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Making Unlimited Primary Care Available – Dr. Holly's Response to Alex Tolbert's question

In an ongoing discussion with Alex Tolbert, which began with his July 1, 2013 article on Subscription Medicine being published in the *Medical Home News*, and which resulted in a note today, he asked the question, "How do you think we can move to a place where people can receive unlimited primary/chronic care, as it seems we both believe they should be able to receive and would have a positive impact on overall health care costs?"

First, there is no such thing in the "real world" as "unlimited" anything in healthcare, unless we are talking about private resource support of care. And, the limitation on the "right" of an individual to pay for care privately and thus to get "unlimited" care, or at the least, all the care the person wants, occurs when the available venues for care are limited. At that point, healthcare ethics apply where the consideration is not the ability or willingness of a person to pay for their own care, but the consideration becomes who will benefit the most from the care. For instance, if a person has a loved one or themselves need to be on a ventilator. The wealthy person comes to the point to where further care is futile; that person could pay for further care privately, unless that ventilator is needed by someone whose care is not futile. In that case the person who has the potential of recovery, no matter how deep or wide their resource base, the person whose care is medically and scientifically futile, could not occupy that ventilator. In this case, care is not "rationed," but it is "rationally" distributed by a triage process much like transplants when there is a limited supply of care.

Second, if "unlimited" means access to evidenced-based screening, preventive and chronic conditions care in a Medical Home setting, I agree that everyone deserves "unlimited care," which however, in fact, is limited by science. In this scenario, I would not pay for care, as a matter of public policy, which is not supported by science and evidence, such as Chiropractic care.

Third, the definition of primary care requires more detail than just "care delivered by a primary care provider." For instance, just because a test is ordered by a primary care provider in contradiction to evidence or accepted standards of care, it would not be an abridgment of our commitment to "unlimited" primary care to deny that care on the basis of clinical judgment

and/or clear scientific evidence. “Unlimited” primary care in this regard would refer to evaluation, treatment and maintenance of evidence-based care which may or may not involved advanced technological intervention.

The original statement of the Triple Aim addressed: improved care, improved health and lower cost. In subsequent iterations the “improved care” was changed to “improved patient experience of care.” This is not unlike the goals of the HCAHPS program in the hospital and the CAPHS program in the clinic. Efforts to change the cost curve of healthcare ultimately making our system sustainable requires that the standard of care in not “unlimited” care but evidenced-based care. **The tragedy of modern medicine is that patients have unwittingly substituted their trust of their primary healthcare provider with trust in technology, thus driving up the cost of care without improving the quality of care.**

Payment Reform is the only way to control cost

As the Accountable Care Act is deployed by the Federal government there is more and more anxiety about whether there will be enough primary care providers to take care of all of the new people who will have insurance. Regrettably, the problem may be less severe than previously thought because it now appears that there will be tens of millions who will still be without insurance. One of the solutions to the primary care dilemma is seen in reforming the way physicians are paid.

In March, 2013, The Commonwealth Fund published a brief entitled, “Paying for Value: Replacing Medicare’s Sustainable Growth Rate Formula with Incentives to Improve Care.” The Sustainable Growth Rate (SGR) is the policy which has been in place for the past forty years to control excessive increases in cost of Medicare. The SGR is also what has resulted in the need for the “doc fix.” The SGR is the accumulated required decreases in Medicare reimbursement which have been postponed for years. “To fix” the SGR problem there has been a threat of a one-time over 20% decrease in physician payments for treating Medicare beneficiaries. In that the SGR has not worked to control cost and in that such a decrease in reimbursement would make it virtually impossible for Medicare beneficiaries to find care, new methods for controlling cost and maintaining quality have been sought.

On April 16th, in SETMA’s providers’ monthly training-and-care-improvement meeting the content of the Commonwealth’s brief was discussed. The mission of The Commonwealth Fund is to promote a high performance health care system. The Fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy.

For 48 years, which is how long Medicare has existed, there have been different payment rules for different providers in different settings. For 30 years, Medicare has “bundled” payments and paid a predetermined lump sum for the treatment of a specific condition regardless of how much it actually cost to treat an individual patient -- for inpatient hospital care with the

introduction of diagnosis-related groups (DRGs). Payments have tended to be tied to the volume and intensity of services provided, with little effort to hold care systems accountable for patients' outcomes or care experiences, much less the total cost of care.

One of the solutions to our health care problem is that for several years, across the nation and particularly with SETMA, there have been efforts to achieve greater transparency in terms of:

- health care quality
- outcomes
- developing value-based purchasing approaches

SETMA's transparency can be reviewed at www.jameslhollymd.com under Public Reporting where SETMA reports by provider name on over 300 quality metrics.

The Commonwealth's March brief elaborated on recommendations made by their Commission on a High Performance Health System in the report entitled, "Confronting Costs: Stabilizing U.S. Health Spending While Moving Toward a High Performance Health Care System." That report focused on improving provider payment by:

- Strengthening primary care
- Providing incentives for physicians to participate in innovative delivery systems
- Requiring accountability for population outcomes and total costs of care
- Rewarding the adoption of best practices.

The expectation is that these policies would:

- Repeal the Medicare SGR immediately
- Direct all future increases in physician payments to those participating in innovative delivery reforms such as accountable care organizations, patient-centered medical homes, or similar approaches.
- Recalibrate payment rates for overvalued, or undervalued, services.
- Establish a new way of paying for primary care and care teams that are able to provide high-value, patient-centered care for high-cost beneficiaries across care systems.
- Institute a new bundled payment approach for hospital episodes that includes both hospital and physician services during the initial hospital stay; any related hospital readmissions for 30 days after discharge; and, for selected conditions and procedures, post acute care as well.

New Payments for Primary Care, Health Care Teams, and Innovative Health Care Delivery

The brief recommends that Medicare payment rates would be maintained at their 2012 level (including the 10 percent increase for primary care applied under a provision of the Affordable Care Act) from 2013 through 2023, but additional policies would seek to strengthen primary care and encourage the availability and use of high-cost care management teams, including:

- A modest additional payment per patient per month for primary care providers to deliver services to Medicare beneficiaries who designate those providers as their regular source of care.
- A somewhat larger additional payment per patient per month for providers who qualify as medical homes, with the potential for further bonus payments for high performance on measures of quality and efficiency.

To provide broad-based support to primary care and provider teams, the federal government would encourage states to use similar payment approaches for their Medicaid programs, or Medicare could join state initiatives to adopt innovative payment methods for their Medicaid programs. For physician practices caring for disabled or seriously mentally ill patients, both Medicare and Medicaid could enhance payments in recognition of the need for a multidisciplinary approach and community-based services. The cost of the enhanced payments would likely be offset by reductions in readmissions and the use of hospital emergency departments.

For other physician services, Medicare payment rates would be maintained at their 2012 level from 2013 through 2023, with eligibility for additional payment if practices participate in

- a high-value accountable care organization,
- bundled payment arrangement, or
- other innovative model of health care delivery

that show promise of encouraging high-value care. As with the primary care policies described above, this policy would be coordinated across Medicare, Medicaid, and private plans participating in the health insurance marketplaces.

Bundled Payment for Hospital Episodes

The following policies would accelerate the application of bundled payment approaches, building on initiatives under way in Medicare and the private sector:

- Bundling all physician services performed at the hospital during the inpatient stay with the hospital DRG payment. This would be a first step to a more comprehensive bundling policy, building on current Medicare demonstrations.
- Including related readmissions in the bundle, building on initiatives already taking place to reduce preventable readmissions.
- Applying this bundled payment approach for hospital episodes to Medicare, Medicaid, and private plans participating in the health insurance marketplaces.
- Payment would be designed to reduce the variation in costs across similar episodes and to provide incentives for providers to adopt best practices and take responsibility for the effectiveness and efficiency of resources used during the episode of care.

Policies designed to strengthen primary care and provide incentives for physicians to participate in innovative models of health care delivery would apply to Medicare and Medicaid

as well as to private plans participating in the health insurance marketplaces. If these policies were implemented quickly and effectively, and spread rapidly across the public and private sectors, they have the potential to yield $496 billion in savings from 2013 through 2023, with $345 billion accruing to the federal government, $88 billion to state and local governments, $14 billion to private employers, and $49 billion to households.

Instituting the bundled payment policy described above for Medicare, Medicaid, and private plans could generate a cumulative $620 billion in savings in national health spending, with the federal government saving $296 billion, state and local governments $64 billion, private employers $66 billion, and households $194 billion.

The potential savings to the federal government from this set of provider payment reforms would be more than enough to completely offset the estimated cost of forgoing the across-the-board cuts required under the SGR formula. These policies not only would reduce Medicare spending but also would address the most important needs of beneficiaries, as well as improve health care and reduce cost growth throughout the health care system.

SETMA endorses the Commonwealth's proposal. In the review of these proposals at SETMA's monthly provider meeting, it was pointed out that the growth and development at SETMA over the past 18 years have prepared SETMA's providers to be read to provide primary care in a medical home setting with high performance on measures of quality and efficiency. With publicly displayed transparency since 2009, SETMA is prepared for this future and can reassure Southeast Texas, that they will always have access to high quality, progressive healthcare.

Conclusion

These are a few of my thoughts. There is more at www.jameslhollymd.com under Your Life Your Health: Public Policy.

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