# DRAFT Principles of Payment Reform

**Primary Care Payment Reform should support payment that…**

1. **Is simple to understand and administer.**
   - The link between financial incentives and performance benchmarks should be clear and direct.
   - Payments should be feasible within existing administrative capabilities.

2. **Balances risk for both provider and purchaser.**
   - Risk to the provider should connect directly results they can control.
     - In the short-term, this may mean focusing incentives on process and structure improvements.
     - In the long-term, the focus should shift to patient outcomes and overall costs.
   - Results should be predictable for the provider, i.e., "If I do this, then I will earn that."
   - Purchasers should provide financial support for the practices, but should not incur excessive risk or costs before improvements are achieved

3. **Recognizes necessary short-term investments.**
   - At inception, practices need to make investments in care improvements that may not generate immediate savings.
   - Practices may need support to make improvements; such support should be specific and time-limited.

4. **Is aligned across multiple purchasers.**
   - Models that require different rules for each purchaser and for different practices add to the burden for all stakeholders.
   - Innovative payment models for practices should be aligned with other innovative payment models (e.g., ACOs)

5. **Recognizes the value of whole-person care delivered, including physician and non-physician work such as:**
   a. face-to-face evaluation and management services
   b. patient care management that falls outside of payment for face-to-face visits, e.g. proactive preventive and chronic care management

c. "medical neighborhood" care coordination (e.g. among hospitals, consultants, ancillary providers, and community resources)
d. remote monitoring of biometric clinical data and patient support

6. **Promotes accountability by rewarding activities that improve patient outcomes and reduce total health care spending through incentives that:**
    a. allow providers to share in savings from reduced hospitalizations, emergency room overuse, and high cost procedures
    b. reward measurable and continuous quality improvements
    c. support providers in engaging patients as partners through shared decision-making and the development of strong, enduring, healing relationships
    d. support the efficiencies of team-based care
    e. support the use of evidence to guide clinical decision making
    f. prioritize the provision of comprehensive primary care services

7. **Compensates the practice's investment in technology and services which enhance patient access and improve care coordination** such as:
    a. improved patient care communication, for example through a secure, Web-based patient portal that supports synchronous or asynchronous e-mail and virtual visits and telephone consultation
    b. acquisition and use of health information technologies (e.g. patient registry systems, evidence-based clinical decision support, electronic health records, etc.)
    c. investment in infrastructure for practice transformation and innovation, e.g. staff training, work flow redesign and practice recognition requirements

8. **Encourages caring for and managing those with complex medical problems, multiple social support needs, and those who are traditionally medically disadvantaged**.