

# Paying for Primary Care: Is There A Better Way?

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

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# Medicare Challenges Makes the Case for a New Model – a Medical Home

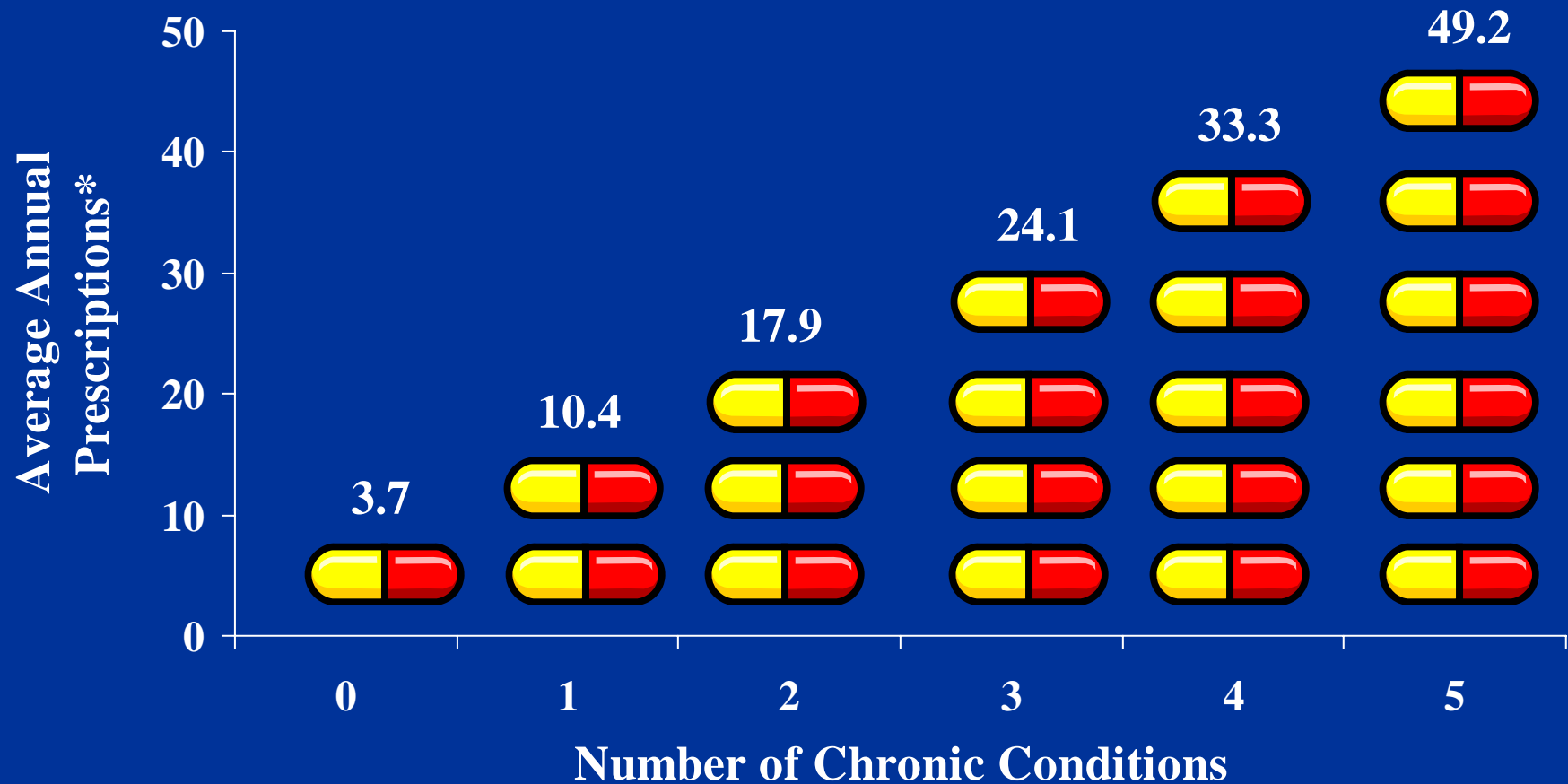
- > 43 million. By 2030, 78 million
- 29% in fair/poor health
- 23% have cognitive impairments
- Age Distribution:

Under 65 (disabled) 14%

➤ 85 11%



# Annual Prescriptions by Number of Chronic Conditions



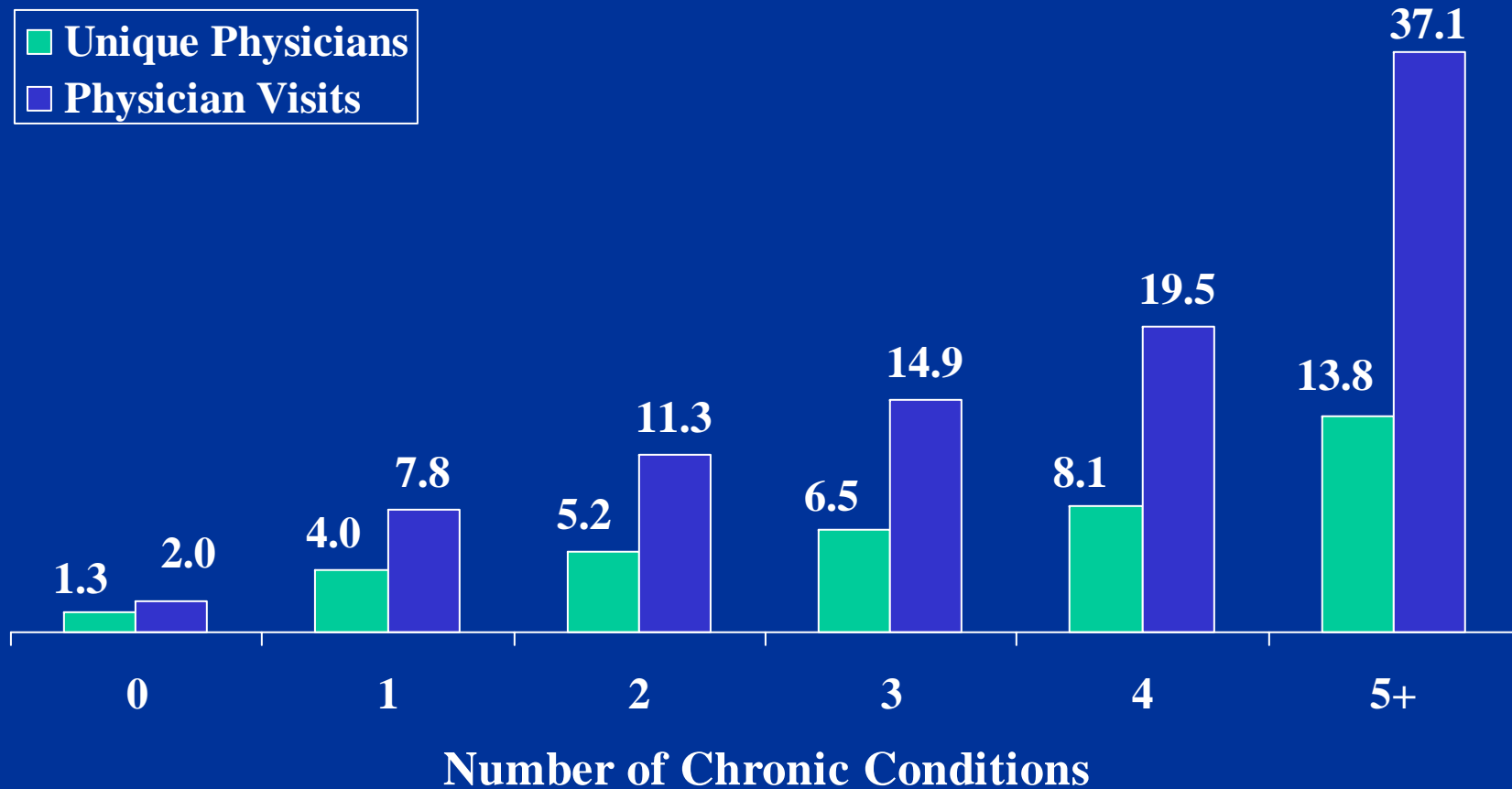
\*Includes Refills

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



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# 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.



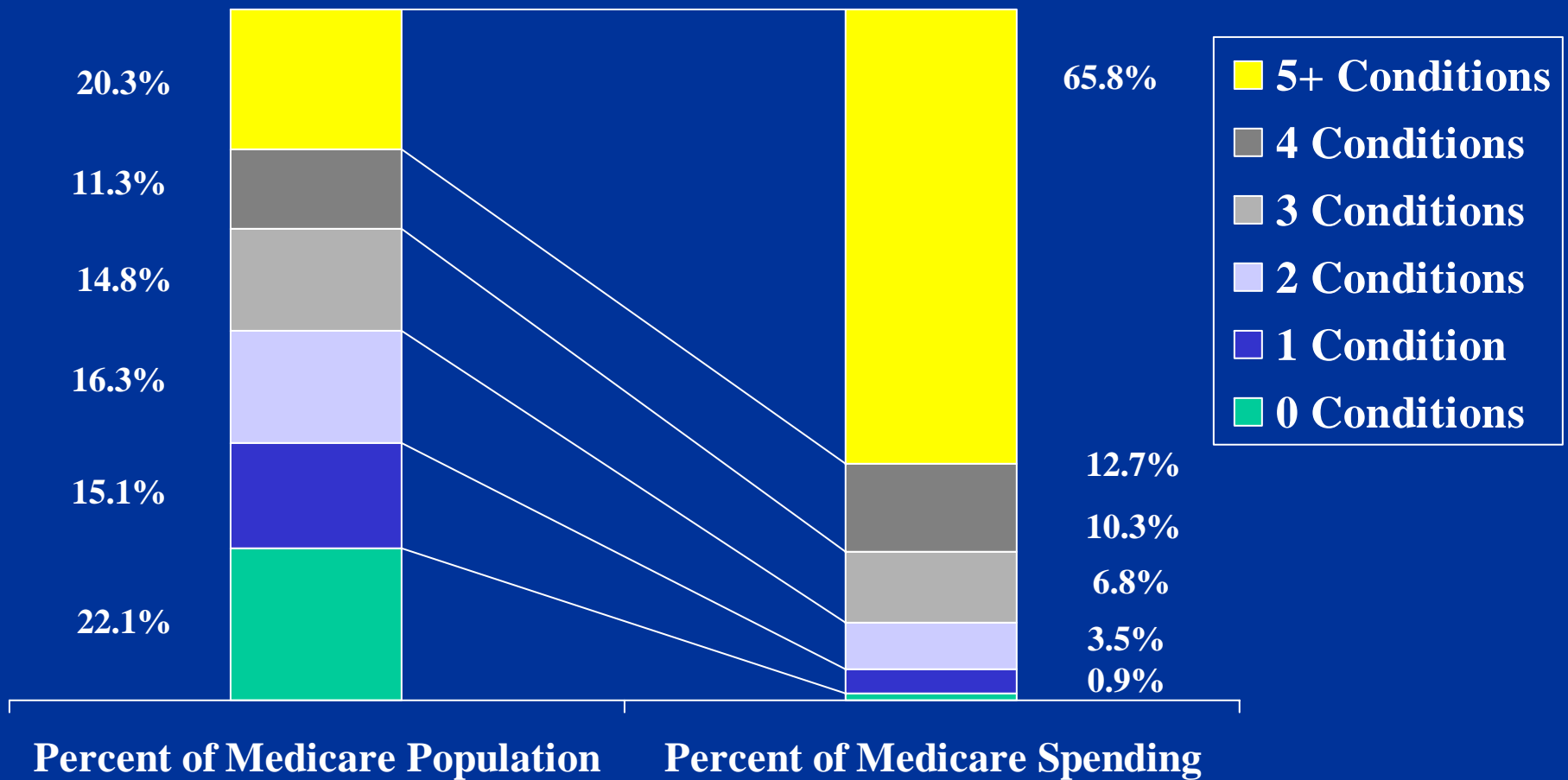
# Incidents in the Past 12 Months

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

	<u>Sometimes or often</u>
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 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 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



# Chronic Care Strategies That Bypass Physicians Make No Sense

- From 30 years of Medicare demos -- approaches that are supplemental to the patient/physician relationship have had little impact – the MMA disease management demo has failed; in commercial and Medicaid settings, D.M. may have some, but limited, usefulness.
- In contrast, CMS announced generally positive results from the Medicare physician group practice demo, which incentivizes, rather than bypasses, practices – mostly, but not only, large groups



# We Should Not Expect Pay-for-Performance to Solve the Problem

- It focuses on marginal dollars and ignores the incentives in the basic payment system -- which drive behavior
- A lot of what we want physicians to do is not easily measurable. Are we looking under the light for the keys lost in the bushes?
- P4P can't easily address "overuse" and "misuse" quality dimensions, much less cost.
- We are still learning about P4P. Don't overload it.



# The Bottom Line

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- In Medicare, fixing the SGR problem – the accumulated \$300 billion “deficit” in the budget baseline -- is the easy part
- The availability of PCPs, geriatricians, and even surgical generalists affects patient care and is in jeopardy -- for all payers and patients. Virtually no one is going into generalist specialties and primary care docs are burning out
- Current payment incentives affect the nature of care and costs and do not produce what changing demographics and chronic care burden require



# The Bottom Line (cont.)

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- A one-size fits all, RBRVS fee schedule no longer makes sense as physicians increasingly do very different things
  - Perhaps, PCPs need mixed FFS and prospective monthly payments (with a dash of P4P)
  - Surgeons could be paid for episodes (but addressing the bias to inappropriate surgical episodes)
  - Other specialists who perform one-time, discrete services might still be paid FFS for their services
- The payment system should promote integrated care, including multi-specialty groups, but not single specialty consolidation



# Continuum of Approaches for Paying for “Medical Home” Services

- Aggressive, politically difficult RBRVS/fee schedule revaluations
- New CPT codes for targeted medical home activities
- A new payment, i.e. pmpm or pppm, for chronic care management activities to the practice on top of FFS payments
- Bundled payment for medical services and medical home activities – either a more improved pmpm (pppm) or a hybrid FFS/bundled payment approach



# FFS Revaluations

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- Hope that better payment for E&M services cross-subsidizes medical home activities (as some are already included in pre and post service work, according to the RBRVS methodology)
- Avoid difficult design issues of a formal medical home --
  - Who qualifies for payment, e.g. primary care or principal care?
  - The physician or the practice?
  - Is there a formal patient lock-in – hard or soft?
  - No obligation to hold any one accountable and all that entails



# FFS Revaluations -- Cons

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- No obligation to hold any one accountable and all that that entails – in a FFS system, it might be putting good money after bad
- Politically difficult to redistribute within a fee schedule context
- A CPT code based payment system that pays for specific services cannot really accommodate the set of “soft” but important activities we want to promote



# New CPT Codes for Particular Medical Home Activities

- Or particular services in the Chronic Care Model
- As examples, palliative care family conferences, “email consultations,” non-face-to-face activity associated with transition care from hospital to home
- These might be included in CPT and paid for, but can’t really include most medical home or care coordination activities on a FFS payment basis
- Even here, face political obstacles to adoption



# Pppm Payment for Medical Home and/or Chronic Care Management

- Assumes there is a definable and designated subpopulation that “qualifies” for additional activities supported with additional payment
  - Would small practices reengineer their processes for a small subset of patients which may make up a highly disproportionate share of health spending but not a relatively small share of their time and attention?
  - Compounded if not an all-payer approach



## An Add-on PMPM Payment (cont.)

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- Which raises the fundamental question, do all patients benefit from a medical home or should the approach be targeted to only some, for efficiency?
- How would eligible patients be selected – physician referral (then self-referral issues), history of high costs, data mining re conditions and co-morbidities – the issues that are relevant to eligibility for case management?



# Bundled (“Capitated”) Payments for All Services and All Patients or a FFS Hybrid

- 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
- But should medical home services be provided to everyone? Do they all want a home? Is this efficient? (But some of us think FFS sends wrong signals for all patients)
- 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?



# A FFS/Bundled Payment Hybrid

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- Some very smart people, e.g., Joe Newhouse, have recommended a mixed approach to soften the effects of capitation and FFS payment incentives
- Some European primary care payment models, e.g. Denmark, is a hybrid
- But surely more complex operationally for the payer and maybe the practice and may negate some of the appeal of bundled/“capitated” payments



# The Patient-Centered Medical Home



# Broad Interest – To the Point of Silver Bullet Status?

- 4 primary care groups have endorsed (even some surgical groups supportive)
- Various purchasers and purchasing groups – IBM, GE, ERISA Industry Council, National Business Group on Health
- Large Insurers – various Blues, WellPoint, Aetna, United
- The largest insurer – Medicare demo(s)
- Democratic Presidential campaigns



# A Caution

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“... [new] definitions of primary care emphasized wide-ranging roles and responsibilities.. A set of characteristics that often proved to be burdensome and unrealistic” –

“Primary Care Medicine in Crisis: Toward Reconstruction and Renewal,” Gordon Moore and Jonathan Showstack, *Annals of Internal Medicine*, 138 (3), 2003, 244-248.



# Problems For Which Medical Home is Held Out As a Solution

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- Deficiencies in “patient-centered” care – based on lots of recent work sponsored by the Commonwealth Fund – on “traditional” attributes of primary care, e.g. access, longitudinal continuity, care coordination
- The growing challenge of chronic care
- Relatively poor primary care compensation



# The Evolution of the PCMH Concept

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- Medical homes in pediatrics – 40 year Hx, oriented to mainstream care for special needs children 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.)

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



# “A 2020 Vision of Patient-Centered Primary Care”

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

- The best synthesis of these 4 development streams into a comprehensive and plausible set of attributes and expectations
- Note it preceded recent PCMH measures



# Seven Core Features Agreed to By The Four Primary Care Societies

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



# Current PCMH Standards Emphasize Organization of the Home

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- NCQA Physician Practice Connection (PPC)  
PCMH Standards emphasize EHRs and  
CCM – less on attributes of patient-  
centeredness
- Bridges to Excellence Office Assessment  
Survey similarly derive from EHR work



# Challenges to Adoption of Patient-Centered Medical Home

- Lack of agreement on definition and emphases – at least among practicing physicians, if not policy elites -- yet
- Practice culture and structure – the “tyranny of the urgent” – see Wagner et al Milbank, 1996
- Practice size and scope – still dominance of solo and small groups – arguably without ability to adopt many elements of PCMH



# Challenges (cont.)

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- To whom should the PCMH apply? All patients or those with special needs, e.g. in Medicare, those with chronic conditions
- Management challenges – even in large groups with an interest, many elements not adopted
- Unfettered expectations



# In conclusion

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“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)

