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Implementing High-Quality Primary Care:

Rebuilding the Foundation of Health Care

Rhode Island – CTC
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Notes

- Christopher Koller was a member of the NASEM committee

- Slides 28-32 in this presentation represent his interpretations of the Committee Report

Committee Members

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- **Asaf Bitton,** Ariadne Labs
- **Tumaini Coker,** University of Washington School of Medicine and Seattle Children's
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Study Sponsors

- Agency for Health Research and Quality
- American Academy of Family Physicians
- American Academy of Pediatrics
- American Board of Pediatrics
- American College of Physicians
- American Geriatrics Society
- Academic Pediatric Association
- Alliance for Academic Internal Medicine
- Blue Shield of California
- The Commonwealth Fund
- Department of Veterans Affairs
- FMA Health
- Health Resources and Services Administration
- New York State Health Foundation
- Patient-Centered Outcomes Research Institute
- Samueli Foundation
- Society of General Internal Medicine

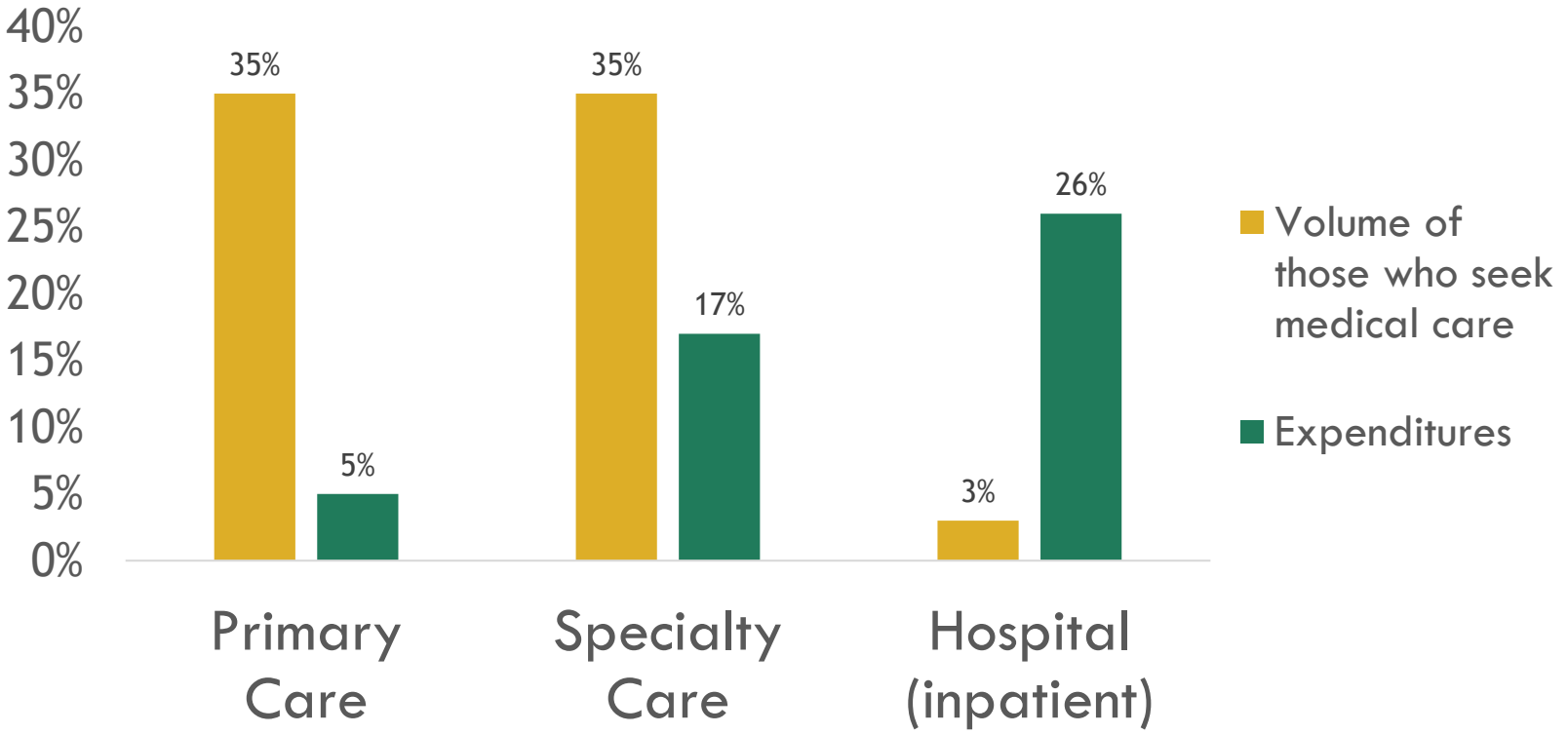
Statement of Task

NASEM committee will examine the current state of primary care in the United States and **develop an implementation plan** to build upon the recommendations from the 1996 IOM report, *Primary Care: America's Health in a New Era*, **to strengthen primary care services** in the United States, especially for underserved populations, and **to inform primary care systems** around the world.

Study Context

- Primary care is only part of health care system that results in longer lives and more equity.
- It is weakening in the U.S. when it is needed most.
- "Islands of excellence": Systems, localities, and states have had success implementing high-quality primary care.

Visits vs Expenditures in Medical Care



SOURCES: Johansen et al., 2016; Martin et al., 2020
All categories are not included in the figure and thus do not add up to 100 percent.

Study Context

- Share of total health care spending on primary care is decreasing in majority of states
- COVID-19 pandemic
  - amplified economic, mental health, and social health inequities
  - Exacerbated access to care problems and financial pressures on practices and sales to higher-priced vertically integrated health systems (April 2021 HPC report)
  - Some meaningful policy changes, including relaxation of telehealth rules

SOURCES: Johansen et al., 2016; Martin et al., 2020

An Updated Definition of Primary Care

High-quality primary care is the provision of whole-person, integrated, accessible, and equitable health care by interprofessional teams that are accountable for addressing the majority of an individual's health and wellness needs across settings and through sustained relationships with patients, families, and communities.

Primary Care as a Common Good

- High quality primary care has high societal value among health care services yet is in a precarious status
- Requires public policy for oversight and monitoring
- Needs strong advocacy, organized leadership, and public awareness

5 Objectives for Achieving High-Quality Primary Care

1 PAYMENT
Pay for primary care teams to care for people, not doctors to deliver services

2 ACCESS
Ensure that high-quality primary care is available to every individual and family in every community

3 WORKFORCE
Train primary care teams where people live and work

4 DIGITAL HEALTH
Design information technology that serves the patient, family, and interprofessional care team

5 ACCOUNTABILITY
Ensure that high-quality primary care is implemented in the United States

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1

PAYMENT

Pay for primary care teams to care for people, not doctors to deliver services.

Action 1.1: Payers should evaluate and disseminate payment models based on their ability to promote the delivery of high-quality primary care, not short-term cost savings.

Action 1.2: Payers using fee-for-service models for primary care should shift toward hybrid reimbursement models, making them the default over time. For risk-bearing contracts, payers should ensure that sufficient resources and incentives flow to primary care.

Why Hybrid?

- Balances incentives of models at the extremes
- Pay FFS only for services you want to encourage to be done in the primary care setting (vaccines)
- Pragmatic – brings up the base, allows for transition
- Those already bearing more risk can continue

Action 1.3: CMS should increase overall portion of health care spending for primary care by improving Medicare fee schedule and restoring the RUC to advisory nature.

Action 1.4: States should facilitate multi-payer collaboration and increase the portion of health care spending for primary care.

Paying for Primary Care Teams to Care for People (RI Has Been Into This Process)

Full Fee-for-service:
- Phase out

Risk Adjusted Capitation + FFS + patient assignment:
- Default payment for primary care
- Revalued E&M codes
- Resources for transformation

Risk Bearing Contracts with Focus on Population Health:
- Sufficient resources and incentives for primary care

Importance of Multipayer Collaboration

- Estimated 60%+ of market needed
- Medicare needs to take leadership
- Large local payers help
- States need to help facilitate (Medicaid/ Governor)
- Neutral convener builds trust
- Provide a forum for provider learning
- Patience – returns come after >5 years
- Encourage involvement by self-insured plans

2

ACCESS

Ensure that high-quality primary care is available to every individual and family in every community.

Action 2.1: Payers should ask all beneficiaries to declare usual source of care. Health centers, hospitals, and primary care practices should assume ongoing relationship for the uninsured they treat.

Action 2.2: HHS should create new health centers, rural health clinics, and Indian Health Service facilities in shortage areas.

Action 2.3: CMS should revise access standards for primary care for Medicaid beneficiaries and provide resources to state Medicaid agencies for these changes.

Action 2.4: CMS should permanently support COVID-era rule revisions.

Action 2.5: Primary care practices should include community members in governance, design, and delivery, and partner with community-based organizations.

3

WORKFORCE

Train primary care teams where people live and work.

Action 3.1: Health care organizations should strive to diversify the primary care workforce and customize teams to meet the needs of the populations they serve. Government agencies should expand educational pipeline models and improve economic incentives.

Action 3.2: CMS, the Department of Veterans Affairs, HRSA, and states should redeploy or augment Title VII, Title VIII, and GME funding to support interprofessional training in community-based, primary care practice environments.

4

DIGITAL HEALTH

Design information technology that serves the patient, family, and interprofessional care team.

Action 4.1: ONC and CMS should develop next phase of digital health certification standards that support relationship-based, continuous and person-centered care; simplify the user experience; ensure equitable access and use; and hold vendors accountable.

Action 4.2: ONC and CMS should adopt a comprehensive aggregate patient data system that is usable by any certified digital health tool for patients, families, clinicians, and care team members.

5

ACCOUNTABILITY

Ensure that high-quality primary care is implemented in the United States.

Action 5.1: The HHS Secretary should establish a Secretary's Council on Primary Care to coordinate primary care policy, ensure adequate budgetary resources for such work, report to Congress and the public on progress, and hear guidance and recommendations from a Primary Care Advisory Committee that represents key primary care stakeholders.

Action 5.2: HHS should form an Office of Primary Care Research at NIH and prioritize funding of primary care research at AHRQ.

Action 5.3: Primary care professional societies, consumer groups, and philanthropies should assemble, regularly compile, and disseminate a "High-quality primary care implementation scorecard" to improve accountability and implementation.

The Big Stories in the Report:

1. High Quality Primary Care is a common good
   - Nothing else in health care improves the health and health equity of populations
2. It is fragile and weakening
3. Everyone should have a usual source of care.
   - A financial and moral argument
4. Get practices off of FFS - now

RI: Still a Model for Implementing High Quality Primary Care?

- Practice transformation: CTC work on BH, CHW's, and SDOH generally.
- Follow the money:
  - What is in Commercial PCP spend these days? Medicaid?
  - How primary care gets paid
    - Independent pratices: Capitation discussion.
    - Employed Practices: Relationship to Alternative Payment Model (APM) adoption, at time of vertical integration?

Implementing High Quality Primary Care: RI Opportunities

- More attention to primary care spend requirement.
  - How much and how are payers paying primary care
  - Understand effects of vertical integration in state.
- Have payment strategies for independent and employed practices.
- Align Medicaid and Commercial Strategies.

Implementing High Quality Primary Care : RI Opportunities (Cont'd)

- Promote "empanelment" with PCP
- Measure/prioritize primary care access in Medicaid

- Facilitate teaching health centers and interprofessional training: RIC/URI/CCRI

- Interoperable HIT/CurrentCare

- What has been learned in RI?
- Primary Care Commission, report card and performance measures

How will change happen?

Gov't Action + Payer/Provider Alignment + Stakeholder Insistence

Download the report and view more resources at:
Nationalacademies.org/primarycare

Questions? E-mail primarycare@nas.edu