MARYLAND
Health Care
Commission

Andrew N. Pollak, MD, Chairman
Ben Steffen, Executive Director

February 23, 2022

The Honorable Delores Kelley
Chair, Finance Committee
3 East, Miller Senate Office Building
Annapolis, Maryland 21401

RE: SB 734 - Health and Health Insurance – Primary Care Reform Commission

Dear Chair Kelley:

The Maryland Health Care Commission (the "MHCC") is submitting this letter of support with amendments on *SB 734 – Health and Health Insurance – Primary Care Reform Commission ("SB 734").* The MHCC endorses the aims of SB 734 but believes formation of a new single-purpose Commission to study primary care issues is not needed.

SB 734 establishes a Primary Care Reform Commission composed of 13 members; three appointed by the Governor, four appointed by the President of the Senate, three appointed by the Speaker of the House, and one member each appointed by the Maryland Hospital Association, MedChi, and the Maryland Nurses Association. The primary responsibility of the Commission is to review and make recommendations on the level of primary care spending relative to overall health care spending for all payors. The Commission is also to make recommendations on expanding access to primary care, lowering overall costs, and increasing health equity and in parallel reducing health disparities. The Commission would apparently develop a uniform definition for primary care, a question on which the clinical care and health services research communities have produced multiple definitions.

The MHCC believes that examining primary care spending as a percent of total health care spending can be a valuable tool for assessing access to primary care and for measuring the overall effectiveness of a health care system. Primary care experts beginning with Dr. Barbara Starfield documented that increased investment in primary care could have a beneficial effect on the quality of care, access to care, and mortality. Starfield and colleagues went on to document that the effectiveness of health care systems in the United States and across developed countries could be measured by the percent of health care dollars

dedicated to primary care.[1] [2] [3] Starfield articulated the four pillars of primary care practice: first-contact care, continuity of care, comprehensive care, and coordination of care. These pillars have been the foundation for all elaborations of the key primary care attributes that provide the basis for launching multiple primary care interventions. Drs. Thomas Bodenheim, Kevin Grumbach and colleagues posited 10 building blocks of high-performing including four foundational elements — engaged leadership, data-driven improvement, empanelment, and team-based care that assist the implementation of the other six building blocks — patient-team partnership, population management, continuity of care, prompt access to care, comprehensiveness and care coordination, and a template of the future.[4] Greater primary care physician supply was associated with lower mortality, but primary care providers per capital have decreased from 2002 to 2016 and prospects for greater supply in the future without major interventions appear dim.[5] Other experts have voiced alarm as the percent of total health care spending attributed to primary care continues to decline. [6]

Primary care experts research has spawned a host of primary care models including patient-centered primary care homes, the Maryland Primary Care Program, and the CareFirst primary care model. These models resemble models being tested elsewhere, the MDPCP closely aligns with current CMS primary care programs such as Comprehensive Primary Care Plus and the recently launched CMS Primary Care First Program. The Maryland Total Cost of Care Model has as a core feature the elevation of primary care and MDPCP is a central element of the broader model. Programs and many others have yielded some successes and demonstrated the importance of primary care on improving population health. Given decades of under investment in primary care, none has yet yielded the health policy

[1] Starfield, B., Shi, L., & Macinko, J. (2005). Contribution of primary care to health systems and health. The Milbank Quarterly, 83(3), 457-502. https://www.milbank.org/wp-content/uploads/2020/04/STARFIELD_et_al-2005-Milbank_Quarterly.pdf

[2] Shi, L., B. Starfield, B. Kennedy, and I. Kawachi. 1999. ''Income Inequality, Primary Care, and Health Indicators.'' Journal of Family Practice 48 (4):275–84.

[3] Macinko J, Starfield B, Shi L, "The Contribution of Primary Care Systems to Health Outcomes within Organization for Economic Cooperation and Development (OECD)Countries, 1970–1998", Health Service Research Review, https://onlinelibrary.wiley.com/doi/epdf/10.1111/1475-6773.00149

[4] Bodenheimer T, Ghorob A, Willard-Grace R, Grumbach K, The 10 Building Blocks of High-Performing Primary Care, Annals Of Family Medicine, Vol. 12, No. 2, March/April 2014, https://www.annfammed.org/content/12/2/166, accessed February 20, 2022

[5] Basu S, Berkowitz S, Phillips R, Bitton A, Landon B. Phillips R, Association of Primary Care Physician Supply With Population Mortality in the United States, 2005-2015 JAMA, February 18, 2019, https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2724393

[6] Martin S, Phillips R, Petterson S, Levin Z, Bazenmore A, Primary Care Spending in the United States,2002-2016, JAMA Internal Medicine, Vol. 180, No. 7, Https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2765245

homerun that advocates have promised. Rather than abandon efforts and watch the slow demise of primary care, more progress and new efforts are needed.[7] [8]

Setting spending floors for primary care is one such approach. Rhode Island, Oregon, and Connecticut have taken a direct approach to rectifying under investment in primary care.[9] These states have established minimum thresholds for primary care spending expressed as a percent of total health care spending.

MHCC supports studying access to primary care and developing recommendations to improve access. MHCC believes that a better approach to examining these questions is to direct the MHCC in consultation with the Health Service Cost Review Commission, with the Maryland Department of Health (MDH) and the Maryland Insurance Administration (MIA) to develop a workgroup to study these issues and develop recommendations by the end of 2023. The MHCC has experience with primary care models as MHCC launched the first PCMH program in 2012 after the General Assembly passed legislation establishing a Patient Centered Medical Home (PCMH) pilot. Most notably that program is the primary care program that required the five largest commercial carriers and the Medicaid MCOs to participate.

More recently, the MHCC has been engaged with the MDPCP program since its inception and currently manages the MDPCP Advisory Council, a blue-ribbon workgroup composed of 20 members including some of the leading primary care experts in the country, local experts, payor representatives, and primary providers participating in the MDPCP. Other key participants on the Council include the MDPCP Program Management Office (PMO) and HSCRC. HSCRC's participation is essential because it has developed care transformation programs that complement the MDPCP. HSCRC's participation has ensured that transformation made in the delivery of primary care services align with current and future Total Cost of Care contracts between Maryland and CMS.

MHCC and HSCRC possess analytic and actuarial staff necessary to conduct the assessment of primary care spending relative to total health care spending. MHCC has responsibility for building the Medical Care Data Base (MCBD), which is Maryland's version of an All-Payer Claim Database. The MCDB is used by the HSCRC, MIA, Medicaid

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[7] Sinaiko A, Landrum MB, Meyers D, Alidina S, Maaeng D, Friedberg M, Kern L, Edwards A, Flieger SP, Houck P, Peele P, Reid R, McGraves-Lloyd, Finison K, Rosenthal M, "Synthesis Of Research On Patient-Centered Medical Homes Brings Systematic Differences Into Relief", Health Affairs, Vol 36, NO. 3 (2017): 500–508 healthaffairs/doi/10.1377/hlthaff.2016.1235

[8] National Academies of Sciences, Engineering, and Medicine 2021. Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care. Washington, DC: The National Academies Press. https://doi.org/10.17226/259

[9] Bailit M, "How States Are Increasing Their Investment in Primary Care", Milbank Memorial Fund, Nov. 19, 2020. https://www.milbank.org/2020/11/how-states-are-increasing-their-investment-in-primary-care/

Administration, and the Maryland Health Benefit Exchange. MHCC released a study of primary care spending as a percent of total spending that mirrors the types of analyses needed to determine possible spending floors for primary care.[10] More recently, MHCC's MCDB contractor worked with six states in New England to develop a comparative report on primary care spending for those states.[11] Other researchers have sought to assess the level of primary care spending using different data sources [12] [13] The MHCC contends that establishing a new commission and directing it to assemble claim data from commercial payors and MCOs is unnecessary and likely duplicative.

MHCC supports the objectives of SB 734. A more cost-effective approach is to ask the agencies already engaged in this work to form a workgroup, study the issue, and report recommendations back to the Committees in December 2023. A letter from the Chairs of Senate Finance and the House Health and Government Operations Committee to MHCC, HSCRC, the Department, and the MIA would be sufficient to engage the respective organizations if the Committee believes legislation is not necessary. Please see the attached amendments.

We hope this information is helpful. If you would like to discuss this further or have any questions, please contact Tracey DeShields, Director, Policy Development and External Affairs at tracey.deshields2@maryland.gov.

Sincerely,

Andrew Pollack
Chair, MHCC

Ben Steffen
Executive Director, MHCC

cc:

[10] MHCC, Primary Care Spending Relative To Total Medical And Outpatient Prescription Drug Spending In Maryland's Privately Insured Markets, 2018, August 2020. https://mhcc.maryland.gov/mhcc/pages/plr/plr_healthmd/documents/cais_Primary_Care_Issue_Brief_08212020.pdf

[11] The New England States' All-Payer Report on Primary Care Payments, The New England States Consortium Systems Organization (NESCSO). Note NESCSO includes Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont. https://nescso.org/wp-content/uploads/2021/02/NESCSO-New-England-States-All-Payer-Report-on-Primary-Care-Payments-2020-12-22.pdf

[12] Pearson E, Frakt A, Health Care Cost Growth Benchmarks in 5 States, JAMA, August 11, 2020, Vol 324, No. 5, https://jamanetwork.com/journals/jama/fullarticle/2769252

[13] Reiff J, Brennan N, Biniek J, Primary Care Spending in the Commercially Insured Population, JAMA December 10, 2019,vol 322,No. 22. https://jamanetwork.com/journals/jama/fullarticle/2757218

The Honorable Clarence Lam, Senator
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