Family Medicine Updates

From the North American Primary Care Research Group

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SHAPING HEALTH-RELATED POLICY IN THE UNITED STATES: 1 FAMILY PHYSICIAN AT A TIME

The Affordable Care Act will profoundly influence health care delivery in the United States. Here, Dr Randy Wexler, an Associate Professor of Family Medicine at The Ohio State University, describes his health policy interests and activities. Through the years, Dr Wexler has worked with local-, state-, and federal-level policy makers. We hope that by sharing his experiences, family physicians will become interested in and prompted to be more involved in shaping health-related policy related to the delivery of primary care.

As a busy family physician, how did you become interested and involved in health-related policy activities?

My interest in policy issues really evolved out of my frustration with the overall health care system. During my family medicine residency training I began attending my local Ohio Academy of Family Physicians affiliate and things just evolved from there.

I think all family physicians must be engaged in health policy-related activities in some manner. You have to make the time to be involved. So many of the decisions made by state and federal agencies impact how family physicians not only practice, but also the manner in which we deliver care. To not engage in any form, even just a little, allows others to determine how we practice. It is just like the old saying, "you can pay (a little time) now or pay (a lot of time) later."

A family physician is seeking to be involved in health-related policy efforts. What advice could you provide him/her in getting started?

Fortunately, there are many ways to get involved. At the local level one can engage with their state American Academy of Family Physicians affiliate. To impact federal issues the American Academy of Family Physicians (AAFP) has many options. For example, the Family Medicine Political Action Committee (FamMedPAC) advocates for family medicine in Washington, DC. Information about FamMedPAC is available at http://www.aafp.org/online/en/home/policy/fammedpac.html?navid=fammedpac.

The AAFP also has a "Speak Out" Web site (http://capitol.aafp.org/aafp/home/) that encourages family physicians to contact their members of Congress and provides a comprehensive list of sample talking points on pertinent issues.

Finally, one can call the office of their General Assembly or member of Congress and request an appointment. Often you will meet with an aide, but aides are the sergeants of government and good relationships to establish. While most meetings will be just 15 or 30 minutes, it is always beneficial to place a follow-up phone call a few days after each meeting. Building relationships with elected officials is the key to establishing a voice for family medicine.

As a whole, NAPCRG advocates for increased primary care research funding. Again, how do you suggest family physicians lead this effort?

The most important thing NAPCRG can do is educate policy makers on the importance of primary care research and the impact such research can have on the nation. The late Dr Barbara Starfield and colleagues demonstrated that primary care services reduce both morbidity and mortality, whether primary care is characterized by primary care provider supply, source of primary care, or which components of primary care are utilized.[1] Further, they found that primary care—in comparison to specialty care—results in not only equitable distribution of health resources and improved outcomes, but also reduced costs.

Primary care research is well suited for evaluation and interpretation of "real-world" problems and can focus improvements on managing health services toward more efficient and higher quality care. Primary care research can be especially relevant in addressing new and emerging issues, in addition to the consideration of questions such as "how the provision of care can be improved."[2]

Furthermore, primary care is ideally positioned to deal with issues related to disparities in health care delivery by addressing areas necessary to resolve such inequities. Rust and Cooper[3] argue that we must: (1) conduct research in real-world, high-disparity primary care settings; (2) develop community partnerships; (3) address the complex mix of disparities in chronic disease risk factors and outcomes; (4) focus efforts on the triangulation of patient, community, and provider; and (5) test dynamic, constantly improving interventions. Research in primary care is ideal for addressing such needs and inequities fomented by the current health care system.

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INVESTMENTS IN MEDICAL HOME MODEL STARTING TO PAY DIVIDENDS

It has been 5 years since the AAFP adopted a policy stating that every American should have a "personal medical home." In the years since then, the Academy has championed the idea of the patient-centered medical home (PCMH) with the belief that the PCMH model improves outcomes and lowers health care costs.

Although many of you have started—and in some cases completed—the long process of transforming your practices into officially recognized medical homes, some of you have decided that the necessary time, money, and effort make it too daunting a task relative to an uncertain financial benefit. In short, you want assurances that your sizable investment will pay off.

Recent events, however, indicate that becoming a PCMH may be an investment worth making:

- Maryland's Multi-payer PCMH program has distributed about $3 million in its first payment to 54 participating primary care health professionals. Of that total, $2.1 million came from private payers, and $900,000 came from the state's Medicaid program, according to a recently published report.
- Earlier this year, 6 health plans paid $1.5 million to 236 primary care physicians from 11 practices in New York's Hudson Valley after those practices achieved PCMH recognition from the National Committee for Quality Assurance.

Skeptics could say these are isolated examples with unnamed docs. Fair enough. Let me tell you about an e-mail I recently received from former AAFP President Jim King, MD, of Selmer, Tennessee, on this very subject. He told me that his practice of 7 physicians has received $114,000 in incentive payments this year: $34,000 from CMS' Physician Quality Reporting Initiative (PQRI); $35,000 for electronic prescribing (eRx); and $45,000 in primary care incentive program payments.

King also expressed concern that PQRI and eRx incentives are beginning to decline, and primary care bonus payments are scheduled to stop after 2014. The important thing to remember, however, is that as these programs are phased out, new opportunities keep coming. When they do come along, it's important to be ready.

For example, last month, the Centers for Medicare and Medicaid Services' (CMS) Center for Medicare and Medicaid Innovation announced the launch of the Comprehensive Primary Care Initiative (CPCI). CMS plans to collaborate with commercial and state health insurance plans to support primary care practices that deliver coordinated and seamless care.

The program will blend fee-for-service payments with a risk-adjusted, per-patient, per-month, care coordination fee that ranges from $8 to $40. Participating practices also will have the opportunity to share in savings resulting from the program. This payment model is what the AAFP has been advocating for some time to reward physicians for coordinating and managing patient care within the PCMH.

In response to the announcement of this plan, AAFP staff members recently met with America's Health Insurance Plans (AHIP), the national trade association that represents health insurance companies. During that meeting, AHIP representatives said that the organization intends to encourage its members to apply to participate in the CMS initiative.

The Academy also has sent letters to each of the nation's major health insurance plans, encouraging them to participate.

CMS will be responsible for recruiting 75 primary care practices in as many as 7 markets for the initial phase of the CPCI, with practices applying to participate in spring 2012. The blended payment model will be used for these practices' Medicare and Medicaid patients, as well as patients enrolled in participating private insurance plans.

The program will be limited to practices that already have achieved Level-3 NCQA recognition and have met meaningful use standards for electronic health records. These requirements reinforce the need for us to transform our practices and to be prepared to participate in such programs.

Although the first phase of this initiative will be limited in scope, CMS officials told me in a meeting recently that they are eager to rapidly and broadly expand the program once it has been shown to reduce costs and improve quality—which it almost certainly will.