



Perspective

Ensuring Progress in Primary Care — What Can Health Care Reform Realistically Accomplish?

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In the current political environment, forging consensus on health care reform has proven challenging. Yet the value of a strengthened primary care infrastructure is one apparent zone of agreement

among policymakers. Leading professional societies have converged upon principles for restructuring primary health care in their support of the patient-centered medical home (see Table 1).¹ In addition to this reorganization of primary care delivery, experts have recommended three other areas of improvement: payment reform, augmentation of the primary care workforce, and better tracking of care coordination between primary care physicians and specialists.^{2,3}

Despite the apparent agreement on reforming primary care, there is no assurance that the health care reform bills currently under debate will make these

consensus-based recommendations a reality. Primary care has thus far taken a back seat to the more contentious elements of the health care reform bills, such as methods of expanding insurance coverage, the institution of individual and employer mandates, financing strategies, and medical malpractice reform. When primary care is discussed, it is often lumped together with “preventive care” — for instance, in the context of increasing incentives for screening — but other important functions of the primary care provider, such as managing chronic disease, are given short shrift.

The major legislative proposals under consideration would

implement varying degrees of reform along the four axes listed above (see Table 2). With respect to reorganizing primary care delivery, both the Senate and the House bills would create “accountable care organizations” that could share in any cost savings achieved for Medicare and be eligible for incentive bonuses based on performance. The House bill is more explicit in its support for the medical home concept, allocating almost \$3 billion for 5-year demonstration projects within Medicare and Medicaid; on the Senate side, medical homes are mentioned as one model of practice reform to be promoted by a new Innovation Center. The Innovation Center would be housed within the Centers for Medicaid and Medicare Services and would receive \$10 billion in funding over a 10-year period. Finally, the bill passed by the Senate Health, Education, Labor,

Table 1. Timeline of Consensus Development on the Medical Home Concept.

Date	Event
July 2002	The American Academy of Pediatrics (AAP) releases a policy statement building on the medical home concept initially described by the AAP in 1967, including an operational definition of the medical home as accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally effective.
November 2004	The Future of Family Medicine Project and the American Academy of Family Physicians (AAFP) release statements asserting that every American should have a personal medical home.
January 2006	The American College of Physicians (ACP) releases a policy paper called "The Advanced Medical Home" that proposes use of the medical home as a means of transforming the way primary care is delivered and financed.
December 2006	The Tax Relief and Health Care Act creates a legislative mandate for a medical home demonstration project within Medicare to be implemented by 2010.
February 2007	The AAP, AAFP, ACP, and American Osteopathic Association release a consensus statement entitled "Joint Principles of the Patient-Centered Medical Home."
November 2007	The National Committee for Quality Assurance announces its Physician Practice Connections, a program that identifies the criteria a medical practice should meet to qualify as a medical home.
June 2008	The Patient-Centered Primary Care Collaborative estimates that 16 significant state-level or multipayer medical home demonstration projects are under way.
November 2008	The American Medical Association and more than a dozen specialist physician organizations have joined the four major primary care associations in endorsing the "Joint Principles of the Patient-Centered Medical Home."
February 2009	"Initial Lessons from the First National Demonstration Project on Practice Transformation to a Patient-Centered Medical Home" is published by the AAFP.

and Pensions (HELP) Committee would initiate a Primary Care Extension Program that would educate providers about evidence-based therapies, preventive medicine, health promotion, chronic-disease management, and mental health.

Payment reform refers both to narrowing the income gap between primary care physicians and specialists and to changing methods of reimbursement to provide incentives for improved performance on quality measures. Under the House bill, Medicare payments for primary care services would increase by 5%; under the Senate Finance Committee bill, these payments would increase by 10%. In addition, the House bill would allow Medicare payments for such services to grow at a faster rate than payments for other services; it would also link state Medicaid reim-

bursements for primary care to Medicare rates and provide federal funding to support this change. The Senate Finance Committee's bill includes a provision authorizing payment for each new Medicare enrollee to visit his or her primary care provider for the specific purpose of creating an individualized prevention plan. In both houses of Congress, however, incentives for improved performance do not go beyond demonstration projects. The Senate bill's Innovation Center, for example, calls for promoting models that transition practices away from fee-for-service reimbursement toward comprehensive payment for episodes of care.

In terms of augmenting the primary care workforce, the House bill is more robust than the Senate bills. Both houses would redistribute currently unused medical residency slots in

favor of training for primary care practitioners. Both would also fund "teaching health centers," or ambulatory-based primary care training in, for instance, community health centers. The Senate Finance Committee's bill authorizes \$230 million over 5 years for this purpose. The House bill goes further by appropriating almost \$7 billion over 10 years for various programs to buttress primary care training. The plans include expanding the National Health Service Corps, which offers debt relief to physicians working in regions that have a shortage of health care professionals; providing financing for loans to medical students pursuing primary care careers; and building academic capacity in primary care by directly supporting residency programs in family medicine, general internal medicine, general pediatrics, and ger-

Table 2. Major Primary Care Components of Current Health Care Reform Legislation.

Area of Reform	Senate (Finance Committee and HELP Committee Bills)*	House (H.R. 3200)
Reorganization of care delivery	<p>Certifies groups of primary care providers as “accountable care organizations” to be eligible to share in cost savings accruing to Medicare</p> <p>Funds an Innovation Center within the government to promote medical homes for high-need beneficiaries and women’s health</p> <p>Creates a Primary Care Extension Program to educate and provide technical assistance to primary care providers (HELP Committee bill only)</p>	<p>Creates Medicare-based “accountable care organizations” to reward practices for cost containment and quality improvement</p> <p>Establishes 5-year medical home pilot programs in both Medicare (authorized to \$1.6 billion) and Medicaid (authorized to \$1.2 billion); both programs would focus on high-need beneficiaries and incorporate community-based models</p>
Payment reform	<p>Establishes a 10% bonus on select Medicare codes (e.g., office and home visits) targeting primary care providers</p> <p>Innovation Center would promote comprehensive payment over fee-for-service models</p> <p>Authorizes payment for new Medicare enrollees to visit a primary provider to create a prevention plan</p>	<p>Increases Medicare payment rate by 5% for primary care services</p> <p>Revises Medicare payment formula to allow primary care services to grow at a faster rate than other services</p> <p>Requires state Medicaid programs to provide reimbursement for primary care services at no less than 80% of Medicare rates in 2010, 90% in 2011, and 100% in 2012 and after</p>
Workforce augmentation	<p>Establishes a policy to redistribute unused residency slots to favor primary care training</p> <p>Authorizes \$230 million over 5 years to support teaching health centers or ambulatory-based primary care residency programs</p> <p>Augments training programs in primary care with an authorization of \$125 million, with priority given to training approaches that are team-based (HELP Committee bill only)</p>	<p>Establishes a policy to redistribute unused residency slots to favor primary care training</p> <p>Creates a demonstration project and channels graduate medical education funding to teaching health centers that would serve as ambulatory-based primary care residency programs</p> <p>Authorizes approximately \$7 billion over 10 years for primary care workforce programs, including the National Health Service Corps, student loan financing, buildup of academic capacity, and training of medical residents in community-based settings</p>
Tracking of care coordination	<p>Incorporates a national quality improvement strategy that includes tracking and reporting on measures of care coordination</p>	<p>Establishes the Center for Quality Improvement to develop, disseminate, and track measures of quality in health care delivery, including care coordination</p>

* HELP denotes Health, Education, Labor, and Pensions.

iatrics, as well as those for physician assistants.

The fourth pillar of primary care reform, better tracking of care coordination, flows from the other three: it is a necessary step in measuring the effects that reorganization of care delivery, payment reform, and workforce augmentation will have on patient outcome. The economic stimulus package passed earlier this year — the American Recovery and Reinvestment Act of 2009 — allocated \$19 billion for support of health information technology. The current bills would build

on that investment by establishing national quality-improvement clearinghouses that would track and report on certain measures of quality, such as health disparities and appropriateness of care. The bills cite measures of care coordination as falling under the purview of quality-improvement initiatives, though none of them explicitly describes the specific measures of quality that would be used to track care coordination.

A critical look at the major primary care components of health care reform legislation reveals both potential for progress

and substantial shortcomings. Pilot programs for accountable care organizations and models of care based on the medical home will provide evidence to guide large-scale reorganization of care delivery. However, skeptics point to the substantial startup costs associated with transforming physician practices into novel delivery structures — and conjecture about the practical difficulties of balancing objectives related to the coordination and accessibility of care with cost-containment goals. Payment reform could help to relieve that tension, and

current legislation would increase Medicare (and in the House bill, Medicaid) reimbursements for primary care services. Yet a tangible shift in health care spending from specialty services (including imaging and procedures) to primary care would probably require spending increases beyond those included in the current bills. Tilting the spending scale more toward primary care, in turn, may be necessary to pave the way for more fundamental payment reform, such as “comprehensive payment for comprehensive care.”⁴

On workforce issues, Congressional proposals would augment the absolute number of residency positions dedicated to primary care and shift the locus of training from hospital-based programs to ambulatory settings. Only the House bill, however, would appropriate enough funding to ensure that these changes were substantial and long-lasting. The House bill would also pilot another provision with long-term implications: altering graduate medical education (GME) to al-

low funding to flow directly to residency programs instead of to hospital systems. The antiquated and byzantine structure of GME payments is partially responsible for the inertia that has kept medical training hospital-centered. Finally, as we have seen in Massachusetts, a key plank of workforce reform is anticipating the immediate surge in demand for primary care providers that will accompany any significant coverage expansion.⁵ Providing funds for the National Health Service Corps and other loan-forgiveness programs is probably the only type of policy change that would work rapidly enough to address the surge in demand.

Progress in the delivery of primary care cannot be measured in a vacuum. Success must be defined by the extent to which the system can coordinate the primary and specialty care services needed to improve outcomes. It is here that the legislation currently under debate leaves the most room for improvement. Delivering high-quality care will require the careful collection of data to

track both the implementation of primary care reforms and the effects of those reforms on patients' health. Genuine progress in health care reform can be evaluated only in this way — both now and for many years to come.

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1. Joint principles of the patient centered medical home. Washington, DC: Patient-Centered Primary Care Collaborative, 2007. (Accessed October 26, 2009, at <http://www.pccpc.net/node/14>.)
2. Bodenheimer T, Grumbach K, Berenson RA. A lifeline for primary care. *N Engl J Med* 2009;360:2693-6.
3. Sandy LG, Bodenheimer T, Pawlson LG, Starfield B. The political economy of U.S. primary care. *Health Aff (Millwood)* 2009; 28:1136-45.
4. Goroll AH, Berenson RA, Schoenbaum SC, Gardner LB. Fundamental reform of payment for adult primary care: comprehensive payment for comprehensive care. *J Gen Intern Med* 2007;22:410-5.
5. MMS Physician Workforce Study — 2009. Waltham: Massachusetts Medical Society; 2009.

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