pcc primary care collaborative

Convening + Uniting + Transforming

Efforts to Further Comprehensive, Team -Based Primary Care & to Address Social Needs

ANN GREINER
PRESIDENT AND CEO

PCC Mission

MISSION

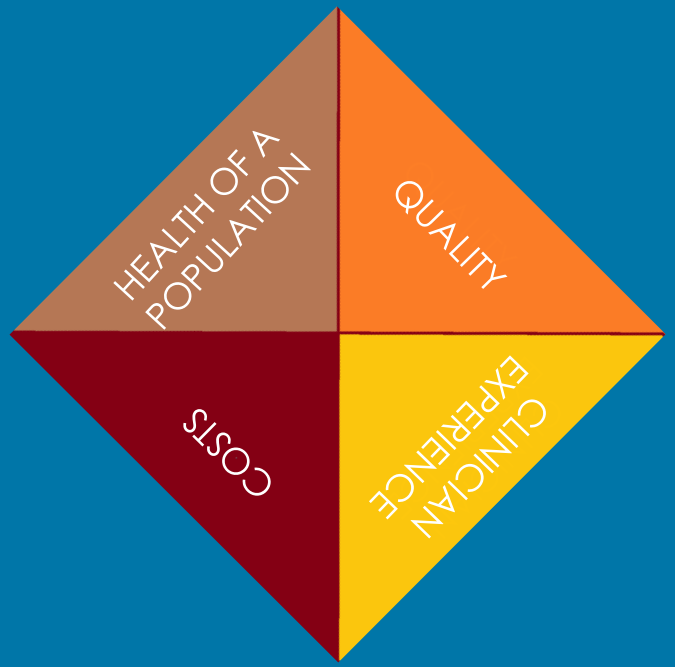
Promote Robust

Primary Care

to Achieve the

Quadruple Aim

Quadruple Aim



History of Primary Care Collaborative

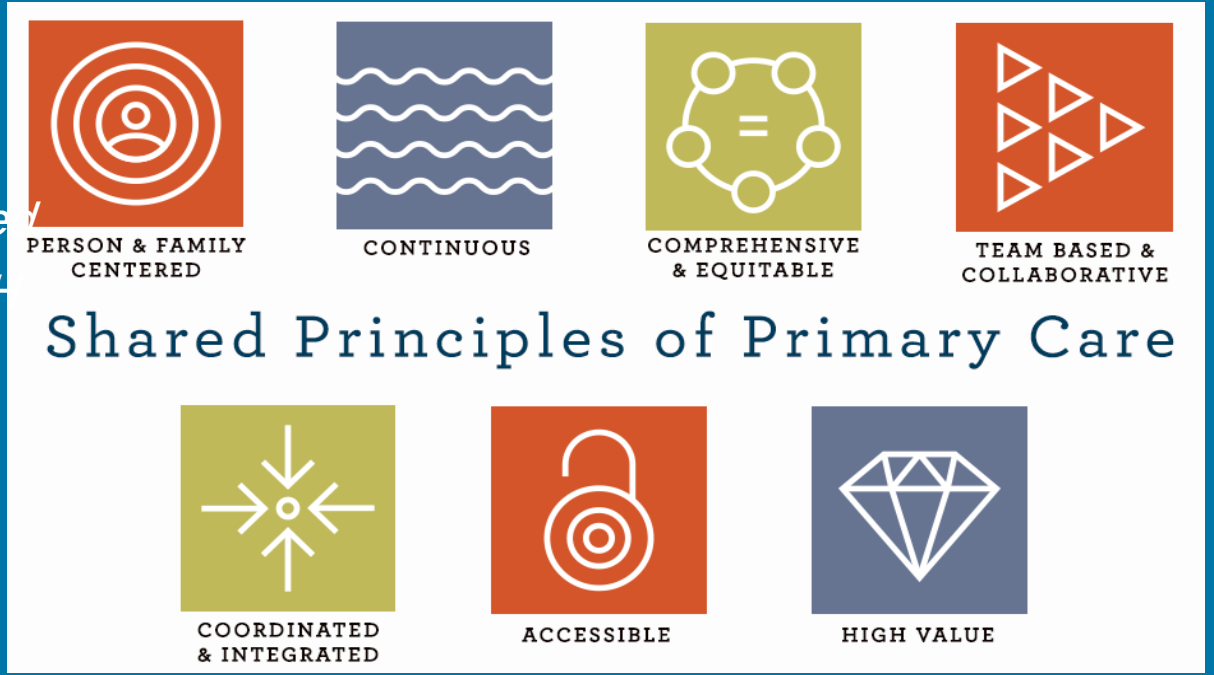
- Initial partnership between employers and physician specialty societies (2006)
- PCPCC launched
  - 2007 PCMH Joint Principles
- Advocacy with plans, states and Federal government spurred widespread adoption of the PCMH
  - 42% of practices with PCPs are in a PCMH (2018, AMA)
- PCPCC became PCC in 2019

Vision for Primary Care Updated

2017: Shared Principles Issued

They updated the 2007 PCMH Principles

350 Signatories to Date



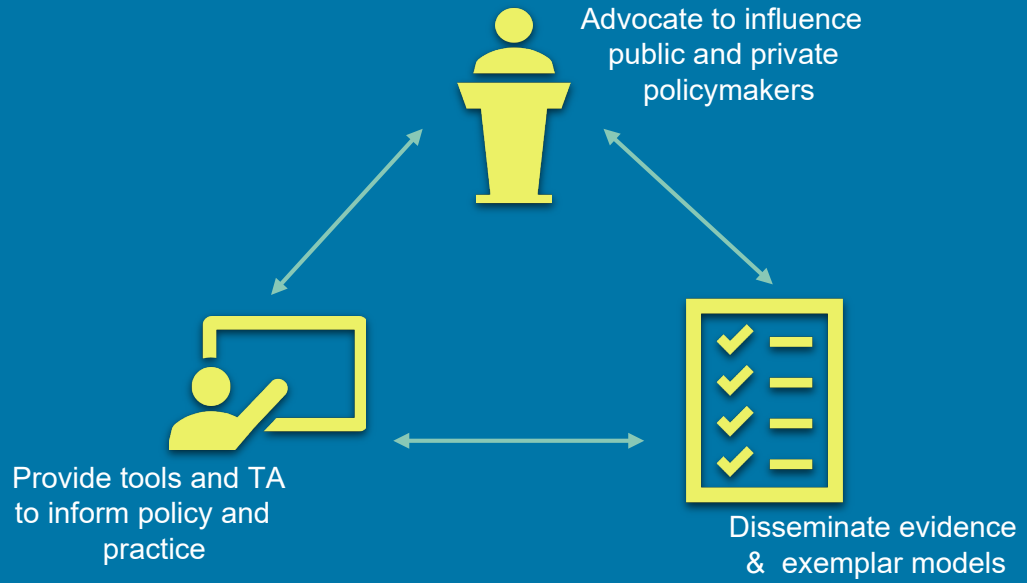
2007 Principles Updated in 2017

Evidence and Changing Practice Arrangements Shape 2017 Shared Principles

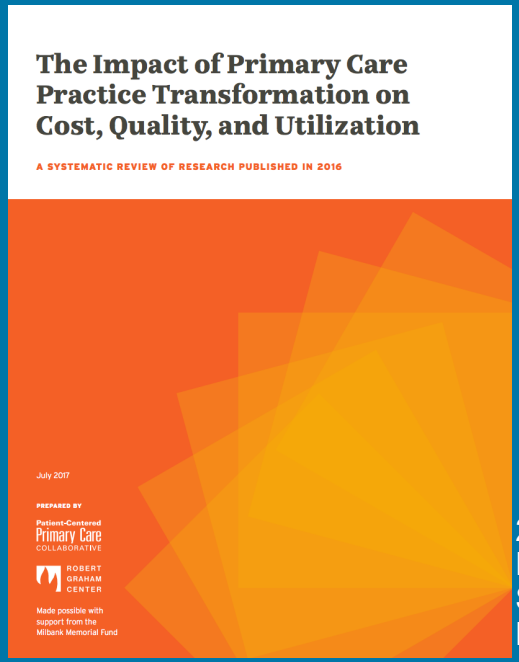
- Team -based – not just the physician -patient relationship
- Equity and the influence of social factors
- Value is a stand -alone principle

Shared Principles shape the PCC's policy/advocacy, education, and research agendas.

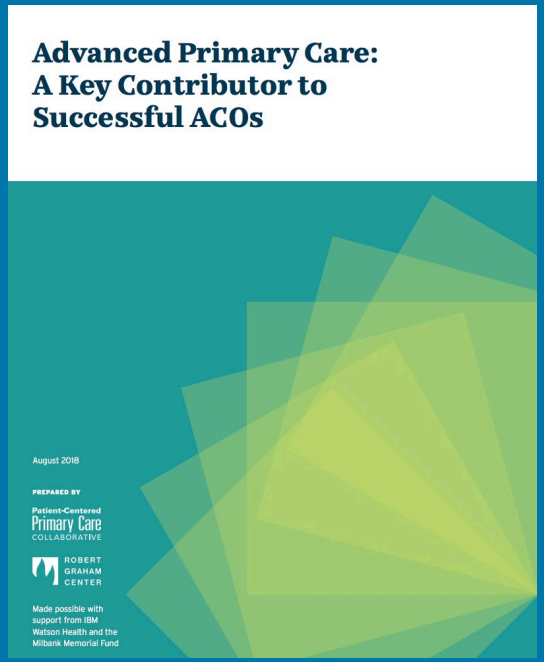
PCC Levers to Achieve Mission and Vision



PCMH Results



2017 PCC Evidence Report Synthesizes Research Literature

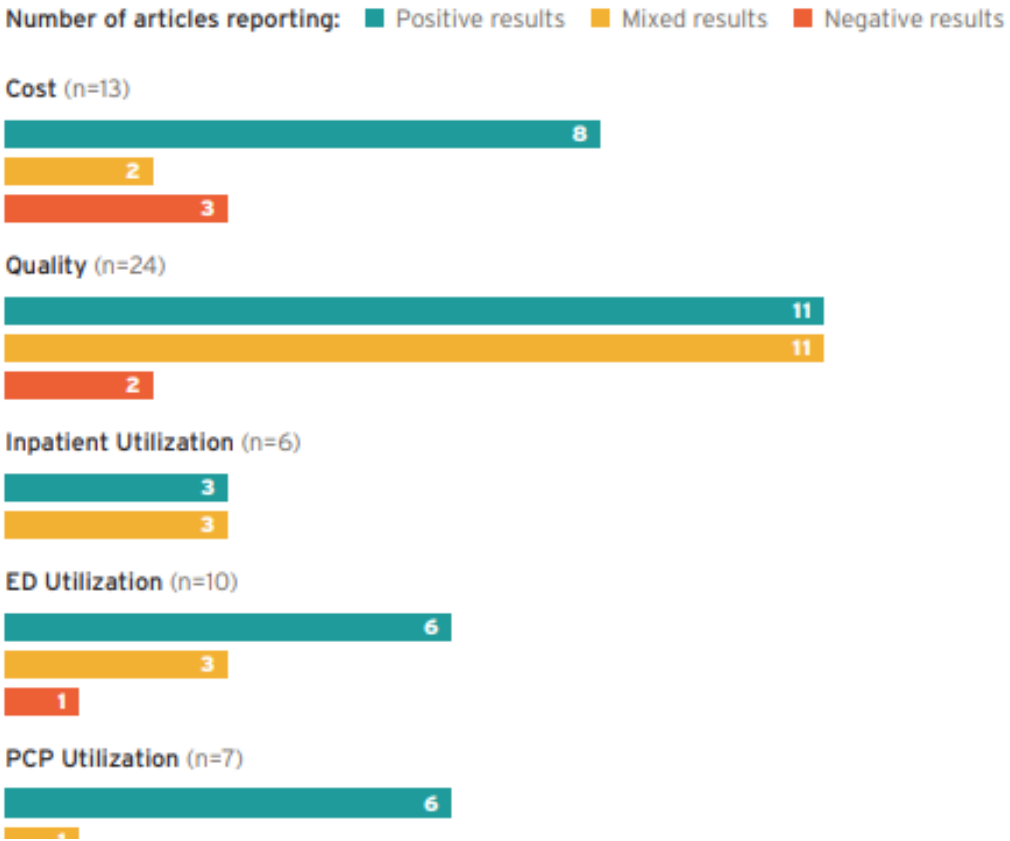


2018 PCC Evidence Report Examines Contribution of PCMH to ACOs

PCMHs Improve Value

FIGURE 1.3

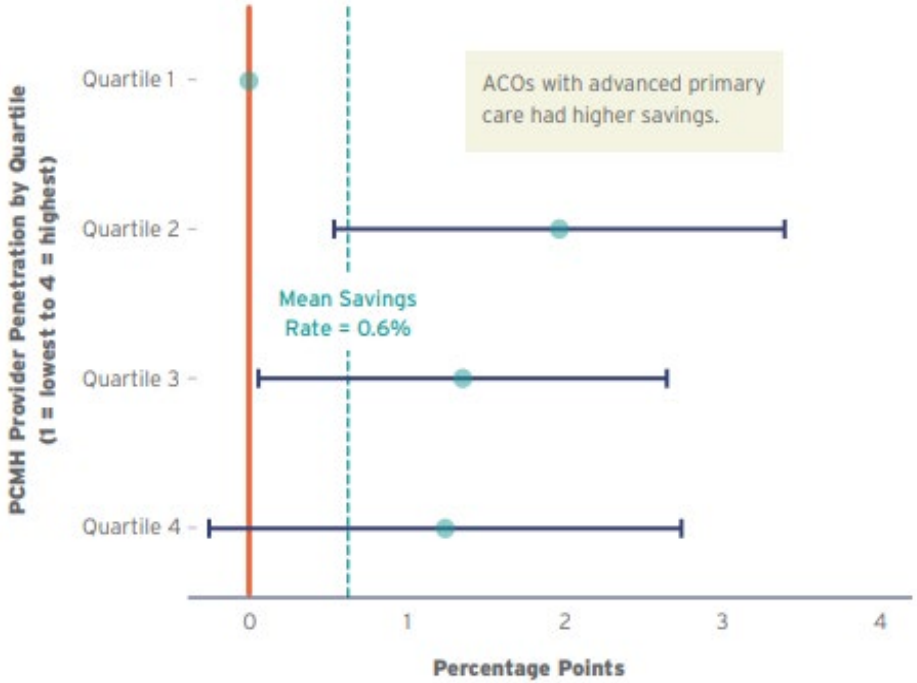
Impact of PCMH on Cost Quality and Utilization 2016-2017: Summary of Peer-Reviewed Articles



ACO Success Linked to PCMH

FIGURE 1.4

Impact of PCMH Physicians on ACO Success

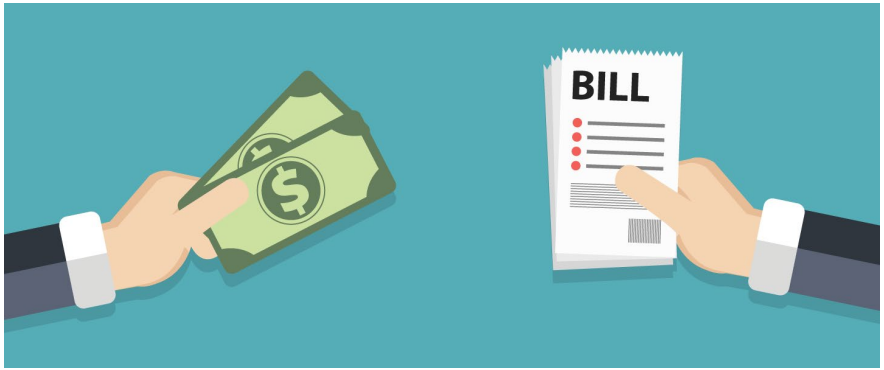


ACO = accountable care organization; PCMH = patient-centered medical home.

We used cross-sectional variation across ACOs that participated in the Medicare Shared Savings Program in 2014 to estimate the associations between the PCMH primary care physician share in the ACO workforce and ACO savings.

This figure shows that the savings rate difference was 1.6% higher for quartile 2 compared to quartile 1 and 1.3% higher for quartile 3 compared to quartile 1. See pcpcc.org/2018EvidenceReport for more details.

PCMH Enhanced Primary Care But



- The Model is **Underpowered:**
  - Most primary care practices paid under FFS
  - Insufficient investment in primary care/PCMH
    - ✓ Team-lets
    - ✓ Care is not truly comprehensive
  - Lack of alignment across the medical neighborhood

Primary Care Practices Moving (Slowly) to Comprehensive Payment

- *Health Affairs* study shows that primary care practices:
  - Need to be at 63% capitation to fund team and non -visit care
  - Nearly all PC practices with < 23% capitation will lose $ with capitation
- Proportion of physicians reporting some capitation revenue is 24% (AMA, 2018), falling slightly since 2014
- Overall 70% of physician revenue remains FFS (60% for PCPs in PCMH and ACO arrangements)

CMS Primary Care Efforts: Potential Game Changers?

- Increasing Medicare primary care E&M codes – baseline for future APMs – effective 2021
- CMMI primary care models: largest investment to date
  - CPC + (2017) – implementation midpoint; evaluation pending
    - 3,000 practices, 18 sites; 15.2 M patients
- Primary Cares models rolled out in April 2019
    - Primary Care First (2)
    - Direct Contracting (3)

Primary Care First RFA

Model implementation begins in January 2021

For most practices, the majority of revenue would come from prospective (capitated) payment + risk -based performance payment + visit fee

- Prospective payment risk adjusted (4 levels)
- Performance payment: up to 50% upside and 10% downside
- Preserve payment for face -to -face visits

Initial Assessment

- Applaud commitment to experimentation, movement toward comprehensive payment
- However, lack of payer alignment and sparse performance measures potentially problematic
- Bottom line: Is there enough investment in the model to attract enough practices ?

CMS: BEYOND PRIMARY CARE

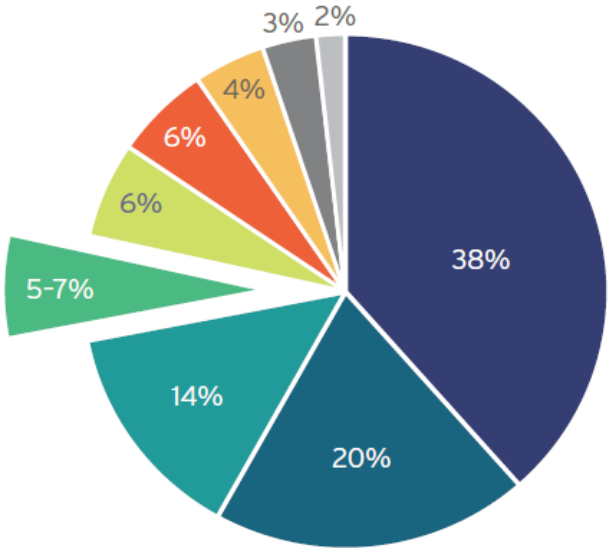
- ACO Models
- Accountable Care Communities
- Addressing Social Needs through Existing Programs

  ✓Medicare Advantage Plans
  ✓Medicaid Waivers

Inadequate investment in primary care

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



2019 PCC Report on Primary Care Spend

- Funded by Milbank Memorial Fund
- Research Partnership with the Graham Center

PCC Report Methods

Data: 2011 - 2016 Medical Expenditure Panel Survey (MEPS): primary care spend

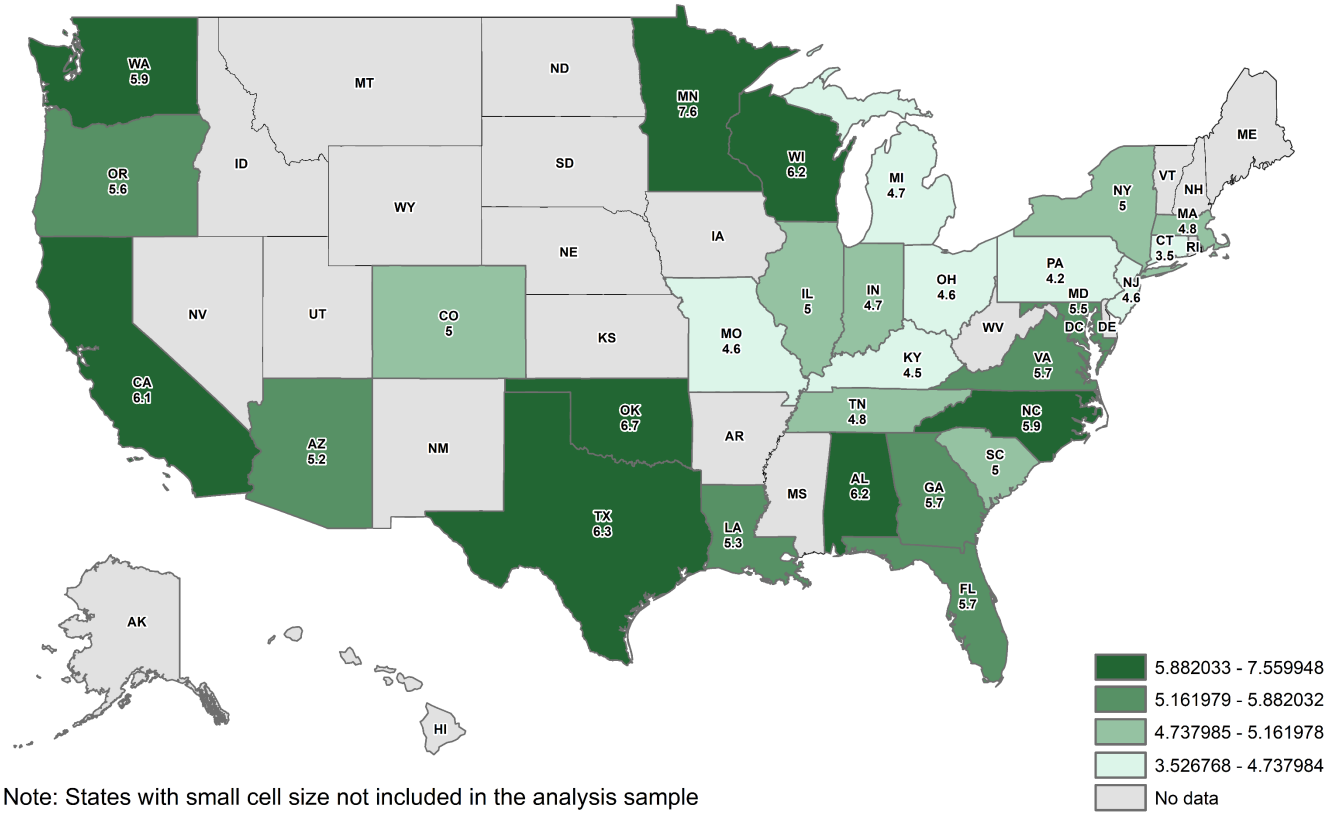
PC Spend: U.S. + 29 states; public/private payers

- PC Narrow – PCP (FPs, GPs, Peds, Geriatricians, Internists)
- PC Broad – PCP, NP/PAs, Psychiatrists, MH non -physicians, and OB -GYN

Health Outcomes

- Any ED visit
- Any hospitalization
- % Ambulatory -care sensitive hospitalizations

Percent PC Spend Variation Across States (Narrow Definition)

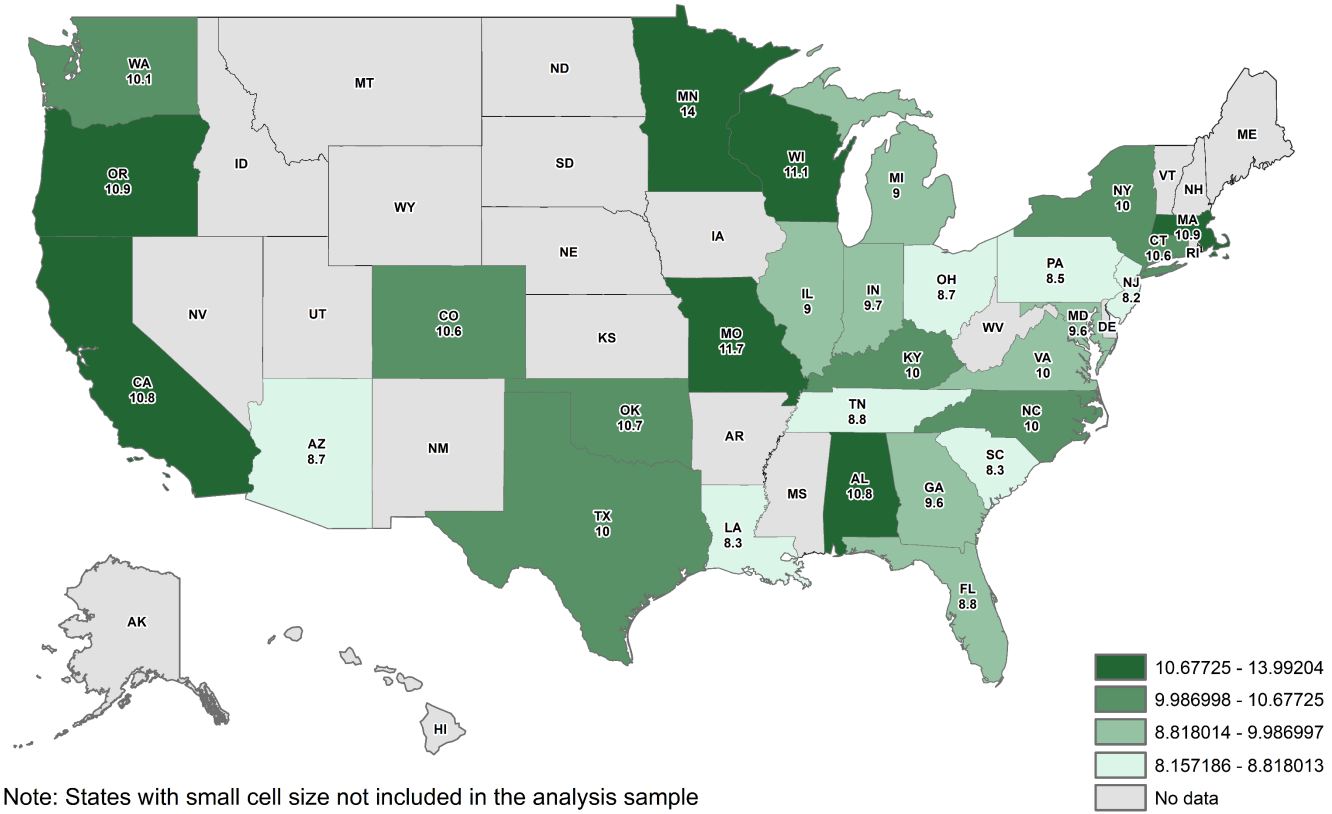


Note: States with small cell size not included in the analysis sample

State	PC Narrow
National	5.6
AL	6.2
AZ	5.2
CA	6.1
CO	5.0
CT	3.5
FL	5.7
GA	5.7
IL	5.0
IN	4.7
KY	4.5
LA	5.3
MA	4.8
MD	5.5
MI	4.7
MN	7.6
MO	4.6
NC	5.9
NJ	4.6
NY	5.0
OH	4.6
OK	6.7
OR	5.6
PA	4.2
SC	5.0
TN	4.8
TX	6.3
VA	5.7
WA	5.9
WI	6.2

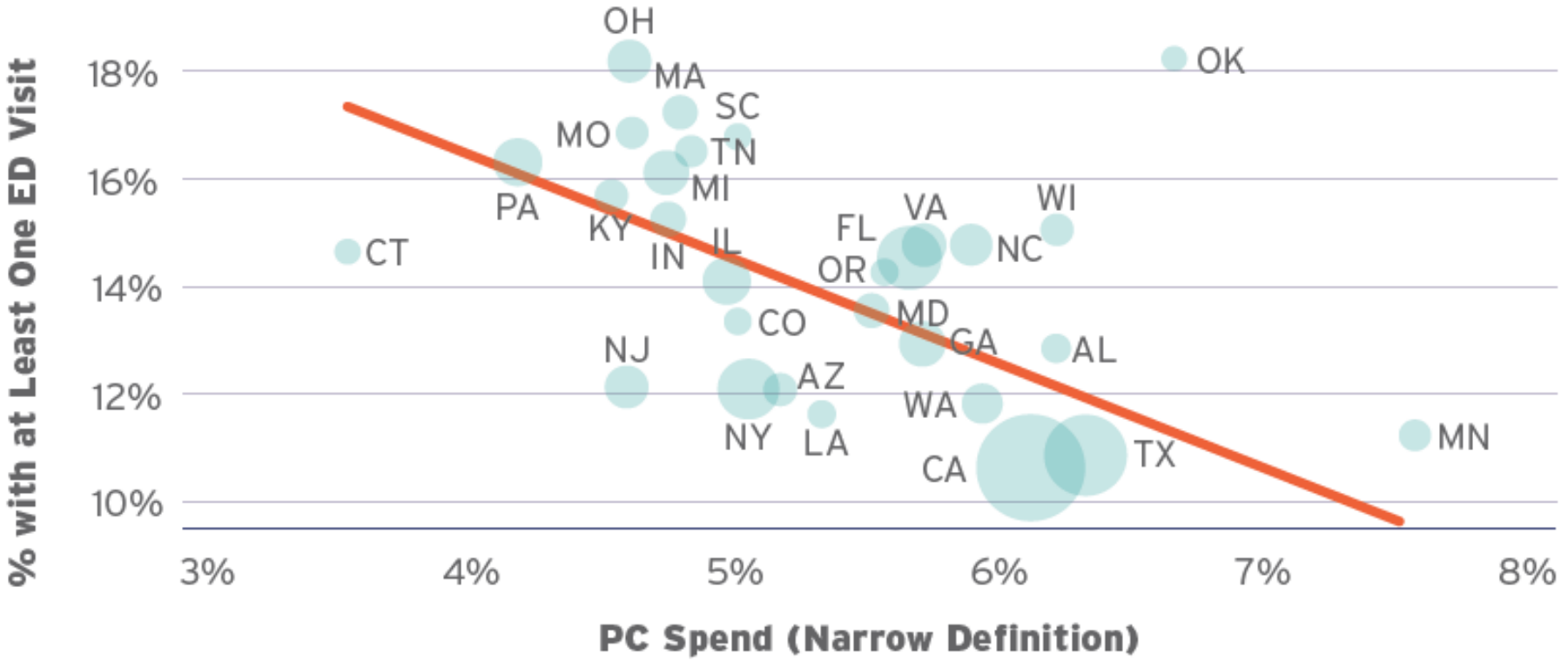
State	PC Broad
National	10.2
AL	10.8
AZ	8.7
CA	10.8
CO	10.6
CT	10.6
FL	8.8
GA	9.6
IL	9.0
IN	9.7
KY	10.0
LA	8.3
MA	10.9
MD	9.6
MI	9.0
MN	14.0
MO	11.7
NC	10.0
NJ	8.2
NY	10.0
OH	8.7
OK	10.7
OR	10.9
PA	8.5
SC	8.3
TN	8.8
TX	10.0
VA	10.0
WA	10.1
WI	11.

Percent PC Spend Variation Across States (Broad Definition)



Note: States with small cell size not included in the analysis sample

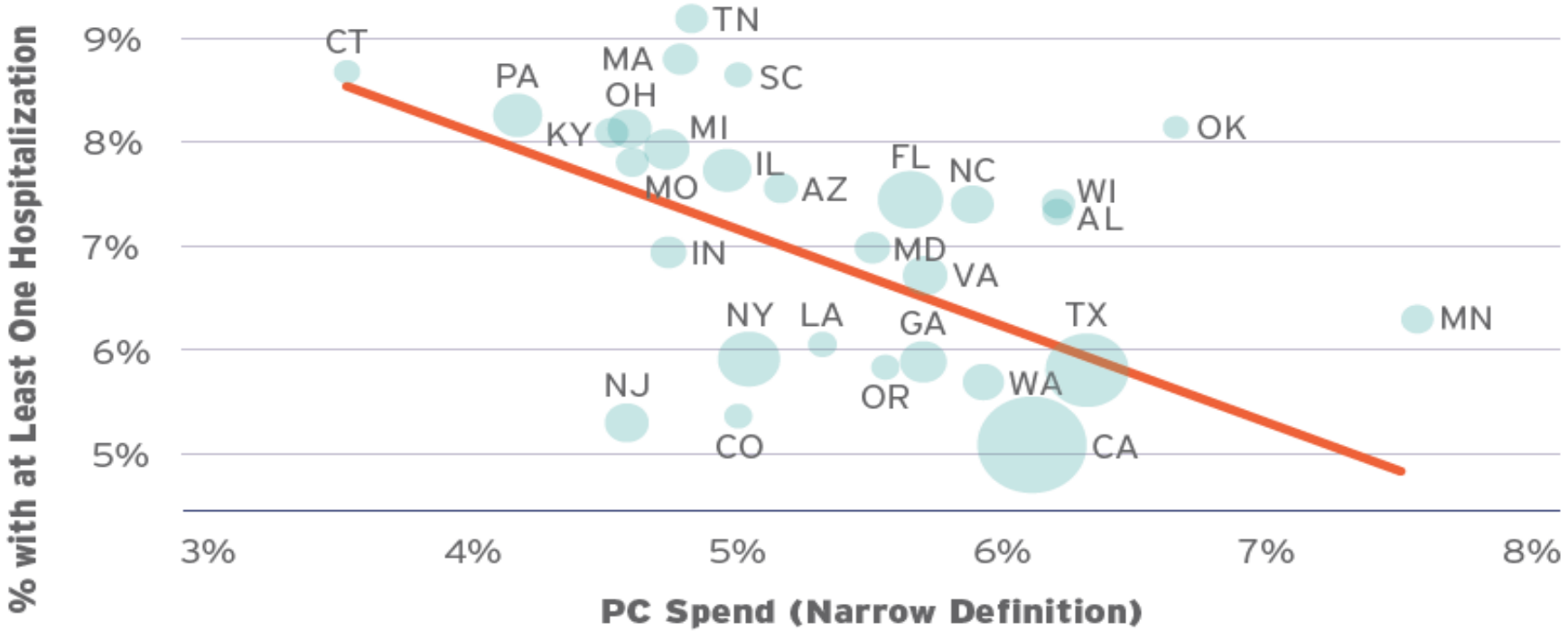
PC Spend-Narrow vs. Percent with at Least One ED Visit in Last 12 Months



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

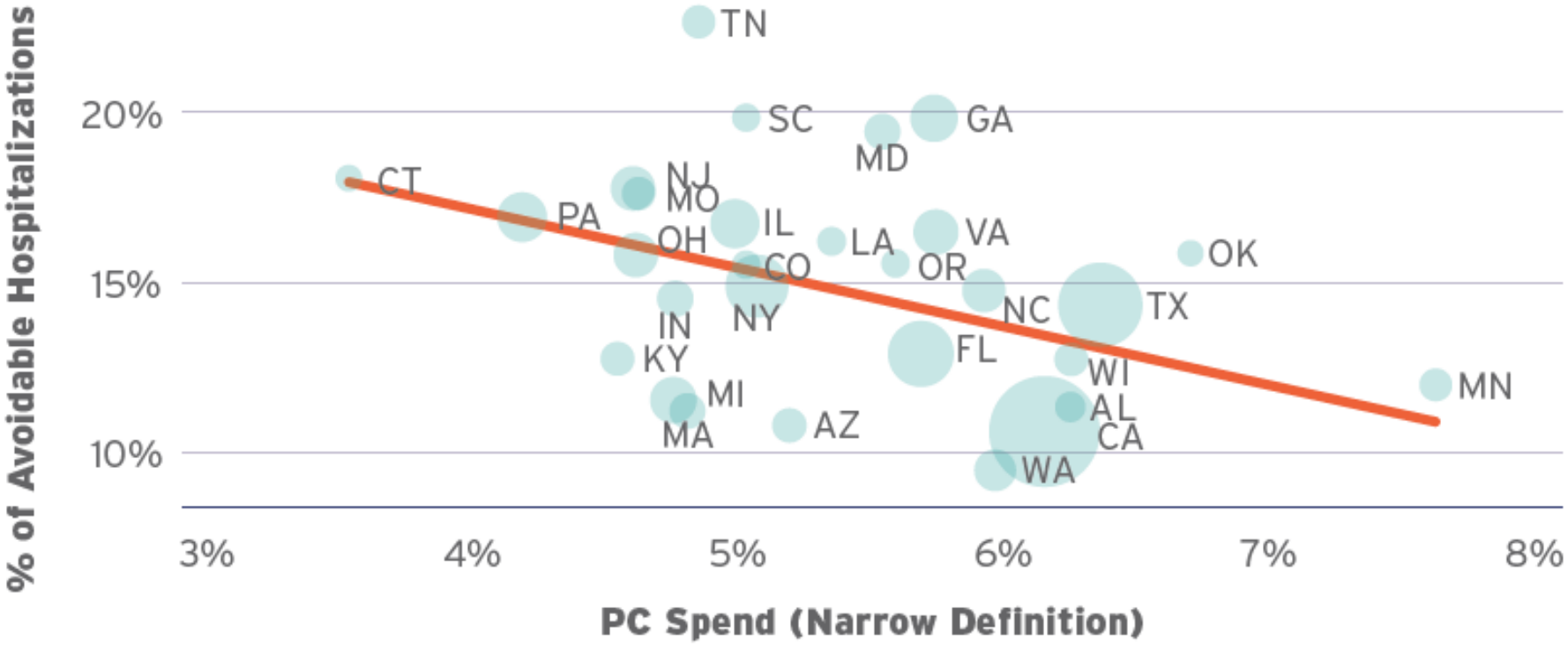
FIGURE 2.4

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.

Study Limitations

- Self-reported data – recall and reporting bias
- Based on non -institutionalized and civilian population
- Some expenses imputed based on costs by region, payer, gender, age
- PC spend not adjusted for payer, health of the population and other confounders

Study Bottom Line

1. PC Spend is lower in the U.S. (5 -7%) when compared to OECD nations (9 - 19% with an average of 14%)
2. PC Spend varies across states and across payers
3. Data suggests higher PC spend is associated with lower inpatient and ED utilization
4. Research has direct implications for policy

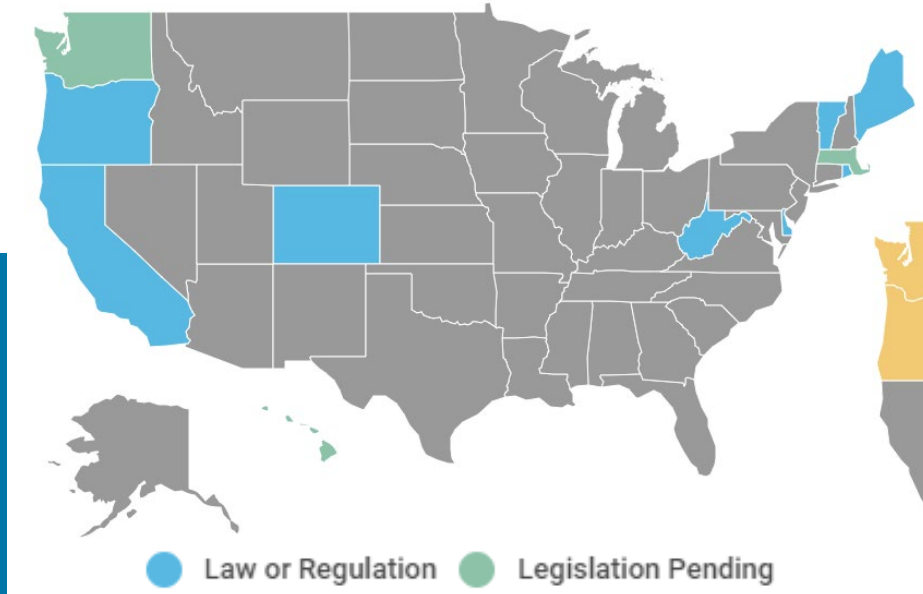
Growing State Momentum

- To date, 13 states have introduced/passed legislation related to primary care investment

- 6 states passed legislation in 2019 – CO, DE, VT, ME, WA and WV – focused on reporting primary care spending levels to achieve more comprehensive PC

- 3 states have set targets for primary care spending in legislation w/out growing total cost of care
  - Rhode Island – 10.7% Connecticut – 10%
  - Oregon – 12%

State PC Investment Legislation



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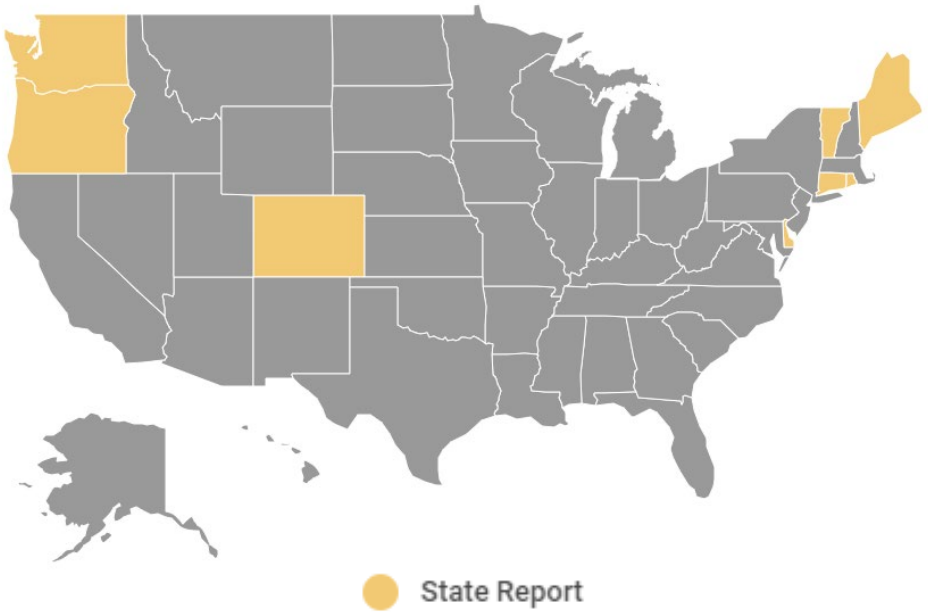

Growing Evidence Base

"The Impact of Primary Care: A Focused Review," Leiyu Shi. *Scientifica* (Cairo). 2012.

"Implementation of Oregon's PCPCH Program: Exemplary Practice and Program Findings," Portland State University, 2016.

Quality and Experience of Outpatient Care in the United States for Adults with and Without Primary Care. David M. Levine et al. *Jama Internal Medicine*, January 28, 2019.

"Health Care Spending Slowed After Rhode Island Applied Affordability Standards to Commercial Insurers," Aaron Baum et al. *Health Affairs*, February 4, 2019

"Association of Primary Care Physician Supply with Population Mortality in the U.S., 2005–2015," Seth Berkowitz, et al. *Jama Internal Medicine.* February 18, 2019

Raising the Visibility About the Importance of Supporting Advanced Primary Care

Prioritising primary care in the USA

Although the USA spends more on health care despite having worse outcomes than other high-income nations, one area where it underinvests is primary care. Research has shown that higher levels of spending on primary care lead to improved patient outcomes and lower overall health-care costs. On July 17, 2019, the Patient-Centered Primary Care Collaborative (PCPCC) issued the first report to look at primary care spending by state, including spending from across different types of payers: commercial insurance companies, government-provided insurance (Medicare and Medicaid), as well as the uninsured. Because of the limitations of survey data originally designed to estimate national and not state-level usage, their report compares primary care spending in the 29 largest states, representing 88% of the US population.

One of the persistent problems with looking at primary care spending is that the definition of primary care remains vague. The PCPCC analysis defined primary care using two standards: narrow and broad. The narrow definition of primary care included expected categories like general practitioners, internal medicine, and paediatrics, whereas the broad analysis expanded that definition of primary care to include obstetrics and gynaecology, visits with nurse practitioners and physicians' assistants, and behavioural health services (including mental health services like psychiatrists and psychologists, as well as social workers).

The report found that the highest level of primary care spending in the USA—in Minnesota, where 14% of health-care spending is dedicated to primary care—is equal to the average primary care spending in Organisation for Economic Co-operation and Development (OECD) countries. The overall US average was only 10·2% using the PCPCC broad definition (5·6% narrow), which more closely accords with the OECD measurement of primary care. The report did not find substantial regional patterns but shows that primary care use is unevenly distributed across age, with care for children younger than 5 years accounting for 26% of primary care spending according to the narrow definition. The report also found an association between increased primary care spending and fewer emergency department visits and hospital admissions.

The proportion of Americans with access to a primary care provider has not changed substantially in nearly 20 years, 76·4% in 2015 compared with 76·8% in 1996. However, an increasing proportion of Americans has been moved into high-deductible health plans (HDHPs; 43% in 2017 *vs* 15% in 2007) that make accessing primary-care services more difficult. In traditional health insurance plans, visits to primary-care doctors are available for a small co-payment, but in an HDHP, payment for any health services—including primary care—is entirely paid by the patient until they have spent more than their annual deductible. In 2018, the average HDHP deductible for an individual was nearly US$1500, or nearly $2800 for a family. The end result is that even people with access to health insurance might not be able to afford primary care visits unless it's absolutely necessary. Meanwhile, the number of primary care doctors in the USA has been declining, with only 20% of new clinicians entering primary care fields. Primary care doctors face heavy workloads, lower pay than other specialties, and large bureaucratic overhead. A report by the Association of American Medical Colleges estimated that by 2032, the USA would face a shortage of up to 55 200 primary care doctors, compared with about 480 000 primary care physicians in the USA in 2019.

Ten states have begun taking steps to increase primary care spending by moving primary health-care services towards patient-centred medical home initiatives and accountable care organisations, care delivery models that reorient financial incentives for care away from fee-for-service payment structures towards accountability for patient outcomes. Although these programmes have shown promise in keeping down costs and delivering superior health outcomes, they have also proven unpopular with hospital systems and physicians and still account for only a small percentage of total health-care spending in the USA.

The PCPCC report gives only a snapshot of primary care spending in the USA at a time when many policy makers at the state level have been looking to shift health care back to a more primary care-focused approach. The report highlights the need for a standard definition of primary care to better benchmark progress across programmes, states, and nations. Access to primary care improves health outcomes and lowers health-care costs, but in the USA, patients are too often driven to wait for care until costs, physical and financial, are much greater than need be. ■ *The Lancet*

For the **PCPCC report** see https://www.pcpcc.org/resource/evidence2019

For the **OECD brief** see http://www.oecd.org/health/primary-care.htm

For more on **Healthy People 2020** see https://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services

For more from the **CDC on high deductible health insurance plans** see https://www.cdc.gov/nchs/products/databriefs/db317.htm

For more on **primary care in the USA** see https://www.healthaffairs.org/doi/10.1377/hblog20181115.750569/full/

For the **AAMC report** see https://news.aamc.org/press-releases/article/2019-workforce-projections-update/

HEALTH AFFAIRS BLOG

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The Importance Of Primary Care—And Of Measuring It

Hoangmai Pham, Ann Greiner

AUGUST 6, 2019 10.1377/hblog20190802.111704

TOOLS SHARE

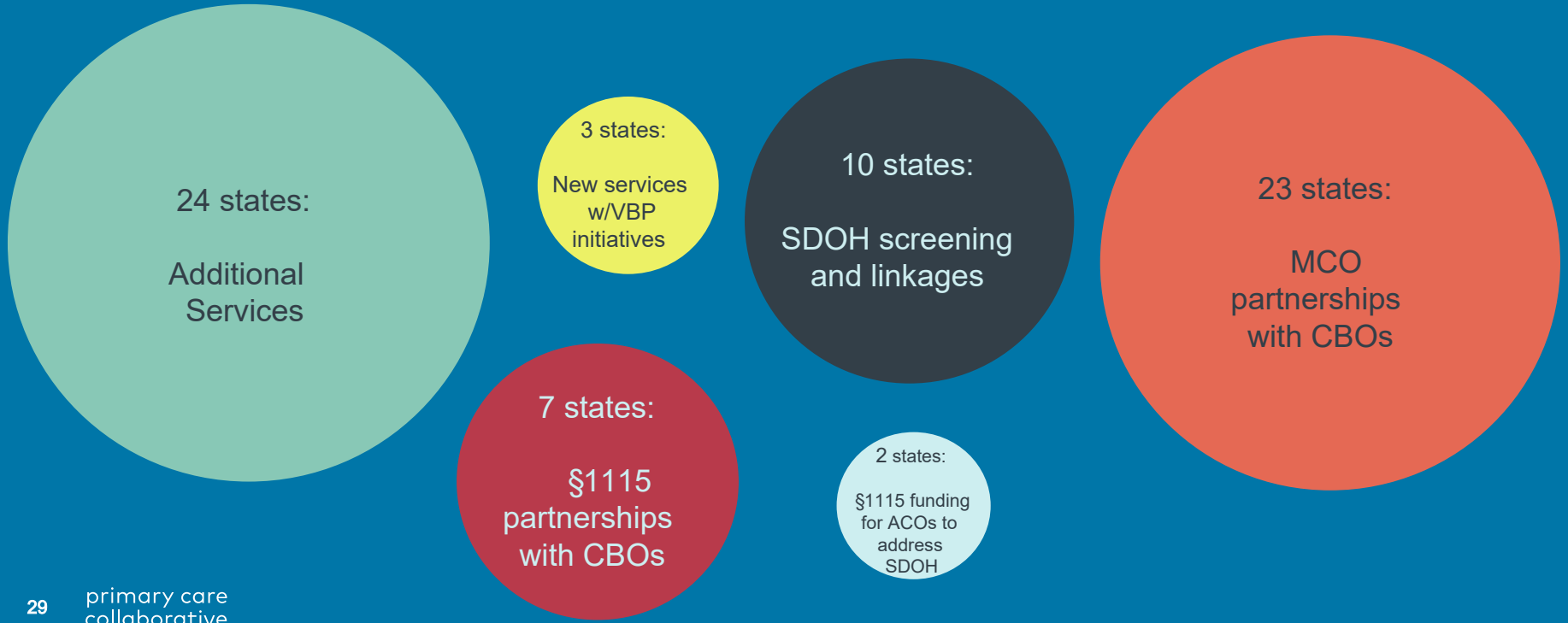
When it comes to US health care, the adage of "you get what you pay for" does not apply. The US spends more on health care than any other country, but we have lower-quality care and worse outcomes than many nations that spend considerably less.

This disconnect stems from how we spend our money. Research confirms that advanced primary care, such as patient-centered medical homes and other accountable care models, help fulfill the "quadruple aim": high-quality care, better health, lower costs, and improved experience for clinicians and staff in the delivery of care.

Despite this understanding, the best available estimates indicate that the percentage of health care spending devoted to primary care in the US is an anemic 5 percent to 7 percent. In a recent study, RAND Corporation researchers estimated that just 2.12 percent to 4.88 percent of total Medicare fee-for-service medical and prescription drug spending goes toward primary care. High-performing health care systems in other countries spend double or triple that amount.

State Innovations: Primary Care + Community Services

- According to a 2018 report by the National Association of State Health Policy (NASHP), 30 states are addressing at least one social need through their Medicaid programs.



Examples of State Efforts to leverage PC and community services

Oregon:

Coordinated Care Organizations (CCOs) have the latitude to pay for flexible services and incentivize upstream health promotion through an 1115 waiver. Some of their measures include:

- Effective contraceptive use
- Cigarette smoking prevalence
- Childhood obesity

California:

California Accountable Communities for Health Initiative (CACHI) was started through several state policy initiatives such as an 1115 waiver.

Conditions focused on include:

- Asthma
- Cardiovascular disease
- Diabetes
- Depression
- Trauma
- Substance use disorders

Examples of State Efforts to leverage PC and community services

North Carolina:

"Healthy Opportunities Pilot" through an 1115 waiver includes enhanced case management for needs related to housing, food, transportation, and interpersonal safety

Figure 1

North Carolina Healthy Opportunities Pilots Eligibility Criteria and Services

Health Risk Factors	Social Risk Factors	Pilot Services
• Adults with two or more chronic conditions or repeated emergency room use or hospital admissions • High-risk pregnant women • High-risk infants and children or infants and children with one or more chronic conditions	• Homelessness and housing insecurity • Food insecurity • Transportation insecurity • At risk of witnessing or experiencing interpersonal violence	• Tenancy support; housing quality and safety; legal referrals; security deposit and first month rent; short-term post-hospitalization housing assistance • Food support and meal delivery • Non-emergency health-related transportation • Interpersonal violence-related transportation, legal referrals, and parent-child supports

Source: KFF analysis of CMS, Special Terms and Conditions, #11W00313/4, North Carolina Medicaid Reform Demonstration, Attachment G: Enhanced Case Management and Other Services Pilot Program Eligibility and Services (approved Nov. 1,2019-Oct. 31, 2024, amended April 25, 2019), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nc/nc-medicaid-reform-ca.pdf

Examples of State Efforts to leverage PC and community services

Delaware:

Healthy Neighborhoods were established through a SIM Testing Grant and focus on four priority areas:

- Healthy lifestyles
- Maternal and child health
- Mental health and addiction
- Chronic disease prevention and management

Washington:

Accountable Communities of Health (ACHs) were established through policy levers such as a SIM Testing Grant, state legislation, and an 1115 waiver. They are required to address at least four DSRIP measures. Areas of focus can include:

- Immunizations
- Physical and behavioral health integration
- Tobacco cessation
- Certain cancer screenings
- SUD service penetration

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Social Determinants of Health. *Healthy People 2020* https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

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Discussion

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