

July 21, 2008

## Trying to Save by Increasing Doctors' Fees

By [MILT FREUDENHEIM](#)

Cutting health costs by paying doctors more?

That is the premise of experiments under way by federal and state government agencies and many insurers around the country. The idea is that by paying family physicians, internists and pediatricians to devote more time and attention to their patients, insurers and patients can save thousands of dollars downstream on unnecessary tests, visits to expensive specialists and avoidable trips to the hospital.

Nationally, [Medicare](#) and commercial insurers pay an average of only about \$60 a visit to the office of a primary-care doctor and rarely if ever pay for telephone or e-mail consultations. Many health policy experts say the payments are not enough to let the doctors spend more than a few minutes with each patient.

Robert Williamson, a 60-year-old Philadelphia man, recalls the cursory exam he received a few years ago from a harried doctor who, Mr. Williamson says, missed the danger signals and sent him home. A short time later Mr. Williamson had a stroke.

For want of a careful examination by a primary-care doctor, Mr. Williamson became one of countless Americans each year whose unidentified or under-treated illnesses escalate into medical conditions with catastrophic personal and economic costs. Besides incurring \$30,000 in hospital bills paid by his employer's insurer, Mr. Williamson had to stop working as a customer service representative at Philadelphia Gas Works and go on Social Security disability, at a current cost to taxpayers of \$1,900 a month.

With Mr. Williamson's new doctor, such an outcome would be much less likely.

"I give him my heart and [diabetes](#) readings by e-mail and phone, without getting up out of my chair," Mr. Williamson said. "I can get better directions, at the very moment I need them. It's life-saving."

His current internist, Richard Baron, is one of more than 100 physicians in metropolitan Philadelphia taking part in the experiment, which is being conducted jointly by some of the region's largest insurers. Dr. Baron still gets a fee of only about \$64 for each office visit. But his five-doctor group will also receive \$200,000 to \$300,000 this year beyond their regular fees to keep better track of their 8,400 patients.

"We are trying to do more e-mail care and telephone care, which we haven't been paid for in the past," Dr. Baron said.

Insurers are conducting similar pilot projects in at least a half-dozen states, in experiments involving thousands of doctors and nearly 2 million patients. Many more are in the planning stages, at the urging of health policy experts and employers that provide medical benefits.

The big government health care programs, [Medicaid](#) and Medicare, are also studying the concept. A Medicaid experiment already under way in North Carolina saved the government program in that state about \$162 million in 2006. That was 11 percent less than the state would have spent under the old system of reimbursement, according to an audit by Mercer, a consulting firm.

Earlier this month, as part of a bill to protect Medicare payments to doctors, the Senate overrode President Bush's veto to authorize \$100 million to finance a three-year Medicare pilot to further test the concept of spending more on primary care.

Under the various payment experiments, family doctors are encouraged to hire additional staff to help monitor patients' treatment and follow-up, and to help patients stay ahead of problems by sending reminders when they are due for preventive tests like [mammograms](#) and colon exams.

For people like Mr. Williamson with serious chronic illnesses, the doctors take personal charge, answering patients' phone or e-mail questions promptly. In emergencies, patients can show up at the office and see their doctors on short notice.

Such features add up to a model of primary care that proponents refer to as providing people with a "medical home" — a base where doctors, staff and patients pull together as one big health-care family. Or at least that is the ideal.

"It's the latest new, new thing — testing whether medical homes can be a vehicle for pulling America upwards from the grossly inefficient swamp in which our health system is currently mired," said Dr. Arnold Milstein, a senior consultant at Mercer who is also member of the Medicare Payment Advisory Commission, an independent Congressional agency.

The panel has recommended that Medicare expand its plans for a medical-home pilot project next year that is expected to pay primary-care doctors in eight states \$30 to \$40 a month extra for each person enrolled with a chronic illness.

In Michigan, the auto industry has been a major force behind one of the largest medical-home projects yet devised. Blue Cross Blue Shield of Michigan, which has 4.7 million members, plans to spend \$30 million this year to help primary-care doctors offer such services. About 4,900 primary-care doctors are participating, said Dr. Thomas Simmer, chief medical officer of Michigan Blue Cross.

Advocates of the approach hope it will attract more doctors to primary care. Last year only 7 percent of medical school graduates chose family practice, a field with a median income of \$150,000, according to the American Academy of Family Physicians. That compares with \$406,000 for gastroenterologists and \$433,00 for cardiac surgeons, as measured by the Medical Group Management Association.

The [American Medical Association](#) said that in its latest count, in 2006, there were slightly more than 251,000 practicing family physicians, general practitioners, and internists in this country, compared with nearly 472,000 specialists.

"The pipeline of primary-care doctors has been running dry for several years," said Dr. Barbara Starfield, a

health policy expert at [Johns Hopkins University](#). Many parts of the country do not meet the generally accepted standard of one primary-care doctor for every 1,000 to 2,000 people, Dr. Starfield said.

The Philadelphia pilot project is sponsored by three of the area's largest insurers — Independence Blue Cross, [Aetna](#) and [Cigna](#) — as well as some local providers of Medicaid services, which together have agreed to spend \$13 million on the program over the next three years.

Dr. Baron expects the project to add as much 15 percent to the annual revenue of his medical group. He declined to specify the practice's total gross income last year, but said that each of the five physicians earned less than the \$177,000 national median for internists.

To participate in the Philadelphia experiment, doctors must arrange for their offices to keep in close communication with their entire rosters of patients. Dr. Baron's practice, besides the physicians, a business manager and clerical assistants, has added a patient educator, whom he said would cost \$60,000 in salary plus \$60,000 more for benefits and supporting technology. The group is also spending \$25,000 for part-time services of a data analyst.

Employers predict that better early care will reduce their health costs in the long run. "We want to buy our care this way, we think it's the right thing to do," said Dr. Paul Grundy, [I.B.M.](#)'s director of health care technology and strategic initiatives.

Despite the hopes riding on the pilot projects, some experts are skeptical. "There is very little concrete rigorous evidence that the medical home will do all those wonderful things they want it to do," said Mark Pauly, a health policy economist at the Wharton School of the University of Pennsylvania.

Even executives at Aetna and Cigna are cautious about betting on a payoff from the Philadelphia project, which was orchestrated by Pennsylvania's Democratic Governor [Edward G. Rendell](#) and his office of health care reform.

It is uncertain whether there will be a direct return on the investment within a "reasonable time horizon," said Dr. Don Liss, an Aetna medical director who is an internist himself. Still, Dr. Liss added, "a reasonable body of evidence suggests that improving primary care as a foundation for health care will improve quality and access to care."

The Pennsylvania program will start expanding to other parts of the state this fall. It comes none too soon, in the view of Dr. Joseph Mambu, a family physician in Lower Gwynedd, a Philadelphia suburb. Trying to build a medical-home practice before the pilot project began, Dr. Mambu said he went into debt installing an electronic medical records system and establishing patient-friendly features like evening and Saturday office hours.

"Last year, I hit the red ink because of all the technology," he said. "Unless we get help from the insurance companies and the government, the system is going down the toilet."

But with the new medical-home money, Dr. Mambu said he expected to pay down his debts and start a patient wellness program. The insurance pilot project, he said, offers "a ray of hope."

Copyright 2008 The New York Times Company

[Privacy Policy](#) | [Search](#) | [Corrections](#) | [RSS](#) | [First Look](#) | [Help](#) | [Contact Us](#) | [Work for Us](#) | [Site Map](#)

---