Health Security Plan Design Presentation to LHHS Committee
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Comments on Physician Payment
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Topic: Primary care faces challenges that impact patient care and are required for payment

Primary care should be first and last in any health system.

In my view as a long-term family physician, primary care should be the first consideration in any health system. Studies from around the world for decades have shown that a model known as the patient-centered medical home (doctors, nurse practitioners, physician assistants, nurses, counselors and pharmacists working together as a team for patient-centered care) are the foundation of high functioning, lower cost care.

Patients benefit in a multitude of ways. Specialists and hospital systems would benefit by elevating their support for high value primary care. Primary care clinicians provide compassionate person-centered care for most medical issues, and refer patients for testing, evaluation and hospitalization in the most efficient manner. We make choices for the best benefit of the patient.

But there are things standing in our way that could be improved and would lead to higher quality, lower cost, efficient care. We focus here on clinician payment. There are also many other things that need to be improved to support primary care all the way through, first to last.

Administrative challenges by category

1. Ordering: a daily necessity that causes headaches.

a. The process known as prior authorization is required in many cases for imaging, medications and out of network referrals. We appreciate recent legislation that has tried to streamline this process with a uniform PA (prior authorization) pathway but it still requires extra administrative time and delays for the patient.

b. Medication formulary changes made regularly by each insurance company for what medications they will cover disrupt the patient's access to the medications that they have used but are no longer on the list. This requires extra time and frustrating effort for both the clinician and the pharmacist to find what is covered, again delaying patient access to proper treatment.

2. The current electronic medical records system: a highly useful, powerful tool, but unnecessarily complex.

a. EMR updates are provided at intervals by vendors. They are quite expensive and disruptive (and are often about appearance rather than substance and function). We need to be sure substantial improvements are the norm.

b. EMR internal alerts during many parts of office visits are frequent, often redundant, lead to alert fatigue, and are sometimes inappropriate. This can be improved.

c. EMR training for clinicians on updates is often inadequate; it must be timely, and in person

d. Information exchange between health care systems (interoperability) is developing at a snail's pace. It needs to be seamless and formatted uniformly.

3. Coding: an every-visit necessity, but some interference is involved. Coding surveillance by coders (people who are internal to health systems with limited or no medical background except training in coding) review our diagnosis and documentation to support higher billing (a form of "up-coding"). But this seldom adds more to the clinical picture and is confusing because it is redundant. It is often used in Medicare Advantage billing, which is entirely legal but of low clinical value for the patient's care. This can be improved.

4. Quality reporting for each insurer, public or private: requirements are too numerous, with moving goal posts, and are often not outcomes-

based. This actually may interfere with good care: checking off boxes while failing to value the time required to educate and to build trust with the patient. We need to make this uniform and outcomes-based.

5. Internal governance within health systems should be improved. There is often low clinician input into administrative decisions and strategy, and a lack of compensation for their participation in these efforts.

6. Challenges from the patient's viewpoint that impact their ability to access high quality affordable care. These are:

a. cost of insurance: premiums, out of pocket costs;

b. insurance verification at the time of service in our clinics;

c. surprise billing issues;

d. timely access to care (for new patients, for post-hospital follow up office visits, access to specialty care, especially behavioral health);

e. fluctuating support for the primary care patient-centered medical home model (we need the right amount of RNs, counselors, etc.);

f. reduction in rural services incrementally over years (for example, in my rural town, urgent care on weekends was closed over 10 years ago; narcotics and sedatives in weekday urgent care are not allowed; casting of broken bones not allowed; many lab services we once had aren't available except by courier to Albuquerque; and most recently, mobile mammography gone);

g. lack of community health/public health attention and investment We need to integrate and collaborate with public health workers within our clinics, and pay clinicians for this work.

Studies suggest that up to 40% of a clinician's time is spent on administrative work. I estimate half of that time could be saved through efficiencies and devoted to direct patient care.

Physician supply is a pressing issue; removing administrative obstacles to good patient care would make the profession more attractive to aspiring students.

Closing remarks: We have a non-system, a patchwork tied loosely together, with perverse incentives at all levels, not the least of which is payment. We must design a real working system that aligns payment with the desired outcomes for all components, which is a complex undertaking.

The NM Office of the Superintendent of Insurance is responsible for working on the actual design of such a model, the Health Security for New Mexicans plan. There is much more work to be done to figure out the solutions. This design process needs to be supported. The work is doable, and it is imperative we do it right for the good of our patients.