Federal Policy, Primary Care and the Medical Home

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Increasing Primary Care

Pre-Med
- K-12 Programs
- Undergrad Programs
- Recruitment Programs

Medical School
- Admission Policies
- Primary Care programs
- Underserved Areas programs

Graduate Med. Education
- Medicare GME
- Increase Primary Care Residencies
- Loan Repayment Programs
- Medicare GME Accountability
- Medicare Reimbursement Reform

Practice
- Delivery System Reform
- Payment Reform
- National Health Service Corps

BA/MD Programs
- Reinvented, Recapitalized Title VII

Increasing Primary Care
“Oh, if only it were so simple.”
US FFS- Undervalue Primary Care

- Fee structure historically favors specialty care-
- FFS has no explicit reward for the primary care function
  - Accessibility and after hours care- NO- once practice is “full” no incentive for additional access
  - Coordination: NO- No explicit payments for inter-visit communication, coordinating across specialists or care givers
  - Comprehensive care- NO- physicians already feel “rushed”; More to do during a single visit now than in 1980’s
    - MOST Medicare beneficiaries have multiple chronic diseases
    - More drug combinations recommended for each disease
    - More preventive services/early interventions
    - More extensive documentation regulations
    - DTCA
Improving Fee Payments to Primary Care Practitioners

- Direct boost to primary care fees
- Allow primary care FFS spending to grow faster than specialty FFS
- Establish expert panel to identify mis-priced physician services (specific attention to services that might have become over-valued)
- Correct practice expense adjustments
- Give HHS Secretary additional authority
  - to reduce work RVUs for specialty physician services growing much faster than overall physician spending
  - to adjust new procedure payment rates for efficiency gains
How to recognize primary care for Medicare fee boost

• Credentialing/certification?
  – Which specialties? family medicine, general internal medicine, general pediatrics, medicine-pediatrics, medical geriatrics
    • 1990’s advocacy: Ob-gyn, endocrinology, oncology, nephrology, cardiology, general surgery…

• Billing pattern analysis: identify practice patterns consistent with primary care services (eg comprehensive mix of diagnoses managed, ambulatory care visits, etc)
"I have no objection to alternative medicine so long as traditional medical fees are scrupulously maintained."
Paying for Primary Care Functions: “Patient-Centered Medical Home”

- Joint Principles adopted March 2007 - AAFP, AAP, ACP, AOA
  - Personal Physician, Physician Directed Medical Practice - meeting special qualifications
  - Whole Person Orientation, Care is Coordinated and Integrated
  - Extra Quality and Safety infrastructure, HIT
  - Enhanced Access
  - Payment Reform
Government payers- many questions

• “How do we tell what’s really a medical home?
• Who should get which medical home services?
• How do we tell if those extra services were actually delivered?
• How do we make sure we aren’t just paying more for the same old care?”
Patients are nervous and confused

- Fear this is a return to the much reviled “primary care gatekeeper.”
- Think of nursing homes or big unfriendly “clinics”.
- Little experience with high-functioning primary care practices
Many practicing generalist physicians are highly skeptical

• Angry over the problematic trajectory of fee-for-service payments, the threats of health plan “report cards,” and the burdens of various P4P initiatives

• Questions about medical home proposals
  – “If I’m the ‘coordinator’ do I have to hunt down reports from consultants? Why aren’t they required to coordinate with me?
  – Am I just going to be a manager of Pas and NPs, with no personal relationship with my patients?
  – Isn’t this just another way of shifting money to big groups and specialists who can afford the paperwork, the EMR, the extra staff?”
Determinants of Congressional Action

- Policy
  - MedPAC, CBO, Professional Staff
- Politics
  - the Members have to defend their votes!
- Procedure
  - The Constitution- House vs Senate
"Here are some of my policy assumptions. Find something to base them on."
Medical Homes a promising concept
Recommends establishing a PILOT program (large scale, rapid cycle, CMS authority to expand nationally)
Monthly payments and P4P incentives
Stringent criteria (primary care, HIT, quality improvement, team care, access)
Initial focus on pts with multiple chronic conditions (~60% of Medicare bene’s)
I share those concerns about primary care…I hear fewer students coming out of medical school…$125,000 for a family physician to start and…a radiologist can make $500,000 a year…they can figure that one out…

And…I share this idea of disease management and the Medical Home…rather than let these commercial companies…sell it to us, we empower the primary care doctors to take on that responsibility and get paid for it,
Baucus- Health Care Reform Proposal Nov 2008

• Expanding Medicare’s role in testing the medical home model — in which practitioners are paid explicitly for comprehensive care management services…

• Medical home expansions in Medicare should focus only on providers who are committed to ensuring that patients truly receive the primary care and care management services...

• Providers seeking to participate in a Medicare medical home… should meet a set of stringent service and capacity criteria in order to qualify… and be willing to have additional payments based in part on the quality of care they deliver.

• The required medical home criteria … can be challenging for the 36 percent of physicians who work in solo or very small-group practices…in rural areas.
  – One option is to invest in community health teams that include nurses, nutritionists, and social and mental health workers.
  – These teams could link primary care practices with additional resources that would allow small or rural offices to participate in the medical home.
Primary care providers... have and will continue to lead efforts to protect and promote the nation’s health.

... expand funding—including loan repayment, adequate reimbursement, grants for training curricula, and infrastructure support to improve working conditions.

...support providers to put in place care management programs and encourage team care through implementation of medical home type models that will improve coordination and integration of care of those with chronic conditions.
The nation faces a primary care shortage.

A health reform plan designed to improve access should start with expanding coverage and improving efficiency, but cannot end there if it is to succeed in promoting access to valuable health care.
SGIM/STFM/APA Medical Home Policy research agenda project

Goals

• organize a 2009 invitational conference to develop a policy-relevant research agenda on the PCMH

• Convene national researchers, major primary care professional organizations, representatives and evaluators of PCMH demonstrations, health care purchasers, payers, patient advocates, and relevant policy makers

• specific objectives:
  – advance the state of the art and science and real world experience about the PCMH in the context of the broader challenges of primary medical care.
  – enhance models for evaluation of the PCMH and related primary care services;
  – Develop a research agenda to inform the ongoing development and implementation of the PCMH
    • in the context of broader primary care payment reform and the generalist clinician workforce
    • the “business case” for primary care payment reform including the clinical and cost consequences of implementing a PCMH
Progress to date

- PI's Bruce Landon (SGIM), Jim Gill (STFM), Rich Antonelli (APA)
- Funding: Commonwealth Fund, ABIM Foundation, AHRQ
- Steering Committee (45)
- Planning Group Committee meeting- DC- Oct 2008 (25)
- Working Paper- potential topics
- PCMH Demo Evaluators meeting- ABIM- Dec 2008 (50-all PCMH Demos plus “TransForMed” represented)
- Finalizing Priority topics for “white papers”
- Research agenda conference June-July 2009 (100-150 invitees anticipated)
SGIM/STFM/APA Medical Home Policy research agenda project

Proposed topics for “white papers”
• Practice Transformation
• Payment Reform and the PCMH
• Financing the PCMH from the Payer Perspective
• Measuring and Operationalizing the PCMH
• Clinical, Satisfaction, and Quality of Care Outcomes of the PCMH
• What is the value of a physician led medical home
• Workforce issues and training requirements
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“Let’s change ‘brink of chaos’ to ‘Everything is wonderful.’”
Roles for Academic GIM leadership in the policy process

• CBO/ MedPAC etc
  – Policy relevant evidence!
  – CBO Panel of Health Advisers, consultants
  – MedPAC Commissioners, consultants

• Professional staff (Health Sub-Committee/key members)
  – Evidence CBO/MedPAC will use!
  – Politically feasible options
  – Constituent support for above
  – Articulate, responsive, credible spokespersons
  – Vivid illustrative examples
Role for Academic GIM leadership in the policy process

- Health staff/ members not on Health Sub-Committees
  - A clear, feasible policy “ask”
  - Policy relevant information/education
  - Constituent support for ask
  - Articulate, responsive, credible information sources (you!)
  - Vivid illustrative examples
“According to an article in the upcoming issue of ‘The New England Journal of Medicine,’ all your fears are well founded.”
GME reform could “jumpstart” the primary care medicine pipeline

• Options
  – Develop new health professions workforce policy recommendations (e.g., revitalize Council on Graduate Medical Education or mandate IOM study or establish national health workforce planning commission)
  – Revise current Medicare GME to better support ambulatory care education
  – Fundamental GME Reform:
    • e.g. GME payments to residency programs, GME grants thru HRSA, GME block grants to states, GME payments to regional academic consortia.
    • Linked to strict control of all training pathways to specialty practice in US
• but…
  – Absent MD payment reform, GME reform may not yield sustained increases in access to primary care services (defections to sub-specialties, hospitalists, emergency medicine, boutique practice, etc)
Funding for primary care training

- HRSA Title VII, Section 747 funds grants to support primary care training for medical students, residents in FM, GIM, and GPeds, and academic unit/faculty development.

- Title VII funding has plummeted 10-fold over 30 years, cut in half again for FY2006.
  - Over the same time frame NIH funding has increased three fold and Medicare GME funding has doubled.
Renewed, substantially funded Title VII grants program could “jumpstart” the primary care medicine pipeline

- Expand dedicated residency and student tracks in primary care
- Add visibility and amenities to primary care training
- Reform failing ambulatory care education sites in teaching hospitals and medical schools
- Develop other tools and curricula relevant to new competencies needed for 21st century primary care
Title VII grants as “jumpstart” for the medical home transformation

• Pilot patient centered medical homes reforms in primary care residency programs, and in affiliated faculty practices
• Develop primary care research expertise to study and evaluate medical home interventions
• Develop tools and curricula relevant to private practice medical home transformation
• Provide formal training to physicians, other health professionals seeking medical home certification
• Serve as a regional resource on primary care/medical home practice transformation available not only to residency graduates but also to local private practices (eg “Primary care infrastructure extension service”)