How the Affordable Care Act Will Strengthen the Nation's Primary Care Foundation

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As the country turns toward implementation of the Patient Protection and Affordable Care Act, realizing the potential of reform will require significant transformation of the American system of health care delivery. To that end, the new law seeks to strengthen the nation's primary care foundation through enhanced reimbursement rates for providers and the use of innovative delivery models such as patient-centered medical homes. Evidence suggests that these strategies can return substantial benefits to both patients and providers by increasing access to primary care services, reducing administrative hassles and burdens, and facilitating coordination across the continuum of care. If successfully implemented, the Affordable Care Act has the potential to realign incentives within the health system and create opportunities for providers to be rewarded for delivering high value, patient-centered primary care. Such a transformation could lead to better outcomes for patients, increase job satisfaction among physicians and encourage more sustainable levels of health spending for the nation.

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BACKGROUND

Patient access to high-quality primary care is essential for a well-functioning, high performing health care system. Previous research has shown that countries with a strong primary care foundation experience better population health outcomes, more equitable care, and greater efficiency of health services.[1,2] Patients with access to a regular primary care physician are more likely to receive recommended preventative services, obtain necessary treatment before more serious and costly problems develop, and have fewer preventable emergency department visits and hospital admissions relative to patients who do not.[3] A robust supply of primary care providers is associated with lower mortality, higher life expectancy, and better self-rated health status.[4]

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Many of the current problems in U.S. health system performance can be traced to the weak primary care foundation that currently characterizes American care delivery.[5] Only two-thirds of American adults report having an accessible primary care provider, while nearly three-quarters have had difficulty getting an appointment, receiving telephone advice, or getting off-hours care without going to an emergency room.[6,7] Such experiences are neither consistent with efforts to improve outcomes and lower costs through preventive care nor conducive to the efficient management of chronic disease.[8]

STARTING ON THE PATH TO HIGH PERFORMANCE

Fortunately, several payment and delivery system reform provisions included in the Patient Protection and Affordable Care Act address these deficiencies and offer the opportunity to change course.[9] In particular, the new law makes a concerted effort to strengthen the nation's primary care foundation through the use of enhanced reimbursement rates for providers and innovative delivery models such as patient-centered medical homes.[3] When combined with the significant coverage expansion initiatives in the Affordable Care Act, successful implementation of the law has the potential to improve access to care for millions of Americans, encourage accountability and greater organization among health care providers, and begin to slow the growth in health care costs by introducing new rewards for practitioners delivering high value, patient-centered care.[10]

Provider Incentives to Provide Primary Care

The Affordable Care Act begins to place greater value on primary care and reduce reliance on specialty care. A key provision provides a 10% primary care bonus to clinicians that participate in the Medicare program. Beginning this year, primary care physicians, nurse practitioners, and physician assistants that provide 60% of their services in primary care codes for office visits, nursing facility visits, and home visits will be eligible to receive the bonus.[3] In addition, providers in health professional shortage areas that perform major surgical procedures can receive the increase.[11] The Congressional Budget Office estimates $3.5 billion will be available to primary care providers from 2011–2016.[12]

The impact of the bonus on individual primary care physicians will vary depending on the percentage of Medicare patients they see and the share of services they provide that fall within the eligible primary care services. An analysis by the American College of Physicians estimates that a general internist with an annual Medicare revenue of $200,000 would receive an additional $12,000–16,000 bonus each year for five years.[13]

Primary care physicians treating Medicaid beneficiaries will also see a brief increase in reimbursement. In 2013 and 2014, Medicaid payment rates to primary care physicians will be increased to match Medicare levels. According to the Congressional Budget Office, Medicaid primary care physicians will see an additional $8.3 billion in reimbursement; the federal government will pay the entire cost through increased federal matching assistance percentages to states.[12] Since provider payment rates vary by state Medicaid program, this policy will have a differential impact on physicians depending on where they practice. Physicians in Rhode Island, where Medicaid pays 36% of the Medicare rate, will see a much greater increase than physicians in New Mexico, where Medicaid pays 98 of the Medicare rate.[14]

Young physicians interested in primary care will begin to see new incentives and opportunities to enter the field while still in medical school. The Affordable Care Act invests $1.5 billion over 2011–2015 for the National Health Service Corps to provide scholarships and loan forgiveness for primary care physicians, nurse practitioners, and physician assistants practicing in health professional shortage areas.

Patient-Centered Medical Homes

Several provisions in the new reform law seek to strengthen the primary care system by encouraging the widespread adoption of patient-centered medical home (PCMH) models of care. Though variations exist, central attributes of PCMHs include enhanced patient access to a regular source of primary care, stable and ongoing relationships with a personal clinician who directs a care team, and timely, well-organized health services that emphasize prevention and chronic care management. An important feature of medical homes is enhanced payment in recognition of the infrastructure needed to provide more services.

While it is not yet possible to conclude which precise element or elements drive positive outcomes, evidence suggests that on the whole PCMHs improve patient experiences and outcomes by increasing access to care, encouraging the receipt of recommended preventive services, and facilitating better management of chronic conditions. In doing so, PCMHs hold the potential to reduce the overall costs of care without sacrificing quality. Recent evaluations of PCMH models at Group Health Cooperative in Seattle, Washington and Geisinger Health System in Pennsylvania have shown cost-savings from reductions in emergency department use and unnecessary hospitalizations.[15–17] Importantly, benefits also accrue to physicians who report lower levels of burnout and higher levels of job satisfaction.

The Affordable Care Act encourages the widespread adoption of PCMHs by offering states the option to increase reimbursement to primary care sites designated as "health homes" for Medicaid patients with chronic conditions. Health homes are similar to medical homes, but tend to emphasize the integration with public health and the potential lead role of advanced practice nurses. Under the law, teams of primary care providers (including physicians, nurse practitioners, and physician assistants) will agree to provide comprehensive care management, care coordination and health promotion, transitional care between hospital and primary care, referral to community and social services, patient and family engagement and use of information technology to link services. The PPACA health home provision gives states flexibility to design payment methodology that works for them, and allows for state variation in the payment approach that they choose.

Recent estimates by the Commonwealth Fund show that up to 10 million Medicaid beneficiaries with at least one chronic condition could have a health care home in 2011 if all states take advantage of the opportunities created by the PPACA.[3] Further, an estimated 20 million Americans will be newly eligible for Medicaid in 2014 when coverage expands to adults up to 133% of the federal poverty level. Among those newly eligible Medicaid recipients, more than 8 million individuals could have a health home in 2014 to help manage their chronic conditions. Numerous studies have shown that patients who receive chronic care management as part of their primary care experience better quality care and better outcomes.[18]

Center for Medicare and Medicaid Innovation

An important and exciting feature of the Affordable Care Act is a new Center for Medicare and Medicaid Innovation (CMMI) within the Centers for Medicare and Medicaid Services. The new center will test innovative payment and delivery system models that show promise for improving or maintaining the quality of care in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) while slowing the rate of cost growth.[19] Beginning this year, the CMMI will research, develop, test, and expand these innovative payment and delivery arrangements. Considerable resources have been invested to help CMMI carry out its mission.

The Affordable Care Act provides the secretary of the Department of Health and Human Services (HHS) significant flexibility in selecting innovations to be tested, but specifically prioritizes testing new models in primary care. For example, the statute suggests testing patient-centered medical homes for high-need individuals, women's health care, and comprehensive or salary-based payment for clinicians. Another recommended model to test is the establishment of community-based health teams to support small-practice medical homes. Already the center has announced two medical home demonstration projects, further details of which are available on the CMMI website.

The secretary of HHS is authorized to spread successful CMMI innovations to all Medicare, Medicaid and CHIP providers who voluntarily choose to participate without additional legislative action. If the tested innovations show improvements in quality without increased spending, reductions in spending without compromising quality, or both, the intervention can be spread voluntarily to Medicare, Medicaid and CHIP providers. Thus far, medical home demonstrations have met this test of improved quality while slowing the rate of health system expenditures. In an independent analysis, The Commonwealth Fund and Lewin Group estimated that universal adoption of the medical home model in Medicare and Medicaid could reduce national health spending, relative to currently projected levels, by an estimated $175 billion through 2020.[20]

Other Provisions

The Affordable Care Act also contains several other provisions that seek to strengthen the nation's primary care foundation and ultimately improve patient outcomes while lowering costs. Among

the most significant is the creation of the new Accountable Care Organization (ACO) provider category in the Medicare program no later than January 2012. A strong primary care base will be essential to success in the program and indeed those seeking reimbursement as an ACO will be required to demonstrate the capacity to deliver sufficient primary care for all patients before participating.[21] ACOs will likely provide the complementary medical neighborhoods in which medical homes are built.[22]

The new law also incorporates incentives to encourage patients to obtain primary and preventive care services. Several provisions eliminate co-insurance, deductibles and co-payments for approved preventive services and tests that will help Medicare and Medicaid beneficiaries detect disease early, while at a more treatable stage. In addition, reform will make preventive services more accessible for seniors by covering an annual wellness visit that provides a personalized prevention plan for each beneficiary, with no co-payment, coinsurance, or deductible.

Other significant provisions include grants and investments in local, state, and national primary care infrastructure that will help some of the most vulnerable patients. This includes enhanced funding for existing community health centers as well as the construction and renovation of new facilities. The law also authorizes funding for community-based collaborative care networks that provide comprehensive, integrated health care services for low-income populations.

CONCLUSION: PHYSICIANS TO HELP LEAD CHANGE

The United States has passed historic legislation that can strengthen the nation's primary care foundation and help usher in a new era in American health care. The combination of coverage expansion efforts with significant new payment and delivery system reform provisions in the law can make major strides toward achieving the goals of affordable coverage for all, better quality, and slower cost growth.

Realizing the potential, however, is not assured. Members of Congress have pledged to deny funding for provisions of the legislation during the appropriations process, and efforts to completely repeal the law and replace it with an alternative set of reforms persist. Legal challenges in our nation's court system are ongoing. Despite promulgation of a number of key rules and regulations, effective implementation remains a large hurdle. Stakeholders need to work together for reform to be successful.

Physicians can and should lead reform efforts. Reforming primary care payment and organization is critical to facilitating better health outcomes, lowering health care costs, and improving physicians' quality of life. The innovative payment pilots as part of the Innovation Center and enhanced reimbursement rates outlined above are just a few of the many new opportunities under the law to strengthen primary care. Active participation by physicians in the design and implementation of these and other efforts (such as Accountable Care Organizations) will be crucial to getting it right and making health reform a success.

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