

# Monitor Primary Care Spending and Investment:

Advancing Primary Care Innovation in Medicaid Managed Care

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## Advancing Primary Care Innovation in Medicaid Managed Care: A State Toolkit

This module is part of *Advancing Primary Care Innovation in Medicaid Managed Care: A State Toolkit*, which was created to help states leverage their managed care contracts and request for proposals to advance innovation in primary care.

The two-part toolkit outlines strategies to support states in: (1) defining primary care priorities and advancing core functions; and (2) achieving primary care innovation goals through managed care contractual levers.

To view the full toolkit, visit [www.chcs.org/primary-care-innovation](http://www.chcs.org/primary-care-innovation).

Primary care spending and investment is an important indicator of a health system's ability to achieve better health outcomes, more health equity, and lower costs.<sup>1</sup> The U.S. has historically spent less than most developed countries on primary care in proportion to other services — between five and seven percent of health care spending — and, arguably experiences higher overall costs and worse health outcomes as a result.<sup>2</sup> By comparison, peer countries average 14 percent spending on primary care.<sup>3</sup>

Recent challenges emerging from the COVID-19 pandemic further highlight gaps in current primary care investment. Primary care providers are under financial strain due to reduced patient visits during the crisis and ongoing impact of COVID-19 surges remain uncertain.<sup>4,5</sup> Moreover, as individuals forgo short-term preventive and chronic care, there is the potential for a mounting backlog of primary care needs.<sup>6,7</sup> In the aftermath of the immediate public health crisis, robust investment in primary care will likely be necessary both to stabilize and potentially rebuild the primary care system. Primary care practices can also play an important role in addressing and coordinating growing behavioral health and social service needs emerging from COVID-19.<sup>8,9</sup>

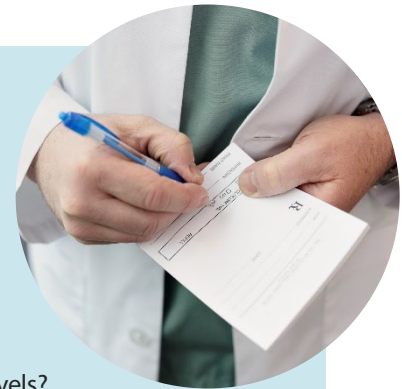
Recognizing the importance of primary care, state legislatures across the nation have recently passed bills to measure or increase health spending devoted to primary care, including in Colorado, Delaware, Maine, Oregon, Vermont, and West Virginia. Connecticut, Rhode Island, and Washington State have implemented similar policies through other regulation. State approaches vary in whether policies target spending among commercial payers, public payers, or both.<sup>10</sup>

In concert with such strategies or in absence of other regulation, states can also consider using existing Medicaid managed care levers to increase health spending devoted to primary care. **This module outlines strategies and considerations for defining, measuring, and ultimately increasing primary care spend for states operating in a Medicaid managed care environment.**

## MONITOR PRIMARY CARE SPENDING AND INVESTMENT: Design Considerations Summary

States interested in tracking and setting targets for primary care spending may consider:

- ✓ What are the state's goals related to primary care investment?
- ✓ How will primary care be defined?
- ✓ What "counts" as improvement in primary care spending levels?
- ✓ Will the state set a specific benchmark for primary care investment, or begin by monitoring spending and/or improvement levels?
- ✓ Which organizations will be subject to the primary care spending requirements?
- ✓ How will the state monitor primary care spending, especially for any non-claims-based care or investments (e.g., bonus payments, shared savings payments, capitation)?
- ✓ How will states monitor primary care in conjunction with overall health care spend? Will the state include other accountability standards?



## Design Considerations

### ✓ **What are the state's goals related to primary care investment?**

Consistent and growing evidence shows that primary care-oriented systems achieve better health outcomes, more health equity, and lower costs.<sup>13</sup> A report from the Patient-Centered Primary Care Collaborative and the Robert Graham Center found an association between increased primary care spend and fewer hospitalizations and emergency department visits.<sup>14</sup> Rhode Island increased its primary care spending from 5.7 percent in 2008 to 9.1 percent in 2012 while also implementing price controls for commercial insurers. Over this same period, total health care expenditures in the state fell by 14 percent. In 2014, an evaluation of Rhode Island identified a 7.2 percent reduction in hospital admissions.<sup>15</sup> A 2016 study in Oregon showed that for every additional dollar in primary care expenditures related to the state patient-centered medical home program, savings of \$13 were found in other services.<sup>16</sup>

However, increasing primary care spend may not result in cost savings in the short term and, moreover, cost savings should not necessarily be the end goal of primary care improvement efforts. Effectiveness of primary care investment may also depend on factors, such as baseline primary care access, care delivery patterns, and payment models. States may need to pair primary care investment policies with additional reforms, such as additional price regulations for other parts of the health systems and/or VBP to realize cost savings.<sup>17</sup> States should be realistic in their expectations about the timeframe of impact of new primary care spending requirements on overall cost and quality of care. For example, Colorado's Payment Reform Collaborative explicitly noted plans to track identified metrics over time, with the expectation that short-term metrics (e.g., emergency department utilization) may show improvement in the first two years while long-term metrics (e.g., growth in total cost of care) may take up to a decade to improve.<sup>18</sup>

## Request for Proposal & Contract Excerpts

Following is sample state managed care request for proposal (RFP) and contract language related to monitoring primary care spending and investment:

- Hawaii (RFP): "To achieve DHS goals, the Health Plan shall support the vision of devoting resources to advancing primary care. To this end, the Health Plan must increase investment in, support of, and incentivization of, primary care in three concentric definitions.
  - a) In the narrowest sense, primary care is the provision of care in the outpatient setting by primary care providers.
  - b) A broader definition includes the provision of preventive services, including behavioral health integration, in the primary care setting.
  - c) In the broadest definition, primary care additionally includes the wrap-around support services including team-based care and SDOH supports that augment and enhance the provider's capacity to manage the patient's care in the outpatient setting.

The Health Plan shall be responsible for tracking its primary care spend using measures corresponding the concentric definitions provided by DHS [...] For each definition of primary care spend, baseline spend will be used to set annual targets to enhance spending in primary care."<sup>11</sup>

- Washington State: "HCA will develop the Primary Care Expenditure report utilizing input from HCA's Public Employees Benefits Board (PEBB) and School Employees Benefits Board (SEBB) program medical carriers, and Medicaid Managed Care Organizations.

The Contractor shall complete HCA's Primary Care Expenditure Report annually, by the last business day in July. The reporting period is January 1 through December 31."<sup>12</sup>



## ✓ *How will primary care be defined?*

There is currently no national standard for how to define and measure primary care expenditures. However, in general, primary care can be defined by type of provider and/or type of service. Within those two categories — provider type and service type — primary care can be defined in both narrow and broad ways, sometimes including spending related to behavioral health and social needs supports (see **Exhibit 1**). For that reason, some states have chosen to define and measure primary care spending according to multiple definitions, rather than just one. For example, Washington State's Primary Care Expenditure report provides a range of spending estimates, according to both a narrow and broad definition.<sup>19</sup> Hawaii is considering requiring managed care organizations to increase investment in primary care in “three concentric definitions,” the broadest of which includes services that address social care needs.”<sup>20</sup> To the extent that primary care practices begin adopting new capabilities to support COVID-19 surveillance, such as testing, contact tracing, or providing supports to high-risk individuals,<sup>21</sup> states may consider including these activities in a primary care definition as well.

### **Exhibit 1. Examples of Narrow and Broad Definitions of Primary Care**

#### **Provider Type**

- Narrow definition: Physicians identified as family medicine, general practice, geriatrics, general internal medicine, and general pediatrics.
- Broad definition: The provider types in the narrow definition, as well as nurses/nurse practitioners, physician assistants, OB-GYNs, general psychiatrists, psychologists, and/or social workers.<sup>22,23</sup>

#### **Service Type**

- Narrow definition: Evaluation and management and preventive services.
- Broad definition: Service types in the narrow definition, as well as: (a) other services performed by primary care providers (minor surgical procedures and tests); (b) wraparound support services including behavioral health, team-based care, and social needs supports; and/or (c) primary care infrastructure/transformation payment (e.g., health information technology supports, and patient-centered medical home transformation payments).<sup>24, 25, 26</sup>



## ✓ What “counts” as improvement in primary care spending levels?

In addition to providing an explicit definition (or definitions) of primary care, states have sometimes chosen to explicitly indicate the ideal source of increases in primary care spending over time. For example, some states have indicated that increases in primary care spend should not come solely from increases in payments to primary care physicians and other providers of primary care services. Rather, such states have provided examples of the specific kinds of activities and services they hope to see increased as a result of the primary care spend policy, including those aimed at broader infrastructure improvements. Such considerations may be particularly important as primary care delivery changes to adapt and respond to the new reality of COVID-19.<sup>27</sup> States may consider how primary care investments can be directed to beneficial innovations such as telehealth or new team-based care models. For additional information on specific care delivery priorities that may be supported by increased primary care investment see the first section of this toolkit, [Advancing Primary Care Innovation in Medicaid Managed Care: Conceptualizing and Designing Core Functions](#).

For example, Delaware’s Primary Care Collaborative noted: “The increase in primary care spending should not be strictly an increase in fee-for-service rates. It should include an upfront investment of resources to build and sustain infrastructure and capacity, including use of health information technology, as well as support needed for a team-based model of primary care across the range of Delaware’s primary care settings. It also should include value-based incentive payments that reward for high-quality, cost-effective care.”<sup>28</sup> Similarly, Rhode Island requires insurers, as a condition for rate approval, to raise their primary care spending rate by one percentage point per year using strategies other than increasing fee-for-service payments. Insurers responded by spending more on patient-centered medical homes (PCMHs), accountable care organization (ACOs), performance incentives, and “common good” services, such as information technology, practice transformation, and loan-repayment programs.<sup>29</sup> In Massachusetts, the Primary Care Investment Working Group developed a list of potential opportunities to increase primary care investment (see **Exhibit 2**).<sup>30</sup>

### Exhibit 2. Primary Care Investment Options in Massachusetts

Proposed legislation in Massachusetts is designed to promote access to behavioral health and primary care services.<sup>31</sup> For flexibility, the bill does not mandate how to achieve goals. The Massachusetts Primary Care Investment Working Group, however, developed the following potential options for increasing primary care investment:<sup>32</sup>

- |   |   |   |
|---|---|---|
| 1. Group visits                         | 7. Care managers/social workers         | 13. Elimination of copays in primary care |
| 2. Integrated behavioral health         | 8. Palliative care                      | 14. Home care                             |
| 3. Health coaches                       | 9. Telehealth (video, email, and phone) | 15. Patient advisory groups               |
| 4. Community health workers             | 10. Additional time with patients       | 16. Collaboration with pharmacists        |
| 5. Medical scribes                      | 11. Walk in/urgent care availability    |   |
| 6. Addiction care (medication-assisted) | 12. Early AM/evening/weekend hours      |   |





✓ ***Will the state set a specific benchmark for primary care investment, or begin by monitoring spending and/or improvement levels?***

States without a clear understanding of baseline primary care spending levels may consider beginning by monitoring primary care spend and/or incentivizing increased primary care spending as compared to a baseline. For example, to increase commercial payer investment in primary care, the Colorado Primary Care Payment Reform Collaborative recommended a baseline year to collect data and subsequently requiring a one percent annual increase in primary care spend. A more stringent strategy is setting a target benchmark for primary care spend as a percentage of total health care expenditure. To date, at least four states have set specific benchmarks, ranging from 10 to 12 percent, for primary care spending as part of their legislation or policies.<sup>33,34</sup>

When setting primary care spend targets, states may also consider how to account for COVID-19 impacts of primary care utilization and spend. For example, 2020 may not be an appropriate baseline year for which to compare future primary care spend given reductions in outpatient utilization. States could alternatively consider using prior years or delaying implementation until the COVID-19 pandemic has passed. Additionally, states may consider whether revised methods or guidance is needed for measuring primary care spend, given the variety of new financing mechanisms being used to support primary care practices through the pandemic (e.g., new, non-claims based payments, advanced payments).

✓ ***Which organizations will be subject to the primary care spending requirements?***

By and large, the primary care spending requirements adopted by states to date have tended to apply solely to health insurers (e.g., Medicaid health plans, state employee health plans, Medicare Advantage plans, self-insured, and fully-insured). However, states may want to consider adopting primary care spending measures not just at the payer-level, but also within certain provider organizations, such as large health systems and/or ACOs. The reason for this is two-fold. A strong primary care foundation has been shown to be a key contributor to successful ACOs.<sup>35</sup> Likewise, ACOs and large health systems can help drive spending and investments in primary care at the ground level, in part by ensuring that primary care physicians and other team members receive the compensation and infrastructure needed to support comprehensive primary care functions. In Massachusetts, a bill sponsored by Governor Charlie Baker would require insurers and *providers* to boost spending in primary care and behavioral health.<sup>36</sup>

✓ ***How will the state monitor primary care spending, especially for any non-claims-based care or investments (e.g., bonus payments, shared savings payments, capitation)?***

Most states collect and monitor primary care spending based on two key data sources: (1) claims-based payments, including payments to primary care providers or provider organizations for primary care services rendered to health plan members; and (2) non-claims-based payments, including payments to health care providers intended to motivate efficient care delivery, reward achievement of quality or cost-savings goals, and/or build primary care infrastructure and capacity.

States with all-payer claims databases (APCDs) tend to use those systems to collect the claims-based data from major health care payers. In some cases, states have passed legislation to enhance their APCDs to have more accurate and complete data for monitoring primary care spend. For example, in 2018, Delaware passed legislation requiring insurers to participate in the state's health care claims database and establishing a primary care reform collaborative.<sup>37</sup>

To capture non-claims-based primary care payments more consistently, states have provided additional guidance and/or reporting templates. For example, Oregon requires its prominent carriers and Coordinated Care Organizations to report non-claims-based primary care spending and total medical spending. Such spending includes (but is not limited to): capitation or salaried arrangements with primary care providers; (1) prospective or retrospective incentives payments to primary care providers aimed at decreasing costs, increasing value; and (2) payments for structural changes, such as adoption of health information technology or new workforce expenses (e.g., supplemental patient navigators or nurse care managers).<sup>38</sup>

✓ ***How will the state monitor primary care in conjunction with overall health care spend? Will the state include other accountability standards (e.g., hospital caps or total cost of care benchmarks)?***

As investing in primary care alone may not be sufficient to impact total health care costs,<sup>39</sup> states may consider monitoring primary care spending in conjunction with total health care spend or pairing primary care investment policies with additional health care spending regulations. For example, states such as Massachusetts, Delaware, Rhode Island, and Oregon have implemented statewide health care cost benchmarks.<sup>40</sup> Such benchmarks could potentially be targeted within Medicaid. For example, in 2012, Oregon's 1115 waiver established a 3.4 percent risk-adjusted, per-capita growth rate for Coordinated Care Organization payment.<sup>41</sup> States could also consider price regulations for non-primary care spend. Rhode Island's 2010 affordability standards promoted such a strategy by implementing hospital price controls, such as annual price inflation caps, in addition to increasing primary care spend.<sup>42</sup>

## Select State Approaches to Primary Care Investment

The following table provides examples of select state approaches to incentivizing primary care investment including definitions of primary care spend and investment requirements. Note that estimates of primary care spending cannot be compared directly across states because of differences in data sets, methodologies, and definitions of primary care.

State	Approach and Current Primary Care Spend Levels	Definition	Investment Requirement	Additional Spending Requirements
<b>Colorado</b> <sup>43,44</sup>	<p>In 2019, CO passed legislation (HB19-1233) that set targets for investment in primary care and established a primary care payment reform collaborative in the division of insurance.</p> <p><b>Primary care spend levels:</b></p> <ul style="list-style-type: none"> <li>■ 1.3 - 13.5% (Colorado's Primary Care Payment Reform Collaborative Report)</li> <li>■ 5.0 - 10.6% (Patient Centered Primary Care Collaborative (PCC) Report)</li> </ul>	The CO collaborative recommends a definition of primary care based largely, but not exclusively, on the type of provider, including family medicine physicians, internal medicine, pediatricians, OB-GYNs, nurse practitioners and physicians' assistants, and behavioral health providers who support integrated services in a primary care setting.	The CO collaborative recommends a 1% point annual increase for commercial payers through 2022.	Increased investments in primary care should be offered largely through infrastructure investments and alternative payment models that provide prospective funding and incentives for improving quality.
<b>Delaware</b> <sup>45,46,47</sup>	<p>In 2018, DE passed legislation requiring insurers to participate in the state's health care claims database. The legislation also established a primary care reform collaborative.</p> <p><b>Primary care spend levels:</b></p> <ul style="list-style-type: none"> <li>■ DE's PCC recommended that payers progressively increase primary care spending to eventually account for 12% of total health care spending.</li> </ul>	"Primary care" means health care provided by a physician or an individual licensed under Title 24 to provide health care, with whom the patient has initial contact, and by whom the patient may be referred to a specialist and includes family practice, pediatrics, internal medicine, and geriatrics.	12% by 2024; 1% point annual increase.	The increase in primary care spending should not be strictly an increase in fee-for-service rates. It should include an upfront investment of resources to build and sustain infrastructure and capacity, including use of health information technology, as well as support needed for a team-based model of primary care across the range of DE's primary care settings. It also should include value-based incentive payments that reward high-quality, cost-effective care.



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State	Approach and Current Primary Care Spend Levels	Definition	Investment Requirement	Additional Spending Requirements
<b>Oregon</b> <sup>48, 49</sup>	<p>In 2015, OR passed legislation to measure and annually report levels of primary care spend. In 2017, OR unanimously passed legislation setting a minimum primary care spend threshold for all payers, both commercial and public.</p> <p><b>Primary care spend levels:</b></p> <ul style="list-style-type: none"> <li>■ 5.6% - 10.9% (PCC Report)</li> </ul>	The Primary Care Spending in Oregon report defines primary care based on the health care provider and what service is given.	12% by 2023; 1% point annual increase.	Not available.
<b>Rhode Island</b> <sup>50, 51</sup>	<p>In 2010, RI's health insurance commissioner implemented affordability standards for all commercial insurers in the state.</p> <p><b>Primary care spend levels:</b></p> <ul style="list-style-type: none"> <li>■ Not available.</li> </ul>	<p>Primary care spending includes "Direct Primary Care Expenses," defined as payments to primary care practices for providing health care services, achieving quality or cost performance goals, and infrastructure development. Primary care spending may also include "Indirect Primary Care Expenses," defined as payments to support primary care capacity that does not fall within the definition of Direct Primary Care Expenses.</p>	10.7% after 2014; 1% point annual increase between 2010 and 2014.	<p>Insurers required to raise their primary care spending rate by 1 percentage point per year using strategies other than increasing FFS payments as a condition for rate approval. Insurers responded by spending more on PCMHs, ACOs, performance incentives, and "common good" services, such as health information technology, practice transformation, and loan-repayment programs.</p> <p>Includes hospital caps.</p>
<b>Washington State</b> <sup>52, 53, 54</sup>	<p>In 2019, WA appropriated \$110,000 for fiscal year 2020 to determine annual primary care expenditures by the state's insurance carriers. The state's first report was issued in December 2019.</p> <p><b>Primary care spend levels:</b></p> <ul style="list-style-type: none"> <li>■ 4.4% - 5.6%</li> <li>■ 5.9% - 10.1% (PCC Report)</li> </ul>	<p>WA uses a narrow and broad definition:</p> <p>Narrow definition - providers who traditionally perform roles contained within strict definitions of primary care, and a specified list of primarily outpatient and preventive services.</p> <p>Broad definition - providers who perform roles not traditionally contained within a strict definition of primary care (e.g., obstetricians), and a broader range of services including psychiatric and hospice.</p>	Not available.	Not available.

## ENDNOTES

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