4sightHEALTH
expect better healthcare

A thought leadership and advisory company working at the intersection of healthcare strategy, economics, capital formation and transformation.

The Primary Care Prescription: Part 1

Putting Patients and Physicians First

By Michael D. Connelly and Richard Afable
January 9, 2024

This is Part 1 in a two-part series.

Imagine U.S. healthcare like a vast network of waterways, each trying to deliver clear, life-sustaining water to a thirsty population. Each reform is intended as a new canal or tributary, designed to improve the flow and reach more people. Gone wrong, these waterways become a series of competing currents, crosscurrents and eddies — and each new reform inadvertently redirects the water away from its purpose.

U.S. health policy is going down the wrong path with its dominant payment focus on evidence and measurement. This focus has created a system where the less quantifiable elements of care are being ignored. Health policy only pays for care that can be measured by codes — that is the foundational principle of fee-for-service (FFS) medicine. Unfortunately, some of the most critical elements of care, like conversations, building trusting relationships and patient education, are not receptive to coding.

Like a lake turned to sand, healthcare in the U.S. is drying up — and costing more than society can afford. While there's no shortage of healthcare reform proposals, they are usually taking policy down the wrong path.

How can we prevent U.S. healthcare from becoming like a river diverted so many times it can no longer find its way to the sea? This Market Corner Commentary documents the turbulence and backflow of failed reform attempts and offers a unique vision to prevent the flood of healthcare to some areas while others remain dry.

HEALTHCARE REFORM FAILURES

In terms of reform, the Omnibus Reconciliation Act of 1989 (OBRA) is a typical misadventure. This legislation was intended to control physician reimbursement spending with a cap on FFS payments under Medicare Part B. This cap stayed in effect for almost 25 years.

Politically, the realities of the cap were untenable, so in most years, Congress created a budget workaround to grant increased payments for physicians beyond the cap. Costs shot up and FFS became more complex each year. The more complex FFS became, the easier it was to increase physician reimbursement by upcoding — another workaround to the cap.

In 2015, Congress abandoned its unsuccessful cap on FFS and replaced it with another well-meaning but flawed reform to FFS: Medicare Access and CHIP Reauthorization (MACRA). MACRA was meant to create an overlay on FFS payment that would promote quality and cost-effectiveness — but the remedy proved worse than the original.

This overlay uses a multifaceted measurement system known as the Merit-Based Payment System (MIPS), which requires 220 different performance measures on each physician. Based on each physician's annual MIPS score, the provider receives either a payment bonus, penalty or no adjustment.

The administrative burden of complying with these reports is overwhelming. After seven years of operation and massive consulting expenses for compliance, the results are negligible. This tendency to use ineffective and overly complex solutions for reform has been the pattern throughout the last 30 years (like the use of 220 performance measures). These supposed reforms have had a cumulative effect. Specifically, they have created an administrative burden that is destroying healthcare professionals' morale.

Primary care is another prime example of failed reform efforts. The decimation of primary care is arguably the direct outcome of an overly complex FFS payment system. Nevertheless, most proposed solutions seem to ignore this reality.

In 2019, The National Academies of Science Engineering Medicine formed a Committee to Implement High-Quality Primary Care and issued its recommendations in May 2021 and spelled out the problem:

> ***"High-quality primary care is the foundation of a high-functioning healthcare system… Without access to high-quality primary care, minor health problems can spiral into a chronic disease, chronic disease management becomes difficult and uncoordinated, visits to emergency departments increase, preventive lags, and healthcare spending soars to unsustainable levels."***

Following this, the Committee proposes a laudable goal:

Objective 1: Pay for primary care teams to care for people, not doctors, to deliver services.

It is an aspirational statement, not a solution to the problem. U.S. healthcare needs concrete changes to the economic incentives for primary care.

MORE RECENT LEGISLATION

A more current example of failed reform lies in the Senate, where Sen. Bernie Sanders, chair of the Senate Health, Education, Labor and Pension Committee, has proposed $26 billion for primary care. While $26 billion is a significant financial commitment to the problem, the proposed legislative solutions are piecemeal and don't address the fundamental problem: a fragmented payment model that encourages volume over value.

Instead, this legislation recommends funding more Community Health Centers (CHC). So why do we need CHCs? Because few primary care doctors see Medicaid patients, and we have fewer and fewer primary care doctors each year. Medicaid only pays 30% to 50% of the physician care costs. Medicaid not only pays poorly, it is burdensome to bill and difficult to collect. This results in Medicaid patients using hospital emergency rooms as their source for primary care, which is a terrible primary care alternative and exceedingly expensive. One solution to this problem has been the CHC. Unfortunately, the CHC is a quick fix, not a solution.

Here is one more example of failed health reform: CMS (Medicare) has recognized the problems in primary care reimbursement. Their response has been a token change by adding another cumbersome billing code (G2211) to improve payment for treating complex patients. However, what CMS fails to understand is that the new documentation requirements for the new billing code will cost as much to implement as the increased payment. Simply put, FFS does not work for primary care because bureaucracy cancels out the benefit of higher payments.

RECOGNIZING THE IMPORTANCE OF PRIMARY CARE

Research supports the argument that improved primary care is perhaps the best opportunity to reform healthcare.

The Milbank Quarterly Journal in September 2005 published a major research article on this topic. Promoting primary care has become a core focus of the Milbank Fund. A synopsis of their 2005 research results is worth quoting at length:

> ***"Evidence of the health-promoting influence of primary care has been accumulating since researchers have distinguished primary care from other aspects of the health delivery system. This evidence shows that primary care helps prevent illness and death… Specifically, a greater emphasis on primary care can be expected to lower the cost of care, improve health through access to more appropriate services, and reduce the inequities in the population's health… In summary, the studies consistently show a relationship between more or better primary care and most health outcomes studied… Efforts to improve the system to achieve better health at a lower cost are rapidly becoming imperative. Primary care offers an effective and efficient approach to achieve this goal."***

Unfortunately, policymakers have ignored this wise counsel. Since that report was issued almost 20 years ago, the investment in primary care has been steadily declining. This research documents primary care's critical role in improving health and lowering costs.

In closing, I'll let the Harvard Business Review have the last word about the importance of primary care:

> ***"There is widespread agreement that the United States must expand and improve primary care in order to achieve better outcomes at a lower cost … For primary care, the conversation with the patient and the longitudinal relationship with the whole-person approach are necessary to achieve results that impact outcomes and costs. Overly concentrating primary care — through policy, payment mechanisms, and infrastructure design — on distinct processes tied to metrics diminishes the powerful role that the patient's relationship with their primary care physician should play in healthcare."***

AUTHORS

Michael Dorning Connelly may be the nation's leading expert on end-of-life care. His outstanding book, "The Journey's End," is an informed and practical guide for managing healthcare decision-making in elderhood and avoiding the industry's pernicious "death trap."

Incorporated within "The Journey's End" is an insider's frustration and disgust with healthcare's all-encompassing billing, payment and collection mechanics and practices.

Dr. Richard Afable is currently the President and Board Chair of BeWellOC, a public-private partnership working to improve the mental health for all residents of Orange County, California. BeWellOC will lead the nation in optimal mental health for all residents.

Dr. Afable is the retired President and CEO of St. Joseph Hoag Health, an Orange County-based integrated delivery system created by the affiliation of Hoag Memorial Hospital Presbyterian and the southern California region of St. Joseph Health. He was also previously the President and CEO of Hoag Hospital in Newport Beach, California.

Dr. Afable has over 20 years of medical practice experience as a solo, group and academic practitioner. He was Associate Professor of Medicine at Wake Forest University School of Medicine in North Carolina, and Clinical Assistant Professor at Northwestern School of Medicine in Chicago. He is board certified in Internal Medicine and has had added qualification in Geriatric Medicine.