Making Primary Care Primary

Maine Primary Care Payment Reform Summit

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President, Milbank Memorial Fund

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Agenda

1. Milbank Memorial Fund
2. Review the Case for Primary Care
3. State Actions
4. Employer Actions
5. Governance
Milbank Memorial Fund

- 105 year old operating foundation
- National scope
- “Improving Population Health by connecting leaders and decision makers with the best evidence and experience”
- Three priorities
  - Be a source for evidence and experience in response to state requests
  - Build state health policy capacity
  - Increase impact of Milbank Quarterly
The Case for Primary Care

• Evidence and Ammunition for our work

• With thanks to efforts of Kevin Grumbach, MD of University of California San Francisco, who assembled several of these slides
“Ample research concludes in recent years that the nation’s over reliance on specialty care services at the expense of primary care leads to a health system that is less efficient...research shows that preventive care, care coordination for the chronically ill, and continuity of care—all hallmarks of primary care medicine—can achieve better health outcomes and cost savings.”
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
Relationship Between Provider Workforce And Medicare Spending: General Practitioners Per 10,000 And Spending Per Beneficiary In 2000

Table:

<table>
<thead>
<tr>
<th>Spending per beneficiary (dollars)</th>
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<tbody>
<tr>
<td>8,000</td>
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<tr>
<td>7,000</td>
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<td>6,000</td>
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<tr>
<td>5,000</td>
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<td>4,000</td>
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Diagram:

- States are plotted based on the number of general practitioners per 10,000 and spending per beneficiary in 2000.
- States are color-coded according to spending levels.

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

Source: Baicker & Chandra, Health Affairs, April 7, 2004
We are Resolute in Ignoring the Evidence

- Medicare RVU’s systematically undervalue primary care.
- Only ~6-8% of total US spend goes to primary care (50% of office visits are to primary care)
- Plummeting numbers of new physicians entering primary care and burnout among PCPs
- Growing problems of access to primary care and “medical homelessness”
- Dysfunctional systems that are not delivering the goods in primary care
“The US is first in providing rescue care, but this care has little or no impact on the general population. We must put more focus on primary care and preventive medicine. How do we transform the system to do this?”

Senator Orrin Hatch; Senate Finance Committee Roundtable: Reforming America’s Health Care Delivery System April 21, 2009
More Radical Support…

- “I will start with the very last question asked by the committee--what is the single most important thing to fix in healthcare? Primary care. Strengthen primary care -- transform it and pay differently using a model like the Patient Centered Medical Home.”

- Congressman: “And the second issue?”

- “Well, if you don't fix the first issue and do not have a foundation of powerful primary care then you can do nothing else. You have to fix primary care before you can even begin to address a second issue.”

Randy MacDonald, Sr VP, IBM
House Ways and Means Hearing April 29, 2009
Ok I Get it - What to do?

- State Government
- Employers
- “La Lucha”
State Government: Think Systematically – Across Payers

- **Reality One:** It is all about the money
- **Reality Two:** Providers do not discriminate by payer
- **Reality Three:** Coordinate state levers

*Source: Preliminary estimates of 2014 volume, modeled using CPS, DHS, OHIC, ACS and MEPS data*
History: New Cabinet-level position as of June 2004

Statutory Responsibility: Commercial Health Insurance

Charge: Four Standards
1. Financial Solvency
2. Consumer Protection
3. New: Fair Treatment of Providers
4. New: See System as Whole and Direct Health Plans towards system improvement

Authority: Rate and Forms Review

Structure:
- Shared services for standards one and two with Insurance Department
Recall OHIC Statutory Charge: “Direct Insurers…”
- “Shall”, not “May”

Originally: “tell us what you are doing”

Change: Facilitated process with Advisory Council
• Staff and consultant
• 7 month process, public
• Standards: Evidence-based; and areas that health plans can influence.
• See paper

1. Health plans will increase the proportion of their medical expenses spent on primary care by five percentage points over the next five years. This money is to be an investment in improved capacity and care coordination, rather than a simple shift in fee schedules.

2. As part of the increased primary care spend, health plans will promote the expansion of the CSI-Rhode Island project or an alternative all payer medical home model with a chronic care focus by at least 25 physicians in the coming year and

3. Health plans will promote EMR incentive programs that meet or exceed a minimum value. (*modified: to Health Information Exchange support*)

4. **Hospital Contracting** – Limits on Price increases to Medical CPI and Quality Incentives. Waiver for Population based contracting – to encourage payment reform
Enforcement: Why Should Insurers Listen?

The Long Arm of the Law:
- Rate Review for All Commercial Products
Outcome Expectations for Affordability Standards

- ER visits and inpatient utilization
- Commercial Medical Trend
- Primary care provider satisfaction
Implementing Standard One

- Meeting with insurers individually and together:
  - Defining Primary Care (by specialty type)
  - Measuring Baseline spend (carriers self report)
  - Budgeting for future years
  - Regular update meetings to institutionalize

- Measuring Performance Publicly
  - Reports and Advisory Council
  - Evaluation

- Issuing Guidance
  - What constitutes non fee for service spend?
  - Priority areas?

- How Formal is guidance
  - Bulletins? Regulation?
Results: nAffordability Standards are increasing RI’s primary care spend

Source:
Health Plans are all moving money into primary care

Figure 2: Primary Care Spending as Percent of Total Medical Spending by Company
2008-2012 Actual | 2013 Projections

- BCBSRI
- United
- Tufts

<table>
<thead>
<tr>
<th>Year</th>
<th>BCBSRI</th>
<th>United</th>
<th>Tufts</th>
</tr>
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<tbody>
<tr>
<td>2008</td>
<td>5.5%</td>
<td>5.5%</td>
<td>5.5%</td>
</tr>
<tr>
<td>2009</td>
<td>6.4%</td>
<td>6.0%</td>
<td>6.5%</td>
</tr>
<tr>
<td>2010</td>
<td>8.0%</td>
<td>7.2%</td>
<td>7.5%</td>
</tr>
<tr>
<td>2011</td>
<td>8.2%</td>
<td>7.5%</td>
<td>8.2%</td>
</tr>
<tr>
<td>2012</td>
<td>9.4%</td>
<td>8.5%</td>
<td>9.5%</td>
</tr>
<tr>
<td>2013 (Projected)</td>
<td>10.6%</td>
<td>9.5%</td>
<td>7.9%</td>
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Slowly trying to wean from FFS
Non FFS Spending is going into Small Number of Categories

Figure 6b: 2013 Projected Spending on Non-FFS Investments
Total: $26,991,640

- HIT: $210,000
- Other: $841,423
- Incentive Payment Providers: $9,793,110
- Current Care: $3,869,116
- Medical Home
  - CSI: ~$3.7m
  - Other Medical Home: About $8.5m
The Good News: Estimated extra $64 million in state’s primary care infrastructure
The Bad News: Self Insured are increasing – limited oversight here.
Outcome Evaluations

• Inconclusive on premium trend and utilization – many other factors going on at same time.

• Increased but hard-to-measure public sentiment for primary care.

• Increasing commitment by all stakeholders to multi payer medical home project
The Future for the Affordability Standards

• Draft Standards call for capping primary care spend at 2014 levels
• Looking for better evidence – in US or abroad – about why to go higher
• How to account for spending through non primary care ACO’s?
Increasing their Impact – Coordinating State Levers

• Good News
  – Public sentiment for Primary Care
  – Multipayer PCMH is central to RI’s SIM Project

• Bad News
  – Increasing self insured enrollment (now 2/3 of commercial market) means more outside the system.

• ???
  – Will SIM and APCD levers lead to even greater systemic focus on primary care in RI?
What Can Self Insured Employers Do to Make Primary Care Primary? (from Grumbach)

1. Ensure employees have access to differentiated high quality primary care practices.
2. Create benefits incentives
3. Make your administrators pay more and differently for primary care
4. Pay for shared transformation services
5. Advocate for system change.
Ensure employees have access to advanced primary care practices, with accountability

- Health plan PC networks
- Direct contracting with delivery organizations
  - Primary care medical home carve out (“direct primary care”)
  - Integrated medical neighborhoods (IDS, ACOs; eg Intel model)
- Employer operated PC clinics
- Retail clinics…IF part of coordinated delivery model
Benefit Reform

- Eliminate cost-sharing for all primary care (not just preventive care)
  - Significant savings at IBM
- Offer incentives for patients to formally enroll in a PC practice even when not in managed care plans (e.g., small premium rebate)
- Reform behavioral health plan carve outs to promote integrated services with primary care
Payment Reform

Topic of meeting tonight. Options include:
– Blended FFS + per person fee
– Per person fee
– Shared risk with emphasis on primary care performance

– 17 state coalitions doing multipayer payment reform. Report:
Invest in primary care transformation process and infrastructure

– Shared resources (eg, complex care coordinator team)
– Practice coaching
  • Great Examples in Maine
– Key word here is “Invest”
Engage in multistakeholder coalitions to drive forward cohesive, scalable primary care reforms
Engage in multi-stakeholder coalitions to drive forward cohesive, scalable primary care reforms.

Maine Quality Counts

Maine Quality Forum

Maine Health Management Coalition

MaineCare (Medicaid)
3. This is “La Lucha”
Making Primary Care Primary is about change – What’s Your Model?

“Perfect Harmony”? 
“The Hero Leader”? 
A health social movement?

- Evidence
- Villains
- Education
- Social Marketing
- Laws and Regulations
Delivering Value in the New Health Care Market?
A Pitch for the Power of A Public Movement

1. Will the market model work for health care?
   - End of life
   - Information inequities.

2. The Societal Value of Primary Care
   - Primary care emphasis as a proxy of a commitment to collective well being.
   - The hinge between medical care and social services.

3. If it is a societal value, then expressed through public policies that promote it as a social good.
A Public Movement Won’t Just Happen

ME Smoking (1990-2014) see more

- **Year**
  - 1990
  - 1993
  - 1996
  - 1999
  - 2002
  - 2005
  - 2008
  - 2011
  - 2014

- **Percent of adult population**
  - 0
  - 10
  - 20
  - 30
  - 40

- **Percentage of population over age 18 that smokes on a regular basis.**

- **Percentage of adults who are smokers (self-report smoking at least 100 cigarettes in their lifetime and currently smoke). (2011 BRFSS Methodology)**
Implications for Policy Setting

• Local accountability
  – How local? 500k-1 million people “units”
  – Setting the culture. Leave space for choice.
  – Reliance on government institutions.

• Control over public dollars
  – Payment reforms
  – Insurance benefits

• Everybody on board
  – Including businesses
  – Whither employer based health insurance?