

**Improving Health Care Access for Older Alaskans:
What Are the Options?**

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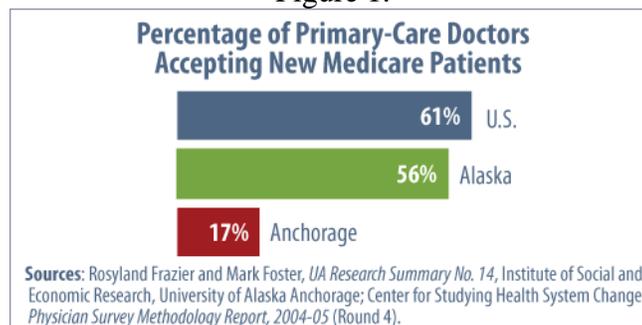
Introduction

This report focuses on the problem older Alaskans who rely on Medicare face getting access to primary care, and discusses some of the options policymakers are considering to resolve the problem. But older Americans across the country also report difficulty getting the primary care they need. The discussion here sheds light on the problem and potential solutions nationwide.

Most Americans 65 and older use Medicare as their primary health insurance. Medicare is federal health insurance for people 65 and older, people under 65 with certain disabilities, and people of any age with end-stage renal disease—but this report looks only at access issues for Medicare beneficiaries 65 and older.

Doctors don't have to participate in the Medicare program. But those who do participate have to accept, as full payment, what Medicare pays for specific services. Many primary-care doctors say Medicare doesn't pay them enough to cover their costs—so growing numbers are declining to see new Medicare patients. Among primary-care doctors nationwide, 61% accept new Medicare patients.¹ National surveys sponsored by the Medicare Payment Advisory Commission have found that 17% of Medicare patients in the U.S. had “a big problem” finding family doctors in 2007—up from 13% in 2005.² In Alaska, a 2008 survey by the Institute of Social and Economic Research (ISER) found that just over half of Alaska's primary-care doctors were willing to treat new Medicare patients.³ The situation was worse in Anchorage, where 40% of all older Alaskans live. Only 17% of primary-care doctors in Anchorage were willing to treat new Medicare patients as of 2008 (Figure 1).⁴

Figure 1.



¹ Center for Studying Health System Change, *Physician Survey Methodology Report, 2004-05 (Round 4)*.

² Medicare Payment Advisory Commission, *Healthcare Spending and the Medicare Program*, June 2009.

³ Rosylard Frazier and Mark Foster, “How Hard Is It for Alaska's Medicare Patients to Find Family Doctors?” *UA Research Summary No. 14*, ISER, University of Alaska Anchorage, March 2009.

⁴ The survey defined primary-care doctors as those practicing general, family, or internal medicine. It excluded pediatricians and obstetrician gynecologists because they don't routinely see older patients. It also excluded those employed by government entities and others who aren't available to see the general population of Medicare patients.

Scope of Report

The first sections of this report set the stage for discussions about potential options for improving access to primary care for older Medicare patients. We start out by reviewing history and aspects of the Medicare program related to participation by primary-care doctors and payment for primary-care services. We then describe what has caused many primary-care doctors in Alaska and nationwide to limit the number of Medicare patients they see, or to stop accepting Medicare payments altogether. After that, we take a closer look at older Alaskans in Anchorage, discussing how limited access to primary-care doctors is affecting them, what other health insurance options they have, and where they are going for primary care.

We then turn to some of the options policymakers are considering to help older Americans who use Medicare—in Alaska and elsewhere—get better access to primary care. These options are not mutually exclusive; they could be implemented in various combinations. We don't endorse any specific option, and this is not a comprehensive discussion. But we hope it helps readers better understand the implications of options being considered.

Policy options we discuss are grouped into two categories: service delivery options—clinic models for delivering primary-care; and payment-for-service options—changes in the payment methods or amounts providers are paid for primary-care services.

Service Delivery Options

- Expanding the capacity of community health centers, so they can see more patients, including older patients.
- Testing a new clinic model. In Anchorage, a nonprofit organization established by a group of physicians and hospitals plans to open a clinic solely for Medicare patients. Organizers say they have so far not been able to identify any other such Medicare-only clinic in the country.
- Establishing a new patient-centered medical home for Alaskans 55 and older. The 2010 federal health-care reform legislation includes provisions for testing demonstration projects of a medical model called the patient-centered medical home, which is intended to provide comprehensive primary care and to take into account and pay for all the kinds of work involved in providing primary care. The standard Medicare payment system pays only for medical services, not related tasks like taking patients' phone calls. In Anchorage, Providence Alaska Medical Center plans to open a senior-care clinic for

patients 55 and older, using the patient-center medical home model. Southcentral Foundation, a tribal health organization serving Alaska Natives (Eskimos, Aleuts, and Indians), has for a decade used use a similar model at its Anchorage clinic; that clinic has been nationally recognized for improving primary care.⁵

Payment-for-Service Options

- Providing financial incentives—like state-funded bonuses or grants—to providers who see older patients.
- Looking at “balanced billing”—that is, allowing doctors to charge patients the full difference between what Medicare pays and what the doctor charges.
- Considering an all-payer system, under which all forms of insurance (public and private) would pay the same amount for the same service, thus eliminating providers’ incentives to choose one payer over another.

All these options could, in one way or another, help ease the primary-care access problem for older patients; all have strengths and weaknesses. Proposed use of additional financial incentives for providers would have to be carefully structured to comply with federal Medicare rules about payments for providers. Other options—the medical home model and an all-payer system—would be major, long-term shifts in the health-care delivery and payment systems.

How Medicare Works

Medicare Coverage

Medicare is the federal health-insurance program that covers most Americans 65 and older, as well as those under 65 with certain disabilities and people of any age with end-stage renal disease (permanent kidney failure requiring dialysis or a transplant).⁶ Congress created the Medicare program in 1965 to ensure that all older Americans could get health care. At that time, only about half of those over 65 had any kind of health insurance. They were the most likely among all Americans to be poor; almost a third lived below the poverty line.⁷

⁵ Alaska Area Office of Indian Health Service web site: <http://www.ihs.gov/facilitieservices/areaoffices/alaska/>

⁶ Medicare.gov, the official U.S. government site for Medicare <http://www.medicare.gov/navigation/medicare-basics/medicare-basics-overview.aspx>, accessed June 5, 2010.

⁷ “Key Milestones in Medicare and Medicaid History, Selected Years, 1965-2003,” in *Health Care Financing Review*, Winter 2005-2006, Volume 27, Number 2; U.S. Bureau of the Census, Current Population Survey.

Medicare now covers about 47 million Americans, or 15% of the U.S. population.⁸ In Alaska, that proportion is only about half—around 57,000 residents, or 8% of the state population.⁹ Even though the number of older Alaskans has been growing fast in recent decades, the percentage of Alaskans 65 or older was so small to begin with—just over 2% in 1960—that it still falls well short of the national average.¹⁰ About 7% of Alaskans are now 65 or older, compared with close to 13% nationwide.¹¹

Historically, many older people left Alaska when they retired; in recent times, however, more have been staying on, and some older people have been moving to Alaska.¹² The Alaska Department of Labor projects that the number of Alaskans 65 and older will nearly double by 2020.¹³

Most Medicare enrollees in Alaska and nationwide are 65 or older. About 21% of Alaska’s 57,000 Medicare enrollees are under 65, compared with about 16% nationally (Table 1.)

Table 1. Distribution of Medicare Enrollees by Age, Alaska (2007-2008), U.S. (2008)

	Elderly 65+	Adults 19 to 64
United States	82.0%	16.4%
Alaska	76.9%	21.5%

Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured; estimates based on the U.S. Census Bureau’s March 2008 and 2009 Current Population Survey (CPS: Annual Social and Economic Supplements); accessed at Kaiser Family Foundation Statehealthfacts.org

Working people pay taxes—Federal Insurance Contributions Act (FICA) taxes—to qualify for Medicare coverage when they are older.¹⁴ Federal law requires employers to withhold part of their employees’ wages and match the amount withheld. Employers send these taxes to the Internal Revenue Service, where they are placed in a government trust fund for the employees’ pension and health insurance—Social Security and Medicare—after they retire.

⁸ Henry J. Kaiser Family Foundation, *Medicare: A Primer*. April 2010.

⁹ Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau’s March 2008 and 2009 Current Population Survey (CPS: Annual Social and Economic Supplements); accessed at Kaiser Family Foundation Statehealthfacts.org (<http://www.statehealthfacts.org/comparebar.jsp?ind=294&cat=6>)

¹⁰ U.S. Bureau of the Census, 1960 census.

¹¹ U.S. Bureau of the Census, Quick Facts (<http://quickfacts.census.gov/qfd/states/02000.html>).

¹² U.S. Bureau of the Census, 2000 census.

¹³ Alaska Department of Labor and Workforce Development, 2007 population projections.

¹⁴ <http://www.socialsecurity.gov/glossary.htm> and <http://www.wisegeek.com/what-is-fica.htm>

People who have paid sufficient Medicare payroll taxes—typically for 40 quarters—are eligible for Medicare coverage when they reach 65. Generally, if you or your spouse have worked for at least 10 years in Medicare-covered employment and you are 65 years or older and a citizen or permanent resident of the United States, you are eligible. But payroll taxes currently finance only about 40% of Medicare costs; general revenues finance almost as much (39%), and premiums paid by beneficiaries another 12%.¹⁵

Medicare has four parts: A, B, C, and D. Part A is hospital insurance that helps pay for inpatient hospital services, skilled nursing facilities, hospice, and home health care. Part B is medical insurance. It covers doctors' services and outpatient care and some preventive services. Part C is Medicare Advantage; under this program, Medicare beneficiaries enroll in health maintenance organizations (HMOs) or Preferred Provider Organizations (PPOs) and thus become members of private health plans approved by Medicare administrators. Medicare pays these plans a set monthly amount for each Medicare beneficiary; the plans offer members Parts A and B services and usually other coverage, including coverage for prescription medicine. Part D helps cover the cost of prescription drugs.¹⁶

This report focuses on issues surrounding Medicare Part B—medical insurance. As with private health insurance programs, beneficiaries pay deductibles and co-insurance. In 2010, the annual deductible was \$155. Beneficiaries also pay 20% of the Medicare-approved amount for all services covered by Part B, except for most laboratory services, which are covered at 100%.¹⁷

¹⁵ *New York Times*, Health Topics: Medicare; updated September 25, 2009; available at: <http://topics.nytimes.com/top/news/health/diseasesconditionsandhealthtopics/medicare/index.html?inline=nyt-classifier>

¹⁶ Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, *Medicare and You* 2009, page 12.

¹⁷ Current figures on premiums, deductibles, and co-pays are available on the federal Medicare Web site, Medicare premiums and coinsurance rates for 2010, published 10/15/2009, updated 4/12/2010 http://questions.medicare.gov/app/answers/detail/a_id/2260/sesseion/L3NpZC9WLWhXYVIzaw%3D%3D

Evolution of Payment Systems for Medicare Services

When Medicare started in 1965, doctors were paid based on their charges. They were allowed to bill Medicare patients the difference between the Medicare payment and their standard charges. But by the mid-1970s, Congress called for development of a system that would limit the annual increases in doctor fees to the increase in costs of practice and earnings. In 1975, the Medicare Economic Index (MEI) was designed to measure changes in the costs of doctors' time and operating expenses and to limit annual increases in Medicare payments for doctors. The MEI was to be adjusted based on doctors' productivity.¹⁸

From 1984 to 1991, Medicare payments for doctors grew faster than projected, so the annual adjustment in fees was determined by Congressional legislation. The 1989 Omnibus Budget Reconciliation Act made changes in payments for doctors, establishing the Medicare Fee Schedule (MFS), effective in 1992. The MFS assigned relative value units (RVUs) for each service type, from the resource-based relative value scale (RBRVS).

The Medicare payment for provider services was a product of the RVU for the service, a geographic adjustment factor (GAF) for the geographic variation in payments, and a global conversion factor (CF) that converts RBRVS units to dollars. The act also ended the policy of letting doctors "balance bill" Medicare patients—meaning it no longer allowed doctors to bill Medicare patients for the difference between the Medicare payment and the doctor's standard charges, as they had previously been able to do.¹⁹ This legislation also initiated the Medicare Volume Performance Standards (MVPS) as a way to control costs.²⁰

From 1992 to 1997, changes in Medicare doctors' payments were adjusted using the MEI and MVPS. This process was an attempt to compensate for the increased number of services doctors were billing for, by reducing payments for services.

In 1997, Congress adopted a formula—the Sustainable Growth Rate (SGR)—tying growth in Medicare spending for doctors to growth in the U.S. economy. It's a complicated formula, taking into account growth in the number of Medicare enrollees and other factors driving spending for doctors. In general, if spending for doctors grows too fast relative to growth in the gross

¹⁸ David O. Barbe, MD, Chair Report of the Council on Medical Service, CMS Report – 6-I-08, American Medical Association.

¹⁹ See more discussion of balance billing on pages 42 and 43 of this report.

²⁰ Lauren A. McCormick, Russel T. Burge. [Diffusion of Medicare's RBRVS and related physician payment policies - resource-based relative value scale - Medicare Payment Systems: Moving Toward the Future *Health Care Financing Review*](#). Winter, 1994, Vo. 16, Issue 2, pages 159- 173.

domestic product, then the formula calls for cuts in Medicare payments for doctors.²¹ The SGR sets yearly and cumulative Medicare spending targets.

When the actual spending for a given year exceeds the spending target for that year, the Medicare payments are reduced by decreasing the conversion factor for the RBRVS relative value units (resulting in a decrease in the Medicare spending for doctors' payments).²²

Since 2002, actual Medicare spending has exceeded the SGR target spending projections. In 2002, Medicare payments were decreased by 4.8%. In 2003, a 4.4% reduction in payment was scheduled, but Congress increased the cumulative SGR target in the Consolidated Appropriation Resolution of 2003 (P.L. 108.7), which allowed payments to doctors to increase 1.6%. In 2004 and 2005, another reduction was scheduled. The Medicare Modernization Act (P.L. 108-173) increased Medicare payments by 1.5% for those two years.

In 2006 Congress again overrode a scheduled 4.4% reduction in payments, through the Deficit Reduction Act (P.L. 109-362), and held Medicare doctor payments in 2006 to the 2005 levels. Similarly, Congressional legislation in 2007 held payments to 2006 levels, and H.R. 6331 held 2008 doctor payments to 2007 levels. That legislation also provided a 1.1% increase in 2009.²³

Most recently, at the start of 2010, the SGR formula called for a cut of 21% in Medicare payments for doctors. As of June, Congress had delayed the cuts until November 2010. Many observers believe Congress is unlikely to approve any large cuts in payments to doctors—but it's not clear right now how the issue will be resolved. For the most current information on Medicare reimbursement rates, please see: http://www.cms.gov/PhysicianFeeSched/01_overview.asp

Medicare Fee Schedule

Payments for Doctors

The Centers for Medicare and Medicaid Services (CMS), a component of the federal Department of Health and Human Services (HHS), administers Medicare. CMS calculates Medicare payments for doctors under a formula that takes into account geographic differences in costs around the country. Alaska's doctors have historically been paid more than the U.S. average for seeing Medicare patients.

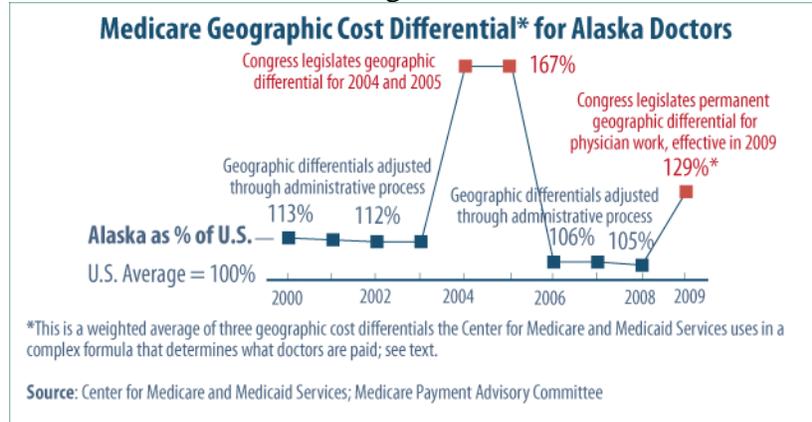
²¹ Paul B. Ginsburg, "Bitter Medicine: Prescription to Fix SGR Requires a Commitment to Major Medicare Reform," *Health Affairs* Blog, February 12, 2008. Available at: <http://healthaffairs.org/blog>.

²² MedPAC Payment Basics, Physician Services, October 2009: http://www.medpac.gov/documents/MedPAC_Payment_Basics_09_Physician.pdf

²³ [Medicare's Physician Payment Rates and the Sustainable Growth Rate](#).(PDF) *CBO TESTIMONY Statement of Donald B. Marron, Acting Director*. July 25, 2006

The CMS formula includes three geographic differentials: one for “physician work,” another for doctors’ costs of operating practices, and a third for doctors’ costs of carrying liability insurance. Figure 2 shows the changing geographic cost differential for Alaska doctors since 2000. The Alaska cost differential is a weighted average of the three geographic cost differentials CMS uses in its formula to calculate doctors’ payments. From 2000 to 2003, the geographic differential for Alaska doctors was about 12% above the U.S. average. That differential was set by CMS’s administrative process. In 2004 and 2005, the differential for Alaska doctors increased to 67% above the U.S. average under a temporary Congressional change in legislation. After that legislation expired, the Medicare differential dropped sharply, to about 5% above the U.S. average from 2006 to 2008. In 2008, Congress permanently set the Alaska geographic differential for “physician work” at 50% above the U.S. average or 135% for Alaska doctors, effective in 2009. When combined with the other two differentials set by CMS—one for doctors costs to operate their practice and the other for carrying liability insurance—the overall Medicare geographic differential for Alaska doctors in 2009 was 29% above the U.S. geographic baseline.²⁴

Figure 2.



²⁴ Frazier and Foster, 2009

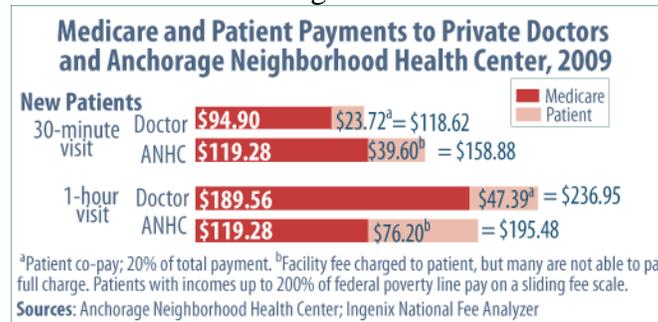
Payments for Community Health Centers

Medicare pays community health centers differently than it pays private doctors. Medicare pays health centers a flat fee—the same amount—regardless of the type of visit, but pays private doctors more for longer, more complex visits. Figure 3 compares payments for 30- and 60-minute visits with new patients at doctors’ offices and at the Anchorage Neighborhood Health Center (ANHC) in 2009. For a 30-minute visit, Medicare paid ANHC \$119 and doctors about \$95 in 2009. But for a 60-minute visit, it still paid ANHC \$119, but paid the doctors \$189.

The co-payment that Medicare patients pay at community health centers and at private doctors’ offices is also calculated differently. Medicare allows the health centers to take their own fee schedule into account when determining what patients are charged, but does not allow private doctors to do the same. Patients of private doctors are responsible for 20% of the allowable Medicare charge. ANHC’s facility fee charges vary—but ANHC patients with incomes below 200% of the federal poverty line are charged on a sliding fee schedule.

Regardless of the payment method, both private doctors and ANHC report losing money when they see Medicare patients.²⁵

Figure 3.



Doctors’ Choices for Participating in Medicare

Private doctors who see Medicare patients have three choices for participating. Choices doctors make affect how much they can be paid.

Some doctors agree to accept standard Medicare fees as full payment for their services. These are called “participating” doctors. Medicare pays them 80% of the Medicare maximum allowable rate (determined by the Medicare fee schedule). The patients or their secondary insurance—if

²⁵ Quoted from Frazier and Foster, 2009

they have any—pay the remaining 20%. Typically, participating doctors do not bill patients for the 20% until after Medicare pays its portion of the bill.

Some doctors are what Medicare calls “non-participating.” These doctors can collect up to 9% more than the allowable Medicare charge for a service, under a formula: full Medicare payment $\times .95 \times 1.15 = 109.25$ percent of the Medicare allowable charge. But patients of non-participating doctors generally (but not always) pay the entire bill at the time they see the doctor, and Medicare reimburses patients slightly less.²⁶

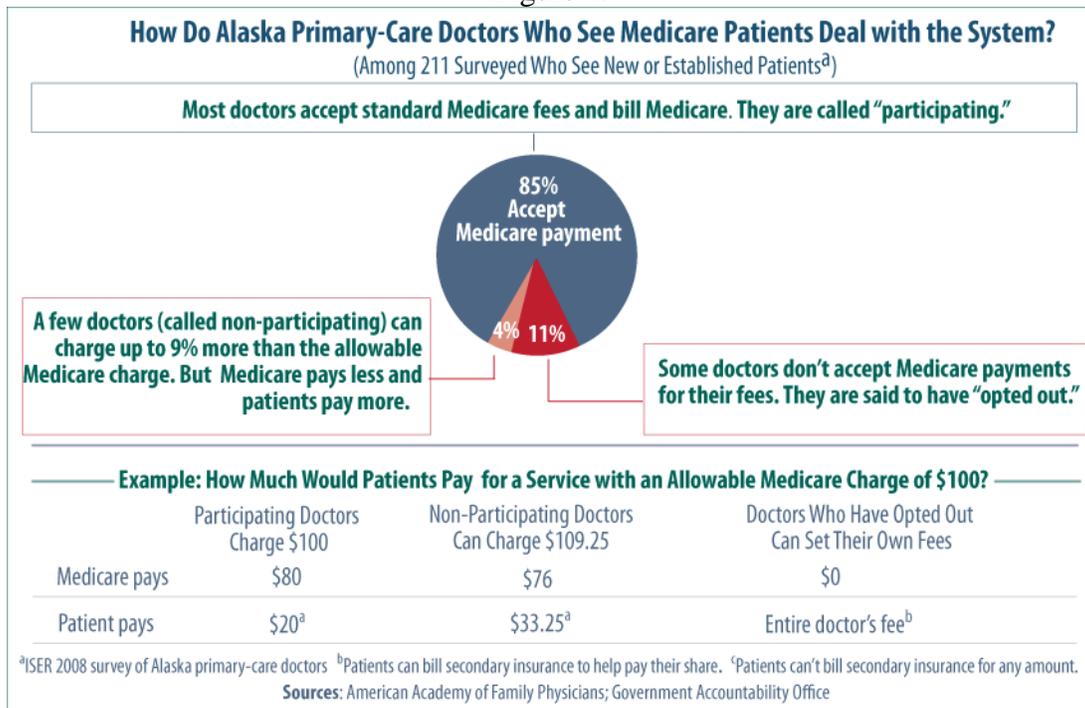
Some doctors simply don’t accept Medicare payments. They are said to have “opted out” of the Medicare program. They can still choose to see Medicare patients, but the patients have to agree to pay charges set by the doctor, with no reimbursement from Medicare. Medicare does not pay either the doctors or patients, and the patients cannot bill any secondary health insurance they may have. They must pay the entire bill themselves. Doctors who opt out have to re-confirm their decision with Medicare every two years, and they can also apply to participate in Medicare again after two years.

These varied methods of payment are only for the charges for the doctors’ services. Medicare patients who see doctors who have opted out of Medicare can still use Medicare to help pay hospital and other medical costs.

Figure 4 shows Medicare participation methods among Alaska primary-care doctors ISER surveyed in 2008.

²⁶ According to the American College of Cardiology, “Non-participating physicians may decide whether to take assignment. If the non-participating physician takes assignment, the 80% of the reduced fee (reduced by 5%) is paid by Medicare to the physician, who then needs to collect the remaining 20% from the patients or their coinsurance. If the physician does not take assignment, he must still submit the claim to Medicare, which will then pay the patient, not the physician. The physician must then collect the entire amount (limited to 109.25% of the allowed charge for participating physicians) from the patient (http://www.acc.org/advocacy_issues/110402_medicare.htm).

Figure 4.



About 85% of Alaska primary care doctors who said in 2008 that they accepted new or established Medicare patients were “participating” doctors. Another 4% were “non-participating” and could collect up to 9% more than standard Medicare fees. The final 11% said they had opted out of the Medicare system, but many enter into private contracts with Medicare patients who agree to pay the entire doctor’s bill themselves.

Medicare Financing Issues

The current director of the Congressional Budget Office (CBO) has included Medicare with Medicaid and Social Security when identifying the most daunting long-term challenges for federal government spending. Medicare spending now makes up \$13 of every \$100 the federal government spends—\$480 billion in 2009.²⁷ In a recent blog, the director wrote:

One should not minimize the variation in some of those budget components (relative to GDP) during the past several decades. However, looking across the whole 40-year period, the basic story of U.S. fiscal policy is fairly simple: The country financed an increase in Social Security, Medicare, and Medicaid spending by reducing defense spending relative to the size of the economy.

²⁷ See National Academy of Social Insurance, “Medicare’s Financial Problems,” at www.nasi.org/learn/medicare/financial-problems.

Essentially, the increased costs of those three big entitlement programs were absorbed by a decline in spending (as a share of the economy) that was not very noticeable to the public because it occurred in an area that most people do not directly observe.

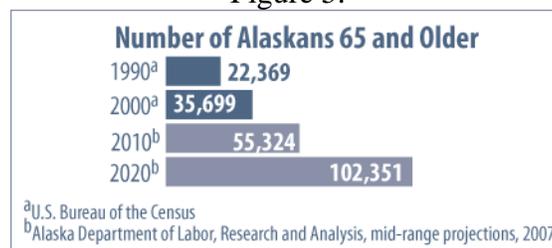
Because defense spending is much smaller relative to those programs today, that approach to funding growth in those programs is not feasible in the future.

Furthermore, the projected increases in spending for Social Security, Medicare, and Medicaid are greater than those we have experienced in previous years. So, we will have to finance most of the future growth in Social Security, Medicare, and Medicaid through a noticeable increase in the tax burden or a noticeable reduction in other domestic programs relative to the size of the economy—or we will have to take noticeable policy actions to reduce the growth of those programs. The alternative of continuing large increases in federal borrowing would pose a serious threat to the future of the U.S. economy.²⁸

The Future

The problem of limited access to primary care among older residents isn't confined to Alaska, but it seems to be more acute for Alaskans, especially in the major metropolitan area of Anchorage (as we noted at the outset of this report). This issue is important in Alaska and nationwide not only for those already 65 or older but also for the many more who will be turning 65 as the huge generation of baby boomers ages into the Medicare system. The U.S. Census Bureau projects that the number of Americans 65 and older will increase about 35% in the next decade, up from about 40 million to nearly 55 million.²⁹ In Alaska, the growth is expected to be even more dramatic. The Alaska Department of Labor projects that the number of Alaskans over 65 will nearly double in just the next 10 years (Figure 5). And over time, the next generations of Alaskans and other Americans will also be reaching the age when they expect to use Medicare as their health insurance. Next we examine why access to primary care has become such a problem for so many Medicare beneficiaries.

Figure 5.



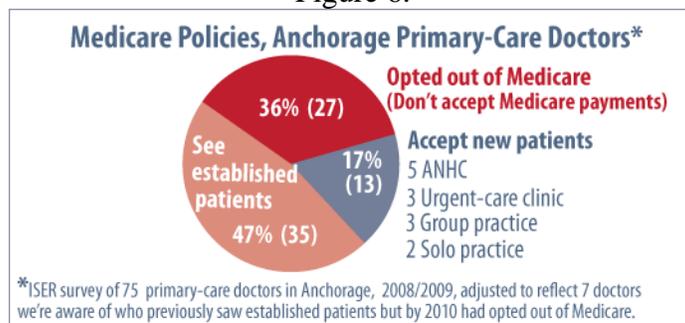
²⁸ Blog of director, Congressional Budget Office, Douglas Elmendorf, quoting a presentation he made March 9, 2010, *Fiscal Policy Choices*, to National Association for Business Economics: <http://cboblog.cbo.gov/?m=201003&paged=2>.

²⁹ U.S. Bureau of the Census, U.S. Population projections, 2008; www.census.gov/population/www/projections/2008projections.html

Closed Doors

As Figure 6 shows, the 17% of primary-care doctors in Anchorage who said they were willing to take new Medicare patients at the time of the ISER survey in 2008 amounted to 13 doctors—and only a handful of those were in traditional private practices. Five were at the Anchorage Neighborhood Health Center—which gets part of its funding from the federal government and accepts all patients—and three were at walk-in, urgent-care clinics.

Figure 6.

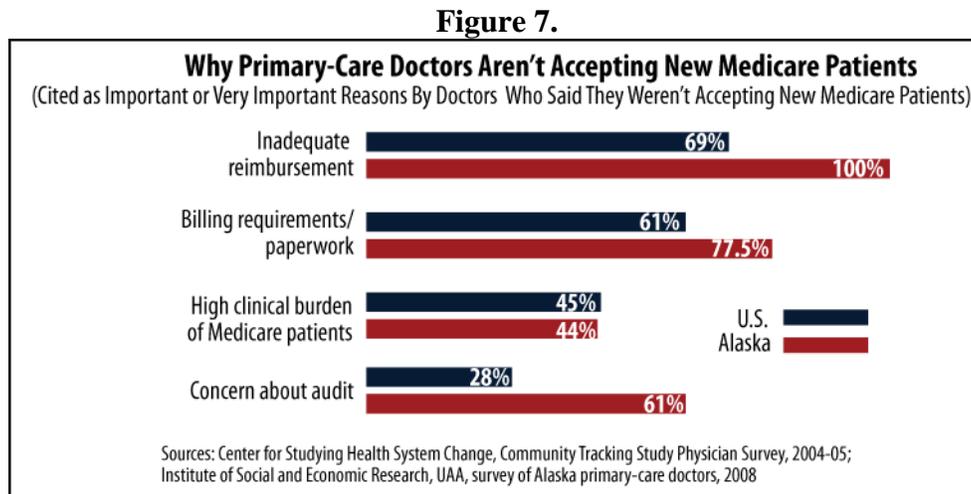


More than one-quarter of the primary-care doctors ISER surveyed in Anchorage had already opted out of the Medicare system in 2008—that is, they didn't accept Medicare payments at all and would treat only Medicare patients who agreed to pay the entire doctor's fee out of their pockets. Since the survey, we have learned of seven more primary-care doctors in Anchorage who have opted out of Medicare, bringing the share of the original survey population who have opted out to more than a third.³⁰

³⁰ That includes six doctors in a primary-care group practice who notified their Medicare patients by letter that they were opting out of the Medicare program, but that they would still see patients who agreed to be “responsible for” the doctor's bill and to acknowledge in writing that they understood Medicare would not reimburse them for the doctor's bill.

Why Primary-Care Doctors Don't Take New Medicare Patients

Figure 7 shows reasons primary-care doctors who don't take new Medicare patients cite for their policies, in Alaska and in the U.S. as a whole.



Alaska primary-care doctors who decline to see new patients universally say Medicare doesn't pay them enough; about two-thirds nationwide also cite inadequate payment. Many doctors in Alaska and elsewhere also cite the complexity of paperwork and fear of audits as important reasons for turning away new Medicare patients—but Alaska doctors are more likely to cite those reasons. And nearly half of primary-care doctors who don't accept new Medicare patients in Alaska and elsewhere cite as another contributing reason the “high clinical burden” of older patients—that is, older patients tend to have multiple medical problems that are complex and time-consuming to treat.

One sign that federal policymakers recognize Medicare may underpay for primary care is a provision in the new health-care reform law that offers a temporary (2011-2016) 10% bonus above standard Medicare rates to primary-care providers—doctors and others—who see Medicare patients.³¹

Why is the Problem Worse in Alaska?

Why is the problem of primary-care doctors' declining to see Medicare patients more common in Alaska, and particularly in Anchorage? Several things may contribute.

³¹ Public Law 111-148, HR 3590 as enacted, Section 5501(a).

All other major health insurers in Alaska pay doctors more for primary-care services than Medicare pays. That includes not only private insurance, but also Medicaid—the federal health-insurance program for low-income Americans—and TRICARE, for military personnel and their families. If private insurance pays \$1 for common office visits, Medicaid and TRICARE pay about 81 cents and Medicare pays 63 cents in 2009.

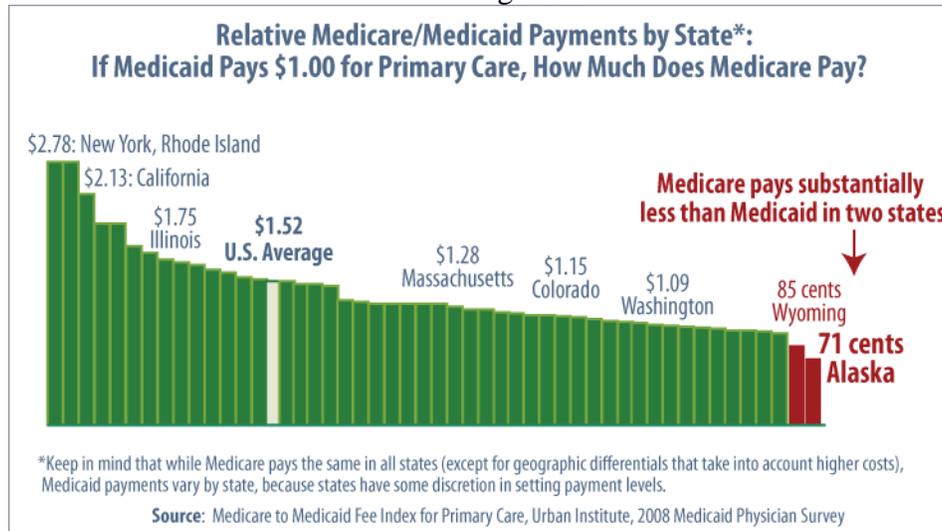
The federal government sets Medicare payments, and Medicare pays the same nationwide, except for geographic cost differentials. Medicare has divided some states into more than one geographic area, but Alaska has only a single geographical differential statewide. Individual states have some discretion in setting payments for Medicaid because states pay part of the costs. Medicaid payments vary from state to state, depending on how much individual states are willing to spend.

In Alaska, Medicaid pays doctors more than Medicare for primary care. In all other states except Wyoming, the opposite is true: Medicare currently pays better than Medicaid—at least as defined by the published reimbursement level for the same procedures.³² Medicare pays twice as much in some states, and nationwide it pays on average 50% more than Medicaid for primary care (Figure 8). But that picture will change in the future: the new health-care reform law provides for increasing Medicaid payments for primary care to Medicare rates for 2013 and 2014, with the federal government funding the increases.³³

³² See Zuckerman, Williams and Stockley “Trends in Medicaid Physician Fees, 2003-2008, Health Affairs, 28 April 09, @ hlthaff.28.3.w510, Exhibit 3: Medicaid-to-Medicare Fee Index, by type of service, 2008. We’ve flipped that to Medicare-to-Medicaid and focused on primary care to emphasize how Medicare compares with Medicaid, from the perspective of the relative value for primary-care practices of the two payers. While the geographic index for physician services was increased by 1.288 for Alaska in 2009, Medicare payments still lag behind Medicaid payments in Alaska.

³³ Public Law 111-152; HR 4872 as enacted, Section 1202, page 24.

Figure 8.



And although TRICARE payment rates for doctors are typically the same as Medicare rates, that's not the case in Alaska in 2010. Since 2007, the U.S. Department of Defense has been paying Alaska doctors 35% more for treating TRICARE patients, in a temporary demonstration project to determine if the increase is enough to persuade more private doctors to see them. The demonstration project is currently set to run through early 2011.³⁴

With private insurance, Medicaid, and TRICARE all currently paying more than Medicare, Alaska doctors can collect more seeing patients with other health insurance. This at least helps explain why Medicare patients in Alaska seem to face bigger barriers getting primary-care doctors than they do in other states.

Another contributing reason may be that Medicare patients make up a smaller share of all patients in Alaska than nationwide. The number of older Alaskans is growing fast, but only about 8% of Alaskans are enrolled in Medicare, compared with 15% nationwide. Figure 9 shows shares of Alaskans with various kinds of health-care coverage, as proportions of a primary-care bus.

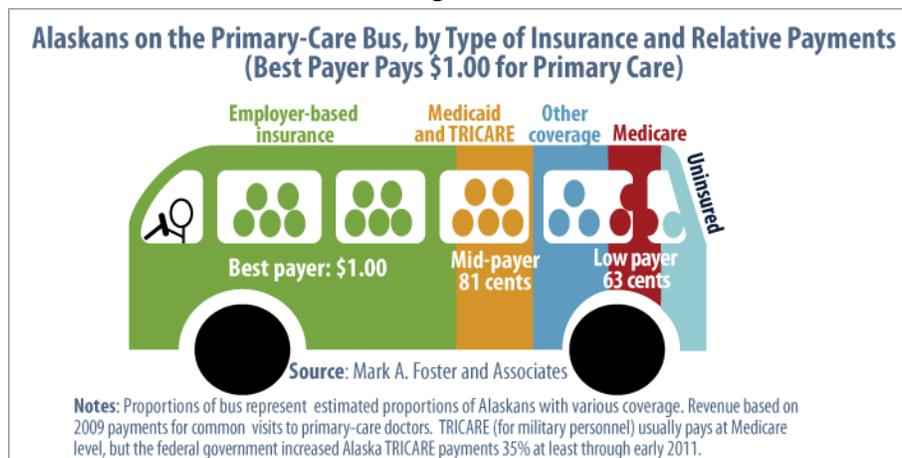
As the figure shows, not only do private insurance and Medicaid pay more than Medicare for primary care in Alaska, there are a lot more of those better-paying patients than there are of Medicare patients. The position of the insurance payers from the front to the back of the bus represents the relative payments for primary care services.

³⁴ See "TRICARE Tests Paying Doctors More in Alaska," TRICARE Management Activity News Release, January 23, 2007 and Federal Register, December 18, 2009 (Volume 74, Number 242)

The green share at the front of the bus is employer-based insurance, which is the largest provider of health-care coverage and the best payer for primary-care services. For each dollar employer-sponsored insurance pays doctors for primary care, Medicaid and TRICARE pay 81 cents for the same service; Medicare is the lowest payer at 63 cents. (The revenue is based on 2009 payments for the most routine office visits to primary-care doctors.)

So Alaska doctors who don't see Medicare patients still have many potential patients, with better-paying insurance.

Figure 9.



Older Anchorage Residents and Primary Care

We've now described the extent of the problem Medicare patients face getting access to primary care and discussed some of the factors that may add to the problem in Alaska, especially in Anchorage. Now, before we look at policy options aimed at making it easier for Medicare patients to get primary care, it is useful to see (1) what kinds of health-care coverage Anchorage's older residents currently have and (2) where they're getting primary care now, when so many primary-care doctors won't see them.

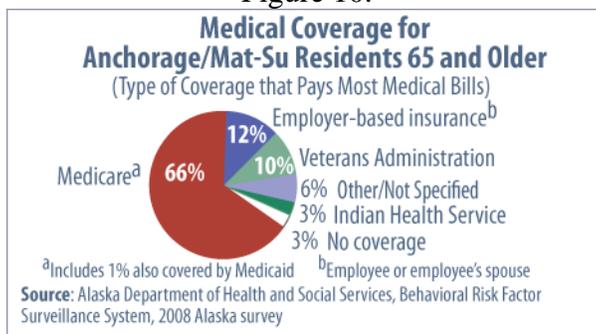
Health-Care Coverage Among Anchorage’s Older Residents

The 2008 Behavioral Risk Factor Surveillance System survey asked Alaska adults what type of coverage paid for most of their medical expenses.³⁵ Figure 10 shows what residents 65 and older in the Anchorage/Mat-Su region reported about their health-care coverage in 2008.

- Two-thirds of older people in the Anchorage/Mat-Su region relied on Medicare—but those who had other options were using them.
- About 12% had insurance through their employers—meaning that either they or their spouses were still working. People over 65 with jobs can often delay using Medicare if they have employer-based coverage.
- About 10% had coverage through the Veterans Administration. Qualified military veterans were eligible for VA health-care services. Most veterans over 65 also have the option of enrolling in Medicare.
- About 3% report the Indian Health Service (IHS) paid for their care. Alaska Natives and American Indians were eligible for care at IHS facilities. Indian Health Service encourages those over 65 to enroll in Medicare—and it bills Medicare. So Medicare may pay the bills for at least some of those who report IHS paid their health-care costs.
- Medicaid covered costs for around 1%. That likely includes low-income older people who were eligible for Medicare and Medicaid as well as residents of nursing homes; Medicaid pays for long-term care for those who have exhausted virtually all their own assets paying for care.
- About 3% of older residents reported having no coverage at all; that includes people who for various reasons never paid an adequate amount of payroll taxes to qualify them for Medicare.
- The remaining 6% reported some other (unspecified) form of coverage or didn’t answer the question.

³⁵ Alaska Department of Health and Social Services, Behavioral Risk Factor Surveillance System, Alaska Behavioral Risk Factor Survey, 2008 annual report.

Figure 10.



Sources of Primary-Care for Anchorage's Older Residents

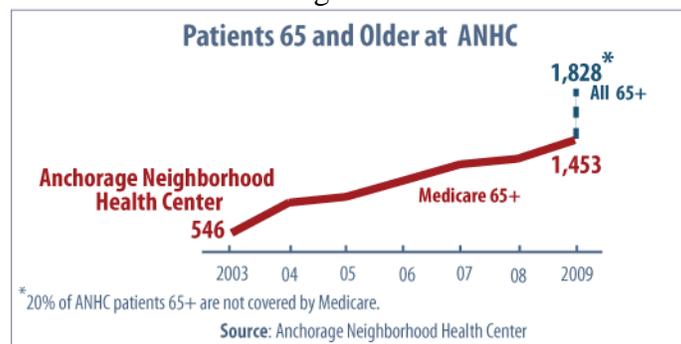
There are many possible places older residents can go for care, using their various kinds of health-care coverage. We have some information about where Anchorage's older residents get their primary care, but we don't have complete information and hope to learn more in future research. Here is what we know so far.

- Some of Anchorage's older residents still see primary-care doctors under various circumstances. Some see their long-time family doctors who accept Medicare payments, but the number of such doctors is dwindling. Others pay for health care with private insurance; these are people who still work. Some pay the doctors' bills themselves (without reimbursement from health insurance); patients who agree to pay the bill themselves can see doctors who've opted out of Medicare.
- Independent nurse practitioners—those who own their own primary-care practices or work in nurse practitioner primary-care group practices—may see roughly 10% of the city's older residents. After Frazier and Foster published the results of the 2008 ISER survey of Alaska primary-care doctors, several nurse practitioners with their own practices got in touch with the authors to say that they did accept new Medicare patients. The Alaska Nurse Practitioners Association reports there were 245 licensed and practicing nurse practitioners in Anchorage and Eagle River in 2009, but only a small share own their own practices or work in such practices. Most nurse practitioners work in doctor's offices or hospital-based clinics. They also see some Medicare patients, depending on the policies of the doctors or clinics; we don't have data on how many Medicare patients see nurse practitioners see in these settings.

In Alaska, nurse practitioners have broad authority to treat patients and prescribe medicine.³⁶ A 2009 survey by the Alaska Nurse Practitioners Association found that most independent nurse practitioners who responded to the survey accept new Medicare patients. But Medicare pays nurse practitioners only 85% of what it pays primary-care doctors. Anecdotal comments from nurse practitioners inform us that they typically limit the number of Medicare patients they accept, in a manner similar to what primary-care doctors do.³⁷ We will soon have better information about Medicare policies of nurse practitioners, through a survey of Anchorage and Mat-Su nurse practitioners, being conducted by Frazier in 2010.

- The Anchorage Neighborhood Health Center sees nearly three times as many older Medicare patients now as in 2003—despite the fact that in 2008 the center had to close one of its two Anchorage locations, when it was unable to recruit enough doctors to staff the second location.³⁸ It also sees hundreds of older people that Medicare does not cover—so altogether it treats close to 10% of the city’s residents 65 and older.

Figure 11.



For years, growing numbers of older people have been turning to ANHC. Community health centers are funded partly with federal money and are required to accept all

³⁶ Nurse practitioners typically have master’s degrees and sometimes doctorates in nursing specialties. Their medical authority varies across the country, depending on the laws and regulations of each state. Nurse practitioners in Alaska have among the broadest authority in the country to treat patients and prescribe medicine. And although many of Alaska’s nurse practitioners work for doctors, they are not required to work under the supervision of doctors. For more information about the medical authority of nurse practitioners by state, see Susanne J. Phillips, “Despite legal issues, ANPs are still standing strong,” in *The Nurse Practitioner*, January 2009.

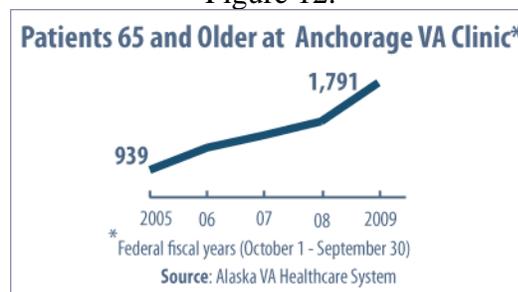
³⁷ Barbara Berner, Alaska Nurse Practitioners Association, 2009 ANPA survey.

³⁸ *Anchorage Daily News* “Health Clinic for poor, uninsured to close,” January 23, 2008.

patients. The centers were initially established to provide primary medical care to uninsured or under-insured people, underserved populations, and to areas (like rural Alaska) where there are few health-care providers.³⁹

- Anchorage’s VA Clinic has seen the number of patients over 65 nearly double since 2005, and in 2009 it treated about 9% of older city residents (Figure 12). The clinic expanded primary care and other services in recent years and has just opened a new, larger facility. It is seeing more veterans of all ages—but the growth among patients 65 and older has been by far the fastest, suggesting the possibility that at least part of the increase within such a short time is because older veterans are finding it harder to get care elsewhere.⁴⁰

Figure 12.



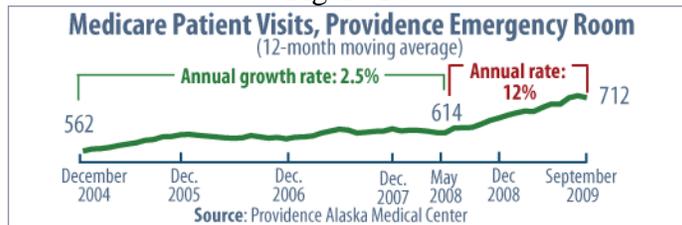
One reason both ANHC and the VA Clinic (and probably nurse practitioners too) have more older patients is just that there are 50% older Alaskans now than in 2000 (as Figure 3 shows)—but that doesn’t account for nearly all the growth they’ve experienced in numbers of older patients.

³⁹ See *Grant Supported Federally Qualified Health Centers* under “Types of Health Centers” at <http://bphc.hrsa.gov/about/>

⁴⁰ Military veterans who qualify can get health care through the Veterans Administration (VA), whatever their age. The VA does not bill Medicare, but it does encourage veterans over 65 to enroll in Medicare, so they have another source of health-care coverage. The VA assigns veterans to priority groups for care; those with major service-connected disabilities have the highest priority. Congress decides how much money the VA gets each year—and if funding falls short, those with higher priorities are ensured care.

- Other providers, such as the Alaska Family Medicine Residency Program, accept some Medicare patients.⁴¹ Providence Alaska Medical Center’s emergency room has seen an increase in Medicare patient visits, but that increase is consistent with an overall increase in emergency room visits (Figure 13). Some urgent-care clinics also accept Medicare patients. But we don’t know how many of those going to the emergency room or urgent-care clinics are doing so because they can’t get primary care anywhere else or because they have actual medical emergencies.

Figure 13.



⁴¹ Providence Alaska Medical Center’s residency program was seeing growing numbers of Medicare patients, but has now capped the number it accepts.

Options for Changing Access to Primary Care for Older Americans: What is Alaska Considering?

In a 2008 survey of Alaska primary-care doctors, Frazier and Foster asked these doctors to suggest ways of improving Medicare patients' access to primary care. Some of their suggestions—changing Medicare payments, offering incentives, and establishing new clinic models—have been prominent in current public policy discussions of ways to ease the difficulties older Alaskans, and older Americans in general, face getting primary care.

Now we examine a few of the options that have been proposed for helping Medicare patients. As we noted at the outset, this is by no means a comprehensive discussion of all the options Alaskans and other Americans are discussing, nor is it an endorsement of any. And the options we discuss are not mutually exclusive.

There are various possible ways to define “access” to primary care, but here we define it simply as the how easy it is for a Medicare patient to obtain an appointment with a primary care doctor. Medicare patients' access to primary care should be same as access for those with other forms of health insurance. When doctors choose to not accept new Medicare patients, it has the same effect as if Medicare patients were uninsured.

Policy options we discuss are grouped around two themes: Service Delivery Options—clinic models for the delivery of primary-care services for Medicare patients; and Payment-for-Services Options—changes in the methods of paying or the amounts paid for primary care services for Medicare patients.

Service Delivery Options

Option: Increase Capacity of Community Health Centers

As one relatively quick way to help older Alaskans get primary care, some policymakers have discussed helping the Anchorage Neighborhood Health Center (ANHC) increase its capacity to see patients. Below, we'll first provide some background information on community health centers and then talk specifically about ANHC and the issues associated with ANHC seeing an increasing number of older patients.

Background: Community Health Centers

ANHC is one of about 1,250 community health centers with more than 7,000 sites across the U.S.,⁴² and the largest of 26 centers with 125 sites in Alaska.⁴³ The first community health centers in the Lower 48 opened in the mid-1960s. These non-profit centers accept all patients, but their main purpose is to provide primary medical care to poor and uninsured people and to areas (like rural Alaska) where there are few health-care providers.⁴⁴

Federal grants to health centers help pay for treating people with low incomes, and nationwide those grants grew from roughly \$550 million in 1990 to \$925 million in 1999 and nearly \$2 billion by 2007. This increased funding for health centers allowed them to treat a lot more patients. The number of Americans getting care at community health centers increased more than 60% nationwide from 2001 to 2007.⁴⁵

But the Center for Studying Health System Change reported in late 2007 that community health centers around the country were being stressed by the growing number of patients, especially uninsured patients, and by difficulties in recruiting doctors, nurse practitioners, physician assistants, and other clinical staff—because hospitals and other health-care providers offer better salaries and benefits.⁴⁶

Another change happening at community health centers nationwide is the growing number of Medicare patients. The National Association of Community Health Centers recently reported that while Medicare patients made up only about 7.5% of all patients at health centers in 2007, the number of Medicare patients turning to health centers rose by 64% between 2001 and 2007.⁴⁷ The association also noted that centers nationwide collect, on average, about 69% of what it costs them to see Medicare patients.

⁴² National Association of Community Health Centers (<http://www.nachc.org/about-nachc.cfm>)

⁴³ National Associations of Community Health Centers, Robert Graham Center, (<http://www.nachc.org/client/documents/research/2007-state-maps/AK-map-11202008.pdf>)

⁴⁴ See *Grant Supported Federally Qualified Health Centers* under “Types of Health Centers” at <http://bphc.hrsa.gov/about/>

⁴⁵ “The President’s Health Center Initiative,” at Health Resources and Services Administration Web site: <http://bphc.hrsa.gov/presidentsinitiative>

⁴⁶ Center for Studying Health System Change, Robert Hurley, Laurie Felland, and Johanna Lauer, “Community Health Centers Tackle Rising Demands and Expectations,” *Issue Brief* 116, December 2007.

⁴⁷ “Health Centers and Medicare: Improving Care for America’s Seniors,” *Fact Sheet*, National Association of Community Health Centers, August 2008.

ANHC Patients and Revenues

Over the years ANHC has seen many of the same kinds of changes as centers nationwide, including treating more uninsured and Medicare patients. It has also—again, like health centers across the country—had trouble recruiting medical staff because the center’s compensation (wages and benefits) is less than private practices offer. In 2008, ANHC closed one of its two locations in Anchorage because it was unable to recruit enough doctors to staff both the Fairview and Mountain View locations when two doctors left.⁴⁸

And although community health centers around the country have also seen growing numbers of Medicare patients, the increase at the Anchorage center has been far larger than it has been nationwide. As we’ve seen (Figure 11), ANHC is already treating many more older patients than it did a few years ago. ANHC treated 11,500 patients in 2009. Of those, about 1,800 were 65 or older; 80% were covered by Medicare, but the remaining 20% were not—so ANHC sees hundreds of older patients who, for one reason or another, aren’t eligible for Medicare coverage. This growing number of patients over 65 substantially contributes to the complexity of patients at ANHC, since older patients tend to have more multiple, chronic problems than younger patients in general.⁴⁹ As of 2008, ANHC had twice the percentage of Medicare patients as the average among health centers nationwide and among other health centers in Alaska.

Figure 14.

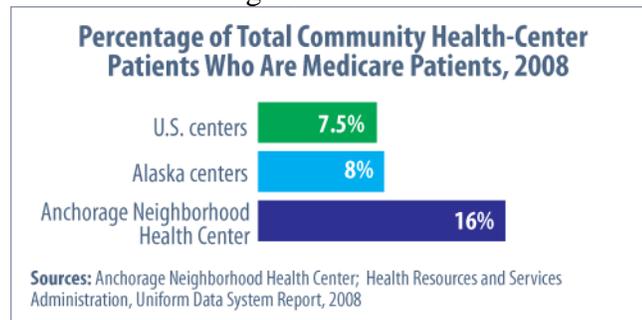


Figure 15 shows how the growing share of Medicare patients at ANHC compares with overall changes among patients. The total number of ANHC patients and the mix of patients vary from year to year. When there are vacancies in its medical staff (as there were in 2008), the center can’t treat as many patients. Economic conditions and other factors also influence the

⁴⁸ See *Anchorage Daily News* “Health Clinic for poor, uninsured to close,” January 23, 2008.

⁴⁹ But ANHC’s former medical director, Tom Hunt, reports that ANHC also sees a disproportionately large percentage of Medicare patients under 65, and that many of them have complex injuries and illnesses as well.

number and mix of patients. But the general pattern at ANHC since 2001 is more lower-paying patients and fewer higher-paying patients. Private insurance is the best payer, followed by Medicaid and then Medicare. Uninsured patients pay what they can, depending on their income. Government grants help pay the costs for low-income ANHC patients.

Figure 15.

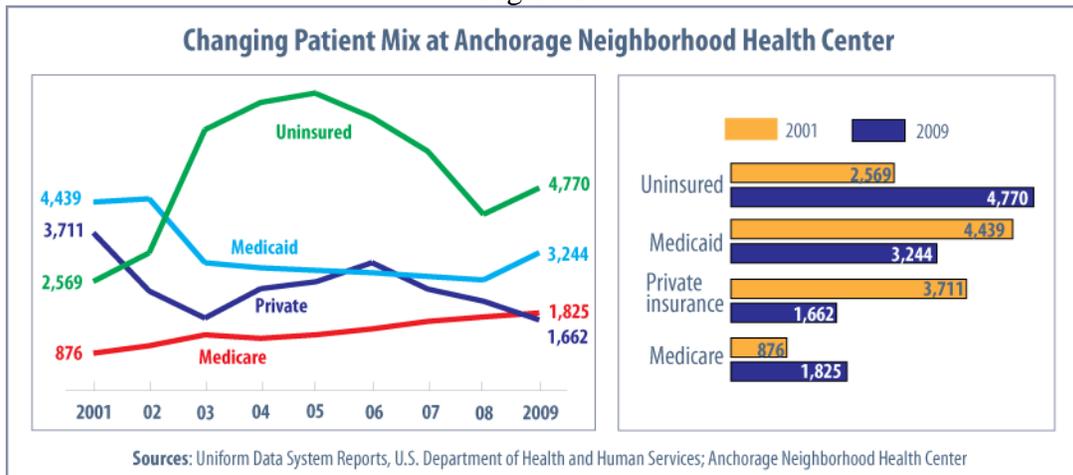


Figure 16 shows ANHC’s revenue sources in 2009. Payments by public insurance (Medicare and Medicaid) and private insurance make up about half the center’s revenues; federal grants contribute about a third. Payments by uninsured patients account for around 12%; state and local grants and donations about 4%. Figure 17 shows percentages of patients by insurance type and by income level. About 60% of ANHC patients have incomes at or below the federal poverty line, and close to 40% are uninsured.

Figure 16.

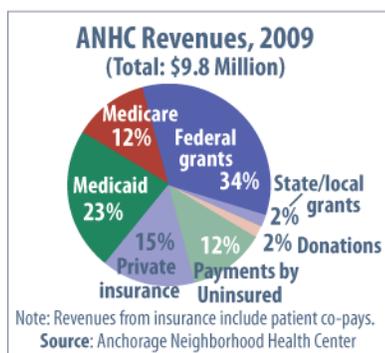
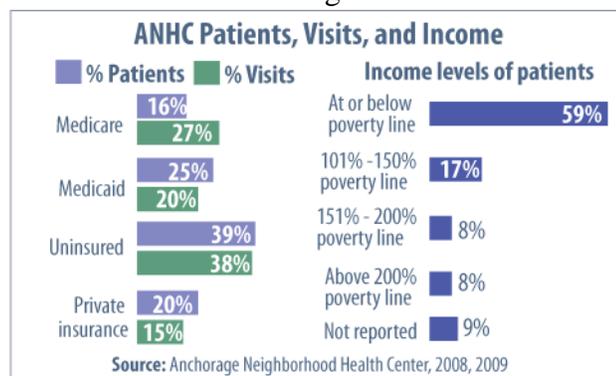


Figure 17.



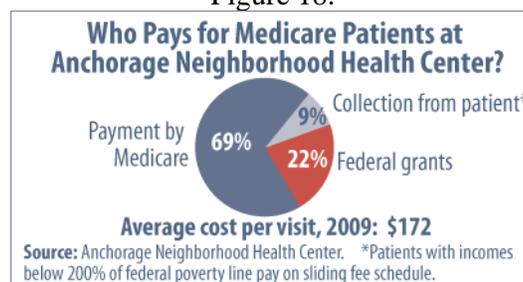
Issues Associated with Seeing More Older Patients

Two issues associated with more Medicare patients at ANHC are the size of the existing facility and the cost of treating Medicare patients.

- **Size of facility.** ANHC is now limiting the number of new patients—Medicare and all others—to two per primary-care provider per day.⁵⁰ ANHC has been raising money for a larger facility that would have four more primary-care providers. Of the \$27 million ANHC needs to build a new facility, it has \$19 million, including \$16 million in state funds.⁵¹

- **Cost of treating Medicare Patients.** In 2009, ANHC's reported that the *average cost* of seeing Medicare patients was \$172, while the average collection from Medicare (including patients' co-pay) was \$134—a gap of 22%, which ANHC covered with federal grants (Figure 18). As we reported earlier, health centers across the U.S. also report that Medicare payments do not cover all treatment costs.

Figure 18.



ANHC staff report that a big factor increasing costs of treating Medicare patients is the time they spend on work that cannot be billed—like phone calls with patients, e-mails, coordinating with other medical professionals, and taking extra time for complex cases.⁵² Older patients, in general, have more complex medical problems and need more frequent visits than other patients. As Figure 17 shows, Medicare patients account for 16% of ANHC patients but 27% of visits; by comparison, Medicaid patients—low-income people, many with children—make up 25% of patients but just 20% of visits.

⁵⁰ Interview with Joan Fisher, executive director, Anchorage Neighborhood Health Center, April 9, 2010.

⁵¹ Those state funds include \$6 million approved in the final budget for fiscal year 2011 (July 1, 2010 to June 30, 2011).

⁵² Interview with Tom Hunt, medical director, Anchorage Neighborhood Health Center, June 1, 2009.

Policy Considerations of a Health Center Seeing more Medicare Patients

- Availability of federal funds. ANHC uses federal grants to help cover its Medicare costs—but those grants are limited and are primarily to help pay ANHC’s costs of providing care to underserved populations such as uninsured and low-income patients. The new health-care reform law will temporarily double federal funds for community health centers nationwide over the next five years—but the amount that may come to centers in Alaska or specifically to ANHC is uncertain.⁵³ ANHC has to balance treating Medicare patients and uninsured patients, both of whom now have limited options for getting primary care elsewhere.
- Potential state grants. State lawmakers have considered—but have not yet approved—possible grants to community health centers as a way of helping more older patients get care. Medicare does allow additional state funding for health centers; the issue for lawmakers is whether they choose to make such grants.

Option: Establish a Medicare-Only Clinic

Another option that’s been proposed to make it easier for Medicare patients to get primary care is establishing a clinic in Anchorage specifically for Medicare patients and limited to Medicare patients.⁵⁴ The group proposing the Medicare-clinic idea is made up of the Alaska Physicians and Surgeons, Alaska State Medical Association, Providence Hospital, and the Alaska State Hospital and Nursing Home Association. Such a clinic might, organizers say, be the first in the United States.⁵⁵

George Rhyneer, a retired Anchorage cardiologist, has been leading efforts to open the Alaska Medicare Clinic and has received support from the Alaska Primary Care Association.⁵⁶ Dr. Rhyneer and others have formed a non-profit corporation that asked for and received a \$1 million grant in the fiscal year 2011 state capital budget. The organization is also hoping to get an additional \$500,000 in federal grant money. The clinic organizers believe \$1.5 million would

⁵³ See CBO Letter to Nancy Pelosi, March 20, 2010, Table 5, page 8, §5708 Community Health Centers and the National Health Service Corps; \$12.3 billion over 2010-2019. (<http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf>)

⁵⁴ This description of the proposed Medicare clinic is largely from a telephone interview with George Rhyneer, March 23, 2010, and a business plan prepared for the Alaska Medicare Clinic by Pathway Alliance, a medical consulting firm; other sources are as noted.

⁵⁵ Pathway Alliance looked for similar clinics elsewhere but found none.

⁵⁶ *Anchorage Daily News*, “Group Seeks Funding for Clinics Treating Medicare Patients” February 13, 2010; Alaska Primary Care Association, February 2010 Newsletter.

cover start-up and operating costs for three years and that the clinic would then be self-sustaining, if it has enough patients.

The medical staff would at first likely include just a single doctor, a nurse practitioner, and two or three nurses or medical assistants; more staff would be added later if the number of patients justified it. The clinic would initially be set up in rented space and operate during standard business hours. It would be equipped to care for common outpatient illnesses, just as traditional primary-care practices do. Supporters say it would have the same role as family doctors traditionally have—referring patients to specialists when necessary, while serving as the patients’ basic health-care provider.

How Would This Clinic Be Different?

But how could a clinic seeing only Medicare patients sustain itself when most of the primary-care doctors in Anchorage—as well as the Anchorage Neighborhood Health Center—report losing money on Medicare patients? The answer, according to Dr. Rhyneer, is that the new clinic would do business much differently from the traditional family doctor’s office, including:

- Minimizing overhead costs. The clinic would be in rented space, with just enough equipment to treat common outpatient illnesses.
- Minimizing expenses that Medicare doesn’t cover. For example, the clinic would submit bills to Medicare—because that’s the only way to get paid—but it would not add the expense of billing patients. The clinic would ask patients to make their co-payments when they come into the clinic. Also, the medical staff would not answer patients’ questions over the phone.
- Seeing more patients in shorter visits. The clinic doctor would see patients for 5 to 10 minutes, for diagnosis and proposed treatment. Other medical staff would do all the patient work-up—taking histories, for example—for a single doctor, so the doctor could see more patients in less time.
- Dealing with one problem per visit. The clinic would deal with just the most urgent problem in a single visit; patients with multiple medical problems would have to make separate appointments for additional problems.

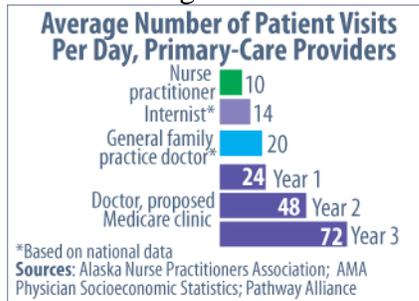
- Accepting only patients able to help with their own care. For example, the clinic would limit patients to only those who could collect any necessary records or tests results themselves and could make follow-up appointments with specialists.
- Making maximum use of electronic records at all stages of treating patients.

How Many Patient Visits Might the Clinic Provide?

To be as efficient as possible, the Medicare clinic plans to hire only medical staff with substantial experience in their fields—in particular, the clinic doctor will be a family practice doctor or internist with years of experience in diagnosing patients. Also, unlike most primary-care providers—who generally have one or two nurses or medical assistants to work-up patients—the plan is for the clinic doctor to have three or four. The productivity of the medical staff will largely depend on how well they screen their patient panel and find patients amenable to the way the clinic plans to operate—high-volume of patients, relatively short simple visits.

The clinic’s business plan calls for the doctor to see three patients per hour during the first year of operation, 6 per hour the second year, and 9 per hour the third year (Figure 19).⁵⁷ That translates into 24 patient visits per day the first year, 48 the next, and 72 the third. By comparison, a typical primary-care doctor sees in the range of 16 to 20 patients per day and family nurse practitioners 10 patients.⁵⁸

Figure 19.



Although there is no precisely comparable clinic in Anchorage today, there is evidence in the Anchorage market that a clinic with high productivity/select patient population might be able to break even, seeing only patients whose insurance pays a relatively low reimbursement, compared with other payers. Ross Tanner, an internist in Anchorage, reports that his practice, the

⁵⁷ Pathway Alliance, “Alaskans for Access to Healthcare Business Plan,” draft (undated). We don’t have the data to convert patient visits per day at the proposed clinic to an annual number of individual patients. On average nationwide, patients visit their primary-care doctors 4.5 times per year, according to Tom Hunt, executive director of physician services, Providence Alaska Medical Center

⁵⁸ AMA, *Physician Socioeconomic Statistics*; Alaska Nurse Practitioners Association, 2009 survey.

Diabetes and Lipid Clinic of Alaska, has been successful at serving a patient panel about twice the size of the typical primary-care provider patient panel, by specializing in patients who keep their appointments, pay promptly, and present a certain set of conditions—for example, diabetes—amenable to diagnosis and treatment at a highly efficient practice making coordinated use of nurse practitioners, physician assistants, and doctors.⁵⁹ That has enabled the practice not only to see more patients per provider but also to see a higher share of Medicare patients than most primary-care practices in Anchorage are willing to see.⁶⁰

Given a high-volume, low-reimbursement business model, a Medicare-only clinic's financial viability would be particularly vulnerable to *volatility* in volume, productivity, and reimbursement levels. In the short run, given the increase in emergency room visits by older Alaskans in the past two years, a Medicare clinic conveniently located on or near a medical campus with a high-volume emergency room could reasonably be expected to pick up a significant volume of patients who do not have regular primary-care providers.

The planned Medicare clinic does, however, face a challenge with respect to the long-term prospects for Medicare reimbursement levels. As we discussed earlier, the Sustained Growth Rate formula that governs Medicare payment rates for doctors called for a 21% cut in those rates in 2010. Congress has now delayed that cut until November 2010, and many observers think Congress is unlikely to let such a drastic cut go into effect. But at this point, in mid-2010, it is uncertain how Congress will resolve this issue. Whatever Congress decides about setting future Medicare reimbursement rates for doctors will be very important for a clinic that proposes to see only Medicare patients.

In the meantime, §5501 (H.R. 3590) “Expanding Access to Primary Care Services and General Surgery Services” provides for a 10% increase in Medicare reimbursement rates for primary-care services. This increase may not be enough to motivate doctors in individual and small group practices to expand their Medicare panels; in 2009, a 28% increase in Medicare payments for Alaska doctors did not persuade those who were not accepting Medicare patients to change their policies.⁶¹ But it could help sustain a Medicare-only clinic or be sufficient to encourage a larger organization with deeper working capital reserves—e.g., Providence Alaska

⁵⁹ See <http://diabetesalaska.com/>

⁶⁰ Personal conversation with Ross Tanner, July 2009

⁶¹ See Frazier and Foster 2009, “How Hard is it for Alaska’s Medicare Patients to Find Family Doctors?”

Medical Center—continue to develop a business case for its planned Senior Clinic, which would serve patients 55 and older (as we discuss more in a later section).

What Issues are Related to a Medicare-Only Clinic?

Those supporting the Medicare clinic believe that the pent-up demand among Medicare patients unable to get primary-care providers, coupled with projected fast-growth in the number of Alaskans 65 and older (Figure 5), mean that the clinic will have more than enough potential patients.⁶²

One potential issue raised by a clinic that maintains a high volume of patients and short visits is that it might take only those with relatively straightforward problems. That would leave the more complex cases for other providers—who would still have to contend with the same relatively low Medicare reimbursements but a higher percentage of patients with difficult, time consuming problems. And the number of providers willing to see such patients would be limited, especially in Anchorage; as we discussed earlier, few Anchorage primary-care doctors will see new Medicare patients. Many of Alaska’s primary-care doctors cite the complexity of older patients as one reason for not treating them (Figure 7).

It is unknown how many Medicare patients will accept the clinic’s way of providing care. Supporters of the proposed Medicare clinic believe that many will accept it—because the clinic will, in turn, provide them with a place they can go for the primary care they need, offer referrals to specialists, and see them for follow-up visits if they have to be hospitalized.

If the clinic does open sometime soon, it would be an experiment—and if it were able to break even, organizers say they would consider opening additional clinics in other urban areas of Alaska. If it were not able to break even and had to close, the limited operation of a Medicare-only facility would provide a lot of information analysts could sift through to find out what happened and what might be done differently.

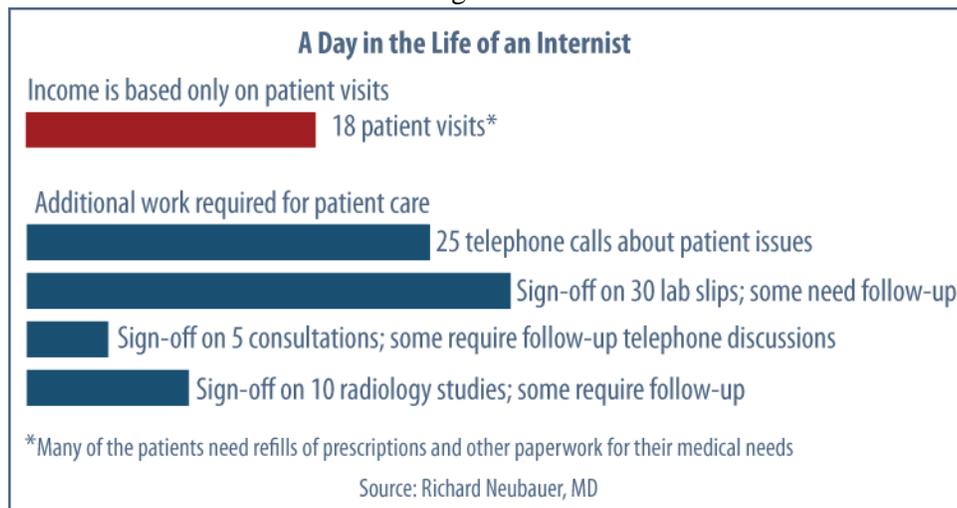
Option: Test Patient-Centered Medical Home

At the national level, critics of the current Medicare fee-for-service-payment system say it underpays for primary care (relative to specialty care) because it under-estimates the complexity of providing primary care—especially for older patients with multiple, chronic medical problems. For example, a 2007 article in the *Annals of Internal Medicine* maintains that

⁶² Interview with George Rhyneer, March 23, 2010

one reason for the widening income gap between primary-care doctors and specialists is the Medicare system’s “underestimating complexity trends of primary care procedures/overestimating complexity trends of specialist procedures.”⁶³ Also, Medicare pays specifically for medical services and not for other related services doctors have traditionally provided. Figure 20 shows one Anchorage internist’s summary of a typical day on the job—seeing 18 patients but also taking dozens of patients’ phone calls, signing off on lab tests, filling out prescriptions, and consulting with other doctors.⁶⁴

Figure 20.



In recent years, several national doctors’ organizations, including the American Academy of Family Physicians and the American College of Physicians, have endorsed a new medical model intended to take into account—and to pay for—all the kinds of work involved in providing primary care, besides the visits with patients. It is called the “patient-centered medical home.” The agency that administers Medicare—the Centers for Medicare and Medicaid Services—and some private insurers have been testing this system. The new health-care reform law also calls for demonstration projects of this model.

⁶³ Thomas Bodenheimer, Robert Berenson, and Paul Rudolf, “The Primary—Specialty Income Gap: Why It Matters,” *Annals of Internal Medicine* 2007;146:301-306.

⁶⁴ Another discussion of the many kinds of unpaid work by primary-care doctors is by Richard Baron, “What’s Keeping Us So Busy in Primary Care? In the *New England Journal of Medicine*, April 29, 2010, Vol 362:1632-1636, Number 17.

Under the medical-home system, patients have personal primary-care doctors who—along with their staffs—are responsible for providing comprehensive care: routinely monitoring patients’ health, making appointments on short notice, consulting by phone and e-mail, teaching patients how to be more involved in their own care, and coordinating with specialists. Doctors are held accountable for the quality of the care they provide and how satisfied their patients are.⁶⁵

The payment system for this model is much different from Medicare’s traditional fee-for-service. Providers are typically paid a monthly amount per patient for managing care, adjusted for the complexity of a patient’s problems, plus payments for office visits and potentially additional payments if they can show their care of patients meets certain standards.

Supporters say this system would save money over the long term by improving patients’ health and making care more efficient. Others (including, for example, the American College of Emergency Physicians) say it remains to be seen whether medical homes can work as hoped and be less expensive than the current system. They also say there should be more proof of cost savings before the medical-home model is more widely adopted.⁶⁶

The “patient-centered medical home” has become an increasingly popular term.⁶⁷ The “medical home” concept tracks back at least to 1967 when it was used by the American Academy of Pediatrics as the ideal of care for children with special health needs.⁶⁸ In 1992 the American Academy of Pediatrics established principles for the medical home, including care that was accessible, continuous, comprehensive, family centered, coordinated, compassionate, and based on trusting relationships.⁶⁹ In 2002, Kevin Grumbach and Thomas Bodenheimer of the University of California, San Francisco, encouraged more general adoption of the “medical home” principles.⁷⁰ In 2007, the American College of Physicians, American Academy of Family Physicians, American Academy of Pediatrics, and the American Osteopathic Association

⁶⁵ For more information, see the Web site of the Patient-Centered Primary Care Collaborative (www.pcpcc.net).

⁶⁶ See, for example, American Council of Emergency Physicians (ACEP) policy statement on medical homes at www.acep.org.

⁶⁷ May 2010 “Reinventing Primary Care”-themed issue of *Health Affairs*, including a feature article by Kilo & Wasson entitled “Practice Redesign and The Patient-Centered Medical Home: History, Promises, And Challenges” (pp. 773-778).

⁶⁸ Sia, et al, “History of the Advanced Medical Home Concept”, *Pediatrics*, 2004; 113: 1473-1478

⁶⁹ American Academy of Pediatrics Ad Hoc Task Force on Definition of Medical Home. *The Medical Home*. *Pediatrics*, 1992; 90(5): 774

⁷⁰ Grumbach & Bodenheimer, “A Primary Care Home for Americans: Putting the House in Order”, *Journal of the American Medical Association*, 2002; 288(7): 889-893

adopted consensus principles of the “patient-centered medical home.”⁷¹ The “medical home” became the “patient-centered medical home” as the shift in focus from clinician-driven care to care based on a collaborative patient-physician relationship has continued to evolve.⁷²

The key principles cited for the patient-centered medical home model include:⁷³

- Comprehensive primary care built around teams working to the top of their license
- Coordinated care
- Relationship-centered care with continuity over time
- Reimbursement reform (to compensate for all patient contacts, including phone calls and e-mails, not just appointments with doctors and tests)

Southcentral Foundation Nuka Model (Customer-Driven Model)

One example of the medical home concept does exist in Alaska—the primary-care clinic operated by the Southcentral Foundation in Anchorage. That clinic is part of the tribal health-care system in Alaska, serving Alaska Natives. That clinic, however, does not describe itself as “patient-centered,” but rather “customer driven.” Patients are considered customer-owners, and the medical staff helps them make informed decisions about their health and medical care. As representatives of Southcentral Foundation wrote in 2008:⁷⁴

There’s a lot of talk in health care today about being “patient centered.”

Unfortunately, what that usually means is that the patient is put in the middle and then all the “really smart, professional people” stand around and try to decide what’s best for that person.

In our organization [Southcentral Foundation], we use the term “customer driven.” This means that everything our customer-owners define as needs, goals and values become the system’s focus. The doctor and the clinical team provide expertise, keep track of preventive matters, explain options, and make

⁷¹ (“Joint Principles of the Patient-Centered Medical Home,” Patient Centered Primary Care Collaborative; 2007 February; available from: <http://www.pcpcc.net/node/14>)

⁷² Kilo & Wilson, p. 776, Health Affairs, 2010; 29:5

⁷³ See for example, Casalino, “A Martian’s Perspective for Primary Care: Overhaul the Physician’s Workday”, Health Affairs, 2010, 29(5); pp. 785-790.

⁷⁴ Katherine Gottlieb, Ileen Sylvester, Douglas Eby, MD, MPH, “Transforming Your Practice: What Matters Most,” *Family Practice Management*, January 2008, p. 34.

recommendations. But the customer-owner is in control and makes decisions, rather than the provider trying to decide what's best.

It turns out that when given this kind of control and partnership over time, customers make knowledgeable, informed decisions about their health care treatment and generally choose less aggressive treatments than medical professionals would choose for them.

Southcentral Foundation reports that its goal is to integrate services into the lives of customers on their terms—essentially putting the services into the culture rather than attempting to graft the culture into the services.⁷⁵

Providence Alaska Medical Center Senior-Care Clinic

Providence Alaska Medical Center, the largest provider of health care in Alaska, is planning to address the issue of Medicare access by opening the Providence Senior-Care Clinic. It is projected to serve approximately 3,000 patients during its first year of service. The clinic will target people older than 55, including Medicare patients. The Providence clinic will be using the patient-centered medical home model to provide care. In line with this model, Providence's approach will be with a team of medical professionals such as a nurse, doctor, and case manager to provide comprehensive care for each patient.⁷⁶

Is There Adequate Potential Demand for These Service Delivery Models?

We've just discussed potential expansion of the Anchorage Neighborhood Health Center and establishment of a Medicare-only and a senior-care clinic in Anchorage. Is there adequate potential demand for these clinic models?

Anchorage currently has close to 21,000 residents over 65. The adjoining Mat-Su Borough has another 6,000. Add to that the number of patients who come to Anchorage from other parts of Alaska, the over-65 referral population in Anchorage is likely around 24,000 and could soon reach 30,000—and it will keep rising.⁷⁷

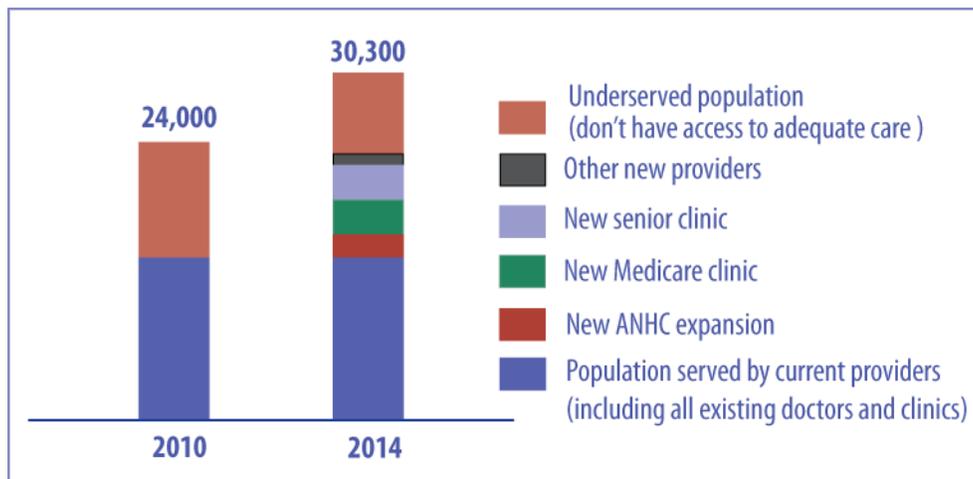
⁷⁵ Gottlieb, Sylvester, Eby, MD, MPH, "Transforming Your Practice: What Matters Most."

⁷⁶ Conversation Tom Hunt, executive director for physician services, Providence Alaska Medical Center, June 1, 2010.

⁷⁷ Estimates of Mark A. Foster and Associates. Based on Medicare Estimates of Aged and Disabled Population by State and County (2007) for Anchorage and a slowly declining portion of Mat-Su Borough, filtered to reflect aged only, adjusted to reflect Alaska Department of Labor population projections for residents 65 and older and to bring the estimate up to 2010.

As an overall preliminary estimate—based on limited information—Figure 21 shows that the current shortfall in provider capacity would be helped, but not entirely eliminated, by the addition of the proposed Medicare-only clinic, the planned Providence Medical Center Senior-Care Center, and an expanded Anchorage Neighborhood Health Center. Even with the addition of projected growth among other primary-care providers willing to accept Medicare patients, total primary-care providers would fall far short of projected growth in numbers of residents over 65 over the coming decade—unless there are other changes that bring even more health-care providers into Anchorage.

Figure 21. Estimated Access to Primary Care, Anchorage Region, Residents 65 and Older



Source: MAFA Estimates, 2010. The underlying assumptions and the numbers used to generate this figure are described in the appendix.

Payment-for-Service Options

Having discussed several options for changing primary-care service delivery for Medicare patients, we now turn to potential options for changing payment for services.

Option: Incentives for Providers to see More Medicare Patients

Various possible ways of giving primary-care providers more incentive to see older patients have been suggested at the state and national levels. Here we look at a few of the incentives to providers that policymakers have discussed.

Medicare Bonuses

The Medicare program already offers a 10% bonus for primary-care providers enrolled in the Medicare system and working in what it defines as “Health Professional Shortage Areas,” which include both rural areas and specific at-risk populations in more urban areas. But the authors of one study found that nearly a third of the time physicians did not file for the 10% bonus for eligible visits.⁷⁸

Table 2 shows the Health Professional Shortage Areas (HPSA) and Medically Underserved Areas and Populations (MUA/MUP) in Alaska. The table shows that several areas and boroughs in Alaska may be eligible for this 10% bonus.

⁷⁸ Leighton Chan, L. Gary Hart, Thomas C. Ricketts III, and Shelli K. Beaver, “An Analysis of Medicare’s Incentive Payment Program for Physicians in Health Professional Shortage Areas,” *Journal of Rural Health*, Volume 20, Issue 2, March 2004, Pages 109-117

Table 2. Alaska Primary-Care Health Professional Shortage Areas, March 2009⁷⁹

Census Area or Borough	Primary Care HPSA
013 - Aleutians East Borough	yes
016 - Aleutians West Census Area	yes
020 - Anchorage Borough	CHC
050 - Bethel Census Area	yes
060 - Bristol Bay Borough	CHC
068 - Denali Borough	yes
070 - Dillingham Census Area	only AN; CHC shortly
090 - Fairbanks North Star Borough	Low income
100 - Haines Borough	CHC
110 - Juneau Borough	-
122 - Kenai Peninsula Borough	CHC
130 - Ketchikan Gateway Borough	-
150 - Kodiak Island Borough	CHC
164 - Lake and Peninsula Borough	yes
170 - Matanuska-Susitna Borough	yes (north); 2 CHCs
180 - Nome Census Area	yes
185 - North Slope Borough	yes
188 - Northwest Arctic Borough	yes
201 - Prince of Wales-Outer Ketchikan Census Area	CHC (lost geo)
200 - Sitka Borough	-
232 - Skagway-Hoonah-Angoon Census Area	yes
240 - Southeast Fairbanks Census Area	yes
261 - Valdez-Cordova Census Area	Cordova geo (and) CHC; CHC Copper Valley
270 - Wade Hampton Census Area	yes
280 - Wrangell-Petersburg Census Area	CHC
282 - Yakutat Borough	yes
290 - Yukon-Koyukuk Census Area	yes

Health Professional Shortage Areas are designated as having “shortages of primary medical care . . . , and may be geographic (a county or service area), demographic (low income population), or institutional (comprehensive health Center, federally qualified health center, or other public facility.”

“Yes” in the column means there is a “geographic” HPSA designation approved by HRSA Office of Shortage Designation, for all or part of the census area or borough.

“CHC” indicates there is at least one Community Health Center with automatic HPSA designation. Where geographic HPSAs exist, the geographic area score is generally higher than the CHC score. Most of the areas with geographic designations also have CHCs in one or more sites within the census area or borough.

⁷⁹ State of Alaska | Alaska Primary Care Programs
http://www.hss.state.ak.us/dph/healthplanning/primarycare/assets/HPSA_MUA.pdf. Assessed July 28, 2009.

The federal health-care reform law offers a new 10% bonus above standard Medicare rates for all primary-care providers (doctors and others) nationwide who see Medicare patients; it's a temporary bonus, to be in effect from 2011 to 2016.⁸⁰ Estimates of the potential cost of this bonus vary widely. The Centers for Medicare and Medicaid Services has estimated costs on the order of \$260 million a year, and the Congressional Budget Office has estimated annual costs of \$700 million.⁸¹

But whatever the potential cost, it seems unlikely that this 10% bonus will persuade many of Anchorage's primary-care doctors to change their minds. In 2009, Alaska's Congressional delegation led a successful effort to permanently increase the geographic differential payment for Alaska doctors by 28%, compared with the average for doctors nationwide. As a follow-up to a 2008 survey of Alaska primary-care doctors about their Medicare policies, in 2009 we called doctors who had told us in 2008 that they weren't accepting new Medicare patients. We found they had not changed their policies after the increase.⁸² Instead, in 2010, we found evidence that additional primary-care doctors had opted out of participation in Medicare.

State Grants

Alaska legislators have several times considered, but have yet to approve, using state funds through a grant program to persuade private primary-care providers to see more older patients. Any such state program would have to comply with federal Medicare rules (which ban outright supplements to Medicare payments); state lawmakers would also have to decide how much to spend for such a program.

The new health-care reform law includes a provision that gives states the authority to “award grants to health-care providers who treat a high percentage, as determined by such state, of medically underserved populations or other special populations in such state,⁸³” as long as they don't use federal Medicaid, Medicare, or TRICARE funds. This means that the state can designate older people as a medically underserved or other special population. As such the state could award grants to providers from state funds. But federal regulations governing that provision of the health reform legislation have not yet been issued—so it's too early to tell how it

⁸⁰ Public Law 111-148, HR 3590 as enacted, Section 5501(a)

⁸¹ CMS Office of the Chief Actuary, memo dated April 22, 2010, Table 3, page 5, §5501 and CBO Letter to Honorable Nancy Pelosi, March 20, 2010, Table 5, page 8, §5501

⁸² See Frazier and Foster, 2009.

⁸³ HR 3590 EAS/PP, pages 2343-2344.

will be implemented. It's also not clear how the state would structure a program based on that provision and comply with existing federal laws and rules governing Medicare.⁸⁴

Option: Balance Billing

Some people and organizations believe the way to persuade more primary-care doctors to see Medicare patients is “balance billing”—that is, changing the Medicare rules to allow doctors participating in the Medicare system to charge Medicare patients the full difference between what Medicare pays and what doctors charge. Right now, doctors who agree to participate in the Medicare system have to accept, as full payment, whatever Medicare administrators set as the allowable charge for a specific service.⁸⁵

So, for instance, if a doctor ordinarily charges \$150 for a particular visit, but Medicare has a maximum allowable charge of \$100 (typically paid 80% by Medicare and 20% by the patient), then the doctor can only collect \$100. Even if Medicare patients carry secondary private insurance, they can only use that insurance to help pay the 20% of the allowable charge that Medicare doesn't pay. They can't use private insurance to make up the difference between what Medicare pays and what doctors charge—nor can they pay the difference out-of-pocket.

A “balance billing” system, on the other hand, would allow doctors to bill Medicare patients for the difference—in the example above, the extra \$50. Patients with secondary private insurance could use that to help pay the balance; patients without secondary insurance would have to pay it themselves.

In fact, the Medicare system allowed balance billing of patients until the late 1980s—doctors could charge patients the full difference between what Medicare paid and what doctors charged. Then, in 1989, Congress adopted a new system under which Medicare administrators established specific fees for specific services—and restricted doctors participating in Medicare from billing patients more than Medicare allowed.⁸⁶ In addition to the existing federal rules that

⁸⁴ Some Alaska legislators did introduce bills in the 2010 legislative session that would have established a program paying grants to “health-care providers for care of patients who are 65 years of age or older” (HB 178 and SB 61), but no such legislation passed.

⁸⁵ Keep in mind we're talking here about doctors who participate in the Medicare system. Doctors who have opted out of the Medicare system can charge older patients their usual fees, as long as the patients have agreed to pay the bill themselves.

⁸⁶ Omnibus Budget Reconciliation Act of 1989, Public Law 101-239

prohibit doctors from balance billing Medicare patients, several states have also enacted their own restrictions on balance billing.⁸⁷

Robin McKnight, writing in the *Journal of Health Economics* in 2007, summarized the arguments for and against the change that established specific fees for doctors' services and ended balance billing.⁸⁸ Those who supported the 1989 change in federal law said that balance billing reduced Medicare patients' access to medical care—because older Americans, especially the poorer ones, were reluctant to get medical care, when they weren't sure how much they would have to pay and whether they could afford to pay the extra amount. Those against the change said doctors would be less willing to see Medicare patients, if they could not bill for their standard fees. They argued that ending balance billing and instead paying doctors' fees set by Medicare administrators would reduce Medicare patients' access to health care.

Many observers think it very unlikely that federal rules prohibiting balance billing will be changed. But regardless of whether federal rules change, Alaska policymakers could consider adopting rules that explicitly call for providers who have opted out of Medicare to charge older patients no more than a usual and customary fee. Such rules would help older Alaskans avoid being charged more by providers who have opted out of Medicare. On the other hand, if there is evidence that providers who have opted out of Medicare are, in fact, discounting their charges for older patients, there could be a danger in introducing state rules: they could have the unintended consequence of causing providers to raise their discounted fees back to the usual level.

Option: All-Payer System

Another option being discussed nationally is an “all-payer” system: all insurance—private, Medicare, Medicaid—would use the same fee schedule: providers would be paid the same payment for the same service regardless of insurer.⁸⁹ Supporters say such a system for health-care providers would have several potential benefits.

⁸⁷ As of 2007, that included Massachusetts, Connecticut, Rhode Island, Vermont, and Pennsylvania; see Robin McKnight, cited below.

⁸⁸ Robin McKnight, “Medicare balance billing restrictions: Impacts on physicians and beneficiaries,” in *Journal of Health Economics* 26 (2007), 326-341.

⁸⁹ Not to be confused with the single-payer system favored by proponents of a national health insurance system. A single-payer insurance system under national health care would collect all medical insurance fees and then pay for all services through a single government or government-related entity. Examples include the United Kingdom's National Health Service and Canada's Medicare.

- An all-payer system would eliminate the incentive for providers to choose one payer over another—which could benefit Medicare patients in Alaska and Medicaid patients in other states—because the provider is paid the same amount for providing a service, regardless of the payer.
- This type of level payment across payer type would stop providers from shifting costs among payers—a common practice that drives up health-care costs. Higher payments from one payer would not be used to supplement those of another payer that pays less, as is the current practice.
- Over the long run, administrative overhead costs associated with operating a provider practice would be reduced by simplifying billing. Billing staff would not have to continue to learn and use the varied billing guidelines that various payers currently have. Those would be simplified or eliminated in an all-payer system.
- The level of effort required to manage different payments systems would be reduced, allowing providers to focus more on patient care.

The Maryland System

Maryland has had an all-payer system in its hospitals since the 1970s. It has a special Medicare waiver that allows a state regulatory commission to determine hospital rates for Medicare and other payers. The rates are also set to cover hospitals' costs of caring for the uninsured—so hospitals are paid the same to treat the insured and the uninsured.⁹⁰

The Maryland Health Services Cost Review Commission, an independent regulatory agency established by the Maryland state legislature, decides how much individual hospitals can charge, based on their costs, the severity of illness among their patients, and other factors.⁹¹ Those rates apply to 53 Maryland acute-care hospitals with current revenues of about \$13 billion.⁹²

⁹⁰ There has been controversy about how hospitals decide which patients qualify for free or reduced-price care. In 2008 a Baltimore newspaper charged that the state had failed to set clear standards and that hospitals were using different definitions of who qualified; see Fred Schultze and James Drew, “In their debt: Maryland hospitals have stepped up debt collection, sometimes from the poor,” *Baltimore Sun*, December 21, 2008. In its 2009 report, the Maryland cost commission said it was undertaking “a review of the existing uncompensated care policy.”

⁹¹ Jane Zhang, “Maryland Reins in Hospital Costs by Setting Rates,” *Wall Street Journal*, September 14, 2009.

⁹² Health Policy Monitor, Web site of the International Network Health Policy and Reform. See Elena Conis, “Impact of a State-Level All-Payer System,” Survey No. 14, 2009.

According to figures reported by the cost commission in 2009, costs in Maryland hospitals haven't increased as fast as they have nationwide.⁹³

- The cost per admission in Maryland hospitals was 26% above the national average in 1976. In 2007, the Maryland cost was at the national average.
- From 1977 to 2007, only two states had slower overall growth in hospital costs than Maryland.
- The hospital mark-up in Maryland—the difference between what hospitals charge for something, compared with what it cost them—was 22%, compared with 187% nationally.⁹⁴
- From 1981 to 2008, the cost per hospital admission of Medicare patients increased 293%, compared with 319% nationwide. An important condition of Maryland's Medicare waiver for hospital rates is that payments for Medicare patients in Maryland hospitals can't grow faster than the national average.

What about Alaska?

Maryland is the only state currently setting hospital rates, but many other states also tried it in the 1970s—although not all those other states received Medicare waivers. Why other states dropped their rate-setting systems seems to be a matter of some debate. Some observers think the move away from government regulation in the 1980s, under President Ronald Reagan, was a big factor leading states to stop rate-setting.⁹⁵ Others think Maryland has been able to succeed in setting rates and controlling costs over the long term because it, unlike other states, established an independent regulatory agency.⁹⁶

Whatever the case, policymakers considering an all-payer system for Alaska would need to first study the histories of such systems in other states. Creating an all-payer system in Alaska would require, among other things, creating a new regulatory system and getting a Medicare waiver that would allow state—rather than federal—regulators to decide what Medicare pays.

⁹³ Maryland Health Services Cost Review Commission, Report to the Governor, Fiscal Year 2009. Available at www.hsrc.state.md.us.

⁹⁴ Data of the American Hospital Association, cited in 2009 report of the Maryland Health Services Cost Review Commission.

⁹⁵ See Gerard Anderson and Samuel Mitchell, "All-payer rate setting: down but not out," Health Care Financing Review, Annual 1991.

⁹⁶ See Paul Ginsburg, "All-Payer Rate Setting: A Response to a 'Modest Proposal' From Uwe Reinhardt," *Health Affairs Blog* (healthaffairs.org/blog/2009/07/24)

Such a waiver could initially increase Medicare rates (to put them more in line with local market conditions)—but at the same time the state would have to commit to containing cost growth and providing value for all payers. Also, Indian Health Service rules for payment would need to be considered and waivers gained to operate such a system in Alaska.

Conclusions

We don't advocate any of the potential options we've discussed for helping older Alaskans get primary care. But knowing about these options—and others we didn't discuss—can help Alaskans (and other Americans) think about the kinds of features that might be included in an effective system of primary care for older patients, who are far more likely than younger people to have complex medical problems.

We talked about several potential models for delivering primary-care to older Alaskans. The planned Providence Senior-Care Clinic and the existing Southcentral Foundation clinic share many of the principles of the patient-centered medical home (as outlined by the Patient-Centered Primary Care Collaborative).⁹⁷ But the Southcentral Foundation has taken the concept another step, referring to those receiving medical care not as “patients” but as “customer-owners,” and its goal is building long-term collaborative relationships, with the customers in charge and ultimately responsible for their own health and medical care decisions.

It seems reasonably likely that the Providence Senior Clinic and the Medicare-only clinic will open, and that the Anchorage Neighborhood Health Center will build a larger facility. Each would have different ways of providing care. But to the extent that they can all focus on prevention, wellness, and customer decisions related to chronic illnesses and long-term conditions, their respective care delivery models might not only expand access to primary-care for older residents of Anchorage and surrounding areas, but could also improve both health outcomes and patient satisfaction, as people find the kind of care that meets their needs.

We also looked at several potential ways of making it more attractive to doctors and others providers to accept more older patients—from allowing doctors to charge patients the difference between their standard charges and what Medicare pays, to creating a system under which all insurance, public or private, would pay the same amount for the same service. So far none of these options have advanced as far as they proposed new clinics have, although the legislature

⁹⁷ “Joint Principles of the Patient-Centered Medical Home Model” (2007).

has several times considered possible ways of using state money to persuade primary-care providers to see more Medicare patients.

Whatever specific policies the state or federal governments—or private organizations—may adopt to help older Alaskans get better access to primary care, in the long run those policies can only be effective if there are enough health-care providers to take care of the growing overall number of Alaskans, in general, and the fast-growing number of those over 65, in particular. Alaska has been training more medical professionals locally, and there are a number of potential options for attracting more providers to the state—including loan forgiveness programs, for example, and recruitment and retention bonuses.

It's also important to keep in mind that doctors are not the only ones providing primary care in Alaska. Nurse practitioners and physician assistants have broad authority to treat illness and prescribe medicine, and they play a bigger role in primary care in Alaska than in the U.S. as a whole. Alaska also has a history of innovation in training non-physicians to provide some basic care, especially in rural Alaska; that includes community health aides and dental therapists.

In future research, we plan to study—in collaboration with other parts of the University of Alaska—the issues involved in recruiting and training medical professionals for Alaska and the options for getting Alaskans the primary-care providers they'll need in the coming years. Ten years from now, there could be nearly twice the number of older Alaskans as today, as more and more baby boomers reach 65. Even if the new Medicare and senior clinics open and the Anchorage Neighborhood Health Center expands, they won't meet all the demand created by growth in the older population.

In the future we also hope to learn more detail about where Anchorage residents over 65 are getting their primary care. Also, if any of the options under consideration for improving Medicare patients' access to primary care are in fact adopted, the picture of where older residents are getting care will change.

In the broad view, any solution to the problem older Alaskans (and other older Americans) face getting primary care will be taking place in the context of implementation of Medicare provisions of the health-care reform law—which include some tests of different Medicare payment systems but also some cost-cutting measures. Any attempts to improve access to care for older people will also be affected by how Congress decides to revise future Medicare

payment levels. The issue of how, and how much, Medicare pays for primary care will remain central to the question of how much practical access older Alaskans have to basic medical care.

But even though payment levels are driving the problem and the discussions about how to fix it, we have little detailed information about what it actually costs to provide health care in Alaska. We and other researchers plan to build a cost/revenue model of the Alaska primary-care system to better understand the costs of providing care—and therefore be able to better assess how to improve access to health care not only for older Alaskans, but for everyone.

Appendix: Data Used in Estimating Access to Primary Care for Residents of Anchorage Region 65 and Older

draft:		7-Jun-10							
q's to:		mafa@alaska.net							
DEMAND-SUPPLY									
		Notes	2010	2011	2012	2013	2014	2015	
DEMAND									
		annual growth rate							
	Alaska Senior (65 & over) Population Growth Rate	(1)	6.0%						
6.0%	Anchorage Senior Referral Area Addressable Population Estimate	(2)	24,000	25,440		26,966	28,584	30,299	32,117
60.0%	Estimate of Seniors with Primary Care Access	(3)	14,400	14,400		14,400	14,400	14,400	14,400
	Estimate of <i>Underserved</i> Seniors without new investment	(4)	9,600	11,040		12,566	14,184	15,899	17,717
SUPPLY									
<u>Proposed New Investments in Capacity to Serve Anchorage Seniors</u>									
	Anchorage Neighborhood Health Center Expansion (All ages) (Joan Fisher)	(5)					2,000	2,000	
	Medicare Clinic (Dr. Rhyneer)	(6)		3,000		3,000	3,000	3,000	
	Senior Clinic (55 & Over) - Providence (Dr. Hunt)	(7)		3,000		3,000	3,000	3,000	
	Other new private providers (Physicians, Nurse Practitioners)	(8)		<u>100</u>		<u>200</u>	<u>300</u>	400	
	Subtotal	(9)		6,100		6,200	8,300	8,300	
<u>Anchorage Senior Access to Primary Care in 2012</u>							2010	2014	
Population Served by Current Capacity							14,400	14,400	
New ANHC Expansion								2,000	
New Medicare Clinic								3,000	
New Senior Clinic								3,000	
Other New Providers								400	
<i>Underserved</i> Population							9,600	7,499	
ck sum							24,000	30,299	

Notes:

- (1) MAFA Analysis of Alaska Department of Labor Population Projections
- (2) MAFA Analysis of Alaska Department of Labor Population Projections and Anchorage Referral Region
- (3) MAFA Estimate
- (4) Calculation (Addressable Market - Market with Access = Underserved Market)
- (5) Estimate of initial ANHC expansion that would be available for Seniors (65 & over)
- (6) Estimate of initial New Medicare Clinic capacity that would be available for Seniors (65 & over)
- (7) Estimate of initial new Senior (55 & over) Clinic capacity that would be available for Seniors (65 & over)

- (8) Estimate of initial capacity from other new providers (net of loss from retirements, cut backs from current capacity) that would be available for Seniors (65 & over)
- (9) Total of Net New Capacity