Payment Theory and the Last Mile Problem

John V. Jacobi

We are in the Affordable Care Act's second decade. Elected and appointed officials, academics, and commentators debate the future of the ACA, and in the process the proper configuration of American health care finance and delivery systems. Much of the debate focuses on at the levels of organization of the health insurance system: should the U.S. retain the ACA with modest tweaks, move toward a single-payer system, retrench to a pre-ACA era of state regulation, or some other step? Other discussion addresses the complementary question of how health delivery should be organized: should we move to large, provider-led integrated delivery systems, smaller, community-based accountable care organizations, or a more dispersed delivery system related only by insurer contracts? Much depends on these debates over the systemic future of health delivery and finance. Tens of millions of Americans are uninsured or underinsured, and many with coverage are poorly served by the lack of coordination among powerful health industry forces.

This commentary focuses on one segment of that debate: the organization and payment of primary care. The means by which primary care providers are paid helps to determine how they deliver care. How they configure their practices is vitally important to the future of health care. The shape of primary care practice matters for two reasons. First, no matter how large system decisions are settled, choices about primary care payment and practice configuration will remain. That is, whether we have a single payer system or a mix of payment from public and private insurers, choices must be made about how to fund primary care. Second, those choices will matter regardless of the choices that are made regarding overall payment and delivery structure. In any public or private insurance system, and in any size health organization, the rubber hits the road in primary care, and questions of organizing primary care to maximize patient health and minimize avoidable costs must be resolved.

This commentary will first describe briefly the larger reform discussions. It will then discuss physician payment as it fits within that broader reform debate. Much of the debate over systemic issues focuses on issues of fragmentation. System fragmentation, in which various sources of payment lack coordination, and in which various sources of patient care operate without apparent awareness of each other's existence, leads to financial waste and poor patient care. Physician[1] payment and delivery reform addresses concerns close to the patient, focusing on the particular

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fragmentation of care that derives from primary care's historic lack of attention to the web of care available to patients, and the network of needs — medical and social — that are causative of good and bad patient outcomes. Primary care practices are, and must be, at the heart of patient care, and efforts to promote care integration and address unmet social needs must therefore contemplate adjustments to primary care as well as grander aspects of our massive health system. This commentary then describes the work that has been done in recent years in primary care organization and payment to achieve care integration at the level of the physician-patient dyad. It will describe U.S. practices and parallel efforts in European countries to improve the primary care component of health care delivery. Well-designed payment reforms can encourage the adoption of emerging integrative care models, and support the cost of the investments needed in expanded analytic and personnel costs to implement these models. It is this "last mile" problem — deciding how the intimate, vital link between the large-scale financial and corporate improvements connects to the end user — that is at the heart of the inquiry into primary care reform.

Coverage and Delivery Reform

Discussions of systemic reform divide into either insurance coverage or delivery reform. Some insurance coverage discussions address versions of federal single payer plans under the rubric of "Medicare for All."[2] Others describe state-level single payer possibilities, including "Medicaid for All."[3] Still others examine the fruits of the ACA's implementation and the possibilities of building on that solid base of insurance reform.[4]

Insurance reform discussions also entail intermediate-level issues, often focusing on the content of insurance coverage. Should mental health and substance use care be in parity with "physical" health care, and if so how; how should outpatient drugs be prices; should reproductive rights be included in employer plans; is it time to include long term services and supports in medical insurance? Into this category of reforms fall behavioral health parity laws, which attempt to broaden public and private health insurance to sweep in essential mental health and substance use treatments[5] and efforts to reduce pricing barriers to other forms of care, including outpatient pharmaceuticals.[6]

While the ACA reduced the ranks of the uninsured by about twenty million and content of many forms of health insurance coverage, tens of millions remain uninsured in the U.S,[7] and many more are covered by plans that leave them underinsured.[8] Expanding insurance coverage is no abstract ideal; those covered by health insurance clearly have superior access to health care services.[9] And insurance coverage only matters if the services needed to remedy disease and maintain wellness are covered. Few are willing to fore-

This commentary focuses on one segment of that debate: the organization and payment of primary care. The means by which primary care providers are paid, and partly in response to the incentives created by those payment choices, how their practices are configured are vitally important to the future of health care. The shape of primary care practice matters for two reasons. First, no matter how larger system decisions are settled, choices about primary care payment and practice configuration will remain. That is, whether we have a single payer system or a mix of payment from public and private insurers, choices must be made about how to fund primary care. Second, those choices will matter regardless of the choices that are made regarding overall payment and delivery structure. In any public or private insurance system, and in any size health organization, the rubber hits the road in primary care, and questions of organizing primary care to maximize patient health and minimize avoidable costs must be resolved.

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cast the shape of the future U.S. health finance system; it could evolve into a single-payer system, a version of our current mixed system, or a reversion toward a pre-ACA vision of state control over much of health policy, with gaping holes in coverage for much of the population.

A second area of systemic reform examines the ongoing reconfiguration of the care delivery system. For many years, dissatisfaction with the unorganized nature of health care delivery and its attendant inefficiencies has led to interest in "Integrated Delivery Systems," by which health care providers, including hospitals, physician practices, imaging centers, and sub-acute providers could gather as one corporate entity to achieve improved care.[10] Accountable Care Organizations, "the Affordable Care Act's centerpiece for systemic reform," encourages the creation of provider entities similarly combining hospitals, physician groups, and other care providers to create, although through contract and not corporate formation, to achieved the hoped-for efficiencies of collaborative, patient-centered care.[11]

At both levels, these reform discussions are at least partially intended to address the problem of fragmentation in our health delivery and finance systems. For care delivery, fragmentation — the disorganization of a patient's care providers — impedes efforts to provide safe, effective care.[12] At the level of insurance coverage, fragmentation is exacerbated by a hands-off posture by public and private insurers with respect to the adoption of evidence-based integrative care methods.[13]

Physician Agency: The Last Mile Problem

Physicians[14] connect the machinery of health insurance and care delivery to patients. Getting physician payment right is health finance's "last mile" problem. It is only a mild exaggeration to say that larger system and coverage reform comes to naught without support for the improvement of physicians' individual treatment decisions. Thoughtfully constructed physician payment methods that are attentive both to the power of independent professional judgment and to the importance of guiding them to evidence-based, integrated forms of care are essential to achieving patient well-being in an efficient and effective manner — the goal of the greater machinery of health reform.

The importance of this final connection — the "last mile" — has been observed in other socially important systems, such as broadband service and interurban freight transport. As reform of those systems to extend appropriate and efficient consumer service have developed, the importance and sensitivity of the final connection has been an area of focus. As in the case of health reform, broadband and freight transport have advanced service goals and system efficiency through technical innovation, economic reordering, and legal restructuring. Essential to the success of these sprawling efforts has been attention to the last mile — the connection of a complex service to the end consumer in a way that serves systemic goals.[15]

As with broadband and consumer transport, so too with health care. Systemic insurance and delivery system reforms are necessary but not sufficient requirements for improving individual and population health. If physician practice in the primary care setting does not itself change to provide a form of integrated care, the goals of larger-scale systemic reform will be frustrated.

The Importance of Integrative Physician Practice

Fragmentation of Care

At the physician level, fragmentation manifests as practices that do not contemplate the full scope of patient needs, but rather addresses immediately-presented conditions in isolation. The "fragmentation" in this sense is the splintering of the physician's and her coworkers' attention in a primary care setting rather than pursuing a practice of "whole person" care. "Whole person" care in the primary care setting entails interdisciplinary practice incorporating insights from the patient, family, and community, including an understanding that supporting wellness requires understanding social as well as medical needs.[16] Primary Care reform is best addressed by empowering physicians to transform primary care practice into a hub of a patient-centered delivery system. Well-organized patient-centered primary care gather and analyze historical and ongoing patient information to foster collaborative care and prevent inconstant treatment, and it can drive an intentional, evidence-based method of achieving patient goals.[17]

Primary care settings are the natural home for coordination so conceived, as they are the point of entry for most patients to courses of care. Integrative care models, to be successful, must also attend to the professional satisfaction of practitioners. A byproduct of the fragmented system has been a rising level of frustration among physicians who bridle at increasingly narrow ranges of practice and pressure to achieve quantity even at the cost of quality of care.[18] Research into optimal practice design is ongoing; however, empowering primary care practices through some of the emerging practice models to engage in the evaluation and management of patients over a course of treatment is likely to both improve patient care and permit more satisfying use of professional skills and knowledge.[19]

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Social Needs and Social Determinants in Physician Practice

It is now well-known that unsatisfactory health outcomes and persistent health inequities in the U.S. system are traceable in large part to social determinants of health. Those determinants include structural and social conditions including access to secure housing, sound education, nutritious food and exposure to racism, poverty, and crime. A necessary concomitant to the goals of patient-centered primary care is attention to social determinants.[20] The incorporation of patients' social needs into physician practices needs to be approached with care. Enthusiasm for making social determinants of health a focus of primary care practice must be tempered; integrated care can knock down silos, but specialization must be respected. While physicians should evaluate patients for social needs that impair health, physicians are not, nor should they be, in charge of the remediation of all inequitable effects of the social determinants of health.[21]

Within the competency of physician practices, however, much can be done to include attention to patient's social needs. Physicians can include assessments for social needs in clinical protocols. They can use screening guidelines in initial patient interviews. They can collocate or forge close relationships with key social service providers and expand the notion of "interdisciplinary teams" to include, for example, lawyers, vocational counselors, and housing specialists as circumstances require. They can also include home visiting services in their practice portfolios.[22] The expansion of practice to include these services can improve patient care and permit more satisfying practice experience. Such expansion of services is not well-supported by traditional payment practices. Reformed payment theory must follow practice reform.

Supporting and Encouraging Integration Through Physician Payment Reform

Payment Reforms Supporting Integrated Primary Care

As is described above, delivery reform is only one-half of the systemic reform puzzle — payment reform is the other half. As reforms in insurance coverage and design proceed, it will be important to recognize the transformation of our *medical* insurance system to a *health* insurance system. Payment reform is necessary to shape and support health systems reform, including reform of primary care. The mechanisms of payment must follow the logic of care delivery reform. Fragmented fee-for-service must give way to payment that supports and fosters more integrated primary care. Value-based payments to support the additional cost of integrated, patient-centered care, and to support date analytic capabilities to gather and report quality and outcomes data will help to align payment and delivery reform for physicians. The costs of robust patient centered care include the use of expanded health records and community resources data bases to both follow patients effectively and maintain current and detailed inventories of social referral sources.[23] The income from value-based payment methods can be sufficiently flexible to permit partnerships with a variety of social service partners to address patients' social needs while providing appropriate incentives for practices to provide high-quality, comprehensive services.

Financial flexibility coupled with well-designed quality and outcomes measures are critical to efforts to implement integrative primary care. The needs of patients with complex medical and social deficits cannot be reduced to a reimbursement formula, and per-service payment is therefore inadequate. Quality bonuses, partial capitation, full capitation, and other forms of alternative payment recognize this uncertainty, and leave to the practice the individual patient assessments of needs and care responses. At the same time, practices must participate in the broader system's goals of improving outcomes within a sustainable cost structure, and suitable measures of quality and outcomes is therefore vital.[24] Primary care practices' leadership is essential to achieve health reform goals, and that requires support as well as clear, system-wide shared goals.

We're Not Alone: The Lessons from Europe

The U.S. may be an outlier in terms of national health costs, but it is far from alone in facing inflationary pressures in the delivery of care. Although starting at a lower base, many other nations have long been concerned about the seemingly inexorable growth in health budgets.[25] European systems are heterogeneous in structure, performance, and outcomes.[26] Cost containment measures sometimes include tools pioneered in the U.S.,[27] and considerations of means to moderate cost and improve quality at the patient level are quite independent of the structure of the national health system.

Research into improvements in health care in Europe have, as in the U.S., addressed the need for integrated care. As in the U.S. researchers have recognized an interest in reducing payer fragmentation, providing increased agency for practitioners, increasing the use of data to coordinate care, and implementing methods to ensure that practices further system goals of improved quality and cost containment.[28] Many European countries employ supplemental payments to primary care providers for care coordination,

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value-based payments such as pay-for-performance, and alternative payment methods such as bundled payments.[29]

Focus on tools that empower physicians to integrate care while setting parameters for outcomes and quality are, then, on the agenda in diverse European health systems. This observation supports the assertion that similar mechanisms are appropriately examined in the U.S., and that their appropriate implementation will be important regardless of the future shape of the U.S. overall health finance and delivery system.

The modest aim of this commentary is ensure a place for physician payment reform within the ongoing examination of the future of our health care finance and delivery system. Whatever the outcome of debates on the proper shape of our payment system (single payer, ACA 2.0 or some as-yet undescribed configuration), primary care practice-level reform will be vitally important. It matters a great deal whether our health system integrates to improve care; it matters that people have insurance coverage and that insurance covers the full range of services needed to maintain health. But when a patient with multiple chronic illnesses, or one experiencing depression, or one in need of prenatal care approaches a care delivery system, she often presents to a primary care practice. It is at that level that our central goals for health care are realized or frustrated.

Discussion

The modest aim of this commentary is ensure a place for physician payment reform within the ongoing examination of the future of our health care finance and delivery system. Whatever the outcome of debates on the proper shape of our payment system (single payer, ACA 2.0 or some as-yet undescribed configuration), primary care practice-level reform will be vitally important. It matters a great deal whether our health system integrates to improve care, and matters that people have insurance coverage and that insurance covers the full range of services needed to maintain health. But when a patient with multiple chronic illnesses, or one experiencing depression, or one in need of prenatal care, approaches a care delivery system, she often presents to a primary care practice. It is at that level that our central goals for health care are realized or frustrated. Care integration as a mantra takes concrete form in a primary care setting. Integration there contemplates the patient as a whole person, attending to medical needs as well as upstream social needs. If the systemic reforms allow for or mandate real integrative practices at the primary care level, goals of improved personal and population health will thereby be advanced. Physician payment structures can help drive — or frustrate — goals of integrated care. They do not follow automatically from higher-level reform efforts, but must be attended to directly, thoughtfully, and intentionally. Research at the physician payment level is ongoing, important, and key to the well-being of patients and populations.

Note

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References

1. The reference to "physician" in this commentary is intended to be read broadly as including an advanced practice nurse, a physician's assistant, or other health professional providing primary care.
2. *See, e.g.*, M. Johnson et al., "Medicare For All: An Analysis Of Key Policy Issues," *Health Affairs* 39, no.139 (2020).
3. *See, e.g.*, L. F. Wiley, "Medicaid for All? State-Level Single-Payer Health Care," *Ohio State Law Journal* 79, no. 843 (2018).
4. *See, e.g.*, A. R. Gluck and T. Scott-Railton, "Affordable Care Act Retrenchment," *Georgetown Law Journal* 108, no. 495 (2020):
5. N. Mulvaney-Day et al., "Mental Health Parity and Addiction Equity Act and the Use of Outpatient Behavioral Health Services in the United States, 2005–2016," *American Journal of Public Health* S190 (2019).
6. L. Adler et al., "Understanding the bipartisan Senate Finance prescription drug reform package," Brookings Institution, October 3, 2019, *available at* <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2019/10/03/understanding-the-bipartisan-senate-finance-prescription-drug-reform-package> (last visited July 22, 2020).

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https://doi.org/10.1177/1073110520958871 Published online by Cambridge University Press

7. J. Tolbert *et al.*, *Key Facts about the Uninsured Population* (KFF, December 13, 2019) *available at* <https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population > (last visited July 22, 2020).
8. S. Collins et al., "Health Insurance Coverage Eight Years After the ACA," Commonwealth Fund, February 7, 2019, *available at* <https://www.commonwealthfund.org/publications/issue-briefs/2019/feb/health-insurance-coverage-eight-years-after-aca> (last visited July 20, 2020).
9. B. Sommers et al., "Health Insurance Coverage and Health — What the Recent Evidence Tells Us," *New England Journal of Medicine* 377, no. 586 (2017).
10. See e.g., C. H. Hitchner et al., "Integrated Delivery Systems: A Survey of Organizational Models," *Wake Forest Law Review* 29, no. 273 (1994).
11. *See, e.g.*, T. L. Greaney, "Regulators as Market-Makers: Accountable Care Organizations and Competition Policy," *Arizona State Law Journal* 46, no. 1 (2014).
12. E. Elhauge, "Why We Should Care About Health Care Fragmentation *and How to Fix It*," in *The Fragmentation* of *U.S. Healthcare: Causes and Solutions*, E. Elhauge ed. (2010); *To Err is Human: Building a Safer Health System*, L. T. Kohn et al. eds. (Washington, DC: National Academies Press, 2000).
13. *See* D. M. Berwick et al., "The Triple Aim: Care, Health, and Cost," *Health Affairs* 27, no. 3 (2008).
14 *Id.*
15. J. Speta, "Handicapping the Race for the Last Mile?: A Critique of Open Access Rules for Broadband Platforms," *Yale Journal on Regulation* 39, no. 1 (2000); S. Balm et al., "Developing an Evaluation Framework for Innovative Urban and Interurban Freight Transport Solutions," *The Procedia - Social and Behavioral Sciences* 125 (2014): 386-397.
16. A. L. Ellner and R. S. Phillips, "The Coming Primary Care Revolution," *Journal of General Internal Medicine* 32, no. 4 (2017): 380-386.
17. *See* C.G. Wise et al., "Journey Toward A Patient-Centered Home: Readiness for Change In Primary Care Practices," *Milbank Quarterly* 89, no. 3 (2011): 399-424; Institute of Medicine, *To Err is Human: Building a Safer Health System*, *supra* note 12.
18. *See* G. L. Jackson et al., "The Patient-Centered Medical Home: A Systematic Review," *Annals of Internal Medicine* 169 (2013): 169-178.
19. *Id.*
20. J. DeVoe et al., "Perspectives in Primary Care: A Conceptual Framework and Path for Integrating Social Determinants of Health Into Primary Care Practice," *Annals of Family Medicine* 14, no. 2 (2016):104-108.
21. *See* K. Green and M. Zook, "When Talking About Social Determinants, Precision Matter," *Health Affairs Blog*, October 29, 2019, *available at* <https://www.healthaffairs.org/do/10.1377/hblog20191025.776011/full/> (last visited July 22, 2020).
22. *See* A. Garg, et al., "Addressing the Social Determinants of Health Within the Patient-Centered Medical Home: Lessons From Pediatrics," *JAMA* 309, no. 19 (2013): 2001-2002.
23. *See* Devoe et al., *supra* note 20.
24. *See* D. Blumenthal and M. K. Abrams, "Tailoring Complex Care Management for High-Need, High-Cost Patients," *JAMA* 316, no. 16 (2016): 1657-1658.
25. *See* S. Thompson et al., *Economic Crisis, Health Systems and Health in Europe: Impact and Implications for Policy* (European Observatory, World Health Organization, 2014), *available at* <http://healthrights.mk/pdf/Vesti/2014/10.2014/2/Economic-crisis.pdf> (last visited Sept. 16, 2020).
26. *See Health System Performance Comparison: An Agenda for Policy, Information and Research* (European Observatory, World Health Organization 2013) *available at* <http://www.euro.who.int/__data/assets/pdf_file/0009/244836/Health-System-Performance-Comparison.pdf> (last visited July 22, 2020).
27. *See* R. Busse et al., "Diagnosis Related Groups in Europe: Moving Toward Transparency, Efficiency, and Quality in Hospitals?" *The British Medical Journal* 346 (2013): f3197, *available at* <https://www.bmj.com/content/346/bmj.f3197> (last visited July 22, 2020).
28. *See* J. C. Langenbrunner and X. Liu, *How to Pay?: Understanding and Using Incentives* (Health, Nutrition, and Population Discussion Paper, The World Bank), *available at* <http://documents.worldbank.org/curated/en/639231468762613437/pdf/316330HNP0LangenbrunnerCh5HowtoPayFinal.pdf> (last visited July 22, 2020).
29. *See* A. Tsiachristas et al., "Exploring Payment Schemes used to Promote Integrated Chronic Care in Europe," *Health Policy* 113, no. 3 (2013): 296-304.

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