The Elephant(s) in the Room: Lessons from Over A Decade of State Policy to Create a More Primary Care Oriented Delivery System

Revitalizing Primary Care Symposium

UC Davis
October 17, 2024

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About The Milbank Memorial Fund

The Milbank Memorial Fund is an endowed operating foundation that works to improve population health and health equity by collaborating with leaders and decision-makers and connecting them with experience and sound evidence.

We advance our mission by:

- Identifying, informing, and inspiring current and future state health policy leaders to enhance their effectiveness;
- Working with state health policy decision makers on issues they identify as important, particularly in areas related to primary care transformation, sustainable health care costs, and aging, and
- Publishing high-quality, evidence-based publications and *The Milbank Quarterly*, a peer-reviewed journal of population health and health policy.

Agenda

- The Theory of Change for Focusing State (and Federal) Policy on Primary Care Spending (Elephant One)
- The State of the State (Policy)
- Lessons so Far – Does the Theory work? (Elephant Two)
- Where Now

Elephant One

What is the Sofa? What is the Elephant?

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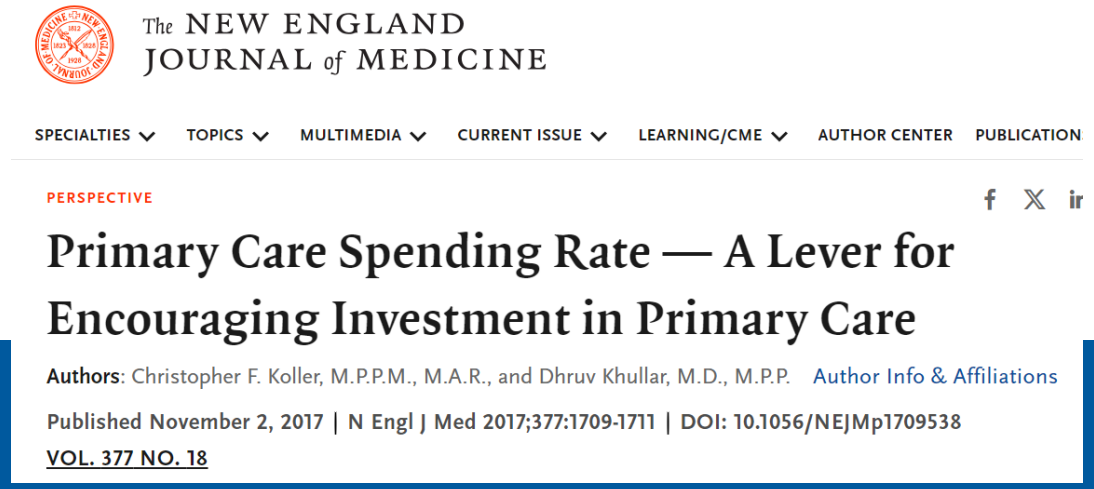
The Theory of Change

1. Primary Care is undervalued in the US Health System
2. Assessing the portion of total health care spending going to primary care ("primary care spend") articulates that under-valuing in an easily-comprehensible way
3. Setting targets for increasing primary care spend and measuring progress is supported by evidence, encourages a systemic view, and is an effective political organizing tool
4. Setting public policy to reach those targets addresses the failure of the health care "market" to value primary care.

“We propose using the primary care spending rate — the proportion of all medical spending devoted to primary care — as a measure for assessing a health system’s orientation toward high-value care. The proportion of a health system’s resources that it devotes to primary care — including clinician incomes, performance payments, case-management activities, and health information technologies — has an important effect on patient care, and in some respects is the clearest reflection of its leaders’ priorities.

Greater use of this metric — for measuring health system performance, studying the role of primary care, and focusing public awareness and policy action — could help close the gap between what the evidence supports and how primary care is practiced in the United States.”



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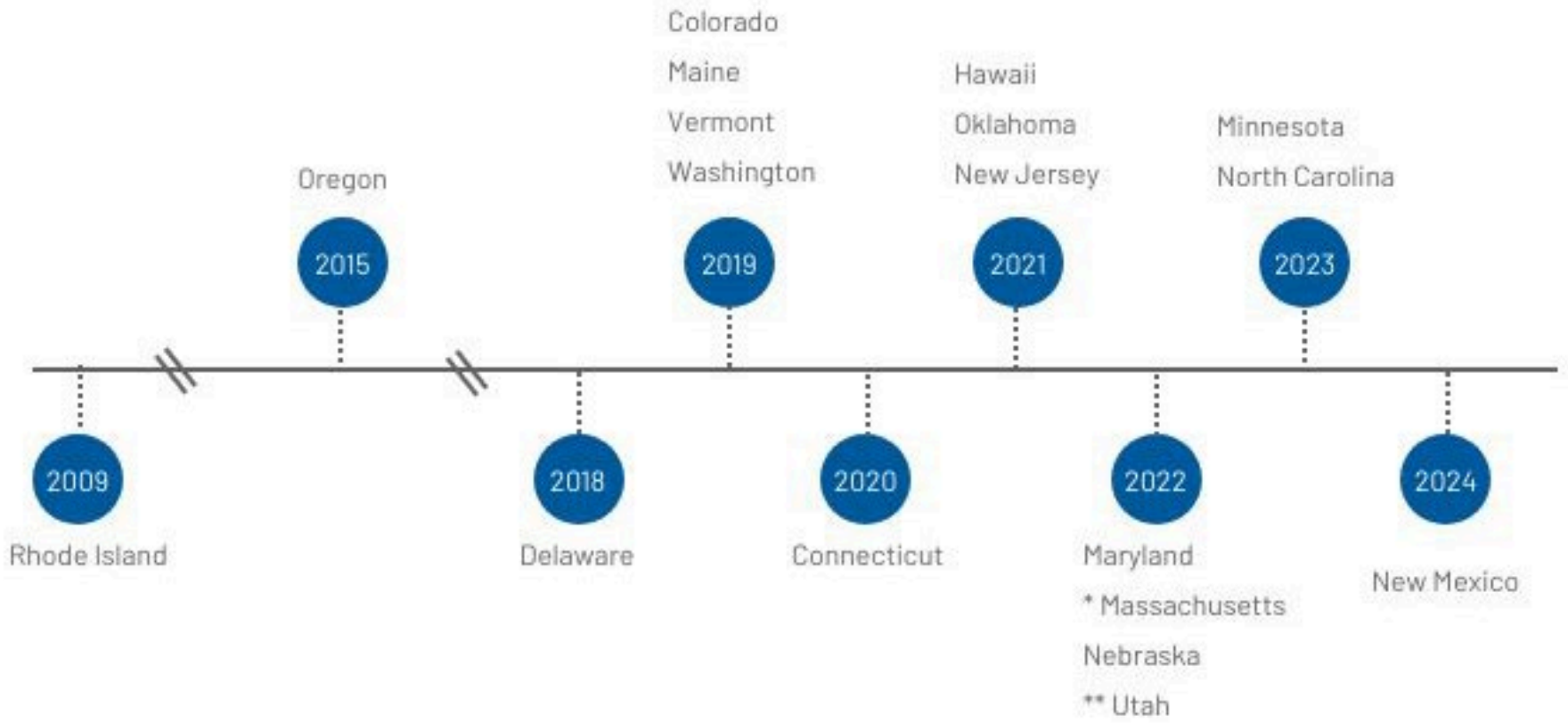
Contrast This with Less Systemic Efforts to Strengthen Primary Care

- Payer- or payer-type specific
  - CMMI payment models – CPC+ and ACO's
  - PCMH efforts
- Private Sector Innovations
  - Telehealth, Convenience Care, Concierge and Medicare Advantage clinics
- Community Health Center Funding
- Workforce efforts

The State of State (Evidence)

- Reasonable evidence that countries with relatively higher primary care spends rates “do better”
  - Precise comparisons are tough
- No evidence for states.
- Good but not systematic evidence that high performing integrated delivery systems have higher primary care spend rates
  - Medicare Advantage delivery system strategies (Oak Street, etc.)
  - See CA data from IHA
  - Physician oriented ACOs do better but more work to be done analyzing pcp spend in ACO data

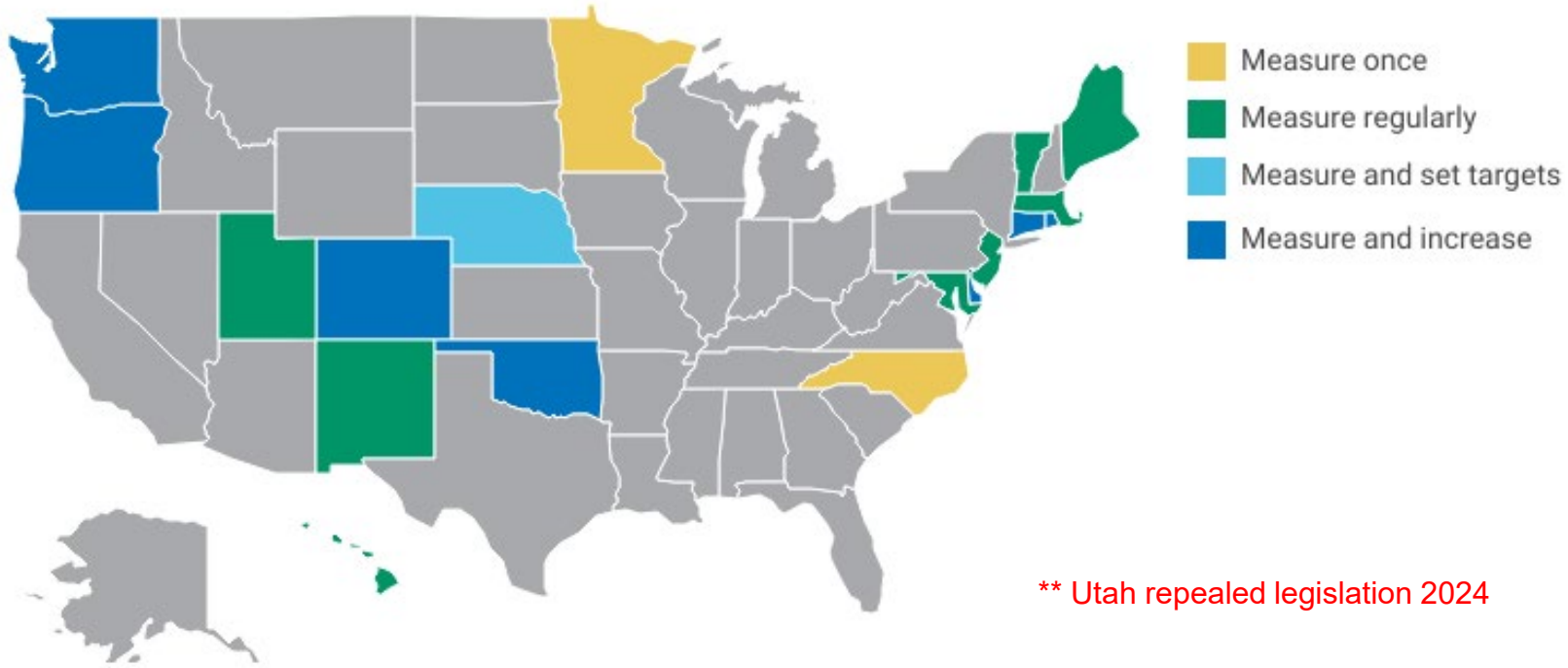
The State of the State (Policy) (I): States Got on Board Relatively Fast



- Massachusetts passed initial legislation in 2012

** Utah repealed legislation 2024

The State of the State (Policy) (II): States Varied in Level of Ambition



** Utah repealed legislation 2024

Milbank/Primary Care Development Corporation/ Commonwealth Fund run a network of state officials and advocates to support this work

Sources: Primary Care Collaborative, California Health Care Foundation, Primary Care Development Corporation

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Feds Follow Suit

- NASEM :”Implementing High Quality Primary Care Report”
- AHRQ report on Primary Care Spending Measurement
- CMMI Ahead Model

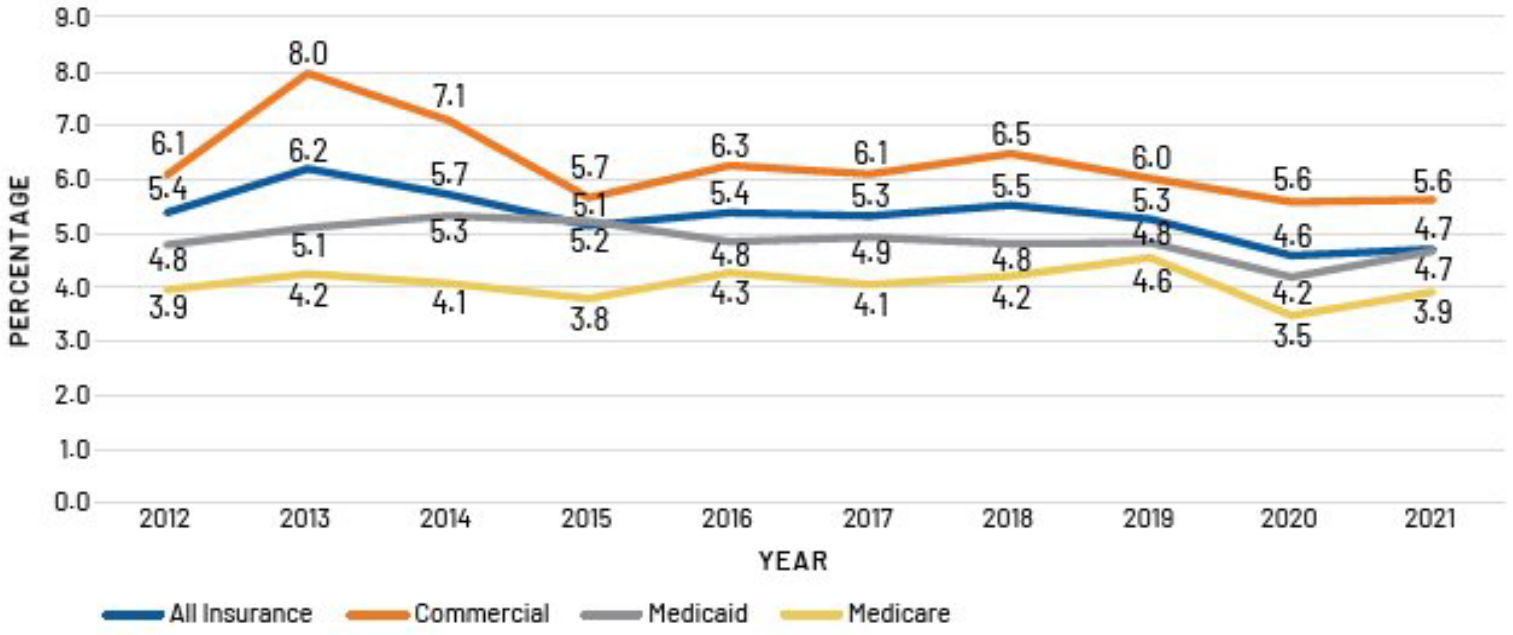
- Opportunity – Primary Care Spending as a Measure for CMMI Payment Model Evaluations

Lessons So Far

1. Primary Care continues to weaken,
2. Primary Care Spend is a Powerful Organizing Tool—at least for the Cognoscenti
3. Technical Questions Remain
4. No clear evidence that states that have increased primary care spend have strengthened primary care

Primary Care Spending Levels Flat or Decreasing

Figure 9. Primary Care Spending (Narrow Definition) Remains Low Across All Insurers (2012-2021)



Data Source: Analyses of Medical Expenditure Panel Survey data, 2012–2021.

Notes: The primary care narrow definition is restricted to primary care physicians only. Primary care specialties included family medicine, general practices, internal medicine, geriatrics, pediatrics, and osteopathy.

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Fewer Primary Care Physicians

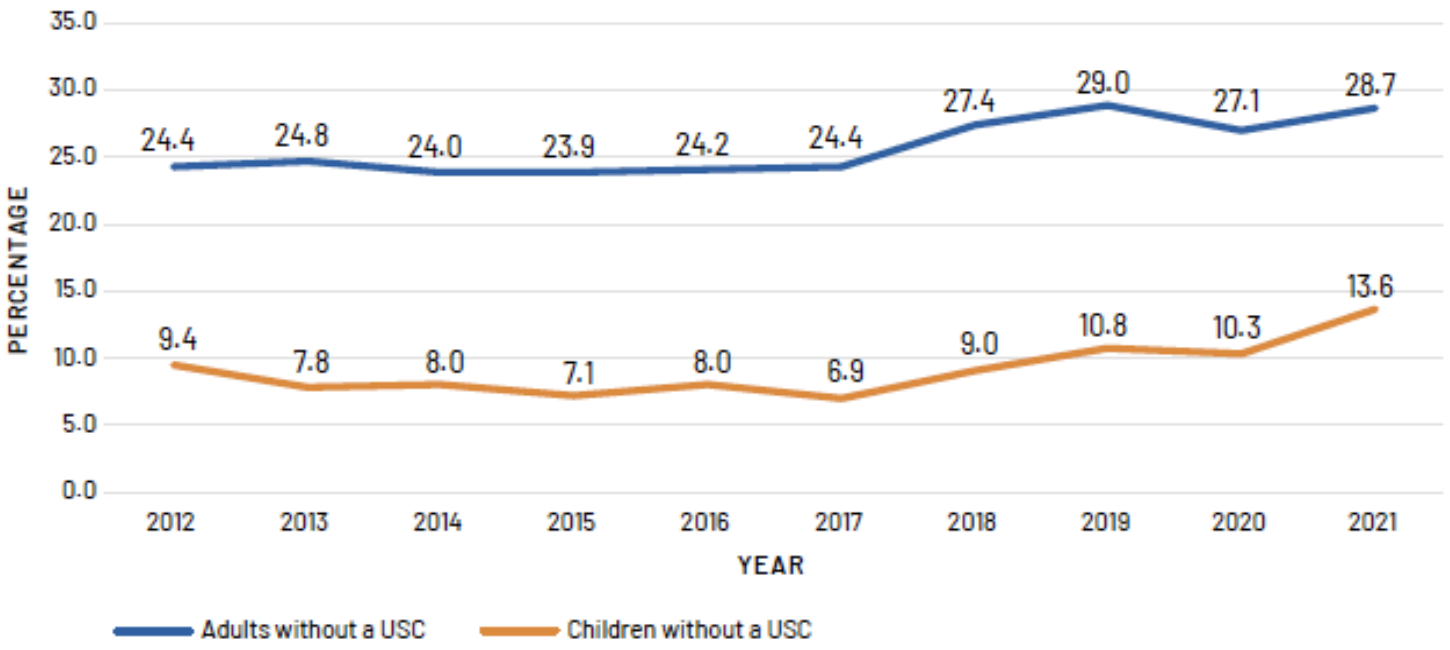
Figure 2. The Number of Primary Care Physicians per Capita Is Falling (2012–2021)

Data Source: Analyses of American Medical Association Masterfile (2012–2021), Centers for Medicare and Medicaid Services Physician and Other Practitioners data (2012–2021), and the American Community Survey Five-Year Summary Files (2012–2021).

Notes: Primary care specialties included family medicine, general practices, internal medicine, geriatrics, pediatrics, and osteopathy.

Patient Access and the Health of Populations at Risk

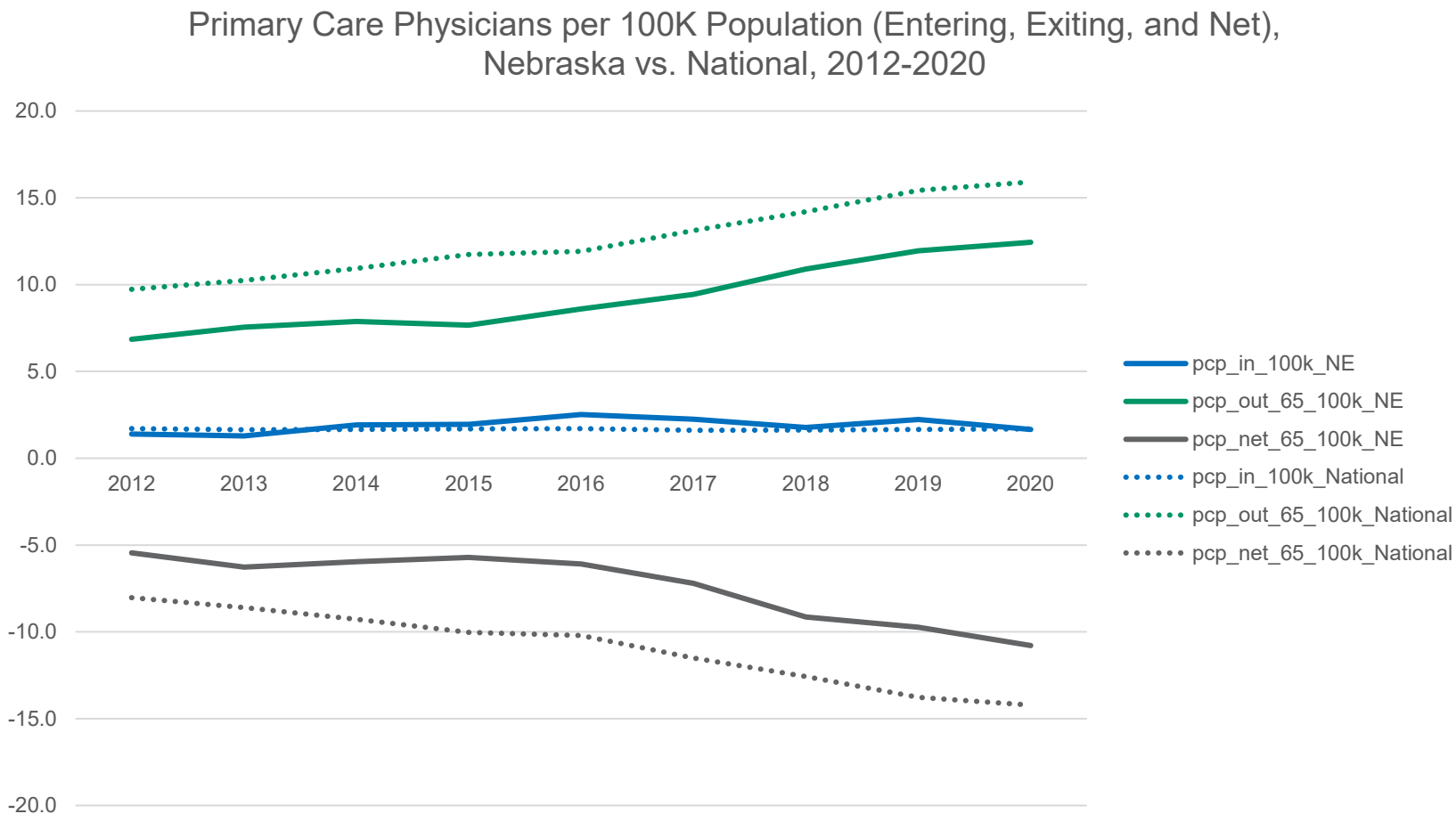
Figure 1. The Percentage of the US Population Without a Usual Source of Care Is Rising (2012–2021)



Data Source: Analyses of Medical Expenditure Panel Survey data, 2012–2021.

Notes: Usual source of care (USC) ascertained whether that is a particular doctor's office, clinic, health center, or other place where the individual usually goes when sick or in need of health advice. No usual source of care includes those who reported no usual source of care and those who indicated the emergency department as their usual source of care.

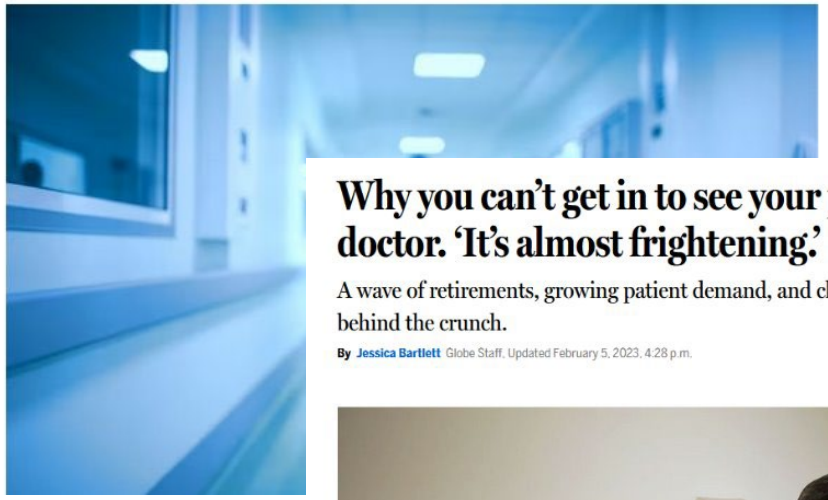
We are Looking at a Future With Fewer Primary Care Physicians



Access Issues Starting to Hit Home

Opinion | **The shrinking number of primary-care physicians is reaching a tipping point**

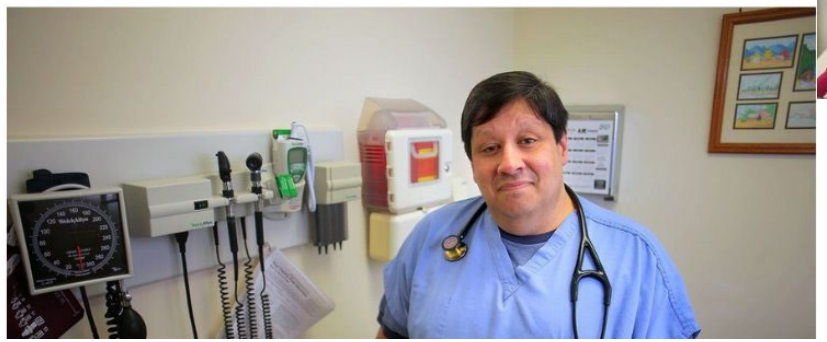
By Elisabeth Rosenthal
September 5, 2023 at 8:34 a.m. EDT



Why you can't get in to see your primary care doctor. 'It's almost frightening.'

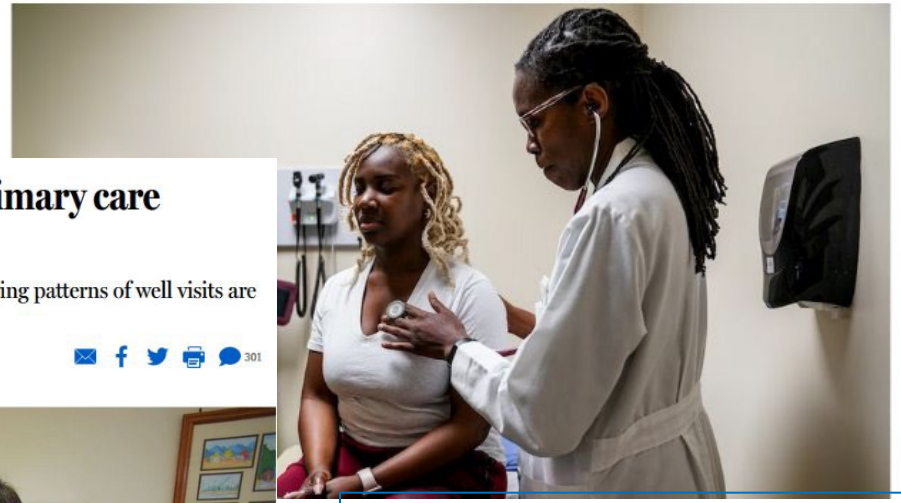
A wave of retirements, growing patient demand, and changing patterns of well visits are behind the crunch.

By Jessica Bartlett Globe Staff, Updated February 5, 2023, 4:28 p.m.



Primary care saves lives. Here's why it's failing Americans.

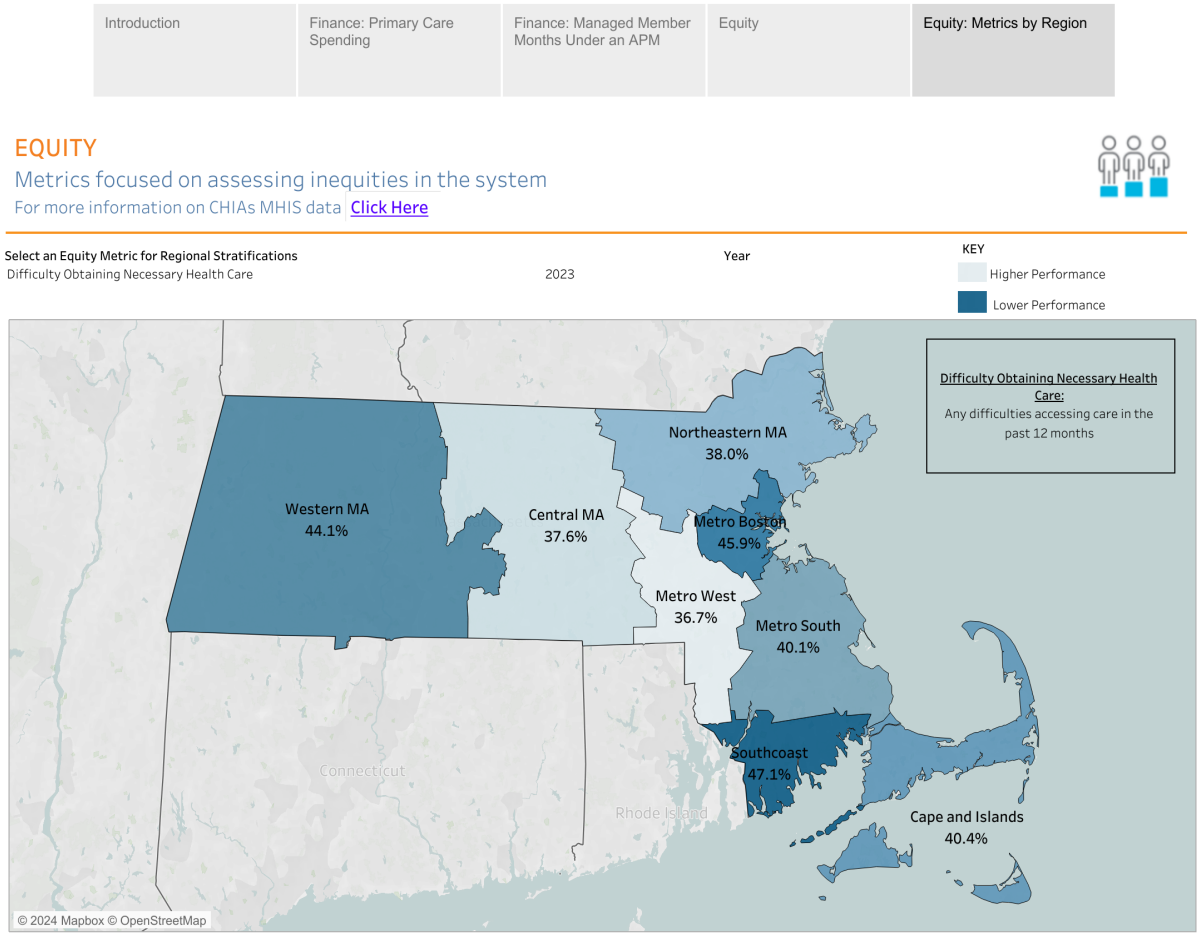
By Frances Stead Sellers
October 17, 2023 at 6:00 a.m. EDT



New CHCF Report – reasons for foregoing care are increasingly appointment access

Lesson II: Primary Care Spend is a Powerful Organizing Tool —for the Cognoscenti

Massachusetts Primary Care Dashboard:
Regional Differences on Equity Measures



Notes: Difficulty accessing care metric will not be populated in 2017, 2019, and 2021. This measure was not collected in 2017 and due to changes in the instrument, "any of these difficulties" is measured differently from 2019 and 2021 measurement. Specifically, it no longer asks residents if they were unable to get an appointment due to a lack of childcare for children at home or if they were unable to get an appointment due to language barriers or a lack of interpreter services. In 2023, this measure includes: unable to get an appointment with doctor's office or clinic as soon as needed; unable to get an appointment with a specialist as soon as needed; doctor's office or clinic not accepting new patients; doctor's office or clinic not accepting insurance type; and unable to get an appointment due to transportation issues. The percent of Massachusetts residents with a PCP was a new metric added to the 2023 MHIS report and will only be populated for data year 2023.
Source: Massachusetts Health Insurance Survey.

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Primary Care in Massachusetts

A high-functioning primary care system leads to better patient outcomes, lower costs, and more equitable care. Tracking the health of primary care in Massachusetts is essential for identifying areas that need strengthening and monitoring the impact of investments.

FINANCE

METRICS FOCUSED ON SPENDING FOR PRIMARY CARE SERVICES

EXPLORE ▶

In 2022, MassHealth MCO and ACO-As had the highest percentage of spending on primary care (7.5%), as well as the highest use of alternative payment methods.

Medicare Advantage plans had the lowest primary care spending (4.2%) compared with other insurance categories in 2022.

PERFORMANCE

METRICS FOCUSED ON ACCESS AND CARE

EXPLORE ACCESS ▶

EXPLORE CARE ▶

In 2023, 41.2% of residents reported difficulty obtaining necessary health care in the past 12 months, an increase from 33.0% in 2021.

Between 2018 and 2022, cervical cancer screening rates dropped by 5.2 percentage points.

CAPACITY

METRICS FOCUSED ON THE PRIMARY CARE WORKFORCE AND PIPELINE

EXPLORE ▶

In 2021, 5.6% of physicians left primary care in Massachusetts, an increase from 3.1% in 2019.

In 2023, 22% of Massachusetts medical school graduates were practicing in primary care six to eight years after graduation.

EQUITY

METRICS FOCUSED ON ASSESSING INEQUITIES IN THE SYSTEM

EXPLORE ▶

There were substantial racial and ethnic disparities in access to and utilization of primary care.

In 2023, compared with other racial and ethnic groups, Hispanic residents reported lower rates of having a preventive care visit and higher rates of avoidable emergency department visits.

CONTEXT

CONTEXT ON THE MASSACHUSETTS PRIMARY CARE MARKET, IMPACTS OF COVID-19, AND AT-A-GLANCE HEALTH OUTCOMES MEASURES

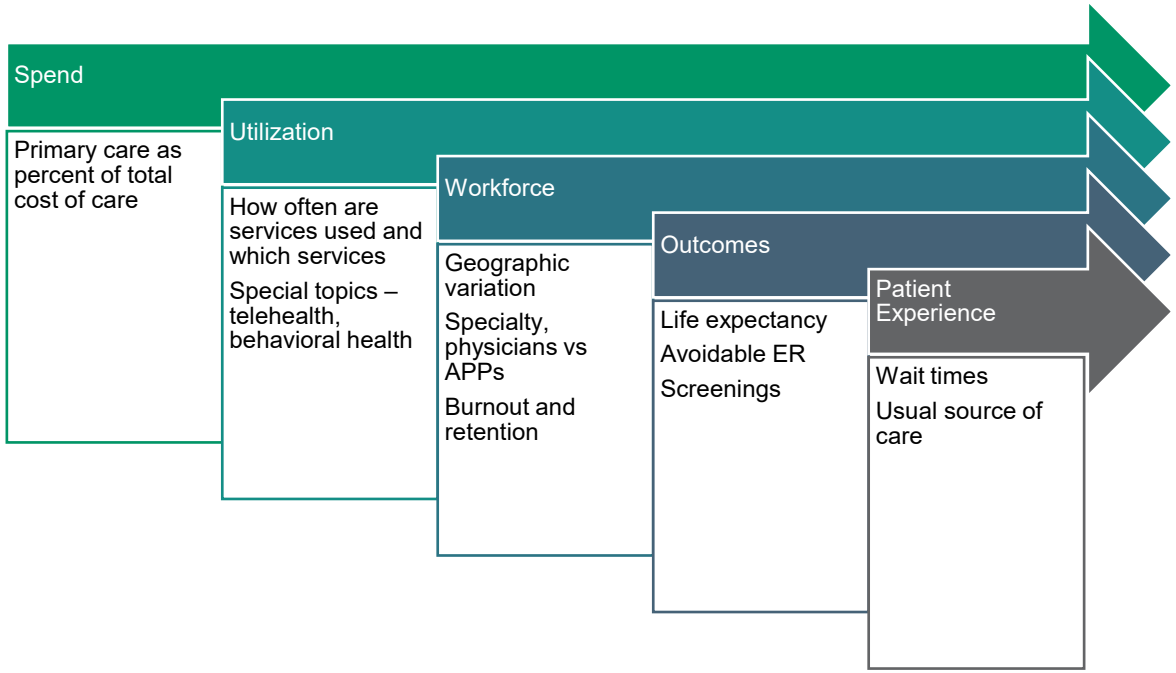
EXPLORE ▶

Metrics included in this dashboard have been collected from various data sources. The Primary Care Dashboard databook includes multi-year trends where data is available. For additional information see the Primary Care interactive Tableau dashboard, databook, and technical appendix.

mhqp
Massachusetts Health Quality Partners
www.mhqp.org

CHIA
www.chiamass.gov

Virginia Primary Care Scorecard



Scorecard

Scorecards also in NY, CA (in development)

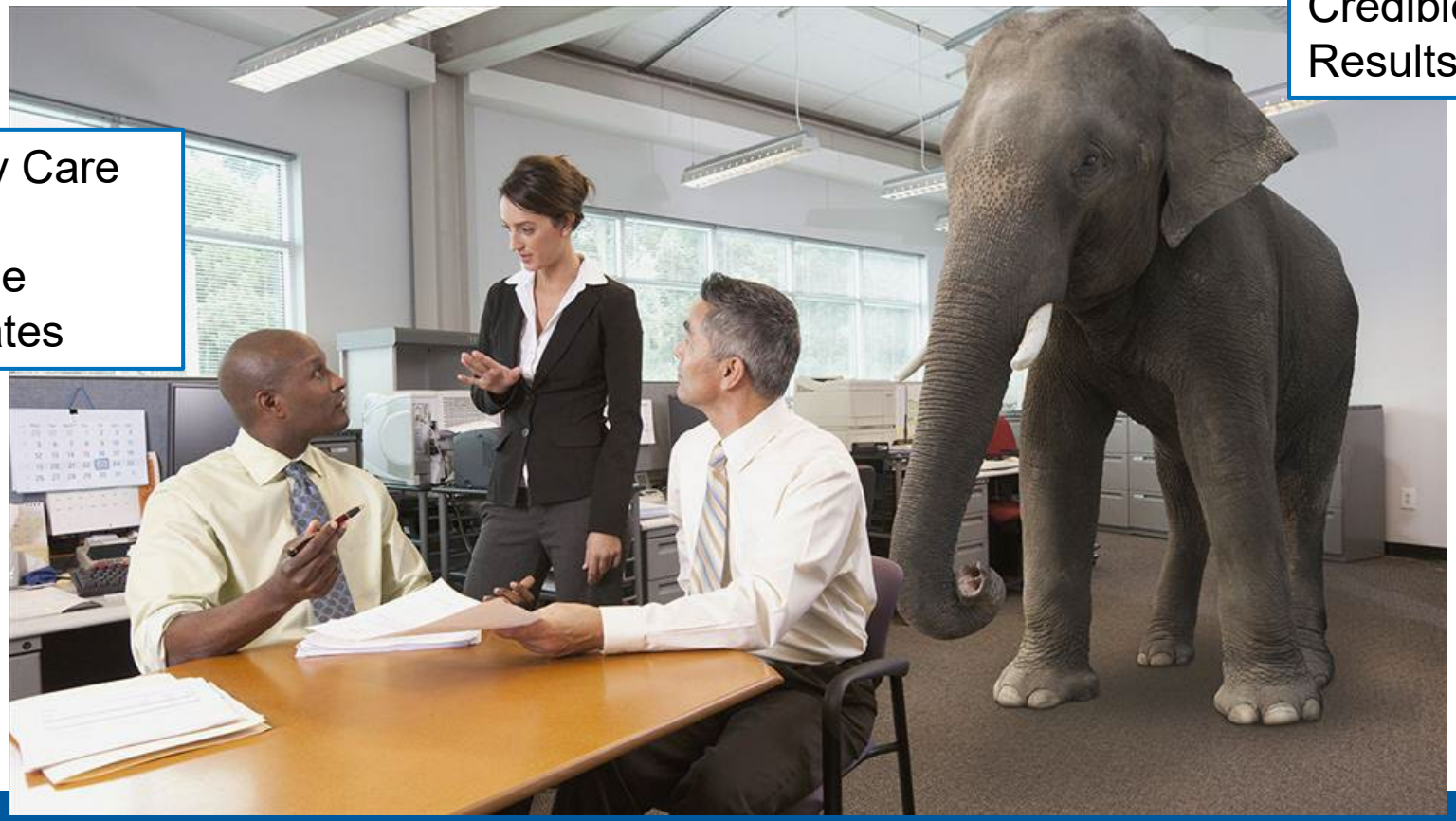
Note: Full set of 2024 Virginia Task Force on Primary Care Reports may be found here

Lesson III: Technical Issues Remain

1. Standardizing Definition of Primary Care (AHRQ)
2. Defining Denominator
3. Data Sources
4. Non-Claims Spend
5. Increased interest in expanding measurement idea to include behavioral health and public health

A Second Elephant:

Lack of Credible Results



Primary Care Spend Increase Advocates

Lesson IV: Limited Evidence that Increasing Overall Primary Care Spend Actually Strengthens Primary Care

1. States with policies in place mandating increases in primary care spend:

   RI, OR, CO and DE

2. What is stronger primary care?
   - Better patient access (usual source of care)?
   - More primary care clinicians?
   - Better , higher quality primary care?
   - Improvements in population health outcomes for system?.

These are Areas for Research

Observed Challenges with Policies to Increase Primary Care Spend

1. Implementing regular, reliable measurement
2. Defining and prioritizing categories of primary care spending
3. Who's accountable – Insurers? Delivery systems?
4. Enforcement mechanisms
5. Aligning Across Payer Type: Commercial, ERISA, Medicaid and Medicare
6. Employed clinicians… (does the money get to them?)
7. ..in a fee for service system (misaligned incentives)
8. Establishing credible oversight and adjustment structure with engaged stakeholders

Ways Forward

1. Remember the Why
2. Measure, measure, measure
3. Learn and Improve
4. Think “systemically”

I. Remember Why We Want a Primary Care Oriented Delivery System

- Not for Near Term "Savings" (Song and Gondi JAMA. 2019 Oct 8; 322(14): 1349–1350.)
    - ~~"Investment"~~ and ~~"ROI"~~

- For Improved Population Health and Health Equity ("Public Good" : NASEM)
    - "Rebalancing"

II. Measure, measure, measure

1. Address technical challenges cited (define primary care, non-claims spend)
2. Reliable data sources
3. Widespread use of measure as evaluation tool by researchers and monitoring tool by policy and administration.
   - Think HEDIS or public health measures

III. Learn and Improve: Refine existing strategy (RI and CA)

- Evaluate current work
- Better political organizing of/by primary care stakeholders
- Statute and Regulation to address challenges
  - Measurement
  - Priorities for increased spending
  - Medicaid and public employees
  - Accountability
    - Employed providers
  - Monitoring
  - Enforcement

See: “Does Higher Spending On Primary Care Lead To Lower Total Health Care Spending?” Swan et al, Gealt5h Affairs Forefront, 10/8/24.

IV. Think About the System:
How much can more water help in a harsh environment?

IV (cont'd). What do we mean by "the System" (in which we want to see stronger primary care)?

A system has defined inputs, known interactions and measurable outputs

Is our system….

- The country?
- The state ?
- Existing healthcare organizations?
- Economically aligned delivery systems and patient populations (Mature ACO's)?
  - This rethinking may be necessary – not just for primary care issues

Hard to rebuild the foundation of the delivery system….

….without changing the rest of the structure

States Can Lead: A Systemic Approach to Affordability

State Policies That Could Collectively Slow Cost Growth and Improve Health and Care.

Policy	Justification
Comprehensive oversight and spending-growth targets: Each state should establish and adequately fund a state agency to track systemwide cost and quality performance, set spending-growth targets, identify drivers of cost growth and opportunities for improvement, and implement or recommend needed reforms.	Systemwide oversight, sound data, and understanding of state-specific drivers of cost growth provide the foundation for effective policy. Having the statutory authority to achieve spending-growth targets makes agencies' actions more likely to withstand legal threats from groups and organizations that resist reform.
Hospital global budgets: States should work with Medicare to establish all-payer hospital global budgets that ensure both adequate local and regional access to needed facilities and services and their financial viability, gradually shifting resources to primary care and population health improvement, as possible.	All-payer hospital global budgets shift incentives by rewarding health improvements, reductions in avoidable utilization, and increased efficiency rather than volume growth for high-margin services. Implemented properly, they can strengthen safety-net and rural facilities while reducing duplication in overserved markets.
All-payer accountable care organizations: All payers should be required to adopt aligned global payment models for physician-led organizations that can deliver comprehensive, coordinated primary and specialty care with accountability for quality and the total cost of care.	Still the predominant payment model, fee-for-service payment rewards overuse and locates accountability at the level of the clinician, resulting in fragmented care. Clinicians and health care organizations that receive global payments for all their patients have powerful incentives to improve care and the necessary freedom to innovate.
Pricing power limited by means of effective regulation: States should adopt policies to preserve competition wherever possible. Where it is not possible, they should establish regulatory bodies authorized to review cost structures and effectively regulate prices as needed.	Consolidation and barriers to entry have led to decreased competition, lower quality of care, and monopoly pricing, especially for hospital services and prescription drugs. In such cases, regulation is essential for improving affordability and access to care.

Fisher et al. New England Journal of Medicine, October 10, 2024

Means getting more alignment

- Economic incentives among providers (accountable care and global budgets)
- Patients with usual source of care (Benefit Design)
- Among payer types (Medicare, Medicaid, Commercial and ERISA)
- The political interests of the 80 percent of the economy that is not health care