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Is Unlimited Primary Care the Goal or Even Possible?
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Recently, SETMA was asked, “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 which care 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 limited source of care.

For instance, if a wealthy person has a loved one who needs to be on a ventilator and 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 should receive the care, no matter how deep or wide the resource base for the person whose care is medically and scientifically futile. Economic considerations alone could not allow the ventilator to be occupied by the a person whose care is futile but who could pay for the care personally 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 organs available.

Second, if “unlimited” means access to evidenced-based screening, preventive and chronic conditions care in a Medical Home setting, then 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.

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 involve0 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.” “Improved patient experience of care” is not unlike the goals of the HCAHPS (Hospital Consumer Assessment of Healthcare Provider and Systems Surveys) in the hospital and the CAPHS (Consumer Assessment of Healthcare Providers and Systems Surveys in the clinic.

Efforts to change the cost curve of healthcare delivery, ultimately making our system sustainable, requires that the standard of care is not “unlimited” care; but, that it is 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 necessarily improving the quality of care.

Payment Reform is the only way to control cost

As the Affordable 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.

For 48 years, which is how long Medicare has existed, there have been different payment rules for similar providers, providing similar services in different settings. For the past 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.

The Commonwealth Fund’s March, 2013 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 in 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.

Bundled Payment for Hospital Episodes

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 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.

SETMA and the Future of Primary Care

SETMA endorses the Commonwealth’s proposal. In the review of these proposals at SETMA’s monthly provider meeting, it was pointed out that the development at SETMA over the past 18 years has prepared SETMA’s providers to be ready 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 have access to high quality, progressive healthcare. SETMA has prepared for the future such that patients will have secure access to care regardless of future changes and SETMA will continue to care for patients on Medicare, Medicaid, Medicare Advantage, Medical Home and Accountable Care Organizations. The future of healthcare is not completely known, but SETMA is prepared, whatever we all may face.