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Primary Care: Foundation for an Evidence-Based Health System



National Business Group on Health
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NATIONAL
COMMITTEE ON
Evidence-Based
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Primary Care: Foundation for an Evidence-Based Health System

Taking Action on Primary Care Physician Payment

As you conduct management reviews of current health plans and consider new plans for next year, I encourage you to address primary care physician payment. Our current system rewards quantity rather than quality of care — and we are getting what we pay for:

A physician spending 30 minutes performing a diagnostic, surgical or imaging procedure is paid about three times as much as a physician conducting a 30 minute visit managing a complex patient with diabetes, heart failure and depression.¹ It is no wonder a multi-national study ranked the U.S. lowest among developed countries in primary care functions and health outcomes, yet highest in health care spending.²

Two decades of research shows a strong primary care system results in better preventive care, fewer diagnostic tests, lower medication use, and higher patient satisfaction and treatment adherence.³ But as the income gap widens between primary care and specialists, the pipeline of primary care physicians is shrinking, moving us farther from the health care system we want.

Use this guide during management reviews and competitive bidding to encourage dialog with health plans and actions that:

- Achieve more balanced spending between primary and specialty care
- Strengthen primary care and enhance its capacity
- Support and reward effective and efficient primary care
- Move toward comprehensive payment reforms for the patient-centered medical home

Part I summarizes the case for employers to take action on primary care and the model known as the Patient Centered Medical Home.

Part II poses questions for your health plans.

Part III considers new primary care physician payment options.

Part IV provides you with links to organizations active in primary care transformation and a list of Primary Care Work Group members.

You can act now to begin building a strong primary care foundation by becoming familiar with physician reimbursement embedded in your health plan contracts and making changes that reflect more balanced spending between primary and specialist care. You can also get involved in medical home demonstration projects taking place in major health plans across the country and in efforts like the new Bridges to Excellence Medical Home Recognition Program. It will take time to achieve the major primary care practice redesign we are seeking, but it will be worth our investment.

Helen Darling
President, National Business Group on Health



I: Why Take Action on Primary Care

Strong primary care is associated with lower costs and better health outcomes. Countries with strong primary care have healthier populations, more satisfied patients, and lower overall spending than countries without a primary care foundation.⁴ In the U.S., states with a greater ratio of generalist physicians to population have higher quality and lower cost care.⁵

The U.S. does not have a strong primary care system and it is growing worse as the supply of physicians shrinks. Medical graduates are shunning careers in primary care due to lower incomes compared to specialists and stressful working conditions.⁶

Our private sector payment system exacerbates the problem by rewarding quantity rather than quality of care. Private insurers paid an average of 133% of the Medicare fee for procedures and imaging and only 104% of the Medicare fee for Evaluation and Management (E/M) services.⁷ E/M services include office visits and are the most common billing codes for primary care physicians. In the highest paid markets, surgeries and diagnostic imaging may be paid at over 250% of the Medicare fee.⁸

Although Medicare's formula for physician payment is outside the scope of this Discussion Guide, demand is growing to change the approach. The Sustainable Growth Rate (SGR) system was created by the 1997 Balanced Budget Act as a way to control Medicare physician spending. But Congress has overridden annual SGR targets again and again in large part because it penalizes primary care. Medicare actuaries found between 1997 and 2006, overall physician spending grew by 90%, E/M services grew by 74% and non E/M services grew by 101%.⁹

Patient-Centered Medical Home

The Patient Centered Medical Home is a primary care model supported by a consortium of physician, consumer and employer groups that has the potential to provide a strong primary care foundation for our health system.¹⁰

Introduced by the American Academy of Pediatrics in 1967, joint principles defining the medical home have now been endorsed by the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, and the American Osteopathic Association. See Part III of this guide for a link to the Joint Principles.

Features of the medical home include a physician directed medical practice with team members who collectively take responsibility for the ongoing care of patients, care that is coordinated across all elements of the health system facilitated by registries and health information technology, quality and safety, enhanced access through open scheduling, expanded hours and new modes of patient

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Part I

communication, and payment that appropriately recognizes the medical home's value.

While some practices qualify as a medical home today, most do not. Major health plans, community-based coalitions, and the Medicare program are undertaking demonstration projects to evaluate outcomes of the medical home including new payment approaches. For information on medical home pilots, see the Patient Centered Primary Care Collaborative in Part III of this guide.

Attributes Employers Should Look For In Primary Care

Significant spending on Disease Management Programs and the rapid growth of Convenience Care Clinics are signs of our weak primary care foundation. While there is a place in our system for those services, these add to the fragmentation of care in the absence of an integrated health care delivery system with primary care at its core. The table below describes attributes employers should look for from primary care.

First Contact & Access

- Initial point of care for medical needs
- Accessible days/nights/weekends
- Timely appointments, open-access scheduling

Comprehensive

- Address majority of health care needs (preventive, acute, chronic, end-of-life)
- Care team meets clinical needs (physical, psychological, emotional)

Continuous & Coordinated

- Sustained relationship with team management of patient care over time
- Facilitate referral and services to other providers
- PC team involvement in care by other providers
- Coordinated patient communications

HIT and Clinical Tools

- EMR, e-prescribing, registries, online scheduling, automated reminders/alerts to patients and physicians
- E-visits, secure messaging, telephone consultation, telemedicine
- Access to lab and test results

Patient-centered

- Patient education, decision support, self-management support
- Respect beliefs, preferences, psychological and physical needs
- Engage family and community resources as appropriate

Transparent

- Price, discount disclosure
- Performance disclosure
- Comparable standards

Adapted by the NBGH Primary Care Work Group from MJ Sepulveda, 2006; B Starfield, Milbank Memorial Fund, 2005; ; IOM, 1996; M Peterson, ACP, AIM 1980;84:843-51.

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Payment Reform as Linchpin to Change

The medical home model cannot be implemented without comprehensive payment reform. Today's system provides physicians financial incentives to see as many patients as possible within the work day and to perform procedures. Payment will need to be restructured in order to recognize the value of coordinated care and other enhanced capabilities described above.

Blended reimbursement is being tested as a potential model including fee-for-service, risk adjusted per-patient monthly payments, extra pay for care coordination, and pay for performance. The blended model would recognize the enhanced capabilities of the medical home and reward high performers while avoiding problems associated with payment systems relying solely on fee-for-service, capitation, or salary.

Nevertheless, financing the conversion of primary care practices to medical homes will likely be an incremental process linked to infrastructure development and performance reporting. The average physician practice does not have the resources to invest in becoming a medical home.¹¹ And while employers believe the medical home is promising, they want budget neutral changes in the absence of evidence demonstrating effectiveness, noting their experience with disease management programs.

A Word on Consumers

It is safe to say most consumers do not understand the value of primary care, no less the medical home. Memories of primary care physicians as gatekeepers during the managed care era will need to be overcome and the value of an ongoing relationship with a physician and team of providers will need to be demonstrated. Many people wrongly believe unfettered access to specialists will get them the best quality care, although research shows “the issue of free access to specialists takes second place when there is confidence in the primary care doctor.”¹²

The era of Consumer Directed Health Care presents a fresh opportunity to educate consumers about establishing a primary care relationship as one way to spend their health care dollars efficiently.



II: Questions for your Health Plan

How can we restructure physician payment in support of primary care?

- How can we modify reimbursement to redistribute payment among procedures, imaging and E/M services?
- Can we increase relative value units (RVUs) for E/M and reduce or hold steady future increases for procedures and specialists?
- Can we design financial rewards for practices that make appropriate referrals and coordinate care efficiently?

What are you doing to work toward comprehensive payment reforms?

- What are you doing to re-engineer network contracting to shift payment and utilization to primary care and away from specialists?
- How are you building performance expectations into physician contracts to encourage primary care capabilities?
- Are you experimenting with pm/pm payment and payment for services associated with care coordination? If so, please describe.
- Are you experimenting with payment for practice services such as secure e-mail, telephone consultations, and remote monitoring of clinical data using technology?
- How are you encouraging physician practices to participate in Physician Practice Connections Patient Centered Medical Home and Bridges to Excellence?

How are you encouraging development and evaluation of the medical home?

- Describe your efforts to educate plan members about the value of primary care and the medical home.
- Describe your efforts to encourage the medical home model among physician practices.
- What incentives and investments are you using to encourage physician adoption of technology systems and tools to better organize patient data, exchange medical information and communicate with patients?
- What potential is there to use existing health plan programs as a “back office” to practices that want to function as a medical home, i.e., support HIT, care coordination with disease and case management programs, and access with 24/7 nurse advice and care advocate services?



III: Primary Care Payment Options

OPTION	CONSIDERATIONS	INITIAL STEPS
<p>Blended reimbursement for practices meeting NCQA PPC- PCMH standards Levels II & III (FFS, care coordination fee, P4P)</p>	<p>Pro: Payment incentives align with long term practice redesign to medical home. Avoids problems associated with systems relying solely on FFS, capitation, or salary</p> <p>Con: Few practices currently qualify as Level II and III medical home. May not be budget neutral. ROI may be achieved through reductions in ER, hospital admissions, inappropriate imaging, but currently untested.</p>	<p>Develop financial projections for costs and timing of expected return.</p> <p>Work with health plans to analyze what markets or practice profiles make it likely to get a return on investment.</p> <p>Work with carriers to identify practices within their networks that meet the criteria.</p> <p>Consider member incentives for choosing medical home practices, e.g., reduced cost-sharing.</p>
<p>Care coordination fee paid to practices meeting NCQA PPC-PCMH standards (e.g. \$4 - \$6 pm/pm)</p>	<p>Pro: Payment incentive aligns with desired medical home capabilities.</p> <p>Con: May not be budget neutral. ROI may be achieved through reductions in ER, hospital admissions, inappropriate imaging, but currently untested. Few practices have NCQA recognition.</p>	<p>Develop financial projections for costs and timing of expected return.</p> <p>Work with health plans to analyze what markets or practice profiles make it likely to get a return on investment.</p> <p>Decide what NCQA recognition level qualifies the practice for payment (e.g., I, II, or III) and determine how many practices meet the criteria.</p> <p>Consider member incentives for choosing medical home practices, e.g., reduced cost-sharing.</p>
<p>Care coordination fee paid to practices meeting standards other than NCQA PPC-PCMH</p>	<p>Pro: Include more practices than currently have NCQA medical home recognition (very few). Payment incentive aligns with desired medical home capabilities.</p> <p>Con: Administration cost. May create a disincentive for practices to apply for NCQA recognition.</p>	<p>Identify standards/measures that would qualify a practice for the care coordination payment.</p> <p>Develop financial projections for costs and timing of expected return.</p>
<p>Target chronic conditions and pay for care coordination to practices meeting standards</p>	<p>Pro: Targets a high cost population that would benefit from care coordination and other enhanced primary care capabilities.</p> <p>Con: Administration cost</p> <p>Identify standards/measures that would</p>	<p>qualify a practice for the care coordination payment.</p> <p>Develop financial projections for costs and timing of expected return.</p>

(Chart continues)

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Part III

OPTION	CONSIDERATIONS	INITIAL STEPS
Performance payment through BTE recognition program	<p>Pro: Directs payment to practices with demonstrated capabilities (i.e., NCQA Level II and III). Established and recognized program.</p> <p>Con: Few practices currently qualify as a medical home.</p>	Contact BTE.
Increase payment to primary care CPT codes (e.g., by 20%) for a set period of time (1 year) with evaluation.	<p>Pro: Supports all primary care, not just those practices with medical home capabilities. Relatively simple to administer using direct contracting.</p> <p>Con: May not be budget neutral: ROI may be achieved through reductions in ER, hospital admissions, inappropriate imaging, but currently untested. May be costly to administer in an ASO arrangement. Continues FFS system.</p>	<p>Determine how much money is at risk. Determine how much primary care physicians are paid and primary care payment as a percentage of all physician payment.</p> <p>In the absence of NCQA recognition, determine pre/post evaluation metrics.</p>
Financially support PCMH pilots	<p>Pro: Directs resources to development of medical home capabilities and systematic evaluation of the model.</p> <p>Con: Requires additional spending.</p>	<p>Determine which carriers are running medical home pilots and in what markets.</p> <p>Set criteria for support and evaluation.</p>
Determine necessary level of investment. Apply a risk/reward metric to the ASO fee to encourage carriers to support practices in developing enhanced capabilities	<p>Pro: Sends a clear message about the importance of primary care practice redesign. Encourages carriers to use their programs a back office to practices that want to function as a medical home, e.g., HIT, disease/case management, care advocate.</p> <p>Con: No short-term payment increase to primary care practices. Instead, a longer term practice redesign approach.</p>	

As of 5/1/08, 3723 Physicians have Physician Practice Connections recognition and 5 physicians have Physician Practice Connections-Patient Centered Medical Home recognition.



IV: Resources & Primary Care Work Group

A Toolkit for Action: The Imperative for Health Reform

http://www.businessgrouphealth.org/benefitsttopics/et_healthcarereform.cfm

The Board of Directors of the National Business Group on Health recently issued a press release on its position on national health reform. To aid employers in taking action, the Business Group developed a toolkit including a detailed position statement on primary care to emphasize its fundamental importance to system reform.

Bridges to Excellence

<http://www.bridgestoexcellence.org>

BTE's Medical Home Recognition Program was developed in collaboration with NCQA and introduced in January 2008 as an extension of its Physician Office Link and condition-specific programs. Physicians with BTE Medical Home recognition are eligible for a bonus payment of \$125 for each patient covered by a participating employer with a suggested maximum yearly incentive of \$100,000.

Center for Excellence in Primary Care (CEPC)

<http://www.ucsf.edu/cepc>

The website of this Center at the University of California, San Francisco, contains important articles and interviews related to the challenges of primary care and the opportunities for re-designing primary care to become a fully patient-centered foundation of the health care system.

Joint Principles of the Patient Centered Medical Home

<http://www.pcpcc.net/print/14>

The PCMH is an approach to providing comprehensive primary care for children, youth and adults. The AAFP, AAP, ACP, and AOA, representing approximately 333,000 physicians have developed joint principles describing the characteristics of the PCMH. Physician organizations are also developing potential reimbursement models to support the medical home and work is underway by ACP and the Urban Institute to cost out the medical home model.

American Academy of Family Physicians

<http://www.futurefamilymed.org>

(Resources continue)

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American Academy of Pediatrics

http://aappolicy.aappublications.org/policy_statement/index.dtl#M>

American College of Physicians

<http://www.acponline.org/advocacy/?hp>>

American Osteopathic Association

<http://www.osteopathic.org>

NCQA Physician Practice Connections Patient-Centered Medical Home

<http://www.ncqa.org>

The PPC-PCMH program reflects the input of ACP, AAFP, AAP, AOA and others in a revision of Physician Practice Connections to assess whether physician practices are functioning as medical homes. PPC-PCMH standards emphasize the use of systematic, patient-centered, coordinated care management processes.

Patient-Centered Primary Care Collaborative (PCPCC)

<http://www.pcpcc.net>

PCPCC is a coalition of major employers, consumer groups, and other stakeholders who have joined with organizations representing primary care physicians to develop and advance the patient centered medical home. Collaborative projects include the All Payer/All Player Demonstration Task Force (serving as a clearing house for information on medical home pilot efforts across the country), the State Medicaid Working Group, and the National Academy for State Health Policy/PCPCC Joint Medicaid Task Force. The National Business Group on Health is an active participant in the collaborative.

Primary Care and the Medical Home: Promoting Health, Preventive Disease, and Reducing Cost

http://www.businessgrouphealth.org/healthtopics/maternalchild/investing/docs/4_medicalhome.pdf

An overview of the importance of primary care services, the medical home model, and guidance on how employers can support both through beneficiary education, benefit design, and reimbursement practices. National Business Group on Health.

(Resources continue)

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Primary Care: Physician Payment as Linchpin to Change Webinar

www.businessgrouphealth.org/members/secureDocuments/webinars/webinar080107ucsf.ppt

Presentation by Thomas Bodenheimer, M.D examining the widening primary care-specialty income gap, August 1, 2007. (Audio recording and presentation slides)

Report to the Congress: Medicare Payment Policy

http://www.medpac.gov/documents/Mar07_EntireReport.pdf

The Medicare Payment Advisory Commission reviews Medicare payment policies and makes recommendations to Congress concerning them each March. MedPAC considers payment policy for hospital inpatient, hospital outpatient, physician, outpatient dialysis, skilled nursing, home health, long-term care hospitals, and inpatient rehabilitation facilities.

Primary Care Work Group

Roger Merrill, MD (*Work Group Chair*), **Perdue Farms, Inc.**; Clarion Johnson MD (*NCEBBD Chair*), **Exxon Mobil**; Brett Baker, **American College of Physicians**, Wayne Burton MD, **JPMorgan Chase**; Collier Case, **Sprint Corporation**; Beth Casteel, **Federal Express Corporation**; Lisa Cummings, **Wal-Mart Stores, Inc.**; Helen Darling, **National Business Group on Health**; Christoph Diasio, MD, **American Academy of Pediatrics**; Joyce Dubow, **AARP**; Anna Fallieras, **General Electric Company**; Carole Flamm, MD, **Blue Cross Blue Shield Association**; Ann Greiner, **American Board of Internal Medicine**; Paul Grundy MD, **IBM Corporation**; David Levin MD, **Thomas Jefferson University**; Sharon Levine MD, **Permanente Medical Group**; Barbara McNeil PhD, **Harvard Medical School**; Melissa Miller, **Florida Power & Light**; Jeff Munn, **Hewitt Associates, LLC**; Alex Ommaya MD, **Department of Veterans Affairs Office of Research and Development**; Brent Pawlecki MD, **Pitney Bowes**; Bob Phillips MD, **The Robert Graham Center**; Mark Smith, MD, **California HealthCare Foundation**; Eric Sullivan, **UnitedHealthcare**; Sheila Sweeney, **Assurant, Inc.**; John Tooker MD, **American College of Physicians**; Kristy Trzcinski, **Fidelity Investments**; Kerr White MD, **University of Virginia**; Fred Williams, **Quest Diagnostics, Inc.**; Terry Wolf, **The Boeing Company**; Janet Wright MD, **American College of Cardiology**

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- ¹¹ The American College of Physicians and the Urban Institute are conducting a project to evaluate additional practice costs to implement and maintain a medical home. cost out the medical home model.
- ¹² B Starfield, "The Importance of Primary Care to Health," <[http://www.medical reporter.org](http://www.medicalreporter.org)>, accessed on 5/14/07.