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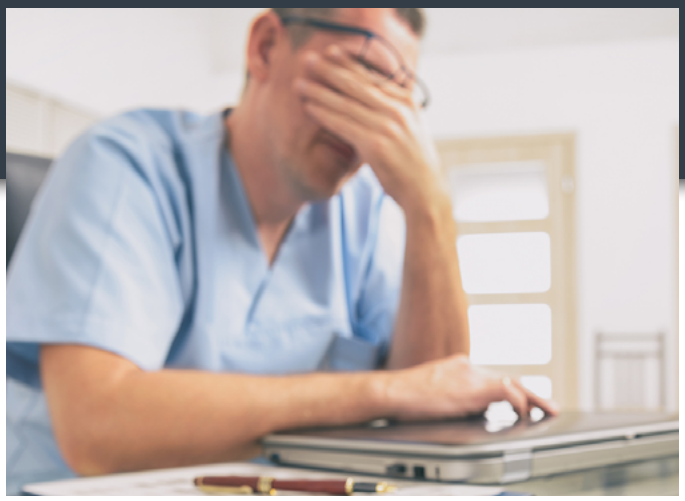
The Primary Care Prescription: Part 2

The Decimation of Primary Care

By Richard Afable and Michael D. Connelly



This is Part 2 in a two-part series.

As we discussed in Part 1, primary care is essential to better public health. The problem: Physicians are not going into primary care because of its burdens and poor compensation, and virtually every reform effort has failed to resolve this core problem. So, how do we stop the steady decline of primary care?

Fewer and fewer physicians are choosing primary care due to noncompetitive pay. The evidence is overwhelming:

> ***From 2012 to 2020, only 20% of physicians trained in primary care residencies stayed in primary care.***

Our nation spends only 4.5% of all healthcare spending on primary care (compared to 6% for dialysis treatment). This inadequate investment in primary care is half of what other advanced nations spend. Finally, this investment percentage has been steadily declining for 30 years. All the alleged reforms to healthcare do not focus on the real problem — economic incentives that drive this decline.

There are three major design flaws in healthcare that drive these undesirable outcomes:

FFS and Coding: The fee-for-service (FFS) payment method dates back to the 1960s. It evolved from merging the American Medical Association's CPT coding system and the World Health Organization's CPT coding system. These organizations initiated coding to classify diseases and facilitate research.

Coding was never intended to be the foundation for physician compensation. These complex codes — all 139,000 of them — drive all payments to providers and overwhelm clinicians. Research studies have documented that physicians now spend almost twice as much time (49%) on administrative activities as they do with patients (29%). Volume has become the driving force in healthcare — no volume, no margin. Primary care, by its nature, offers services that are not amenable to coding and volume. Primary care is about conversations, coordinating care, patient education and building trusting relationships with patients. None of these activities get much recognition in the coding system. Hence the massive decline in the funding of U.S. primary care.

Compliance: Beyond coding complexity, healthcare dedicates enormous time and resources to limit fraud and abuse of medical claims. The federal bureaucracy to police claims has mushroomed along with many rules requiring caregivers to comply with onerous fraud and abuse legislation and regulation.

Two observations: First, if we did not have a FFS payment system based on volume, we would not need fraud oversight. If payment were not based on volume, there would be no incentive for overutilization. Second, none of these expensive oversight initiatives have successfully curbed overutilization. In addition to being poorly paid, primary care spends needless time and resources on expensive fraud compliance.

Revenue Cycle Mania: Healthcare billing has become so complex because of coding and fraud oversight that providers have been forced to outsource billing to experts. The complexity of coding has generated a new overhead industry, Revenue Cycle Management (RCM). Unbelievably, this massive new industry generated $140.4 billion in revenues in 2022. 4sight Health now projects that if one combines provider in-house billing expenses with RCM, the U.S. healthcare billing cost approaches $1 trillion annually.

In sum, RCM and in-house billing systems exist because of the insane coding system and the fear of fraud accusations — all this massive expense adds zero value to patient care. Primary care offices are forced to devote tremendous resources to an expensive billing infrastructure that yields minimal payments.

The FFS system is dysfunctional, but it is most destructive in primary care. Coding is a measurement system. It can only measure what it can quantify. If a physician's services are primarily cognitive and conversation-based, these services are difficult to measure. Furthermore, these services do not benefit from volume. The coding and billing system is incapable of adequately recognizing the difficult-to-measure services of primary care. The result has been a steady decline in investment for primary care for decades. Today, primary care is more important than ever, yet few physicians are willing to live under its administrative burdens and poor compensation. The declining numbers of those practicing primary care speak for themselves.

THE QUALITY CONSEQUENCES OF FRAGMENTED CARE

An excellent book, "Fragmented: A Doctor's Quest to Piece Together American Healthcare" by Ilana Yurkiewicz, M.D., focuses on how fragmented care has become dangerous for all of us. The root cause of this problem stems from Primary care no longer assuming responsibility for care coordination.

Two variables make care coordination more important than ever: the explosion of chronic illness and the massive expansion of specialization. Today, patients are cared for by many physicians and given multiple drug prescriptions for their numerous chronic disorders. No single physician oversees all this care and, as a result, care has become fragmented. The invisible costs of fragmented care are manifested throughout healthcare. One of Dr. Yurkiewicz's most significant concerns is the fragmentation of the patient's medical history or story. Multiple caregivers with non-integrated medical records make it difficult for changing providers to understand a patient's history. Understanding that history is critical to providing quality healthcare. Dr. Yurkiewicz's book is full of patient stories to illustrate this point.

One quote, in particular, illustrates how billing and coding is negatively impacting care. When electronic records were initially adopted, the Centers for Medicare and Medicaid Services (CMS) created a standard for "meaningful use" — another failed reform effort. Unfortunately, the metrics developed for this standard were based on billing needs not patient care needs.
This quote describes the consequences of these flawed standards:

> ***"… these metrics were fundamentally designed for billing, not patient care, doctors were required to jump through all sorts of clunky hoops to prove their clinics were worthy of reimbursement… These factors [the metrics] are irrelevant at best and distracting at worst… The electronic ecosystem became littered with useless information, while important things got buried. Over time we have just kept adding to this junk pile. A poll by Stanford Medicine researchers of more than five hundred primary care doctors found… [that] 71% felt that electronic charts contribute to physician burnout; 49% felt the charts detracted from medical effectiveness, and 59% believed they need a complete overall." (p56-57).***

This quote poignantly illustrates the impact that the complexity of billing and coding has on healthcare generally and primary care specifically. The fact that CMS chose to focus the use of the electronic medical record on billing and coding rather than patient care is a powerful statement about U.S. health policy.

The fact that patient information is not easily available across multiple providers is made worse by the fact that once it is available the format of the patient information is not very usable. The consequence of all this fragmentation is real. Today, no physician is responsible for a patient's medical history or story, and the importance of this history becomes more significant with the growth of chronic illness and the growth in provider specialization. Add to this dilemma the fact that electronic records are more focused on billing than on patient usability. Fragmented care is costing the U.S. billions and harming patients. High-quality primary care and payment reform is a powerful remedy to the problem of fragmented care.

PRIMARY CARE IS A PUBLIC GOOD AND DESERVES A DEDICATED PAYMENT MODEL

One could argue that primary care plays such an essential role in the health and well-being of individuals that it deserves specific public policy consideration and with it a unique financing formula. One can even go so far as to suggest that primary care is a public good, like national defense, clean water and public education. Primary care is the foundation of a high-functioning healthcare system and should be made available and accessible to all.

There is a precedence for paying physicians in the context of a public good. Since 1923, the U.S. has supported a system of graduate medical education (GME), training physicians via hospital-based residencies with its own unique payment formula. It uses a salary model for residents and a cost reimbursement formula to fund additional costs of GME. Since 1965, the primary funding of GME has been financed by the federal government through Medicare using direct and indirect payments to hospitals and academic medical centers.

So how might we apply the GME financing model to primary care in a way that would encourage more physicians to choose primary care and further enable time for care coordination and building a trusting relationship with patients?

One concrete approach would be eliminating the fee-for-service payment model for primary care. Most of primary care is about talking with patients and building trusting

relationships. Building relationships with patients takes time and FFS does not compensate for either conversations or care coordination, two critical responsibilities within primary care. The consequence of FFS payment for primary care has been a shortage of primary care physicians and an explosion of fragmented care.

In a new dedicated model for primary care, payers — i.e., Medicare, Medicaid and private commercial insurers — would eliminate FFS payment as the formula for primary care compensation. A direct payment model would be instituted, similar to the financing of GME and the salaries of resident physicians. Direct financing and a salary model would change the economic incentives for primary care physicians and allow them to focus on caring for their patients, not generating volume. Direct payment would eliminate the enormously complex and expensive requirements of FFS billing and collecting, thus reducing the cost of medical practice. These savings could be redirected to improve compensation for primary care physicians, making the field more attractive and thus primary care more available.

A NEW DEDICATED PAYMENT MODEL FOR PRIMARY CARE

Primary care needs a single payment model that is attractive to physicians, encourages sustained relationships with patients, eliminates fragmentation and is affordable over time. And as importantly, a model that can be taken to scale quickly and efficiently in all healthcare settings.

Our extensive years in healthcare have taught us that even the most complex problems can be solved by focusing on simplicity. We need to make primary care compensation simple. We need a simple and single payment methodology that allows logic and common sense to determine primary care compensation — not a Byzantine coding system with thousands of moving parts. We should eliminate the use of insurer's medical-necessity requirements for all primary care services. Services and patient interaction should be encouraged — not discouraged. Insurer oversight should be kept to a minimum through aligned incentives. Furthermore, we need a payment model that rewards quality of care and not the volume of patients or tests. These changes keep primary care simple.

Under this new approach, payers including Medicare, Medicaid and private insurers would pay primary care organizations (PCOs) to provide essential primary care in all clinical settings. Payment covers the direct costs of providing care, including physicians, advanced practice practitioners, clinical and non-clinical staff, electronic medical records, technology, rent, malpractice costs, supplies and so forth. This is a cost-based model based on the GME methodology that has worked in this country for more than five decades.

Within each PCO, physicians would negotiate salaries based on prescribed ranges established in collaboration with the CMS

and private insurers. By eliminating revenue cycle expenses and with prompt and consistent payments from payers, PCOs should be able to maximize primary care physician salaries, promote retention in the field, and build out a sustainable business model without needing subsidies from other services. Sustainability in the business of primary care would be a boon to healthcare overall.

It should be noted that PCOs can be owned and operated by many different types of organizations. Hospitals, health systems, insurers, private equity firms and physician groups would all likely be interested in forming PCOs to be paid directly by Medicare and private insurers in a cost-based system. Small physician groups even down to solo practitioners would be encouraged to form PCOs and be paid directly at cost by payers.

This "simple" cost payment model requires much more detail, but we believe this direct payment method has precedence and great potential to drastically improve primary care attractiveness and affordability. Organizing primary care in such a structure is seen as sustainable and more effective than the unsustainable issues with the current FFS system.

Commentary co-author Michael Connelly's book, "The Journey's End," covers the details of funding primary care in-depth; however, the key points are simple and straightforward:

It rewards quality and builds patient relationships.

It is simple to administer.

It is simple to operate under, thus making primary care a rewarding specialty.

It is cost-effective. The costs and burdens of billing and compliance are eliminated.

It will improve quality by supporting care coordination and reduce fragmented care.

It will lower total healthcare spending.

It is not volume-driven, so most concerns about fraud and abuse are eliminated.

High-quality primary care's ability to drive improvements in the healthcare system is supported by the evidence. As such, primary care can and should be the centerpiece of healthcare reform.

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.