Primary Care 101: A Glossary for Substance Misuse Prevention Professionals

Over the past two decades, the health care landscape has experienced numerous and rapid changes, including new laws, diseases, behaviors, research findings, technologies, and funding mechanisms. These changes have resulted in growing recognition of the value of prevention, including substance misuse prevention, for improving health outcomes and reducing costs. They have also opened the door to new opportunities for primary health care and prevention to work together in more deliberate and coordinated ways.

This glossary is designed to facilitate collaboration across prevention and primary care, specifically, by defining key terms and concepts familiar to primary care providers that may not be known to prevention professionals. Specifically, it describes:

FEDERAL LEGISLATION

Understanding the effects of legislation on primary care can help prevention practitioners capitalize on these opportunities to strengthen the scope and reach of prevention services. For example, the Affordable Care Act includes many potential funding avenues for substance misuse screenings and referrals. This section describes federal legislation that has altered insurance

coverage, service delivery, benefits packages, and the availability of other health care resources for millions of Americans in recent decades.

- **2008: Mental Health Parity and Addiction Equity Act (MHPAEA).** Also known as "parity," MHPAEA imposed a conditional behavioral coverage requirement on certain insurers. While MHPAEA does not require insurers to offer behavioral health coverage, those who provide it must do so at the same level of coverage they provide for general health care services. For instance, applicable plans must cover depression screenings at parity with cancer screenings.

- **2010: Affordable Care Act (ACA).** The ACA was originally passed to expand health insurance coverage, reduce the growing cost of health care, and improve the quality of health care services. It expanded coverage by offering subsidies for certain individuals to purchase private insurance and allowing states to expand their Medicaid programs. As a result, uninsured individuals decreased from 46.5 million in 2010 to 27.5 million by 2021. The law also encouraged integration of care and sought to improve the quality of health coverage through Essential Health Benefits:

    - **Essential Health Benefits (EHBs).** These are a set of 10 health benefit categories that certain insurers must provide. One of the 10 is "mental health and substance use disorder services, including behavioral health treatment" as well as "preventive and wellness services." The EHBs present an opportunity to secure coverage for numerous substance misuse prevention services. For example, by 2019, 87% of people with employer-sponsored health insurance were enrolled in plans required to cover EHBs. The EHBs were designed to synergize with MHPAEA's provisions to expand access to behavioral health coverage.

- **2018: Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT).** The SUPPORT Act dedicated federal funding to a wide array of new initiatives and reforms to advance overdose prevention, education, and treatment programs. It required state Medicaid programs to cover medications for opioid use disorder (MOUD) and eliminated geographic restrictions on Medicare coverage of behavioral telehealth services. It also funded primary care provider training on improving care coordination for people with co-occurring substance use and physical health problems.

- **2020: Coronavirus Aid, Relief and Economic Security Act (CARES).** The CARES Act was a temporary emergency stimulus bill crafted in response to the emergence of the COVID-

19 pandemic. The CARES Act also significantly expanded access to telehealth services (including behavioral telehealth services) through federally qualified health centers, rural health clinics, and Medicare coverage.

- **2022: Inflation Reduction Act (IRA).** The Inflation Reduction Act aimed to reduce the federal deficit to fight inflation. It created a three-year extension of ACA subsidies designed to lower (or eliminate) health care premiums for millions of Americans. These subsidies continued the ACA's goal of expanding coverage and creating new opportunities for accessing behavioral health services. It also allowed Medicare to negotiate drug prices for certain drugs and put a $2,000 cap on out-of-pocket costs for prescription drugs (including those used to treat behavioral health disorders).

PAYERS

When collaborating with primary care, it is important to understand how your partners are funded. Whether, how, and to what extent prevention services can be funded are likely to drive their service delivery decisions. Payers are the entities that fund health care services. They dictate where individuals can receive health care and the types of services they can receive. In many cases, health care providers will make service delivery decisions based on payers' policies.

- **Children's Health Insurance Program (CHIP).** CHIP provides free or low-cost health insurance coverage for children through age 18 in low-income families who earn too much to qualify for Medicaid (see below). Each state uses federal funds to subsidize CHIP, but qualification and benefit rules and coverage types vary. Although CHIP is not a part of Medicaid, it works closely with state Medicaid programs, and states may choose to use funds from CHIP to expand their Medicaid program to include children through age 18, establish a standalone children's health insurance program, or some combination of both.

- **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.

- **Medicare.** Medicare is the country's federally funded health care program for older adults. Because it is so large, Medicare is the focus of myriad integration and cost-saving initiatives, often as part of major health care legislation (see Federal Legislation, above). Medicare provides coverage for inpatient and outpatient behavioral health treatment services. It also covers and promotes a wide range of preventive and screening services, including tobacco cessation counseling. Additionally, it covers yearly wellness visits, which provide an opportunity for substance misuse screenings and other prevention services.
- **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 have obtained private insurance. This presents new opportunities to expand coverage for prevention screenings and early interventions. However, even with legislative requirements such as EHBs and parity, implementing coverage changes can be a slow and difficult process. Insurers' relationships with providers will be heavily influenced by existing reimbursement systems.

Additional Payment Mechanisms

In addition to knowing the payers themselves, it is helpful to know about the mechanisms that can influence payment decisions. Two important examples are:

- **Medicaid Waivers/Medicaid State Plan Amendments (SPAs).** Medicaid waivers or SPAs are mechanisms states can use to modify their Medicaid programs. Modifications can include adding/changing coverage or adjusting payment methodologies. They can also exempt states from certain federal requirements if the exemption would further advance health care outcomes. The federal government must approve proposed changes, and states must guarantee that they will continue to meet federal coverage requirements and not increase federal costs. States seeking to expand substance misuse prevention coverage beyond federal requirements may be able to use these mechanisms.
- **Payer of Last Resort.** This applies to certain payers that only pay for services after all other potential payers have paid for the services they cover. The term most often refers to government health care programs. Medicare and Medicaid are both payers of last resort.

- **TRICARE.** TRICARE is the government-managed health care system for military personnel, including active-duty service members and retirees, their families, and dependent

survivors. The program allows enrollees to select from several different plans and payment systems that allow them to see any primary care organization that accepts TRICARE. As a result, many enrollees see health care providers outside of the Defense Health Agency or the Veterans Health Administration. This presents opportunities for civilian providers to improve behavioral health outcomes among military personnel, veterans, and their families.

PRIMARY CARE ORGANIZATIONS AND RELATED TERMS

Primary care describes a patient's source of regular health care, and primary care providers are often a patient's first contact with the health care system. Primary care may include health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis, and treatment. Primary care practices are typically owned by either hospital groups or individual physicians.

- **Hospital-owned primary care practices** are 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.

- **Physician-owned primary care practices** are 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). Physician-owned practices have discretion over the services they offer and the payers they accept.

Regardless of ownership structure, primary care organizations can take many different forms that influence how they interact with consumers, health insurers, and other health care providers—including organizations providing prevention services. Understanding the different types of primary care organizations can help prevention professionals decide where to direct their collaborative efforts.

- **Accountable Care Organizations (ACOs).** These are collaborative organizations that comprise numerous health care 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—while also reducing costs—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 Medicaid and private insurer ACOs 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.

- **Charitable (Free) Clinics.** These are non-profit health care organizations that provide a range of free health care services (including but not limited to primary care) to those who are uninsured, underinsured, or have limited access to health care. Many community health centers (see below) that charge a sliding scale fee are still considered charitable clinics if they provide care regardless of a patient's ability to pay.

- **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.

- **Coordinated or Integrated Care**. Together, these concepts refer to multiple health care professionals or organizations with different specialties working together to treat their shared 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 integrating behavioral health and primary care or integrating specialty services and primary care.

- **Employee Wellness Programs.** Also known as workplace health programs, these programsseek 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 offer 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.

- **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 Look-Alikes (FQLA).** 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.
- **Integrated Delivery Systems (IDS).** Also commonly known as integrated delivery networks or provider-sponsored health plans, an IDS is a comprehensive network of health care services where the provider also operates a health insurance plan. An IDS health insurance plan is unique in that IDS patients are restricted to seeing providers at facilities operated by the IDS. An IDS offers a network of inpatient and outpatient care services, including hospitals, primary care, surgery centers, and more.
- **Nurse-Managed Health Centers (NMHCs).** These health centers provide primary care and disease prevention services to patients with limited access to health care. NMHCs are often affiliated with universities, nursing schools, or CHCs in communities with high uninsurance rates. NMHCs are managed by Advanced Practice Registered Nurses and often staffed by an interdisciplinary team of health care providers (e.g., physicians, therapists, and social workers) to provide wraparound physical and behavioral health care.
- **Patient-Centered Medical Homes (PCMHs).** This is a care coordination model that puts patients at the center of a highly personalized treatment plan, with a team of providers working together to provide services. PCMHs require either a single practice with both primary and specialty care providers or a primary care practice with care coordination agreements with specialty providers. PCMH providers collaborate to provide broader access to services, comprehensive care management, and patient engagement in health care services. This model allows for early identification of behavioral health needs as part of a patient's overall treatment plan.

PAYMENT SYSTEMS AND RELATED TERMS

When partnering with primary care providers, it is important to understand not only the payer(s) and provider(s) but also the payment/reimbursement structures through which they interact, as these may influence if or how a provider is willing to implement new prevention initiatives. Most providers see patients from multiple payers and each of these payers compensates the provider

through its own payment structure. Understanding how providers get paid can help you develop innovative ways to fund primary care collaborations.

- **Direct Primary Care.** In a direct primary care model (sometimes known as "membership medicine" or "concierge medicine"), patients pay a primary care physician or practice a fixed monthly or annual fee for highly personalized, comprehensive care. Typically, insurers are not involved and providers bill patients directly for services rendered.

- **Fee for Service (FFS).** This is the most "basic" health care payment model. In an FFS 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 that are more likely to reduce costs.

- **Managed Care.** This broad term refers to several related strategies designed to reduce costs and improve the quality of health care. Managed care strategies can include (but are not limited to): contracting with a select set of health care 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. Examples of managed care systems include health maintenance organizations, preferred provider organizations, and point of service plans.

- **Provider Network.** In certain managed care systems (see above), the provider network is the group of organizations (e.g., physician groups, hospitals) that agree to accept pre-negotiated payments for a set of enrollees from one specific payer. For example, "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.

- **Value-Based Purchasing (VBP).** Counter to traditional fee for service models (see above), value-based purchasing (also known as pay-for-performance) refers to a set of related strategies that link some portion of a health care provider's compensation directly to

patient outcomes (e.g., payments based on lowering patients' blood pressure). VBP programs may also penalize providers for poor outcomes. Providers within VBP programs may have a financial incentive to implement new prevention initiatives to avoid penalization for poor patient outcomes related to substance misuse. Alternative Payment Models (APMs) are the mechanism by which VBP strategies are implemented. Some examples include:

- **Capitated Payments.** Under this APM, health care providers receive a lump sum payment for each patient for a set period (e.g., one year). Providers must cover all patient costs during that time 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 APM, health care 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 bundled payment; however, they may also favor those services to achieve long-term savings.

TRADE ASSOCIATIONS

Health care trade associations represent different types of health care 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 Academy of Family Physicians (AAFP).** The AAFP represents family physicians with the goal of improving health care through advocacy, practice enhancement, and education.
- **American College of Physicians (ACP).** The ACP represents internal medicine specialists (i.e., physicians who provide primary care for adults) in enhancing quality and effective

health care through improving clinical knowledge, providing continuing medical education, and supporting advocacy initiatives.

- **American Hospital Association (AHA).** The AHA is the largest trade association for hospitals and health care networks in the United States. It supports research, provides technical assistance, develops standards, promotes advocacy, and lobbies for its members. It also publishes multiple journals and newsletters. The AHA is organized by region, with each region (and some states) represented by a single executive.
- **American Medical Association (AMA).** The AMA is the largest physician and medical student trade association in the United States. It 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.
- **Continuing Medical Education (CME).** Many states require physicians and other medical professionals to attend ongoing professional development in order to maintain their professional licensure. CMEs help to ensure that medical professionals maintain their knowledge and skills, including learning about new research or practices. Several 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.
- **Federation of State Medical Boards (FSMB).** The FSMB supports state medical boards licensing and regulating primary care physicians and other medical professionals. It provides exam and credentialing services, medical professional query services, CME (see above), and advocacy efforts to improve the safety and well-being of patients.
- **National Association of Community Health Centers (NACHC)**. The NACHC works with a network of state health centers 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 under-resourced communities. States and regions have their own NACHC affiliates, including primary care associations and associations of community health centers.