Acting on the Evidence: Investing in Primary Care

Christopher F. Koller
Patient Centered Primary Care Collaborative
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There is a fundamental disconnect between the importance of primary care and value we give it in the US.

“This evidence shows that primary care helps prevent illness and death, regardless of whether the care is characterized by supply of primary care physicians, a relationship with a source of primary care, or the receipt of important features of primary care. The evidence also shows that primary care (in contrast to specialty care) is associated with a more equitable distribution of health in populations, a finding that holds in both cross-national and within-national studies”.

Source: (Starfield Milbank Q. 2005 Sep; 83(3): 457–502.)
U.S. Trails Other Countries in Portion of Health Care Expenses Going to Primary Care

OECD average of 24 countries: 12% (2013)

Milbank average of 9 US carriers: 7.7% (2015)

Rhode Island Commercial: 5.8% (2008)

Ontario, payments to family physicians: 8.1% (2010)

UK, payments to general practitioners: 8.4% (2012)

Source: Koller & Khullar, NEJM, 2 November 2017
Typical Approach to this Dilemma for Primary Care Advocates

HOW CAN WE LOSE WHEN WE'RE SO SINCERE?!
Typical Outcome
Change the Script – in response to Physician and Employer Outcry Over Insurer Behavior, RI Legislature Strengthens Health Insurer Oversight

New Charge
- See the system as a whole and direct insurers to policies that promote affordability, accessibility and quality of system
What is the Evidence?
Primary Care Associated with Higher Quality…

EXHIBIT 8
Relationship Between Provider Workforce And Quality: General Practitioners Per 10,000 And Quality Rank In 2000

Quality rank

1

26

51

General practitioners per 10,000

SOURCES: Medicare claims data; and Area Resource File, 2003.
NOTES: For quality ranking, smaller values equal higher quality. Total physicians held constant.

Source: Baicker & Chandra, Health Affairs, April 7, 2004
...And Lower Costs

EXHIBIT 9
Relationship Between Provider Workforce And Medicare Spending: General Practitioners Per 10,000 And Spending Per Beneficiary In 2000

Spending per beneficiary (dollars)

8,000

7,000

6,000

5,000

4,000

1 2 3 4 5

General practitioners per 10,000

SOURCES: Medicare claims data; and Area Resource File, 2003.
NOTE: Total physicians held constant.

Source: Baicker & Chandra, Health Affairs, April 7, 2004

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Comprehensive Set of Affordability Standards for RI Insurers

1. Invest in Primary Care (Raise Primary Care Spend by One Point a Year for Five years)
   • Not in FFS increases, not add on to overall costs
2. Support Multipayer Efforts
3. Invest in Health Information Technology
4. Implement Value Based Payment Model with Caps on Hospital Rate Increases

Developed with Advisory Council.
Enforced through rate review process
Why Primary Care Spend as a Goal?

1. Supported by evidence
2. Number and implications easily comprehended by public
3. Non-partisan
4. Communicates misplaced social priorities and builds consensus on societally-oriented goals:
   • “Gateway” policy to more attention to social services investing
Primary Care Spend: Lots of Second Order Questions

• What’s in? Standard definition of primary care?
  • Telehealth? Convenience Care?
• Shouldn’t we be investing only in “good primary care”?
• What payment model is best?
• What do we get in return for that investment?
• What is the optimum level of primary care spend?

All valid points, but all secondary to the goal, which is a change in state health policy values and priorities.
Making Primary Care a Priority for the State’s Health Care System: A little gets you a lot.

In RI, primary care spending by commercial insurers increased from $47 million/year to $73/year over this period. Self insured not captured.

Source: Office of the Health Insurance Commissioner, State of Rhode Island

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What Happened in RI?

Top Ten Medicare ACO

Successful PCMH at Blue Cross

Health Information Exchange

Multi-payer Primary Care Transformation

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RI Defied Trends and Increased Primary Care Supply
(No Specialty Flight)

Primary Care:

Specialists:

Notes: MDs only;
Primary Care: FP, Peds, IM;
Sources: AMA Licensure and Census.Gov

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Commercial Insurance Spend: Together, RI’s Interventions Bent the Curve

Risk Adjusted Commercial Insurance Spending per Enrollees in Rhode Island vs. Matched Control

Spill Over Effects? Per CMS Actuary, across all payers RI went from 4th most expensive state for health care in 2009 to 9th in 2014.

Source: Landon et al, Academy Health Annual Research Meeting, 2018
Not a Crazy Idea from the East

Primary Care Spending in Oregon
A report to the Oregon State Legislature

February 2018

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Not directly comparable to others:
Included OB and Psychiatry

How did this happen
- Legislation (Senate Bill 231) – More to Come

Goal-Baseline and Document Variation by Product Line

Percentage of total medical spending allocated to primary care
In 2016, CCOs allocated an average of 15.7 percent of total medical spending to primary care. Commercial, Medicare Advantage, and PEBB and OEBB plans allocated an average of 13.6 percent or less of total medical spending to primary care.

Per-member per-month (PMPM) primary care spending
In 2016, PMPM primary care spending ranged from $42 for PEBB and OEBB plans to $83 for Medicare Advantage plans on average. Non-primary care spending ranged from $257 PMPM for CCOs to $613 PMPM for Medicare Advantage plans on average.
Don’t Overpromise: Increasing Primary Care Spend is Necessary but not Sufficient for a High Performing Health System

Success is a More Primary Care Oriented Delivery System:
- Increased investment with no effect on overall costs
- More and better local primary care infrastructure (providers and systems of care)
- Reduced ambulatory care sensitive ER visits and admissions
- Public support for state oversight and upstream investments

For More Comprehensive Delivery System Reform:
- Commercial Payer Oversight
- Large Provider Oversight
- Robust System Performance Measurement
- Multipayer Strategies on Payment Reform
- Employer Engagement (the other 80%)
- Social Capital
How will we get to a Primary Care Oriented Delivery System – your work today

A primary care oriented US delivery system

Increased investment in primary care in U.S.

Increased investment in primary care in particular states

Implementation of value-based payments

Employer benefit changes

Regulatory and statutory actions to increase primary care spending

At the State and Regional Level: Baseline and ongoing measurement of primary care spend, evidence dissemination, leadership recruitment and organizing the other 80 percent around the measure

National Payers jump on board

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Steps to Increasing Primary Spend Locally

1. Baseline and ongoing measurement
   • National measures (MMF, PCPCC, etc)
   • Local – Insurance Commissioner, Medicaid Agency, All Payer Claims Database

2. Evidence Dissemination
   • Making the case: what is most persuasive?

3. Recruiting Leadership
   • Who will be your spokespeople? Legislative champions, agency officials, governors, clinicians.
   • What action are you making the case for? (Statute? Value based purchasing? Measurement?)

4. Engaging the other 80%
   • Awareness of PCP spend levels is low. Sympathy is high.
   • “Where would you want your next dollar in health care to go?”
Work is already underway

- Statutory or Regulatory Action
- Proposed Legislation
- State-wide Measure of Primary Care Spend
Measuring Primary Care Spend as an Organizing Tool

Vermont: 9.7% (Medicare, Medicaid, & Commercial, 2016)

Massachusetts: 6.6% (Commercial Payers, 2015)

Rhode Island: 11.5% (All Commercial Payers, 2016)

Connecticut: 4.7% (State Employees, 2017)

Source: NESCSO Primary Care Workgroup Presentation, 18 October 2018

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Source: (Starfield. *Milbank Q*. 2005 Sep; 83(3): 457–502.)
The Possibility:
With a Stronger Primary Care System We Have More Tools and More Will to Address What Really Keeps All of Us Healthy
Contact

Christopher F. Koller
(212) 355-8400
Ckoller@milbank.org
@MilbankFund
www.milbank.org
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