

Primary Care 101: A Glossary for Prevention Practitioners

As the U.S. healthcare landscape continues to change under the Affordable Care Act (ACA), primary care will play an increasingly large role in preventive care, including the prevention of substance use and related behavioral health problems. As more communities reach out and forge relationships with practitioners working in primary care settings, the need to understand the context in which primary care services are provided becomes increasingly important.

This glossary offers an introduction to the basics of primary care. Specifically, it describes:

- [Legislation that influences healthcare](#)
- [Payers that fund healthcare](#)
- [Organizations that provide healthcare](#)
- [Payment systems that reimburse providers](#)
- [Trade associations that represent healthcare professionals](#)

Legislation

Recent legislation has altered the primary care environment, creating new opportunities for partnerships with substance misuse prevention. Understanding the effects of this legislation on primary care can help prevention work with primary care partners to capitalize on new opportunities (e.g., increase screenings and referrals). This section provides context on the new and complex legislation that has altered insurance coverage, service delivery, and benefit packages for millions of Americans.

- **Affordable Care Act (ACA).** Often referred to as “Obamacare” or “health care reform,” the ACA was passed in 2010 to expand health insurance coverage, reduce the growing cost of health care, and improve the quality of healthcare services. The ACA expands coverage by offering subsidies for certain individuals to purchase private insurance and by allowing states to expand their Medicaid programs. The law also encourages integrated care (see below) and seeks to improve the quality of health coverage through Essential Health Benefits (EHBs).

- **Essential Health Benefits (EHBs).** Created under the ACA, EHBs are a set of 10 health benefit categories that certain insurers must provide. EHBs include “mental health and substance use disorder services, including behavioral health treatment” as well as “preventive and wellness services.” As a result, these EHBs present an opportunity to secure coverage for numerous substance misuse prevention services.
- **Mental Health Parity and Addiction Equity Act (MHPAEA).** Passed in 2008, MHPAEA (also known as “parity”) imposes a conditional requirement on certain insurers. MHPAEA does not require insurers to offer behavioral health coverage. However, if applicable health plans cover behavioral health conditions, under MHPAEA they must do so at parity with general healthcare services. When combined with state laws and the ACA, MHPAEA will expand or improve behavioral health coverage for an estimated 62.5 million individuals by 2020.

Payers

Payers are the entities that fund healthcare services. When collaborating with primary care, it is important to understand your partners’ funding sources (i.e., payers), which are likely to drive their service delivery decisions. Payers dictate where individuals can receive health care and the types of services they can receive. In many cases, healthcare providers will make service delivery decisions based on payers’ policies.

- **Private Insurance.** Refers to any insurance not provided by the government. Private insurance can be provided by an employer or purchased directly by the consumer. Under the ACA, many more individuals will obtain private insurance. As insurance coverage grows, working to secure coverage for prevention screenings and early interventions will become increasingly important. However, insurers’ relationships with providers will be heavily influenced by the reimbursement systems they have in place.
- **Medicare.** Medicare is the country’s federally funded healthcare program for the elderly. Because it is so large, Medicare is the focus of myriad integration and cost-saving initiatives. Medicare covers and promotes a wide range of preventive and screening services, including tobacco cessation counseling and yearly wellness visits, which may have implications for substance use screening.
- **Medicaid.** State Medicaid programs offer health coverage to low-income Americans, including adults, children, pregnant women, and individuals with disabilities. States administer their own Medicaid programs, but Medicaid is jointly funded with the federal government. As a result, while every state has a Medicaid program, each Medicaid program is unique. The federal government sets basic Medicaid requirements, but states have wide latitude to provide more benefits or serve more people than the federally-mandated minimum.
- **Medicaid Waiver/Medicaid State Plan Amendment (SPA).** States can use Medicaid waivers or SPAs to modify their Medicaid programs. Modifications can include adding/changing coverage or adjusting payment methodologies. The federal government must approve proposed changes, and

states must guarantee that they will not offer less than federal requirements or increase federal costs. States that cannot pay for substance use screenings through Medicaid may be able to modify their programs through these mechanisms.

- **Payer of Last Resort.** This applies to certain payers that will only pay for services after all other potential payers have paid for the services they cover. The term most often refers to government healthcare programs. Medicare and Medicaid are both payers of last resort.

Primary Care Organizations

Many different organizations can deliver primary care services, from a lone physician running an independent practice to vast health centers and provider networks. Each of these organizations has its own concerns and experiences both collaborating with other organizations and providing prevention services. Understanding the different types of primary care organizations can help prevention professionals decide where to direct their collaborative efforts.

- **Primary Care.** This describes a patient's source of regular health care. Primary care providers function as a patient's first contact with the healthcare system. Primary care may include health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis, and treatment. Patients requiring specialized care may be referred to specialist physicians or practices.
- **Physician-Owned Primary Care Practices.** This is defined as one or more physicians who provide primary care out of one or more offices and own their own practice. These practices often include other medical professionals (e.g., nurses, nurse practitioners, physician's assistants, etc.). Physician-owned practices have discretion over the services they offer and the payers they accept.
- **Hospital-Owned Primary Care Practices.** These include practices owned by hospitals or hospital groups rather than by the individuals who comprise the practice. Because these networks are often quite large, collaborating with hospital-owned practices may allow prevention professionals to reach many more individuals than through physician-owned practices. However, physicians in hospital-owned groups will have less authority to add new services, necessitating partnerships with the owner hospitals.
- **Community Health Centers (CHCs).** This general term refers to community-based outpatient clinics that provide primary and preventive care in their communities. Many CHCs play a significant role in providing health care to uninsured individuals by accepting patients regardless of ability to pay.
- **Charitable Clinics (Free Clinics).** These are non-profit healthcare organizations that provide a range of free healthcare services (including but not limited to primary care) to disadvantaged individuals. Charitable clinics restrict their services to those who are uninsured, underinsured, or have limited access to health care. Many CHCs that charge a sliding scale fee are still considered charitable clinics if they provide care regardless of a patient's ability to pay.

- **Federally Qualified Health Centers (FQHCs).** FQHCs are CHCs (see above) that meet certain federal criteria, including serving an underserved or vulnerable population and offering a sliding fee scale. FQHCs receive designated federal grants and enhanced Medicare and Medicaid reimbursements. FQHCs are a significant source of services for substance use treatment and may be interested in expanding the substance use arm of their preventive services.
- **Federally Qualified Health Center (FQHC) Look-Alikes.** These are community-based primary and preventive care provider organizations that meet all federal FQHC administrative and clinical requirements but do not receive federal FQHC funding.
- **Accountable Care Organizations (ACOs).** These are collaborative organizations that comprise numerous healthcare providers (e.g., doctors and hospitals) and one or more payers to coordinate care for their shared patients. ACOs are designed to better coordinate and improve care, and their members agree to be accountable for the quality, cost, and overall care of their patients. ACOs were originally limited to Medicare; however, there are now ACOs in Medicaid and private health insurance, as well. ACOs often emphasize preventive services as a way to improve patient outcomes and reduce costs. As a result, ACOs are likely to value substance misuse prevention partnerships and services that can help prevent more costly treatment.
- **Employee Wellness Programs.** Also known as workplace health programs, these programs seek to improve employees' health outcomes by promoting healthy behaviors within an organization. Among other tools, wellness programs can provide health education, weight management, and medical screenings. Though wellness programs do not provide primary care, they are a potential partner for substance misuse prevention (particularly for screenings) because of their focus on preventive care and long-term health.

Payment Systems and Related Terms

When partnering with primary care providers, it is important to understand not only the payer(s) and the provider but also the payment structures through which they interact, as this may influence if or how a provider is willing to implement new prevention initiatives. Most providers see patients from multiple payers, each of which compensates the provider through its own payment structure. Understanding how providers get paid may help you develop innovative ways to fund primary care collaborations.

- **Fee for Service (FFS).** Fee for service is the most “basic” healthcare payment model. Under this structure, providers receive payments for each service delivered. When operating under FFS, providers have a straightforward financial incentive to implement new substance misuse prevention initiatives (e.g., screenings). However, that financial incentive only exists if the applicable payer covers those services. Note that a provider operating under FFS for one patient may operate under a different payment structure for another patient (e.g., if the patients have different insurance plans). In addition, many payers are attempting to phase out simple FFS models in favor of other payment mechanisms. Several of those models are outlined below.
- **Managed Care.** This is a broad term referring to a number of related strategies designed to reduce

the cost and improve the quality of health care. These strategies can include (but are not limited to): contracting with a select set of healthcare providers, offering incentives for providers or patients to choose less costly care (e.g., by changing their reimbursement systems), reviewing the medical necessity of specific services, and intensive management of high-cost patients. For example, Health Maintenance Organizations (HMOs) are a common managed care strategy utilized in private insurance to control costs by restricting patients to a certain network of providers and negotiating fees with providers. Managed care also utilizes other payment structures outlined in this section.

- **Provider Network.** In certain managed care systems, the provider network is the group of organizations (including physician groups, hospitals, etc.) that agree to accept prenegotiated payments for a set of enrollees from one specific payer. For example, under an HMO, “in network” providers accept their patients’ insurance payments because they are part of the managed care system. In contrast, “out of network” providers do not have pre-existing agreements with the payer, and so require patients to pay for care through other means.
- **Capitated Payments.** Under this payment model, healthcare providers receive a lump sum payment for each patient for a set period of time (e.g., one year). Providers must cover all patient costs during that time period, and may keep any remaining funds as profit. Providers using capitated payments may be resistant to new prevention services that were not considered as part of their capitated payment. However, they may also recognize prevention as a way to achieve long-term savings (e.g., by preventing a more costly substance use disorder through preventive screenings).
- **Bundled Payments.** Also known as episode-of-care payments, under this model healthcare providers receive a single payment for all services that a patient receives for an acute or chronic health condition within a set period of time. As with capitated payments, providers using bundled payments may resist new prevention services that were not considered part of their capitated payment; however, they may also favor those services to achieve long-term savings.
- **Pay-for-Performance.** Pay-for-performance, also known as P4P, refers to a set of related strategies that link some portion of a healthcare provider’s compensation directly to patient outcomes (e.g., payments based on lowering patients’ blood pressure). P4P programs may also penalize providers for poor outcomes. Medicare has implemented a number of P4P pilot programs. Providers within P4P programs may have a financial incentive to implement new prevention initiatives to avoid penalization for poor patient outcomes related to substance misuse.
- **Integrated or Coordinated Care.** Together, these concepts refer to multiple healthcare professionals or organizations with different specialties working together to treat their common patients. Some experts distinguish between care provided in a single location by multiple professionals in multiple disciplines (integrated care) and care provided by professionals or providers that are working together but not at a single location (coordinated care). The term “integrated care” may also refer to the integration of behavioral health and primary care or to the integration of specialty services and primary care.

Trade Associations and Related Terms

Healthcare trade associations represent different types of healthcare professionals and organizations. Though trade associations have a diverse set of purposes and are generally national in scope, they offer an avenue through which substance misuse prevention can establish partnerships that “filter down” to the association’s members. Many national associations also have state, regional, or metropolitan associations or chapters that present opportunities for local collaboration with substance misuse prevention.

- **American Medical Association (AMA).** The AMA is the largest physician and medical student trade association in the United States. The AMA supports research, provides education, conducts advocacy and lobbying activities, and develops standards. The AMA also publishes the *Journal of the American Medical Association*, a weekly medical journal.
- **American Hospital Association (AHA).** The AHA is the largest trade association for hospitals and healthcare networks in the United States. The AHA supports research, provides technical assistance, develops standards, promotes advocacy, and lobbies for its members. The AHA also publishes multiple journals and newsletters. The AHA is organized by region, with each region (and some states) represented by a single executive.
- **National Association of Community Health Centers (NACHC).** The NACHC works with a network of state health center and primary care organizations to advocate for health centers and their clients, educate the public about health centers, train and provide technical assistance to health center staff, and foster alliances with partners to facilitate the delivery of primary care in needy communities. States and regions have their own affiliates, including primary care associations and associations of community health centers.
- **American Academy of Family Physicians (AAFP).** The AAFP represents family physicians with the goal of improving health care through advocacy, practice enhancement, and education.
- **Continuing Medical Education (CME).** This refers to regular classes that many states require physicians and other medical professionals to attend in order to maintain their professional licensure. CMEs are intended to ensure that medical professionals maintain their knowledge and skills, including learning about new research or practices. A number of sources offer CMEs, including many trade associations. Professionals working to prevent substance use and misuse may consider working with partners to develop CMEs specific to substance use prevention or screening.