The legislation isn't perfect, but it makes an important point – that primary care deserves more attention.

How Health Care Reform Will Affect Family Physicians

BRANDI WHITE

On March 23, with the strokes of 22 pens,[1] President Obama signed into law the Patient Protection and Affordable Care Act. This sprawling health care reform bill has many unknowns – chief among them, will it really reduce the deficit by $143 billion over 10 years, as the Congressional Budget Office estimated? But here's what we do know: The bill will expand health insurance to an estimated 32 million Americans and provide important consumer protections, such as an end to pre-existing condition exclusions. It also includes a variety of less-talked-about measures designed to improve the quality and cost-effectiveness of health care.

To find out how these measures will affect family physicians, *FPM* sat down with Kevin Burke, a Washington expert and director of government relations for the AAFP.

FPM: What aspects of the bill are likely to have the biggest effects on family physicians?

Burke: There are two provisions related to payment that are important, not simply for the payment differential they provide but also because they send a pretty clear signal that ripples throughout the bill that primary care deserves a lot more attention than it's gotten in the past. Beginning Jan. 1, 2011, primary care physicians – defined as those in family medicine, internal medicine, geriatric medicine and pediatric medicine – will get a 10-percent bonus for Medicare services. To qualify for the bonus, 60 percent of their Medicare charges must be for primary care services as defined by evaluation and management (E/M) codes for office visits, nursing home visits and home visits.

Our view is that the 60-percent threshold is probably too high. The Graham Center recently found that at a threshold of 60 percent, only 59 percent of family physicians would qualify for this bonus.[2] If the threshold were lowered to 50 percent, then 69 percent of family physicians would qualify. The threshold has a particularly negative effect on rural primary care physicians because they're the ones who, by virtue of the fact that there are not a lot of specialist physicians in rural areas, end up providing more procedures to their patients. This can skew their ratio of primary care to total services and disqualify them for the bonus.

We're also concerned that this is just a five-year program, scheduled to end Jan. 1, 2016, and that it applies only to payments for primary care services, not to all Medicare services that primary care physicians provide. So we still have some legislative changes to request and hope to be able to convince Congress to extend the bonus permanently. Nonetheless it makes the point, however imperfectly, that the physician payment mechanism we have right now undervalues primary care and needs to be fixed.

The second payment program in the bill is also a time-limited one. In 2013 and 2014, all Medicaid payments for primary care services will be increased so that they are at least equal to Medicare payments. This will have a variable effect on family physicians. In some states, like North Carolina, Medicaid already pays 95 percent of Medicare, but in states like California where the discrepancy is much larger, family physicians who care for Medicaid patients will, for two years, see significantly

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better payments. And again, it's just for primary care providers and for primary care services.

One bad thing is the lack of resolution on the sustainable growth rate formula, which affects Medicare payments.

***FPM:* The bill creates an Independent Payment Advisory Board starting in 2014 that will recommend Medicare spending reductions to Congress. Should physicians be concerned about this?**

Burke: This is one of the most significant provisions in the bill aimed at trying to reduce the cost of health care. There is considerable concern in the physician community that the burden would be borne mostly by physicians, whose payments would be cut, especially in the early years, because hospitals and hospice programs are exempt from the actions of this board until 2020. You can't control health care costs without controlling the costs of hospitals – one of the major players in the health care delivery system. A second concern is that this advisory board isn't required to reflect the community that's affected. In other words, the board is not required to have a consumer or primary care physician representative, and we recommended that both should have been included. Also, there needs to be a longer public comment period for any of the cost-cutting measures this board eventually makes.

***FPM:* A number of measures in the bill emphasize quality measurement and paying for value instead of volume, which worries physicians who have had a negative experience with Medicare's Physician Quality Reporting Initiative. What would you say to those physicians?**

Burke: For the moment, these are just pilot programs in the legislation, but I do think value-based payment is inevitable and could actually help primary care physicians in the long run, because they have stronger relationships with their patients. Physicians are concerned that basing payment on outcomes is unfair because patients are the ones who determine their outcomes, in many cases, depending on whether they follow their physician's directions and advice. But while the legislation is clearly moving toward more of an accounting for outcomes, I don't think physicians will ever be penalized because patients don't lose weight, for example. Instead, there is simply going to be a lot more of, "Have you counseled your patient to do X, Y and Z?" I think patients will be held more accountable by their health insurance companies as well.

***FPM:* The AAFP and other primary care organizations have been advocating for the patient-centered medical home (PCMH) model. What role does the PCMH play in the legislation?**

Burke: It's pretty notable in a couple of places. First, the legislation establishes a new Medicaid demonstration program that attempts to prove the medical home model. However, it does have a restriction that we think isn't helpful – that PCMH demonstrations should include only what they call high-need patients, such as those with two or more chronic conditions. Limiting patient eligibility makes the per-unit cost of transformation for the practice much higher. Physicians aren't going to transform their practices into patient-centered medical homes for only a portion of their patient panel. Instead, they're going to become a patient-centered medical home for all of their patients. But if they are only eligible to receive enhanced payment for a small portion of their patient population, then the PCMH doesn't meet the cost test for a lot of physicians, and it is unlikely that they will undergo this fairly costly and certainly time-consuming transformation.

There is also a stipulation in the Medicare side of the legislation that allows the Centers for Medicare & Medicaid Services a great deal of flexibility to experiment

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with the PCMH model and to use it more broadly as soon as it begins showing savings or improved quality.

***FPM:* Currently, the United States has a deficit of roughly 40,000 primary care physicians, according to AAFP estimates. As the newly insured enter the system over the next few years, the primary care shortage is expected to worsen. How does the legislation address this?**

The health care reform legislation creates temporary increases in Medicare and Medicaid payments for certain physicians.

The legislation also takes steps to control health care costs and address the primary care shortage.

Tort reform and an SGR fix were not included in the bill.

Burke: About a year ago, the Graham Center conducted a study with the Macy Foundation showing that the most important thing a medical student takes into account when choosing a specialty is payment.[3] So addressing the primary care payment rate is one step. The bill also includes loan forgiveness provisions for primary care providers who work in underserved areas, and it provides a new graduate medical education funding stream for teaching health centers, which are residency programs based in community health centers or other federally qualified facilities that are not hospitals. This is the first time that graduate medical education funding is being directed to certain non-hospital sites, which is good, and we're hopeful we can persuade Congress to expand that. The bill also establishes a workforce commission, which will presumably make recommendations about how to support additional training for primary care. Congress also reauthorized the Title VII Health Professions Programs, which directly fund family medicine schools and residency programs.

***FPM:* "Comparative effectiveness research" is mentioned in the bill as a way to improve health care quality and decreases costs; however, some physicians worry that this will evolve into the government deciding which services they can or cannot provide. What exactly does the legislation mandate in this regard?**

Burke: It's understandable that people don't want health care decisions to be based on abstract models or generalized research that doesn't apply to an individual case, but that's not what comparative effectiveness research is. Comparative effectiveness research simply compares one treatment against another treatment or one drug against another. The goal is to help physicians answer questions such as, "Which statin is the best choice for my patient?" That kind of information should be more readily available. The legislation includes restrictions on how insurers can use comparative effectiveness research in coverage decisions.

***FPM:* Does the legislation take any significant steps toward tort reform?**

Burke: No, but the legislation does authorize $50 million in grants for alternative dispute resolution demonstration programs at the state level. There is such an impasse on tort reform that I think it was helpful to focus instead on alternative dispute resolution. I don't think these programs will completely solve the problems of defensive medicine or frivolous lawsuits – which are genuine concerns – but I do think it is helpful to explore other solutions and see if they have any merit. If they don't, then we'll continue to press for tort reform.

***FPM:* For family physicians who are small business owners and provide health insurance for their employees, what effect will the legislation have on them?**

Burke: It exempts small businesses with fewer than 50 employees from any shared health insurance responsibility, so if you have fewer than 50 employees, you are not going to be required to provide health insurance and you will not be subject to any fines. The bill does provide a tax credit for small businesses that provide health insurance, equal to 50 percent of the premium you pay, and it creates state insurance pools that will presumably help small businesses negotiate better rates.

***FPM:* The administrative complexities of dealing with health insurers can be**

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quite costly to medical practices. How does the legislation address this problem?

Burke: There are several requirements for administrative simplification in the bill, such as establishing a standardized claim form, streamlining claims processing requirements and improving interoperability to allow for more electronic information sharing. The rules have not yet been developed but will be implemented between 2013 and 2016.

***FPM:* Is there anything in the legislation related to health information technology?**

Burke: The Health Information Technology for Economic and Clinical Health Act, which was enacted in February 2009 as part of the American Recovery and Reinvestment Act, effectively took health IT out of the health reform debate, except for the interoperability issues already discussed. The legislation did establish primary care extension agencies, which are designed to be local resources for physicians not just on health IT issues but on a variety of innovations and best practices to improve community health.

***FPM:* So many forces seem to be pushing doctors from small, private practices into larger, more integrated settings. Will reform make small, private practices more secure, or will it further destabilize them?**

Burke: I think both forces are at work in the legislation. Models like the patient-centered medical home and the accountable care organization, in which providers come together to care for a population and share in any cost-savings they achieve for Medicare, will either make or break small practices. They could help small practices become drivers of health systems in their areas. Or they could help hospitals or large integrated delivery systems take over small providers. The health reform bill reflects both approaches, and the tension remains. FPM

Send comments to **fpmedit@aafp.org.**

1. Marr K. 22 pens: Reid, Pelosi, Keehan, more. *Politico*. March 23, 2010; http://bit.ly/c0VKdq.

2. *Effects of Proposed Primary Care Incentive Payments on Average Physician Medicare Revenue and Total Medicare Allowed Charges: A White Paper*. Washington, DC: The Robert Graham Center. May 2009; http://bit.ly/aOMhPn.

3. *Specialty and Geographic Distribution of the Physician Workforce: What Influences Medical Student and Resident Choices?* Washington, DC. The Robert Graham Center and the Josiah Macy Jr. Foundation. March 2009; http://bit.ly/9mhjXd.

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