U.S. Efforts to Strengthen Primary Care Organization and Payment

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The Primary Care Shortage Problem

- In 1998, 54% of internal medicine residents chose general medicine; by 2005 – 20% -- many now becoming “hospitalists”
- U.S. medical school graduates entering family medicine residencies:
  - 1997 – 2340; 2005 – 1132
  - More than 50% of residency slots fill with international medical graduates --raises issues of cultural competence for primary care and contributing to “brain drain”

Median Compensation, 1995-2004
(analysis by Bodenheimer, MGMA data)

	1995	2004	10 year increase
All primary care	133K	162K	21%
All specialties	216	297	38%
Dermatology	177	309	75%
Radiology	248	407	64%

A Short History of Medicare Physician Payment

- Initially, "customary, prevailing, reasonable," CPR – modeled after "usual, customary, reasonable" used by private insurers
  - Paid lowest of actual charge, MD's customary charge (median of previous year's), and prevailing charge in area (75th percentile of customary charges) – quasi-fee schedule
  - Came to be viewed, correctly, as inflationary and to reward procedural specialties

1989 Legislation Took Effect in 1992

- Relative value scale to rationalize payment and redistribute across type of service and geography – called "resource-based relative value scale (RBRVS)" -- a relative value unit (RVU) represents sum of practice expenses and work to equal resource costs for each of > 7000 services. One goal was to redistribute from specialists to GPs
- Overall expenditure controls through a Volume Performance Standard, now called Sustainable Growth Rate tied to growth in GDP
- Dollar amount physician allowed to charge the patient above the fee schedule allowed amount - "balanced bill" – was limited

Medicare Fee Schedule Used in Medicare and by Commercial Payers

- Current work at Urban Institute to simulate hourly and annual compensation if the Medicare Fee Schedule were used by all payers shows certain specialties have relative returns of 2-2.5:1 compared to Family Practice. (Similar to ratios of private insurance.) Highest returns are in non-surgical procedural specialties – cardiology, gastroenterology. Also, radiology

Urban Institute Analysis of Impact of RBRVS with Expenditure Limits

- Expected redistribution to "evaluation & management" (E&M) services and MDs who do them, including primary care, did not occur
- Although there was modest increase in valuation of E&M services, RVU growth is driven by service volume for new services
- The process for setting relative values – including reliance on estimates from an AMA multispecialty committee viewed by many as political and tilted in favor of technical services and procedures

Current Paralysis In Fee Schedule Payment Policy

- Consensus that current system for setting expenditure limits – if volume increases beyond target amount, fees are supposed to drop – is broken both conceptually and politically
- No agreement on intellectual component in RBRVS calculation; no gold standard
- Practice expense calculations have been flawed and the process remains non-transparent
- Medicare distortions replicated in commercial insurance fee schedules, but they pay more

Other Current Topics in FFS Reimbursement

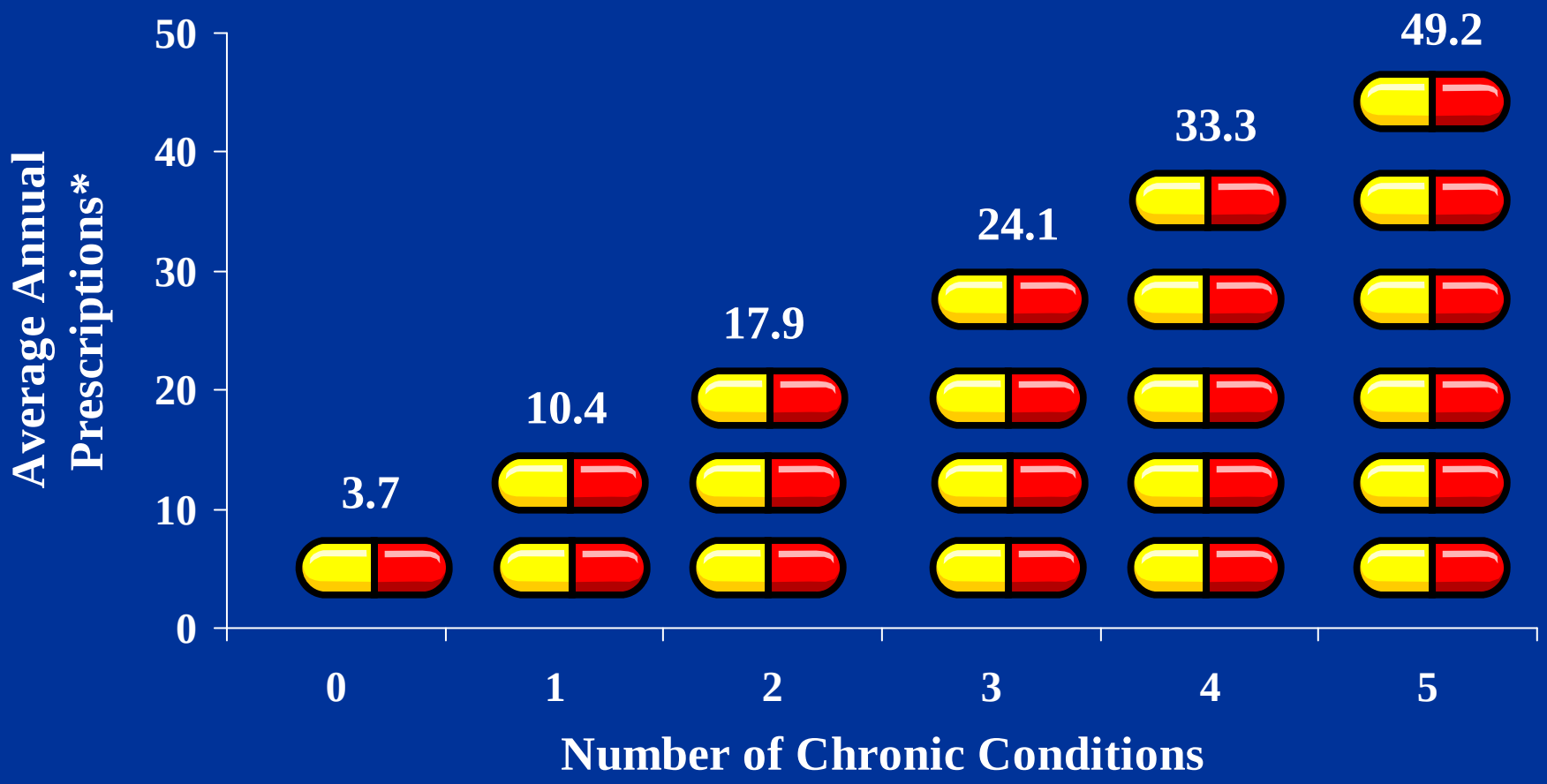
- Pay-for-Performance (starting with Pay-for-Reporting) at its infancy with a few %, not 25%, the marginal bonuses being implemented
- Growing recognition that many needed activities for increasing problem of patients with multiple chronic conditions can't be reimbursed FFS
  - high transaction costs
  - program integrity concerns -- fraudulent billing
  - one place where "moral hazard" concerns may be valid

Gaps in FFS Payments

- Current payment policies do not support the activities (not services) that comprise the Wagner Chronic Care Model, incl. expanded use of secure email and phone, non-physician care, team conferences, coordinating with others , harnessing community resources, using patient registries to facilitate preventive services, etc.

The Growing Challenge of Chronic Care and Role of Primary Care

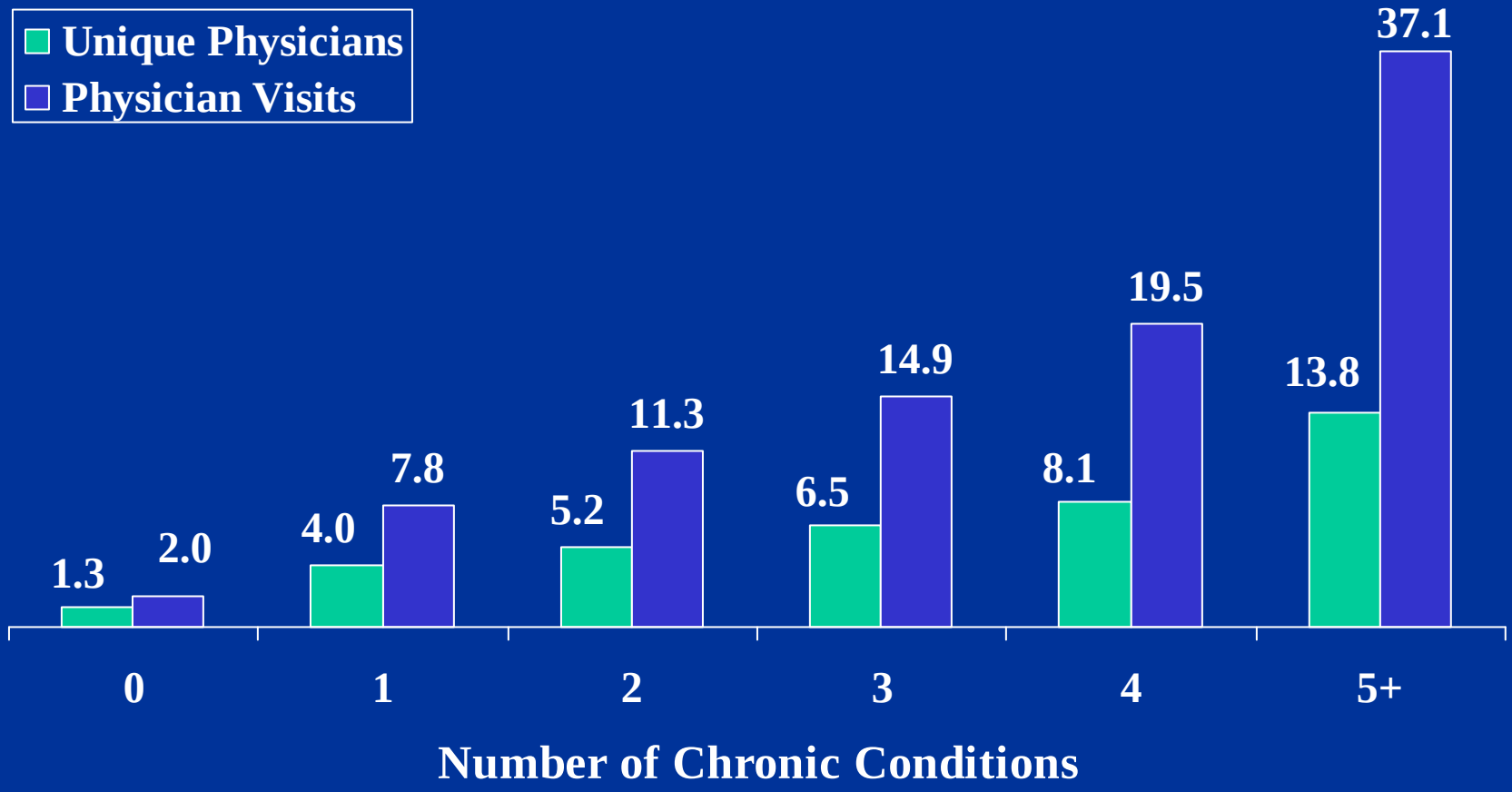
Annual Prescriptions by Number of Chronic Conditions



*Includes Refills

Sources: Partnership for Solutions, "Multiple Chronic Conditions: Complications in Care and Treatment," May 2002; MEPS, 1996.

Utilization of Physician Services by Number of Chronic Conditions



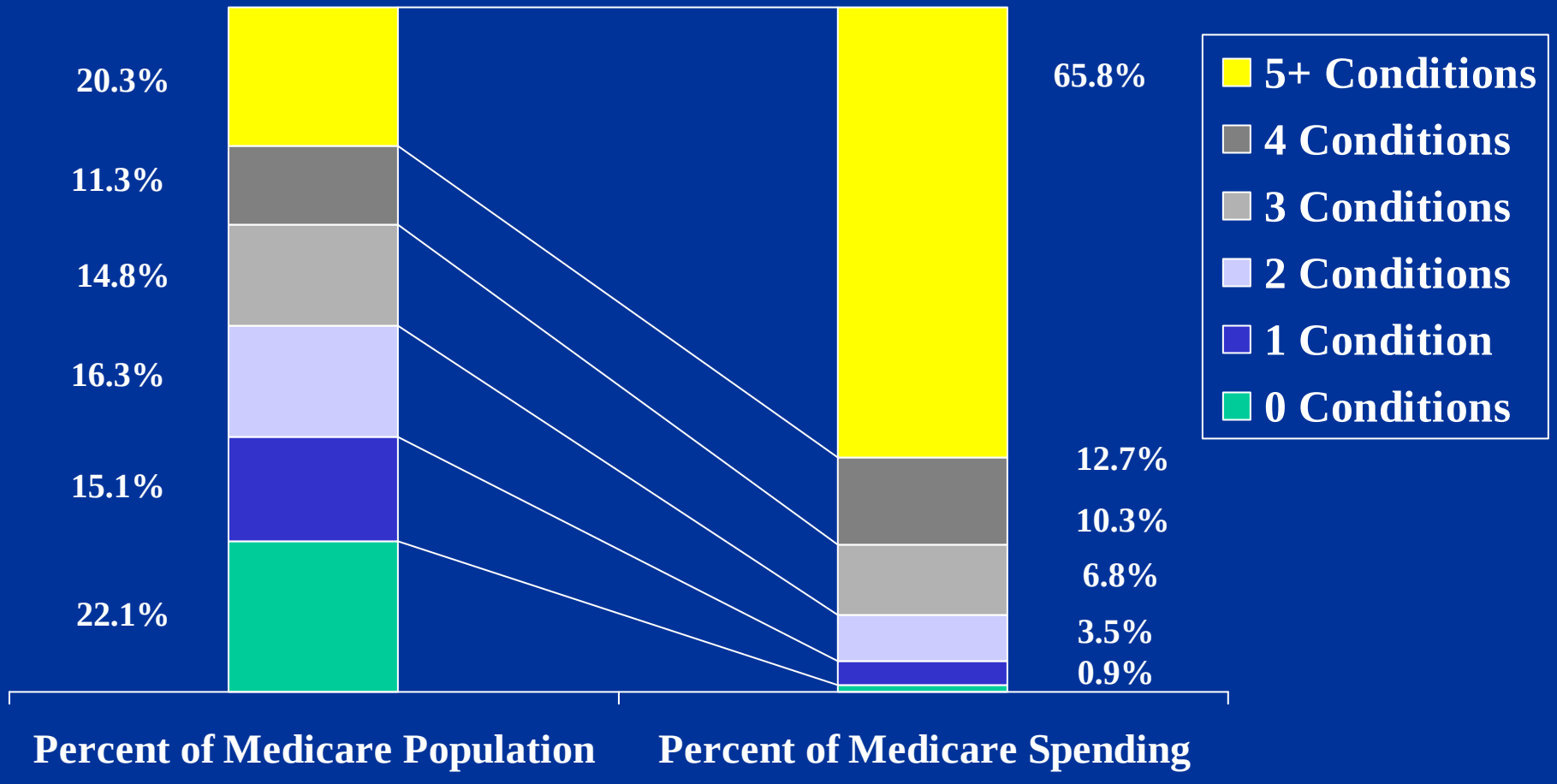
Sources: R. Berenson and J. Horvath, "The Clinical Characteristics of Medicare Beneficiaries and Implications for Medicare Reform," prepared for the Partnership for Solutions, March, 2002; Medicare SAF 1999.

Incidents in the Past 12 Months

Among persons with serious chronic conditions, how often has the following happened in the past 12 months?

	Sometimes or often
1. Been told about a possibly harmful drug interaction	54%
2. Sent for duplicate tests or procedures	54%
3. Received different diagnoses from different clinicians	52%
4. Received contradictory medical information	45%

Medicare Spending Related to Chronic Conditions



Source: Partnership for Solutions, "Medicare: Cost and Prevalence of Chronic Conditions," July 2002; Medicare Standard Analytic File, 1999.

The Patient-Centered Medical Home (PCMH)

Problems For Which Medical Home is Offered as a Solution

- Recognized deficiencies in "patient-centered" aspects of care, e.g. respect for patient values and preferences, access, availability, coordination, emotional support, etc. – most related to competing claims on physician time
- The growing challenge of chronic care
- Relatively poor primary care compensation and the difficulties in relying on FFS to support primary care activities

How Patients are Affected

- Asking patients to repeat back what the physician told them, half get it wrong. (Schillinger et al. Arch Intern Med 2003;163:83)
- Patients making an initial statement of their problem were interrupted by the PCP after an average of 23 seconds. In 23% of visits the physician did not ask the patient for her/his concerns at all. (Marvel et al. JAMA 1999; 281:283)

Readmissions

- In Medicare, about 11% of patients are readmitted within 15 days and almost 20% within 30 days
- 50% of patients hospitalized with CHF are readmitted within 90 days
- The majority of readmissions are avoidable – declining with time from index admission
- Half of patients discharged to community and readmitted within 30 days after medical DRG had no bill for physician services in the interval

The Evolution of the PCMH Concept – The Confluence of Four Streams

- "Medical homes" in pediatrics – 40 year Hx, oriented to mainstream care for special needs children especially needing care coordination
- The evolution of primary care deriving from WHO meeting in Alma Alta in 1978 – as summarized by Starfield, core attributes are: first contact care, longitudinal responsibility for patients over time, comprehensive care, coordination of care across conditions, providers and settings

Evolution (cont.)

- "Primary care case management" in commercial HMOs and a few Medicaid programs – with some success in latter and (probably in former despite disrepute); formal gatekeeper requirements in about half of OECD countries
- Practice redesign focused around EHRs and, somewhat separately, around the Wagner Chronic Care Model (which includes use of EHRs)

"A 2020 Vision of Patient-Centered Primary Care"

Karen Davis, Stephen C. Schoenbaum, and Anne-Marie Audet, *Journal of General Internal Medicine*, 2005; 20:953-957

- An excellent synthesis of these four streams into a comprehensive and plausible set of attributes and expectations – although not necessarily achievable in all practice situations

Core Principles Agreed to by the Four Primary Care Societies in 2007

- Personal physician
- Physician directed medical practice
- Whole person orientation
- Care is coordinated and/or integrated
- Quality and safety
- Enhanced access
- Supportive payment

Challenges to Adoption of the Patient-Centered Medical Home

- Lack of agreement on operational definition and emphases; alternative foci – traditional primary care or EHRs or Wagner Chronic Care Model or all of the above
- Practice size and scope – still dominance of solo and small groups – arguably without ability, even with new resources, to adopt many elements of PCMH -- rural vs. urban; small vs. large practice. Do we have same expectations and same models for differently situated practices?

Challenges (cont.)

- Shortage of primary care physician workforce combined with more demand for services -- if insurance coverage is expanded
- Medical practice culture and structure – the "tyranny of the urgent"
- To whom should the PCMH apply? All patients or those with special needs, e.g. in Medicare, those with multiple chronic conditions only

Challenges (cont.)

- Should principal care physician practices, e.g. endocrinologists for diabetics, qualify?
- Is there any kind of patient "lock-in" – hard or soft?
- Management challenges – even in large groups with an interest, many elements not adopted so far – but there have been no payment incentives to do so

Challenges (cont.)

- Unfettered expectations – every one has a favorite attribute to hang on the PCMH – care coordination, population health, shared decision-making, cultural competence, reducing disparities, detection of depression – or alcoholism – or cognitive deficits. The list goes on.

A Cautionary Note

"Primary care could also expand beyond its more restrictive role as provider of medical care… The danger, of course, is that primary care's new role will be even more expansive and varied than today's already diverse activities. A redefinition of primary care must be cognizant of this risk, focus on optimizing primary care's strengths, and avoid assuming too many peripheral responsibilities in its formulation." (Moore and Showstack, Ann Inter Med, 138:244, 2005)

Five Specific Payment Options (not mutually exclusive)

- Enhanced FFS payments for office visits (5 levels)
- Reimburse for newly defined services
- Regular FFS for OV's and small PPPM (per person per month) for medical home activities to the practice
- Reduced FFS for OV's and larger PPPM for medical home activities
- Comprehensive (capitated) payment for medical services and medical home activities

"The Tyranny of the Urgent"

"Amidst the press of acutely ill patients, it is difficult for even the most motivated and elegantly trained providers to assure that patients receive the systematic assessments, preventive interventions, education, psychosocial support, and follow-up that they need." (Wagner et al. Milbank Quarterly 1996:74:511.)

The Pressure of the 15 Minute Visit

"Across the globe doctors are miserable because they feel like hamsters on a treadmill. They must run faster just to stand still…The result of the wheel going faster is not only a reduction in the quality of care but also a reduction in professional satisfaction and an increase in burnout among physicians." (Morrison and Smith, BMJ 2000; 321:1541)