EXECUTIVE SUMMARY

Investing in Primary Care

A STATE-LEVEL ANALYSIS

July 2019

PREPARED BY

Patient-Centered Primary Care COLLABORATIVE

ROBERT GRAHAM CENTER

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Authors

Yalda Jabbarpour, MD
Ann Greiner, MCP
Anuradha Jetty, MPH
Megan Coffman, MS
Charles Jose, MD
Stephen Petterson, PhD
Karen Pivaral
Robert Phillips, MD, MSPH
Andrew Bazemore, MD, MPH
Alyssa Neumann Kane

Reviewers

Mark Friedberg MD, MPP
Worthe S. Holt Jr., MD, MMM
Ira Klein MD, MBA
Bruce Landon MD, MBA, MsC
Lance Lang, MD

Special Thanks

Rachel Block
Stephanie Gold, MD
Chris Koller, MA
Karen Montemayor
Yolanda Raine

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About the Patient-Centered Primary Care Collaborative

Founded in 2006, the Patient-Centered Primary Care Collaborative (PCPCC) is a not-for-profit multi-stakeholder membership organization dedicated to advancing an effective and efficient health system built on a strong foundation of primary care and the patient-centered medical home. Representing a broad group of public and private organizations, PCPCC's mission is to unify and engage diverse stakeholders in promoting policies and sharing best practices that support growth of high-performing primary care and achieve the "Quadruple Aim": better care, better health, lower costs, and greater joy for clinicians and staff in delivery of care.

www.pcpcc.org

About the Robert Graham Center

The Robert Graham Center aims to improve individual and population healthcare delivery through the generation or synthesis of evidence that brings a family medicine and primary care perspective to health policy deliberations from the local to international levels.

www.graham-center.org

About the Milbank Memorial Fund

The Milbank Memorial Fund is an endowed operating foundation that works to improve the health of populations by connecting leaders and decision makers with the best available evidence and experience. Founded in 1905, the Fund engages in nonpartisan analysis, collaboration, and communication on significant issues in health policy. It does this work by publishing high-quality, evidence-based reports, books, and *The Milbank Quarterly*, a peer-reviewed journal of population health and health policy; convening state health policy decision makers on issues they identify as important to population health; and building communities of health policymakers to enhance their effectiveness.

www.milbank.org

Topline Results

Relative to its international counterparts, the United States underinvests in primary care, as reflected in spending by both public and private payers. On average, the United States spends 5%-7% on primary care as a percentage of total health care spending. By comparison, Organisation for Economic Co-operation and Development (OECD) countries average 14% spending on primary care.

This underinvestment represents a major disconnect given the robust evidence base showing that health systems with a primary care orientation have superior patient outcomes, fewer inequities, and lower costs. On these key attributes, performance of the U.S. health system pales in comparison to systems in other industrialized nations.

In a first-of-its-kind study, the 2019 Patient-Centered Primary Care Collaborative (PCPCC) Evidence Report examines states' primary care spending patterns, including spending across payer types, and considers the implications of these results for select patient outcomes.

More specifically, the 2019 PCPCC Evidence Report finds:

- There is a lack of agreement about how to measure primary care investment. Consequently, this report includes two leading approaches that reflect a narrow definition and a broad definition of primary care spend.
- Between 2011 and 2016, spending on primary care as a percentage of overall health care expenditures was low. It varied considerably across states, across payer types, and across age groups.
- The national average for primary care spend across public and private payers was 5.6% using a narrow definition, as compared to 10.2% using a broad definition.
- An association was found between increased primary care spend and fewer emergency department visits, total hospitalizations, and hospitalizations for ambulatory care-sensitive conditions. Given the limitations of our data set, we cannot conclude that this is causal, but it is a relationship replicated in the research literature.
- Minnesota had the highest percentage of primary care investment using both narrow and broad definitions, and performed well with respect to patient outcomes. Connecticut had the lowest primary care spend using the narrow definition. Using the broad definition, New Jersey's primary care spend was lowest. No pattern was observed for primary care spend by region.

State leaders have a growing interest in using their legislative and regulatory authority to measure and report on primary care spend and, in some cases, to set targets for increasing investment in primary care over the coming years within their jurisdictions. This report provides a high-level description of such efforts in 10 states, seven of which initiated their efforts in 2019. This focus on primary care spend and primary care investment suggests policymakers have some momentum to shift the U.S. delivery system back to its primary care foundation, so that it can better address diverse patient needs across different age and sociodemographic groups.

Executive Summary

IMPORTANCE OF THE RESEARCH

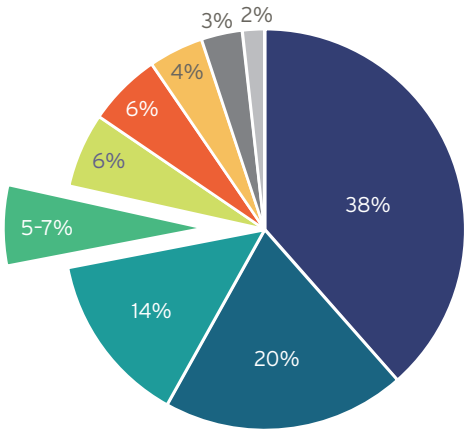
Consistent and growing evidence shows that primary care-oriented systems achieve better health outcomes, more health equity, and lower costs. Yet, despite this strong evidence that primary care is associated with the outcomes that policymakers and patients seek, such care has been chronically underfunded in the United States. On average, the United States invests 5%-7% of total health care spending on primary care. Health systems in other industrialized nations spend twice that or more (e.g., the average among OECD countries is 14%) .

This underinvestment in primary care has significant consequences. It thwarts the ability of primary care practices to provide patients with the personal attention and scope of services that they want and need, and it has negative implications for the robustness of advanced primary care models such as the patient-centered medical home (PCMH). Underinvestment in primary care is related to the U.S. payment system, which is still largely focused on fee-for-service (FFS) payment. FFS payment rewards provision of more health care services rather than rewarding efforts to prevent patients from getting sick in the first place. It overvalues procedures and interventions at the expense of cognitive health care services that are key to the management of chronic conditions.

A number of national and state leaders are calling for a reorientation of the nation's health care system toward primary care in light of the growing evidence base showing its value. This report provides quantitative data and analysis of primary care spend at the state and payer levels; a window into the association between primary care spend and key patient outcomes; and a description of state-level efforts to measure primary care spend and shift more resources into primary care. This research is particularly useful for state-level policymakers who can influence health care spending priorities. These leaders are in the challenging position of having to balance their state's budget—of which health care-related expenses are a large part—on an annual basis.

Health Care Spending

- Hospital care
- All other physician and professional services
- Prescription drugs and other medical nondurables
- Primary care
- Nursing home care
- Other health, residential, and personal care
- Dental services
- Home health care
- Medical durables



RESEARCH AND FINDINGS

Research Question. This analysis sought to report a national average for primary care spend and to understand if such spending differs across states and types of payers. Researchers also examined investment in primary care and its association with key patient outcomes. In addition, 10 recent state legislative and regulatory efforts to invest more in primary care were examined.

Methods. Researchers at The Robert Graham Center for Policy Studies in Family Medicine and Primary Care pooled data from the 2011-2016 Medical Expenditure Panel Survey (MEPS) to examine and compare cross-sectional variation in primary care investment at the state level. Given limitations of the MEPS data, they were able to report results for 29 out of 50 states and conduct subgroup analysis by the following payer types: commercial, Medicare, Medicaid/SCHIP, dual eligible, and the uninsured. MEPS is an annual survey of 30,000 to 35,000 U.S. civilians; it excludes those in institutions and oversamples for key demographic groups. Because MEPS provides national estimates of annual health care insurance coverage, utilization, and expenditures based on interviewee recall, the data have some limitations.

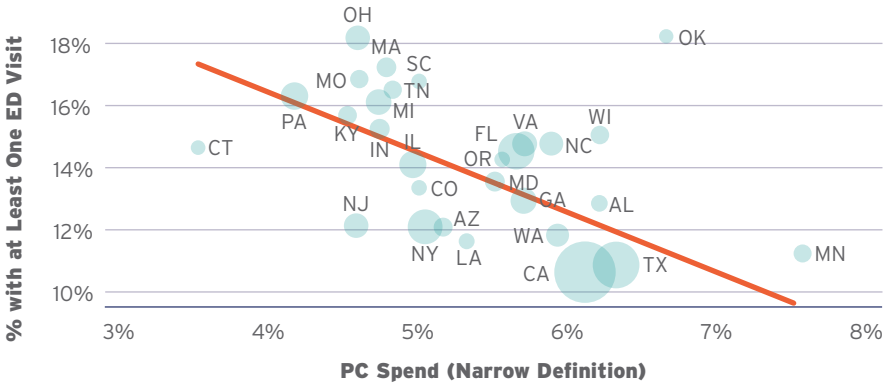
Multiple definitions of primary care spend exist domestically and internationally, making comparisons of primary care spend challenging. To mitigate these challenges, researchers reported a narrow definition and a broad definition of primary care spend by state and by payer. Both measures were based on office-based and outpatient expenditures. The narrow definition focused on spending related to primary care physicians in offices and outpatient settings. The broad definition included all of the above, plus other members of the primary care clinical team, including nurses, nurse practitioners (NPs), physician assistants (PAs), OB/GYNs, and behavioral health professionals (i.e., psychiatrists, psychologists, and social workers). The PCPCC favors the broad definition and also sees merit in definitions of primary care spend that include non-clinical staff (e.g., community health workers) and infrastructure investments.

Results. Using aggregated data from 50 states, the analysis showed a national average for primary care investment of 5.6% using the narrow definition and 10.2% using the broad definition. There was significant variability across the 29 states included in the study. Minnesota had the highest primary care investment rate using both the narrow (7.6%) and broad definitions (14.0%). Connecticut had the lowest primary care spend (3.5%) using the narrow definition, and New Jersey had the lowest using the broad definition (8.2%).

Further analysis that examined associations between primary care investment and three outcomes—total hospitalizations, hospitalizations for ambulatory care-sensitive conditions, and emergency department visits—found an inverse association. In other words, as primary care investment increased, both hospital outcomes and emergency department visits decreased. Causality or directionality cannot be inferred here because of an inability to control confounders other than population size. However, in the research literature, studies have shown this kind of relationship. The association between primary care investment and patient satisfaction was not statistically significant.

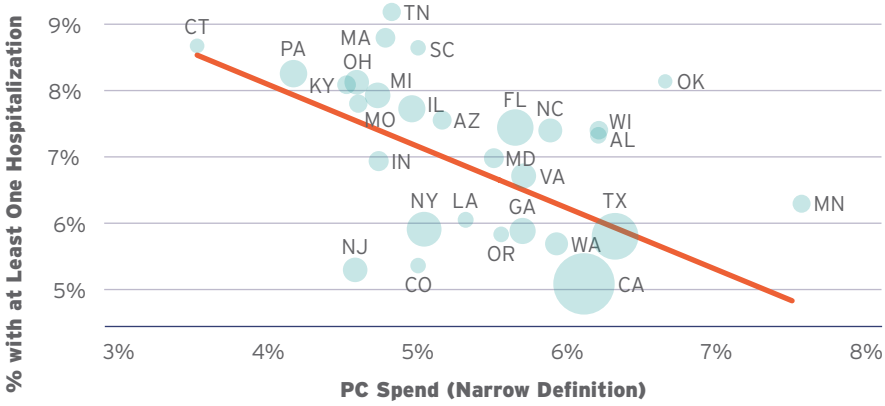
In addition, a review of legislative and regulatory efforts in 10 states showed that state policymakers had increased momentum, with efforts in seven of the 10 states initiated in 2019. A review of the seven initiatives that made it into law or executive order identified some common themes. These efforts generally included setting up some kind of multistakeholder collaboration in order to get diverse input on defining and measuring primary care

PC Spend-Narrow vs. Percent with at Least One ED Visit in Last 12 Months



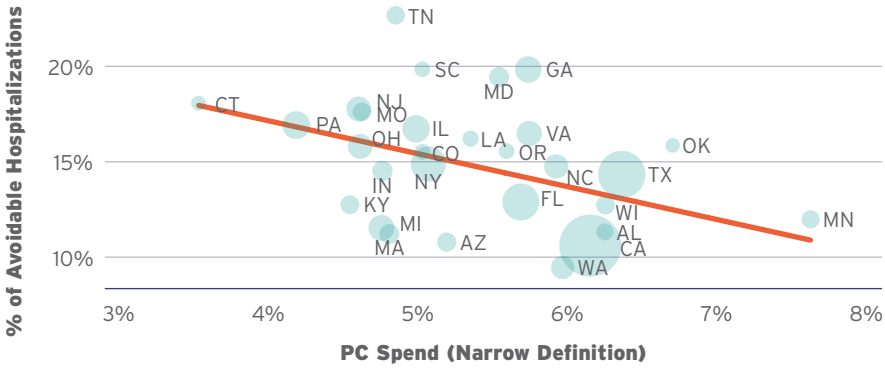
R = -0.58. Note: Size of circles represents the population size of the state.

PC Spend-Narrow Vs. Percent with at Least One Hospitalization in Last 12 months



R = -0.58. Note: Size of circles represents the population size of the state.

PC Spend-Narrow Vs. Percent Avoidable Hospitalization



R = -0.44. Note: Size of circles represents the population size of the state.

spend and on establishing a mechanism for collecting and reporting related data. Some efforts set goals for what the community wishes to achieve with increased primary care investment, and some set primary care spend targets to achieve during a given time period. In many cases, the legislation that passed built on previous legislation or statutory efforts, with leaders iterating to reach future goals.

Implications. Regular measurement of primary care spend at the national and state levels can heighten visibility of how public and private payers value primary care over time and by comparison to their other health care expenditures. The PCPCC's first-of-its-kind report demonstrates that such reporting is feasible. The robust and growing evidence base about the value of primary care underscores the importance of reporting such measures.

Given the growing number of states that have recently introduced bills, enacted legislation, or issued executive orders to measure primary care spend with the goal of increasing such investment, the findings in this report—both analytic and descriptive—are timely and relevant.

Percent PC Spend Across States by PC Definition Compared to National Average

State	PC Spend-Narrow	PC Spend-Broad
National	**5.6**	**10.2**
AL	6.2	10.8
AZ	5.2	8.7
CA	6.1	10.8
CO	5.0	10.6
CT	3.5	10.6
FL	5.7	8.8
GA	5.7	9.6
IL	5.0	9.0
IN	4.7	9.7
KY	4.5	10.0
LA	5.3	8.3
MA	4.8	10.9
MD	5.5	9.6
MI	4.7	9.0
MN	7.6	14.0
MO	4.6	11.7
NC	5.9	10.0
NJ	4.6	8.2
NY	5.0	10.0
OH	4.6	8.7
OK	6.7	10.7
OR	5.6	10.9
PA	4.2	8.5
SC	5.0	8.3
TN	4.8	8.8
TX	6.3	10.0
VA	5.7	10.0
WA	5.9	10.1
WI	6.2	11.1

Source: Medical Expenditure Panel Survey (2011-2016); Includes 29 states. National average includes all 50 states.

Percent PC Spend-Narrow Across States by Payer Type Compared to National Average*

	PC Spend-Narrow					
State	Private	Public	Uninsured	Medicaid	Medicare	Dual
National	**6.0**	**4.7**	**7.3**	**6.0**	**4.4**	**3.4**
AL	6.4	5.9	4.0	8.5	5.1	4.2
AZ	6.1	3.7	5.9	4.5	3.6	2.7
CA	6.3	5.6	8.1	6.5	4.4	5.3
CO	5.2	4.4	5.1	10.0	4.4	3.1
CT	3.6	3.3	4.5	5.4	2.1	2.5
FL	5.5	5.8	6.0	7.1	5.8	3.1
GA	6.7	3.8	7.1	5.4	4.4	3.0
IL	5.0	4.6	6.6	6.8	4.3	2.9
IN	5.2	3.5	4.9	5.1	4.1	2.5
KY	4.8	3.8	5.2	4.8	3.8	2.3
LA	5.3	5.0	7.3	7.6	4.2	7.9
MA	5.7	3.4	10.3	5.2	3.4	2.3
MD	6.0	3.6	6.8	5.3	3.9	2.4
MI	4.8	4.4	5.2	5.0	3.5	2.9
MN	7.8	6.7	3.9	5.4	6.9	6.9
MO	4.7	4.2	6.6	3.8	4.7	3.0
NC	6.3	5.1	5.9	8.5	4.5	3.9
NJ	4.7	5.1	2.1	7.6	4.0	3.3
NY	5.2	4.6	8.8	6.1	4.3	2.5
OH	4.8	3.5	14.1	3.9	4.5	2.2
OK	7.6	5.6	6.1	10.7	5.2	3.7
OR	5.9	5.1	4.0	5.6	4.4	5.5
PA	4.8	3.1	2.9	5.0	3.6	2.1
SC	4.6	5.1	9.1	5.9	4.3	5.1
TN	5.0	4.3	6.4	6.1	4.3	2.7
TX	6.4	5.6	9.3	8.5	4.9	3.1
VA	5.4	6.1	11.7	4.0	5.4	2.8
WA	5.6	6.7	7.3	7.0	4.8	4.1
WI	6.9	4.1	5.2	5.9	3.4	3.2

* National average is based on 50 states.

Source: Medical Expenditure Panel Survey (2011-2016); Includes 29 states. Please note Private, Public, Uninsured add up to 100 percent. Medicare, Medicaid and Dual do not add to public (imputed)

Patient-Centered Primary Care COLLABORATIVE

PCPCC.ORG

601 Thirteenth Street, NW
Suite 430 North
Washington, DC 20005

ROBERT GRAHAM CENTER

GRAHAM-CENTER.ORG

1133 Connecticut Avenue, NW
Suite 1100
Washington, DC 20036

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645 Madison Avenue, 15th Floor
New York, NY 10022