

Concordance Recommendations for Primary Care Payment and Investment

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The COVID-19 pandemic, coupled with the heightening national awareness of the persistence of racism and other structural inequities, shone a harsh spotlight on the urgent need for a more resilient, equitable, and higher-value healthcare system for our nation. Primary care must be at the center of the transformed health system we need to ensure that everyone in the country has an equitable opportunity to attain the best possible health and wellness and bend the healthcare cost curve over time. To succeed in this transformation and improve healthcare delivery, we need better healthcare payment systems as well as significant up-front investment in health care in the communities that have been systematically under-resourced and structurally disadvantaged.

The Primary Care Collaborative (PCC) has committed to advancing a set of recommendations designed to achieve a higher-value health system built on the foundation of high-quality, comprehensive primary care¹ to produce better population health, greater affordability, and the reduction of racial, ethnic, and other structural inequities that sap the health and vibrancy of many communities across the country. In the summer and fall of 2021, the PCC convened two meetings to discuss using the National Academies of Sciences, Engineering, and Medicine (NASEM) primary care report's five payment recommendations² as a launching point for healthcare transformation that improves value and achieves health equity.

1. Primary care payment should create pathways to rapidly transition from a predominantly fee-for-service model to a predominantly population-based prospective payment (hybrid) model coupled with up-front and ongoing investments and guardrails to ensure that patients and communities most affected by health and health care inequities, and the primary care clinicians and teams that care for them, realize the benefits of a higher-value health system.

These payment pathways should include adjustment for health status, risk, social drivers of health and social risk, historic under-investment, and other elements. Such hybrid models should be implemented and aligned across payers, while being mindful of practice heterogeneity, preserving the viability of primary care clinicians who have earned the trust of structurally disadvantaged communities, providing culturally congruent, care, and supporting greater adoption of telehealth. There should be a pathway for practices to voluntarily pursue higher levels of prospective payment at an even quicker pace with sufficient support.

¹ See the Shared Principles of Primary Care, available at www.pcpcc.org/about/shared-principles, and the Attributes of Advanced Primary Care, available at www.pcpcc.org/resource/attributes-advanced-primary-care

² See National Academies of Sciences, Engineering, and Medicine. 2021. *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care*. Washington, DC: The National Academies Press. <https://doi.org/10.17226/25983>.

2. To achieve rapid transition to and sustainability of comprehensive primary care practice models, overall healthcare spending, both in terms of ongoing payment and needed investment, must be rebalanced towards primary care. Currently, primary care spending in the U.S. amounts to only approximately 5% to 7% of total cost of care and is trending down. There is strong evidence that countries that devote considerably more resources to primary care as a share of total health spending than the U.S. achieve more equitable health outcomes, better overall population health, and much lower per capita spending. Policymakers committed to slowing spending growth in our inefficient health system should implement needed resource shifts now, understanding that they will ultimately result in a more efficient, higher-value healthcare system.
3. Overall primary care funding levels (both ongoing payments and needed investments) must be risk-adjusted and sufficient to support multidisciplinary primary care teams that reflect, and can meet the needs of, diverse populations, with an emphasis on providing high-quality comprehensive, integrated care to communities that are structurally disadvantaged by discrimination and other social drivers as well as those with complex medical and behavioral health needs. Primary care teams should also be supported with resources to allow them to prioritize and proactively address equity within their practices, in partnership with the communities they serve.
4. To better support both patient-clinician relationships and accountability for population health outcomes, patients should be encouraged to choose a regular source of accessible, culturally centered primary care. Patients may wish to change their source of care for varied reasons, including, but not limited to, evolving medical needs, negative experiences such as discrimination in any form, accessibility requirements, or convenience. Patients should continue to have the option of changing to another source of care if their needs are not being met.
5. Increasing Medicaid primary care payment to at least the level paid by Medicare is critical to address health inequities and a key step on the path to hybrid primary care Medicaid models. The federal government should fully fund state efforts to achieve this standard of payment. Medicaid parity must be pursued in tandem with initial efforts to reform Medicare payment and investment detailed above and encourage commercial, Medicaid and other payers to align on policy initiatives and payment design. State innovations in primary care payment reform and investment represent a learning lab for Medicare and other payers and should be encouraged through federal partnerships. Primary care safety-net provider organizations such as community health centers and rural health clinics rely on federally required payment structures like the Prospective Payment System (PPS) and All-Inclusive Rate (AIR) for their continued financial viability. It is critical that future policy protect these tools while supporting these organizations' participation in mutually agreed upon payment models that improve access and quality.

The following organizations agree with this consensus document and are signaling as much by signing onto it.

To see the updated list of signatories, visit
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