IMPLEMENTING HEALTH REFORM

Health Reform's 10% Primary Care Bonuses Begin

One aim of the Affordable Care Act was to boost primary care, and one of the law's strategies was to create 10% incentive payments for primary care services provided by some physicians and other practitioners.

The Nov. 29 "Federal Register" published Medicare's final rule specifying that primary care physicians, nurse practitioners, clinical nurse specialists, and physician assistants whose practices comprise mostly primary care would qualify for the payments as of Jan. 1.

The Centers for Medicare and Medicaid Services excluded hospital inpatient care and emergency department work from qualifying practitioners for the incentive.

Although many leaders in primary care endorsed the incentive program in official comments to the CMS, several also said that the provision is not without disadvantages and limitations. Dr. Roland Goertz, president of the American Academy of Family Physicians, discussed the health reform law's new primary care incentive program.

FAMILY PRACTICE NEWS: How can a physician qualify for the incentive payments? Will physicians outside of primary care specialties qualify?

The broken Medicare SGR formula is the most important factor affecting all of medicine.

DR. GOERTZ

Dr. Goertz: Because the Affordable Care Act specifies the medical specialties that will qualify for the 10% Medicare incentive, only physicians whose primary specialty is family medicine, internal medicine, geriatric medicine, or pediatric medicine will be eligible for the bonus.

Additionally, only those primary care physicians whose primary care billings comprise at least 60% of their total Medicare-allowed charges will qualify for the incentive payments. In its final regulation, CMS estimated that up to 80% of all family physicians would qualify.

FPN: What do qualifying physicians need to do to receive the incentive payments?
Dr. Goertz: Nothing. If CMS determines a primary care physician's 2009 Medicare charges – the most recent data – meet the 60% threshold, then it will automatically send the bonus check quarterly to the physician.

FPN: Are there any disadvantages to the provision?
Dr. Goertz: There are two main disadvantages to the provision. First, it's currently only a 5-year program. If the purposes of the program – to begin to pay primary care physicians more fairly and to attract more medical students into primary care – are to be successful, we'll need to continue the incentive program beyond Dec. 31, 2014. Secondly, the bonus probably should be gradually increased until we demonstrate that it's doing the job of attracting a sufficient number of medical students into primary care.

FPN: Will this provision have an impact on the shortage of primary care physicians?
Dr. Goertz Legislators recognized that we need to address the primary care physician shortage if we are to have an efficient, high-quality health care system. They specifically targeted this incentive in an effort to improve the payment environment for primary care physicians. It's a step in the right direction, but much more is needed to close the income gap between primary care physicians and other specialists.

FPN: What is the next step toward addressing the primary care physician shortage?
Dr. Goertz: The most important factor currently affecting primary care – and all of medicine – is the need for a permanent solution to the Medicare physician payment's broken sustainable growth rate formula. Once that has been addressed, we need to continue to close the income gap between primary care and other specialty physicians and continue to implement the patient-centered medical home because we know it is a critical component for the best future care.

These actions will make family medicine more attractive to medical students and will invigorate the primary care medical education process to robustly fill the pipeline of need. ■

POLICY & PRACTICE

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HHS Seeks Better Chronic Care

The Department of Health and Human Services says it has a new strategy to improve the care of patients with multiple chronic conditions while cutting costs. The effort will give health professionals new information on such care and will facilitate research under the auspices of the Centers for Disease Control and Prevention and the Centers for Medicare and Medicaid Services. More than one-quarter of all Americans – and two-thirds of older Americans – live with multiple chronic conditions, according to HHS. "Focusing on the integration and coordination of care … is critical to achieve better care and health for beneficiaries, and lower costs through greater efficiency and quality," said CMS Administrator Donald Berwick in a statement.

State Smokes Heart Disease

The Massachusetts Medicaid program has curbed smoking prevalence and hospital admissions for some smoking-related diseases, according to a study published online in Public Library of Science Medicine. In 2006, the program began comprehensive coverage of tobacco cessation therapies and counseling. About 75,000 Medicaid recipients used that benefit from 2006 to early 2009, and smoking dropped 10% among the Medicaid population, reported researchers from the state's Tobacco Cessation and Prevention Program and Harvard Medical School, Boston. The rate of Medicaid hospital admissions for coronary atherosclerosis declined 49%, and that for acute myocardial infarction dropped 46%. But there was no change in admissions for lung diseases or some other tobacco-related conditions.

Medical Prices Vary Worldwide

U.S. prices for medical procedures again surpassed those in other countries, according to a survey by the International Federation of Health Plans. For example, the average hospital stay costs $1,679 in Spain and $7,707 in Canada but can range from $14,427 to $45,902 in the United States. One month's supply of esomeprazole (Nexium) costs $30 in the United Kingdom but $186 in this country. The difference was greatest for surgery, according to the 2010 edition of the federation's annual survey. For example, cataract surgery cost an average of $1,667 in Spain but $14,764 in the United States. "As countries around the world look at the impact of their health care systems on their economies, the cost per unit of services, procedures, and drugs is a key factor that needs to be understood," said the federation's chief executive, Tom Sackville, in a statement.

Primary Care Strategy Needed

A nonpartisan think tank is calling for a national strategy to reinvent primary care so it uses lesser-trained health workers to provide more patient care. The recommendations from the Hope Street Group, developed with input from numerous prominent health policy makers, would reorient primary care toward prevention, wellness, and disease management, according to the report. The document calls for using workers "trained at the community college and vocational levels to help people with health care that does not entail examining the patient." It also urges the federal government to foster an environment in which new practice models, payment structures, and technologies can be tested and disseminated more rapidly. The country's health care system needs to implement payment reform and strategies to address the health of populations rather than just individuals, according to the report.

Life Expectancy Declines a Bit

Overall life expectancy in the United States declined by about 1 month from 2007 to 2008, but it will take more years to determine whether that represents a trend, according to the CDC's National Center for Health Statistics. Life expectancy at birth fell from 77.9 years in 2007 to 77.8 years in 2008 for both men and women. However, black men gained a record-high life expectancy of 70.2 years in 2008, up from 70.0 years in 2007, and the gap between white and black populations was 4.6 years in 2008, a decrease of two-tenths of a year from 2007, the agency said. Heart disease and cancer, the two leading causes of death, accounted for 48% of all deaths in 2008. Stroke fell from the third leading cause of death to the fourth, while chronic lower respiratory diseases took its place as number three, the CDC said. However, that shift may be due to a modification in how deaths from chronic lower respiratory diseases are classified, the agency said.

HIV Testing Reaches Record High

While the number of U.S. adults tested for HIV reached a record high in 2009, 55% of all adults and 28% of adults with at least one HIV risk factor still haven't been tested, the CDC said. The agency recommended in 2006 that HIV testing become a routine part of medical care for adults and adolescents and that high-risk individuals be tested once a year. In 2009, nearly 83 million adults aged 18-64 years said they had been tested for HIV at least once. However, only 60% of gay or bisexual men said they had been tested in the past year. The agency estimated that about 1.1 million U.S. adults are living with HIV, including about 200,000 who don't know their HIV status.

–Jane Anderson