Paying for Primary Care: Is There A Better Way?

And What Does the “Patient-Centered Medical Home” Have to Do With It?

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The National Congress of Health Reform

Broad Interest – To the Point of Silver Bullet Status?

• Four primary care societies have endorsed (even some surgical groups)
• Various purchasers and purchasing groups – IBM, GE, ERISA Industry Committee
• Large Insurers – various Blues, United, Aetna
• The largest insurer – Medicare demo(s)
• Democratic and Republican Presidential campaigns
• Patient Centered Primary Care Collaborative www.pcpcc.net
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, coordination, emotional support, etc.

• The growing challenge of chronic care

• Relatively poor primary care compensation – leading to a growing workforce problem
“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.)
“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)
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)
<table>
<thead>
<tr>
<th>Percent of Medicare Population</th>
<th>Percent of Medicare Spending</th>
</tr>
</thead>
<tbody>
<tr>
<td>20.3%</td>
<td>65.8%</td>
</tr>
<tr>
<td>11.3%</td>
<td>12.7%</td>
</tr>
<tr>
<td>14.8%</td>
<td>10.3%</td>
</tr>
<tr>
<td>16.3%</td>
<td>6.8%</td>
</tr>
<tr>
<td>15.1%</td>
<td>3.5%</td>
</tr>
<tr>
<td>22.1%</td>
<td>0.9%</td>
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</tbody>
</table>

Recent Data on High Cost Patients

- 75% of high cost beneficiaries had one or more of 7 chronic conditions: asthma, COPD, CRF, CHF, CAD, diabetes or senility; 70% of inpatient spending was for beneficiaries with one of these – CBO, 2005
- 5% of beneficiaries accounted for 43% of total Medicare spending; the costliest 25% for 85% of spending – CBO, 2005
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 the 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.
Annual Prescriptions by Number of Chronic Conditions

Number of Chronic Conditions

Average Annual Prescriptions*

0  1  2  3  4  5

3.7  10.4  17.9  24.1  33.3  49.2

*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

Number of Chronic Conditions vs. Unique Physicians and Physician Visits

## Incidents in the Past 12 Months

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

<table>
<thead>
<tr>
<th>Incident</th>
<th>Sometimes or often</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Been told about a possibly harmful drug interaction</td>
<td>54%</td>
</tr>
<tr>
<td>2. Sent for duplicate tests or procedures</td>
<td>54%</td>
</tr>
<tr>
<td>3. Received different diagnoses from different clinicians</td>
<td>52%</td>
</tr>
<tr>
<td>4. Received contradictory medical information</td>
<td>45%</td>
</tr>
</tbody>
</table>
The Primary Care Shortage Problem and Relative Incomes

• In 1998, 54% of internal medicine residents chose general medicine; 2005 – 20%
  (Bodenheimer, NEJM; 355:861)

• U.S. medical school graduates entering family medicine residencies:
  • 1997 – 2340
  • 2005 – 1132 (Pugno, Fam Med; 37:555)
### Median Compensation, 1995-2004
(analysis by Bodenheimer, MGMA data)

<table>
<thead>
<tr>
<th></th>
<th>1995</th>
<th>2004</th>
<th>10 year increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>All primary care</td>
<td>133K</td>
<td>162K</td>
<td>21%</td>
</tr>
<tr>
<td>All specialties</td>
<td>216</td>
<td>297</td>
<td>38%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>177</td>
<td>309</td>
<td>75%</td>
</tr>
<tr>
<td>Radiology</td>
<td>248</td>
<td>407</td>
<td>64%</td>
</tr>
</tbody>
</table>
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
· “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 EMRs and, somewhat separately, around the Wagner Chronic Care Model (which includes use of an EMR)
“A 2020 Vision of Patient-Centered Primary Care”


- An excellent synthesis of these four streams into a comprehensive and plausible set of attributes and expectations
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
The Basic Problem with How Medicare (and others) Pay M.D.s

- The Resource Based Relative Value Scale (RBRVS)-based fee schedule has inherent limitations, even if improved (which is overdue)
- By design, the relative values of 6000+ codes are, at best, an approximation of underlying resource costs, not an attempt to determine what services beneficiaries need, that is, real value
- And, what purports to be an objective process is, despite good intentions, inherently subjective and political. It does not favor primary care.
Fee-For-Service Is Necessarily Rooted in Face-to-Face Encounters

- There are plenty of reasons, e.g.,
  - high transaction costs, associated with non-face-to-face, frequent, low dollar transactions;
  - major program integrity concerns
  - “moral hazard” driving expenditures
- Yet, increasingly, face-to-face visits do not encompass the work of primary/principal care for patients with chronic conditions (most Medicare beneficiaries). Thus, we need to think about payment mechanisms other than FFS.
Gaps in FFS Payments

• Current payment policies do not support the activities (not services) that comprise the Wagner Chronic Care Model, incl. non-physician care, team conferences, coordinating care with other physicians, harnessing community resources, using patient registries to facilitate preventive services, etc.

• N.B. This model is more than an electronic health record, which some of view as necessary but not sufficient for what a medical home needs to do
Bundled ("Capitated") Payments for All Services and All Patients or a FFS Hybrid

- Don’t call it capitation, which is a four letter word.
- The advantage is that all patients are included, so no practice dissonance for different patients, and risk adjustment handles the fact that different patients have different needs for chronic care management.
- Can we correct the execution errors of 1990s capitation approaches related to: insurance risk, absence of risk adjustment, mechanical actuarial conversion of pmpms under FFS to a situation when more is expected of the practice?
Challenges to Adoption of the Patient-Centered Medical Home

- Lack of agreement on operational definition and emphases; alternative foci – traditional primary care or EMRs or Wagner Chronic Care Model
- Medical practice culture and structure combined with the “tyranny of the urgent,” at least in small practices
- Practice size and scope – still dominance of solo and small groups – arguably without ability, even with new resources, to adopt many elements of PCMH
Challenges (cont.)

· Shortage of primary care physician workforce combined with more demand for services, especially if we do expand coverage a la Massachusetts

· To whom should the PCMH apply? All patients or those with special needs, e.g. in Medicare, those with multiple chronic conditions. (Note CMS has decided that up to 86% of beneficiaries qualify)

· 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.)

- Should principal care physician practices, e.g. endocrinologists for diabetics, qualify?
- Is there any kind of patient “lock-in” – hard or soft?
- Unfettered expectations – every one has a favorite attribute to hang on the PCMH – shared decision-making, cultural competence, reducing disparities, detection of depression – or alcoholism – or cognitive deficits. The list goes on.
Options for How to Financially Support Enhanced Primary Care

- **Enhanced FFS**
  - Higher payment rates to support cross-subsidization
  - New CPT codes
- **Improved PPPM Payments** – risk adjusted, actuarially fair, no insurance risk
- A hybrid – FFS for visits and PPPM for PCMH
- Condition-based
- P4P can be added to each one to mitigate concerns about incentives in each basic payment model
Pay Whom?

- All to the medical home practice, which may allocate to others?
- Separate payment streams for different parts of the medical home activities, as in North Carolina Medicaid Community Care Networks, Oklahoma Medicaid?
Emerging (and Somewhat Understandable) Payer Resistance

- Skeptical about cost savings since other approaches, e.g. disease management by vendors, haven’t reduced costs – “prove it”

- Concern that PCMH is a stalking horse for more money for services practices should already be providing

- Will consumers accept this? Is this gatekeeper in drag?
So Some Payers May Want to Limit:

- The amount of dollars put up
- The number of patients involved – only to “complex” patients (the 5% or so that produce >50% of costs)
- The number of practices who get to play – who agree to “comprehensive redesign”
- These limitations may limit true test of concept
“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)