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Are Primary Care Physicians Finally Ready for Value-Based Reimbursement?

The call from primary care physicians for changes to the current healthcare reimbursement structure is growing louder in the face of the hardships endured as a result of the coronavirus (COVID-19) pandemic. In response, professional organizations, payor organizations, and payors themselves are answering that call, in the form of two July 2020 announcements related to innovative payment systems directly targeted at independent medical practices and primary care physicians.

Currently, the most commonly-used reimbursement structure in the U.S. healthcare delivery system is *fee-for-service* (FFS) payment models.[1] Under an FFS model, healthcare providers receive separate compensation for each service provided, such as an office visit or procedure.[2] Over the past several decades, however, the U.S. healthcare system has been moving away from FFS and toward value-based reimbursement (VBR).[3] The *Centers for Medicare & Medicaid Services* (CMS) has introduced numerous VBR models over the past decade, largely as a result of legislation such as the *Medicare Improvements for Patients & Providers Act* (MIPPA), the *Patient Protection and Affordable Care Act* (ACA), and the *Medicare Access & CHIP Reauthorization Act* (MACRA), all of which place more emphasis on VBR.[4] The adoption of VBR models has similarly skyrocketed on the state level over the past decade, with the number of states utilizing VBR models increasing from three in 2011 to 48 states as of 2018.[5] In addition to government payors, commercial payors have established various VBR models over the years, albeit at a slower rate than the federal government.[6]

The key difference between these two reimbursement systems is the emphasis placed on *quantity* of services provided (emphasized by FFS) versus *quality* of services provided (emphasized by VBR). Many VBR models use benchmarks to compare facility performance in categories such as immunization rates, Medicare spending per beneficiary, and patient feedback, and rewards those above those benchmarks.[7] Other VBR models utilize *bundled payments* (also known as *global* or *capitated* payments) in reimbursing providers for all of the treatment related to a specific disease/condition or a specific timeframe, which in turn rewards hospitals who provide high-quality care for a lower cost than the bundled payment.[8]

Physicians, especially primary care physicians, have previously been unwilling to take on the financial risk inherent in VBR models.[9] However, perhaps as a result of the pandemic, physicians are beginning to petition for this shift to value-based care as well. The COVID-19 pandemic has particularly devastated the healthcare services sector, as it caused a dramatic drop in FFS reimbursement even as expenses increased due to the higher costs of obtaining *personal protective equipment* (PPE) and the costs related to implementing technology for those physicians seeking to provide telehealth services.[10] Further, both before and during the pandemic, physicians have been providing a greater number of non-billable services, such as monitoring chronic disease and coordinating the delivery of pharmaceuticals to patients.[11] Many primary care physicians are being forced to reconsider their financial viability in light of this public health emergency (especially those who did not already have telehealth capabilities);[12] the recognition that the subsequent closing of many of these practices could result in reduced healthcare access has led to significant pushback against this development, as well as against the lack of reimbursement sufficient to drive intended outcomes, as many industry stakeholders point to higher quality, more proactive, and more inclusive primary care as a means to slowing the rise of overall healthcare costs.[13]

An additional weakness in the healthcare delivery system exposed by this pandemic has been providers' dependency on elective procedures. This reliance is incentivized by FFS – providers earn more for performing more procedures and for over-treating patients.[14] However, since the start of the pandemic, elective procedures, which comprise the majority of hospital revenue, have plummeted, leading to serious financial issues for many providers.[15] While many elective procedures are essential,[16] others (despite bringing in significant revenue) have been found to be ineffective or even harmful for patients.[17] This overuse has created a considerable amount of waste resulting in substantial healthcare costs.[18] In fact, payors have stated that the money being saved from cancelled procedures exceeds the amount of funds being expended for the treatment of COVID-19 patients.[19]

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In response to these issues, and the growing call for change, the *American Academy of Family Physicians* (AAFP) and *National Alliance of Healthcare Purchaser Coalitions* (National Alliance) announced on July 15, 2020, their creation of a partnership for the purpose of leveraging regional employer coalitions and physician networks to create a national prospective payment system for primary care.[20] This effort builds on the work of many business groups and alliances across the U.S., all of whom are committed to reorganizing primary care and transforming the U.S. healthcare system in order to maintain a healthy workforce and help their communities thrive.[21] The AAFP and National Alliance asserted that "*[t]he primary care system in the United States is collapsing*," pointing to causes such as long-standing underinvestment, poor financing structures, and overwhelming administrative work.[22] These organizations believe that prioritizing and properly funding "*comprehensive and continuous*" primary care will lead to better health outcomes and lower per-capita costs.[23] Under such a system, primary care physicians would have the resources needed to perform patient-centered care and provide patients with the requisite support through a core team of care coordinators, case managers, social workers; a centralized network pharmacy; and, programs to address social determinants of health.[24] Physician practices would also be able to invest in telehealth offerings and expand service lines to provide vital services to patients, both during the pandemic and thereafter.[25]

Private payors are also seeking solutions to ameliorate the shortcomings of FFS models in relation to primary care and independent medical practices. Blue Cross Blue Shield (BCBS) of Massachusetts announced in July 2020 the establishment of a new value-based payment model that extends financial support through "*global payment, upside risk incentives, and an immediate support payment*" to small practices.[26] Notably, BCBS of Massachusetts was the architect of the 2008 *Alternative Quality Contract* (under which providers were rewarded for quality), one of the first modern shifts to a VBR system.[27] While many physicians recognize the importance and potential of value-based care for their patients, it may be difficult to implement these changes without a payment structure that incentivizes these priorities.[28] The barriers of entry may be especially high for small practices, for whom caring for seriously ill patients is a significant cost burden.[29] BCBS's new program aims to change this.[30] The new upside-only risk model consists of three primary payment strategies:

(1) Providers are given a "*global*" fund based on their number of patients, which funds are detached from billing codes, for the provider to use at their discretion;

(2) Incentive payments for providers who achieve high scores on certain quality measures; and,

(3) Immediate support payments for providers who sign the VBR contract with BCBS.[31]

These two announcements are indicative of changing perspectives relating to reimbursement models, particularly as relates to independent primary care physicians. While the AAFP and National Alliance announcement, and creation of other such alliances across the U.S., indicates rapidly-growing support for systematic change, the BCBS announcement provides an example of a financially-feasible entry point for primary care providers (and other independent medical practices) into value-based care. The advantages to these innovative models are numerous: reduced spending for patients, payors, and the entire healthcare system; greater provider efficiency; higher patient satisfaction; reduced payor risk; supply prices aligned with real value to patients; and healthier communities overall.[32] However, it is not without risks or weaknesses – increased regulations may restrict providers' activities, and bundled payment or other shared savings programs may be difficult to implement and sustain, often requiring considerable initial investment from the provider in order to collect the data needed to report quality metrics.[33] Critics are also concerned about the establishment of appropriate historical benchmarks and changing expectations once healthcare costs start to decline.[34] While there may be some immediate drawbacks in the form of costs and implementation difficulties, the current healthcare environment has exposed the fact that the current healthcare reimbursement system has been one public health emergency away from a virtual collapse. Payors are adopting different strategies to combat this frailty and protect primary care providers, including innovative reimbursement strategies and programs to help providers secure funding.[35] Whatever the method, the consensus among industry stakeholders appears clear: changes need to be made to prevent a critical physician manpower shortage resulting in significantly decreased access to care. More and more primary care physicians are committing to the VBR shift, and the formal alliances and reimbursement model initiatives have now begun to follow.

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