September 2021

Primary Care Payment Reform Workgroup

Employers Leading the Way to Sustainable, High-Quality Care

Purchaser Business Group on Health

WHAT IS THE WORKGROUP?

Purchaser Business Group on Health (PBGH) members are committed to improving the quality, affordability and equity of health care on behalf of their employees. They know that robust primary care is the foundation of a high-value system but is too often undervalued and under-resourced. The PBGH Primary Care Payment Reform Workgroup is a groundbreaking, employer-/purchaser-led initiative launched in 2020 to promote structural health care payment reform and bolster the nation's faltering primary care system. Employers want the best care for their employees and are determined to use their market clout to push for changes that will substantially improve quality while reducing costs.

The most significant barrier to scaling advanced primary care is payment. To that end, the workgroup has created a health purchasing template that can help employers and other purchasers accelerate the transition from traditional, fee-for-service reimbursement to a payment system that supports comprehensive, or advanced, primary care. The initiative is grounded in extensive research showing that improvements in primary care both enhance quality and substantially reduce costs. While the ideas are not new, the effort represents the first national, employer- and purchaser-led push aimed at fundamentally reengineering health care delivery and reimbursement.

WHY WAS THE WORKGROUP CREATED?

Many large employers and public purchasers are increasingly concerned that the care they buy is difficult for employees to access, of uncertain quality and poorly integrated. They also are alarmed by inexorably rising health care costs, which are making employer-sponsored coverage increasingly unaffordable for purchasers and employees alike. The workgroup reflects a commitment by the nation's largest employers to leverage their collective purchasing power in support of proven delivery and payment reforms.

These reforms are designed to support revitalized primary care and reflect the pioneering work of PBGH's California Quality Collaborative (CQC), as well as numerous other entities and individuals. Extensive research and pilot programs across multiple decades have repeatedly shown that a robust, integrated and accountable approach to primary care — characteristics collectively defined as advanced primary care — can dramatically reduce overall health care costs while improving patient outcomes and experiences.

For example, an extensive, four-year primary care improvement effort in California overseen by CQC and completed in 2019 resulted in the avoidance of almost 50,000 hospital-bed days and sharply reduced emergency room utilization, for a total savings of $186 million. All told, the program produced $10 in health savings for every $1 invested in primary care, or about $42,000 per enrolled physician. And most importantly, this effort improved patient outcomes.

HOW HAS COVID-19 INFLUENCED THE WORKGROUP'S MISSION?

Payment reform efforts have taken on a new urgency amid the COVID-19 pandemic, which has laid bare the extent to which primary care is vulnerable to negative consequences associated with the existing fee-for-service system. Many practices experienced insolvency or have been forced to consolidate with larger entities due to reduced patient volume and dramatically lower revenues. At the same time, a large number of primarily digital startups have entered the health care arena. While these entities aim to improve quality and reduce cost through innovation, most are point solutions that do not integrate or coordinate with other parts of the health care system. This reality threatens to further increase costs, redundancy and fragmentation for purchasers and consumers. As these entities grow — and they are doing so at an accelerated rate — they create increased competition for primary care practices and resources. While many of these new entrants may bring needed improvements and better patient experience, time is of the essence if the existing independent primary care infrastructure is to be revitalized.

WHAT HAS BEEN ACCOMPLISHED SO FAR?

The workgroup focused initially on learning from experts, including physicians and other providers, about the characteristics of advanced primary care and existing impediments to achieving them. They also reviewed earlier efforts aimed at altering primary care payment — both unsuccessful and successful — to better understand what works and what does not.

From this effort, consensus was achieved around the desired and necessary elements of advanced primary care, including the integration of behavioral health and a commitment to equity. Workgroup members also developed mechanisms to identify and appropriately reimburse high-performing advanced primary care practices. This work has led to the creation of an initial set of outcome, cost and patient experience measures that will evolve over time, and a companion purchasing agreement template that employers can use to communicate their priorities and engage payers and

providers to make changes to care delivery and payment to meet purchaser and patient priorities.

WHAT PRINCIPLES FORM THE BASIS FOR THE PURCHASING AGREEMENT TEMPLATE?

PBGH Medical Director Arnie Milstein, M.D., a professor of medicine at Stanford University and a national leader in primary care reform research, outlined extensive field studies that he oversaw at Stanford that identified three delivery innovations consistently present with the highest-performing (low-cost/high-quality) primary care practices:

- Comprehensive and nuanced risk stratification of patient populations to support appropriate, timely and consistent individual care.
- The development of skill sets by primary care physicians that enable them to perform low-acuity interventions that would otherwise require specialist referrals.
- The implementation of a team approach to care that includes extensive use of physician extenders to perform simpler clinical tasks.

Several providers subsequently offered clinician perspectives on how they are working to mitigate the shortcomings of the existing primary care system. Key points included:

- Primary care reimbursement today incentivizes the wrong behavior by paying providers per illness. The emphasis must be on sustaining health.
- Spending on primary care, which is currently about 4% of total health care expenditures, should be increased to 10%-15%. Despite accounting for 55% of health care office visits, current investment in primary care is actually declining.
- The existing transactional model of care must be replaced with a relationship model that emphasizes wellness and care continuity.
- Barriers that create disincentives to primary care utilization, notably high copays and deductibles, should be eliminated.
- Providers collectively are supportive of primary care payment reform and must play an integral role in the process. Many are disillusioned by the emphasis on volume and the constraints that this imposes both on optimal care and professional satisfaction.

WHAT'S WRONG WITH PRIMARY CARE?

In another presentation to the workgroup, Harold Miller, president and chief executive officer of the Center for Healthcare Quality and Payment Reform, enumerated five key problems with the existing system that negatively affect patients and ultimately, purchasers:

1) **Short office visits** result in inaccurate diagnoses, unnecessary tests, excessive referrals and patient frustration.

2) **Schedules filled with office visits** to maximize revenue result in long scheduling lag times, access barriers and consequent excessive use of emergency departments and urgent care.

3) **Poor preventive care** results in failure to prevent illness and higher costs associated with treatment delays.

4) **Inadequate chronic disease management** contributes to poor health, avoidable complications and frequent emergency department visits and hospitalizations.

5) **Overworked, underpaid primary care physicians** lead to physician shortages and the acquisition of independent practices by health systems, which contributes to higher prices. Burned-out physicians also can result in poor patient experience.

Rushika Fernandopulle, M.D., a primary care physician and co-founder and chief executive officer of Boston-based Iora Health, told workgroup members that purchasers and employers need to exert greater control over health care purchasing by essentially viewing it as another component of supply chain management. Because they're buying a service on behalf of employees, employers should assess and monitor quality and cost as they would with the acquisition of any other good or service. Doing so will enable them to better identify and address inherent inefficiencies and substandard performance.

Judy Zerzan-Thul, M.D., chief medical officer of the Washington State Health Care Authority, showed that aligned multi-payer change is possible by sharing primary care reforms being implemented in her state, including an all-payer agreement to dedicate a percentage of spend to primary care. In addition, she noted that a set of shared quality measures reflecting purchaser and patient priorities is being rolled out

statewide to reduce administrative burden and incentivize improved chronic and preventive care, as well as behavioral health integration.

Grace Terrell, M.D., chief executive officer of Charlotte, North Carolina-based Eventus WholeHealth, an integrated medical group providing comprehensive, whole-person care to patients, shared her experience of building an advanced primary care system only to see it go out of business due to fee-for-service payment and market competition. She said condition-based management fees structured around specific populations and illnesses offer the most equitable and efficient means for reimbursing primary care physicians.

The workgroup also heard from health plan leaders to understand the barriers they face in changing payment and results from successful health plan pilots and payment reform initiatives.

Dana Gelb Safran, Sc.D., shared the experience of the Alternative Quality Contract (AQC), which invested in robust primary care while holding practices accountable for quality and costs. The AQC showed significant and measurable improvements in quality and outlined a road map for what is possible through new payment models.

WHAT IS NEXT?

The workgroup leveraged its months of expert input and direct dialogue across purchasers to establish a "common purchasing agreement," reflecting priorities shared by many employers and purchasers. While not unanimous on all fronts, the principles were broadly supported across the membership. The finalized purchasing agreement is being shared with payers and providers in advance of a summit meeting at the end of September 2021. The summit is a forum for participants to share feedback and jointly identify and solve any barriers to implementation. Two versions — health plan and direct contract iterations — will be made available to PBGH members.

With the drafting of the agreement now complete, PBGH's focus has shifted to supporting regional implementation of the shared principles across multiple markets and purchaser-payer relationships.

To assist in and inform this effort, PBGH's CQC is currently designing a multi-payer implementation plan for California purchasers. PBGH also is learning from similar efforts underway in Washington state.

Because members have expressed a desire to roll out the agreement in multiple states and regions, PBGH is working to align members in specific areas to pursue implementation strategies. Additionally, PBGH is in communication with the Center for Medicare & Medicaid Innovation about possible multi-payer opportunities and joint participation in emerging regional implementations.

While adaptations will be needed based on market conditions, and regional or organizational differences and/or emerging learnings, PBGH members understand that time is of the essence in bringing fundamental change to the health care system to ensure their employees have access to needed care. As noted repeatedly in the workgroup, much of the evidence for what is needed is decades old and discussion about the need for change has been ongoing for years. It is time to act. As such, members are committed to implementation in as many markets as possible to accelerate the process of establishing a new, more effective dynamic for the purchase of health care services. PBGH and its members look forward to partnering with providers, plans and others to bring about long- overdue change on behalf of their employees and all Americans.