Increasing Primary Care Spending in Massachusetts: A Path Forward

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INCREASING PRIMARY CARE SPENDING IN MASSACHUSETTS

A PATH FORWARD

April 2019

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Harvard Medical School and Harvard Kennedy School of Government
Expected Graduation Date: May 30, 2019
Client: Harvard Center for Primary Care
Advisers: Russell Phillips, Sheila Burke, Julie Wilson
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This Policy Analysis Exercise/Scholarly Project reflects the opinions of the author and should not be viewed as representing the views of the Center for Primary Care nor Harvard University or any of its faculty. This report was prepared as a Scholarly Project for Harvard Medical School and as a Policy Analysis Exercise for the Kennedy School of Government as part of graduation requirements for both institutions. The pilot study conducted as part of this project was approved and supervised by the Harvard Medical School Institutional Review Board.

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The Problem

- Commercial insurers in Massachusetts spend less than 7% of all health spending on primary care. As the foundation of the health care system, primary care in Massachusetts is essential to supporting the state’s multiple experiments in cost control, payment reform, and delivery system reform.
- Primary care practices need to invest to develop the teams they will need to tackle the evolving needs of the Commonwealth, and chronic underinvestment hurts their ability to serve Massachusetts’ patients and communities.

This report was prepared for the Harvard Center for Primary Care in order to help the Center think about primary care spending in the state of Massachusetts. The report works to answer 2 central questions:

1) How can primary care spending be increased in the state of Massachusetts? Which approach might be best for the state?
2) What does the path forward look like? How should advocates begin the process of advocating for action on primary care spending in Massachusetts?

The Case For Primary Care

Robust primary care is an important tool health care systems use to expand access, ensure quality care, and promote health equity.

- Primary care helps control costs within a health care system. High continuity of care with a PCP is associated with overall health care savings of about $1,000 per patient, and one analysis of Medicare data found six-fold returns on investment for primary care investments.
- Evidence from the medical and public health literature in general supports the importance of primary care to patient and population level health outcomes. All-cause mortality, infant mortality, and rates of low birth weight all tend to decrease when there is more access to primary care in a community. One study found that the addition of just one primary care doctor per 10,000 patients reduced mortality rates by 14.1 deaths per 100,000.
- Access to primary care is often cited as an important step to reducing the health disparities that continue to plague American health care. In some cases, the negative health impacts of income inequality appear to be somewhat mediated if the population also has high levels of access to primary care.

Problems in Primary Care

Primary care faces challenges related to workforce shortages, provider burnout, and under-compensation.

- Primary care has struggled to recruit and retain enough health professionals to the field, and more than 79 million people lived in primary care health professional areas (HPSAs) in 2018.
- An average face to face visit lasts just 18.5 minutes and on average family physicians discuss three separate issues with their patients during a visit. Given these chaotic work environments, in 2017, 55% of both family medicine physicians and internal medicine doctors reported burnout, defined as “a loss of enthusiasm for work, feelings of cynicism, and a low sense of personal accomplishment.”
- Closely related to the issue of primary care physician burnout is the chronic problem of low reimbursement rates for primary care services. The so-called “income gap” between primary care physicians and their specialist colleagues means that the median salaries of primary care physicians are about $135,000 less than the median salary of specialist physicians. Over a career, this means that a medical student choosing a primary care career will make $3.5 million less than students who choose specialist fields.
Primary Care Investment: Using Spending Levels in Advocacy

“Primary care spending,” or the ratio of total spending on primary care versus all healthcare spending, has been proposed as a new way to measure the way in which health systems value primary care. Primary care spending, in the words of one of its first champions Dr. Christopher Koller “encourages clear, financial accountability for whoever is spending the health care money—whether it’s insurers, integrated delivery systems, or public payers.” The primary care spending rate is simple enough to be accessible to lay audiences, and importantly, it can be directly used by policy makers looking to change spending patterns within their state’s health care entities.

Primary care spending allows policy makers on both federal and state levels to focus on individual health care entities in their jurisdiction and how these entities are committing to team-based primary care within their networks. Moreover, policy makers can use this rate to set benchmarks for health care entities they feel are not investing in ways they feel benefit the public good. In an era where policy discussions are rightly dominated by payment reform away from fee-for-service (FFS) models, primary care spending is also an intriguing way to monitor how health systems are changing their investments to adopt changing financial incentives. Several states have experimented with the primary care spending to track investments in their state with promising results.

Primary Care Spending In Massachusetts

Despite the wealth of health resources available in Massachusetts and the seeming abundance of health professionals, 30% of counties in Massachusetts do not have a single primary care office. (Figure 1) Moreover, 38 municipalities are classified as Federal Health Professional Shortage Areas for primary care providers. It is estimated that commercial insurers in Massachusetts typically spend less than 7% of all health spending on primary care.

In order to understand where primary care fits into larger health policy trends in the state, this report reviews relevant events in Massachusetts health policy history as well as recent events for the state’s health policy stakeholders.

Primary Care Spending in Massachusetts: A Pilot Interview Study

In order to better understand if and how primary care investment can be increased in Massachusetts, a pilot interview study was conducted with key stakeholders in Massachusetts. Eleven participants agreed to be interviewed in ten interviews including one Massachusetts health system CEO, one state senator, one former head of American Academy of Pediatrics and pediatrician, one primary care researcher/ chair of a hospital payment and contract committee/PCP, one primary care system disruptor system CEO, one current president of a family medicine advocacy group and practicing family doctor, one former network president for a major Massachusetts provider network, one Massachusetts Health Policy Commissioner, two executive leaders from the Massachusetts Association of Health Plans, and one current head of a MassHealth primary care ACO. Seven core themes emerged from the interviews.

Core Theme #1 The Role of Primary Care in a Health System: Quality, Equity, and Business Sense
Core Theme #2 Primary Care Investments Should Be About Building and Supporting Team Based Primary Care
Core Theme #3 Mandated Primary Care Spending Levels as a Policy Tool
Core Theme #4 Alternative Payment Methods as a Path to Primary Care Reform
Core Theme #5 The Massachusetts Context: Cost Control, MassHealth ACOs, and Hospital Mergers
Core Theme #6 Next Steps
Core Theme #7 Obstacles
A Strategy to Increase Primary Care Investment in Massachusetts

Key Findings

- **The Value of Primary Care Teams:** Most interviewees agreed that the future of primary care should involve more team-based care, particularly teams capable of more actively addressing the social determinants of health. Most interviewees emphasized the particular importance of behavioral health integration in primary care settings, particularly in Massachusetts where rates of access to behavioral health and substance abuse care were concerning to many interviewees.

- **Primary Care Payment Reform Is Central to Primary Care Delivery Reform:** Most interviewees commented on the close relationship between payment and delivery reform in primary care. Many interviewees believed that system-level payment reform, i.e. capitation, ACO arrangements, and bundled payments, would support system-level investments in primary care. However, some interviewees doubted that the magnitude of investment will be enough to support large scale reform of the primary care team.

- **Cost Control is Priority #1:** While policy makers and health systems in Massachusetts remain committed to improving the quality of their care while promoting equitable access to health care, ultimately cost control is a top priority for the state. A determination that something will raise health care spending is a powerful trump card in Massachusetts health care policy.

- **Ongoing Responses to Crises:** The attention of the legislature in the 2018 session was dominated by securing reproductive rights, fighting the opioid epidemic, and zeroing in on exploding pharmaceutical costs. These crises were politically salient to constituents and forced a quick response from elected officials and health policy leaders. Access to behavioral health is still a central issue for policy makers.

- **Hospital Mergers and Community Hospitals:** The Massachusetts provider networks and hospitals compete aggressively with each other, and many of the networks have attempted to merge in recent years. These mergers have been contentious and have attracted a deal of public attention. Interestingly for primary care, the BIDMC/Lahey merger negotiated with the state at the end of 2018 actually required the new health system to invest in community health centers, mental health services, and primary care.

### Proposed Policy Options

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<td>Write and pass legislation mandating a certain level of primary care spending</td>
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<td>Add an indicator to the MassHealth ACO program evaluations that measures primary care spending by the new MassHealth ACOs</td>
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Final Recommendations

This report recommends using the primary care spending rate as one lever by which to begin the process of deepening primary care investments. Among the different policy options available to begin using the primary care spending rate in Massachusetts, this report recommends starting by working with the Health Policy Commission (HPC) to begin measuring and publishing the primary care spending rate for major health care entities in the state. As the central hub for health care spending data in the state, the HPC has the ability to quickly begin measuring and reporting on primary care spending if the Commission believes this rate plays a role in affecting health care spending trends for the state. This report might take forms similar to those found in Figure 2.

Action Step #1: Prepare a report for the Health Policy Commissioners on the Importance of Measuring Primary Care Spending by Health Entities

- This report should make the case specifically to the Commissioners that measuring primary care spending is an appropriate way to determine how much health care entities are investing in community-level services. It should also demonstrate using data how these services are ultimately aimed at promoting cost-effective, quality, and equitable health care.
- The report should include a definition of primary care that is actionable and measurable using existing data collected by the HPC and CHIA. It should also report a plan for how to capture non-fee-for-service spending including primary care spending made in capitated arrangements. It might also include examples from other states of how the data has proven useful for tracking and evaluating health entities. Several definitions are available as starting points, either from other states or from research published by the Milbank Fund.

Action Step #2: Assemble a Community Advisory Board to Guide the Primary Care Spend Task Force and Expand Task Force Membership to More Members of the Primary Care Team

- Whatever definition of primary care services used by this group should be community-led and driven. The group might consider using a community-needs assessment type approach to develop the definition of primary care services.
- The task force itself should be expanded to include other members of the primary care team aside from physicians including nurses, nurse practitioners (NPs), physician assistants (PAs), social workers, and psychologists.

Action Step #3: Continue to Build the Evidence Base Supporting the Use of the Primary Care Spending Level

- The pilot study in this report identified that many stakeholders in Massachusetts did not necessarily believe the primary care spending level was a necessary or essential measure for health care systems. Measurement of the primary care spending rate in Massachusetts, even in the form of a pilot study, could help demonstrate the measure’s value in tracking and comparing the progress of health entities across the state.

Figure 2. Example Primary Care Spending Graphs. Data collected by state agencies in Rhode Island (a) and Oregon (b) show how primary care spending data can be used to monitor spending trends across insurance networks or health entities. Graph A (left) from Rhode Island Office of the Insurance Commissioner, “Primary Care Spending” Jan 2014. Graph B (right) from Oregon Health Authority, “Primary Care Spending in Oregon: A Report to the Oregon Legislature,” Feb 2019.
Part I

The Case for Primary Care

Primary care is the bedrock of a health care system, providing essential medical care and coordinating all aspects of a patient’s care.

In 1996, the Institute of Medicine (IOM) defined primary care as “the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.” While the IOM called primary care “the logical basis of an effective health care system,” primary care in the United States remains undervalued, and the field continues to face a multitude of issues.

The core tenets of quality primary care are often described using Barbara Starfield’s 4 C’s: Continuity of Care, Comprehensive Care, First Contact Care, and Coordination. Reflecting the rapid changes in the field, additional C’s have been suggested in recent years including physician credibility, collaborative learning, cost-effectiveness, capacity expansion, and career satisfaction.

Many of the essential tenets of primary care have become central aspects in health reform efforts of the past decade. As the entire health care system works to take care of more patients in better ways without spending more, the value of primary care and its 4 C’s has become an active area of interest. Most agree that comprehensive, well-coordinated care provided via continuous relationships is key to quality patient interactions with a health care system, but there is less agreement on how exactly to actualize these principles of care in health care systems.

The Affordable Care Act (ACA) expanded insurance coverage to 20 million more Americans, and launched multiple experiments intended to reform and restructure health care payment and delivery systems. These initiatives, including the promotion of alternative payment models (APMs) like Accountable Care Organizations (ACOs), have been important steps to aligning incentives to promote quality care through financially responsible health care systems.

The effects of the 2010 reforms, however, have yet to dramatically change the actual settings in which patients receive care. While payment reform that holds health care entities responsible for the overall health of its population is expected to incentivize investments in preventative health care and primary care, to date only about 5-8% of all U.S. healthcare dollars go into primary care systems.

As the “logical basis of an effective health care system,” primary care reform has to be an important part of the general health care reform movement in the United States. Robust primary care is an important tool health care systems use to expand access, ensure quality care, and promote health equity. Primary care is also often the heart of a health care system where patients build meaningful connections that promote both individual and community wellness.

Part I of this report summarizes evidence to date that primary care 1) helps control overall health care costs, 2) improves individual and population level health outcomes, and 3) helps ensure equitable access to the health care system.
In the Fall of 2018, CMS Administrator Seema Verma put the U.S. healthcare system’s largest problem in simple terms saying, “Our health care system is the best in the world, but it simply costs too much and is not sustainable.” While ACA advocates work to protect patients’ access to the health care system, skyrocketing costs threaten the entire system.

The United States continues to spend more on health care than any nation in the world (Figure 3), while producing health outcomes out of step with the rest of the developed world. In 2017, the Commonwealth Fund's Annual Mirror Mirror report comparing world health systems ranked the United States dead last among developed countries on health care outcomes, health equity, and overall health care access. Primary care is a crucial tool for health systems looking to control costs. In general, evidence indicates that patients with a usual source of care have lower healthcare utilization rates, higher satisfaction scores, lower rates of emergency department (ED) use, and ultimately have lower overall healthcare costs. On a regional level, areas of the United States with higher ratios of primary care doctors to patients tend to have lower healthcare costs, rates of ED usage, and rates of hospitalization.

Primary care, a core tenant of quality primary care, has also been linked to cost savings. Recent analysis using national Medicare claims for nearly 1.5 million patients showed that overall healthcare costs were 14.1% lower for patients with primary care doctors who provided more continuous care versus physicians who scored lower on continuity of care indices. Odds of hospitalization for those with more continuous care from a PCP were also 16.1% lower. Translated into dollar amounts, having a PCP who provided high continuity of care (meaning when the person goes to the doctor, they are more likely to see the same doctor each time), resulted in savings of about $1,000 per patient annually.

Indeed in some environments, investments made in primary care can yield savings for the healthcare system as a whole. A 2012 analysis of Medicare spending by the Commonwealth Fund found a six-fold return on investment for primary care investment, mostly arising from decreased inpatient and post-acute rehabilitation spending. Despite additional spending on primary care services, overall spending for these patients was actually 2% lower.

None of this is new to primary care disruptor companies, many of whom have used expanded primary care services to produce overall health care savings. Primary care disruptor Iora Health found overall health care spending decreases of between 11-15% when they ramped up primary care support services and realigned payment incentives for their practices. Oak Street Health, with its mission to provide “the world’s best primary care to the poorest, sickest elderly patients,” cut hospitalizations by 40% in a traditionally very expensive population.

Of course, primary care alone is not a simple silver bullet for health care spending. Primary care is just one part of a fragmented health care system still largely driven by fee-for-service payments, and not every pilot or primary care expansion has produced net savings. Notably, the Comprehensive Primary Care (CPC) pilots from the Centers for Medicare and Medicaid Studies (CMS) actually showed no net savings after four years despite quality and efficiency incentives and practice coaching. Not all primary care investments are created equal, and the primary care evidence base bears this out.

**Figure 3. Health Care Spending as Percentage of GDP.** Image from Schneider, *Mirror, Mirror* 2017 from the Commonwealth Fund, July 2017.
While not a panacea, primary care is an important tool for health systems looking to control costs. Primary care brings patients into the office, determines rates of referral and testing, and ultimately coordinates most aspects of care for a patient. These functions are essential for systems to understand as they work to control how patients and providers use system resources. Bearing this idea out, early evidence from Accountable Care Organizations (ACOs) indicate that those centered around primary care organizations or with more emphasis on primary care medical homes (PCMH) have seen relatively more financial success.\footnote{xxxii}

**Improving Health Care Outcomes and Primary Care**

In the midst of health care reform debates in 1994, Senator Ted Kennedy said, “What we have in the United States is not so much a health-care system as a disease-care system.” American health care for many years has struggled to treat patients in holistic and personal ways, and the quality of care available to patients has suffered.

Aside from being incredibly expensive, American health care also faces a crisis of quality. The U.S. ranks last among developed countries on several population level health indicators including mortality amenable to health care, or deaths that could have been prevented with appropriate health care. (Figure 4)\footnote{xxxiii} Remarkably given the level of resources available in the health care system, infant mortality in the United States is 6.0 per 1,000 live births, compared to just 4.8 in Canada and 3.9 in the United Kingdom. The US also has many more avoidable hospitalizations for asthma, diabetes, and heart failure than most developed nations.\footnote{xxxiv}

Despite these disappointing population level measures, American health care does outperform many other developed countries on measures related to communication between providers and patients including discussion of goals for chronic disease management and health and wellness counseling. Vaccine rates, mammography rates, and rates of screening for tobacco and alcohol misuse are also relatively high in the U.S.\footnote{xxxv}

Primary care plays a significant role in powering many of the quality measures on which the United States is actually seeing success. Primary care, most health care experts believe, provides preventative care that can reduce hospitalizations, avoid disease complications, and provide early diagnosis for treatable diseases.

Evidence from the medical and public health literature in general supports the importance of primary care to patient and population level health outcomes. In general, patients with access to primary care have higher rates of immunization and are more likely to be up to date on appropriate cancer screenings.\footnote{xxxvi} Patients with a continuous relationship with their primary care provider have better glycemic control,\footnote{xxxvii} better rates of medical adherence for depression,\footnote{xxxviii} and better self-reported perception of their health.\footnote{xxxix}

**SPOTLIGHT: Primary Care and Cancer Screening and Detection Rates**

Patients with access to primary care are more likely to be up to date on cancer screenings which translates into higher rates of early detection of breast, colon, and cervical cancer in areas with more access to family physicians.\footnote{1} Additionally, cancer survival rates appear higher in regions with more primary care doctors.\footnote{1} In particular, breast cancer survival rates cancers\footnote{1} tend to be higher when patients have more access to primary care, and in one Florida study, a ¼ increase in family physicians was associated with a 20% drop in mortality from cervical cancer.\footnote{1}

Even more impressive, all-cause mortality, infant mortality, and rates of low birth weight all tend to decrease when there is more access to primary care in a community.\footnote{x} One study found that the addition of just one primary care doctor per 10,000 patients reduced mortality rates by 14.1
deaths per 100,000. Though there is regional variation and differences between the effects of access to primary care in urban and non-urban areas, the ability to access primary care has been widely associated over many years of study with improved health outcomes for communities.

Ensuring Health Equity and Primary Care

Despite gains in insurance coverage, very serious disparities both in the experience of health care and health outcomes persist. The United States ranks last among developed nations on measures of health equity driven by large differences between health care for high and low income individuals, particularly on measures related to financial barriers to care. In 2017, 44% of black women in 2017 reported having unpaid medical bills compared to 32% of white women and 26% of Latina women. In 2016, 22% of Latinos and 20% of American Indians/Alaskan Natives deferred care because of cost compared to 13% of whites.

Even more important, these unequal barriers to care lead to real and devastating differences in health outcomes. In 2019, the Centers for Disease Control and Prevention (CDC) The life expectancy in the United States has decreased for three years in a row, fueled by drug and alcohol related deaths and suicides among poor Americans. Black women in the United States are 3 to 4 times more likely to die in childbirth, and Native Americans have the lowest 5 year cancer survival rates of any racial/ethnic group.

Access to primary care is often cited as an important step to reducing the health disparities. Primary care providers serve as a point of first contact with the health care, and this role as the “front door” of the health system is particularly important when working to connect disadvantaged populations to care. The Community Health Center movement of the past 50 years is based on this idea, and advocates within this movement have worked to provide primary care and social supports to the poor and disadvantaged in settings that empower communities.

Prolific primary care researcher Barbara Starfield dedicated the last portions of her career to examining primary care’s influence on health equity. Evidence from her work and the subsequent work of others has outlined the importance of primary care in health equity. In general, many of the positive effects of primary care on health outcomes appear to be relatively larger in low-income areas versus high-income areas. Furthermore, in many cases, the negative health impacts of income inequality appear to be somewhat mediated if the population also has high levels of access to primary care.
For example, overall rates of death and rates of death from heart disease and cancer are all higher in areas of the United States with high degrees of income inequality. However, Starfield’s group found using county level analysis from the early 1990’s that the impact of income inequality on overall mortality, heart disease deaths, and cancer survival were all smaller when a county had higher ratio of PCPs to patients. 

Furthermore, analysis done on the state level in the United States also suggests that the reductions in mortality associated with primary care are larger for African-Americans than for whites. In one study, the statistical association between lower mortality rates and the supply of primary care physicians was four times stronger for black Americans than for white Americans.

Evidence from the Community Health Center (CHC) movement also supports the central role of quality primary care in tackling health disparities. In the high intensity, socially integrated setting of community health centers, rates of diabetes control and blood pressure control are higher than patients seen by private practice physicians, despite CHC patients at baseline being higher risk. Rates of mammography and colorectal screenings are also higher among black and Hispanic patients treated at CHCs. For these and other reasons, CHCs and the primary care they provide to the underserved have been viewed by many providers, communities, and legislators as essential to rectifying ongoing health disparities.

Of course, the evidence connecting primary care to health disparities is not all straightforward. The relationship between primary care access and health disparities appears weaker in urban areas, and much of the evidence supporting primary care’s relationship to disparities is powered by observational studies that cannot perfectly control for the effects of other social welfare resources in addition to primary care. However, as the point of first access for healthcare, it is hard to imagine that primary care is not a centrally important part of connecting the underserved to health care and other community resources aimed at reducing the disparities in health care and health outcomes for disadvantaged populations.
Part II

Problems in Primary Care

Despite being its central role in facilitating cost-effective quality care for patients, the field of primary care continues to face a multitude of challenges.

In 2006, the American Academy of Physicians issued a report on the “impending collapse of primary care” due to a “dysfunctional financing and delivery system.” Though primary care is still standing thirteen years after this statement and eight years after the passage of the Affordable Care Act, it is hard to deny that significant problems do not still exist in primary care. Primary care providers are still overburdened and undercompensated, and the U.S. still ranks last among high income countries on a variety of health care outcome and health equity measures.

Despite the demonstrated impacts of primary care on costs, health outcomes, and health disparities, primary care faces a multitude of issues. The work of primary care providers has increased, both in terms of recommended services for patients and reporting requirements, but compensation has not appreciably changed. The difficult landscape of practice has contributed to the fact that the primary care fields have struggled to attract both medical students and health professional students into primary care versus medical specialty work.

Not all is lost, however, as even in areas of physician shortage, expanded insurance coverage rates have associated with higher rates of check-ups, appointments for chronic conditions, and even improvements in patient reported quality of care. These improvements come with a cost, however, and physician burnout rates continue to rise across the country.

The gains of the ACA cannot maintained without attention to the primary care networks that serve the base of the country’s quickly changing health care systems.

Part II of this report summarizes the major challenges facing primary including 1) workforce shortages, 2) provider burnout, and 3) the primary care pay gap.
Physician professional groups of all stripes often concentrate their advocacy on combating workforce shortages. Though often aimed at carving out more Graduate Medical Education (GME) funding for residency training programs and hospitals, this line of advocacy relies on projections from many different sources that predict an upcoming shortage of physicians to care for the U.S.’s increasingly elderly and chronically ill population.

Primary care advocates have been particularly vocal about workforce shortages and given primary care’s central importance in guiding the way patients experience the health care system, their work has been relatively persuasive to policy makers both on the federal and state levels. However, despite multiple programs designed to spur student interest in primary care and forgive educational loans, more than 79 million people lived in primary care health professional areas (HPSAs) in 2018.\textsuperscript{xxiii} In Massachusetts, a state incredibly rich in health care resources, more than 500,000 people still live in primary care health professional shortage areas.\textsuperscript{xxiv}

Beyond shortages in the absolute number of providers, the field also suffers from poor distribution of providers such that many rural or underserved communities lack providers while other areas of the country enjoy an abundance of primary care resources.

While there has been concern about the number of primary care physicians since the 1960’s,\textsuperscript{xxv} the field has struggled to recruit and retain trainees. The era of Hospital Maintenance Organizations (HMOs) and its emphasis on primary care drove up the percentage of U.S. medical students planning to enter primary care from 15% in 1992 to 40% by 1997.\textsuperscript{xxvi} However, by 2011 only 7% of medical students chose to enter primary care careers.\textsuperscript{xxvii} Of those students that do enter primary care fields for residency training, an increasing number choose to sub-specialize later in their career (Figure 6).

While the ratio of physicians to patients increased dramatically in the U.S. between 1965-1992, the ratio of PCP per 100,000 patient increased just 14% compared to 120% for specialist physicians.\textsuperscript{xxviii}

While many other high income countries have a 70:30 ratio of specialist to primary care physicians, in the U.S. that ratio is very nearly reversed as just 35% of all clinicians (including Nurse Practitioners and Physician Assistants) currently practice primary care.\textsuperscript{xxix}

Worse still, the primary care workforce is “graying,” and nearly 25% of primary care physicians are older than 60 years and likely to retire within 10 years.\textsuperscript{xxx}

Increasing use of nurse practitioners, physician assistants, and other expansions of the primary care team have been proposed as solutions to workforce shortages.\textsuperscript{xxxi} However, it is estimated that as of 2016, just 52% of NPs and 43.4% of PAs were actually practicing primary care versus specialty care.\textsuperscript{xxsii}

In addition to face-to-face time with a patient, each visit is accompanied by a roughly equal amount of time
It is estimated that if PCPs would need to work an unrealistic 17 hours every working day in order to provide all guideline recommended care for the acute, chronic, and preventative needs of their patients.\textsuperscript{lxxxvi}

The increasing complexity of primary care patients paired with stagnant reimbursement rates and increasing administrative duties leads to overworked physicians.\textsuperscript{lxxxvii} In 2017, 55% of both family medicine physicians and internal medicine doctors reported burnout, defined as “a loss of enthusiasm for work, feelings of cynicism, and a low sense of personal accomplishment.”\textsuperscript{lxxxviii}

Among the causes of this burnout, physicians listed too many bureaucratic tasks, spending too many hours at work, and “feeling just like a cog in a wheel” as the top three drivers of their dissatisfaction. Given that physician burnout is associated with a nearly two times increase in patient safety incidents, physician satisfaction and well-being is an urgent issue.\textsuperscript{lxxxix}

Closely related to the issue of primary care physician burnout is the chronic problem of low reimbursement rates for primary care services and the corresponding under-compensation of primary care providers. The so-called “income gap”\textsuperscript{xc} between primary care physicians and their specialist colleagues means that the median salaries of primary care physicians are about $135,000 less than the median salary of specialist physicians. Over a career, this means that a medical student choosing a primary care career will make $3.5 million less than students who chose specialist fields.\textsuperscript{xci}

With an average annual salary of $223,000,\textsuperscript{xcv} primary care physicians are not poor, however, it isn’t hard to see why medical students facing down an average of $196,520\textsuperscript{xcvii}in educational debt at graduation shy away from primary care fields.\textsuperscript{xcvi} In fact, while specialist physicians’ salaries grew by 37.5% between 1995-2004, primary care physicians’ salaries grew by just 21.4%. Factoring in inflation, the real value of primary care salaries over this period actually decreased.\textsuperscript{xcvii}

In 2010, a JAMA estimated the hourly wage for internal medicine and pediatric specialists at $84.85/hr versus just $58.25 for family doctors and $60.48 for internal medicine primary care.\textsuperscript{xcviii} The income gap is not justified by differences in hours worked per week,\textsuperscript{xcix} and persists even when the additional years of training needed to specialty fields are factored into estimates of lifetime earnings.\textsuperscript{cxc}

![Figure 7. Cumulative Wealth Potential for Cardiologists, Primary Care Physicians, and Other Career Tracks, Ages 22-45. Image from “Can We Close The Income and Wealth Gap Between Specialists and Primary Care Physicians,” by Vaughn, et al., May 2010, Health Affairs.](image)
Underlying the issue of the primary care income gap is the core issue of how public and private insurers pay for primary care. On the federal level, the Relative Value Update Committee (RUC) provides suggestions to the Centers for Medicare and Medicaid Services (CMS) on how various medical services should be valued by Medicare. This body is extremely controversial, and family physicians and primary care providers have lobbied for years against the power of the RUC.

In short, the RUC determines the relative value units (RVUs) for a certain medical service, and the higher the RVU, the higher the CMS is likely to set the reimbursement rate. RVUs are determined by the RUC and intended to be based on 1) the amount of work required for the medical service, 2) the expense incurred by a practice to provide the service, and 3) the malpractice insurance required to cover the medical service.

The RUC is a board of 31 physicians, most of which are appointed by their respective professional groups. Twenty-three members of the RUC members are appointed by physician specialty groups, and nine are appointed by primary care professional groups. Owing that a ⅔ vote is needed to adopt changes to recommendations, the nine voting members from primary care fields are at a significant disadvantage.

Between 1995-2005, the RUC recommended no increases in compensation for office-based visit services. Negotiations in 2006 resulted in some increases in primary care compensation, especially after the Medicare Payment Advisory Committee (MedPAC) publicly criticized the survey processes used by the RUC to determine RVUs. The RUC also created two new seats in 2012 to increase primary care representation, however, a 2015 GAO report again reported significant weaknesses in the processes used by the RUC to justify decisions presented to CMS. The RUC’s recommendations to CMS in 2018 were almost entirely approved by the Trump Administration’s CMS, and included minimal changes to the way in which primary care services are valued.

The architects of the ACA took their own shot at spurring payment reform in primary care in 2010 by including a temporary bump to Medicaid primary care reimbursement rates. Doctors are paid much less for seeing Medicaid patients as opposed to Medicare or commercially insured patients, and in an effort to make sure PCPs could afford to handle an influx of new Medicaid patients, the ACA subsidized states’ Medicaid reimbursements. This was expected to infuse roughly $7.3 billion in to primary care between 2010-2019. However, just 19 states continued the fee bump once federal funding under the ACA expired, and by 2016 only 14 of those states still had Medicaid: Medicare reimbursement ratios above 0.8.
Part III

Primary Care Investment

Using Spending Levels in Advocacy

Decades of primary care advocacy have begun to change the way primary care is provided, but there is still much work to be done. Primary care investment is another potential tool for policy makers looking to increase investment in primary care teams.

Despite ongoing difficulties in primary care, the last ten years of primary care advocacy have seen a variety of efforts to reform both the way in which primary care is delivered and the way in which care is compensated. A highlight of these efforts has been the widespread adoption of the patient-centered medical home (PCMH) delivery model. Primary care medical homes deliver primary care using a team-based model that helps providers deliver more patient-centered, accessible, and coordinated primary care.\textsuperscript{cxvii}

In addition to the PCMH movement, primary care advocates and others have also pushed health systems and insurers to experiment with alternative models of payment for primary care physicians including value-based payments and capitation. The Affordable Care Act (ACA)'s Accountable Care Organizations (ACOs) were designed to provide more financial incentives for health systems to address population health outcomes, and many believe given the evidence of the population level effects of primary care, that these systems will invest in primary care as they mature. Appendix 1 contains more background material information about Alternative Payment Models and primary care as well as details on the federal Comprehensive Primary Care (CPC) advanced primary care medical home pilot from 2012-2016.

The ACA also included a temporary Medicaid fee bump for PCPs in order to help practices accommodate a large influx of newly insured patients.\textsuperscript{cxviii} These primary care advocacy efforts have won some important victories for the field. More and more practices are adopting the PCMH model, and by 2016 nearly 45% of PCPs practiced in PCMHs.\textsuperscript{cxix} Evidence continues to accumulate that this model of care can reduce healthcare costs while improving the quality of care provided to patients.\textsuperscript{cxvxx}

The temporary Medicaid fee bump in the ACA does appear to have done some work to improve reimbursement for PCPs taking care of Medicaid patients, and 19 states chose to maintain the Medicaid primary care fee bump after the temporary federal support for the fee bump expired.\textsuperscript{cxii} Even more promising, many ACOs earning shared savings chose to share large portions of those bonuses with their PCPs.\textsuperscript{cxiii}

However, not all has been rosy. Despite the fact that ACOs with advanced primary care have experienced success and generated savings,\textsuperscript{cxiv,cxv,cxvi} the magnitude of the shared savings payments are not nearly enough to make a large difference in clinics, and health systems have yet to increase their primary care investments in other ways. Despite years of advocacy, just five to eight cents of every health care dollar spent in the United States is going towards primary care services.\textsuperscript{cxvi}

Part III of this report summarizes the importance of primary care investment or so-called “primary care spend” as a measure and expands on its potential as an advocacy tool for policy makers looking to deepen investments in primary care.
Many policy makers and health policy experts would agree that health care systems focused on supporting community-based primary care are more likely to deliver quality, cost-effective care. However, there is widespread disagreement on how to best build and support health systems that prioritize primary care and preventative health care.

One way policy makers and researchers have chosen to conceptualize the degree to which health systems prioritize primary care is “primary care orientation.” Primary care orientation is a term used to describe how much a system is centered around its primary care practices. In research, it has been measured by the ratio of PCPs to patients, the ratio of PCPs to specialists, the ratio of PCP to specialist incomes, or the proportion of patients who have their usual source of care with a PCP.

These ratios are lower in the United States compared to other high income countries, but these measures of primary care orientation have not proven especially helpful or actionable for policy makers. The most natural action provoked by these ratios is to increase the number of providers. However, the loan forgiveness and hiring incentives promoted in public policy to recruit providers have produced only small and temporary changes. The new models of primary care delivery showing success rely on expanded primary care teams and physical and electronic practice infrastructures. Primary care is in need of other primary care orientation measures that are more easily actionable for policy makers looking to invest in new delivery models and team-based care.

To this end, another measure referred to as “primary care spending,” or the ratio of total spending on primary care versus all healthcare spending, has been proposed as a new way to measure the way in which health systems value primary care. Figure 8 shows the primary care spending rates for several health care entities.

Primary care spending, in the words of one of its first champions Dr. Christopher Koller, “encourages clear, financial accountability for whoever is spending the health care money—whether it’s insurers, integrated delivery systems, or public payers.” In general, people and institutions invest in what they value. Primary care spending levels are an easily understood way in which to measure how health care entities value primary care within their institutions.

The primary care spending rate is simple enough to be accessible to lay audiences, and importantly, it is actionable in a more targeted way. Regional ratios of

![Primary Care Spending Rate by Health System](chart)

**Figure 8. Primary Care Spending Rate by Health System.** Table from “Primary Care Spending Rate — A Lever for Encouraging Investment in Primary Care” by Koller and Khuller, November 2017, New England Journal of Medicine.

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*PPO denotes preferred provider organization, and HMO health maintenance organization.*
primary care providers to patients incentivize authorities to craft broad policies aimed at increasing overall numbers of providers. Primary care spending allows policy makers on both federal and state levels to focus on individual health care entities in their jurisdiction and how these entities are committing to team-based primary care within their care networks. Moreover, policy makers can use this rate to set benchmarks for health care entities they feel are not investing in ways they feel benefit the public good. In an era where policy discussions are rightly dominated by payment reform away from fee-for-service (FFS) models, primary care spending is also an intriguing way to monitor how health systems are changing their investments to adopt changing financial incentives.

The primary care spending rate has been adopted as a major policy priority by primary care advocacy groups in recent years including the American Academy of Family Physicians (AAFP), the Milbank Fund, and the Patient-Centered Primary Care Collaborative, and has led to legislation and regulation in several states.

Before the primary care spending rate can be used, however, policy makers must figure out how to 1) define primary care, 2) measure primary care spending, and 3) identify ways to influence the spending rate.

In order to measure how much a health care system is spending on primary care, it is necessary to first decide what exactly is going to be counted as primary care spending. While Barbara Starfield’s Four C’s of primary care (Comprehensive, Coordinated, First-Contact, Continuity) are a classic grounding of the concept of American primary care, actually sitting down to decide which services will be considered primary care is another matter entirely.

While services like well-child visits, immunizations, or blood pressure checks might be easily classified as primary care, the question becomes more complicated when it must be determined if services like gynecologic exams, prenatal care, or behavioral health services should be classified as primary care spend. Even more complicated is the determination of who exactly should be a considered a Primary Care Provider. If a woman sees only her gynecologist and has her PAP smear done by this physician or advanced practice provider, is the service considered primary care? Defining primary care means deciding what services exactly are primary care at a granular level and/or deciding who exactly provides primary care. Moreover, it can be a methodological challenge tracking primary care spending in systems experimenting with various levels of capitation or making investments outside of fee-for-service payments.

While a complicated task, a July 2017 Milbank/Rand study demonstrated the feasibility of using eight different definitions of primary care to measure primary care spending using insurer generated data. Each definition generated slightly different levels of primary care spending, but each also demonstrated that primary care spending at most amounts to just 7-8% for the 10 major insurers considered.

A methods conference hosted by the AAFP in December 2017 convened experts in an effort to standardize the primary care definitions being used in research and advocacy. The panel of experts proposed a definition that includes “primary care services, delivered by primary care teams, within the context of first-contact care, comprehensive services, in continuous relationships, with coordination of care” as the goal for ideal definitions, but agreed that more granular definitions would need to be created on a country by country basis. In the United States, each state that has considered defining primary care in legislation and regulation has done so in slightly different ways depending on local preferences and political climates.
claims data, and the databases serve as policy making and research tools for state officials. Some state APCDs also combine information from Medicare and Medicaid into their state database.

Maine launched the first APCD in 2003, followed shortly by Kansas, Massachusetts, Maryland, and New Hampshire. By 2018, 26 states had functioning APCDs. These databases have been used by states to monitor areas of spending growth, track variation in pricing between healthcare systems, and track trends in diagnosis of chronic diseases. Many states that have sought to increase primary care spending have leveraged their APCD to determine how much payers in their state are spending on primary care.

Of course, the granularity of the data available from these databases varies from state to state. The ability of these databases to pick up spending not tied to fee for services is also variable, an especially important shortcoming in states experimenting with system-level or primary care practice capitation.

States have multiple authorities available to them as they look to direct investments in primary care. To date, state authorities have largely used four different approaches to increasing primary care spending in their state: 1) legislation, 2) direct regulation, and 3) Centers for Medicare and Medicaid (CMS) pilot projects including the Comprehensive Primary Care Initiative (CPC), and 4) Experiments with Alternative Payment Models (APMs). More information on the CPC pilots and APMs can be found in Appendix 1.

Legislative approaches to increasing primary care spending have varied in approach with states largely taking a step-wise approach. The central example for this approach is Oregon whose legislature started the process of primary care reform in 2009 with legislation authorizing the Patient-Centered Primary Care Home Program. This program provided a hub for primary care payment reform conversations while supporting

![Figure 9. Per-Member Per-Month Primary Care Spending in Dollars, Among HMO Patients in Mean (Range), HMO and PPO.](http://www.milbank.org/wp-content/uploads/2017/07/MMF-Primary-Care-Spending-Report.pdf)
the development of Primary Care Medical Homes (PCMHs) in the state.

Building on momentum from the PCMH movement, the legislature took a step farther in 2016 and required the Oregon Health Authority and its Department of Consumer and Business Services to begin reporting annually on the levels of primary care spending for major insurers and Medicaid coordinated care organizations (CCOs). The legislature also created a Primary Care Payment Collaborative tasked with providing recommendations to the Oregon Health Authority on how to target primary care investments.

In 2017, the Oregon state legislature, led by a Senator who is also a family physician, unanimously passed Senate Bill 934 requiring all payers to spend at least 12% of all healthcare spending on primary care by 2023. The Oregon Health Authority’s report to the legislature in 2018 provided legislators with detailed information on state level trends in primary care spending and showed that by 2018, commercial insurers were spending roughly 13.6% of all spending on primary care in 2018. Figure 10 contains a graph from Primary Care Spending 2018 Report to the Oregon State Legislature and shows how the Oregon Health Authority (OHA) and the Department of Consumer and Business Services (DCBS) are able to use the data they collect to advise legislators on state progress on primary care investment health entity by health entity.

Though the 2018 report showed that primary care spending overall stayed fairly constant from 2017, it was noted that more non-claims based payments (capitation, salaries, primary care medical home payments) were being directed into primary care by Oregon’s Medicaid program as well as its commercial insurers.

Delaware has taken a similar approach to Oregon’s and passed legislation in August 2018 creating a Primary Care Reform Collaborative charged with providing recommendations to the Delaware Health Care Commission. The Collaborative’s first set of recommendations were published in January 2019 and included a recommendation that the state mandate all payers spend at least 12% on primary care through either further legislation or new regulations via state agencies. A bill to mandate 12% primary care spending was introduced in the Vermont House of Representatives on January 25, 2019. (Appendix 5)
While momentum has been building behind primary care spending legislation, similar bills introduced in California\textsuperscript{cxlviii} and Colorado\textsuperscript{cxl} for the 2018 legislative session did not pass after becoming ensnared in other health care debates within each state. Even in Oregon, some have worried that Oregon’s broad definition of primary care, which includes both pregnancy care and behavioral health services, has allowed insurers to “game” the definition and avoid making new commitments to primary care infrastructure and staff.

**Direct Regulation**

In some states, health care administrators and commissioners have been able to act directly with their existing authorities to increase the primary care spending in their state. The most prominent examples of this strategy are recent reforms in the state of Rhode Island.

Rhode Island’s state legislature passed The Rhode Island Health Care Reform Act of 2004\textsuperscript{cl} and created a cabinet-level Office of the Health Insurance Commissioner. In addition to the normal authorities of a state insurance commissioner, the new Office of the Commissioner was directed to “guard the solvency of health insurers,” and “protect the interests of consumers.”\textsuperscript{clii} The statutory guidance for the Office of the Commissioner made explicit reference to ensuring the affordability of insurance,\textsuperscript{cliii} but was vague in exactly what affordability meant or how the Office should guide insurers.\textsuperscript{cliv}

This vague language created a wide window of opportunity, and the Office of the Commissioner ended up using the authorities to specifically target primary care investments in the state. The Office of the Commissioner developed four regulatory “Affordability Standards” for insurers with regard to primary care and used these standards to guide contract negotiations with the state’s major insurers.\textsuperscript{clv}

From 2004-2009, primary care spending in Rhode Island went from $47 million to $74 million, and over this period Rhode Island had the lowest rate of per-capita healthcare spending growth rate in New England.\textsuperscript{clvi} Early evidence showed that per member spending decreased by $76/enrollee after the adoption of the policy.\textsuperscript{clvii}

Notably, the percentage of primary care investment dedicated to non-fee-for-service payments by Rhode Island insurers grew rapidly after the Affordability Standards were put in place as insurers funneled more money into PCMH development, health IT, pay for performance primary care payments, practice coaches, and new primary care clinics. These non-FFS payments were considered essential by the Office of the Commissioner as they signaled long term new investments in the state’s primary care infrastructure.\textsuperscript{clviii}

The case of Rhode Island has sparked much excitement by primary care advocates, however, it is important to consider that the success in the state was certainly supported by the unique powers of the Insurance Commissioner. Rhode Island is also a small state with only a handful of large insurance companies. However,

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{figure11.png}
\caption{Rhode Island Primary Care Spending, Total and as Percent of Total Medical Spending - 2008-2015. Image from the 2018 Rhode Island Health Insurance Advisory Council’s Annual Report.}
\end{figure}

\section*{The 2010 Rhode Island Affordability Standards}

1) Insurers should raise their percentage of spending going toward primary care by 1% each year until the total spend is 11%

2) Insurers must support PCMH expansion

3) Insurers must support expansion of Electronic Health Records (EHR) programs

4) Insurers must submit guidance and data to the Commissioner’s workgroup on payment reform
evidence from the state continues to accumulate that the Affordability Standards have not only increased primary care investment (Figure 11) but have been associated with overall slowing of health care growth rates.
As of 2014, Massachusetts was home to nearly 28,000 physicians and the ratio of physicians to residents in the state was the highest of any state. Using a broad definition of primary care providers that includes internal medicine, general practice, adolescent medicine, pediatrics, family medicine, and obstetrics/gynecology, the Massachusetts Department of Public Health estimates that 20% of physicians in Massachusetts practice primary care.

Despite the wealth of health resources available in Massachusetts and the seeming abundance of health professionals, 30% of counties in Massachusetts do not have a single primary care office. Moreover, 38 municipalities are classified as Federal Health Professional Shortage Areas for primary care providers. (Figure 12)

The Graham Center projected that Massachusetts would need 725 additional PCPs by 2030 to meet the rising demand for primary care services driven by population growth, aging, and projected expansions of insurance coverage in the state.

Massachusetts doctors are relatively high earners in the state, and the average salary of all Massachusetts physicians was a healthy $286,971 in 2017. Over the same period, the average annual salary for all occupations in Massachusetts was $62,110. Despite these relatively high earnings, Boston physicians were still among some of the lowest paid in the nation in 2017. In 2017, physicians in Connecticut were paid an average of $353,925 and physicians in Philadelphia were paid $296,351. The average salary for a primary care doctor in Massachusetts was roughly $210,000 in 2018.

**Figure 12.** Physician Practice Location Distribution by County and Residents Per Primary Care Physician Ratio by City/Town 2014. A) Map shows the 2014 distribution of all physicians in Massachusetts. B) Map shows the 2014 Ratio of Residents to PCPs for Massachusetts cities/towns. Both images from Health Professions Data Series-Physicians 2014 from the Massachusetts Department of Public Health. April 2016.
Health policy in Massachusetts is a vibrant and active field, and Massachusetts’ actions to reshape health care over the past several decades have had consequences that reverberated across the country. From Dukakis’ “Health Care For All” legislation in 1988 to Romneycare in 2006 to massive post-ACA experiments in cost control and alternative payment models, Massachusetts leaders have been eager and willing to take an active role in reshaping the Commonwealth’s healthcare system. Consideration of a few key moments are important to understand the current health policy landscape of Massachusetts and how any proposal at reforming primary care might be viewed by the state’s key health policy groups.

The Massachusetts Health Security Act of 1988
Under the leadership of then Governor Michael Dukakis and State Senator Patricia McGovern, the Massachusetts Legislature passed The Massachusetts Health Security Act in 1988. The first of its kind, the legislation imposed steep fines on employers not offering insurance and promised to provide coverage to the uninsured through income-adjusted premiums sponsored by the state. Dukakis celebrated at the time saying “We have good reason to rejoice today, as we once again become the nation’s laboratory, the nation’s pathfinder, blazing a trail that leads to affordable, quality health care for every man, woman and child.” The legislation fell apart over the next few years as the tenuous alliances that supported the bill weakened, the Governorship changed parties, and the economy slowed. As would be the case with most health reform in Massachusetts over the coming years, the focus of efforts was on expanded insurance coverage rather than health systems delivery reform or primary care reform.

The Medicaid Expansions of 1990’s
Massachusetts submitted for a federal Section 1115 Research and Demonstration waiver to expand its Medicaid program to cover more low income adults and children in 1994, and Chapter 203 of the Acts of 1996 passed by legislature authorized and expanded further expansions. MassHealth, the name given to Massachusetts Medicaid by the Acts of 1996, was expanded to cover 300,000 more residents by the time the expansions were fully implemented in 1997. The expansions focused primarily on insuring children and were financed in part via a tax on cigarettes levied by the legislature. Buoyed by a diverse coalition brought together by then-Representative John McDonough, the legislation was successful in the legislature due to its deliberate focus on the health of children, its promises of budget neutrality, and its repeal of the employer mandate which brought the state’s business community on board. Despite the veto of then-Governor Weld related to the cigarette tax, the legislation passed with overwhelming bipartisan support. Again, health care reform undertaken by the legislature remained focused on access without specific attention to primary care or health systems reform.

Romneycare
In 2006, the Commonwealth passed Ch. 58 An Act Providing Access to Affordable, Quality, Accountable Health Care. “Romneycare,” as the Act came to be known, was an impressive package of insurance and health care delivery reforms that would later come to serve as the basis for national health care reform in the form of the Affordable Care Act. Romneycare expanded MassHealth even further, provided subsidies for private insurance, established an insurance connector, and put in place individual mandates to purchase insurance as well as employer mandates to provide health insurance. The new infusion of insured patients into the health care system stressed primary care providers (PCPs) and wait times to see a PCP in the state increased by 50% from 2006-2007, a fact that was used by Republican opponents of the law to argue the law had actually decreased access to primary care. Later research firmly disputed that access to primary care had decreased in meaningful ways and the reforms of 1996 were later associated with decreases in overall mortality rates and improvements in outcomes for patients with chronic disease. Nevertheless, Romneycare and its effects on primary care remained an active area of interest, and set the stage for increased interest in primary care delivery reform in Massachusetts.

The Patient-Centered Medical Home Movement in Massachusetts
The Patient-Centered Medical Home is a primary care delivery system designed to improve the functioning of primary practice through five key tenets: 1) comprehensive care, 2) patient-centered design, 3) care coordination, 4) accessible services, and 5) continuous.
attention to quality and safety improvements. The movement, kicked off in full by reports from the American Academy of Family Physicians (AAFP) and The American College of Physicians (ACP) in 2006, emphasizes care delivery through interdisciplinary teams that allow for easier and more consistent access to care for patients. The ACA authorized CMS to test patient-centered medical home models and provide transformation grants. The medical home movement found an early footing in Massachusetts with the launch of the Massachusetts Patient Centered Medical Home Initiative in 2011.

State officials most recently in January 2019 expanded their PCMH certification criteria to include behavioral health integration as standard, once again pushing the envelope on the PCMH model. The uptake of PCMH in Massachusetts coincided with substantial experimentation by insurers and providers in the state adapting to new payment models and ACOs. The conversation surrounding this issue brought together primary care advocates across the state and continues to dominate much of the conversation in Massachusetts on primary care innovation.

Chapter 224: The Health Policy Commission
In 2012, the Commonwealth of Massachusetts under the leadership of Governor Deval Patrick, passed Chapter 224: An Act Improving the Quality of Health Care and Reducing Costs Through Increased Transparency, Efficiency, and Innovation. A follow-up to Romney-era reforms that primarily focused on access to care, Ch.224 took aim at reforming the way the Commonwealth paid for health care. The legislation targeted fee-for-service (FFS) reimbursement and mandated that 80% of MassHealth beneficiaries be covered under Alternative Payment Models (APM) by 2015. Notably, the architects of Ch.224 chose not to mandate APM adoption by commercial insurers, anticipating significant pushback from the state’s insurers.

Ch.224 also took the unprecedented step of establishing an independent agency called the Health Policy Commission (HPC) composed of 11 appointed Commissioners and charged with setting and enforcing a health care spending benchmark for the state’s insurers. The Center for Health Information and Analysis (CHIA) was also created by Ch.224 and was established to provide the HPC with data on health care spending.

Figure 13. Major Moments in Massachusetts Health Policy with a Focus on Primary Care.
The results of Ch.224 are still unfolding, but the HPC’s Annual Cost Reports have proven to be influential evaluations of the performance of various insurers and health systems. The reports make spending levels public in a way that allows for easy comparisons between systems and insurers, enhancing transparency in the system. The HPC also quickly established its authority and credibility when the Commissioners came out publicly against the proposed Partners-South Shore merger in 2015, citing evidence that the merger would increase overall healthcare spending for the state.

With regard to primary care, Ch.224 also contained explicit support for expansion of the PCMH model and charged the HPC with certifying primary care practices as PCMHs. Per Ch.224, one commissioner must be a primary care physician. Ch.224 also required MassHealth to collect data on payments made to primary care physicians and established several primary care workforce development programs including loan forgiveness programs.

The HPC’s Cost Trends Report for 2017 focused primarily on trends in pharmaceutical spending, unnecessary utilization, and price variation between provider networks. However, the Report also included recommendations to expand substance abuse treatment in primary care settings and a strong call for health care entities to more directly engage with addressing the social determinants of health in their populations.

The MassHealth ACO Pilots
Ch.224 mandated a transition to alternative payment models (APMs) in MassHealth, and by 2016 36% of patients in MassHealth Managed Care Organization (MCOs) were covered under APM contracts. MassHealth launched a large scale experiment with ACOs in 2016, building on the experience of that state’s providers with the ACO model in the commercial and Medicare markets. The new MassHealth ACOs have three options for contracting with the state, one of which involves capitated payments. Authorized by the state’s massive $50 billion Medicaid Section 1115 Waiver, the pilot was expanded to 17 sites in 2017 covering 800,000 MassHealth patients. While the results of these MassHealth reforms are forthcoming, the HPC included in its yearly set of recommendations a call to continue expanding and experimenting with APMs.

With regard to primary care, Massachusetts’ experiments with Medicaid have created openings to experiment with primary care reimbursement. It has long been thought that movement towards APMs could spur health systems to invest in their primary care systems, however, experience on the national level seems to suggest that idea has not yet materialized for primary care practices. Despite nationwide experiments with ACOs and APMs, primary care visits actually decreased 18% from 2012 to 2016 and primary care spending is estimated to be still just 5-8% of all health expenditures nationwide. Despite all of the experimentation with health care delivery in Massachusetts, primary care spending is still estimated to be just 6.6% of all health expenditures in the Commonwealth.

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Governor Baker
Elected in 2014 by a narrow margin, Governor Charlie Baker has since established himself as a dedicated manager and has even been nicknamed “Governor Fix-It.” Governor Baker had the highest approval ratings of any Governor in 2018 and cruised to re-election with 64.7% of the popular vote in one of the bluest states in the country. The Governor has a reputation for working well with his Democrat colleagues in the legislature, a necessity given that Democrats dominate the legislature and can typically easily override any veto threats.

Governor Baker has worked directly in health policy for more than 25 years and has an extensive understanding of the intricacies of Massachusetts’ health care system. Baker was appointed Massachusetts Secretary of Health and Human Services (HHS) in 1992 and was appointed Secretary of Administration and Finance in 1994. Baker later served as the CEO of Harvard Pilgrim from 1999-2009, where he was widely credited with saving the organization from bankruptcy.

As Governor, Baker has faced a multitude of tests with regard to health policy, including managing numerous political challenges related to hospital mergers including the proposed Partners-South Shore merger of 2014, the Partners-Harvard Pilgrim proposed merger of 2018, and the BIDMC-Lahey merger of 2018. These mergers and proposed mergers have been deeply contentious political fights that have occupied a great deal of time for the Governor’s office.

The attentions of the Governor and his Secretary of HHS, Mary Lou Sudders, have also been dominated by the state’s opioid addiction crisis and the urgent need for expansion of behavioral health services in the state.

Lastly and most importantly for primary care, the Governor was deeply involved in the MassHealth reforms of the 1990’s, and Baker is heavily invested in the ongoing MassHealth alternative payment model (APM) pilots established by the state’s 1115 Medicaid waiver. Based on the Governor’s past work in health care as a former health plan CEO, he likely appreciates the value of primary care to health systems. That said, during his time as Governor, he has primarily focused on curbing MassHealth spending and is likely to continuing concentrating on the potential of APMs to cut costs versus pushing investments to any particular sector of health care.

Joint Committee on Health Care Financing
The Joint Committee on Health Care Financing is composed of legislators from both the House and Senate and serves a central hub for legislation related to health care cost control and MassHealth. Specifically, the committee is charged with “all matters concerning the direct funding of health care programs and any other Medicaid or public health assistance matters, fiscal matters relating to health care policy, Medicaid, MassHealth, the Uncompensated Care Pool and such other matters as may be referred.”

With regard to primary care, the Committee members are likely to be supportive of primary care and primary care providers in general. However in 2018, the agenda of the Committee was dominated by the issue of financial support for community hospitals and behavioral health access last year. Appendix 2 contains a review of the 2019 Massachusetts Legislative Session. In 2019, the Joint Committee this year may have its hands full trying to salvage the work of last year’s failed reform packages. Given the Committee’s full agenda, it

In order to understand if and why primary care investments might be important to health care stakeholders in Massachusetts, it is necessary to consider each party’s particular interests and priorities.
would likely not be eager to take on an entirely new initiative on primary care investment. However, the Committee may be eager to continue building on alternative payment models given the importance placed on the model by the HPC and Governor Baker. Primary care also plays an important role in expanding community access to behavioral health services, and the Committee may find this valuable to their ongoing efforts.

Health Policy Commission

Established in 2012 by Ch.224, The Health Policy Commission (HPC) is composed of 11 Commissioners appointed by either the Governor or the Attorney General or the State Auditor. Terms for Commissioners are 2-5 years with options for reappointment. There are very strict rules regarding conflicts of interests, and Commissioners cannot have direct financial interests in any health care entity in the state. The HPC typically releases its Annual Cost Trends Report in March and holds its Cost Trends Hearing in October.

The HPC has established itself quickly as a trustworthy, unbiased source of guidance on health care spending in the state. The Commissioners’ opposition to the Partners-South Shore merger of 2014 was an important factor in the merger’s ultimate failure and raised the profile of the HPC in Massachusetts. The HPC opposed the merger on the basis of its impact on health care spending, an argument that was persuasive to many in state government. In 2018, the HPC conducted a cost analysis on a ballot measure regarding nurse-patient ratios and found the measure would drive up health care costs. Again the HPC’s estimates were highly influential in the debate, and the measure failed in November 2018. The Commissioners took some heat from the state’s nursing associations regarding their analysis, but was generally thought to have once again served as an unbiased source of information regarding health care costs.

As the HPC geared up to release its March 2019 Annual Cost Trends Report, it found itself again in the political hot seat as it conducted another cost analysis on the proposed BIDMC-Lahey merger in Fall 2018. The merger was approved, though the new system was forced by state regulators to adhere to a seven-year price growth cap to mediate some of the projected increases in health care spending related

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**Figure 14. Massachusetts Health Policy Stakeholders and Factors Affecting Potential Support for Primary Care Investments.**
With regard to primary care, the Health Policy Commissioners are likely to be sensitive to the importance of primary care, especially with regard to community-based primary care’s ability to address the social determinants of health with patients. As experts on health policy and health care spending, they would likely be aware of the body of literature supporting the importance of primary care in efficient health care systems.

However, the HPC concentrates on controlling spending through very high-level analysis of health systems, and the Commissioners may not support directly mandating primary care spending in particular without data showing how such a mandate would affect overall spending. As health care entities in the state adjust to changing payment models, the Commissioners may want to give these bodies enough flexibility so as to respond in their own ways to the new incentives around financially responsible care.

The HPC is entirely focused on measuring health care spending, establishing benchmarks for spending, and enforcing these benchmarks statewide. The HPC is an ideologically neutral body and would certainly not support any measure that was viewed as pitting specialists versus PCPs, nor any measure that would raise overall health care spending.

The HPC’s 2018 Recommendations suggest the group is highly focused at this moment on pharmaceutical spending, price variation, and alternative payment models. Primary care investment could find its way onto the HPC’s radar by examining the importance of primary care to the success of ongoing APM pilots. The HPC has also written about the enormous role social determinants of health play in growing health care costs, and primary care investments are certainly important to building out the kind of community based, comprehensive, team-based medical care that the HPC has recommended.

Lastly, as the keeper and chief analyst for health care data and spending data for the state, the HPC has the capacity to expand primary care measurement in the state. Measuring and reporting primary care spending by different insurers and hospitals in the state could be an important first step to building the argument for primary care investment in Massachusetts. If argued correctly, the HPC might be willing to add primary care spending to the list of targets by which it measures health care insurers and provider networks.

Large Hospital and Provider Networks
Massachusetts is dominated by several large provider networks and hospitals, and the state is extremely proud of its high performing hospitals and cutting edge medical research. Partners Healthcare is the largest hospital network and represents a partnership between the nationally recognized Massachusetts General Hospital and Brigham and Women’s Hospital. The University of Massachusetts Hospital, The Beth Israel Deaconess Medical Center (BIDMC), Tufts Medical Center, and Boston Medical Center (BMC) are the main competitors for Partners. The variation in costs between the providers has been an active area of discussion in Massachusetts, particularly with regard to Partners who spends $600/year more per patient than the next highest spending ACO.

The patient populations served by the hospital networks tend to be very different with Baystate and BMC in general serving patient populations with lower socioeconomic status. This has been a source of contention between the hospitals and was a politically active issue after the Boston Globe Spotlight Team featured the city’s hospitals as part of its 2017 investigation into race relations in Boston. Just 11% of patients admitted to MGH are black, and the percentage of MassHealth patients seen at the Partners Hospitals is lower than at Massachusetts’ safety net hospitals.

The proposed mergers of Massachusetts’ provider networks in recent years have been controversial in the state and have been political headaches for the hospitals. When Partners moved to merge with South Shore hospital in 2012, the company pitched the merger as a way to coordinate and improve care. At the time, Partners said it could save the state money by investing in primary care and care coordination at South Shore. The HPC was critical of the deal, launching a statewide political conversation. State Attorney General Maura Healey eventually had to threaten to sue before the merger was eventually
withdrawn. The attempted merger created a great deal of bad press for Partners, and the Partners CEO stepped down shortly after the proposed merger fell through.\textsuperscript{ccxvii}

**Health Insurance Companies**

The three largest insurers in Massachusetts are Blue Cross/Blue Shield with 56% market share, followed by Harvard Pilgrim at 13%, and Tufts at 11%.\textsuperscript{ccxviii} Massachusetts has been an early and enthusiastic adopter of the ACO model and 16 different ACOs have been certified by the HPC as of 2019.\textsuperscript{ccxix} Massachusetts has one of the highest rates of people covered by ACO contracts, and the state is one of three states with more than 30% of their population covered by ACOs.\textsuperscript{ccxx} While Blue Cross/Blue Shield Massachusetts does its own lobbying, most insurance companies in the state are represented by the Massachusetts Association of Health Plans (MAHP).

Massachusetts insurance companies have faced a multitude of financial issues over the past several years, including Blue Cross/Blue Shield which reported $6.9 million in net losses over FY2017.\textsuperscript{ccxxi} Harvard Pilgrim and Tufts have also reported losses, and Minutemen Health actually went under in August 2017.\textsuperscript{ccxxii} The companies have struggled with rising prices from their providers, rising pharmaceutical costs, and their somewhat limited ability to adjust premiums in a competitive and highly regulated insurance market.\textsuperscript{ccxxiii,ccxxiv}

With regard to primary care, Massachusetts’ insurers would likely be sensitive to the importance of primary care to systems level cost reduction. Particularly for insurers operating in risk-bearing ACO contracts, investments in primary care would be theoretically attractive. However, given the financial struggles of Massachusetts’ insurers, they are likely to be much more invested in reducing pharmaceutical costs and unnecessary utilization. As the insurers claimed last year while fighting proposed levies to support community hospitals,\textsuperscript{ccxxv} their strapped financial situations limit their ability to make large new investments.

However, insurers might be in favor of primary care investments in the form of support for expanded urgent care hours or care coordination services as part of a strategy to reduce unnecessary admissions and readmissions.

**Health Professional Groups**

Massachusetts has nearly 28,000 physicians,\textsuperscript{ccxvi} many of whom take a great deal of pride practicing in one of the most forward-thinking and advanced medical systems in the country. Patients from all over the world come to see medical experts in Boston, and area physicians have been responsible for many of the most consequential moments in medicine from the first use of anesthesia at Massachusetts General Hospital in 1846 to the first full face transplant at Brigham and Women’s in 2011.

Massachusetts, and in particular Boston, has a medical community that is dominated by specialist physicians. Only about 20% of Massachusetts physicians practice in primary care settings,\textsuperscript{ccxxvii} and within physician circles, primary care providers (PCPs) tend to be viewed with less prestige in than their specialist colleagues. Despite this bias, the largest physicians’ group in the state, the Massachusetts Medical Society (MMS), has elected a family physician for its president two times out of the last four elections.

Alain A. Chaoui, a family physician, was elected to head the MMS in May 2018. However, the MMS was not focused on primary care issues in 2018 and instead worked to fight new physician licensing fees and proposed fees on outpatient surgery centers, office-based surgery, and urgent care centers. The MMS also supported paid family leave initiatives and bills to support access to reproductive care during the 2018 legislative session.\textsuperscript{ccxxviii}

Massachusetts is home to a variety of active physician groups for each specialty, including the Massachusetts American Academy of Physicians (AAFP). While the Massachusetts Chapter of the AAFP is not the largest or strongest physician lobby in the state, it is backed by the considerable resources of the national AAFP and the research group at the Robert Graham Center for Policy Studies in Family Medicine. Primary care investment is a priority issue for the national AAFP, and the group is engaged in several state level initiatives to spur primary care spend legislation.

Massachusetts’ allied health professionals, including nurse practitioners, physician assistants, and nurses,
are also potent political forces in the state. In 2014, Massachusetts was home to more than 2,200 physician assistants,\textsuperscript{ccxxx} more than 123,000 registered nurses,\textsuperscript{ccxxx} and roughly 9,000 nurse practitioners (NPs).\textsuperscript{ccxxxi} With regard to health policy, the Massachusetts NP community has been very concerned with expanding the practice authority of NPs to practice more independently of physicians.\textsuperscript{ccxxxii} The state’s nurses were extremely active in 2018 promoting an initiative to require hospitals to maintain a certain ratio of patients to nurses. The ballot initiative was defeated soundly after a HPC report concluded that it would cost the state $900 million per year,\textsuperscript{ccxxxiii} and the state’s nursing lobbies are still regrouping from their 2018 loss.\textsuperscript{ccxxxiv}

With regard to primary care, the state’s physician community is very diverse and not easily mobilized on issues related to primary care. While most physicians would acknowledge the basic importance of primary care to a well-functioning system, specialist physicians would adamantly oppose primary care investments if they represented a cut to the pay of specialists. Massachusetts’ allied health professionals are similarly diverse in terms of their interests, and it is not clear that primary care spending would be a natural priority for these groups. While many allied health professionals work in primary care settings, many also work in specialty offices, operating rooms, and other non-primary care settings. It may also be difficult to get physicians and allied health professionals to work together in a policy space, as they are sometimes opposed to each other on issues such as scope of practice for advance practitioners. Primary care investment proposals would need to be designed to minimize the divisions that exist within both the physicians and allied health professional communities.

**Public Opinion**

Health care reform in Massachusetts has been made possible in part by the unique characteristics of Massachusetts residents. In 2007 as Romneycare took off in Massachusetts, 92% of residents believed health care is a right and 90% supported health care reform because “it was the right thing to do.” Moreover, prior to reform in 2003, 47% of residents believed that government should make a major effort to provide health insurance for most uninsured residents, even if a tax increase was likely.\textsuperscript{ccxxxv} Given that polls rarely show voters in favor of tax increases, this was impressive and surely helped build momentum behind the 2006 reforms.

In polling from several years after the roll out of Romneycare in 2006, voters remained committed to the goals of the program.\textsuperscript{ccxxxvi} Importantly, however, at the time of Massachusetts health care reform in 2006, just 20% of residents actually believed Massachusetts health reform would directly influence them.\textsuperscript{ccxxxvii} In 2008, 67% of residents said that health care reform had had little effect on them personally.\textsuperscript{ccxxxviii} While the electorate is committed to universal access, a minority of Massachusetts residents actually felt directly impacted, positively or negatively. This has created a favorable, non-threatening environment to continue and expand upon ongoing health reform efforts in the state.

Massachusetts residents enjoy the lowest un-insurance rates in the country,\textsuperscript{ccxxxix} and in 2018, 96% of adults were insured.\textsuperscript{ccxl} However, a 2018 survey by Blue Cross showed 46% of insured adults in Massachusetts had difficulty getting health care over the past 12 months. Of those who sought help for a mental health or substance abuse problem, 55% had difficulty accessing care. 30% of insured residents reported difficulty affording health care over the previous year, and of those who needed mental health and addiction treatment.
services, 50% reported difficulty affording care. Given these numbers, issues of cost and access are likely to be the most salient for the general public.

With regard to primary care, patients in Massachusetts typically report favorable experiences with their primary care physicians. For adults patients, almost 95% of patients were satisfied with patient-provider communications, and nearly 90% felt their providers knew their patients well. Importantly, 87% reported ease of access to primary care and nearly 87% also reported satisfaction with the coordination of care services at their PCP. While physicians and practices might be feeling squeezed, it is not evident to patients that there are problems with the care they receive from their well-liked PCPs.

The Massachusetts electorate is generally left-leaning with 33.2% of registered voters identifying as Democrats. Massachusetts also has a very large and growing group of independent voters with 55% of registered voters in 2018 identifying as Independent. As was the case for much of the country in the 2018 Midterm elections, Massachusetts voters are very concerned about healthcare and 1 in 4 voters listed health care as the most important issue facing the country. Importantly, an enormous number of voters work in healthcare. Partners employed 60,300 people in 2018 and was the state’s largest employer.
Primary Care Spending in Massachusetts
A Pilot Interview Study

In order to better understand if and how primary care investment initiatives can be advanced in Massachusetts, a pilot interview study was conducted with key stakeholders.

Methods

Study procedures and recruitment were approved by the Harvard Medical School Institutional Review Board. Interviewees were recruited and interviewed over the month of February 2019.

Recruitment
Interviewees were selected by Megan Townsend and Russell Phillips and recruited via email to participate in a recorded thirty (30) minute semi-structured interview. The individuals selected for interviews were identified by the researchers as healthcare experts with an interest in Massachusetts primary care.

The interviews sought to engage a diverse set of opinions from healthcare stakeholders, and to do so, recruitment focused on individuals from the state legislature, major hospitals, physicians’ groups, insurance plans, the academic health policy community, and the Massachusetts Health Policy Commission. Many of these experts were identified via background interviews with those familiar with primary care investment in the state.

Interviews
Interviews were conducted either in person or over the phone and recorded. All interviews were conducted by Megan Townsend and employed a semi-structured interview script [Appendix 3]. Interviewees were provided with the interview script in advance of the interview. Participants were verbally consented and asked to sign a quote release at the time of interview. Signed quote releases were obtained after the interview for those interviewed by phone.

Interviews were transcribed, and transcripts were coded for this pilot study by Megan Townsend. Codes were selected as core themes emerged from the interviews. Participants were given the option to edit or redact quotes given during their interview via email in advance of the publication of this report.
Eleven participants agreed to be interviewed in ten interviews including one Massachusetts health system CEO, one state senator, one former head of American Academy of Pediatrics and pediatrician, one primary care researcher/chair of a hospital payment and contract committee/PCP, one primary care disruptor CEO, one current president of a family medicine advocacy group and practicing family doctor, one former network president for a major Massachusetts provider network, one Massachusetts Health Policy Commissioner, two executive leaders from the Massachusetts Association of Health Plans, and one current head of a MassHealth primary care ACO.

Seven core themes emerged from the interviews including the role of primary care in health systems, the importance of primary care teams, thoughts on the role of primary care spending as a policy tool, the role of alternative payments models in building primary care services, the particular Massachusetts context, next steps for primary care advocates, and anticipated obstacles.

The Role of Primary Care in a Health System: Quality, Equity, and Business Sense

All interviewees generally agreed that primary care is an important part of a health care system. One legislator said of primary care, “I see it as such an integral part, and if you believe in primary care, if you believe that it plays a really significant role in good health care, then you have to focus on it. You have to start treating it as a piece that's as important – maybe even more so – as any other healthcare piece, which means that you have to start looking at how you're going to shift healthcare dollars so that you can support it.”

Some interviewees stressed the cost savings of primary care, including one who said, “I think also we need to work on how to reduce the need for these big expensive services, and I think primary care is an amazing lever to do that. What we've found, again, if you do primary care right and invest the right amount in primary care, you can make huge impacts on the need to go to the hospital, the need to go to the specialists, the need to go to the emergency room. And on the whole, that's hugely A, better for patients, but B, better for the system because the aggregate cost of healthcare goes down.”

Other interviewees spoke to primary care’s role in improving overall quality of care and patient access. One interviewee expressed skepticism regarding the ability of primary prevention services in primary care to curb overall costs, but argued that quality primary care including primary prevention “should be pursued on moral grounds, on mission grounds, but not necessarily on a return on investment grounds.”

An ACO leader stressed the importance of primary care to the business of health care saying, “For a health system, primary care is a loss leader within its cost center. However, the primary care base provides a core engine to power needed utilization to specialists and the hospital. Most health systems are pretty open about this.” A health system CEO agreed saying, “The reason that we spend as much as we do on primary care and intend to spend more is it ultimately benefits patients certainly, and it also benefits the system.” The interviewee added, “Primary care physicians are the primary drivers of patient volume to a hospital, specialists, procedures and other things.”

Primary Care Investments Should Be About Building and Supporting Team Based Primary Care

Appetite for Change in Primary Care

While a few interviewees commented that primary care providers themselves are underpaid, most interviewees agreed that new primary care investments should not be directed at increasing provider pay. One provider and primary care health system CEO said, “Simply giving primary care doctors more money is necessary but not sufficient. They have to use that money to actually re-engineer the care they deliver...unfortunately, too often you see primary care docs getting extra payments, they just sort of put it in their pocket, ‘You paid me so badly for so long, I’m just going to take this money home.’ That doesn't change anything. You have to actually use that money to be able to provide a different sort of care.”
Some expressed frustration with existing care delivery models in primary care, and one interviewee said, “So the typical system, someone walks in in 7 minutes and I write a prescription, I say, ‘You should eat less, exercise more, take your medicines, good luck... I'll see you in three months.’ Then you come back in three months, ‘You're a bad, bad patient,’ right? Of course, if it was that easy, we wouldn't be talking about this.”

Representatives from the health insurance industry emphasized the importance of expanded hours and building the capacity of practices to take same day appointments. Expressing their desire for innovation, an insurance industry representative said, “We spend a lot of time throwing money at things and saying here is a pilot on this. If we were going to put money into something to do with primary care, I would want it to be pretty innovative and a little different.”

Multi-disciplinary Teams
When prompted to imagine where they felt investments could most improve primary care, all interviewees made reference to building and supporting multi-disciplinary primary care teams. One interviewee said, “Expanding the workforce and coming up with a more team-based primary care, I think, is an important, modern vision of what we should be meaning by primary care... I think community health workers, community-based services, extension agents and others in the community are part of a modernized primary care system, and [also] the much more expanded use of telemedicine and telehealth. I mean, primary care could be the home for coordinating, communication with patients, decreasing the need for visits, decreasing the need for referrals by the proper use of digital approaches to care.” A legislator added, “I would require that there be a more holistic approach to ensure that not only is there the doctor there but there's a nurse practitioner, there's a real set of behavioral health services, there's good physical therapy, there is all that is needed to actually provide a whole person health model.” A practicing primary care doctor added they would like “to build infrastructure of team care... So, staffing up. More medical assistants, potentially using team members like scribes to help take away the documentation burden from providers to keep them in practice longer and more full-time, because a lot of docs go part-time because it's too much to do...”

Interviewees commented on the ability of teams to better address the needs of families and communities. One interviewee specifically believed teams allowed primary care practices to respond better to population health needs saying, “For population health, we need other care team members that can crunch data and give us useful information that's actionable on our patient population to help control costs and provide quality care.” A pediatrician added that “families need concrete services that doctors don't know a damned thing about... there oughta be someone in the practice who can help with that. There are ways of dealing with housing. There are ways of getting families who are hungry food, and access to food. Doctors don't know much about that, but there ought to be someone in the staff that does.”

One interviewee believed that care teams can only be funded with new investment, saying “You've got to spend enough to hire the right people, have the right time... I think there's a threshold function. That's why I'm very frustrated, including CPC where they fuss around with these tiny increments... No. Either you believe in primary care or you don't. Either you invest the right amount or you don't. And thinking, "Oh. Well, we'll go halfway. We'll go a quarter of the way and give people... Let's pay them 7% [of all health spending].” [That] may not get you anywhere, right? You might have to go all the way.”

Behavioral Health
Most interviewees specifically emphasized their belief that behavioral health services should be expanded in primary care settings. One legislator commented on their displeasure that “there's still such silos in how we deliver healthcare based on what kind of health care it is, and that does not serve people who are ill, and especially people who have serious mental illness or substance use disorder. Their head is not separated from the rest of the body, so they need integrated care... They need a space where you're not only being taken care of for your mental illness or SUD but you're being taken care of for physical health needs as well- they're all connected.” Another interviewee believed there should be “investment in outreach community-based mental health resources, even housing and
transport and work on criminal justice and other arenas which affect health status which I think can properly be, if not orchestrated, at least stimulated by primary care.”

When prompted to think about where investments in primary care should be directed, one pediatrician commented that, “I would want to see [behavioral health services] singled out as a critical piece of investment...I think it’s really, really important. And just to think about where we are in Massachusetts right now, the New York Times yesterday reported Massachusetts does a lousy job on children with serious emotional disturbance...So, the conversation often goes to the really sick people, and it ignores the opportunities for prevention, and early intervention at the primary care level. That's why I think it's really critical to talk about the inclusion of behavioral health integration, and to be explicit about what we mean about behavioral health integration.”

Current behavioral health integration investments were viewed as important to one hospital CEO who said, “We looked at some of the most pressing issues that our patient population is facing. And what we know is that approximately half of the adults in the state of Massachusetts that have some form of mental illness, say that they do not have access to care, which is a staggering statement. If we were to switch out the words mental illness for any other, for diabetes, we would not find that acceptable and the legislators would immediately pass legislation demanding and funneling money into providing access...So, now as we're growing and we've thought about how we want to be different and what we want to invest in, we've decided to make investment in behavioral health within primary care clinics. Because we did the math and came to the conclusion that we'll have a large number of primary care clinics and that...we could increase access to approximately 500,000 patients that currently don't have access to behavioral health resources, and we would do that within a primary care clinic...So, that's one of the number-one places that I would use more money if I was given it.”

Interviewees expressed very different opinions on primary care investments as a priority for Massachusetts and on mandated primary care spending levels as a policy tool. In general, most interviewees agreed that any hypothetical investments would need to be paired with payment reform and delivery system reform. As one interviewee said, “I would caution just increasing spending for primary care alone is not enough. It's exactly the right thing to start with. But then you have to make sure that that money's actually being used to actually improve primary care...and not just go into people's pockets, etc. So I think you would have to think carefully about being clear about what sort of incremental investments, etc., would be made...because again, if this doesn't translate into better care for people, it's a waste of time.”

Skepticism
Many interviewees expressed the framing of the argument for primary care investment as “primary care spending.” One participant said, “I'm not sure I'd frame it as primary care spending, it's primary care activity that may require more resources. But Massachusetts, like a lot of other states in this country, has an imbalance, an over-investment in advanced high-tech care that's redundant or oversupplied, and too little support for primary care.” The term “primary care spending” worried some participants as suggesting the state should spend more on health care overall, which most interviewees agreed was not an option.

Other suggested in their comments that the frame of “primary care spending” implied investments would be directed at improving physician pay, which was also very unpopular with most interviewees. As one interviewer advised potential advocates of primary care spending, “If their goal is for primary care physicians like me to get paid more for doing what we currently do, I think that they should give up and go home. They should figure out what are they really going to organize around that other people will get behind. And organizing around meeting the needs of the poor, meeting the needs of the elderly, meeting the needs of the chronically ill, I would make those the unit of analysis, not primary care.” Another interviewee said, “[If] we're trying to enhance the salaries of primary care physicians...That's not a very broadly interesting topic. If you're trying to make it be that we know that people in the Commonwealth don't have adequate access to good, high quality primary care,
and we have a couple of strategies to make that happen, that's a better sell, and then more organizations would likely be interested in working on it.” As another interviewee added advocates should concentrate on “improving the value of care, eliminating low value care, making care better...that's a much better selling point than, ‘We have a bunch of whiny primary care docs, so you might want to do something for them.’ That argument falls on deaf ears when – even though primary care physicians are way underpaid, compared to dermatologists and whatnot -- they’re still in the 90th percentile or so.”

Others believed that concentrating on system level reform, rather than primary care reform, was essential. As one interviewee said, “I think primary care spending is not the right goal. I think the goal is meeting the primary care needs, and the other health care needs of people, and focusing on increasing primary care spending is a bit like trying to treat a fever when there's an underlying problem... I think we have a health care problem in Massachusetts. I think it's simplistic to speak about primary care in isolation, I think we have a healthcare problem in Massa[chusetts]... And...I don't think it's Massachusetts, we have a healthcare problem in this country. I don't think we have a greater health care problem in Massachusetts than we do in this country, other than the fact that it's really, really expensive here. The reasons that it's really, really expensive in Massachusetts are not related to whether or not we spend money on primary care. But in general, it's a health care problem. Primary care is but one piece of that health care problem.”

Other interviewees believed that regulating the amount of primary care spending by health entities was an ineffective way of influencing the commitment of health systems to primary care. One former network president said, “I'm more of a believer in competition and markets to drive improvement than I am in regulation, because I just know the limits of regulation so, so well. And so I believe that trying to create a market where there's competition on improving care, improving the value of care, I think that can and should lead to organizations investing more themselves in primary care. I don't think some threshold number should be legislated.” A hospital CEO supported this view saying “as somebody who employs a lot of primary care physicians... we strongly believe that... primary care is incredibly important, and [we] spend a fair amount of money on primary care... The things that affect whether or not we choose to spend on primary care have to do with fundamental business decisions ultimately, though... That wasn't the result of public policy advocacy, that wasn't a result of legislation, it wasn't even the result of telling the payers that they needed to increase the amount of reimbursement for primary care physicians, although I would be delighted if that happened. No objection on my part. That was simply the result of a pretty clear understanding of, it would be beneficial to the system that I run if we made that investment.”

An interviewee worried that regulation would not provide the correct incentives to health systems saying, “There’s gamesmanship and there's value creation. Gamesmanship is where you're trying to negotiate for more money or something, but you're not actually changing what's happening. Value creation is when you change what's happening in order to try to make things better and be successful. I think regulation inevitably leads to gamesmanship. And people just try to say, okay, what do I have to do so I can get this money? Marketplaces with real competition on the right things leads to people thinking, how do I create more value? And that should lead to more primary care.” One CEO added, “I think what works, what we've seen is we make investments where it makes sense for the system and it turns out actually, it's beneficial to the system for us to make those investments, not because there's legislation. I just don't think that that... I think that those ideas and solutions are from people who are divorced from actually running systems.”

One interviewee also worried about the metrics that would be used to measure primary care spending, commenting that a metric would need to be based on community priorities saying, “…The profile of primary care services which...might be needed in a rural community or in an underserved area of the state or in a place characterized by people of color and minorities, minority populations that are under stress, they may need a completely different version of what we're calling primary care than a leafy suburb or a downtown area. So, developing measures to monitor and then hold people accountable for it would be a pretty difficult enterprise and you might find pushback if the measurement isn't truly sensible.”
Support

Some interviewees believed that primary care spending levels could be used to influence primary care investments in Massachusetts. One primary care physician and advocate said, “I think it absolutely needs to be a priority for Massachusetts and for many states. But I believe that increasing primary care spend is really the way in our current system, that we're going to get at some of the challenges that our healthcare system has...by increasing primary care spend, I believe, or advocating for it, we will be able to make primary care really, a focus of the healthcare system in Massachusetts...There's lots of data out there that shows that when we focus on primary care, we have improved outcomes and lower cost of care and especially in that part, lower cost of care should absolutely be something that Massachusetts should be talking about until we get there. I know it's already a priority for the governor and so, I think that this makes a lot of sense. And having a state like Rhode Island right next to us, who has seen a lot of saving as a result of investing in primary care, to increased primary care spend, I think we have good partners next to us that we can talk to about how to make this happen.”

One primary care disruptor CEO added that his system has been “building what we think is a vision of what primary care ought to be. So not starting where we are but if we had what primary care ought to be which means being able to optimally take care of patients, what would it look like. And absolutely we have come to the conclusion that the right amount of our total resources going to primary care needs to be something in the order of 12%...We refuse to do primary care at anything less than about 12% of total spend because that allows us to do the right thing...And what we find is if you do that, you make big impacts on the downstream spend for hospitalizations, ER visits, caths, labs, etc. And that, on the whole, actually lowers healthcare spend, it doesn't make it go up...we need to double down on primary care, that's sort of the work we do, is double down on primary care and that will give us a shot at actually doing the right thing for patients.”

Alternative Payment Methods as a Path to Primary Care Reform

Most interviewees commented on health care payment reform and the need to transition away from fee for service. As one interviewee said, “I would go so far as to say that trying to expect we're going to get the transformation we need with the current payment model is wasting our time...fee-for-service is the wrong way to pay for primary care. Period, end of sentence. So stop doing it...We should be holding people accountable for outcomes not process.” Another interviewee added, “I think if we just do it [primary care investments] at the margin, it won't work. It will work, in the sense that it'll put more money into primary care and make primary care more attractive, maybe make the physicians happier, but it won't achieve the system-level stuff that we want to achieve.”

Many interviewees expressed their belief that primary care is an important part of ensuring health system success under alternative payments models (APMs). One PCP practicing in a capitated primary care system said, “...when you're in a capitated system and you're accountable for the cost and you're given the money to spend, where do you see these organizations invest their money, right? ...They invest it where they're going to save money and improve their quality and they spend it on primary care.” A health system CEO agreed saying, “Primary care becomes very, very important under capitation, and under bundle payments as well. They become the coordinators. They're where patients start with the system.” Insurance company representatives agreed saying, “If...you move into an ACO model you want the right care at the right time, at the right setting...you are really counting on the primary care physician to...direct the care and to set up a practice where a patient has easy access.”

Several interviewees commented on ongoing payment reform efforts in Massachusetts and the effect on primary care. According to one interviewee, “…the Medicaid ACO, to a degree, was designed to improve the primary care spend. That was just not a sort of formal, stated objective, but in reality, there is a substantial commitment to improving the spend, and the resources available in primary care through the Medicaid ACO.” A leader of a MassHealth ACO agreed saying, “In my experience with the MassHealth ACO program, I definitely think the way that the Executive Office of Health and Human Services has designed this program in collaboration with CMS, it’s absolutely designed to support investments in primary care.”

A health system CEO added, “I think increasing the rate of payment reform will result in [primary care...
improvements]...Increasing the velocity of that will mean that we will all be incentivized to provide care within our own networks and to do it in a cost-effective way. And the best and most cost-effective way to do it is to have a lot of primary care physicians who provide really good care and who keep their care within the system. That would do a great deal more than any legislation that would pass about spending X dollars or spending Y dollars.”

One interviewee questioned the ability of high level payment reform alone to change primary care practices saying, “The big problem that often happens including in ACOs, is that although the institution is paid with capitation, if they're still paying their doctor based on RVUs, then nothing really happens, right?... We see this all the time where someone might have a creative payment model from the payer to the big entity but then you need to also change how doctors are paid. If they're still paid per RVU, they're still going to be incented to keep turning the wheel and doing more stuff to people and not actually doing the right thing? So I think that's a big, big caveat. And the other one is that the capitation rate has to be high enough. So, many of these capitation programs still are paying 5% of total spend to primary care. This simply isn't enough and doesn't work. Yes, the payment should be capitated, but also needs to be scaled up appropriately so you have the right amount of resources going to primary care.”

A MassHealth ACO leader added, “…if you really want to get to the tipping point of entering a new landscape of primary care driven value-based health care, you need to move beyond financial investment, and move toward changing the foundation of payment methodology. This means getting off the fee for service chassis altogether. Because even if you look at the advanced value-based models in Massachusetts, within Medicare, and Medicaid, and commercial, they are still disproportionately risk contracts sitting on top of a fee for service chassis.”

When asked if APMs create change too slowly to make a difference in primary care practice, one interviewee responded, “It depends on how long your perspective is. I mean, nothing happens as fast as you’d like it to happen. I actually feel like the arc of history is in the right direction. Care is getting better, it is getting better organized. I wish it would go faster, but I think the challenges in getting organized become greater and greater, because there's more and more knowledge, and that leads to more and more specialty type care. But the need to coordinate things, it's not just a financial thing, it's an experience of care thing, for patients and providers. So someone really coordinating things, taking responsibility for coordinating things, I think [primary care investment] is inevitable, and I think it's becoming more and more prominent.”

As direct stakeholders in Massachusetts health policy, interviewees commented specifically on how the issue of primary care investment fits or does not fit into ongoing health policy reform efforts in the state.

Cost Control
Most interviewees agreed that cost control was especially important in Massachusetts including one interviewee who said, “Obviously the cost of health care is a huge problem. Massachusetts is one of the highest spend places in the country...And I think that is problematic in terms of competitiveness for jobs and new businesses. Obviously, Economics 101, spending or cost is price times quality...I think we need to work on both those things...the prices here in Massachusetts are ludicrously high, partly driven by health system monopolies that we've allowed to happen. So I think we need to work on that. But I think also we need to work on how to reduce the need for these big expensive services, and I think primary care is an amazing lever to do that.” Despite an emphasis on controlling health care costs, most interviewees were also very concerned with continuing to work on improving care quality and access to care including one hospital CEO who said, “Everybody agrees the problem is that there's not universal access, the problem is that in most places other than the United States, and I wish that it were here, health care is a basic fundamental human right, all should have access to health care.”

MassHealth ACOs
Several interviewees stressed the relationship between the MassHealth ACO pilots and primary care investments. One interviewee thought that primary care investments are important to the success of the MassHealth ACOs saying “if we want this to work, we
have to think about strengthening the underpinning of the system. That will not work if we don't have a good, strong primary care system underlying it…” Most interviewees commented that primary care payment reform should include both public and private payers including one interviewee who said, “I think it would be completely disingenuous and deleterious to not put your money where your mouth is with your public payers.” One interviewee worried that initiatives to reform primary care spending in particular would be crowded out in the state by more general payment reform initiatives saying, “I do worry about with the Medicaid ACO going on now, that there may not be much of an appetite for this legislatively because we're trying something already...and we want to kind of see the results of Medicaid ACO and does that help. So, that may take precedence over something like [mandated primary care spending levels] legislatively.”

A health insurance industry representative believed that instead of being crowded out, primary care spending could actually become a tool to help the state judge the success of these models saying, “I think the priority of the state is moving to value-based payment. That was part of chapter 224, and what the Health Policy Commission looks at in its Annual Rate Conference hearings. And so I think that this level of primary care spending can be incorporated into that agenda as a way to help reach or exceed those annual benchmarks.”

Large Health Systems and Mergers
Several interviewees commented on the large hospital systems in the state, and the role these systems play in health care spending growth overall. Of the new BIDMC/Lahey merger, one interviewee said Massachusetts will see “a whole set of changes in this market that I've not occurred in many years, as for the first time in 25 years, there'll be strong and effective competition to the largest and most expensive alternative in the market.” Regarding the behavioral health and community health centers investments stipulated by Attorney Maura Healey and mandated by the terms of the merger, one interviewee did not believe that these new investments would improve primary care investments enough saying, “I think if one looks to the BI/Lahey ultimate spend, it's not going to be a whole heck of a lot in primary care, or community-based services. It'll do more than they would have done if Maura Healey hadn't stepped in, but we're not going to bring it up to 10 or 12%.”

Framing the Discussion
Many interviewees worried that working to increase primary care spending would be solely about improving physician pay rather than facilitating delivery system reform, and many suggested that the focus should be explicitly on building primary care teams capable of meeting community priorities. As one interviewee put it, “I think the most important thing is to first take a step back and say, ‘What is your goal of potentially increasing primary care spending?’ And the goal could be one of several types. One is, ‘We want more people to go into primary care, and if we increase primary care spend, you'll probably increase their salaries, so maybe we'll attract more people.’ The second one is improving the primary care experience in patients, in terms of service delivery, access, and all that sort of stuff. A third one, which I think is more important, is, ‘By increasing primary care spend, can we achieve system-level policy goals? So, is this a mechanism by which we can improve population health, by which we can impact the growth rate in overall spending, by which we can do a better job of holistically caring for patients...?’ And I would say I don't think the first two issues are unimportant, but the overridingly important part is the third issue, and simply toggling up the amount of spending is not sufficient to achieve the third aim.”

Making a similar point, one interviewee said, “I feel like primary care is the wrong unit of analysis. What really matters is what's happening to patients. And I think that health care is a good thing. I'm for health care. I feel like we're spending enough on health care. It's crowding out so many other things that we need, like housing and schools and stuff like that. So, I don't want Massachusetts or other states to spend more on health care than they already spend. So that means either we're going to have to have the fight among health care providers about who gets paid more, or who gets paid less than they currently get. If that's what life is about, then I guess I'm for primary care people getting paid more and plastic surgeons getting paid less. But I'm hoping that's not what it's about. I'm hoping it's about getting rewarded for working together in meeting patients’ needs in some new and different way than business as usual.”
Community Driven Planning and Initiatives
Some interviewees emphasized a desire to focus on community priorities related to primary care including one interviewee who suggested a “a community needs assessment, and where...forget the label primary care even for a minute, but some real dialogue with patients and families and communities about what they need...what matters to them in terms of their interface with the healthcare system, and if you want to focus on primary care, it would be [as] their first interface, you know, where they regard the beginning of contact and the coordinator center and the people that, kind of, the go-to support systems and I'd love to know what people say about that.” Continuing, the interviewee said, “...To me there's a lot of value here in narrative and in real serious exploration and empowerment of local communities. If that led to a recognition of a need for statute or regulation, of course, I mean, that should be on the table but I wouldn't necessarily be getting there. Without a vision, we wouldn't know what laws to write.”

Coalition Building and Potential Supporters
Of the interviewees who supported increasing primary care spending, most agreed that coalition building was an important first step including one ACO leader who said, “I think Massachusetts has this spectacular track record of saying, we've got a goal, we're going to put a stake in the ground and get to that goal. We're going to get all of the right people together with legislative leadership, and leadership from the executive branch, and define how we're going to get to our goal. I think Chapter 58 was an example of that, as well as Chapter 224, and I think that's an approach that could be used to get to this policy agenda.”

Several interviewees commented that primary care physicians, community health centers, church and faith groups, might be in favor. Some interviewees believed that employers might in favor in primary care investments, particularly if these investments could lower their employee health care costs or reduce absenteeism. A few interviewees believed patient groups might support efforts to increase primary care investment including one interviewee who said, “So I think if you ask patients, 80% of the first contact that people have in health care is with their primary care doctors. And I think if you could radically use some of that funding to improve the experience for patients, don't make them wait, give them bigger teams, more time, they would be very supportive. I don't think patients think our primary care system's all that great, right now. They all like their own doc, but hate the system. It's like Congress. People like their own congressmen, but they hate Congress.

Several interviewees commented on the necessity of building a multi-disciplinary coalition to “to start the discussion, to try to work out some of those issues that we're going to face early on as a multidisciplinary team.”

Interviewees varied in how they believed insurers in the state would react to primary care investment initiatives. Some thought insurance companies might be in favor of primary care investments given primary care's ability to curb overall costs, including one interviewee who said, “I think philosophically many executives of insurance companies are aligned. The big problem is that these are big, ungainly institutions and change is really hard. And one doesn't go into insurance because one is a risk taker.” Another interviewee focused on the relationships of the insurers to the providers saying, “If I were an insurance company, I would say give the risk to the providers and let them decide whether they want to make the investment or not, because the providers are close to what's actually happening, insurance companies are not close enough.” Confirming, a representative from a health insurance advocacy group said, “Again, we're going to oppose the bill if it's just health insurers need to pay primary care [doctors], give them a 20% increase or something. Pay them like you pay neurosurgeons...We're going to oppose that. But what we would support is saying that primary care, whether that's ACOs or [health] systems...that X percent of the operating revenue needs to be directed. We would support that.”

A representative from an insurance plan advocacy group agreed that provider networks and hospitals have more control over where investments go within a health system saying, “I think on the one hand our members would say yes, primary care is at the center of a patient’s health and they should be appropriately reimbursed, but I’m not sure today that health plans have as much control over it as you would think.” Continuing another insurance industry representative added, “As we moved towards more APMs, the plans really don’t necessarily have a say in the percentage of
the payment that go to primary care. If you pay on a global basis, the system really makes the determination. The plans wouldn’t necessarily have as big a role…”

Specific Actions
If interviewees thought primary care spend was worth advocating for, many believed that examining efforts to increase primary care spending in other states was another important first step. One interviewee wanted to look at “what has worked in Rhode Island, what hasn't worked in Oregon. So, looking at other states and the models of what's happened so far. I think a lot of it is then just taking whatever comes out of that work group to start to think of other stakeholders and refining what legislation we're trying to work on.”

Several interviewees commented on the need for specific projections and estimates to build the case for primary care investments. According to one legislator, “I think we need to get all of the data and information compiled in a way that people can understand it. We need to prove that we’re right about primary care, and if we're right, we need to present in a way that people can understand what we’re telling them. And I think we also have to know what the ramifications of doing that are... in other words what is going to change in other aspects of health care if we were to take 5% away from specialized medicine for example and give to primary care. What would that look like and what would happen to those other segments? We really have to know what the changes would look like because so many people are affected. Legislators especially get really concerned when it looks like we’re going after the largest employment sector in Massachusetts. What is that going to mean for people and our fiscal health as a state? And we need to make sure we have what we need so that we can explain and develop policy that makes sense, that isn't going to create a series of unintended consequences, or be presented and then right out of the gate people tell us, ‘This isn't going to work, this isn't going to work, this isn't going to work, and this isn't going to work,’ because we haven't thought the issues through.”

One interviewee stressed that any definition or measurement of primary care should be constructed with ample consideration from communities and allow for enough flexibility to accommodate the unique needs of various regions and cities within Massachusetts. With that perspective, the interviewee thought advocates should “Take...Pittsfield or Greenfield or Roxbury and say what is the configuration of resources that would be needed to really do what matters to people and to meet them where they are, [un]til we create a smooth flow and coordinated system of care. I would treat it as a matter of design. And until we have that design in mind, ...what the care system... should look like...I don't think we know what to do. Once we have that in mind, then we can ask questions like, well, what would be the changes in funds flow and payment mechanisms that would allow this to merge and maybe, what statutes or regulations would better support it. But I think it's better to begin with vision and with a sense of designs that are fit for purpose.”

While many interviewees agreed that experimenting with simply measuring primary care spending would be a good first step, one MassHealth ACO leader expressed some skepticism that measuring alone would provide enough incentive to change patterns of investment saying, “For many years now, The Health Policy Commission has published all sorts of information about spending by health care system. I'm not sure if publishing of this information has changed the trajectory of spending by these organizations. So if the idea is that publishing the information creates an imperative to change, I don't think that that has proven to be true in Massachusetts so far. I think there's some evidence that consumers equate higher costs with higher quality, so some people feel that publishing the information has the opposite effect.”

Obstacles

Hospitals Unlikely to Support Efforts to Direct Their Spending

Most interviewees did not believe that hospital systems would support efforts to mandate the level of primary care spending including one interviewee who said, “I think it is fairly clear that there's no extra money out there. So if we're going to be putting more money into primary care, the money has to come out of somewhere else, right? It's hard to imagine that anyone's going to raise taxes or whatever to be able to do this. So the obvious place for this money has to come out of is the hospital.”

One interviewee added that “hospitals clearly are feeling for good reason, over-regulated and over-
measured. They have enormous burdens of reporting and compliance that, I think, they’re right about that. So, I think they are legitimately asking for more focus, more parsimony, more thoughtfulness about what is being measured and in what their reporting requirements are...So, because of that background, not because of the relationship to primary care, I think you'll find hospitals pretty skeptical about adding additional burdens of reporting or metrics.” One former health system network CEO agreed adding, “we certainly would have opposed [mandatory levels of primary care spending.] Things are complicated enough, making things work without an outside force regulating how to do things, and how to pay people. I think that providers need flexibility in what they do, and they need the right market forces to make them do good things, but then they need flexibility to do it. So I'm against nursing ratios, staffing ratios. I'm against telling us how we have to pay anybody.”

Another interview anticipated the reaction of hospitals saying, “If they see this as taking money away from them, they will react pretty negatively. I mean, they'll frame it well, and you know just to think narrowly at a place like the BI or Partners, there's a...level of understanding at the highest levels of the importance of primary care. Nonetheless, when they come back to their boards of trustees, and so forth, and are being told, well, the Commonwealth is requiring us to reallocate monies from our new surgical suits to primary care supports, the boards of trustees are going to be really unhappy about that. So, I think the big players are going to come out of hiding if there's a substantial decrease in their income as a result of a reallocation to primary care.”

One interviewee emphasized how important the hospitals are in Massachusetts saying, “Frankly, these are the folks that have in many ways driven the debate about how do you get, and allocate healthcare funding. And these are really good institutions...I don't think they're bad institutions at all, but they are the big players who really drive the investments in here, and needless to say, that investment, therefore, is much more into hospital care, and some specialty care, and then into primary care.”

Given these incentives for hospitals and provider networks, one insurance industry representative added, “That’s why you need the...legislation...because the money center is always going to be in the orthopedic area or another specialty area...I think the way they make money is unfortunately not through primary care, it’s through complex surgeries and complex patients that are generally seen by specialists that are very highly paid. Unless the legislature or Congress were to say you need to pay differently, I don't think [primary care is] ever going to be top man on the totem pole.”

Division in Physician Groups
Many interviewees pointed out that specialist physicians have little incentive to support primary care investments, particularly if such investments were viewed as taking away revenue from specialist practices. As one interviewee said, “Medical groups that are made up of primarily primary care providers are going to be an ally versus large multi-specialty groups and hospital systems where that may impact their revenue in certain parts of the organization negatively.” In talking about their particular multi-specialty physician advocacy group, one physician recounted a visit to their national office by a primary care spending advocate who received a “lukewarm reception” because the group is “working its tail off to increase its attraction to... sub-specialists. Now traditionally, the [group] has been far more generalist oriented...but the last decade, we really worked to get the pulmonologists, the cardiologists, and so forth involved too. So, that lead to a somewhat lukewarm response to the question of are we interested as a national organization in supporting increased primary care spend.”

Time Frame
One primary care disruptor CEO advised advocates to take a long term view of reform commenting that “one of the big mistakes people make a lot of times in health policy is they expect change too quickly. We too often have the experience when we [reform a primary care] practice and three months later, are asked ‘Where are your results?’ The obvious answer is, ‘It's only been three months, you idiots.’ We're trying to change behavior. This is really hard, trying to fundamentally change behavior of both doctors and patients. Thinking that'll happen when we snap our fingers is fooling yourself...We have to think of this in terms of 5 or 10 years, not one or two.” The primary care disruptor CEO continued adding, “The other caveat that we've seen over and over, by the way, is that when you do the right
thing by increasing resources to primary care, in the beginning, total cost may actually go up. Because you pick up a bunch of underuse...If you are doing the right thing with these extra resources, you start finding things and then should deal with what you find. For [example] finding out about childhood trauma or screening tests people have not had. Eventually, it all pays off, but you need to have a long enough time horizon to be able to ride that out.”
A Strategy to Increase Primary Care Investment in Massachusetts

Several states have taken steps to more actively manage and direct primary care spending in their states, and primary care advocates in Massachusetts are interested in exploring how Massachusetts can encourage investment in its primary care system.

Problem Statement
Quality primary care is associated with lower overall healthcare costs, better healthcare outcomes, and more equitable access to care. Despite this central importance, primary care in the United States faces a workforce shortage, burnout among providers, and an increasing workload arising from increasingly complex and chronically ill patients. Underlying many of these issues is the central problem of chronic underinvestment in primary care systems and primary care teams. Parts 1-3 of this report summarized the national discussion on these issues. Parts 4-6 focus on primary care investment in Massachusetts.

Commercial insurers in Massachusetts typically spend just under 7% of all health spending on primary care. As the “logical basis of an effective health care system,” primary care in Massachusetts is essential to supporting the state’s multiple experiments in cost control, payment reform, and delivery system reform. Primary care practices need to be investing in developing the kind of teams they will need to tackle the evolving needs of the Commonwealth, and chronic underinvestment hurts their ability to serve Massachusetts’ patients and communities.

Several states have taken steps to more actively manage and direct primary care spending in their states, and primary care advocates in Massachusetts are interested in exploring how Massachusetts can encourage investment in its primary care system. Proposals that directly address the state’s level of primary care investment have been slow to materialize.

This report was prepared for the Harvard Center for Primary Care in order to help the Center advise other primary care advocates in the state of Massachusetts. Part 6 of this report will attempt to answer 2 central questions:

1) How can primary care spending be increased in the state of Massachusetts? Which approach might be best for the state?
2) What does the path forward look like? How should advocates begin the process of advocating for action on primary care spending in Massachusetts?
Several key findings from both this report’s background research and pilot studies emerged.

**The Value of Primary Care Teams**
Most interviewees agreed that the future of primary care should involve more team-based care, particularly teams capable of more actively addressing the social determinants of health in patient populations. Most interviewees emphasized the particular importance of behavioral health integration in primary care settings, particularly in Massachusetts where rates of access to behavioral health and substance abuse care were concerning to many interviewees. Importantly, these team arrangements should be flexible enough to allow for adjustments tailored to the unique needs of communities.

**Primary Care Payment Reform Is Central to Primary Care Delivery Reform**
Most interviewees commented on the close relationship between payment and delivery reform in primary care. Many interviewees believed that system-level payment reform, i.e. capitation, ACO arrangements, and bundled payments, would support system-level investments in primary care. Others added that capitation at the level of primary care practices themselves allows for the flexibility needed to invest in appropriate teams tailored to the needs of a patient population.

Massachusetts has placed a great deal of time and energy into experimenting with alternative payment models (ACOs, bundled payments, capitation). The MassHealth 1115 waiver experiment with ACOs has shifted many Massachusetts residents into a capitated system, and delivery System Reform Incentive Payment (DSRIP) funds that have come with the waiver have supported investment in transitioning MassHealth plans into the ACO model. The state is dedicated to making sure these pilots are successful.

Many interviewees believed that ACOs, bundled payments, and system-level capitation will lead to primary care investments. However, some interviewees doubted that the magnitude of investment will be enough to support large scale reform of the primary care team. Payment reforms is not a new concept for Massachusetts health entities, but primary care spending remains at less than 7%.

**Cost Control is Priority #1**
While policy makers and health systems in Massachusetts remain committed to improving the quality of their care while promoting equitable access to health care, ultimately cost control is a top priority for the state. Care in Massachusetts is more expensive than in similar states, and the state is looking to correct the factors driving these high prices.

Many of the disagreements in health policy over the past several years have ultimately come down to a question of how they would affect health care spending. The Partners mergers, the BIDMC-Lahey merger, and the nursing ratio ballot initiative of 2018 eventually all came down to decisions about how these actions would affect spending growth. A determination that something will raise health care spending is a powerful trump card in Massachusetts health care policy.

**Ongoing Responses to Crises**
The attention of the legislature in the 2018 session was dominated by securing reproductive rights, fighting the opioid epidemic, and zeroing in on exploding pharmaceutical costs. These crises were politically salient to constituents and forced a quick response from elected officials and health policy leaders. Access to behavioral health is still a central issue for policy makers, and any push to expand primary care should include careful attention to how such investment incorporates integrated behavioral health.

**Hospital Mergers and Community Hospitals**
The Massachusetts provider networks and hospitals compete aggressively with each other, and many of the networks have attempted to merge in recent years. These mergers have been contentious and have attracted a deal of public attention. Interestingly for primary care, the BIDMC/Lahey merger negotiated with the state at the end of 2018 actually required the new health system to invest in community health centers, mental health services, and primary care. The financial struggles and closing of community hospitals are salient issues in Massachusetts, and many of the large provider networks and hospitals have received unfavorable press coverage for their role in health care consolidation in the state. The issue of community hospitals was also a wedge between the House and Senate during the 2018 session, and the issue of financial support for small hospitals will come up again in 2019. Given that the large hospitals are accused to limiting access to care by boxing out smaller hospitals, these provider networks may be looking for opportunities to show their commitment to their communities.
Primary Care Spending
Proposed Policy Options

Using the key findings from Parts 1-5 of this report, three policy options were selected for consideration including a full legislative push, rate reporting by the Health Policy Commission (HPC), and primary care spending evaluation within the state’s ongoing 1115 Waiver.

Full Push: Legislative Mandate to Measure
National primary care organizations have made primary care investment a priority and have invested in building state-level initiatives on the issue. The goal for these initiatives has been to write legislation that requires state entities to measure, report, and then regulate the percentage of all health expenditures that go towards primary care. By measuring and regulating primary care spending, advocates want to build the primary care teams necessary to deliver quality, holistic care.

In Massachusetts, one way that primary care investment could be increased is by legislation that requires the Health Policy Commission (HPC) to 1) establish a definition of primary care for Massachusetts, 2) set an acceptable threshold for healthcare entities and ACOs that does not involve increasing overall spending, 3) require performance improvement plans (PIPs) for healthcare entities found to be in non-compliance, and 4) levy fees for non-compliance in same way the HPC does for healthcare entities out of sync with the state’s established growth rate.

This approach is supported by national primary care groups, and a legislative task force has been assembled out of a Massachusetts legislator’s office. The group, composed of primary care experts from around the state, held its first meetings in March 2019. The filing deadline for the Massachusetts Legislature is 5 p.m. on the first Wednesday in December, so the task force would most likely be looking to introduce legislation in December 2019 at the earliest. Each year roughly 6,000 bills filed in the House and 2,000 are filed in the Senate. An example bill from Vermont is provided in Appendix 5.

HPC Report Out: Measurement and Reporting
The Health Policy Commission (HPC) compiles an Annual Report on Cost Trends that is highly influential in setting the health policy priorities for the state. Another way to increase primary care investment is to ask the HPC to begin tracking and reporting annually on primary care spending by large healthcare entities.

The HPC’s mandate as established by statute is to “(i) set health care cost growth goals for the commonwealth; (ii) enhance the transparency of provider organizations; (iii) monitor the development of ACOs and patient-centered medical homes; (iv) monitor the adoption of alternative payment methodologies; (v) foster innovative health care delivery and payment models that lower health care cost growth while improving the quality of patient care; (vi) monitor and review the impact of changes within the health care marketplace and (vii) protect patient access to necessary health care services.” Under clause (ii), the HPC likely already has the authority to start measuring and reporting on primary care spending.

Publication of primary spending levels by different health care entities in the state might be expected to spur competition between the groups. In Rhode Island, data on primary care investments by health care entities is made public each year in a report and serves a way for regulators and the public to evaluate the performance of plans. In Massachusetts, publication of primary care spending could be used to evaluate the commitment of the state’s health care entities to primary care. Especially given that the Attorney General recently required BIDMC/Lahey to promise they would invest in community health centers, behavioral health, and primary care, this spending level could be used by the state to evaluate health plans on their commitment.
to primary care and expanded access to services in communities. If the HPC were to begin measuring and reporting primary care, the first task would be to establish a primary care definition. Ch. 224 has a preliminary definition of a primary care physician as “a physician who has a primary specialty designation of internal medicine, general practice, family practice, pediatric practice or geriatric practice.” This is a very broad definition that would need to be refined. The first step in this process would likely be to create a primary care spending advisory board within the HPC to guide the creation of a definition and support data collection. Several definitions are available as starting points, either from other states or from research published by the Milbank Fund.

Once a definition is established, the Massachusetts All Payer Claims Database and federal databases for Medicare spending likely already have enough information to calculate primary care spending by the state’s health care entities. Logistically, the HPC has its own research staff and is provided information by its sister agency Center for Health Information and Analysis (CHIA) and has the capacity to do these calculations.

The HPC Annual Cost Trends Report comes out each year in March, and the Commission hosts its Cost Trends Hearing in October. If the Commissioners could be persuaded to start a working group, it is reasonable that preliminary spending levels could be made available for study and discussion by the Cost Trends hearing in October 2019. The HPC has the authority to require PIPs for health entities out of compliance with the health spending benchmark, but it would likely require additional legislative support to levy a PIP based on primary care investment.

Importantly, the HPC does not often actively guide or advocate for specific aspects of health care reform. The HPC serves as an expert advisory body and is rightfully guided only by concrete data and system-level goals. The HPC’s connection to primary care would be exclusively through primary care’s ability to address goals set by the Commission including addressing the social determinants of health, improving quality, and preventing unnecessary utilization. It is possible that measuring and reporting may serve as a first step as advocates build momentum for larger legislative efforts.

**MassHealth 1115 Waiver**

Massachusetts’ 1115 Waiver from the Centers for Medicare and Medicaid Services was approved in 2016, and was a huge achievement for Governor Baker and his administration. Nearly 800,000 MassHealth beneficiaries were enrolled in the new ACOs, and it is expected the findings from these ACO experiments will have national implications for Medicaid programs.

Primary care investment in Massachusetts might be increased if primary care spending levels could be more precisely specified within these new ACOs through amendments to the waiver.

CMS, through its authority to test and develop new models of healthcare payment, has permitted Vermont since 2016 to experiment with an all-payer (Commercial, Medicaid, and Medicare) ACO model. New legislation before the Vermont legislature introduced January 26, 2019, would require the state’s health advisory body to measure and report on primary care spending by health care entities in the state, including the state’s new all-payer ACOs. In Massachusetts, the state might also consider requiring its new MassHealth ACOs to report on their primary care spending. If the state were able to measure the spending on primary care by its new ACOs, the spending level could be another way of monitoring the progress of these ACOs on redirecting spending into high-value activities like primary care.

The Massachusetts 1115 Waiver has 5 goals: (1) Enact payment and delivery system reforms that promote integrated, coordinated care; and hold providers accountable for the quality and total cost of care, (2) Improve integration of physical, behavioral and long-term services, (3) Maintain near universal coverage, (4) Sustainably support safety net providers to ensure continued access to care for Medicaid and low-income uninsured individuals, and (5) Address the opioid addiction crisis by expanding access to a broad spectrum of recovery-oriented substance use disorder systems.
The MassHealth ACOs are a huge priority for the state. If the concept of primary care spending levels can become attached to the MassHealth ACO movement, it may be able to tap into the momentum around the project. Primary care spending, as yet another way to monitor the progress of the ACOs, might become a valuable tool for legislators and regulators. Within ACO models using capitated payment models, it would likely be possible for health entities to compile and report on how much of their overall “lump sum” is going towards primary care practices. This data could also help the state know how capitation is changing patterns of investment within ACOs.

The Massachusetts Department of Health and Human Services (HHS) and MassHealth likely already have the authority to request data on spending, and the HPC and CHIA likely have capacity to compile and analyze data. However, the first pilot MassHealth ACOs were not rolled out until March 2018, so the actual data on the new model’s performance may be forthcoming.

The state is likely not willing to make any changes to the actual 1115 waiver at this time to make primary care investment a more formal requirement for the new ACOs. However, Massachusetts HHS and MassHealth might be open to collecting and publishing data on primary care investments in their new ACOs. Particularly if the data suggests the model is deepening investments in primary care, the state could use this data to prove the waiver is achieving its goals.

Massachusetts’ Section 1115 is evaluated by the state on a yearly basis. Primary care spending levels might fit underneath several goals of the waiver, including the waiver’s commitment to support delivery system reform and improve integration of care. The draft evaluation plan for the waiver already specifies that the waiver will be evaluated on its ability to promote engagement with primary care services, and it may be a natural fit to begin examining how the ACO transition affects primary care investments within these new healthcare entities.
Criteria for Evaluating Policy Options

**Impact:** Will this option increase primary care spending in a meaningful way?

- An effective intervention must increase the actual percentage of health expenditures directed into primary care services. It must do so in a way that allows practices to build teams capable of responding to the specific needs and priorities of communities.
- Raising primary care spending can be easy if a very broad definition is selected, and an effective policy option will result in additional funding for practices providing care consistent with Barbara Starfield’s 4 Pillars of Primary Care.

**Time:** Will this option increase primary care spending in a timely manner?

- An effective intervention should be able to be implemented with 1-2 years. Primary care systems are already stressed in Massachusetts, and ongoing neglect of the system will hinder overall health reform efforts in the state.
- Health systems and hospitals are currently in the process of adapting to the state’s new APMs, and failure to act at this stage could allow the systems to develop without adequate attention to primary care.

**Feasible:** How difficult is this option to implement? How strong would support for this option be among stakeholders?

- An effective intervention must be capable of gathering a large coalition of supporters from Massachusetts’ multiple health policy constituencies. Hospitals, insurers, providers, and legislators must be on board or at least neutral to the policy change.
- The support of the HPC is especially critical given the body’s influence with other health policy stakeholders in the state.
- Health policy is a high stakes issue in Massachusetts, where the most important issue to voters is health care and hospitals are some of the largest employers in the state. A feasible option does not hurt hospitals or pit lawmakers against hospitals.

**Synergy:** How well does this option fit into the already ongoing health reform efforts in Massachusetts?

- An effective intervention will need to align with the state’s existing goals for healthcare reform. The state is very focused on cost control, alternative payment models, and the response to the opioid epidemic. A good solution takes advantage of the momentum and resources surrounding these issues.
- The Massachusetts’ health policy landscape is crowded and fast-moving. It is also very difficult to cut through with an entirely new idea. An effective solution pairs well with ongoing trends in health care reform for the state.
Each policy option was evaluated on each decision criteria using a Decision Matrix (Appendix 4). While each option approaches primary care spending in a slightly different way, each course of action emphasizes the need to begin collecting data on primary care spending in the state in some way. Each policy option selected also explicitly views primary care spending as a way to advance primary care teams rather than reimbursement rates or salaries for primary care providers themselves.

Each policy option presented would start the process of generating the data needed to show if and how primary care investments are actually changing in the state. This data would also facilitate research to investigate how primary care investments affect the fiscal success of health systems as well as population health outcomes for patients cared for by a health entity.

A legislative approach would seek a mandate from the State House to begin measuring and regulating spending, while the second and third policy options would work with Massachusetts state agencies to begin generating primary care spending data. Once the state begins measuring primary care spending, advocates would then have the opportunity to think about ideal ways to begin using that data to increase investments in the state.

Based on the decision criteria selected, the most viable path to begin generating data on primary care spending was determined to be through the existing research activities at the Health Policy Commission (HPC). The Commission likely already has the data available to begin analysis as well as the research capacity to generate quality information (feasibility, time). Given that this policy option did not involve any actual penalties for health entities not increasing their investments in primary care, this policy option did score slightly less than a legislative push with regard to spur new primary care investments (impact).

The HPC may also be open to measuring and reporting primary care spending, as the measure fits closely with their existing goals (synergy). The Commission’s Annual Goals include explicit attention to better addressing the social determinants of health within Massachusetts’ health care systems, and primary care is an important part of doing this. A primary care measure could be a part of monitoring how health care entities are investing in their community-level primary care services.

The HPC is an un-biased group of health policy experts, and they will not be open to any measure or initiative that is not based on solid data and aimed directly at community-driven priorities. The HPC also would also be very unlikely to support any initiative that is seen as advancing the interests of any particular physician group over another.

Rather than directly mandating or regulating primary care spending rates as has been done in other states, measurement by the HPC begins the process of generating data that could give health entities an opportunity to demonstrate to state authorities how investments are being used to support primary care teams providing comprehensive care in line with the state’s priorities.

It is possible that generating this data will not provide enough incentive on its own to alter investments in health care systems. Additionally, as a newer measure to Massachusetts, some understandably doubt the usefulness of the primary care spending level in assessing commitment to population health or state-level priorities like the expansion of primary care teams and behavioral health integration. However, given the absence of other good measures in the state to track investments within health entities, primary care spending levels could help policy makers better track if health entities are actually making significant investments in line with state priorities.
Final Recommendations

Among the different policy options available, this report recommends starting by measuring and reporting the primary care spending rate for major health care entities in the state with the help of the Health Policy Commission.

Policy Recommendation: In order to start gathering data on how the primary care spending rate can be used to measure investments being made in primary care services and teams across the state, advocates should begin by asking the Massachusetts Health Policy Commission to begin measuring and reporting on primary care investments.

Rationale: Quality primary care services serve as the base for cost-effective health care systems, improve health care outcomes, and support equitable access to the health care services. While primary care serves as the base for quality systems, Massachusetts spends less than 7% of all health expenditures on primary services. In order to build and strengthen the quality primary care teams the state needs, primary care investments by health care systems should be deepened.

This report recommends using the primary care spending rate as one lever by which to begin the process of deepening those investments. Among the different policy options available to begin using the primary care spending rate in Massachusetts, this report recommends starting by first measuring the primary care spending rate for major health care entities in the state through research activities at the Health Policy Commission (HPC). As the central hub for health care spending data in the state, the HPC has the ability to begin measuring and reporting on primary care spending if the Commission believes this rate plays a role in affecting health care spending trends for the state.

First Steps

Action Step #1: Prepare a report for the Health Policy Commissioners on the Importance of Measuring Primary Care Spending by Health Entities

This report should make the case to the Commissioners that measuring primary care spending is an appropriate way to determine how much health care entities are investing in community-level services. It should also demonstrate how these services are ultimately aimed at promoting cost-effective, quality, and equitable health care.

The report should include a definition of primary care that is actionable and measurable using existing data collected by the HPC and CHIA. It should also report a plan for how to capture non-fee-for-service spending including primary care spending made in capitated arrangements.

The definition of services should be flexible enough so as to support the development of primary care teams that are tailored to support the needs of individual communities. However, it should be narrow enough so as to prevent health care entities from gaming the definition. Given Massachusetts’ low access rates and the fact that many stake-holders particularly value behavioral health integration in primary care, this should be an important part of the primary care teams defined by the measurement.

A legislative task force has already been formed out of a State Senator’s office to begin looking at how to use the primary care spending rate in Massachusetts to deepen primary care investments. A report to the HPC might be an appropriate first step for this group as it begins the process of introducing the primary care spending rate as an advocacy tool for Massachusetts.
The report should provide a specific ask for the Commission, which at this time might be a pilot study on primary care spending by health care entities in the state. This study might help produce more information about existing primary care investments in the state and what further opportunities exist. It would also test the feasibility of a primary care spending measurement while raising awareness by insurers and health care entities on the concept of primary care spending as an indicator of a system’s commitment to primary care. A sample graphic (Figure 15) shows how this data has been compiled for use by policy makers in other states.

Whatever definition of primary care services used by the Primary Care Spending Task Force should be community-led and driven. The group might consider using a community-needs assessment type approach to develop the definition of primary care services. Whatever definition created should support the development of teams that are able to respond to community needs. Each member of the legislative task force might consider nominating a few of their patients to serve on a separate advisory board for the task force. The task force itself should be expanded to include other members of the primary care team aside from physicians including nurses, nurse practitioners (NPs), physician assistants (PAs), social workers, and psychologists.

### Action Step #3: Continue to Build the Evidence Base Supporting the Use of the Primary Care Spending Level

The pilot interview study in this report identified that many stakeholders in Massachusetts did not necessarily believe the primary care spending level was a necessary or essential measure for health care systems. Analysis from other states who have begun using the primary care spending rate has shown interesting observations about the return on investment for primary care spending and primary care’s effect on overall health care cost trends. Measurement of the primary care spending rate in Massachusetts, even in the form of a pilot study, could help demonstrate the measure’s value in tracking and comparing the progress of health entities across the state. Information on primary care spending could be particularly interesting for those looking to learn how payment reform is affecting different health care entities across the state. It may also help legislators better understand the relative commitments of health care systems across the state to community health, behavioral health, and preventative medicine.

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**Figure 15. Example Primary Care Spending Graphs.** Data collected by state agencies in Rhode Island (a) and Oregon (b) show how primary care spending data can be used to monitor spending trends across insurance networks or health entities. Top graph from Rhode Island Office of the Insurance Commissioner, “Primary Care Spending” Jan 2014. Bottom graph from Oregon Health Authority, “Primary Care Spending in Oregon: A Report to the Oregon Legislature,” Feb 2019.
Anticipated Obstacles
This report recommends starting the process of measuring and using primary care spending levels in Massachusetts by asking the Health Policy Commission to measure and report on spending levels. However, advocates should be wary of several potential obstacles as they begin working to generate more data on primary care spending.

The Definition of Primary Care
Before primary care spending can be measured in Massachusetts, a consensus definition of primary care must be reached. Creating this definition is an intensive process and would likely require a work group and a pilot study specifically with Massachusetts health care entities before state officials would be willing to invest as primary care spending as an indicator. The process of creating a definition has to be able to capture non-fee-for-service (FFS) payments and payments made under capitation. The definition also has to incentivize payments that support the entire primary care team, which may not occur if only payments tied specifically to a patient’s primary care physician are tracked. There are many different definitions available from other states that might be used as starting points.

The definition of primary care has been a stumbling block in many states. The easiest definition is likely services provided by a person’s insurance-designated PCP, which would also pick up services from NP/PAs billing under that PCP’s license. However, this definition may not capture behavioral health services, community health workers, or non-FFS payments for other members of the primary care team.

Primary Care Spending Levels Versus Outcome Measures
In Oregon and Rhode Island, advocates have set an ideal primary care spending rate at 10-12% for insurers/health entities. However, in the pilot study contained in this report, some interviewees were skeptical that an ideal primary care spending level exists, and instead preferred measures that more explicitly tracked outcome measures rather than spending levels. Some interviewees believed that correctly aligned financial incentives would lead to primary care investments and believed population health outcomes or spending trends were an adequate way to measure health systems.

Given decades of primary care advocacy, many primary care advocates are skeptical that primary care investments will budge in significant ways even with payment reform. Primary care advocates need to continue building the evidence base to support the idea of an ideal primary care spending rate, particularly on the ability of this spending level to support urgently needed services such as behavioral health.

Measurement of primary care spending in Massachusetts could be an important first step in exploring how a primary care spending level could be helpful to legislators, regulators, patients, providers, and the state’s large health entities.

Shaping the Argument and The Self-Interest Problem
Many of the primary care interest groups in the state are understandably interested in addressing issues such as the primary care pay gap and documentation burdens in primary care. They see these issues as central to correcting workforce trends and realigning system level priorities.

However, there is not a large constituency for these issues at this time in Massachusetts. While other states with larger rural populations or a stronger culture of primary care/family medicine have been able to mobilize around primary care workforce issues, Massachusetts is understandably much more focused on system level cost control while preserving universal access. The argument for primary care investment in Massachusetts centers around primary care’s role in supporting quality care in cost-effective and equitable systems.

Primary care investments support the development of robust primary care teams more capable of providing holistic care in cost-effective settings. If primary care spending levels are viewed as advancing the interests of just primary care providers at the expense of specialist providers or to the exclusion of other members of the primary care team, it will not find support in Massachusetts.

Limited Impact on the Primary Care Pipeline
In states that have measured and regulated primary care spending, it appears that the investments go into supporting the development of primary care medical homes, care coordinators, electronic health records, expanded hours, urgent care hours, etc. While the investments improve the ability of physicians to do their jobs well, the investments do not appear to raise compensation for providers in any consistent way. If the goal of advocates is to impact the primary care pipeline, it may be more valuable to focus on medical education and residency level initiatives or loan forgiveness programs.
Appendices
Appendix 1. The Centers for Medicaid and Medicare Services (CMS) Comprehensive Primary Care (CPC) Initiatives and Alternative Payment Models (APMs) in Primary Care

The Centers for Medicaid and Medicare Services (CMS) Comprehensive Primary Care Initiatives

Federal authorities have also acted in recent years to deepen health care systems’ investments in primary care, most notably through the Center for Medicaid and Medicare Services (CMS)’s Comprehensive Primary Care (CPC) Initiative in 2012.

As Medicare comprises 20% of national health expenditures\textsuperscript{cdlv} and roughly 1/3 of PCPs have patient panels with more than 50% Medicare patients,\textsuperscript{cdli} CMS used its huge influence on primary care spending to bring together providers, commercial insurance providers, and state Medicaid programs to align investments in primary care. States competed to be involved in the pilot and ultimately seven regions were selected.\textsuperscript{cdlvii}

The CPC Initiative expanded into the Comprehensive Primary Care Plus (CPC+) Initiative in 2017 to include 56 payers in 18 regions across the U.S. Participating practices were eligible for care management fees, and performance based incentive payments. One track of participants were eligible to receive a portion of their reimbursement in an enhanced rate lump sum, i.e. capitation, rather than traditional fee-for-service payments.\textsuperscript{cdlviii} The original CPC program was able to double primary care spending for complex patients\textsuperscript{cclix} but produced only moderate savings primarily through reductions in emergency room visits.\textsuperscript{cclx} While cost savings data are still emerging from the new CPC+ initiative, the program’s first annual report\textsuperscript{cclxi} showed participating practices adopting population health tools, tracking social needs, and making use of non-office based care such as home visits, nursing home visits, and telehealth visits. The third Annual Report from December 2016 also showed modest cost savings that varied substantially across regions (Figure 12).\textsuperscript{cclxii}

It was disappointing to some advocates that the CPC pilots did not produce larger cost savings. However, many states and CPC regions saw their private insurers eager continue in the program given improvements in the quality of care provided and high levels of provider satisfaction with the program.\textsuperscript{cclxiii} Given that primary care and preventative medicine success is often achieved on a longer time frame than was allowed in the CPC pilots, it may be that health systems and providers observed improvements not captured by simple cost savings measures.

For states looking to deepen primary care investment, participation in the CPC+ program represents another avenue for spurring investment.

![Figure 12. Probability that CPS Achieved Savings During the First Three Years. Graph from the 2016 Mathematica Evaluation of the Comprehensive Primary Care Initiative: Third Annual Report.](image-url)
Alternative Payment Models (APMs) refer to a movement within health care in general to reform the way in which providers and hospitals are reimbursed for the care they provide. Traditionally, reimbursement has been done in a fee-for-service (FFS) manner such that providers are paid for each individual service they provide. The incentive within this system is to provide more visits, more imaging, more procedures, etc. as the system makes money each time a service is provided.

In general, APMs rearrange financial incentives in payment contracts such that health care entities are held accountable for population level spending and/or outcomes. Rather than being paid simply for the volume of services they provide, health care entities must figure out how to invest within their systems to promote value rather than volume.

Accountable Care Organizations (ACOs) are the best example of APMs and have become central to health care reform across the country since the ACA. These organizations, often composed of hospitals, primary care practices, insurers, and sometimes private companies, work together to control costs for their population. If the organization meets its spending target, it is eligible for shared savings payments that are returned to the company from the federal government. ACO arrangements now exist in Medicare, Medicaid, and commercial markets across the country.

Other examples of APMs include bundled payments and capitated payments, both of which have also found their way into some ACO models being experimented with across the country. In bundled payments, provider systems are paid a pre-determined lump sum for a certain service or procedure. If the provider can deliver the service for less than the predetermined rate, they can make more money. In capitated models, a provider network is paid a lump sum for all of a patient’s care in a month or a year. If the provider can deliver health care for that patient for less than the predetermined capitated sum, that provider can make money. Capitation has been especially popular with primary care disruptors like Iora who believe this payment model provides flexibility for primary care practices to adopt to the unique needs of their patients in ways that are not possible under FFS.

Payment reform has long been viewed as essential to overall health care reform, and many believe that correctly executed payment reform will increase primary care orientation in health care systems. If health care entities are being held for population level spending and outcomes, they should have incentives to invest in preventative care and other primary care services.

For example, as an ACO works to earn its shared savings bonus, it might look to reduce unnecessary emergency department visits. Given primary care importance to reducing these visits, the ACO might invest in expanding its primary care office hours or after-hours staff. Similarly, if the ACO wants to avoid costly mental health complications in its population, it might expand behavioral health services available in its affiliated primary care practices.

Beyond simple savings, it has been argued that APMs such as capitation are also essential to improving care quality. Especially in primary care where the needs of patient populations and communities can vary greatly, capitated payments may be one way to give practices the financial freedom they need to invest in services tailored to the unique needs of their population.

As these payment models are incorporated into payment contracts across the country in a variety of commercial, Medicare, and Medicaid markets, evidence is accumulating that in general these models can promote quality care delivered in financially responsible systems. However, especially within ACOs still reliant on FFS, it is unclear that incentives for providers are changing in meaningful ways. Additionally, given that primary care spending as a measure is not routinely available from health care entities, it is not entirely clear that spending within health systems is shifting to support or build primary care to date.
The Massachusetts Context

The 2018 Legislative Session

The Massachusetts Legislature was in session from January 3, 2018-July 31, 2018. The session was dominated by bills restricting access to firearms for those with mental illness, education funding, and a sweeping set of compromises on the minimum wage, paid parental leave, and the Massachusetts sales tax. Health care continued to remain a centrally important topic for the legislature, and the Governor’s proposed FY2019 budget was dominated by MassHealth, which in FY2018 accounted for roughly 40% of the state’s entire budget.

The budget negotiations at the end of session were hurried, and the legislature was unable to come to an agreement between the Senate and the House before the start of FY 2019. While the House, Senate, and Governor all proposed major health care reform language at various points during the legislative session, the budget eventually passed on July 26, 2018, did not contain any major health reform aside from expanded support for efforts to combat the state’s opioid addiction crisis.

The House

The House passed The Honorable Peter V. Kocot Act to Enhance Access to High Quality Affordable and Transparent Healthcare in the Commonwealth near the end of the 2018 legislative session on June 20, 2018. The bill passed 117-32 and was spearheaded by the House Chairman of the Joint Committee on Health Care Financing Peter Kocot before his unexpected death in February 2018.

The law also gave more direction to the HPC with regard to clarifying price variation between health systems and moved the state’s Health Planning Council from Massachusetts HHS to within the Health Policy Commission. This council was once again charged with advising the state on “(i) the anticipated needs of the commonwealth for health care services, providers, programs and facilities; (ii) the resources available to meet those needs; and (iii) the priorities for addressing those needs.” The council specifically provides “recommendations for the appropriate supply and distribution of resources, programs, capacities, technologies and services” on a variety of healthcare topics including specifically “primary care resources.”

The Senate

The Senate passed its health reform package on November 10, 2017. S.2202, titled “An Act Furthering Health Empowerment and Affordability by Leveraging Transformative Health Care,” was passed 33-7 without any Republican votes. The bill was spearheaded by Senator James Welsh and also contained measures to limit “surprise billing” and promote telehealth. The bill also made changes to the Health Policy Council (HPC) including establishing 5 regional Councils to assist the Policy Council in its work and adding a mandate to examine quality measures used in pay-for-performance contracts.

The Senate’s bill also asked the HPC to establish a Hospital Readmissions Benchmark by which to measure the state’s hospitals’ progress on preventable readmissions and granted the HPC authority to levy fines against hospitals found to be not making progress on this issue. The Senate also charged the HPC with a...
variety of programs designed to increase the state’s control and influence over pharmaceutical spending. Though Ways and Means Chairman Karen Spika claimed the bill could save MassHealth $114 million by 2020, Governor Baker objected saying the proposed reforms would not curb MassHealth spending growth. The Senate’s bill made little to no mention of primary care reform aside from clarifications on telehealth regulation.

**Governor Baker**
Governor Baker filed his FY2019 budget recommendations on January 24, 2018. The Governor’s budget reflected his Administration’s continued commitment to reducing growth in MassHealth spending and specifically mentioned the MassHealth ACO demonstrations as central to his cost-curbing plans. The Governor’s plan also contained new proposals for curbing pharmaceutical spending through changes to the state’s negotiations with pharmaceutical companies and increased public reporting related to prescription drug prices.

**2018 Negotiations**
Negotiations between the Senate ultimately broke down primarily over the House’s plan to levy fees on large hospital systems to support community hospitals with some in the Senate alleging undue influence of Partners Healthcare and the Massachusetts Hospital Association (MHA) in decisions made in the House to lessen the proposed fees. The Senate had proposed a rate floor as another way to stabilize community hospitals, but the idea found little support in the House. Baker expressed his willingness to tackle the issue of financially challenged community hospitals, but ultimately, the session closed without reconciliation between the House and Senate versions.

**Previewing the 2019 Legislative Session**
The Health Policy Commission’s Annual Hearing took place in October 2018 and highlighted the agency’s continued recommendation to expand alternative payment models (APMs), control pharmaceutical spending, and expand easy access to primary care and behavioral health services through telehealth and expanded urgent care services. Notably the primary care seat on the HPC turned over in January 2018 with Dr. John Christian Kryder joining the board. Looking forward to the 2019 Legislative Session, both the House and Senate have expressed a desire to take up the issue of health care reform again.

Stabilization of community hospitals and health system cost control are likely to feature prominently as the legislature looks to make progress this year after a disappointing failure to reach consensus in July 2018.
Appendix 3. Interview Script

Pilot Study Interview Script

Preamble
My name is Megan Townsend, and I am a dual degree candidate at Harvard Medical School and the Kennedy School of Government. I am currently working on a thesis project related to the topic of primary care spending. I am particularly interested in learning about your thoughts on primary care investment in Massachusetts.

Primary care faces many challenges including the increasing complexity of chronically ill and aging patients, burnout of overburdened providers, and difficulty recruiting and retaining health professional students. Underlying all of these issues is the problem of long standing under-investment in primary care.

Recently, at the national level, several primary care advocacy groups such as the Milbank Fund and the American Academy of Family Physicians have focused their efforts on increasing the amount of spending by commercial insurers at the state level. Large databases of health insurance claims in many states make it possible to track and measure how much insurers spend on primary care. Data from these databases in Massachusetts suggests commercial insurers are spending just over 6% of all healthcare dollars on primary care.

Some advocates have suggested that this percentage could be higher. States like Oregon and Rhode Island that have taken steps in recent years to regulate and legislate on this issue have been able to raise the percentage spent on primary care in their states to closer to 10-12%.

1. To begin, I am interested in your thoughts on primary care spending in Massachusetts. There are many different issues to be addressed in Massachusetts regarding health policy. **Do you think primary care spending should be an advocacy priority in Massachusetts?**
   a. **If yes, why?**
      i. **PROMPT if necessary:** Is the timing appropriate to begin raising this issue?
      ii. **PROMPT if necessary:** Are there other competing priorities for the legislature or the Health Policy Commission over the next 1-2 years which may take priority over primary care spending?
   b. **If no, are there other issues in health policy that are more of a priority for state at this time?**
      i. **PROMPT if necessary:** Is there anything you believe that could be done to make Massachusetts more ready for legislation/regulation on the issue of primary care investment?

2. Hypothetically, if Massachusetts were to increase its primary care spending in the way Oregon and Rhode Island have in recent years, primary care spending could potentially double. Based on estimates of health care spending in Massachusetts, moving from 5% spend on primary care to 10% spend on primary care could mean that nearly $3 billion could be funneled into primary care. **If it were up to you, how would you spend that money? I invite you to dream big here! How would you use this money to improve primary care in Massachusetts?**
   a. **PROMPT if necessary:** For example, in Rhode Island the new investments tended to end up supporting primary care medical home payments, investments in electronic health records, and the
hiring of new care managers. **If the money in Massachusetts could go toward any part of primary care, where do you think it could be best used?**

b. **PROMPT if necessary:** Other options that have been floated for ideal places for investment include community health workers, nurse managers, loan forgiveness for physicians, infrastructure investments, or even changes to claims based fee for service reimbursement rates for primary care services. **What would you like additional primary investment in Massachusetts to support if you could choose?**

3. As described, there are several states in the U.S. including Rhode Island, Oregon, and Delaware that have passed legislation or set regulations that defined, measured, and then regulated primary care spending by insurers in their states. It has been suggested that primary care spending in Massachusetts might be increased in the state through legislation. This legislation would impact Massachusetts’ large hospital systems, insurers, employers, physicians, allied health professionals, and patients. I am interested in your thoughts on how these groups might react to efforts to increase primary care spending.

   a. To start, what groups or people in the state do you think would be major allies for legislation increasing primary care spending?
      i. **PROMPT if necessary:** What about Massachusetts’ major insurance companies? Hospital systems? Employers? Physicians and allied health professionals? Patient groups?

   b. What groups or people in the state do you think would be major opponents for legislation increasing primary care spending in Massachusetts?
      i. **PROMPT if necessary:** What about Massachusetts’ major insurance companies? Hospital systems? Employers? Physicians and allied health professionals? Patient groups?
      ii. **FOR GROUPS IDENTIFIED AS OPPOSED:** Do you think there is anything that could be done to sway the group’s opinion?

   c. How do you think the groups you represent/are affiliated with would respond to hypothetical legislation increasing primary care spending in Massachusetts?
      i. If unlikely to support, why would this group be unlikely to support legislation to increase primary care investment?
      ii. If unlikely to support, do you think there is anything that could be done to sway the group’s opinion?

4. If you were going to create legislation that would define, measure, and then regulate primary care spending by insurance companies in Massachusetts, what are the key steps you would take to get the effort started?

   **What do you think would be a good next step?**

   a. **PROMPT if necessary:** For example, interested groups in other states have in the past convened their hospitals, insurers, and professional groups at large group meetings to begin discussing the idea together. Others have suggested forming task forces to put together legislative language. Still others have suggested pilot studies to refine and test definitions of primary care. What do you think would be an appropriate next step?

   b. To continue exploring the topic of legislation to increase primary care investments, **do you have any thoughts on whether such legislation should seek to regulate the public payers like Medicaid and Medicare, private insurance companies, or both?**

5. Regarding hypothetical legislation aimed at increasing primary care spending in Massachusetts, are there any key obstacles you would anticipate?
a. Regarding these obstacles, do you have any thoughts on how to face these potential issues?

6. Is there anything else you would like to share with me on the topic of primary care investment in Massachusetts? (as time allows)

7. Is there anyone else you think we should be speaking to about this issue in Massachusetts or nationally? (as time allows)
## Appendix 4. Decision Matrix

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<th>Full Push: Legislative Mandate</th>
<th>Impact</th>
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<td>Legislation aimed at measuring and regulating primary care spending could have a huge impact on primary care spending. Legislation would have to be written carefully to avoid gaming by health care entities, but based on experience from Rhode Island, a legislative approach could have a huge impact on primary care spending in the state.</td>
<td>At the earliest, legislation could be filed for the 2020 session by the filing deadline in October 2019. Before legislation can be written, a clear and operationalizable definition of primary care would need to be decided. Experience in other states suggests this step is an involved process that would probably require a working group of its own. Realistically, the definition might be ready for Fall 2019, but it may take until the 2021 legislative session to get full legislative language together.</td>
<td>Advocates in the state already have a state senator interested in potentially sponsoring a bill on primary care spending. A workgroup to help guide the drafting of language began in March 2019. The concept of regulating primary care spending is a new idea for Massachusetts. Without more data and projection on how legislation would affect spending, it is not clear that hospitals, insurers, and specialist groups would offer anything but strong opposition. As Massachusetts health care entities work to adjust to the state’s changing payment environment, they would likely be wary of anything that regulates how they spend their money. Prioritizing flexibility as important to their ability to compete, hospitals and providers may be nervous about anything that regulates their spending.</td>
<td>Legislation that instructs the state to begin measuring and regulating primary care spending is a new idea for Massachusetts and may not be seen as in step with the state’s current priorities. Massachusetts is heavily invested in its MassHealth ACO pilots, and many assume that these pilots and other alternative payment models (APMs) will lead to primary care investment in the long-term. Legislation aimed at measuring and regulating primary care spending would need to be drafted to show its connection and importance to APM experiments in the state. As one interviewee suggested, legislation might work to make sure that capitated primary care payments amount to a certain percentage of a health system’s overall spend.</td>
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<td>HPC reports have a huge impact on the priorities of legislators and state agencies. If the HPC started collecting and publishing data on primary care spending by health care entities, it may signal to hospitals and provider networks that primary care investments are a priority for the Commission as the HPC works to better address the social determinants of health in Massachusetts.</td>
<td>The HPC has already done preliminary studies using data from the state’s commercial insurers to calculate a primary care spending level. It is likely that the HPC could measure primary care spending and be ready to present it either at its Annual Briefing in October 2019 or for the 2020 Health Costs Report in March 2020.</td>
<td>The HPC likely has the capacity to begin measuring primary care spending. The issue is also likely to importance to the current Commissioners, and it likely they would support at least a trial period of experimenting with the measure.</td>
<td>The HPC would be interested in primary care’s ability to affect overall spending. Given their current agenda, measuring and reporting on primary care might be a natural fit.</td>
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<td>Publication of this data would also make it available to state officials. AG Maura Healey required BIDMC/Lahey to make a commitment to community health centers/behavioral health/primary care as part of its merger, and primary care spending could become another tool for state regulators looking to hold hospital systems accountable.</td>
<td>However, the definition of primary care used by the HPC may differ from definitions used in other states, and it is possible that several primary care stakeholders may wish to clarify this definition before the HPC uses it in a formal way.</td>
<td>The HPC is an independent agency, and its interest in this issue is purely related to its interest in controlling healthcare costs. If this issue were viewed as benefiting just primary care providers, the Commissioners would be likely not support primary care spending measurements.</td>
<td>The HPC has been very invested in promoting APMs in Massachusetts, and the Commissioners are likely interested in seeing how these models are affecting health system spending/investment s. Primary care spending could be an attractive indicator for them that fits well with their current objectives.</td>
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<td>However, the HPC likely does not have the authority to levy fines based on primary care spending. Health care systems may not take the spending level seriously if there is no threat of enforcement behind it.</td>
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<td>The Commissioners likely do not need additional authority to begin measuring and reporting on primary care spending.</td>
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<td>MassHealth 1115 Waiver</td>
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<td>The MassHealth ACOs cover more than 800,000 people in Massachusetts. Moreover, the results of the pilots are likely to have national consequences. If primary care spending within the MassHealth ACOs was measured, it could help raise awareness about how primary care is faring in these new systems. However, given that the ACOs are being evaluated on many different measures, it unlikely that measuring primary care in the programs’ evaluations would drive large new investments at this point in the pilot.</td>
<td>The state reports on progress in their 1115 Waiver projects on an annual and quarterly basis. The criteria for these evaluations has already been set, and it is unclear how quickly a new indicator could be added. Adding an indicator for primary care spending would require a consensus definition of primary care. This would likely take at least a year to develop via a work group.</td>
<td>Adding a new performance measure to the ACO pilots would represent somewhat of a risk for state officials, many of whom have invested many years in the success of the program. Many of these officials would likely be wary of adding a new performance measure at this time. However, these officials might be more open to the idea if it is pitched as a research initiative or a pilot study.</td>
<td>The experiments with APMs in Massachusetts are a priority for state officials, the HPC, and legislators. Most experts in the state hope that these models will help realign health care to promote high value activities like primary care. Measuring investments in primary care in the MassHealth pilots fits directly with the state’s current priorities.</td>
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Appendix 5. Primary Care Spending Bill Text as Introduced In Vermont Senate on January 24, 2019.

Vermont Senate
BILL AS INTRODUCED S.53 on January 24, 2019
2019 Page 1 of 6
VT LEG #336877 v.2
1 S.53
2 Introduced by Senator Ashe
3 Referred to Committee on
4 Date:
5 Subject: Health; Green Mountain Care Board; health care reform; primary care
6 Statement of purpose of bill as introduced: This bill proposes to require the
7 Green Mountain Care Board to determine the proportion of health care
8 spending currently allocated to primary care, recommend the proportion that
9 should be allocated to primary care going forward, and project the avoided
10 costs that would likely result if that proportion were achieved. It would then
11 direct certain payers to provide a plan for achieving the allocation of primary
12 care recommended for them by the Board.
13 An act relating to increasing the proportion of health care spending
14 allocated to primary care
15 It is hereby enacted by the General Assembly of the State of Vermont:
16 Sec. 1. PRIMARY CARE; FINDINGS
17 The General Assembly finds that:
18 (1) Primary care, especially care that incorporates mental health and
19 substance use disorder services, is critical for sustaining a productive
20 community.

BILL AS INTRODUCED S.53
2019 Page 2 of 6
VT LEG #336877 v.2
1 (2) Primary care provides a setting in which patients can present a wide
2 range of health problems for appropriate attention and, in most cases, can
3 expect that their problems will be resolved without referral.
4 (3) Primary care providers and practices assist patients in navigating the
5 health care system, including by providing referrals to other health care
6 providers for appropriate services.
7 (4) Primary care providers and practices facilitate an ongoing
8 relationship between patients and clinicians and foster participation by patients
9 in shared decision-making about their health and their care.
10 (5) Primary care provides opportunities for disease prevention, health
11 promotion, and early detection of health conditions.
12 (6) Primary care helps build bridges between personal health care
13 services and patients' families and communities that can assist in meeting
14 patients' health care needs.
15 (7) Despite significant emphasis on the importance of primary care over
16 the past few years, the dollars needed to support primary care have not kept
17 pace with the need for these services. In order to maximize the benefits of
18 comprehensive primary care, it is essential to maintain consistent, targeted
19 investment over time.

BILL AS INTRODUCED S.53
Sec. 2. GREEN MOUNTAIN CARE BOARD; DEFINITION OF PRIMARY CARE; SPENDING ON PRIMARY CARE; REPORTS

(a) The purpose of this section is to determine the percentage of health care spending that is currently allocated to primary care in order to target appropriate increases to that percentage and plan for achieving those increases over time.

(b) The Green Mountain Care Board, in consultation with health insurers, the Department of Vermont Health Access, and other interested stakeholders, shall identify:

(1) the categories of health care professionals who should be considered primary care providers when the services they deliver primarily constitute primary care services, as determined pursuant to subdivision (2) of this subsection;

(2) the specific procedure codes that should be considered primary care services when billed by a primary care provider, as determined pursuant to subdivision (1) of this subsection; and

(3) the categories of non-claims-based payments to primary care providers and practices that should be included when determining the total amount spent on primary care.

(c) Using the categories and codes determined pursuant to subsection (b) of this section, the Green Mountain Care Board shall determine the percentage of total spending that was allocated to primary care by each of the following in the most recent complete calendar year for which information is available:

(A) each health insurer with 500 or more covered lives for comprehensive, major medical health insurance in this State;

(B) Vermont Medicaid;

(C) the State Employees' Health Benefit Plan;

(D) health benefit plans offered pursuant to 24 V.S.A. § 4947 to entities providing educational services; and

(E) the entire Vermont health care system.

(d) On or before October 1, 2019, the Green Mountain Care Board shall use information from the Vermont Health Care Uniform Reporting and Evaluation System (VHCURES) to the extent available in determining the percentages required in subdivision (1) of this subsection.

Each entity listed in subdivisions (1)(A)–(D) of this subsection shall provide to the Green Mountain Board the entity's non-claims-based primary care expenditures for the most recent complete calendar year for which information is available.

The entities listed in subdivisions (1)(A)–(D) of this subsection, and any other entity with relevant data, shall provide pertinent information in response to all reasonable requests from the Board.
2 report to the House Committee on Health Care, the Senate Committee on Health and Welfare, and the Senate Committee on Finance:
3 (A) the percentage of total health care spending that the Board
determined each entity, and the health care system as a whole, allocated to
6 primary care pursuant to subsection (c) of this section;
7 (B) the percentage of total health care spending that the Board
8 recommends that each of the entities, and the health care system as a whole,
9 should be allocating to primary care in future years in order to fully realize the
10 benefits of primary care, including improved health outcomes, increased
11 patient satisfaction, and reductions in overall health care spending; and
12 (C) a realistic time frame within which to expect each entity to
13 realize the Board’s recommended allocation.
14 (2) On or before the date that the Board reports to the General Assembly
15 pursuant to subdivision (1) of this subsection, the Board shall provide to each
16 entity listed in subdivisions (c)(1)(A)–(D) of this section the Board’s
calculation of its primary care spending and the Board’s recommended target
17 primary care allocation and time frame.
19 (e) On or before January 1, 2020, each entity listed in subdivisions
20 (c)(1)(A)–(D) of this section shall report to the House Committee on Health
21 Care, the Senate Committee on Health and Welfare, and the Senate Committee
Bil
2 on Finance its plan for a plan for achieving the percentage that the Board
determined, pursuant to subdivision (d)(1) of this section, that the entity should
3 be allocating to primary care within the specified time frame. The plans shall
4 not include higher health insurance premiums or an increase to the entity’s
5 overall health care expenditures.
6 (f) On or before January 1, 2020, the Green Mountain Care Board shall
7 report to the House Committee on Health Care, the Senate Committee on
8 Health and Welfare, and the Senate Committee on Finance the Board’s
9 estimate of the total amount of health care costs that would be avoided if each
10 entity listed in subdivisions (c)(1)(A)–(D) of this section increased the
11 percentage of health care spending it allocates to primary care in accordance
12 with the Board’s recommendations pursuant to subdivisions (d)(1)(A) and (B)
13 of this section.
14 Sec. 3. EFFECTIVE DATE
15 This act shall take effect on passage.


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