

Starfield Summit Issue Brief

DISCUSSION TOPIC:

- ▶ Statewide innovations in primary care payment: Implications for teams
- ▶ “Follow the money: focusing on primary care spend as a policy priority”

Why This Is Important (*brief description*):

- ▶ Evidence shows that health care systems with robust primary care produce better health outcomes at lower costs. Rather than try to have primary care earn a greater share of a health care budget by demonstrating its economic value in the health care marketplace – through pay for performance - what happens when we act on the evidence and spend more on primary care as an investment. Does that investment pay off?

What We Think We Know (*bulleted evidence + seminal references*):

1. Primary care based delivery systems perform better.
2. Private payers constitute roughly 50% of health care spending, basing their allocation on utilization and the prices they have negotiated with providers.
3. Although the details of the insurers' contracting results are confidential, we know the prices they pay are driven by: 1) Medicare as a reference; and 2) the relative negotiating power of the insurer and the provider. Primary care providers lose on both of those marks relative to their physician peers, resulting in significant salary disparities¹
4. (BIG IDEA 1) Insurers' statutory accountability typically rests on protecting consumers and maintaining solvency. In 2004, Rhode Island (RI) expanded it to include health care system improvement.²
5. (BIG IDEA 2) The primary care spend is an important metric, and it is possible, through regulatory standard setting to have commercial insurers spend a greater portion on primary care.
6. The effects of such an effort are hard to assess definitively but here are some things that did happen during the same five year time period: 1) Commercial health care spending in RI grew at a slower rate than any other New England state; 2) A top 10 performing primary care led Accountable Care Organization (ACO) was established; 3) A health information exchange was built; 4) Largest commercial insurer established and supported a network wide PCMH program which reduced utilization; 5) An all payer PCMH program was established.
 1. Council on Graduate Medical Education. *Twentieth Report: Advancing Primary Care.*; 2010. <http://www.hrsa.gov/advisorycommittees/bhpradvisory/cogme/reports/twentiethreport.pdf>. Accessed April 9, 2016.
 2. Koller CF, Brennan TA, Bailit MH. Rhode Island's Novel Experiment To Rebuild Primary Care From The Insurance Side. *Health Aff (Millwood)*. 2010;29(5):941-947. doi:10.1377/hlthaff.2010.0136.



QUESTIONS FOR GROUP DISCUSSION (PRECONFERENCE)

Questions for Group Discussion (*add brief answers post-conference*)

1. RI regulation said the increased spend could not be for increased fee for service rates but only for alternative payments, broadly defined, and designated public utilities, like the health information exchange. Was this the right call? Why?
2. Missing from the RI story is the role of Medicaid, self-insured, and Medicare. How would you get them into the primary care spend game?
3. We compel ER docs to treat patients, but do not compel auto mechanics to treat cars. Given this difference in social values, why does every state but RI hold health insurers and auto insurers to the same statutory standards?

Ideas Worthy of Policymaker Attention (*lists ideas for policy preconference, refined ones post-conference*)

1. Broaden standards for accountability for commercial insurers in state law to include affordability.
2. Include primary care spending as separate reporting line in Health and Human Services (AHRQ/ASPE/CMS/HRSA) spending reports
3. State-level primary care coalitions advocate for “state of primary care” reports in each state, measuring staffing and spend
4. Primary care spend requirements in Medicaid managed care organization contracts
5. Include ERISA (Employee Retirement Income Security Act) data in an all payer claims databases

Important Unanswered Questions & Ideas Worthy of Research Community Attention

1. How much does the US spend on primary care compared to other countries?
2. How are primary/specialty pay gaps changing in the US compared to other countries?
3. How have primary care specialties fared in shared risk/population based payment administration?