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Investing in Primary Care:

A Work in Progress

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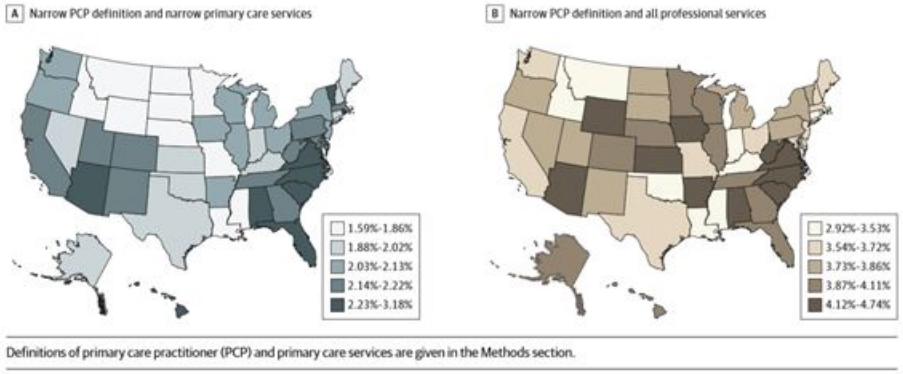
INTRODUCTION: The Need for Change

> "We are convinced that strengthening primary health care (PHC) is the most inclusive, effective and efficient approach to enhance people's physical and mental health, as well as social well-being, and that PHC is a cornerstone of a sustainable health system..."[1]

This opening statement from the World Health Organization (WHO) reflects the value of effective, quality primary care to the delivery of overall health care. While the WHO was addressing the continued need for systemic change to promote a strong primary care delivery system on a global level, there has been growing evidence of that need within the United States. One recent study from this year reported that overall investment in primary care (PC), as reflected by overall spending within the fee-for-service Medicare population, was as low as 2-3 percent in a narrow definition, but no higher than 4.88 percent in the broader definition (see Figure 1).

Figure 1. Primary Care Spending as a Proportion of Total Medical and Prescription Spending Among Fee-for-Service Medicare Beneficiaries[2]



This significant underinvestment has continued to exist, despite increased interest in optimizing access to primary care, as it may not only provide quality and effective health care but also may decrease the total cost of health care spending.[3] It is a well-established fact that the overall health care spending in the U.S. is out of proportion to our health outcomes with the United States, spending twice as much per person as the average for most other industrialized countries (see Figure 2). Supporting a stronger and more sustainable primary care system is essential to achieving better health outcomes and bending our cost curve. However, the greater investment necessary at multiple levels, such as innovative care and payment models, expansion of workforce incentives and decreasing infrastructure costs to providers, may require a more systemic change than what has occurred incrementally over the past 10 years.

Figure 2. Health consumption expenditures per capita, U.S. dollars, PPP adjusted, 2017[4]

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To that end, several states, including Delaware, have passed legislation which is specifically focused on analyzing and increasing investments in primary care. These legislative efforts should not be considered cumulative, but rather foundational to the necessary elevation of systemic investment in primary care.

NATIONAL TRENDS

Of the multiple components to a sustainable level of investment in primary care, the most common starting point is the measurement of primary care spending within total health care spending. This has been studied globally and to a limited degree, within the United States. The Organization for Economic Co-operation and Development (OECD) provided a general definition of primary health care in 2004:

> "Primary health care, i.e. the subset of diagnostic and therapeutic activities considered as being the first line of organized personal medical care (in contrast to specialized medical care such as provided by medical specialists and in hospitals). Apart from general forms of diagnosis and treatment, the Panel regarded the coordination of care between different providers and the provision of guidance to patients through the health care system as key functions of primary health care."[5]

While this broad definition precludes true uniformity, since then, OECD has received data annually from 22 of the 36 contributing countries regarding the level of spending on primary care services within the total health care spending. The latest report estimates that in other countries, primary care accounts for approximately 14 percent of total health care spending (see Figure 3).

Figure 3. Spending on primary care services as share of total health spending among 22 OECD countries, 2016[6]

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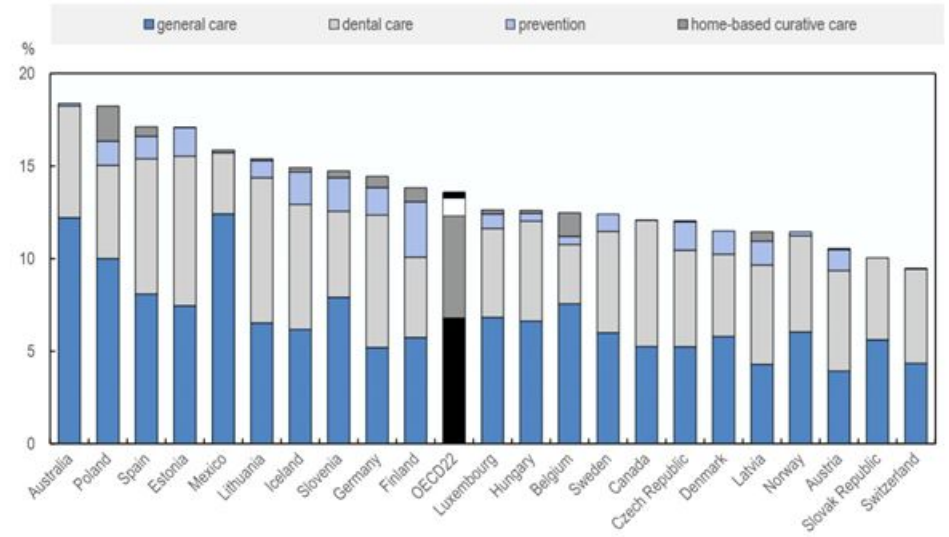

Source: OECD Health Statistics 2018.

When compared to the data from the fee-for-service Medicare study, the United States investment in primary care appears to be significantly low, at less than half of other OECD countries. However, the lack of a "standard" definition for primary care (PC) nationally has prevented alignment by providers, insurers and policymakers on what is an accurate assessment of PC spending in the U.S. and what should be an acceptable, meaningful investment into primary care. This has led to individual states, such as Rhode Island and Oregon, to establish their own key components for primary care spending (see Figure 4).

Figure 4. PC Spend Definitions by Organizations and Select States

TABLE 2.1

PC Spend Definitions by Organizations and Select States

✓ Included in definition

Categories	OECD	Milbank Definition 1- PCP-C	Oregon	Rhode Island	Robert Graham Center Narrow	Robert Graham Center Broad
Preventive Health Services	✓		✓	✓		
Family Medicine	✓	✓	✓	✓	✓	✓
General Practice	✓	✓	✓	✓	✓	✓
Internal Medicine	✓	✓	✓	✓	✓	✓
Pediatrics	✓	✓	✓	✓	✓	✓
Geriatrics	✓	✓	✓	✓	✓	✓
Obstetrics and Gynecology	✓	✓	✓			✓
Nurse Practitioners/Physician Assistants	✓	✓	✓			✓
Behavioral Health Services			✓			✓
Homeopathy/Naturopathy			✓			
Home-Based Care Services	✓					
Outpatient Rehabilitation	✓					

OECD = Organisation for Economic Co-operation and Development.

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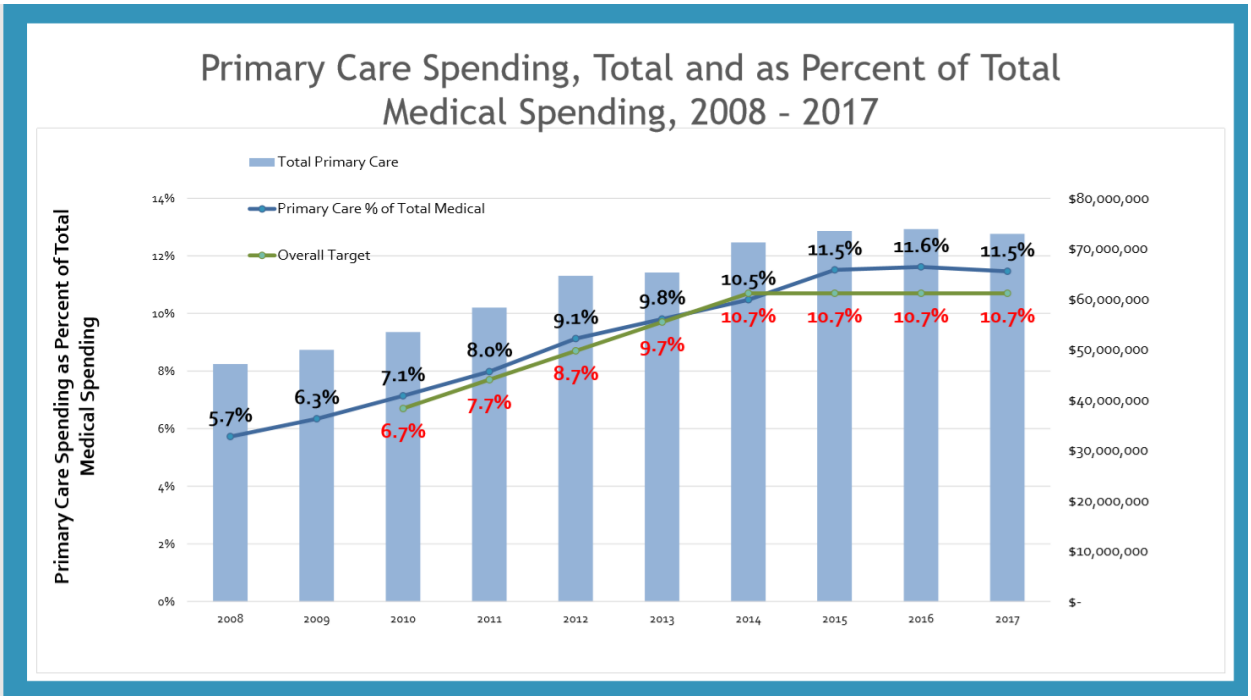
At first view, it would seem that Rhode Island began its work in primary care in 2010, with the passage of its affordability standards, which not only mandated insurers to increase their PC payments by one percent per year to a statewide benchmark of 10.7 percent, but also to increase participation on the part of providers in patient-centered medical homes (PCMH).[7] However, in 2004 the state had already established the cabinet-level Office of Health Insurance Commissioner. This office provides crucial infrastructure for the data analysis of the state's health care spending as well as regulatory capacity to address possible issues of non-compliance by insurers or the need for cost containment regarding acute inpatient hospital costs. Within this framework, Rhode Island has achieved some measurable success with increasing investments in primary care (see Figure 5). Besides reaching the benchmark of 10.7 percent PC spending, approximately 70 percent of practices are in a PCMH model of care and Rhode Island has seen an increase in the number of physicians providing primary care. The development of a sustainable workforce with the tools for practice transformation are other key components for delivery of quality primary care.

Figure 5. Rhode Island Primary Care Spending, Primary Care Collaborative Report, January, 2019. Delaware Primary Care Collaborative



In 2017, Oregon passed Senate Bill 934, which established a PC spending benchmark of 12 percent by 2023. This was a continuation of work that started in 2016 with SB 231, which established the Primary Care Payment Reform Collaborative to advise the Oregon Health Authority on the implementation of the Primary Care Transformation Initiative. The Collaborative includes 46 stakeholder members who present recommendations to use value-based payment methods to increase investment in primary care, without increasing costs to consumers or to the total cost of health care, as well as consider innovative payment models which may include investments in social determinants of health and integration of primary care behavioral and physical health care.[8]

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In 2019, Colorado, Maine, Vermont, Washington and West Virginia all enacted legislation that focused on primary care investment.[7] Maine, Vermont, Washington and West Virginia have similar mandates to collect and analyze data on PC spending and calculate the percentage of total medical spending on primary care. West Virginia also established the Primary Care Support Program, which is directed at community-based primary care services. Vermont's legislation additionally requires the Green Mountain Board to determine how much spending should be allocated to primary care in the state and certain insurers to submit plans, which may reach the recommended level of PC spending. Colorado created a multi-stakeholder primary care payment reform collaborative and directed the insurance commissioner to establish affordability standards with targeted investments in primary care by insurers. Hawaii and Missouri have introduced legislation with similar mandates (see Figure 6).

Figure 6. Hawaii and Missouri Primary Care Legislation[7]

HI	HB 1444 (2019) would establish the Primary Care Payment Reform Collaborative task force to examine issues related to primary care spending and data collection in Hawaii and to develop recommendations to the legislature.
MO	HB 879 (2019) is the Primary Care Transparency Act, which would establish a primary care payment reform collaborative for Missouri.

A recurring theme is the need to determine what is the current level of PC spending and how far or near it is to the level necessary to sustain primary care as a "the cornerstone of a sustainable health care system."

In an effort to establish standardization for a determination of PC spending, the Patient Centered Primary Care Collaborative, in conjunction with the Milbank Memorial Fund and the Robert Graham Center, compared various definitions of primary care spending based on provider-type in their comprehensive overview, Investing in Primary Care: A State Level Analysis (see again Figure 4).[7]

There is general agreement among the various organizations listed in the chart and with the two first states who had enacted primary care legislation, Rhode Island and Oregon, that the core primary care specialties include internal medicine, family medicine, general practice, pediatrics and geriatrics. The authors define this core group as "PC-narrow." Some other definitions of primary care also include obstetrics and gynecology, behavioral medicine, as well as nurse practitioners and physician assistants, which the authors grouped as "PC-Broad." Interestingly, the Centers for Medicare and Medicaid Services (CMS) uses the "PC-narrow" definition of primary care, but includes hospice and palliative medicine and excludes pediatrics.

After determining the definitions, the authors analyzed data from the 2011-2016 Medical Expenditure Panel Survey (MEPS) from 29 states. The data were based on office-based and outpatient expenditures for each specific provider-based definition in each state and across all payer types. While there was wide variation among the 29 states, across both PC-narrow (3.5 – 7.6%) and PC-Broad (8.2 – 14%), the national average calculated was 5.6% and 10.2% respectively.

As noted previously, this is far below the global average for PC spending of 14 percent. Although the comparison cannot be considered direct, given that the OECD included broader

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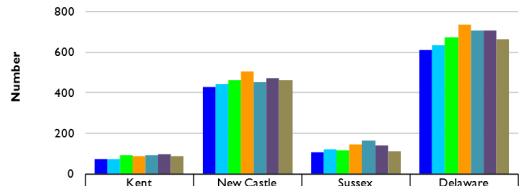
categories than what the authors used, it is does provide meaningful analysis of current data for PC spending in the U.S. Such data are crucial for states to develop meaningful processes for the sustainability of primary care.

Delaware

In Delaware, there has been a significant decrease in the availability of primary care providers in the state, which has resulted in a crisis of access for patients. The initial impetus for action came from anecdotal reports of primary care physicians leaving practice, primarily through retirement or changing their practice to "concierge." Concierge practices have a retainer-based or direct care payment model, in which the patients directly pay the practice a fee and receive greater access to the physician. While this model offers practices less administrative burden, with more financial stability and greater patient and physician satisfaction, it may decrease overall general access as there are fewer patients cared for within each practice. The recent Primary Care Physicians Survey 2018[8] provided data research from 2013-2018, which supported the overall perception that there has been a decline in the total number of practicing primary care physicians. Statistically, there has been an approximate eight percent decline in primary care physicians, which was defined as internal medicine, general practice, family practice, pediatrics and obstetrics/gynecology (see Figure 7).

Figure 7. Full-Time Equivalent Primary Care Physicians by County and Year, Delaware, 1998-2018[8]



	Kent	New Castle	Sussex	Delaware
1998	72	429	109	610
2001	75	442	119	636
2006	93	463	115	671
2008	89	504	143	736
2011	92	452	163	707
2013	99	470	138	707
2018	89	461	112	662

This trend is even more alarming when taken into consideration that on average, only 40 percent of all primary care physicians throughout the state are under 50, indicating a lack of growth in the physician workforce (see Figure 8).

Figure 8. Age of Primary Care Physicians by County, Delaware, 2018[8]

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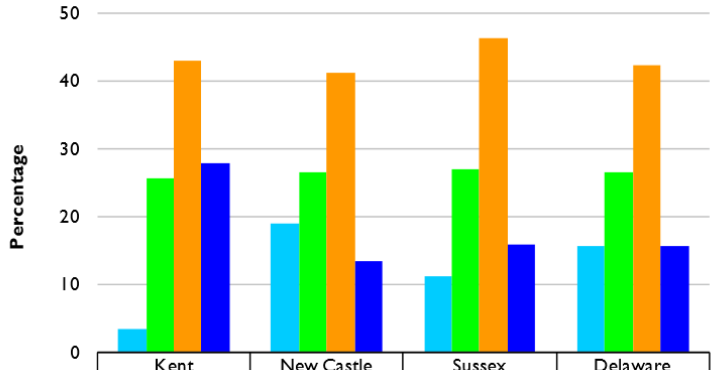

	Kent	New Castle	Sussex	Delaware
Under 40	3.5	18.9	11.1	15.5
40-49	25.6	26.6	26.9	26.5
50-64	43.0	41.2	46.3	42.3
65 and above	27.9	13.3	15.7	15.7

The combination of a decrease in the total number of practicing physicians as well as a decrease in the number of patients seen by practicing physicians in practice models, such as a concierge practice, has resulted in the primary care access crisis.

SB 227, which was passed in 2018, attempted to address this crisis through immediate payment reform to sustain current practices and provide long-term recommendations that would "strengthen the primary care system in Delaware." Many practices indicated that the current level of reimbursement for primary care services was inadequate to cover the costs of the practices and, therefore, was driving physicians to the concierge model or to leave practice completely.[9]

To stabilize the current market, the first legislative step taken was to mandate an increase in reimbursement from non-Medicare insurers to the level of Medicare. Interestingly, as the first study noted, the level of PC spending within fee-for-service Medicare is still well below what occurs in other countries. SB227 defined primary care for Delaware with the "PC-narrow" definition: family practice, internal medicine, pediatrics and geriatrics. Additionally, as with other states, it created a Primary Care Collaborative, which was tasked with collaborating with the Delaware Health Care Commission (DHCC) on the recommendations and whether a level of 12 percent PC spending was appropriate. This legislation also included the use of the Health Care Claims Database for the data analysis and describing how expanding investments in PC spending supported the State's effort in decreasing health care costs through the benchmarking process. The PC Collaborative then convened a series of meetings with stakeholders for a more deliberative discussion about the current state of primary care in Delaware; which initiatives have been started to support primary care by providers and insurers, as well as what a higher percentage of PC spending would include and through what mechanisms; and what could be learned from other states, such as Rhode Island and Connecticut. A report submitted to DHCC in January 2019 supported the concept of increasing PC spending to 12 percent within the benchmarking process and not just by increasing payments through the fee-for-service payment model, but by greater participation in value-based payment models, as well as investing in initiatives that may increase workforce and integrate women's health and behavioral health with a primary care practice.

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After the report, there has been another series of roundtable meetings by the Collaborative with stakeholders, followed by a second bill passed in 2019. SB 116 expanded the Primary Care Collaborative from three to 17 members, and formally to include stakeholders from insurers, health care systems and providers, both physician and advanced nurse practitioners. It also created under the Department of Insurance, the Office of Value-Based Health Care Delivery, which will make recommendations for affordability standards; collect data regarding current investments in primary care; calculate the annual PC spending within the total health care spending; as well as make recommendations regarding appropriate levels of reimbursement for primary care.[10]

The process, which has evolved in the past 18 months in Delaware, is reflective of how other states are developing policy concerning primary care. Common concepts include the inclusion of stakeholders in a collaborative, iterative process; the collection and use of data to define the metrics of PC spending and to determine a more optimal level of PC spending necessary to promote and sustain primary care; and the use of the legislation to identify areas of investment and to create infrastructure. Some states, such as Rhode Island, proactively realized the importance of a healthy primary care system for their overall health care delivery and developed policy and regulations to address deficiencies, whether in payment or workforce. Other states, such as Delaware, have been driven to develop legislation and policy in response to a critical loss of access and increasing overall health care costs, also by addressing deficiencies in payment and workforce. Efforts to increase primary care workforce are hampered by the fact that primary care specialties are not competitive in regards to hours and salary, when compared to other specialties, and most graduating medical students have an overwhelming amount of debt accumulated during the educational process. Delaware is attempting to address this problem of student debt with a state-sponsored student loan repayment program, which would assist primary care providers by paying a certain percentage of their debt in return for practicing in Delaware at qualified locations. This collaborative effort among insurers, health care systems, providers and the Delaware Health Care Commission offers one tool to reverse the decline in practicing providers and improve access for primary care with an expanding (not shrinking) workforce.

Next steps

Health care stakeholders and policymakers in the U.S. have begun to recognize the importance of primary care as a foundation for the delivery of quality and cost-efficient health care. Bending the cost curve while improving health outcomes can be key benefits from having strong, sustainable primary care. As more states, including Delaware, progress toward this goal, there is the need for accurate and meaningful data to assess current levels of PC spending and to recommend the changes in payment and infrastructure that are necessary to achieve a higher level of investment. The challenge of using data and developing metrics to measure “value” has added importance to establishing a benchmark definition of primary care spending. The creation of primary care collaboratives through legislation has been the pathway most states have taken to building the infrastructure for the collection, analysis and monitoring of payment data and establishing the definition and levels of primary care spending.

Alignment of payers and providers on such definitions and what level of primary care spending is substantial enough for a “sustainable health system” is both challenging and progressive. Besides increasing primary care spending through payment reform, states such as Rhode Island

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and Oregon have also prioritized practice transformation with an emphasis on patient-centered medical homes and provider participation in accountable care organizations. This use of innovative models of payment and health care delivery models create other opportunities to enhance primary care. As the impetus increases to move primary care practices away from fee-for-service toward value-based payment models, there needs to be greater incentivization for practices to engage in practice transformation and investment in allocation of resources for practices to be successful. An example of non-payment resources include supporting a robust health information technology for optimal data collection and analysis - both at the practice and system level - as well as introducing telehealth in appropriate clinical settings to increase access and improve care coordination. Additionally, stimulating workforce growth and sustainability should not be just a collateral benefit of a robust primary care, but include addressing factors that inhibit primary care workforce expansion, such as alleviating the level of educational debt by medical students.

This high-level overview of the current state of primary care support within the delivery of health care demonstrates that more states are developing policies to prioritize primary care. It is becoming clear that there is both a need for stronger investment in primary care and that there are significant benefits of such investments, with improved health outcomes and lower costs. The states that have successfully achieved a greater level of PC spend, such as Rhode Island and Oregon, have established primary care delivery models, focused on patient-centered care, as well as mandated minimal levels of PC spending and investment through state organizations, such as the Oregon Health Authority and the Office of the Health Care Insurance Commissioner. Rhode Island also has demonstrated that payment reform and consideration of cost-containment measures, with all stakeholders, including payers, providers and health care systems, does not need to result in a higher level of total health care spending, even with a higher level of PC spend.

For Delaware, all these efforts are achievable. While the Primary Care Collaborative engages multiple stakeholders and the Office of Value-Based Health Care Delivery will provide data analysis of PC spending in conjunction with the analysis of total health care spending by the benchmarking process, they are only first steps at establishing infrastructure. Oregon has a specific Patient Centered Primary Care Home program with alignment of payers and providers to establish the metrics and resources for practice transformation to patient-centered care, such as practice infrastructure and health information technology. Delaware would greatly benefit from such alignment and scope of implementation, as this type of infrastructure would not only provide needed support to practices, but also resources that could enable practices to transition successfully to value-based payment models. Incorporating a 12 percent PC spend as recommended in the first PC Collaborative report does not need to drive up total health care costs, if they are in conjunction with practical and much-needed cost-containment measures in other areas of health care delivery, e.g, acute and inpatient care as well as long-term, end-of-life care.

As I look forward to the future health care system in Delaware and in the United States, I am optimistic that it will reflect primary care as the cornerstone of greater access and healthier outcomes with lower health care costs for all.

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