SJR 35: Health Care

Primary Care Issues and Health Care Reform

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for the Children, Families, Health, and Human Services Interim Committee
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<u>*Background*</u>

After Massachusetts required all residents to obtain health insurance by mid-2007, many newly insured patients still used hospital emergency rooms for routine care – some out of habit and some because they couldn't find a primary care doctor or arrange a timely visit.[1] A Harvard Medical School professor told the U.S. Senate Finance Committee earlier this year that the state's experience provides a timely lesson for national health care reform efforts.

"The take home message from the data: health reform in the absence of strengthening the primary care base is not likely to succeed," Dr. Allan H. Goroll told committee members.[2]

If approved, congressional reforms could extend health insurance to many of the country's 46 million currently uninsured residents. As a result, they may be seeking medical care at the same time that the number of primary care physicians is declining nationwide.

<u>*Primary Care: What Is It and Why Is It Important?*</u>

Primary care is medical care that provides people with:

- a first contact for any new health care problem or need;
- continuity of care over time;
- comprehensive care; and
- coordination of care when a patient has more than one health care provider.

Typically, family physicians, general internal medicine practitioners, general practitioners, and pediatricians provide this type of care to patients. Some physician assistants and advanced practice registered nurses also work in the primary care field.

The current debate over how best to reform the health care system has focused attention on the value of primary care.

"When people have access to primary care, health care costs are lower, health status is better, and health disparities are fewer," Goroll noted in his testimony to the Senate Finance Committee.

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[1] Kay Lazar, "Costly ER still draws many now insured," *The Boston Globe*, Oct. 6, 2008.

[2] "Workforce Issues in Health Care Reform," testimony to the U.S. Senate Finance Committee from Allan H. Goroll, professor of medicine at Harvard Medical School and physician with the Massachusetts General Hospital, March 12, 2009, P. 1.

Yet numerous studies have concluded that many areas of the country already lack an adequate number of primary care providers, particularly rural and sparsely populated areas. Studies also have shown that the number of medical students planning to enter primary care practice is too low to meet the current need, let alone any increased need that may occur if universal health insurance coverage is enacted.

In Montana, about 150,000 people may gain insurance if federal health care reforms go into effect. Yet many counties in the state already face a shortage of primary care providers. In fact, Montana is a prime example of the type of area that has trouble attracting and retaining primary care physicians.

According to the Department of Public Health and Human Services, all or parts of 55 of Montana's 56 counties are considered health professional shortage areas (HSPAs) for primary care.[3] These counties don't have enough providers for either the entire county or for the areas within the county that are designated as HPSAs. The designation can apply to a geographic area, a specific group of people, or a facility. Only Beaverhead County is without a HPSA designation of some type.

The Problem of Pay

Studies consistently point to the lower earnings potential for primary care physicians as a key reason for the decreasing numbers of medical students interested in primary care.

Medical students often rack up sizable debts before they enter practice, making higher-paying specialty fields more attractive. The Association of American Medical Colleges estimates that 86% of graduating medical students have educational debt; total loans average $145,000 for public school students and $180,000 for private school students.[4]

The current fee-for-service system used for Medicare reimbursements is often cited as the driving factor in the discrepancies in physician pay. The system not only sets the payments that doctors receive for seeing Medicare patients, but also is generally used as a basis for setting reimbursement rates paid by Medicaid and private insurance companies.

The Medicare reimbursement system uses the Resource-Based Relative Value Scale (RBRVS), which measures the costs required to provide each medical service and then ranks a each service relative to all other services. The costs are expressed in Relative Value Units (RVUs) to indicate:

- the amount of physician work that goes into providing the service;
- the costs the physician incurs, in overhead and other expenses, in providing the service; and
- the liability insurance costs of providing the service.

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[3] "Montana Shortage Designations," *Department of Public Health and Human Services*, January 2009.

[4] "Solutions to the Challenges Facing Primary Care Medicine," Policy Monograph, *American College of Physicians*, 2009, P. 10.

The RVUs are then adjusted to reflect geographical costs differences and are multiplied by a "conversion factor," or dollar multiplier, to come up with the dollar amount that a doctor will be paid for a specific service.

The system is designed to take into account the complexity of various medical procedures. But critics say it fails to factor in the time required for a primary care physician to evaluate and manage a patient's overall health – particularly for patients with chronic conditions. They say it also provides an incentive for physicians to perform more medical procedures, rather than spend time managing care, because they are paid for each procedure.

"Because primary care doctors spend relatively less time doing procedures, this reimbursement system results in a wide income disparity" between primary care doctors and specialists, The Kaiser Family Foundation maintains.[5]

And a 2009 report by the American College of Physicians pointedly stated: "The physician payment system today places more value on the volume of services than on the preventive care and coordination of care that can lead to better outcomes. For example, Medicare will pay $30,000 on average under Medicare Part A for a limb amputation for a diabetic patient but pay very little to the primary care physicians for helping their diabetic patients avoid the medical complications that lead to amputation."[6]

More Than Money: Educational and Livability Issues

A medical student who does choose to enter the primary care field is more likely to end up practicing in a metropolitan area than in a rural area such as Montana. Studies note that doctors tend to go into practice in the geographic area where they completed their medical residency program, and most programs are located in urban areas.

Dr. Fitzhugh Mullan of The George Washington University told the Senate Finance Committee that residency programs "serve as the final pathway into practice" and essentially determine the size and makeup of the physician workforce.[7]

In addition, metropolitan areas usually offer more employment opportunities for a spouse, as well as a greater ability to interact with other physicians and greater access to other amenities.

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[5] "Primary Care Shortage," *The Kaiser Family Foundation* [online], available at http:kaiseredu.org/topics_im.asp?id=1032&imID=1&parentID=70, accessed Aug. 21, 2009.

[6] "Solutions to the Challenges Facing Primary Care Medicine," Policy Monograph, *American College of Physicians,* 2009, P. 9.

[7] "Workforce Issues in Health Care Reform: Assessing the Present and Preparing for the Future," testimony to the U.S. Senate Finance Committee from Dr. Fitzhugh Mullan of The George Washington University, March 12, 2009, P. 4.

Turning the Trend Around
Suggestions abound for ways to reverse the declining interest in primary care medicine. Some ideas that consistently arise in studies and in testimony to Congress include:

- changing the RVRBS fee-for-service reimbursement system or giving greater weight to primary care within that system;
- changing the federal requirements for residency slots so that graduate medical students can more easily gain experience in rural areas and in primary care;
- providing more incentives for medical students to choose primary care, including more loan repayment opportunities;
- putting more state funds into programs that provide medical education opportunities, and requiring students to return to their home states to practice for a period of time; and
- creating networks to link doctors in rural areas so they can interact with colleagues.

Some of these ideas have made their way into the health care reform legislation being readied in Washington, while others are topics for consideration by state policymakers.

Primary Care Education and Practice in Montana
Montana students aspiring to become doctors can participate in the WWAMI program, which trains medical students from several Northwestern states at the University of Washington. The program allows up to 20 Montana students into the program each year. It's designed to encourage graduates to choose careers in primary care medicine and to practice in non-urban areas in the Northwest.[8]

In addition, Montana has one residency program that focuses on primary care and is open to six medical students each year. The Family Medicine Residency Program, based in Billings, was established in 1995 and is affiliated with the University of Washington. Residents do rotations throughout the state to gain experience in rural settings.[9]

Despite these programs, Montana still faces shortages of primary care physicians. A study by the Office of Rural Health at Montana State University shows that 33 of Montana's 56 counties have a lower ratio of primary care physicians to the patient population than the

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[8] "WWAMI Medical Education Program," *Montana State University* [online], available at http:www.montana.edu/wwami, accessed Sept. 4, 2009.

[9] Montana Family Medicine Residency Web site, [online] available at http://www.mfmr.org/programs.html, accessed Aug. 4, 2009.

national average of one physician for every 1,160 residents.[10] Twelve counties have no primary care physicians, while nine have no physician at all.[11] Overall, 862 of the state's 2,139 licensed physicians are primary care physicians.[12]

Physician assistants (PAs) and some advanced practice registered nurses (APRNs) also may provide primary care. It's difficult to specify which of the 326 PAs licensed in Montana are providing primary care, because some may be working for specialists. However, pinpointing which of the 722 licensed APRNs provide primary care is a little easier because nurse practitioners and nurse midwives are most likely to provide that type of care. Montana has 411 licensed nurse practitioners and 41 nurse midwives.[13]

Under Montana law and administrative rule, PAs and APRNs may perform many of the same tasks as physicians. In general, however, PAs have a greater degree of physician supervision, while APRNs may operate more independently. Under 37-20-301, MCA, a physician must supervise a PA, through a written supervision agreement. The physician retains professional and legal responsibility for the patients who are under the PA's care. In addition, the physician and PA must have a written "duties and delegation agreement" that outlines the duties that the PA is authorized to perform.

The table on P. 6 summarizes some of the key educational and scope-of-practice provisions established for these two types of providers under state law and regulations.

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[10] Saul M. J. Rivard, "Montana's Primary Care Workforce," *Montana State University Office of Rural Health/Area Health Education Center*, August 2009, P. 3.

[11] Ibid, P. 2.

[12] Ibid, P. 6.

[13] Ibid, P. 10.

PROVISIONS GOVERNING PAs AND APRNs

	Physician Assistants	APRNs
Educational Requirements	Completion of an accredited PA training program; passage of national PA exam; continued certification by national board	Master's degree in nursing; passage of exam offered by appropriate national certifying body; 40 hours of continuing education every 2 years
Licensure	Board of Medical Examiners	Board of Nursing
Supervision	By physician, as set out in supervision agreement and described in duties and delegation agreement; supervision may be direct, on-site, or general	Not required
Practice Areas	As authorized in duties and delegation agreement. Is considered an agent of supervising physician with regard to all delegated duties	Assess health status; make medical and nursing diagnoses; receive and interpret test results; order treatments; provide health instruction and counseling; provide pre-natal and newborn care (nurse midwives)
Prescribing Authority	If authorized in duties and delegation agreement	If authorized by Board of Nursing following completion of a graduate-level course in pharmacology and clinical management of drug therapy

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