STARFIELD SUMMIT
...where primary care research inspires policy and practice

Starfield Summit Issue Brief

DISCUSSION TOPIC

- What would effective primary care look like, and what outcomes would it lead to? What components would a payment model need to best support and advance the primary care functions of contact, comprehensiveness, coordination, and continuity?

Why This Is Important *(brief description)*:

- Barbara Starfield showed that a strong primary care foundation is associated with improved population health, higher quality, decreased costs, and improved health equity. This stands in contrast to the U.S., where we have a shortage of primary care providers, and subsequently, have fallen short of the Triple Aim. One of the central factors contributing to the diminished role of primary care is a fee-for-service payment model that incentivizes volume and specialty care, at the expense of value and preventive care. MACRA presents an opportunity to facilitate the transition from volume- to value-based payment. Yet, the opportunity needs to be seized strategically to move us toward a payment model that provides value to the patient, as several alternative payment models have failed to deliver the Triple Aim. Disruptive payment innovation models have emerged to align payment with primary care delivery, such as comprehensive primary care payment and direct primary care, but questions remain about their feasibility and generalizability. To avoid the primary care paradox, payment models should also be judged based on population/patient-centered outcomes.

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

- Primary care accounts for 5-6% of healthcare expenditures; experts have recommended increasing to 10-12%. Rhode Island did this, spent $18 million on primary care, and saved $115 million.
- P4P, bundled payment, and shared savings have failed to consistently improve outcomes and decrease costs, with concerns that they may not advance the primary care function well.
- Care management fees aim to support the medical home principles, but have delivered mixed results in preliminary findings of the MAPCP and CPCI demonstration projects. Bright spots have emphasized data-enabled teams that coordinate social services.
- Payment models are largely judged on cost containment and quality metrics, with $15.4 billion spent annually on monitoring quality. The vast majority of metrics assess process/disease-centered metrics, which could perpetuate the primary care paradox. Advancing the primary care function could mean capturing SDHs, patient-centered outcomes, delivery of 4Cs.
- MACRA presents opportunities and pitfalls on this continuum towards value-based payment: support administrative burdens on providers to aid transition towards alternative payment models; define “nominal” financial risk and “comparable” quality metrics; engage TAC to be proactive allies.

QUESTIONS FOR GROUP DISCUSSION *(PRECONFERENCE)*

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

1. What would primary care payment have to pay for, to deliver effective primary care: teams (who is included in those teams?), EHR (what would the EHR look like to enable primary care functions?), non-office visits (e.g., telehealth, lab review, time spent on coordination, etc.)?
2. Should financial accountability be shared across a PCMH (teams) or a medical neighborhood (specialists/hospitals, social services)? What are the advantages/disadvantages of both?

3. How much downside risk is appropriate to hold providers accountable for provisions of appropriate services and quality of care, without conferring too much provider risk? Or, would effective primary care payment only include upside risk?

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

- Increasing proportion of healthcare expenditures invested in primary care
- Increasing social service expenditures to improve population health, including data sharing between health, public health, social service sectors
- Advocate for APMs (via TAC?) that advance comprehensive primary care payment
- Risk-adjusted capitation in comprehensive primary care payment warrants funding research in validated risk-adjustment tools (particularly in community/SDH risk)
- Engage primary care community with MACRA implementation, particularly in helping shape/define nominal risk and comparable quality metrics in APM track, as well as workflow of TAC
- Fund demonstration projects on comprehensive primary care payments that help practices invest in primary care infrastructure; advocate for appropriate study intervals to assess success (PCMH demonstration projects demonstrated need for 3-5 years for positive impacts to occur)
- Fund research on validated metrics that capture primary care-relevant "outputs," including delivery of the 4Cs, impacts on patient-centered outcomes/SDHs

Important Unanswered Questions & Ideas Worthy of Research Community Attention

1. What is the best methodology for calculating comprehensive primary care payment (e.g., panel size, team members, PCMH services, link to quality metrics) and its risk-adjustment?
2. What impacts, if any, would comprehensive primary care payment have on panel sizes and subsequently, the primary care shortage?
3. How are other countries paying for primary care? How are those payments specifically enabling the primary care function and improving population health?
4. How do we measure effective primary care (systems-centric) vs. tertiary and subspecialty care? How do we measure primary care value (patient-centric) vs. tertiary and subspecialty care?