Primary Care Investment:

Opportunities in New Jersey

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Milbank Memorial Fund
About The Milbank Memorial Fund

The Milbank Memorial Fund is an endowed operating foundation that works to improve population health by connecting leaders and decision-makers with the best available evidence and experience.

We advance our mission by:

• Identifying, informing, and inspiring current and future state health policy leaders to enhance their effectiveness;

• Working with state health policy decision makers on issues they identify as important, particularly in areas related to primary care transformation, sustainable health care costs, and aging, and

• Publishing high-quality, evidence-based publications and *The Milbank Quarterly*, a peer-reviewed journal of population health and health policy.
Agenda for Today

1. The case for primary care as a common good
2. 2021 NASEM report recommendations
3. New Jersey budget language implications
4. Experiences and lessons earned in other states
Implementing High-Quality Primary Care:
Rebuilding the Foundation of Health 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 Matters

• Primary Care is only part of health care system that results in longer lives and more equity.
  – Areas with more primary care (per capita and relative to specialists) have longer lifespans
  – Primary care-oriented delivery systems have lower disparity rates

• Primary Care is weakening in the U.S. when it is needed most.
  – Portion of health care spending going to primary care is decreasing
  – At a time of increasing inequity and low pandemic resilience.

• A primary-care oriented system is a less expensive one
  – *In the long run*
High Quality Primary Care is a Common Good

• “Common Good”: all have access (EMTALA) but limited supply (more for you means less for me)
  – K-12 education is an example

• Compare to other framing:
  – Primary Care is a service - subject to private transactions
  – Access and scarcity addressed by market

• Common Goods require public policy to steward
  – We will not innovate our way to high quality primary care for all
What Will it Take to Strengthen Primary Care?

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.
Pay for 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.

**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*. 
New Jersey Budget Language

• Medicaid and Public Employees collect and publish primary care spend information by carrier
• Office of the Treasurer conduct a market scan of State-funded team-based primary care models and publish findings
New Jersey: relatively less primary care-oriented than its neighbors

Primary care spending as share of total health care spending among Medicare beneficiaries age 65 and older (%)

- United States: 5.66%
- Mid-Atlantic: 5.37%
- New Jersey: 5.13%
- Maryland: 5.50%
- New York: 5.26%
- Delaware: 5.31%

https://datacenter.commonwealthfund.org/topics/primary-care-spending-share-total-age-65-and-older
One in six adults in NJ do not have a usual source of care

Adults Who Report Not Having a Personal Doctor/Health Care Provider by Race and/or Ethnicity (2020)

<table>
<thead>
<tr>
<th>Location</th>
<th>All Adults</th>
<th>White</th>
<th>Black</th>
<th>Hispanic</th>
<th>Asian/Native Hawaiian or Pacific Islander</th>
<th>American Indian/Alaska Native</th>
</tr>
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<tbody>
<tr>
<td>United States</td>
<td>20.1%</td>
<td>16.3%</td>
<td>18.9%</td>
<td>36.5%</td>
<td>26.0%</td>
<td>25.3%</td>
</tr>
<tr>
<td>Delaware</td>
<td>15.8%</td>
<td>11.3%</td>
<td>11.5%</td>
<td>40.1%</td>
<td>21.7%</td>
<td>NSD</td>
</tr>
<tr>
<td>Maryland</td>
<td>12.7%</td>
<td>9.6%</td>
<td>11.0%</td>
<td>41.2%</td>
<td>16.3%</td>
<td>NSD</td>
</tr>
<tr>
<td>New Jersey</td>
<td>16.9%</td>
<td>12.8%</td>
<td>17.0%</td>
<td>31.9%</td>
<td>17.7%</td>
<td>NSD</td>
</tr>
<tr>
<td>New York</td>
<td>17.7%</td>
<td>13.8%</td>
<td>16.3%</td>
<td>31.2%</td>
<td>25.2%</td>
<td>26.4%</td>
</tr>
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¹US totals exclude data from the territories
Making Primary Care a State Policy Priority

Lessons from Other States
State activity to measure or increase primary care spending

States that have set primary care investment targets

Oregon (requirement): 12% by 2023
Rhode Island (requirement): 10.6% by 2014
Connecticut: 10% by 2025
Delaware: 9-11% by 2025 (provisional target)
Colorado: 1 percentage point increases in 2022 and 2023

State legislation/action pending or in the works

Maine, Massachusetts, Connecticut: Legislation pending on setting primary care spending targets
New Jersey, Colorado, Rhode Island: Updated regulations/executive orders on affordability standards
California, Pennsylvania: Bills pending on affordability standards
New York, Utah, Maryland, Nebraska, Hawaii: Legislation pending on reporting primary care spending
Pennsylvania: Executive Order to develop primary care spending targets
Lesson #1: Keep it Simple, Stupid

- First goal is more money into primary care and pay in non FFS ways
- Everything else (what kind of primary care, how to pay) is secondary

Primary Care Spending as Percent of Total Medical Spending in RI by Insurer (2008-2017) *(Self-insured plan payments not captured)*

Source: Office of the Health Insurance Commissioner, State of Rhode Island
Lesson #2: The More Payer Types the Better

• Oregon has Medicaid, Medicare Advantage, Commercial and Public Employees in its spend target.
• Necessary to mover the market – and change the economics of the system
Lesson #3: Measure Regularly, Publicly and By Payer

Primary Care Spending in Oregon 2021

**Primary care spending**

Select Line of Business

As percent of total

- Kaiser Foundation Health Plan of the Northwest: 16.5%
- UnitedHealthcare Insurance Company: 14.2%
- AVG (WEIGHTED): 13.9%
- Regence BlueCross BlueShield of Oregon: 13.7%
- AVG (UNWEIGHTED): 13.2%
- Moda Health Plan, Inc.: 12.9%
- PacificSource Health Plans: 12.7%
- Health Net Health Plan of Oregon, Inc.: 11.5%
- Providence Health Plan: 10.8%

For more information, visit [this link](https://visual-data.dhsoha.state.or.us/t/OHA/views/PrimaryCareSpendinginOregon2021/Primarycarespending?%3Aembed=y&%3AisGuestRedirectFromVizportal=y)
Lesson #4: Have a State-Convened Table to Build Alignment and Political Will

Colorado: House Bill 19-1233 in 2019 established a Primary Care Payment Reform Collaborative at Department of Insurance to:

- **Recommend** a definition of primary care to the Insurance Commissioner;

- **Advise** in the development of broad-based affordability standards and targets for commercial payer investments in primary care;

- **Coordinate** with the All-Payer Claims Database (APCD) to analyze the percentage of medical expenses allocated to primary care by insurers, Health First Colorado (Colorado’s Medicaid Program), and Children’s Health Plan *Plus* (CHP+);

- **Report** on current health insurer practices and methods of reimbursement that direct greater resources and investments toward health care innovation and care improvement in primary care;

https://doi.colorado.gov/insurance-products/health-insurance/health-insurance-initiatives/primary-care-payment-reform
Colorado (continued)

**Identify** barriers to the adoption of APMs by health insurers and providers and develop recommendations to address these barriers;

**Develop** recommendations to increase the use of APMs that are not FFS in order to:
- Increase investment in advanced primary care models,
- Align primary care reimbursement models across payers,
- Direct investment toward higher-value primary care services with an aim at reducing health disparities;

**Consider** how to increase investment in advanced primary care without increasing costs to consumers or increasing the total cost of health care;

**Develop** and share best practices and technical assistance to health insurers and consumers. Each year by December 15, the Collaborative publishes primary care recommendations in a report.
Challenges/Opportunities for New Jersey

- Define the problem you are trying to solve (Payment model? Care model? Supply? Dollars?)
- Is there state government capacity and will to attend to this Public Good?
- Link to Governor’s Cost Growth Affordability Work (see WA)
- Getting to multipayer impact
## Improving COVID-19 Outcomes for Medicare Beneficiaries: A Public Health–Supported Advanced Primary Care Paradigm

**Chad Perman, Eli Adashi, Emily Gruber, and Howard Haft**

<table>
<thead>
<tr>
<th></th>
<th>PCP teams with Support and Payment Reform</th>
<th>PCP Teams without</th>
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<tbody>
<tr>
<td>% with Covid DX</td>
<td>4.3</td>
<td>4.6</td>
</tr>
<tr>
<td>% with COVID admission</td>
<td>1.29</td>
<td>1.43</td>
</tr>
<tr>
<td>% with COVID Death</td>
<td>.41</td>
<td>.50</td>
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Questions?