Testimony to Illinois General Assembly Health Care Work Groups - May 2020

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Let me start by extending our condolences to the families who have lost loved ones and share that our thoughts are with those who are battling the virus. Despite the robust response of the physician and health care community, thousands of families have been impacted.

Family physicians and providers on the frontlines of the COVID-19 pandemic are not only caring for the growing population of individuals infected but also maintaining access to and continuity of care for the ongoing needs of their communities. Everyone knows the majority of care in every state and across the country is provided outside the hospital walls. In fact, the largest number of office-based primary care physician visits were to family medicine . Sadly, because of the sharp reduction in revenue from cancelled office visits and the disparity in payment for telehealth, a majority of primary care physician practices are now on the verge of closing. Our national organization, the American Academy of Family Physicians has reported that nationwide practice closures could be 4 to 6 weeks away without financial assistance – especially independent and small practices in rural and/or underserved areas that are very reliant on Medicaid payments.

How are we coping? Many are expanding and modifying their practices to ensure that their patients and communities have access to health care in a setting that protects them from exposure to COVID-19. Others are moving into full-time inpatient roles as part of workforce surges. In response to the COVID-19 crisis, public and private payers alike have altered benefit design and begun making advance payments to family physicians. The pandemic has brought to light how inflexible and unresponsive our health care system has become. It took several weeks to create a pathway for family physicians to provide and be compensated for virtual care visits via telemedicine or the telephone. Why? Because we currently pay for units of care and units of time, and our regulatory structure is designed accordingly. Imagine if every family physician had had an attributed panel of patients and an associated prospective payment for each when the crisis hit. Transformation from office-based to virtual workflows would have been easier and quicker. Home visits? Fine. Telephone visits? Fine. A game of virtual checkers with Ms. Smith because she is isolated and gets lonely? Fine. When units of care and units of time no longer get measured, providing care to patients becomes the focal point. And, when providing care to patients is the focal point, everyone wins.

We believe in finding the silver lining during these unprecedented times and expanded telehealth coverage is one such area. On account of the COVID pandemic, parity in reimbursement between video and face-to-face visits (both in Illinois Medicaid and Medicare) now includes both audio-only and video encounters. This step in the right direction makes permanent sense, as may many other innovations in healthcare that prove helpful to Illinoisans accessing care and improving their health.

Currently, our health care system is largely a top-down model in which the vast majority of spending is allocated to the least-used services. According to *Health Affairs* ,(www.healthaffairs.org) . How was that money distributed on a per capita basis? Physician and clinical services represented about 20% of overall health care spending, while hospital spending represented 33% of overall spending. Specifically, primary care represents about 5% of overall spending.

What about utilization? According to statistics from the Robert Graham Center for Policy Studies in Family Medicine and Primary Care for 2018, about 7% of the population received care in a hospital compared to roughly 60% of the population who received care from a family physician. Why is one-third of our overall spending going to 7% of the population receiving care in a hospital while only 5% of our overall spending is covering 60% of the population relying on family physicians and other primary care providers.

We are not suggesting that family physicians and primary care need to be paid on par with hospitals. However, we know the impact of family medicine in Illinois : an overwhelming majority of people rely on their family physicians and other primary care clinicians, yet we invest only pennies on the dollar in our primary care system. We must increase the investment in primary care, especially while we are struggling to mitigate the impact of this virus, and we must recognize that primary care is a critical component of that response.

We look to our state's lawmakers and leaders to preserve our primary care system. Failure to act in a meaningful way will result in a step back in the progress to effectively manage chronic diseases, vaccine adherence, and overall population health and wellness.

Thank you for your time. I am happy to answer any questions you may have.