American Board of Family Medicine, Inc.

Primary Care In Transition:

The Role of Primary Care in Controlling Health Care Costs

ACS Dialogue for Action/Prevent Cancer

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Learning Objectives

- Provisions in the Affordable Care Act related to strengthening primary care delivery to patients
- How strengthening the primary care system adds value and improves patient outcomes related to cancer prevention and early detection
- The role of primary care in controlling costs, especially related to cancer screenings

How the ACA Strengthened Primary Care

- Medicaid expansion and payment increase
- Primary Care Incentive Payments (Medicare)
- Misvalued payments
- Primary Care Extension

- Primary care training

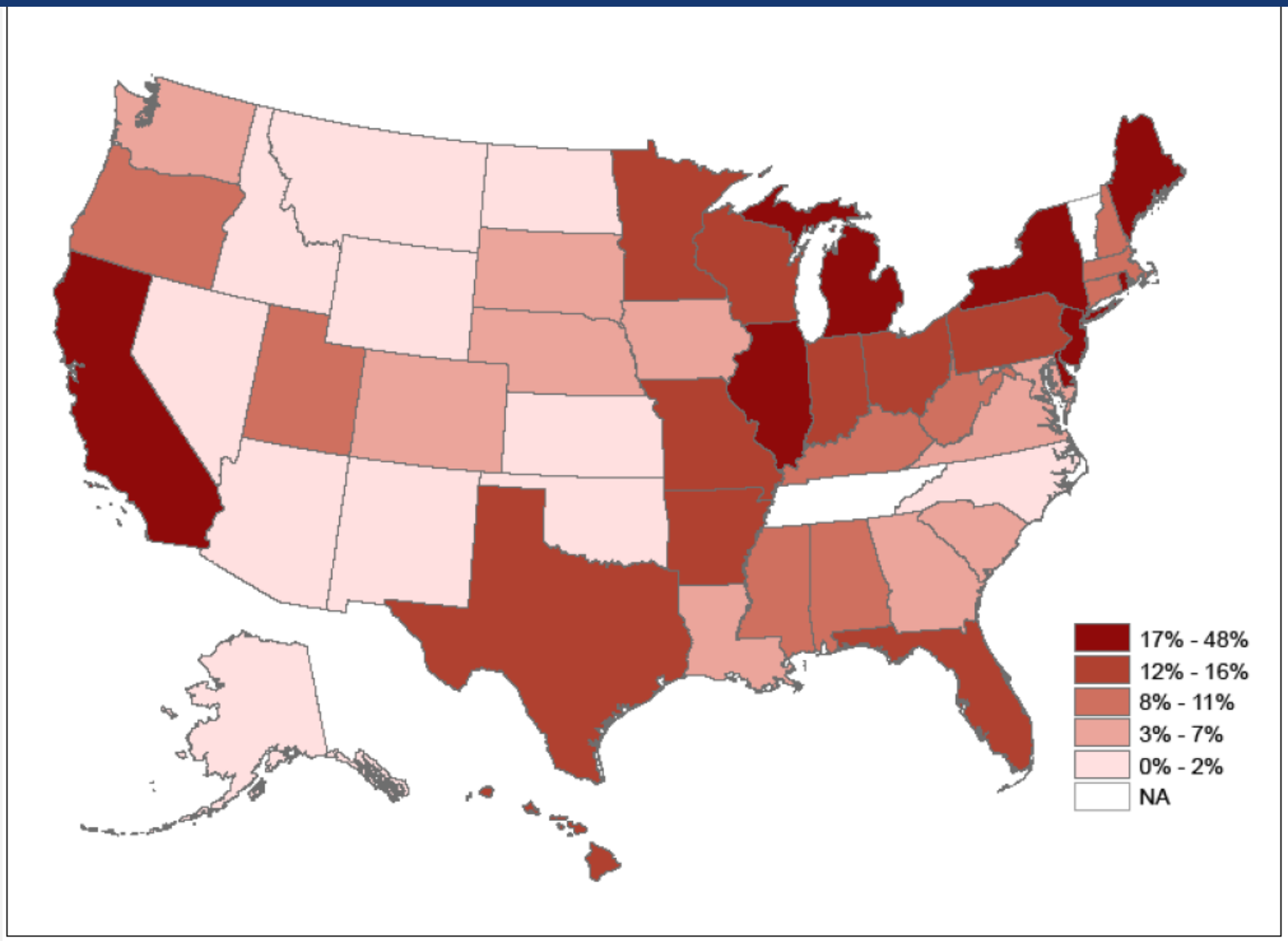
Medicaid

	HOUSE	SENATE
Medicaid	Phased increases Primary Care payments to 100% of Medicare by 2012 to 150% FPL	Expands to 133% of FPL

Blend

- Increased Medicaid payment rates to be equivalent with Medicare for primary care
- Covered more people in many states
- Lots of experimentation with Medicaid waivers

Estimated FP increased income from House Medicaid Adjustment



Incentives and Misvalued Medicare payments

	HOUSE 3926	**SENATE 3590**
Primary Care Bonus	5% primary care bonus - must furnish >50% of care in select codes - 10% bonus if located in a HPSA	10% primary care and general surgery bonus - must furnish 60% of care in select codes - 50% of cost offset through cuts in other codes
Misvalued Codes	Secretary shall identify misvalued codes, make appropriate adjustments, and establish a process to validate RVUs	Secretary periodically required to identify misvalued codes and make appropriate adjustments

Blend

Primary Care Incentive Payments

$660 million paid out in the first year

Data, Statistics & Tools

Publications & Products

Research Findings & Reports

- EPC Evidence-based Reports
- Fact Sheets
  - Aging
  - Children's Health
  - Computers and Medical Informatics
  - Coronary Artery Disease
  - Diabetes

IMPaCT (Infrastructure for Maintaining Primary Care Transformation)

Award Recipients

AHRQ has awarded four cooperative grants to support model State-level initiatives using primary care extension agents in small and mid-sized independent primary care practices to assist with primary care redesign.

AHRQ has awarded four cooperative grants for "Infrastructure for Maintaining Primary Care Transformation (IMPaC —Support for Models of Multi-Sector, State-Level Excellence." These grants support model State-level initiatives using primary care extension agents in small and mid-sized independent primary care practices to assist with primary care redesign and transformation.

The IMPaCT grant recipients, announced in September 2011, are four established programs that will serve as model

Strong Evidence for the Value of Weakly Supported Primary Care

- Ecologic evidence about costs, utilization, mortality
  - Starfield & Shi, Franks & Fiscella, Baiker & Chandra, Chang & Goodman, Kronick
- Claims-based evidence
  - Phillips & Dodoo, Chang & Goodman

Dartmouth (Chang, Goodman)

- A higher level of primary care physician workforce, particularly with an FTE measure that may more accurately reflect ambulatory primary care, was generally associated with favorable patient outcomes.
  - Lower Acute Care Sensitive Hospitalizations
  - Lower Mortality
  - Consistent with many similar studies by Shi, Starfield, Franks, Fiscella, etc.
    - Chang et al, JAMA. 2011;305(20):2096-2105

Ecologic Evidence for Cancer

- For Cervical Cancer, in Florida, found that PC ↑ 1/10,000 yielded:
  - incidence rate ↓1.5 cases/100,000 persons
  - mortality rate ↓0.65 cases/100,000 persons
- For Colorectal Cancer, in Florida, each 1% increase in the proportion of county physicians who were primary care yielded:
  - incidence rate ↓0.25 cases/100,000 persons
  - mortality rate ↓0.08 cases/100,000 persons

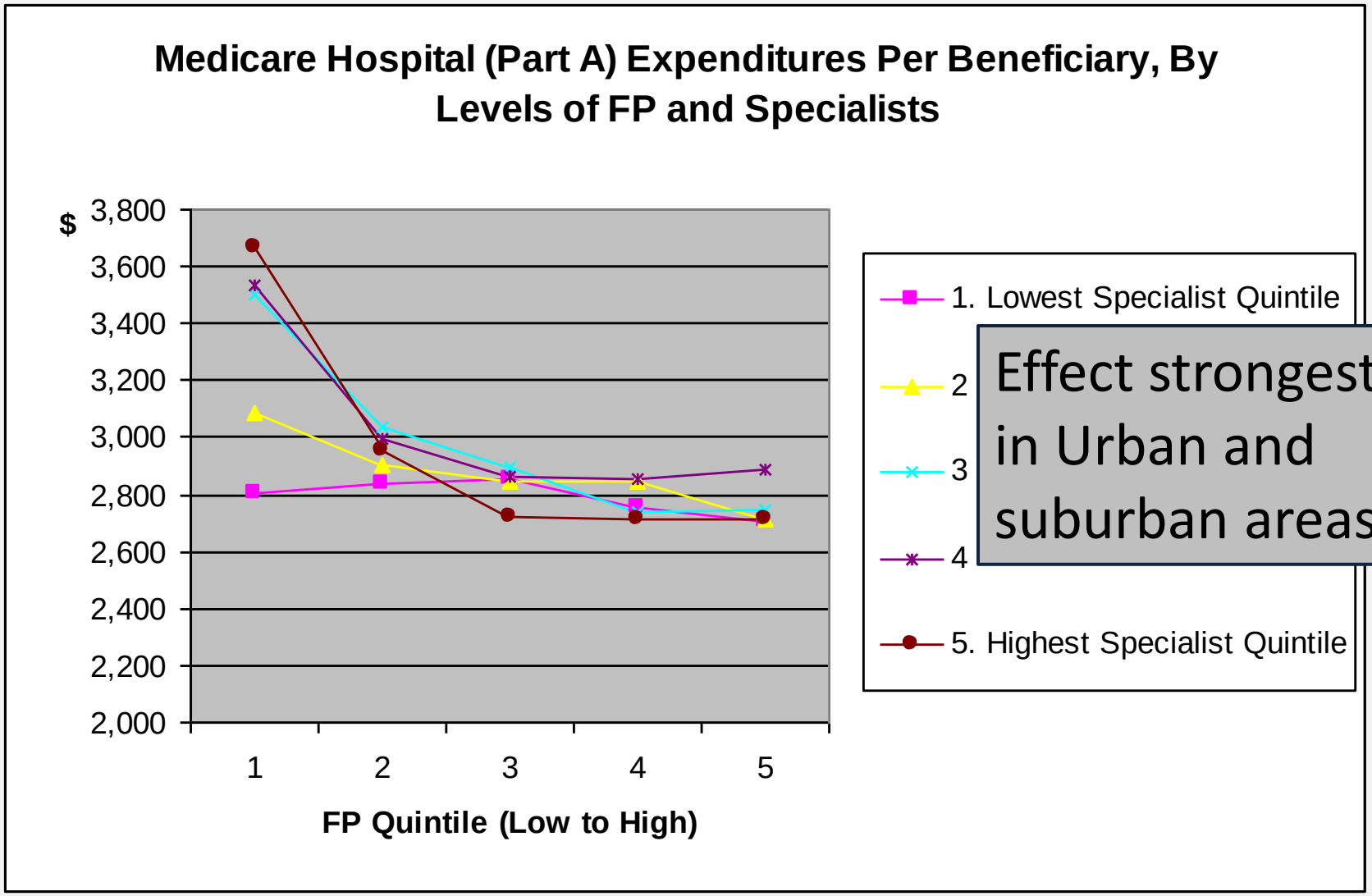
Campbell RJ. Ramirez AM. Perez K. Roetzheim RG. Cervical cancer rates and the supply of primary care physicians in Florida. Family Medicine. 2003;35(1):60-4.
Roetzheim RG. Gonzalez EC. Ramirez A. Campbell R. van Durme DJ. Primary care physician supply and colorectal cancer. Journal of Family Practice. 50(12):1027-31, 2001 Dec.

In regression analyses that adjust for sociodemographic characteristics at the county level, each one-third increase in the supply of family physicians decreases the incidence of invasive cervical cancer by 10%, and the mortality from cervical cancer by 20%.

There is no effect of non primary care physicians.

Sources: Campbell et al, Fam Med 2003; 35:60-4.

Family Medicine and Medicare costs



Primary Care protects

Table 1. Recommended intervals for repeat colonoscopy based on colonoscopic findings

Finding	1997 recommendations	2003 recommendations[24]	2006 recommendations[25]
Normal	10 years	10 years	10 years
Hyperplastic polyps	N.R.	N.R.	10 years
1–2 small (<1 cm) tubular adenoma	N.R.[a]	5 years[b]	5–10 years
3–10 adenomas or any adenoma ≥1 cm or high grade dysplasia	3 years[a]	3 years	3 years
>10 adenomas on one examination	N.R.[c]	N.R.[c]	<3 years
Adenomas that are removed piecemeal	N.R.	N.R.	2–6 months
Family history of colon cancer[d]	5 years	5 years	5 years

Table 4. Percentage of patients with repeat colonoscopy intervals consistent with contemporaneous guidelines[a]

	Referent guideline[b]		
Finding[c]	1997 guideline[23] (n=113)	2003 guideline[24] (n=328)	2006 guideline[25] (n=74)
Total consistent with guideline	43.4	38.1	37.8

Applied to the US population:

- **2.85 million excess colonoscopies over 10 years**
- **2561 perforations,**
- **5692 major hemorrhages,**
- **14,229 serious complications,**
- **$3.4 billion in direct costs,**
- **approximately 142 deaths**

Krist AH, Jones RM, Woolf SH, et al. Timing of Repeat Colonoscopy: Disparity Between Guidelines and Endoscopists' Recommendation. *American Journal of Preventive Medicine.* 12// 2007;33(6):471-478.

What will Transformed Primary Care do for Cancer?

- Increase access for newly insured (prevent and find cancers for pre-Medicare)
- Bring more resources to bear in primary care
  - Increase complexity of services where patients are
  - Increase prevention counseling and access (population health focus)
- Better coordination during and after cancer treatment
- Protect people from overzealous screening and treatment