASEM report also called for the Centers for Medicare and Medicaid Services (CMS) to decrease its current overreliance on the American Medical Association's (AMA's) Relative Value Update Committee in determining relative values under the Medicare Physician Fee Schedule (MPFS); we have separately recommended a number of reforms that could substantially improve the MPFS.[7]

Numerous clinicians and policy experts have called for a decisive pivot away from FFS payments by adopting primary care PBPs, while retaining a relatively small share of FFS payment (see Table 1). The American Academy of Family Physicians proposed an alternative payment model to the Physician-Focused Payment Model Technical Advisory Committee that similarly would move payment toward near-total capitation.[8–14]

Many high-income countries have successfully adopted blends of FFS payment and PBP to pay primary care clinicians.[15] Numerous countries now provide between 35% and 70% of primary care payments via PBP, with the remaining share paid mostly FFS. Yet, the United States continues through a seemingly never-ending succession of demonstration projects—now exceeding 10 years—to adopt a hybrid payment model in Medicare, which would also serve as a model for adoption by other public and private payers. In this

Received: April 21, 2023; Revised: June 8, 2023; Accepted: June 26, 2023

Table 1. Overview of select hybrid primary care models.

Model	Broad approach	TCOC accountability	Distinctive features
Comprehensive Primary Care Plus ("CPC+", Track 1)[9]	Primarily FFS	No	PBPs for care management services ($15 per beneficiary per month, on average)
Comprehensive Primary Care Plus ("CPC+", Track 2)[9]	50/50	No	Reduced FFS payment for E/M visits with remainder in PBP—either 40% or 65% discount from MPFS; all other services paid FFS
Primary Care First[10]	50/50	Yes	Flat fee for a single office visit; a major feature is total cost of care accountability
AAFP PTAC Proposal[8]	Primarily PBP with limited FFS	No	Participants choose between capitation for office-based E/M visits or for all E/M visits regardless of site of service
Antonucci PTAC Proposal[11]	Primarily PBP with limited FFS	No	Simpler, patient survey–based risk adjustment and performance assessment
Wasson, Sox, and Miller[12]	50/50	No	"Wellness" visits and "chronic care management" paid via PBP, "acute" visits paid FFS
Gorroll, Greiner, and Schoenbaum[13]	Primarily PBP with limited FFS	No	Emphasizes increased investment in primary care with substantial payment increase
Emanuel, Mostashari, and Navathe[14]	Primarily PBP with limited FFS	Yes	Strong P4P incentive to restrain TCOC and improve quality; focuses FFS payment on high impact, preventive services

Abbreviations: E/M, evaluation and management; FFS, fee-for-service; MPFS, Medicare Physician Fee Schedule; PBP, population-based payment; P4P, pay-for-performance; TCOC, total cost of care.

paper, we explore the challenges and design options in adopting a hybrid payment model in the standard MPFS in the near future, supported with increased payment.

Fee schedules relying on discrete, service-based payment are best suited for procedural, technical services with clear-cut beginnings and endings—the antithesis of high-quality, continuous primary care.[6] Fee-for-service payment cannot readily provide financial support with requisite flexibility for the adoption of multidisciplinary care teams; patient engagement; efforts to tackle social determinants of health and health disparities; greater use of email and phone communication with patients, physicians, and health and social service providers; and adoption of various forms of telehealth functioning as alternatives to in-person patient encounters.

Over the past decade, CMMI has advanced 3 sequential demonstrations of hybrid primary care models for potential adoption in Medicare, relying on various mixes of FFS and PBP. These demonstrations did not notably improve quality or reduce spending, perhaps because most practices opted for participation tracks with only a small percentage of PBP and because these demonstrations did not provide the added payment needed for the models to work as envisioned. Nevertheless, evaluators identified positive aspects of the demonstrations.[16] Instead of mounting more demonstrations that must meet Medicare short-term savings requirements to allow expansion into standard payment, there is a compelling need to adopt the NASEM recommendations urgently, best accomplished via adoption in the MPFS.

Legal authorities for establishing the hybrid in the MPFS through rule-making

Although fee schedules for clinicians may seem like the prototype of pure FFS payment, the MPFS already includes bundled payments that pay for services provided over an extended period. The most prominent examples are the 10- and 90-day "global payments" that bundle the visits typically provided after a procedure and monthly payments to nephrologists for managing dialysis.

Despite these precedents, in the 2015 MPFS final rule establishing the chronic care management code, CMS stated that Medicare's statutory language does not provide authority to base payment on a recurring per beneficiary per month basis–true prospective payment.[17]

Our discussions with legal and policy experts suggest that CMS's interpretation that Section 1848(b)(1), the governing statutory language that refers to payment for "services furnished," does not permit per person-per-month payments is not necessarily dispositive. However, recent Supreme Court decisions chill flexible interpretations of ambiguous text, even to accomplish consistent and worthy objectives. In *West Virginia v. EPA*, the court signaled that it is moving to limit the "Chevron deference" that has long given agencies power to accomplish what it considers the purposes of the legislation through regulation, in the absence of explicit statutory authority.[18]

In 2021, CMS established a new code (G2211) that pays physicians extra for "visit complexity inherent in evaluation and management associated with services furnished as part of an ongoing relationship," but specialists pushed to postpone implementation of this payment.[19] Although not strictly a PBP capitated payment, it comes quite close because it makes extra payments available based on a relationship with the physician and not on the level of services furnished. Congress should clarify the current ambiguity to allow CMS discretion to adopt bundled methods that include prospective PBP in the MPFS.

The Medicare Shared Savings Program (MSSP) offers an immediate opportunity for adoption of a hybrid model for primary care clinicians aligned with accountable care organizations (ACOs).[20] Section 3022 of the Affordable Care Act established that providers and suppliers participating in an ACO under the MSSP are paid according to standard Parts A and B payments, including the MPFS for practitioners.[21] However, any provision of Medicare Title 18 of the Social Security Act can be waived to carry out the MSSP under statutory waiver authority. The statute specifically mentions the possibility of implementing new payment methods.

Design issues

The CMMI's iterations of hybrid primary care payment models over the past decade—Comprehensive Primary Care (CPC), Comprehensive Primary Care Plus (CPC+), and

Primary Care First (PCF)—adopted different approaches to key design elements. In addition, health policy researchers and clinicians recently proposed their preferred, varying blends of per capita and FFS payment models.[13,14,22] Commercial payers have also experimented with hybrid primary care models, some of which have been discussed and evaluated in the peer-reviewed literature.[23–25]

Some of the initial model differences demonstrate an evolution toward a workable approach and consensus, building on lessons learned in pilots. One such design element for which consensus has been achieved is attribution—how patients are aligned to primary care practices to determine the flow of PBPs—with most endorsing prospective claims-based attribution after an opportunity for voluntary patient registration with a practice. Some important design features remain controversial, however, with divergent recommendations on specific design features.

Determining the mix of FFS and PBPs

Perhaps the most important unsettled design feature relates to determining which services should be paid through FFS payment versus PBP. Fee schedules relying on FFS payment can function reasonably well when code descriptions are concise, unambiguous, and stable.[26]

Some would include office visits in the PBP, leaving FFS payment targeted to specific "clinically essential" services that are mostly low-cost services with evidence of improvement in patient outcomes and access.[8,14] Previous analyses show that, for both family physicians and general internists, approximately 90% of Medicare-allowed charges come from evaluation and managemen (E/M) services, with the remaining 10% distributed across minor procedures, drug and immunization administration, tests, and imaging.[27] However, there is variation across primary care practices in the mix of E/M services. Only some primary care practices provide substantial hospital and nursing home visits. The implication is that FFS must continue for services that not all primary care practices furnish as part of receiving PBP payments, such that the blend of FFS and PBP payments will vary substantially across primary care practices.

Some proposals would no longer pay office visits by FFS, both to reduce current incentives to deliver an unnecessarily high volume of visits—sometimes referred to as "churning" visits—and to shift substantial payments into PBP to support practice transformation. The PCF demonstration continues to pay FFS for office visits but uses a single visit code (replacing 9 current office visit codes), and priced somewhat below current level 3 (current procedural terminology (CPT) code 99213) prices.[28] Denmark's hybrid payment approach attempts to pay FFS for visits at a level that makes the physician financially indifferent to providing additional office visits,[29] which we estimate would be close to the office visit payment level in the PCF demo. Denmark's principle could guide determination of an office visit fee level, while also replacing the complexity and upcoding incentives of fee schedule payments for 9 codes.

Another consideration is the need for office visit data for accountability. Documenting the provision of office visits is needed to detect stinting on care under PBP. Further, CMS needs an accurate count of primary care office visits to attribute patients to practices; many doubt the accuracy of non-pay, encounter submissions as an alternative.[30] These considerations suggest that CMS should maintain a per-visit payment at a reduced but reasonable level.

Services paid via PBP versus FFS

Decisions about the inclusion of non-E/M services in the PBP will also determine the relative hybrid mix. Payment for "small ticket items"—high volume, low resource use—are best made by PBP. PBPs that include services that most primary care providers perform, such as minor office procedures and common office-based labs and tests, would reduce volume-based incentives and increase delivery flexibility. PBP is also appropriate for care management and coordination along with other services not linked to a visit, where current burdensome documentation requirements suppress delivery. Similarly, PBP is administratively simpler for telehealth services and avoids arbitrary distinctions between televisits and other important patient communications, like through patient portals, that cannot be accurately or efficiently paid as FFS. As telehealth technology continues to rapidly evolve, payers respond with arbitrary distinctions among modalities (eg, that "audio-only" inherently has less value than video), and/or payers impose burdensome and likely ineffective documentation requirements to limit increases in service volume and fraud.[31] The attendant FFS billing rules would be difficult for providers to navigate and for payers to administer over the long term.[32]

Further, now that the public health emergency has expired and related extensions of telehealth payment policy will soon sunset, CMS is likely to revert to its established method for determining relative value units for MPFS telehealth codes, such that many telehealth services likely would be priced near or even below marginal costs. Billing costs alone for a telehealth encounter likely would be at least $20,[33] discouraging practices from providing these virtual services. Further, CMS views telehealth payment as applicable only for close substitutes to in-person visits,[34] not for broadly expanding communication like more frequent phone calls, email, and patient portal communication. A recent survey found that patients would prefer telemedicine over in-person care for prescription refills and minor illness care, and expanded communication modalities such as text messages, health apps, and websites are gaining in adoption.[35] PBP in a hybrid payment model can fund a broad expansion of telehealth along with provision of additional small-ticket activities central to the NASEM vision of primary care practice.

FFS payments would be retained for services that primary care providers do not consistently perform, such as facility-based and home visits. Likewise, FFS could continue for clinically essential services like immunizations. We estimate that, on average, 20–30% of primary care payments would remain FFS, even if office visits were paid totally through PBP, although with substantial variation across practices.

Risk adjustment and accountability for spending

FFS payment for office visits serves as a crude, but reasonably effective, risk adjuster because more seriously ill patients use more office visits, generating practice revenue. The greater the reliance on PBP, the greater the need for population-based risk adjustment. The model could adjust PBPs to reflect the health risks and/or social complexity of primary care clinicians' patient panels so that payments fairly represent service needs. Data suggest that historically disadvantaged racial and ethnic minority populations have lower risk-adjusted total spending than White beneficiaries because they face access barriers, despite having worse risk-adjusted health and

functional status,[36] pointing to the important methodological distinction between risk adjustment based on prior spending versus actual health-related need.

The risk-adjustment approach depends on whether primary care practices are being held accountable for the total cost of care ("insurance risk") or for the practice's own work burden for their attributed patients ("performance risk"). Some hold that a major purpose of strengthening primary care, supported with additional funding, is to reduce health spending throughout the health system. Others, including the authors, argue that primary care physicians, who receive only about 5% to 7% of overall spending and even less in Medicare,[37,38] cannot readily reduce the total cost of care for purposes of spending accountability.[39] Research shows that primary care is associated with reduced spending over the long term but not necessarily in the short term.[40,41] Instead of total cost of care, we recommend reliance on utilization-based metrics, such as emergency department visits and referral rates[42]—outcomes over which primary care clinicians arguably have direct influence.

In the primary care demonstrations, CMMI has relied on the Hierarchical Condition Categories (HCCs). HCCs, designed for Medicare Advantage (MA) plan bidding, represent a "prospective" model, in which risk factors in year 1 predict spending for all Medicare-covered services in year 2. Relative to MA plans, practices have small numbers, such that a few complex patients might skew their assessed financial performance. If the goal, instead, is to recognize the work burden on the practice for its current patient panel, the model could be partly or totally "concurrent" to pay fairly for practices' actual workload. A challenge, however, is that concurrent risk adjustment accentuates the incentive observed in MA for upcoding to obtain greater payment.[43] Most CMS programs and demonstrations, including MA and MSSP, rely on prospective risk adjustment. However, the 2023 ACO Reach for High Needs Populations uses a concurrent HCC model.[44]

Although CMS has not adopted a hybrid-specific risk adjuster for primary care, ideas that seem straightforward for testing and adoption have been advanced. These include the following: prior utilization of primary care E/M visits and minor procedures to create a risk-adjusted PBP payment,[23] determination of primary care activity levels,[45] and a simple patient-reported health status survey such as "How's Your Health."[46] CMMI demonstrations inappropriately seem wedded to the CMS-HCC risk adjuster that was developed specifically for MA plans not clinician practices.

Accountability for quality

It is increasingly evident that the 2-decade run of quality accountability based on measurement of a raft of process and outcome, clinical measures, and patient experience surveys has not achieved the lofty aspirations associated with their adoption.[47] Instead, the "measurement industrial complex" may have actually compromised care delivery—at a high cost.[48,49] It is time for policymakers to rethink the approach to quality accountability. The first priority should be to identify and sanction substandard quality to protect patients.[50] Quality measurement as implemented cannot reliably distinguish fair, good, or excellent care, but it can identify substandard care.[51] Yet, the array of performance measures and substantial reporting burden distract from identifying substandard performance and other quality-compromising issues. Prime examples include the continued high prevalence of diagnosis errors[52] and unacceptable delays in translating new evidence into practice, such that only 1 in 5 evidence-based interventions make it routinely into practice.[53]

To address these and other festering quality problems, an alternative approach focusing on quality-improvement (QI) activities would provide better support and motivation to clinicians for taking responsibility for improving care.[54] Quality measures would be used mostly internally by practices rather than publicly reported or in pay-for-performance schemes. This approach requires a reporting mechanism to assure that practices implement chosen QI projects and a broad learning collaborative where practices can share QI successes and challenges.

To implement the hybrid model quickly, we would maintain the current paradigm but, for primary care practices, would replace the large menu of self-selected measures in Medicare's failed Merit-based Payment System with a parsimonious set of required primary care–specific measures relevant to hybrid payment, such as those used in the Maryland Primary Care Program model.[55] In trying to preserve some level of accountability using measures, CMS can also give consideration to its Universal Foundation measures.[56] Over time, the quality accountability approach should evolve to achieve QI and focus on a set of 4 to 6 meaningful outcomes at a time. Selected metrics should capture improvements in (1) patient-reported assessments of comprehensiveness, continuity, trusted relationships, and other key dimensions of primary care that are not well captured in current Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys[57]; (2) primary care–amenable behavioral health care, including depression and substance-abuse prevention outcomes; (3) efforts to address health equity by establishing partnerships with community-based social services[58] and elements of universal practice design,[59] such as accessible materials for patients and families who speak other languages; and (4) referral management to efficient, high-quality specialists, which CMS identifies using tools such as episode groupers and condition-specific outcome measures.[60] Practices could benefit from external benchmarks for some metrics, such as depression outcomes, but CMS can hold practices accountable for other metrics by assessing their change in scores over time, thereby promoting continuous improvement.

These preliminary suggestions point to the importance of shifting quality measurement away from what appears to be proceeding on automatic pilot. The hybrid payment model for primary care presents a prime opportunity for CMS to explore better accountability approaches that could be generalized to other providers and MA plans.

Conclusion

Although the United States once was in the forefront of delivery system and payment reform, it now lags behind. After a decade of demonstrations that yielded inconclusive, modestly promising results, there is urgency in adopting a hybrid approach for primary care at scale, relying on stronger and improved design features.

One lesson from the last decade is that incremental fee schedule changes, while helpful, are insufficient to achieve primary care transformation or to address shortages in the primary care workforce. And demonstrations have also proven difficult to expand. To make progress now, the MSSP program should adopt a hybrid payment method consistent with the accountability provided by ACOs. In addition, if CMS does not already have legal authority to adopt a hybrid payment model

broadly in the MPFS, Congress needs to make clear in statute that its previous call for more bundled payments within the MPFS should include PBPs.

CMS should also move affirmatively to develop the design features of a hybrid payment model based on considerations described in this paper. CMS may need to do limited testing of a model to flesh out and fix operational challenges and we acknowledge that fixes to risk adjustment and quality accountability will need further revision, but there is no need for further CMMI demonstrations and delays in adoption in the MPFS. Finally, generous extra FFS payments for telehealth should continue only until the new hybrid model is implemented. Afterward, payments for these activities would only be made as part of the PBP in the hybrid, providing an incentive for practices to participate.

Supplementary material

Supplementary material is available at *Health Affairs Scholar* online.

Conflicts of interest

Please see ICMJE form(s) for author conflicts of interest. These have been provided as supplementary materials.

Notes

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