PRESIDENT'S MESSAGE

Redesigning primary care is the first step

By Dr. Jayesh Shah, 2016 BCMS President

Last week, the Centers for Medicare & Medicaid Services (CMS) announced the final rule for MACRA (Medicare Access and CHIP Reauthorization Act). It replaces the old and flawed sustainable growth rate formula for physician pay with a new method meant to shift patients away from the fee-for-service model to a value-based payment system, so physicians will get paid by either a merit-based incentive payment system (MIPS) or advanced alternative payment models. In MIPS, physicians' pay is based on four performance categories including quality, resource use, clinical practice improvement and advancing care information.

CMS is actively making efforts to nudge physicians towards value-based care. The final rule developed some more exemptions which include exemptions for physicians who have less than $30,000 in Medicare charges or physicians seeing less than 100 unique Medicare patients per year. CMS also pledged $100 million in technical assistance to clinicians participating in MIPS who are in small practices, rural areas, and/or in areas with a shortage of health professionals.

In spite of this hurricane effort by CMS to change the direction of health care towards value-based care, the majority of physicians working in the trenches are skeptical that this effort will increase value or decrease cost. Some solo practitioners feel that this will be a last nail in the coffin for their practices and will force them to close their practices.

I recently read an article by well-known business strategist and Harvard Business School Professor Michael Porter about, "How primary care needs to be redesigned."

Porter and his colleagues define "value" as patient outcomes achieved relative to the amount of money spent. I like his practical approach of redefining and deconstructing the primary care practices and grouping the patients into subgroups. Chronic diseases account for 75 percent of our health care costs. If we subgroup all chronic disease management patients into subgroups under primary care practices, such as end stage renal disease subgroup, coronary artery disease subgroup, diabetes mellitus subgroup, etc. and then connect these subgroup teams with telemedicine, it would definitely decrease cost and increase value. I agree with Porter and his colleagues that by dividing and organizing teams and providing specialty care around patients' subgroups will most likely make the provision of holistic and integrative care more efficient.

I also like his idea of creating an umbrella structure for small primary care practices so that they can redesign themselves. The article suggests that the payment to the primary care practices should be in the form of monthly fees based on the complexity of patients, i.e. more monthly payments if a patient has more chronic diseases like diabetes mellitus, hypertension, hypercholesterolemia and renal disease. This model also allows paying for episodic care if necessary, and gives incentives to physicians to take care of complex patients in a value-based scenario.

Behavioral health care should not be considered separately. Rather, it should be a part of chronic disease management because many of the chronic diseases will be managed better when these patients get treatment of their co-existing mental illness simultaneously.

Redesigning primary care is necessary before any of the payment models will make a meaningful difference in health care reform.