Primary Care Spend

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WVAFP Legislative Co-Chair

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Credentials

Dr. Hendershot, MD, DC, FAAFP is a past Paul Ambrose Health Policy Fellow.
He trained at Marshall University's Joan C. Edwards School of Medicine with completion of a family practice residency at the same.

He's worked in private practice as a chiropractor from 1996-2004.
As an MD he's served as CMO of a rural FQHC and Past Chair of the WV PCA CMO committee. He's now employed in the WVU Medicine Health System, in Mineral Wells, WV. He follows his patients, including pediatric patients, in the hospital setting, the clinic and on the sideline. He is currently the CMO of OVHC, an SNF owned by WVU Medicine.

Dr. Hendershot has served as Past President of the WVAFP.
He serves as Co-chair of the WVAFP Legislative Committee.
He's currently serving as WVAFP Delegate to the AAFP Congress of Delegates.
He sits on the AAFP Commission on Finance and Insurance, and
serves as a board member of the Family MedPAC

Conflicts

Dr. Hendershot has **no** conflicts of interest or disclaimers to announce and receive no renumeration from any entity for this lecture.

Objectives

After participation in this Systems Based Practice lecture the learner will:

- Consider health care delivery settings and systems relevant to their practice.
- Consider cost awareness and risk/benefit analysis in patient care.
- Be more able to advocate for quality patient care and optimal patient care systems.
- Understand how work in interprofessional teams can enhance patient safety, improve patient care quality, and reduce health care cost.
- Feel more comfortable identifying system challenges and implementing potential systems solutions

Defining the Current Challenges

BY JAMIE DUCHARME MAY 16, 2023 11:08 AM EDT

More than 70% of U.S. adults feel the health care system is failing to meet their needs in at least one way, according to new data from the Harris Poll, shared exclusively with TIME.

WASHINGTON, D.C. -- For the first time in Gallup's two-decade trend, less than half of Americans are complimentary about the quality of U.S. healthcare, with 48% rating it "excellent" or "good." The slight majority now rate healthcare quality as subpar, including 31% saying it is "only fair" and 21% -- a new high -- calling it "poor."

Majority of Americans unhappy with health care system: AP-NORC poll

Politics Sep 12, 2022 1:06 PM EDT

https://www.medpagetoday.com/opinion/second-opinions/103166 accessed 3/10/24

Americans Sour on U.S. Healthcare Quality (gallup.com) accessed 3/10/24

https://time.com/6279937/us-health-care-system-attitudes/ accessed 3/10/24

https://www.pbs.org/newshour/politics/majority-of-americans-unhappy-with-health-care-system-ap-norc-poll accessed 3/10/24

US Health Care Spend

In 2022 U.S. health care spending grew

4.1 %

reaching **$4.5 trillion**

or

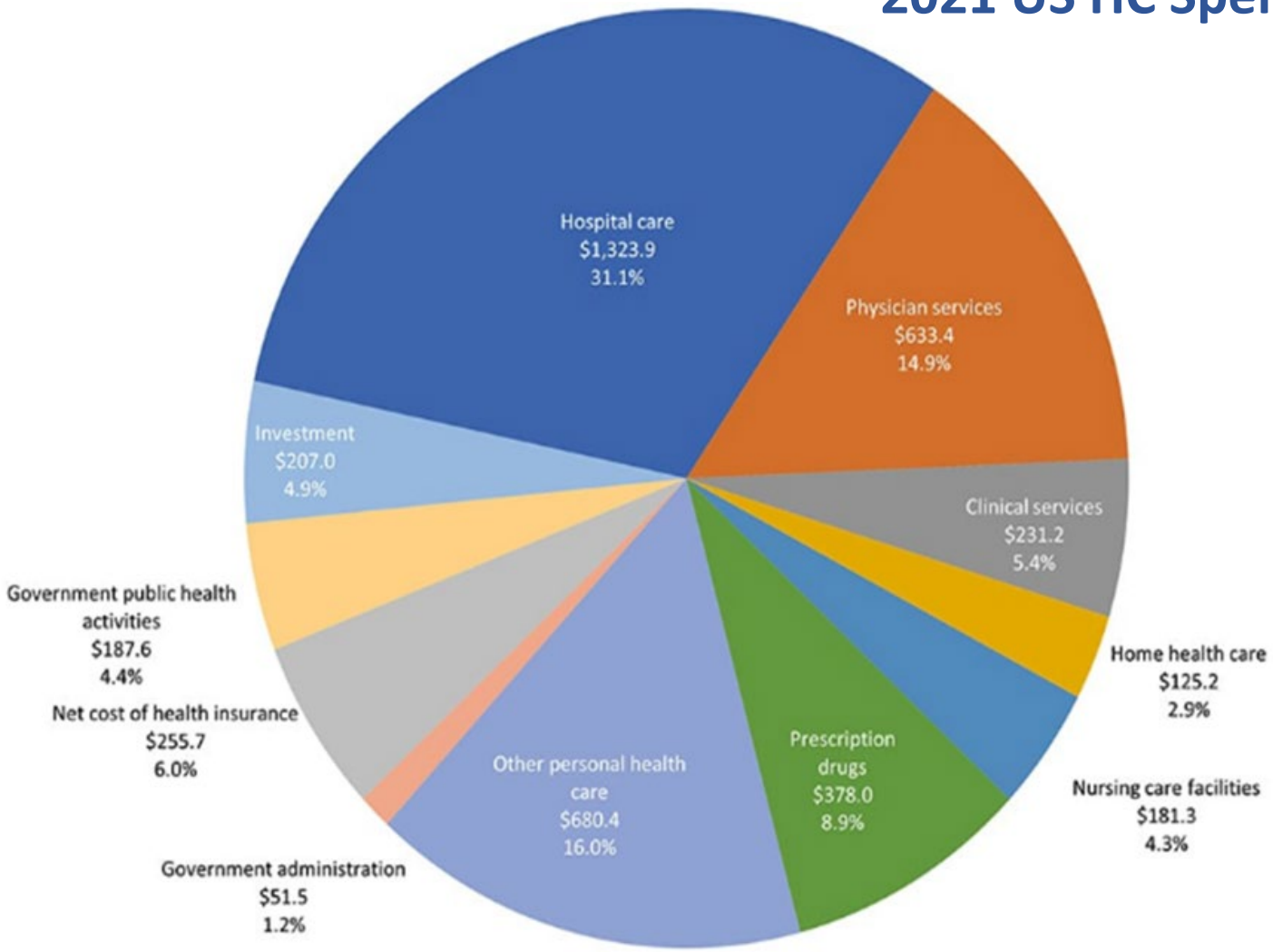
$13,493 per person.

Health spending accounted for

17%

of the nation's GDP,

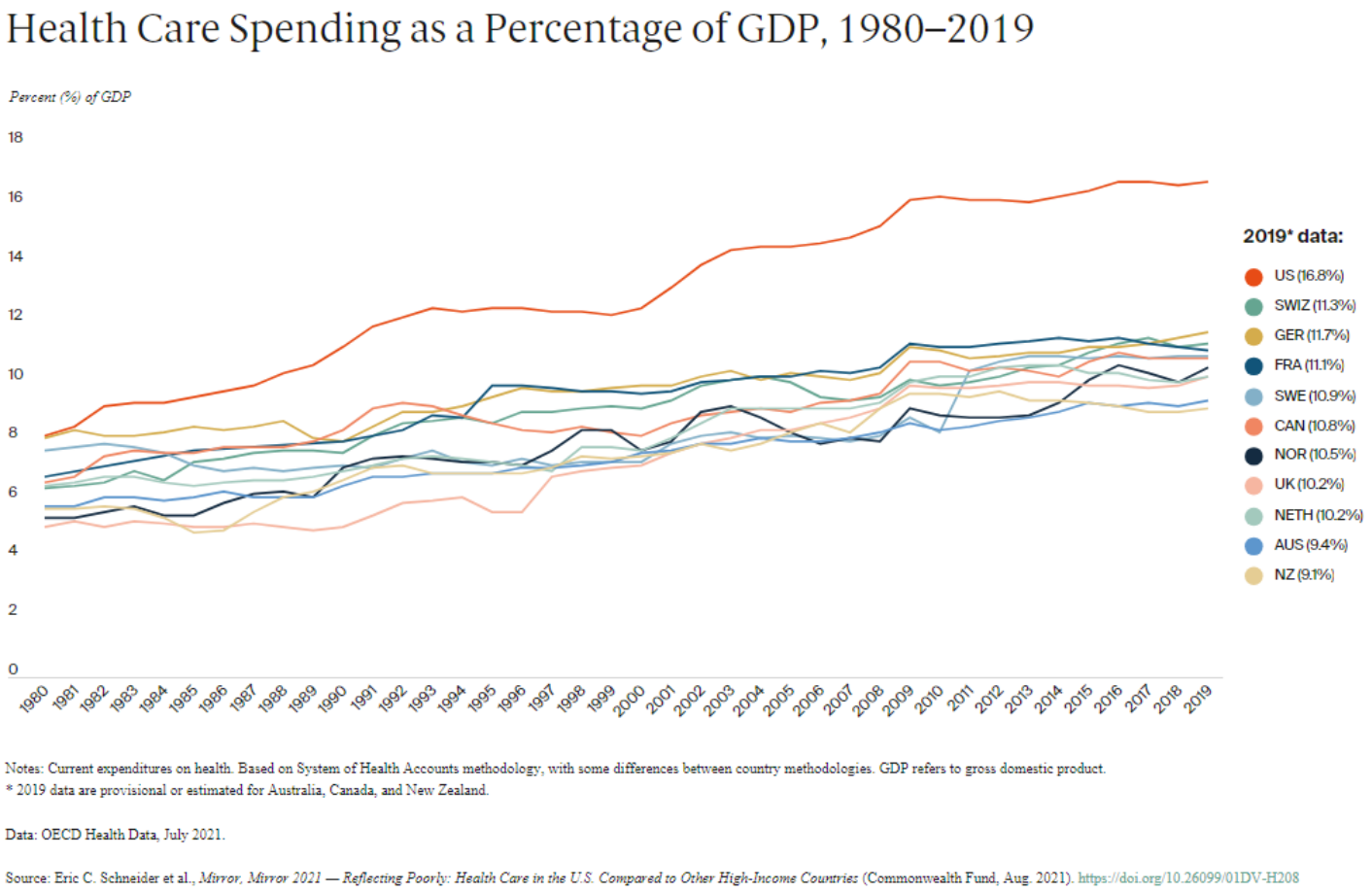
2021 US HC Spend



CMS.GOV accessed 2/3/24

AMA: Trends in health care spending UPDATED MAR 20, 2023

US Health Care Spend



In 1980, most industrialized nations spent between

4-8% of GDP

on Healthcare

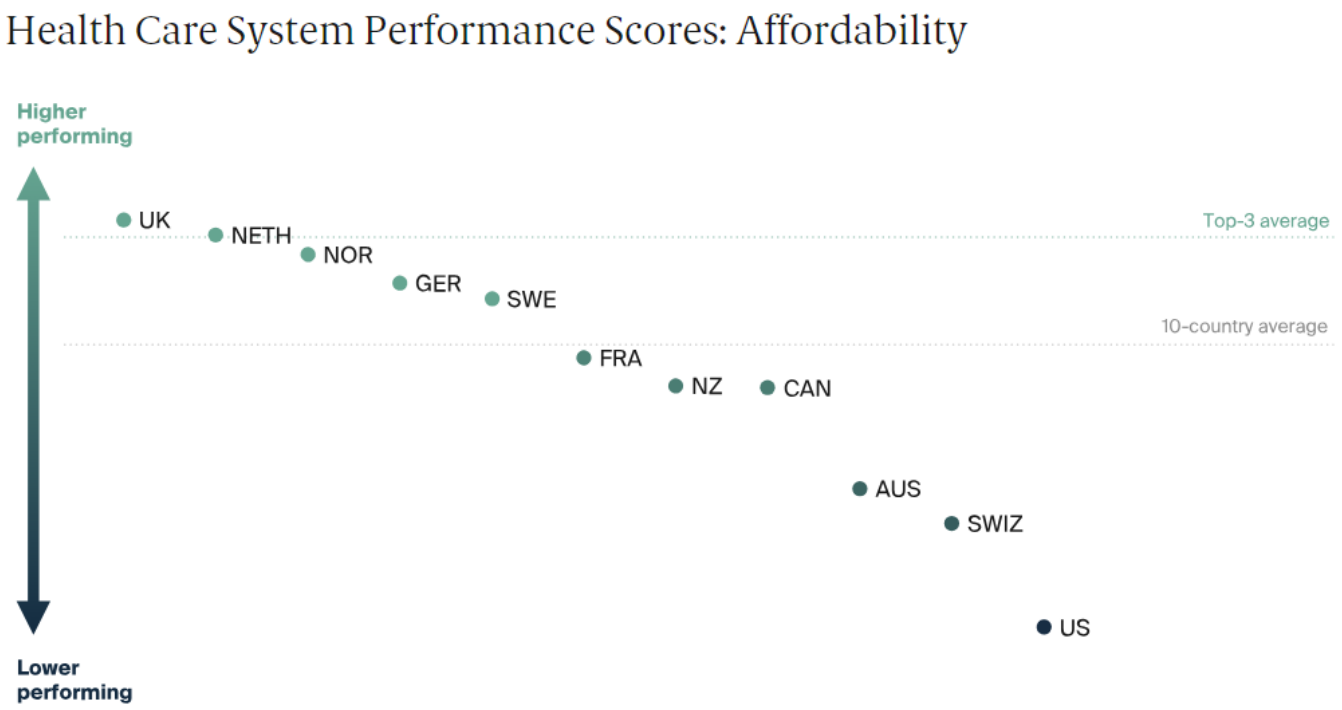
By 2019 most spent between

7-11% GDP

on Health care

The US was 16%

US Health Care Access



Note: To normalize performance scores across countries, each score is the calculated standard deviation from a 10-country average that excludes the US. See How We Conducted This Study for more detail.

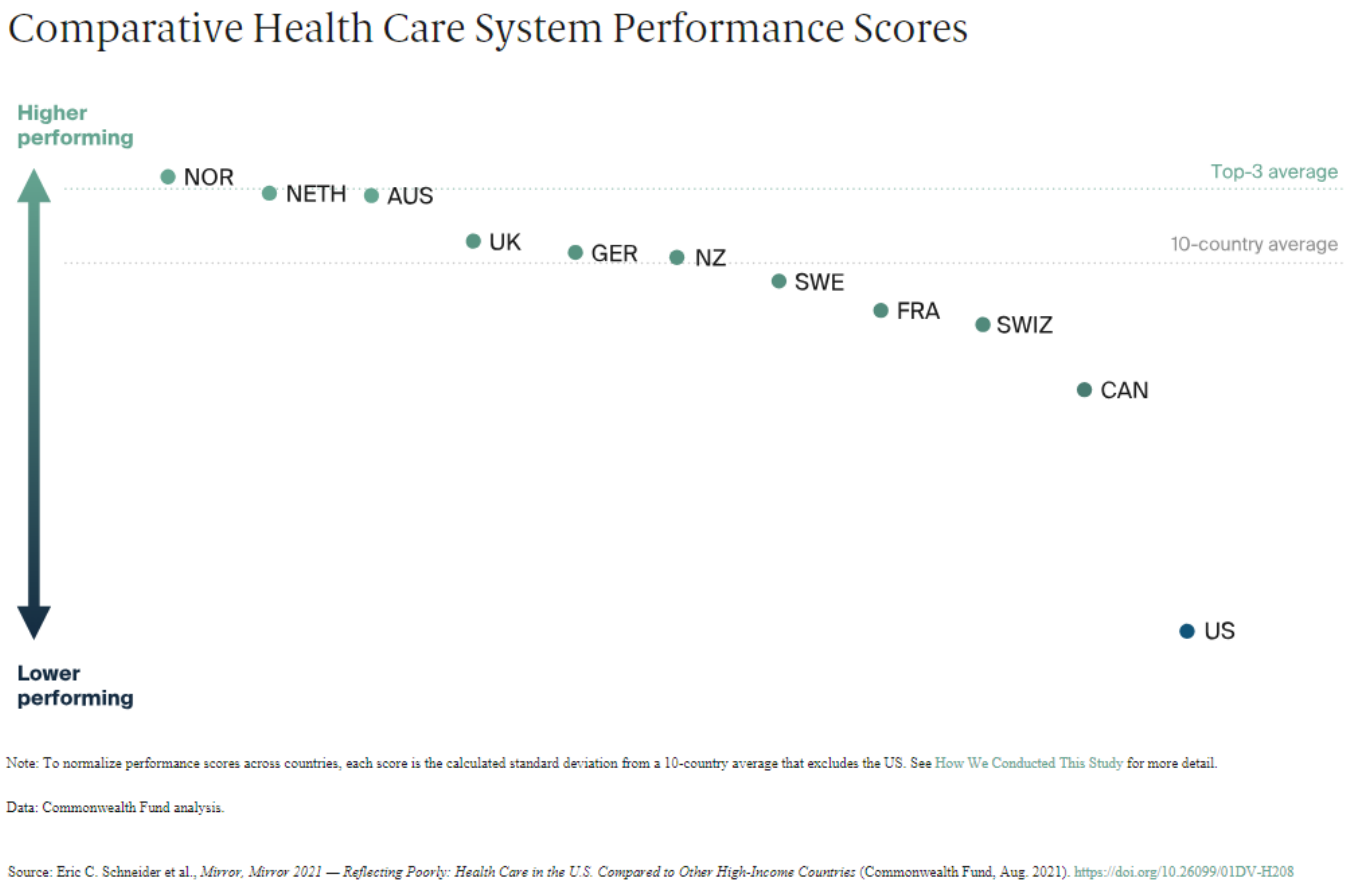
Data: Commonwealth Fund analysis.

Source: Eric C. Schneider et al., *Mirror, Mirror 2021 — Reflecting Poorly: Health Care in the U.S. Compared to Other High-Income Countries* (Commonwealth Fund, Aug. 2021). https://doi.org/10.26099/01DV-H208

The argument that
US wealth can tolerate the disproportionate HC spend is not born out by the data.

In fact,
US HC is less affordable
to its citizens than other industrialized nations.

US Health Care Outcomes



Despite the highest HC Spend..

The US continues to have

Inverse outcomes

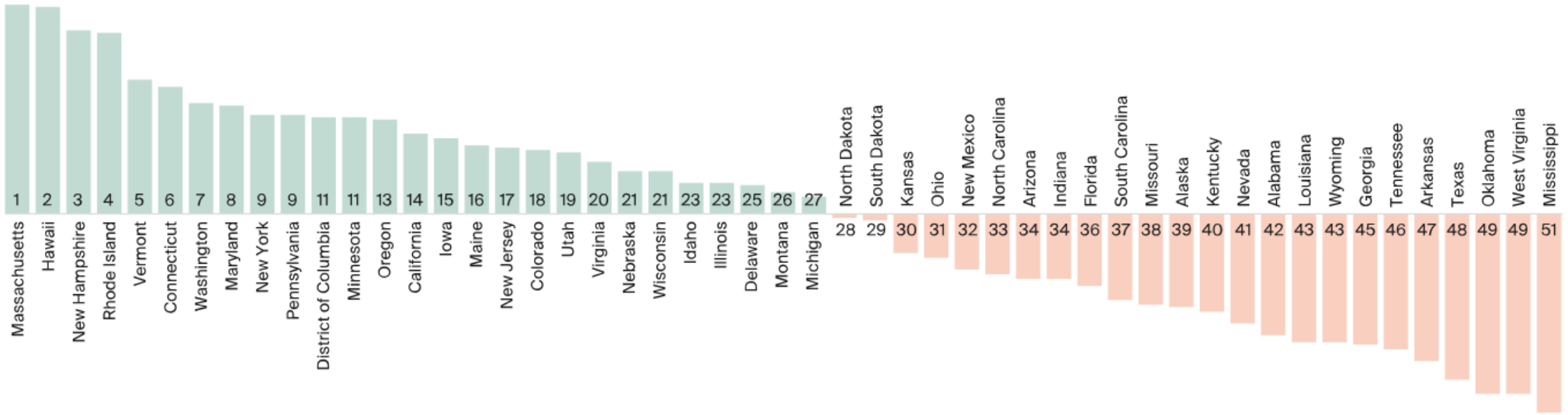
US Health Care Outcomes

Some states outperform other states..

State Outcomes

Massachusetts, Hawaii, and New Hampshire top the overall rankings on health system performance for 2023.

Overall Rankings for 2023 Scorecard on State Health System Performance



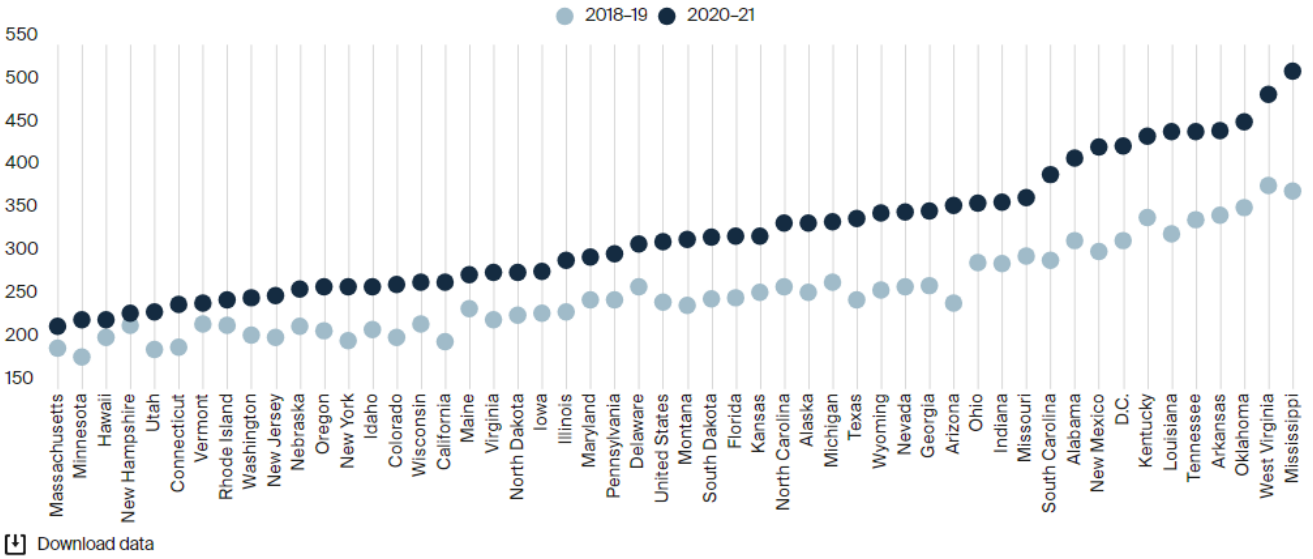
Notes: States arranged in rank order. Bar height corresponds to overall performance score. Green bars indicate better than average performance; orange bars indicate lower than average performance.

Source: David C. Radley et al., *The Commonwealth Fund 2023 Scorecard on State Health System Performance: Americans' Health Declines and Access to Reproductive Care Shrinks, But States Have Options* (Commonwealth Fund, June 2023). https://doi.org/10.26099/fcas-cd24

State Outcomes

Deaths from preventable and treatable causes rose between 2019 and 2021 amid the COVID-19 pandemic.

Avoidable deaths before age 75 per 100,000 population, by state (2018-19 and 2020-21)



Download data

Note: Number of deaths before age 75 per 100,000 population that resulted from causes that can be mainly avoided through timely and effective prevention and treatment. Methodology developed by the Organisation for Economic Co-operation and Development (OECD) and Eurostat, as published in Avoidable Mortality: OECD/Eurostat Lists of Preventable and Treatable Causes of Death (January 2022 Version).

Data: 2018-2019 and 2020-21 National Vital Statistics System (NVSS), All-County Micro Data, Restricted Use Files.

Source: David C. Radley et al., *The Commonwealth Fund 2023 Scorecard on State Health System Performance: Americans' Health Declines and Access to Reproductive Care Shrinks, But States Have Options* (Commonwealth Fund, June 2023). https://doi.org/10.26099/fcas-cd24

If you live in WV,

you are more than

2X

as likely to die

from an **avoidable death**

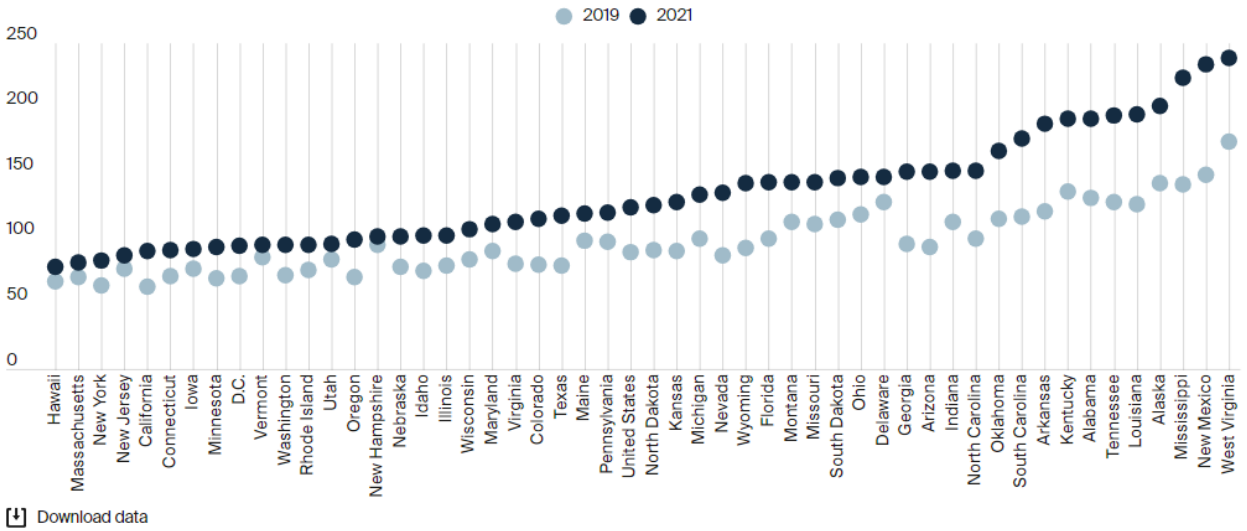
than if you live in

Massachusetts

State Outcomes

All-cause mortality rates for women of reproductive age vary widely across states and increased significantly from 2019 to 2021.

Age-adjusted all-cause mortality rate per 100,000 females ages 15-44, by state (2019 and 2021)



Download data

Data: 2019 and 2021 National Vital Statistics System (NVSS), via CDC WONDER.

Source: David C. Radley et al., *The Commonwealth Fund 2023 Scorecard on State Health System Performance: Americans' Health Declines and Access to Reproductive Care Shrinks, But States Have Options* (Commonwealth Fund, June 2023). https://doi.org/10.26099/fcas-cd24

If you are a **WV Women**

15-44 YOA

you are

3X

more likely to die

than a same aged women in New York.

(Where you live matters)

WV Health Outcomes

Avoidable Hospital Use & Cost	2023 Scorecard					Baseline			
Potentially avoidable emergency department visits									
Ages 18–64, per 1,000 employer-insured enrollees	2021	133	134	122	21	2019	153	137	Improved
Age 65 and older, per 1,000 Medicare beneficiaries	2021	176	141	115	51	2019	237	185	Improved
Admissions for ambulatory care–sensitive conditions									
Ages 18–64, per 1,000 employer-insured enrollees	2021	5	4	4	29	2019	7	7	Improved
Age 65 and older, per 1,000 Medicare beneficiaries	2021	40	29	16	50	2019	53	41	Improved
30-day hospital readmissions									
Ages 18–64, per 1,000 employer-insured enrollees	2021	3	3	2	23	2019	3	3	Improved
Age 65 and older, per 1,000 Medicare beneficiaries	2021	43	33	16	51	2019	54	40	Improved
Skilled nursing patients with a successful discharge	2020	51%	57%	69%	48	2018	47%	54%	Improved
Home health patients with a hospital admission	2019	19%	15%	11%	51	2017	17%	16%	Worsened
Adults with inappropriate lower back imaging	2021	69%	69%	60%	21	2019	65%	68%	Worsened
Employer-sponsored insurance spending per enrollee	2021	$7,545	$6,060	$4,255	47	2019	$6,495	$5,354	Worsened
Medicare spending per beneficiary	2021	$10,253	$10,478	$6,915	25	2019	$10,324	$10,180	No Change
Primary care spending as a share of total health care spending									
Ages 18–64 (employer-insured enrollees)	2021	5.7%	6.9%	10.0%	41	2019	5.8%	7.2%	No Change
Age 65 and older (Medicare beneficiaries)	2020	5.3%	5.5%	7.6%	24	2018	5.8%	5.7%	Worsened

	National Rank	Rank Among Southeastern States*
Overall	**49** of 51	**11** of 12
Reproductive & Women's Health	38	6
Access & Affordability	37	4
Prevention & Treatment	39	6
Avoidable Hospital Use & Cost	50	12
Healthy Lives	51	12
Income Disparity	33	2
Racial & Ethnic Health Equity	45	11

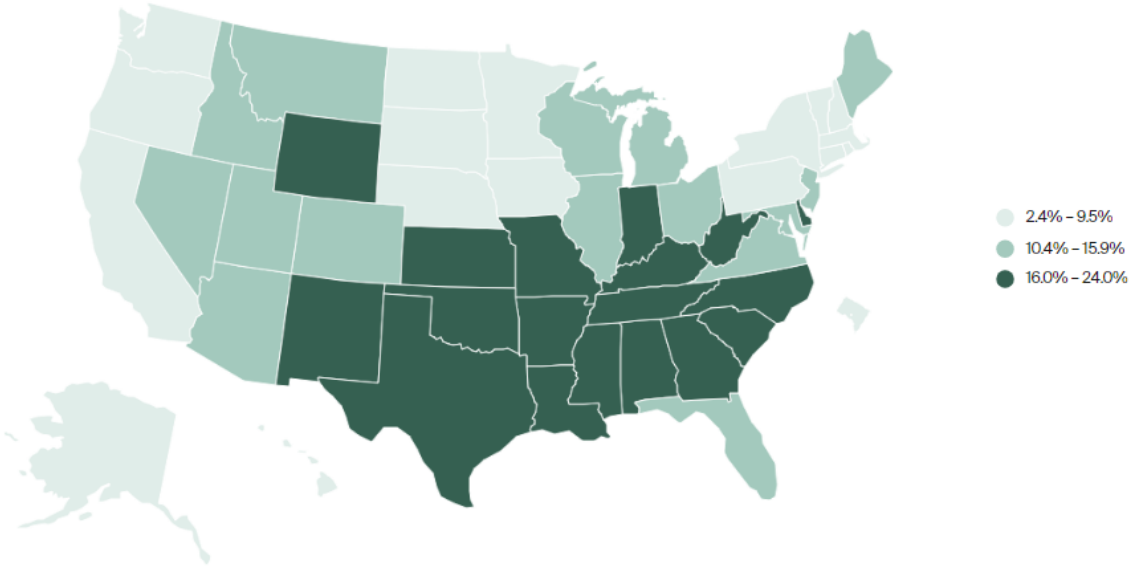
* Southeastern states include AL, AR, FL, GA, KY, LA, MS, NC, SC, TN, VA, WV

WV leads the nation in avoidable Hospital use and cost..

State Accessibility

In some states, particularly in the South, as many as a quarter of residents have medical debt; a symptom of coverage gaps and inadequate insurance.

Share of people with a credit bureau record who have medical debt in collections, by state (2021)



Download data

Note: Urban Institute analysis is based on a 4 percent nationally representative sample of consumer records from a major credit bureau as of February 2022.

Data: Alexander Carther, et al., *Debt in America* (Urban Institute, June 2022). Accessible from https://datacatalog.urban.org/dataset/debt-america-2022

Source: David C. Radley et al., *The Commonwealth Fund 2023 Scorecard on State Health System Performance: Americans' Health Declines and Access to Reproductive Care Shrinks, But States Have Options* (Commonwealth Fund, June 2023). https://doi.org/10.26099/fcas-cd24

And despite poor medical outcomes,

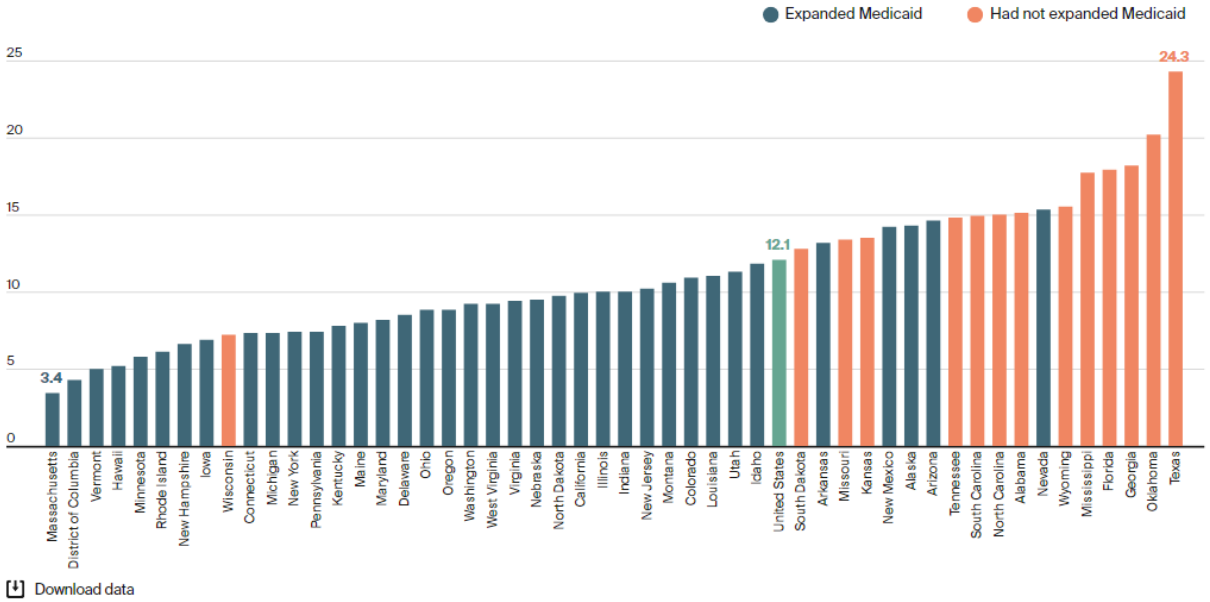
Approximately 1:5 WVs

carry medical debt.

State Accessibility

Adult uninsured rates have fallen since 2019 but remain highest in states that have not expanded their Medicaid programs.

Percentage of adults ages 19-64 who are uninsured, by state (2021)



Download data

Note: States with orange shading had not fully expanded their Medicaid program under the Affordable Care Act by January 1, 2021.

Data: U.S. Census Bureau, 2021 One-Year American Community Survey, Public Use Microdata Sample (ACS PUMS).

Source: David C. Radley et al., *The Commonwealth Fund 2023 Scorecard on State Health System Performance: Americans' Health Declines and Access to Reproductive Care Shrinks, But States Have Options* (Commonwealth Fund, June 2023). https://doi.org/10.26099/fcas-cd24

WV does have a bright spot,
having only
9-10% uninsured.

This means 90% of WVs belong to a payment model.

(Note-this chart includes the covid Medicaid expansion.)

The Solution?

WV spends more on worse healthcare..

How do we fix this?

The Importance of Primary Spend

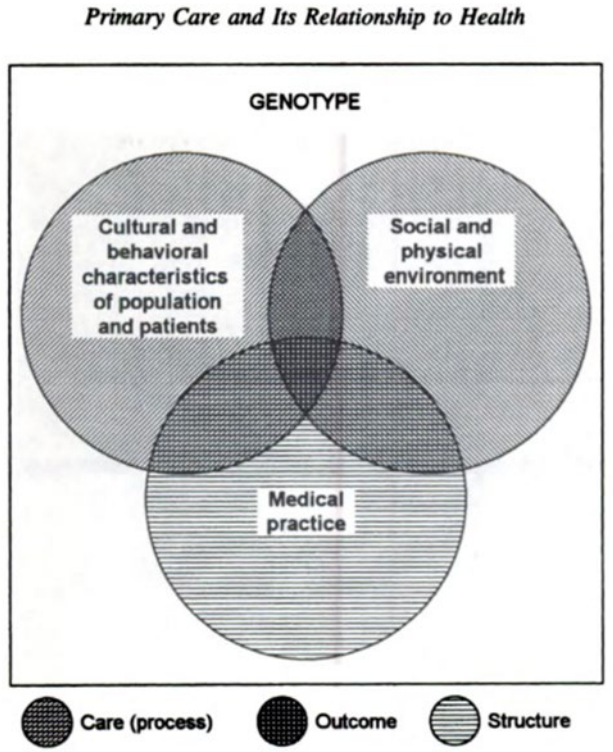
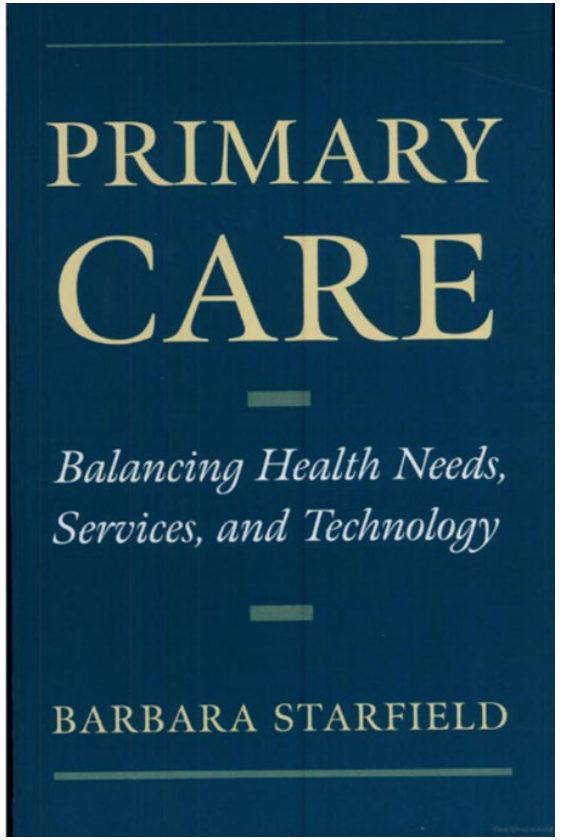


Figure 1.1. Determinants of health status. Source: Starfield (1973).



https://www.starfieldsummit.com Accessed 2/3/24.

The Importance of Primary Spend

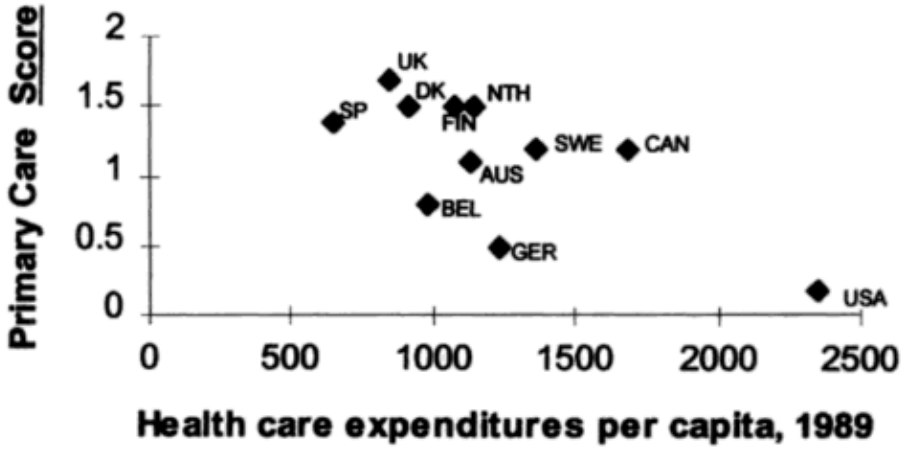


Figure 1.4. Relationship between strength of primary care and total health care expenditures.

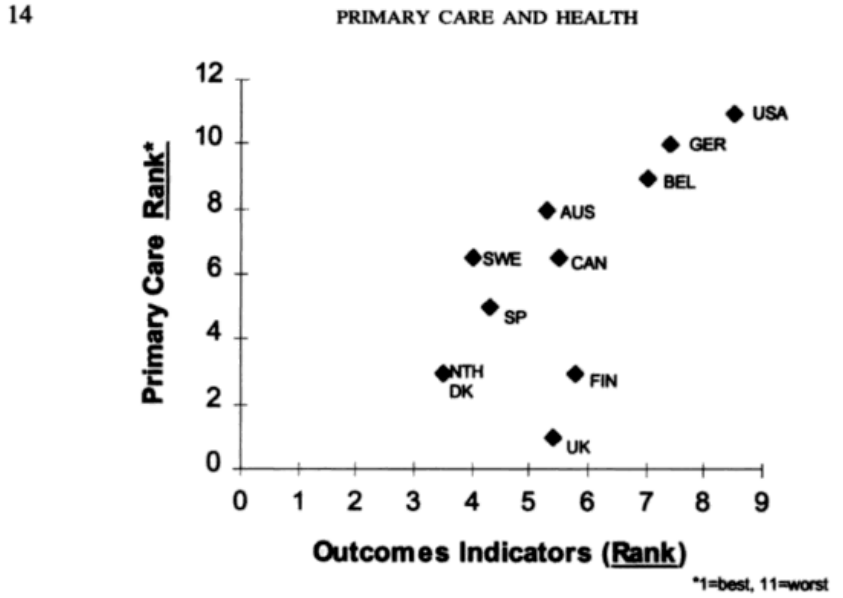


Figure 1.3. Relationship between strength of primary care and combined outcomes.

As early 1989 Dr. Starfield was outlining the correlation between primary care, cost of care and outcomes.

The Importance of Primary Spend

The four key concepts of primary care as identified by Barbara Starfield:

- First Contact accessibility,
- Coordination,
- Comprehensiveness, and
- Continuity.

https://www.nytimes.com/2023/02/14/health/doctors-medical-guidelines.html. Accessed 3/10/24

Primary Care Balancing Health Needs, Services, and technology. Barbra Starfield. Oxford University Press, 1998

The Importance of Primary Spend

1. Raising the professional earnings of primary care physicians to parity or near parity with specialists
2. Establishing a more rational basis for referral and especially for long-term management of patients (In particular, primary care physicians could care for more patients with ongoing health problems with more appropriate consultation arrangements and shared care with subspecialists, thus reducing the demand for direct services by subspecialists. That is, primary care with appropriate back-up from specialists could reduce the demand for subspecialist care.)
3. Restructuring state licensing policies to limit physician supply to areas of need
4. Providing financial incentives to programs that educate primary care physicians
5. Expanding and improving loan forgiveness programs for primary care physicians
6. Restructuring fee schedules for primary care to encourage the provision of important primary care services
7. Reducing burdensome administrative paperwork associated with billing and quality assurance activities
8. Providing bonuses for achieving important primary care objectives
9. Providing bonuses for team practice in primary care
10. Rewarding higher levels of achievement of primary care functions
11. Earmarking increased funding for primary care research to enhance the intellectual challenges of primary care and increase the scientific base for its practice
12. Involving trainees in ongoing quality of care monitoring to prepare them for critical review of their own practices

Starfield's recommendations are the template of many of the healthcare reform efforts pursued over the last 25 years.

Not surprisingly-

- funding primary care,
- increasing PCP workforce, and
- rewarding outcomes

form the bases of her recommendations.

Primary Care Balancing Health Needs, Services, and technology. Barbra Starfield. Oxford University Press, 1998

Effect of Primary Care: Continuity

Higher Primary Care Physician Continuity is Associated With Lower Costs and Hospitalizations.

Medicare claims data for 1.4M beneficiaries obtaining care from a national sample of 6,551 PCPs to calculate continuity scores by 4 established methods. Patient-level continuity scores attributed to a single physician were averaged to create physician-level scores.

Adjusted expenditures for beneficiaries cared for by physicians in the highest continuity score quintile were **14.1% lower** than for those in the lowest quintile **$8,092** vs **$6,958**.

The **odds of hospitalization were 16.1% lower** between the highest and lowest continuity quintiles.

All 4 continuity scores tested were significantly associated with lower total expenditures and hospitalization rates. Such indices are potentially useful as QPP measures.

Bazemore et al. Higher Primary Care Physician Continuity is Associated With Lower Costs and Hospitalizations. Ann Fam Med. 2018

Effect of Primary Care: Continuity

The Effect of PCP Visits on Total Care Cost: Evidence From the VHA

A retrospective study of over **5M** patients assigned to a PCP in the VHA in FY 2016-2019. The main outcome was **total annual patient care cost.**

On average, each additional in-person PC visit was associated with a total cost reduction of **$721** (per patient per year). **The first PC visit was associated with the largest savings, $3976 on average**, and a steady diminishing return was observed.

The higher the patient risk (severity of illness), the larger the cost reduction: Among the top 10% of high-risk patients, the first PC in-person visit was associated with a reduction of **$16, 406** (19%).

Gao J et al. The Effect of Primary Care Visits on Total Patient Care Cost: Evidence From the Veterans Health Administration. J Prim Care Community Health. 2022

Effect of Primary Care: Continuity

PCP Continuity, Frequency, and Regularity Associated With Medicare Savings

Among 504,471 beneficiaries temporally regular visits with higher continuity were associated with the highest savings.

The savings increased with increasing visit frequencies.

Peak savings observed at higher visit frequencies as clinical complexity increased.

	Per-patient spending	ED visits (per 1000 pts)	Hospitalizations
Highly continuous regular	$8,367	305	159
Noncontinuous, irregular	$14,269	640	283

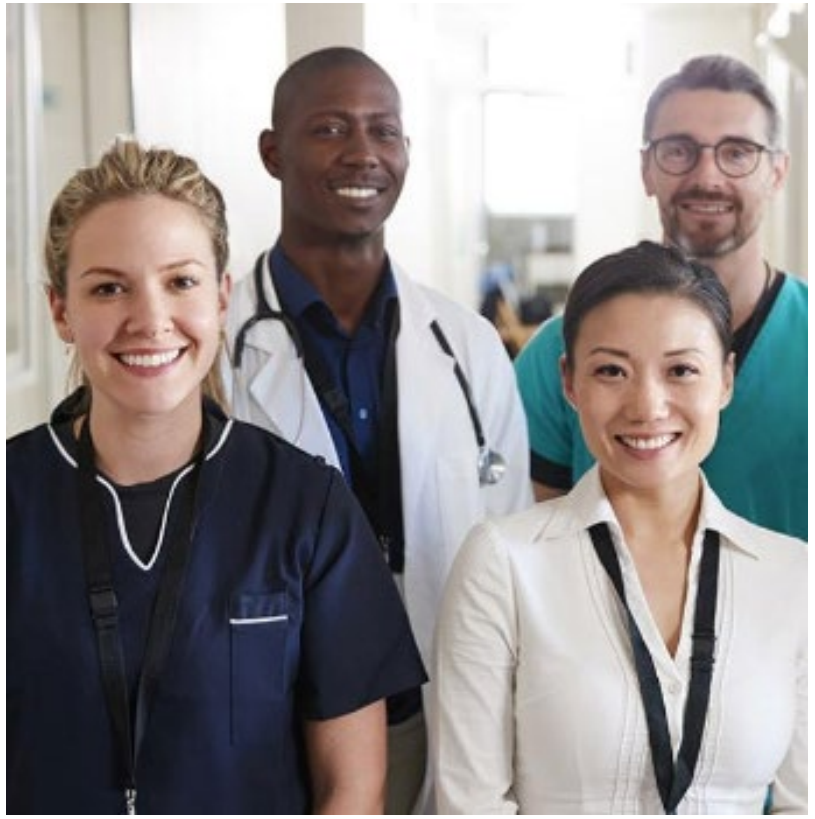
Sonmez D, et al. Primary Care Continuity, Frequency, and Regularity Associated With Medicare Savings. JAMA Net Open. 2023

Shortages in Primary Care Providers

Most Common definition

Primary Care Clinician (PCC) : Clinicians practicing in the specialties of -
family medicine,
general internal medicine,
general pediatrics, and
general medicine;

includes Nurse Practitioners, and
Physician Associates/ Physician Assistants.



About Us | Ohio Independent Collaborative. Accessed 3/10/24

Primary Care Physician Workforce

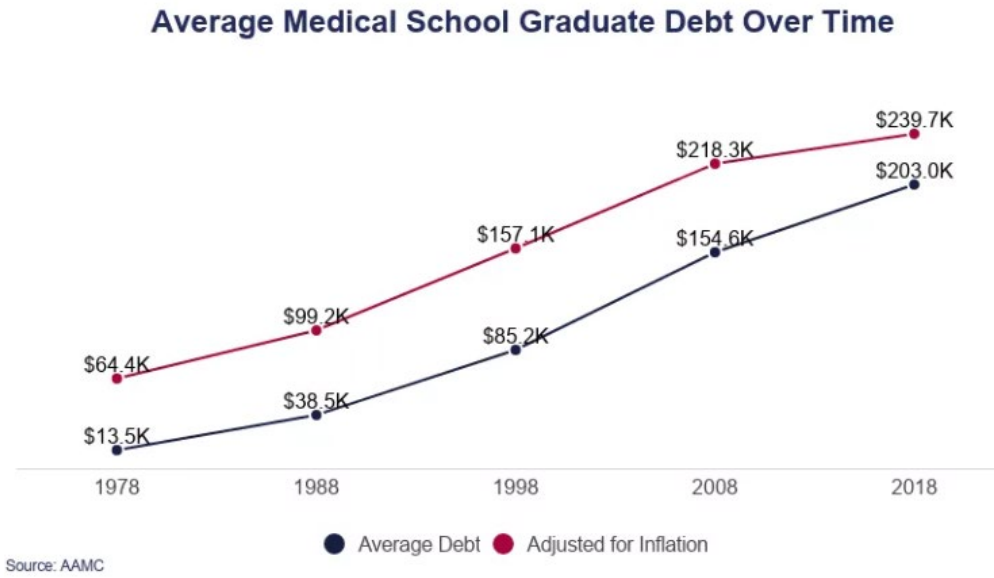
'The number of med students…has increased, but we have an even greater problem. The number of US MD grads choosing primary care…keeps decreasing.

In the 2009 NR Match, only 7% of graduates chose FP, and 19% chose IM.

..Of those choosing IM…the majority will become subspecialists or hospitalists. Hauer et al reported that only 2% of US senior MD med students planned to have a career in general IM.

<u>One reason that med students enter specialties is that the average educational debt of the class of 2008 MD graduates was $150,000.</u>

This influences many graduates to enter specialties that pay, on average, twice as much as primary care so that they can pay off their educational debt."



..Family medicine represents 12% of all U.S. students or graduates who matched in 2023

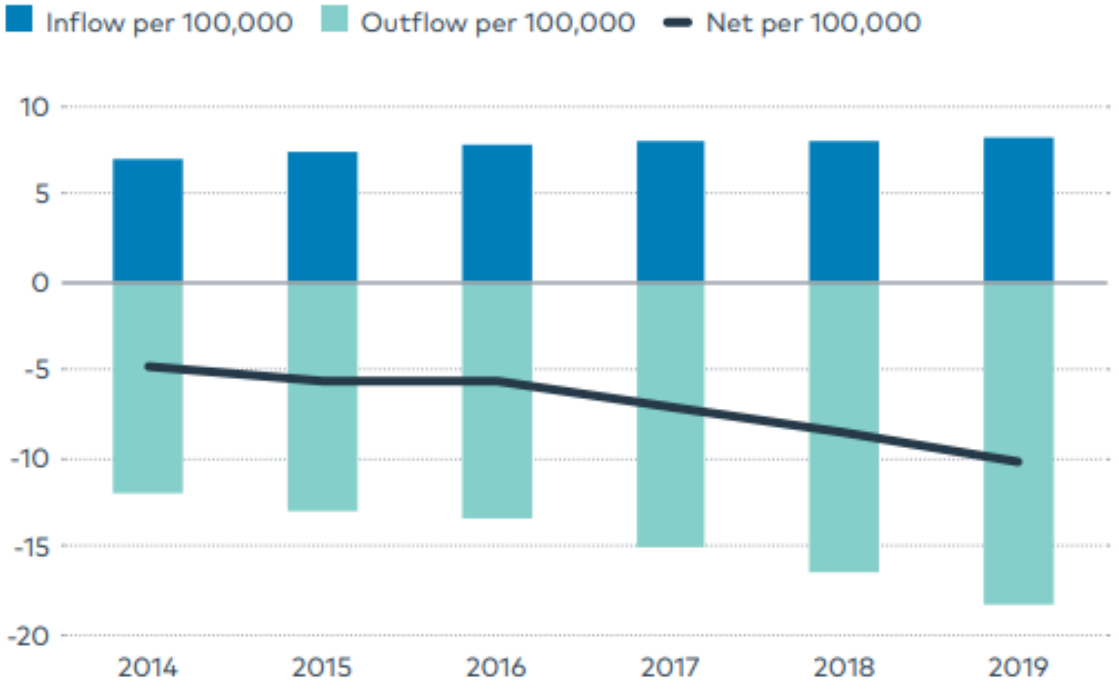
Family Medicine National Resident Matching Program (NRMP) Results Analysis | AAFP. Accessed 3/10/24

James E. Dalen, MD, MPH, COMMENTARY. We Can Can Reduce US Health Care Costs.AMJMED. VOLUME 123, ISSUE 3, P193-194, MARCH 2010

US Primary Care Pipeline

FIGURE 1

Inflow and Outflow, Primary Care Clinicians per 100,000 Population, 2014–2019 (with Physician Retirement at Age 65)



Data Source: American Medical Association Physician Masterfile 2012-2020; Medicare Provider Utilization and Payment Data: Physician and Other Supplier Public Use File 2013–2020; U.S. Census 2012-2020

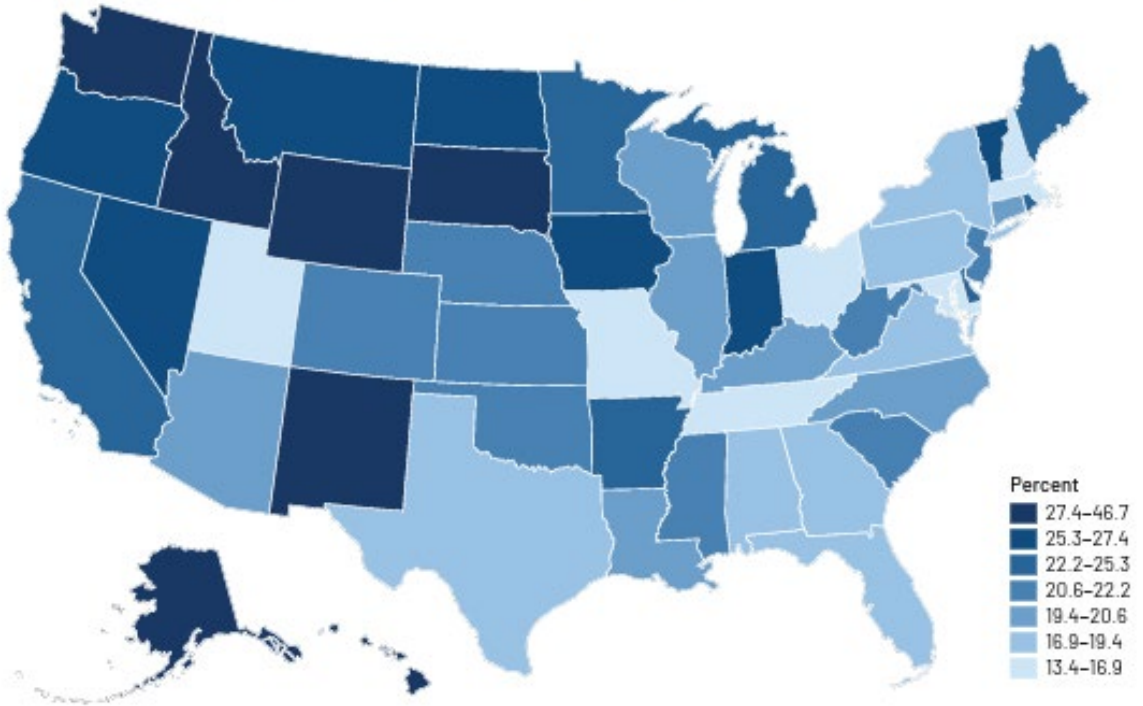
Notes: Primary Care Clinicians includes PCPs, NPs, and PAs. As for PCPs, inflow was calculated as the number of PCPs (per 100,000 population) entering the workforce after completion of their fields training program, while outflow was calculated as the number of PCPs retiring at age 65. As for NPs and PAs, inflow and outflow were identified based on Medicare billing such that we assumed someone billing for the first time was a new provider and when someone no longer billed for at least two consecutive years we assumed they were no longer providing those services.

The supply of incoming PCPs has remained flat.

But those retiring and leaving practice has increased consistently over the previous decade.

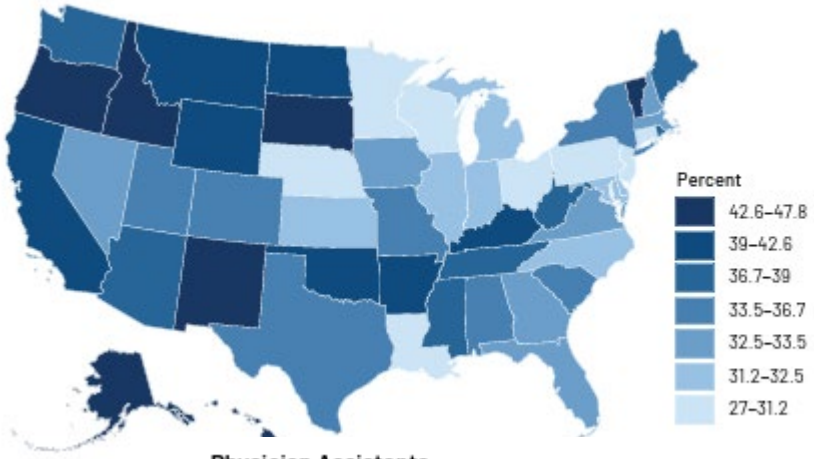
US Primary Care Pipeline

Figure 2. Percentage of Physicians Entering Primary Care by State in 2020

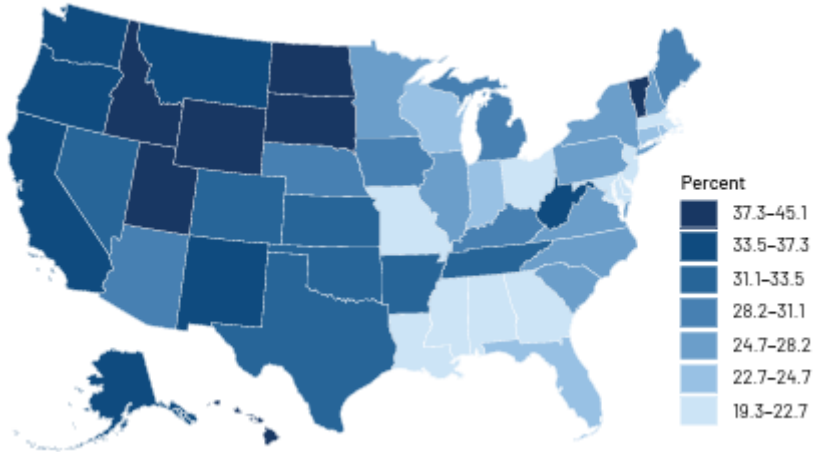


Data Source: Analyses of Accredited Council of Graduate Medical Education data in American Medical Association Masterfile, 2020.
Notes: Primary care specialties included family medicine, general practice, internal medicine, and pediatrics.

Nurse Practitioners



Physician Assistants



WV Workforce Needs

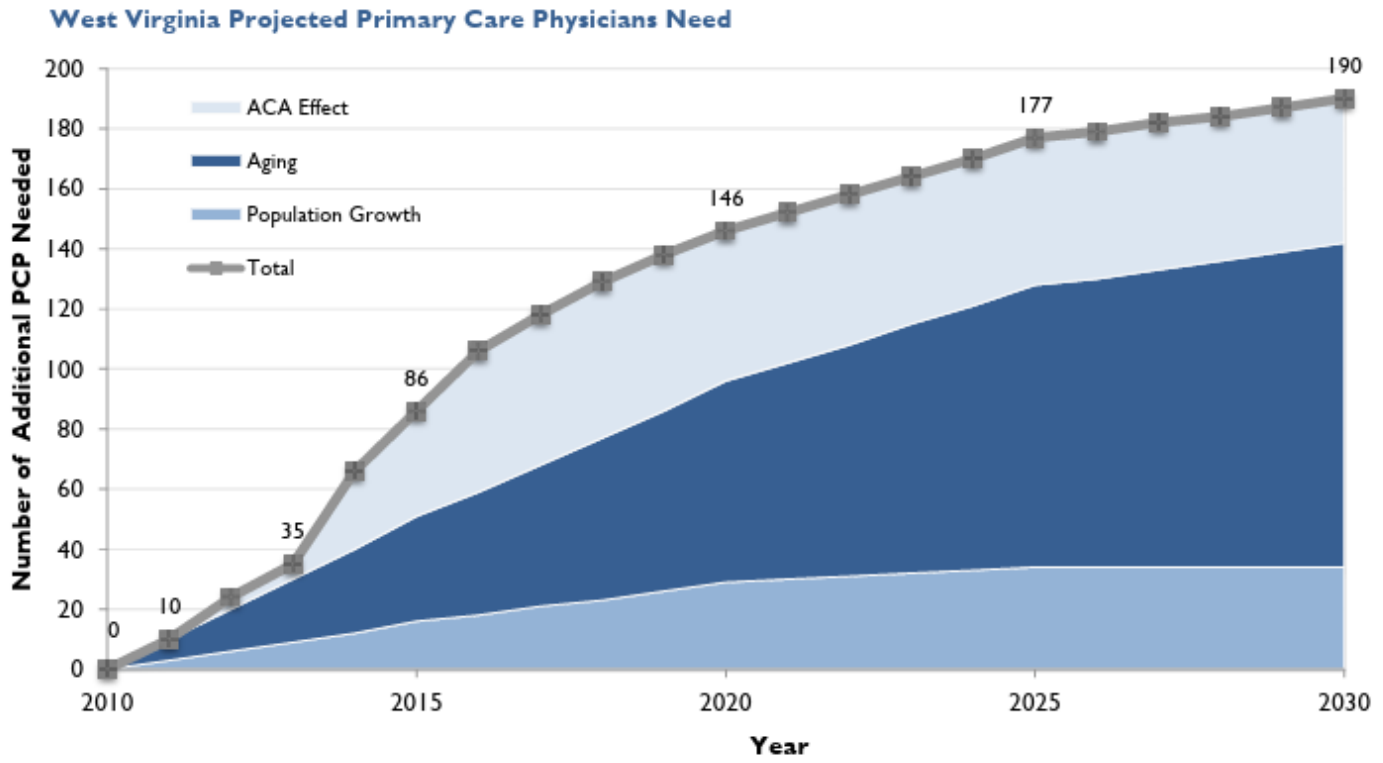
WV has 1,330 Primary Care Physicians

Paradoxically, it has a PCP to patient ratio of 1392:1,

Lower than the national average of 1463:1.

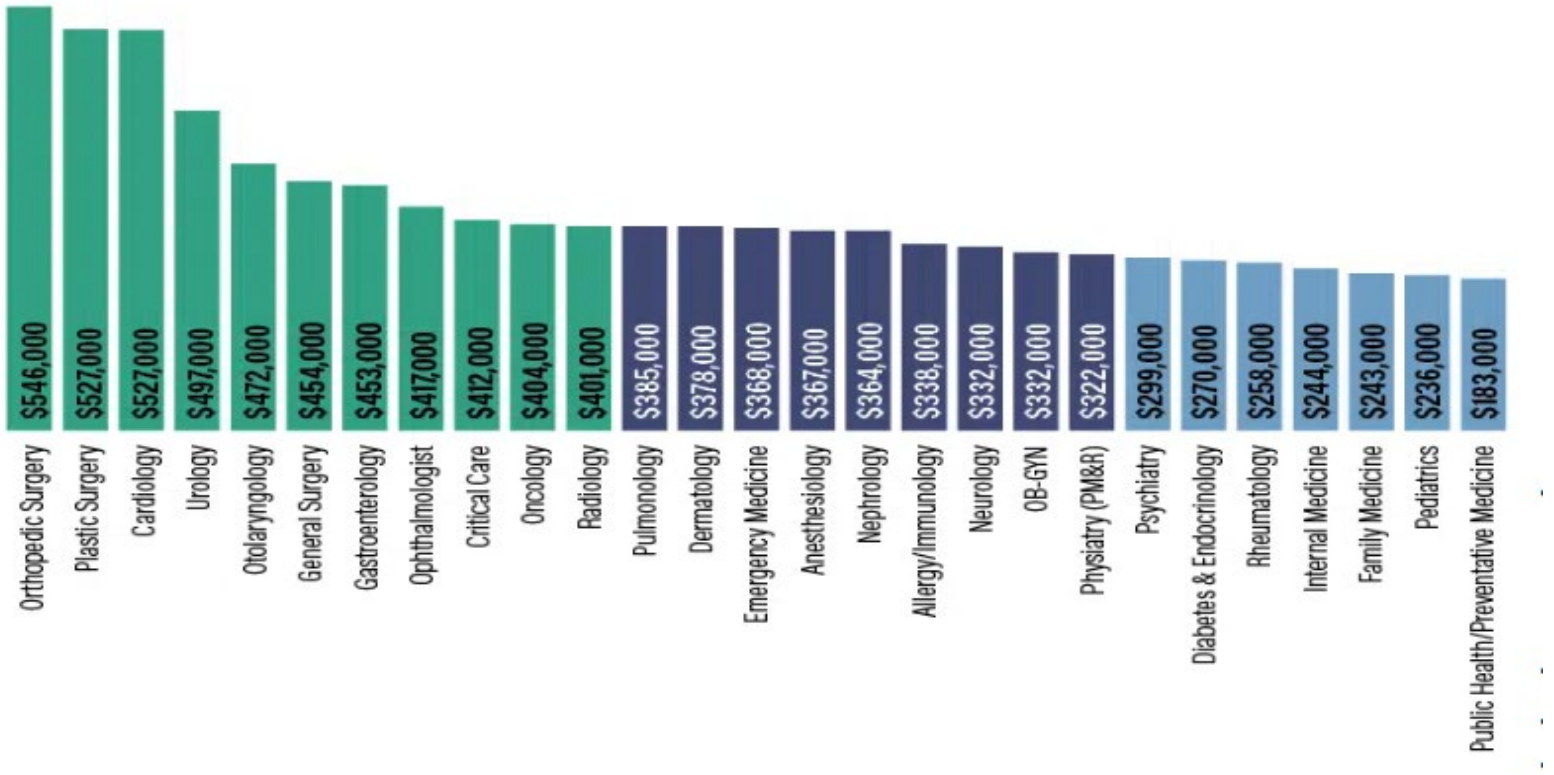
It will need **190** new PCPs by 2030
to maintain that ratio.

To maintain current rates of utilization, West Virginia will need an additional 190 primary care physicians by 2030, a 14% increase compared to the state's current (as of 2010) 1,330 PCP workforce.



ROBERT GRAHAM CENTER

Primary Care Workforce-Wages



PCPs earned an average of **$251k** in 2022, a 3% increase over 2021.

Grouped together, specialists earned an average of **$351k** in 2022, up from $344k in 2021.

Physician Thrive's Physician Compensation Report [2023 Report] (physiciansthrive.com)

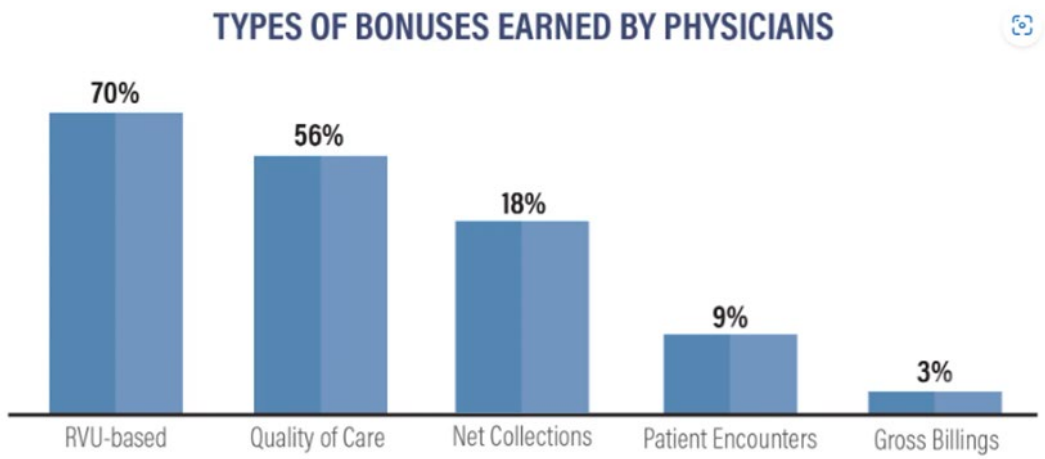
Primary Care Workforce-Wages

Primary care payment drives workforce shortage and promotes volume over value

For 54% of FPs..

the salary of $250K, includes an **average bonus of $30K**.

Those bonuses are increasing in frequency and are most often based on RVUS.



Physician Thrive's Physician Compensation Report [2023 Report] (physiciansthrive.com)

Primary Care Workforce-Hiring trends

Despite increasing salaries, benefits are decreasing.

- Health insurance: 68% (down from 78% last year)
- Malpractice: 66% (down from 78% last year)
- Retirement/401k: 61% (down from 68% last year)
- Disability: 61% (down from 70% last year)
- Educational Forgiveness: 16% (down from 21% last year)

Underserved and Rural areas pay the highest salaries as well as the biggest bonuses.

Family Physicians, which used to be in the highest demand, **have not been the most recruited physicians since 2020.**

Physician Thrive's Physician Compensation Report [2023 Report] (physiciansthrive.com)

Primary Care Workforce-Inhibitors

Aspects of the job that physicians like the least:

Having so many rules and regulations: 23%
Working long hours: 15%
Difficult patients: 15%
Difficulty getting reimbursement: 12%
Working on an EHR system: 12%
Other: 10%
Worrying about being sued: 7%

How Many Hours Are Physicians Working?

75% of physicians work more than 40 hrs/wk.

25% work between 50 and 59 hrs/wk.

30% work more than 60 hrs/wk.

Physicians are spending an average of 15.48 hours per week on paperwork and administration

Physician Thrive's Physician Compensation Report [2023 Report] (physiciansthrive.com)

WV Workforce-Wages

- As of 1/28/24, the average pay for a FP in WV is **$167,920** a year or $80.73 an hour.
- Salaries range from $255,089 to $62,708.
- ZipRecruiter reports the **WV FP market is not very active** as few companies are currently hiring.
- West Virginia ranks number **45** out of 50 states nationwide for FP salaries.

City	Annual Salary
Beckley	$219,589
Weirton	$212,773
Morgantown	$194,079
Parkersburg	$193,377
Bluefield	$191,454
Wheeling	$190,437
Josephine	$189,150
Clarksburg	$184,690
Charleston	$183,321
Huntington	$183,278

Salary: Family Practice Physician in West Virginia (Feb 24) (ziprecruiter.com) accessed 2/4/23

The Primary Care Spend Solution

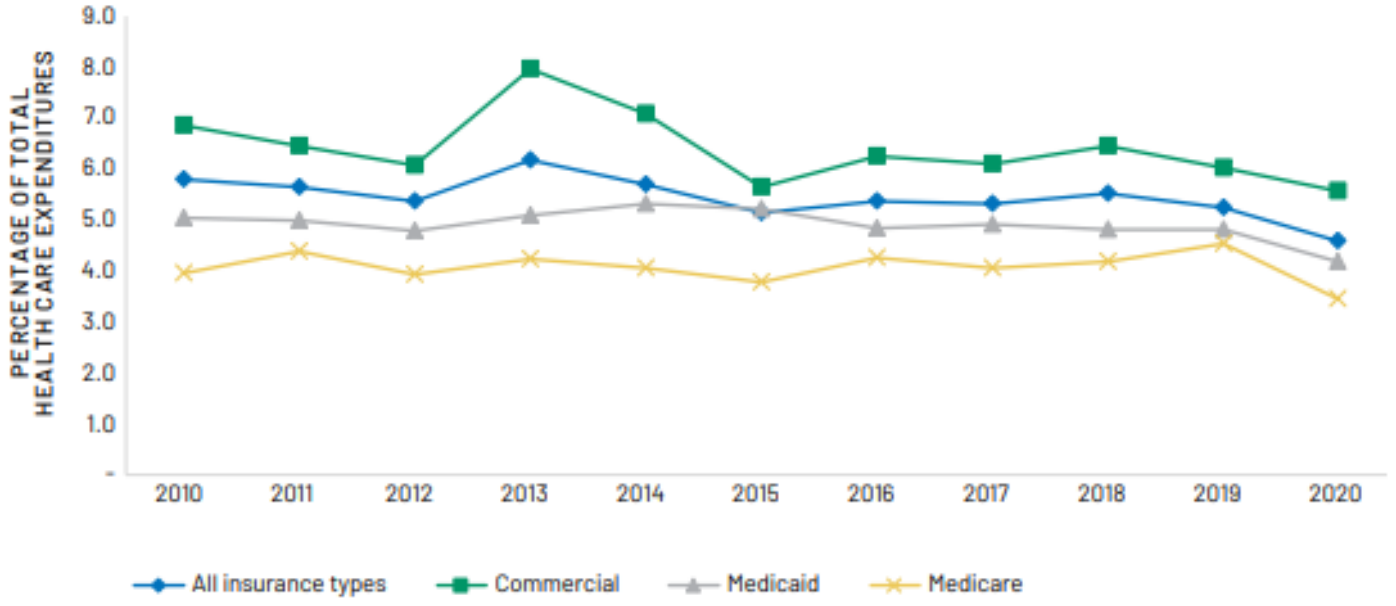
"Primary Care spend" is a concept born out of the idea that systems will change to improve efficiency and outcomes if incentivized by increased, directed, spending.

Primary care spend generally seeks to improve PC workforce, PC access and reward PC based outcomes.

In 2010, **Rhode Island**, was an originator of legislative action on primary spend…however, the concept is not based solely on legislative action.

Historical US Primary Spend

Figure 1: Primary Care Spending (Narrow Definition) from 2010 to 2020



Data Source: Analyses of Medical Expenditure Panel Survey (MEPS), 2010-2020. MEPS was redesigned in 2018. Data on ambulatory care expenditures derived from the consolidated, office-based, and outpatient event files. See Appendix B for details.

Notes: The primary care narrow definition is restricted to primary care physicians only. The primary care specialties included family medicine, general practice, internal medicine, pediatrics, geriatrics, and osteopaths.

Primary care spend has been tracking down, despite knowledge that increased PC spend results in less cost and better outcomes.

Commercial, not public insurance, has the best track record.

Historical US Primary Spend

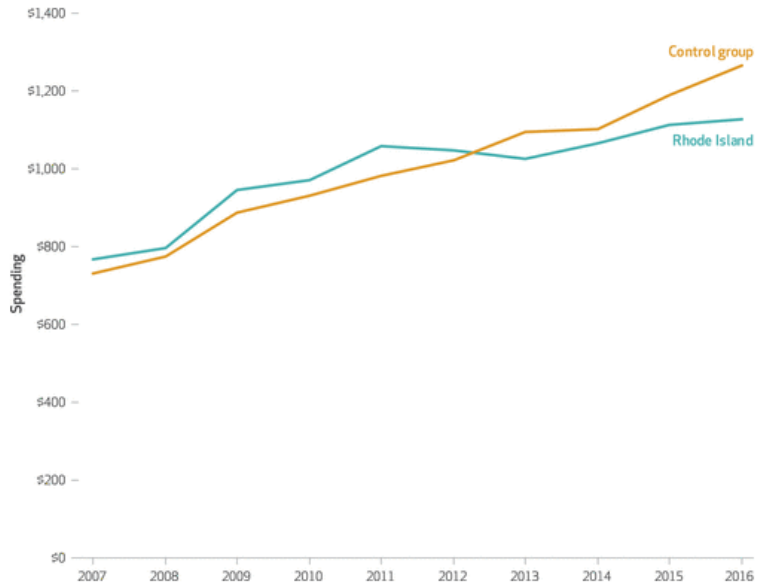
Primary care accounts for 5-6%
of US healthcare expenditures;

experts have recommended increasing to 10-12%.

Rhode Island **did** this, the result:

It spent $18 million on primary care and
saved $115 million.

Exhibit 2 Quarterly per enrollee fee-for-service spending in the Rhode Island and control-group cohorts, 2007–16



SOURCE Authors' analysis of data for 2007–16 from the Truven MarketScan Commercial Claims and Encounters database. NOTES The cohorts are explained in the notes to exhibit 1. All values were adjusted to a standardized ninety-day quarter. Dollar amounts were inflation adjusted to 2015 dollars. Rhode Island's affordability standards were implemented in 2010.

https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2018.05164 accessed 3/10/24

Starfield Summit Issue Brief , "What would effective primary care look like?" STARFIELD SUMMIT WASHINGTON DC APRIL 23–26, 2016

Other State's Experiences

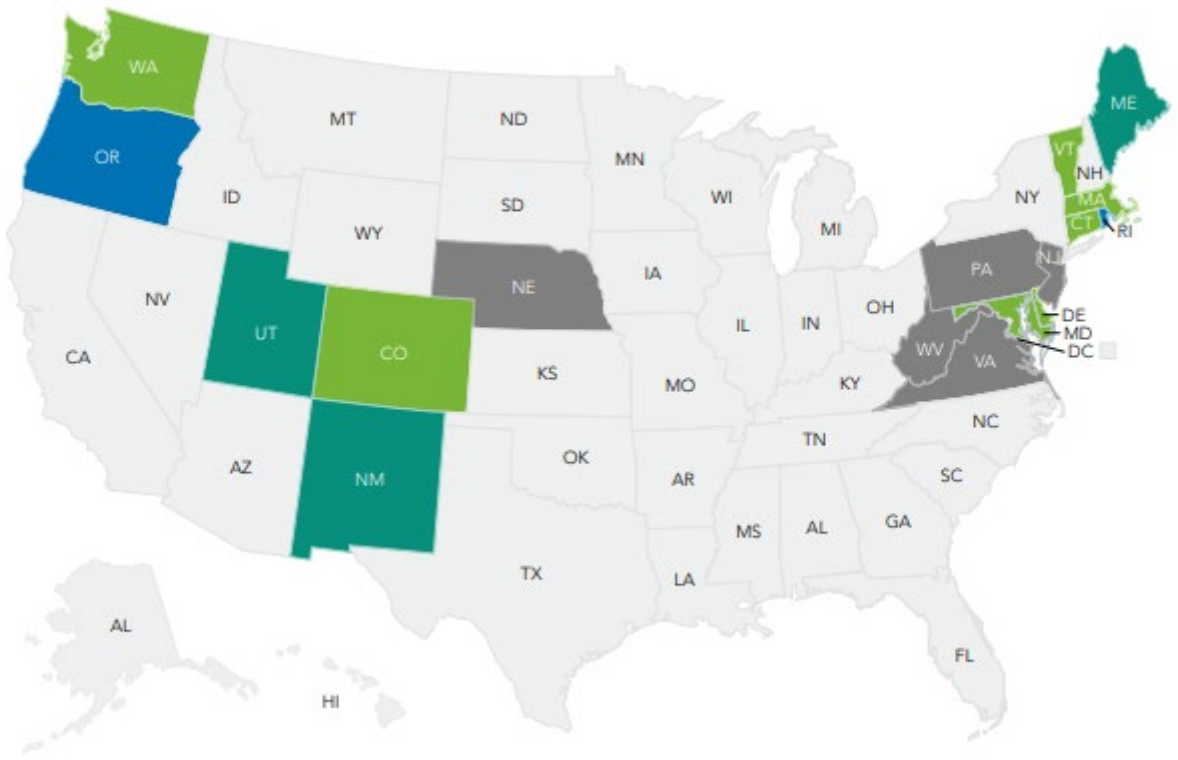
If WV wanted to have better outcomes and spend the same or less,

how would it start?

National organizations have been tracking other states experiences and can offer insight..

Other State's Experiences

Figure 1. States with Interest in Increasing Primary Care Investment



PRACTICING (Oregon, Rhode Island)
GETTING STARTED (Maine, New Mexico, Utah)
IN PROCESS (Colorado, Connecticut, Delaware, Maryland, Massachusetts, Vermont, Washington)
ASPIRATIONAL (Nebraska, New Jersey, Pennsylvania, Virginia, West Virginia)

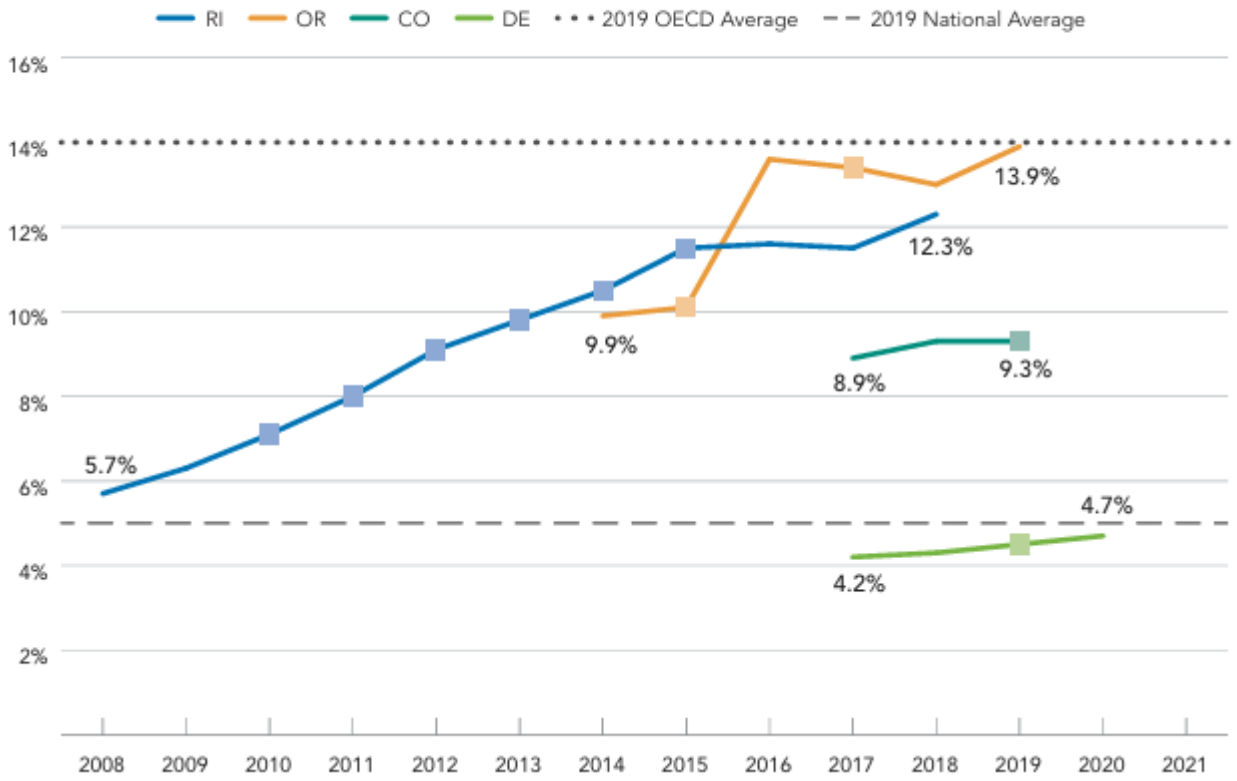
1/3 of US states and several public and private purchasers have prioritized shifting more of the health care dollar to primary care.

Common mechanisms and tools, often used in combination, can achieve this goal:

- **Transparency.** Measurement and reporting
- **Contracting**. Shaping formal agreements
- **Regulatory**. Statutes and regulation

Other State's Experiences

Figure 3. Percentage of Health Care Dollars Invested in Primary Care, Selected States, 2008–2021



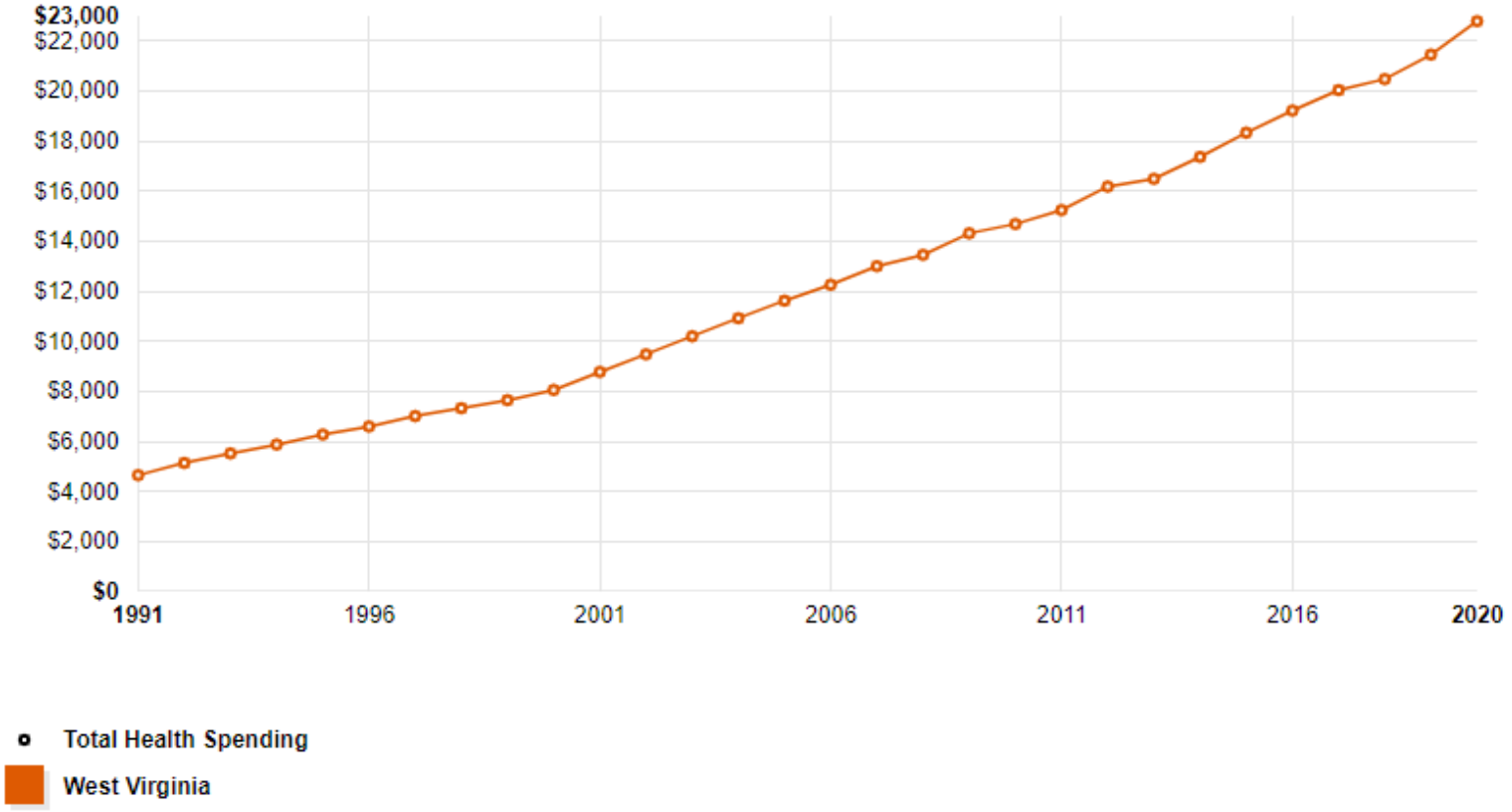
RHODE ISLAND MILESTONES 2010–2014
Carriers required to increase by 1% per year. 2015 Carriers required to spend at least 10.7% on primary care.

OREGON MILESTONES 2015 Law passed that requires reporting of primary care spend percentage by payer. 2017 Carriers/CCOs required to allocate at least 12% to primary care in 2023.

COLORADO MILESTONE 2019 Primary care spending first reported; 1% increase not required until 2022 and 2023.

DELAWARE MILESTONES 2019 PCRC set target to increase primary care investment to 12%. 2022 Carriers required to increase primary care spend to 7%, then 1.5% a year until 11.5%.

WV Primary Care Spend



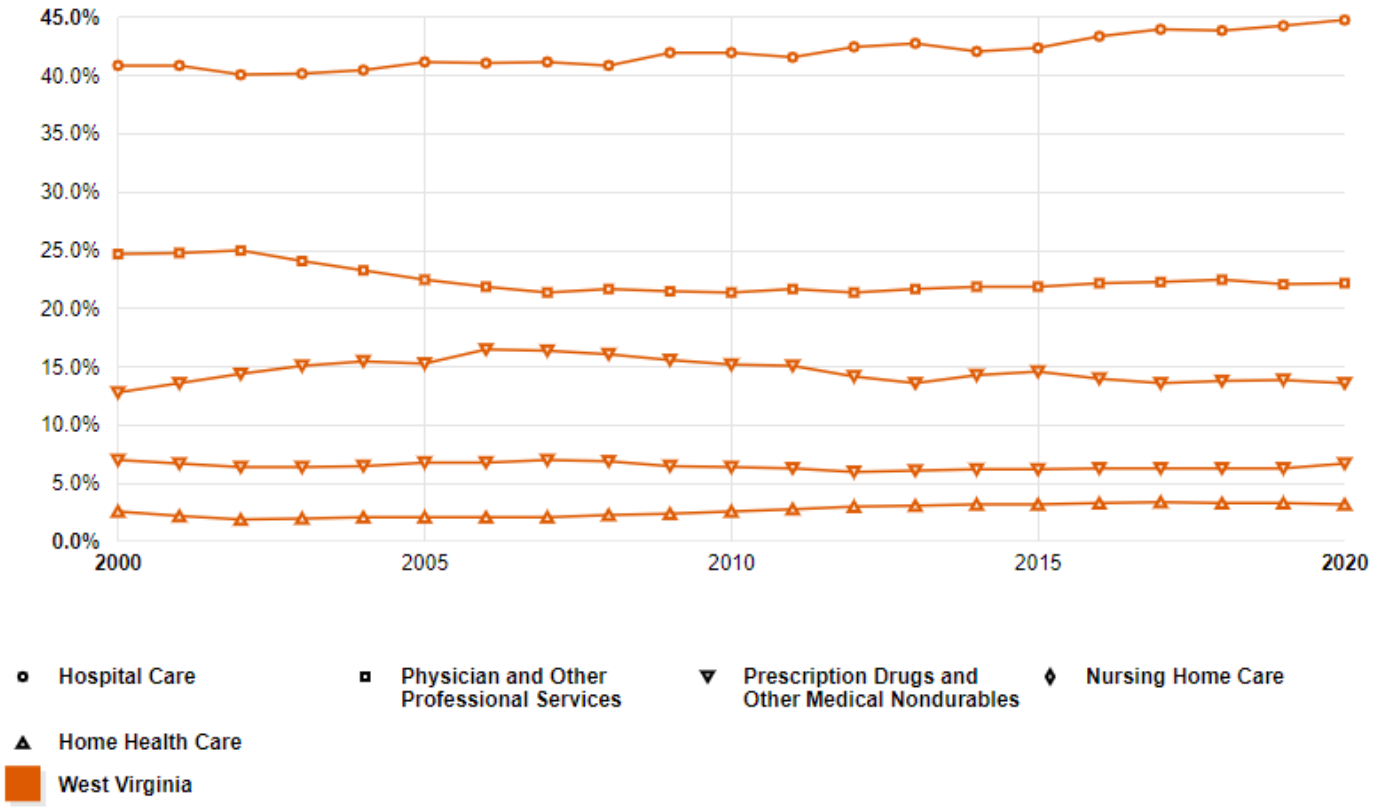
This shows the overall **growth of WV Health care spend**,

in millions of dollars.

(Recall our outcomes)

The data was reviewed to help define WV total primary spend.

WV Primary Care Spend



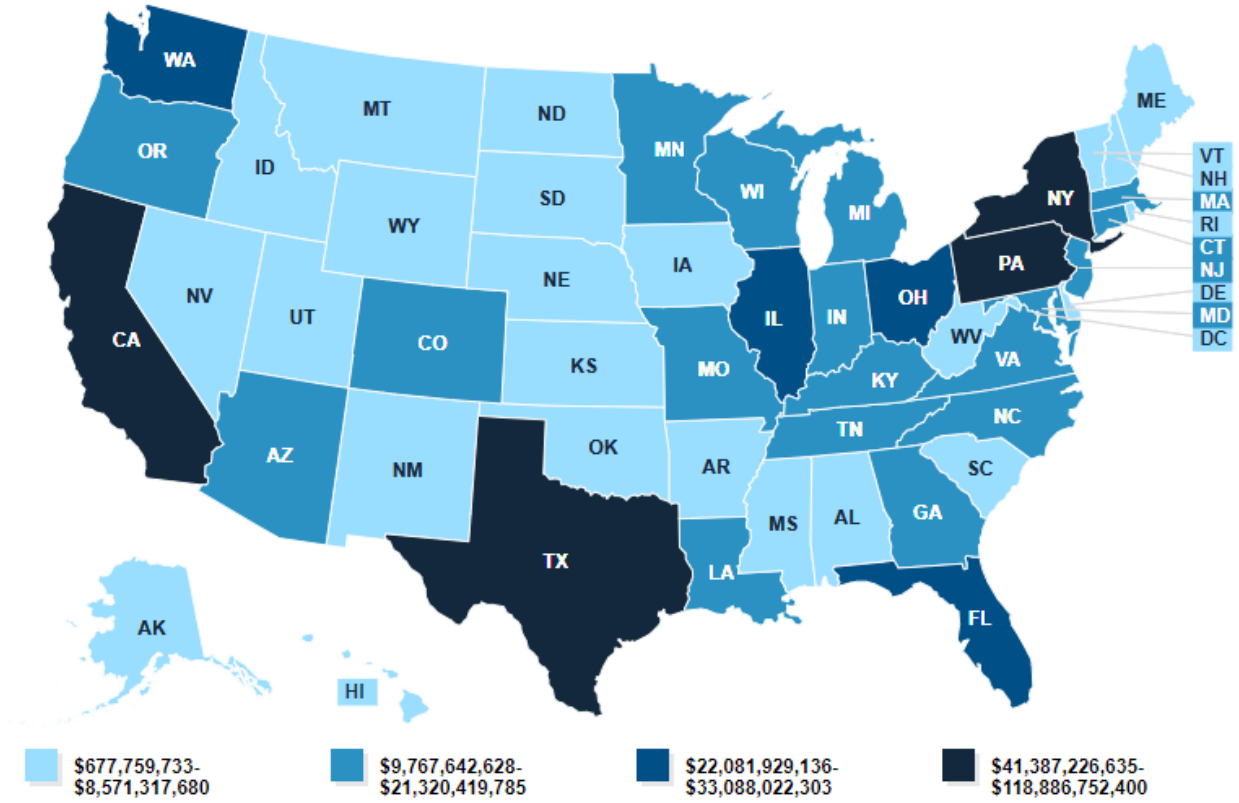
Hospital care has seen steady increases.

Physician and professional services have declined.

SNF are fixed due to strict regulation and policy.

Distribution of Health Care Expenditures by Service by State of Residence (in millions) | KFF accessed 2/3/24

WV Primary Care Spend



Location	Total Medicaid Spending
West Virginia	$5,223,455,595

FY 2022

This sets our base WV Medicaid spend,
But elicits the complexity of actual spend

In 2022 WV Medicaid Spent
$5.2B on health care.

It is the single largest portion of the WV Budget.

For 2022, WV general fund expenditures were **$2.6B** and **$18.8B** in total spending- including fed transfers.

Total Medicaid Spending | KFF Accessed 2/3/24
Urban.Org . WV budget, accessed 2/18/24

WV Primary Care Spend

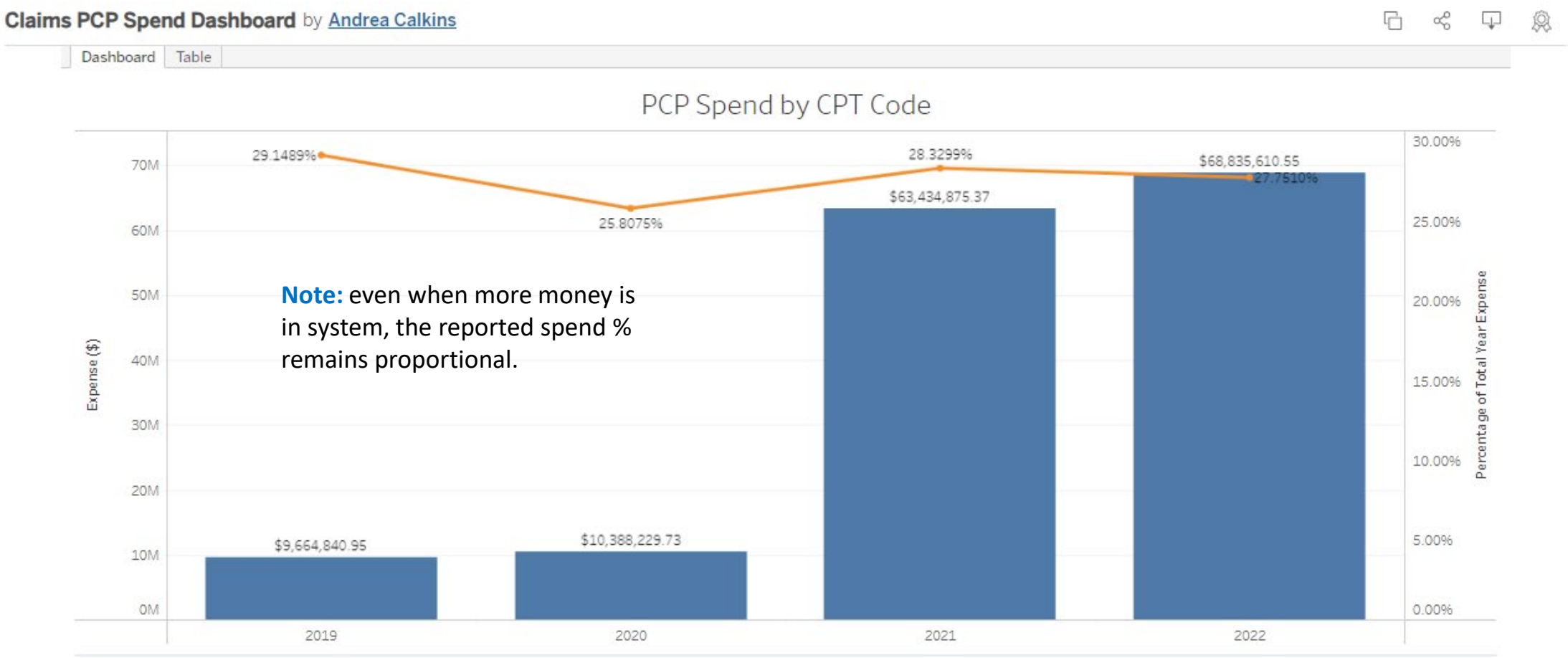
WV Department of Health and Human Resources Bureau for Medical Services Total PCP Spend by CPT Code

- 2019 $ 33,156,759.75
- 2020 $ 40,252,777.76
- 2021 $ 223,914,765.90
- 2022 $ 248,047,722.67

Based on the
$5.2B
WV Medicaid spent in
2022

The percentage spend on primary care would be **4.7%**

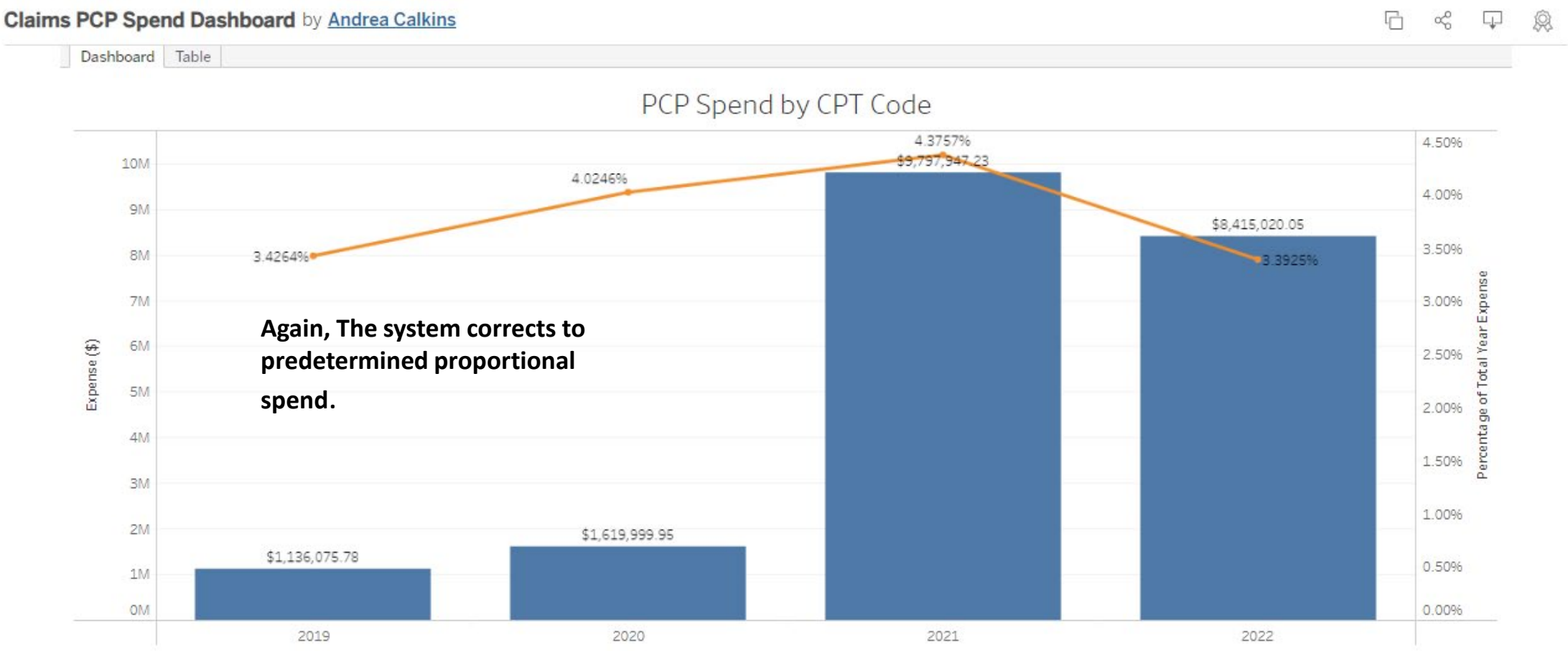
WV Primary Care Spend



99211-99215 established problem-based office visit

2022: 1.3% when denominator is $5.223 B

WV Primary Care Spend



99391-99397 established pediatric well visits

2022 .16% when denominator is $5.223 B

Other State's Experiences

How to start:

Form a stakeholder workgroup: including PCPs, representatives of health systems, commercial health plans, Medicaid, PEIA , employers, and consumers. The stakeholders create a balanced/consensus vision, with clear aligned expectations including how primary care should be funded.

Set investment targets: By law or contractual requirements, clear goals are essential. Targets should reflect the true cost of agreed upon goals., including

- expenses related to additional staff,
- new technology, and
- ongoing training and technical assistance.

Targets can include incremental annual % changes, or absolute targets, i.e., 14% of total costs on primary care. Targets can be set by purchasers and/or the state, they can be voluntary or required, they can be enforced through penalties.

Gather data and report: An all-payer claims database facilitates data collection. Annual reporting reinforces expectations and helps to define new goals/benchmarks .

Other State's Experiences

PRIMARY CARE DEFINITION	PRACTICING		IN PROCESS				
	OR	RI	CO	CT	DE	MA	MD
Narrow (N), Broad (B), or No Distinction (ND)	ND	ND	ND	N, B	ND	ND	ND
Most Common Provider Specialties							
▸ Family/general practice	✔	✔	✔	✔	✔	✔	✔
▸ Internal medicine (no subspecialty)	✔	✔	✔	✔	✔	✔	✔
▸ Pediatrics (no subspecialty)	✔	✔	✔	✔	✔	✔	✔
▸ Nurse practitioner/physician assistant	✔	✔	✔	✔	✔	✔	✔
Expanded Provider Specialties							
▸ Certified clinical nurse specialist	✔		✔			✔	
▸ Nurse, nonpractitioner	✔		✔			✔	✔
▸ Internal medicine (geriatric specialty)	✔	✔	✔	✔	✔	✔	
▸ Adolescent medicine	✔	✔	✔	✔		✔	
▸ Obstetrician/gynecologist	✔		✔	✔		✔*	
▸ Behavioral health practitioner	✔		✔			✔‡	
▸ Homeopath/naturopath	✔					✔	✔
▸ FQHC/primary care clinic/rural health clinic practitioner	✔	✔	✔	✔	✔	✔	✔
▸ Other			✔	✔		✔	

Defining Primary Care Requires the stakeholders to agree..

In addition to other parameters, it can be done by

Provider or Service.

Other State's Experiences

PRIMARY CARE DEFINITION	PRACTICING		IN PROCESS							GETTING STARTED		
	OR	RI	CO	CT	DE	MA	MD	VT	WA	ME	UT	CA/IHA
Services and Expenses												
▸ Office visits/preventive visits/vaccine administration	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
▸ Behavioral health	✔		✔			✔	✔	✔				
▸ Care coordination and/or management	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
▸ Health information exchange/other infrastructure	✔	✔	✔	✔		✔		✔				
▸ Maternity	✔[5]		✔[5]					✔				
▸ Primary care incentive payments		✔	✔	✔	✔	✔		✔				
Data Source												
▸ All-payer claims database (APCD)	✔		✔	✔	✔		✔	✔	✔	✔	✔	✔
▸ Payer submits Excel template to state	✔	✔	✔	✔	✔	✔		✔				✔
▸ Non-claims-based payments included	✔	✔	✔	✔	✔	✔		✔				✔
Definition of Total Spending Includes												
▸ Non-claims payments	✔	✔	✔	✔	✔	✔		✔				✔
▸ Prescriptions (Rx)		✔		✔		✔	✔		✔			✔

The most consistent attributed primary care services are:

- **Office visit** by provider type,
- **Care coordination.**

Non-claims payments and prescription data are often included in total spend.

The point is the states' **stakeholders define primary care**

Primary Care Spend Solutions

Recurrent State level themes regarding solutions include:

Data: Changes to workforce and payment data systems so policymakers are better able to make data-driven decisions related to primary care

Payment: Pay primary care more and differently to achieve greater access to primary care and to support a team delivering more comprehensive care

Workforce: Enact policies to leverage, support and retain the current primary care workforce

Education/Training: Incentivize, inspire and diversify the future primary care workforce

Employers: Educate employees about the importance of a primary care relationship and urge health plans to encourage establishing such relationships; and remove financial barriers to primary care

WV Steps to Primary Care Spend

Form a stakeholder group

WVAFP, The Osteopathic Association, State Medical, Medical Schools, School of Public Health representative, The PCA, the Rural Health Association, Dept of Pub Health representatives, Medicaid MCOs, Commercial insurer representatives, PEIA representatives. Etc,

Legislate a database

WV had an "All Payer Claims Data Base" but was removed from Code in 2023, initiated by house health. If enacted, where should this be housed?

Codify the stakeholder groups primary care recommendations

Likely an incremental approach and include in MCO contracts.

Report outcomes annually-then revisit goals.

https://www.cleveland.com/news/2020/02/dr-checklist-bows-in-for-second-act-at-university-hospitals-in-cleveland.html Accessed 3/10/24

WV Primary Care Spend

Funding Shifts…A single example:

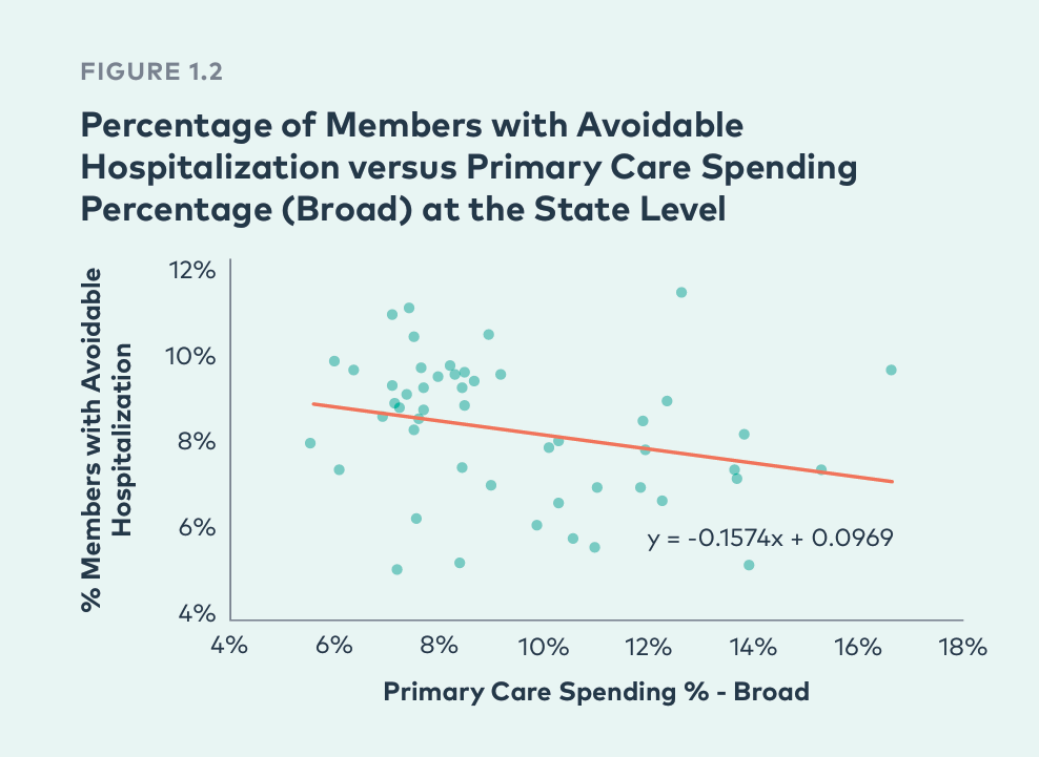
Hospitalizations-it is estimated that 1/3 of admissions are unnecessary.

In 2020 WV

population of 1,792,147 had

10.26%, or 179,000 persons with a preventable hospitalization.

This represents a potential cost savings of $1.5B



Ann Kempski, MS, Ann Greiner, MCP, Primary Care Spending: High Stakes, Low Investment December 2020. Primary Care Collaborative. PCC_Primary_Care_Spending_2020.pdf (thepcc.org). Accessed 3/9/24

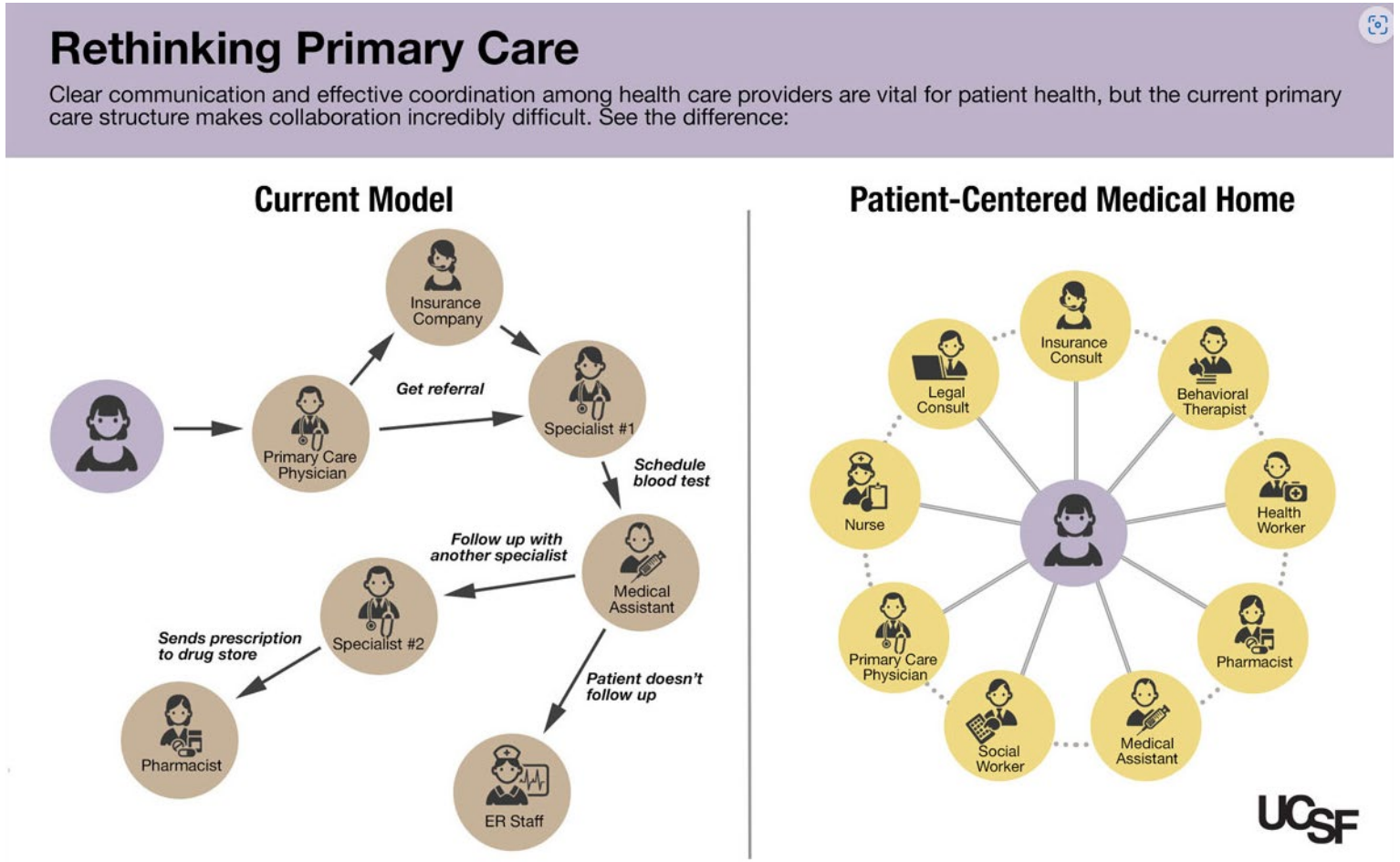
Visualizing Enhanced Primary Care Spend

Primary spend increases should increase numbers and salaries of PCPs.

But to be successful the stakeholders should visual a primary centric delivery system:

https://www.pennmedicine.org/departments-and-centers/family-medicine-and-community-health/education-and-training/residency/our-graduates. Accessed 3/10/24

Visualizing Enhanced Primary Care Spend



A 2014 cartoon showing the patient at the center of all care

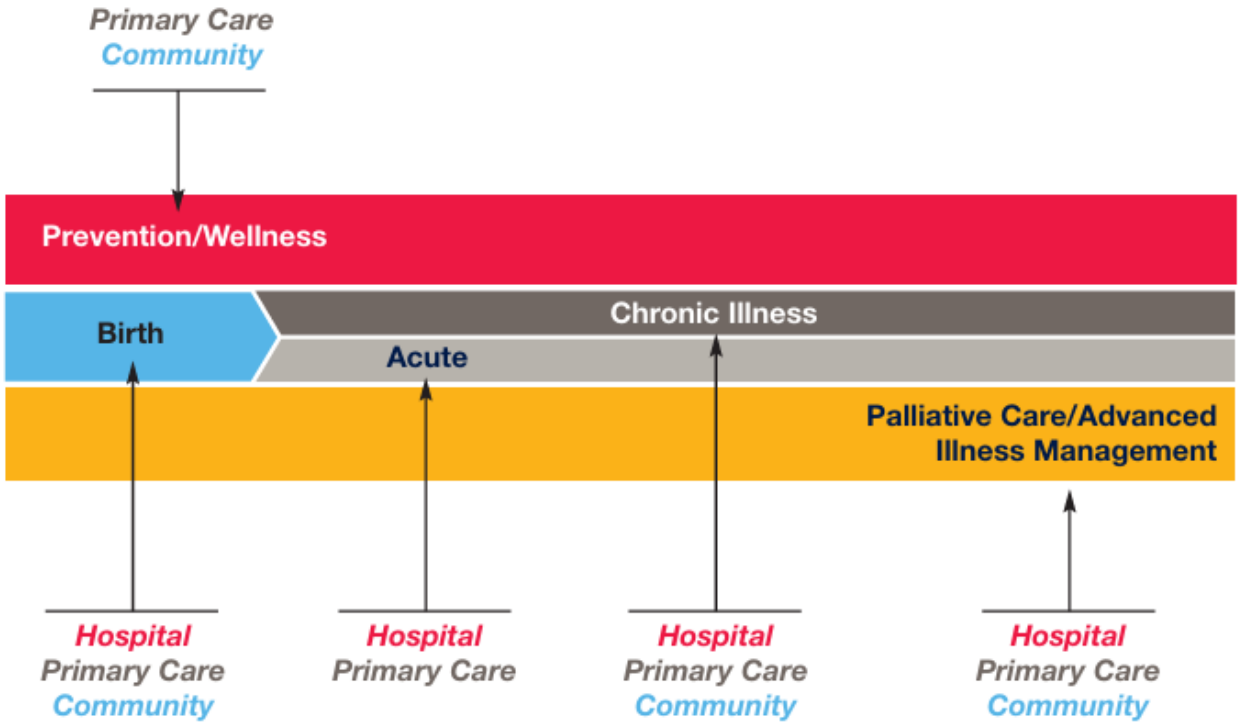
Note:

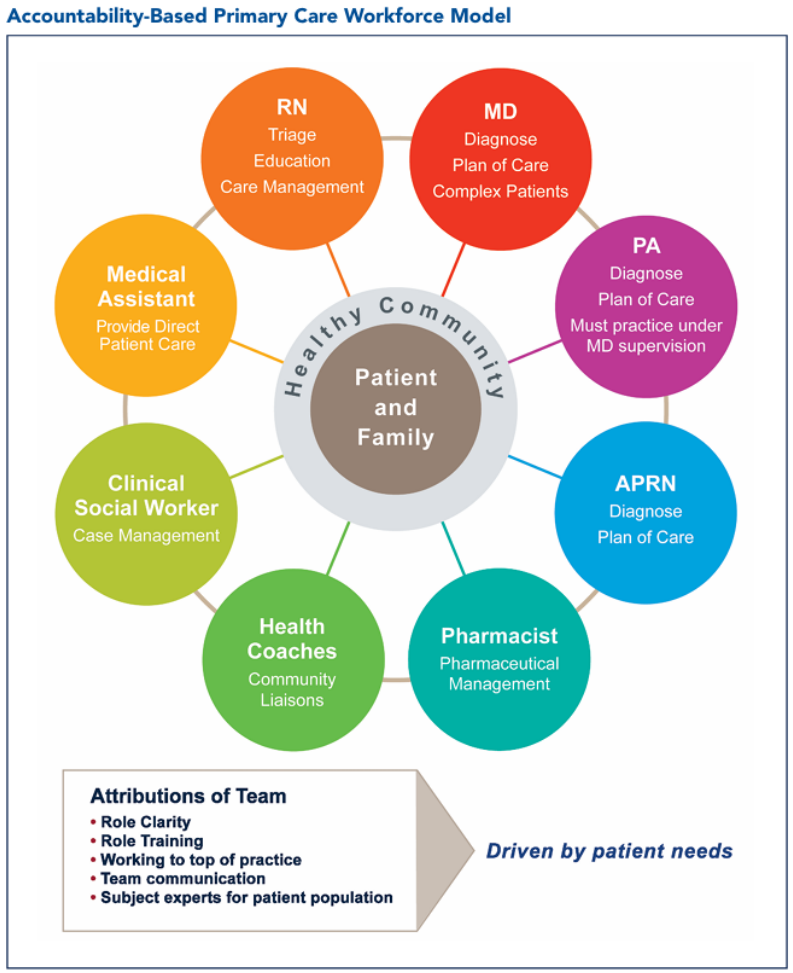
In the first cartoon the arrows only move in one direction.

the PCP is not in central position in the second cartoon

https://www.ucsf.edu/news/2014/08/116856/team-based-approach-primary-care Accessed 2/17/24

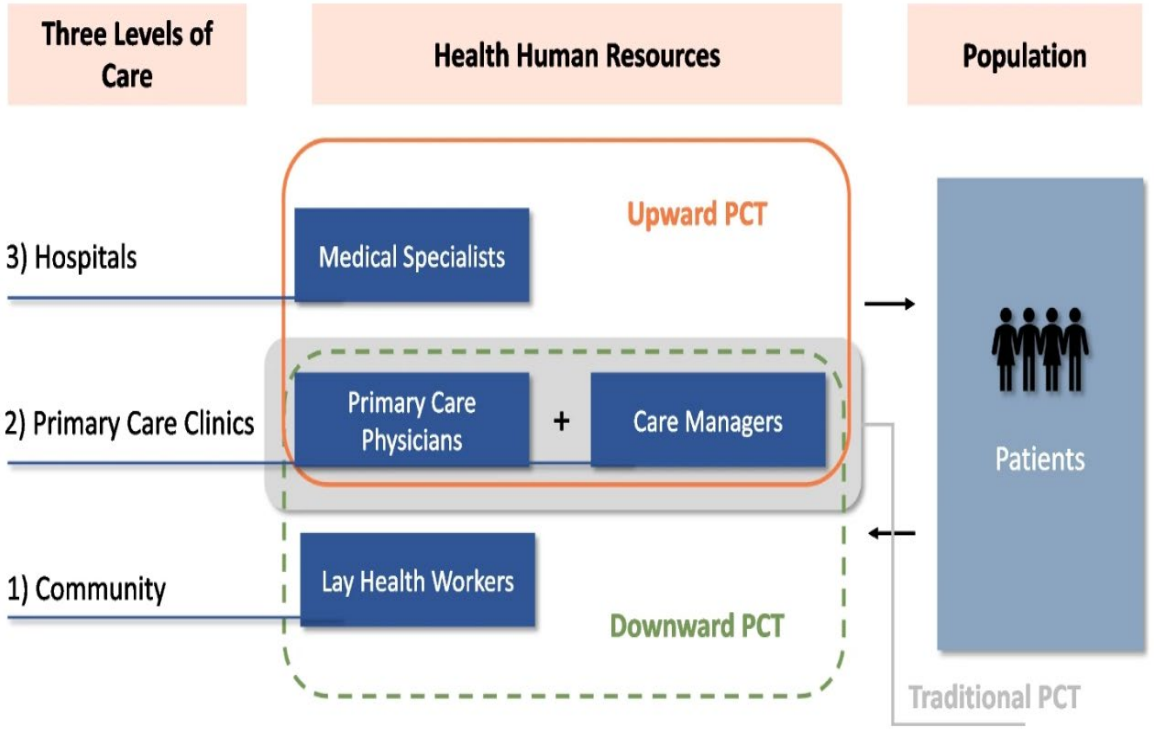
Visualizing Enhanced Primary Care Spend





https://www.aha.org/sites/default/files/aone/primary-care-workforce-needs.pdf

Visualizing Enhanced Primary Care Spend



A functional primary centric model would have:

- PCP as first contact and with a patient in a longitudinal relationship.
- PCP should be:
  - highest level of education/training
  - Working at limit of scope
  - Competitively reimbursed
  - Free of unnecessary administrative burdens
  - Managing a reasonable panel size
  - Having a flexible schedule
  - Able to direct pts to affordable complimentary care, ie behavioral health, PT, etc.

From: Primary care team and its association with quality of care for people with multimorbidity: a systematic review

Final Thoughts:

Current WV delivery models have not resulted in desired outcomes.

Patient morbidity and mortality are worst in nation.

Cost of care is not sustainable.

Primary care in WV requires re-investment and redirection.

Primary care spend increase with specific consensus driven targets can result in improvement of cost and outcomes.

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