



POLICIES TO TRANSFORM PRIMARY CARE:

*The Gateway to Better Health
and Health Care*

DECEMBER 2018



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DEFINING PRIMARY CARE

Defining Primary Care is a complicated and often controversial undertaking. The Institute of Medicine defines 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.”² In addition to this general definition, the Agency for Health Care Research and Quality has identified several cardinal features of primary care, including care that is accessible in a timely manner without a referral, continuous, coordinated, comprehensive, whole-person and accountable.³ Many primary care experts also emphasize the relationship-based nature of primary care, with providers often serving as a trusted source of health care knowledge for their patients.⁴ Primary care can be thought of as a set of providers, a set of services, or as an orientation of the health care system.⁵

Primary Care: The Entry Point to The Health System

From new parents calling their pediatrician’s office when their baby is running a fever to older adults trying to manage diabetes or high cholesterol, most patients’ main point of contact with the health system is most often through their primary care provider’s office. Primary care serves as an entry point to the health care system, connecting patients to the other specialists, treatment options, and even social services, they need to get and stay healthy.

We know that access to primary care is associated with better health outcomes and lower costs. Yet, in the U.S., we invest in primary care at lower rates than other countries and have failed to address coverage and affordability barriers that prevent people from accessing care. As a result of these many failures to provide adequate access to primary care, 20 percent of Americans report that they have no consistent source of health care and there is a steady decline in the number of Americans who report having a personal relationship with a primary care provider.¹

At the same time, rapid changes in the health system are changing the way primary care is both delivered and accessed. The Affordable Care Act (ACA) improved access to coverage and incentivized the use of preventive services, while the increasing prevalence of high-deductible health plans made accessing primary care financially difficult. When patients do access primary care services, they are increasingly doing so in non-traditional ways, such as through online health services or at retail clinics and urgent care centers. A growing movement to better address the upstream factors that influence health has many reimagining the way primary care could be structured and delivered to better meet a community’s broader health needs. As the system becomes increasingly complex, primary care providers have an important role to play in helping patients navigate this complexity. It will be crucial that the primary care system is prepared to meet the challenges and demands of a changing health system while maintaining its role as the central providers of continuous, comprehensive relationship-based care.

This issue brief examines some of the challenges currently facing primary care and offers a menu of federal and state policy solutions that, taken together, will move us towards a system centered on primary care, where access to coordinated, patient-centered primary care is available to all.

Why Consumer Advocates Should Prioritize Improving Primary Care

We are at a crossroads in American health care. The significant gains in coverage under the Affordable Care Act created a solid foundation that allowed policy makers and stakeholders to make progress on improving the delivery of care to make it more efficient and person-centered. However, in recent years, the gains in coverage have eroded and are under increasing threat. Amidst the uncertainty and immediate threats, it can be difficult for advocates, organizers and policy makers committed to making the health system work for patients to focus on building a long-term proactive policy agenda.

Although the future remains uncertain, strengthening the primary care system should be a top priority. Primary care is the entry point to the health care system for most Americans, and as such, presents opportunities for demonstrating immediate and tangible benefits to consumers. Advancing primary care can be an important part of a policy platform both for advocates who are working towards a system of affordable, universal coverage, and for advocates who are trying to mitigate harmful health care service and benefit cuts. Below are compelling, tangible reasons why advocates should focus on primary care in both the short-term and long-term.



- **Access to primary care improves health outcomes, particularly for patients with complex health needs**

While there are a number of strategic and cost-related reasons why consumer health care advocates should focus on policies that strengthen primary care, the core reason is that improvements to the access and delivery of primary care benefit patients. Access to primary care can lead to better health outcomes and lower costs. States with more primary care providers (PCPs) per capita also see lower rates of mortality and lower incidences of certain diseases.⁶ When patients have a consistent PCP relationship, they develop more trust in their provider. This results in improved patient-provider communication, improved likelihood that patients will receive the care they need, and lower mortality from all causes.⁷ The potential benefits of an improved primary care system are even greater for patients with complex health needs.⁸

- **Increasing access to primary care can reduce health system costs and provide a patient-centered policy alternative to harmful cuts**

The current political reality at the federal level and in many states means that in the short term, many advocates are spending their time fighting harmful health care cuts and changes to Medicaid, such as the imposition of work requirements and lockout periods. While fighting back against these cuts, it is important that advocates can articulate and offer patient-centered alternatives for addressing health system costs and inefficiencies. Policy changes that strengthen primary care could be particularly successful alternatives, as regular access to primary care leads to a decrease in the utilization of specialists, preventable emergency department visits, and hospital admissions.⁹ International comparisons show that countries with more primary-care-oriented health systems have lower health care costs, yet better health outcomes than other countries.¹⁰

- **A strong primary care infrastructure is necessary to support expanded coverage models**

For many health care advocates, expanding coverage beyond the Affordable Care Act is an important long-term goal, and policy makers and thought leaders are exploring various options for

achieving universal, or close-to-universal coverage. Strengthening primary care is a necessary corollary to fulfilling our promise of expanded health insurance coverage. Only when consumers have access to a frontline provider with whom they can have an ongoing relationship are the coverage goals of access, better health, equity and lower costs attainable.

- **Improving primary care access and delivery can reduce health disparities and advance health equity**

In the United States, people of color experience worse health outcomes across a number of indicators. Rates of asthma, diabetes and cardiovascular diseases are higher for Blacks, American Indians, and Alaskan Natives. Black women have rates of maternal and infant mortality much higher than that of white women. And the rate of HIV and AIDs is significantly higher for the Black population.¹¹ A lack of access to a regular primary care provider both contributes to and exacerbates these disparities. For example, primary care providers often regularly screen for conditions such as HIV and diabetes, which, if detected early, can be attenuated and better managed. Black, Asian and Hispanic patients report having a regular primary care provider at lower rates than white patients, and non-English-speaking patients are less likely to have a regular primary care provider than English-speaking patients.¹² In addition to the improvements in chronic disease outcomes associated with increased access to primary care, efforts to better integrate primary care and behavioral health, address the social determinants of health through primary care settings, and utilize peer supports and community health workers in primary care settings also have great promise for reducing disparities and improving health equity.

A VISION FOR PATIENT-CENTERED PRIMARY CARE

The first step in successfully advocating for a primary care system that meets the needs of consumers is to articulate a positive vision of what that system should look like. The policy options offered in this document, when taken together, would move us towards a system of primary care that lives up to the following principles¹³:

- Patients are able to access primary care services in their community, regardless of income, insurance status, or immigration status.
- Access to primary care services is both affordable and timely.
- Care is comprehensive, high quality and longitudinal.
- Primary care providers are able to focus on delivering care to patients with a minimum of red tape or unnecessary administrative burdens.
- Care is delivered by a multidisciplinary team, including care coordinators, social workers, peer supports, and community health workers.
- Primary care is focused on the whole person, with successful integration of behavioral and oral health services and an emphasis on addressing the social determinants of health.
- Care is culturally competent, trauma-informed, and able to meet the unique health needs of the individual, regardless of their race, age, ability, sexual orientation, gender identity or background.
- Financing of primary care is sustainable and reflects the importance and value of primary care in the health system.
- Consumers are treated as partners in their care and primary care providers have the time, resources, and incentives necessary to actively engage patients in care decisions.

Barriers to Access and Effectiveness in Primary Care

Despite the numerous benefits high quality, accessible and person-centered primary care provides to patients and the health system overall, consumers in the US continue to experience a number of problems in accessing and utilizing primary care services. This is due in large part to a failure to adequately value and invest in this kind of care. In the U.S., the overall system investment in primary care remains low, the fee-for-service payment system does not incentivize the delivery of high value primary care services such as prevention and care coordination, and primary care providers receive reimbursement rates much lower than that of their specialist colleagues. On average in 2013, OECD countries had a primary care spending rate of 12 percent, while in the U.S., spending on primary care services was only between five and eight percent.¹⁴ Although it is highly unusual to see a decline in health spending in the U.S., spending on primary care actually fell by 6 percent between 2012 and 2016.¹⁵ This historic and current undervaluing has resulted in a health system where patients often can't access or afford primary care, and even when they can, that care often fails to meet their health care needs.

- **Even with coverage gains, consumers still face affordability barriers to accessing primary care**

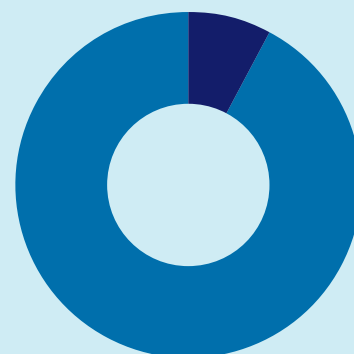
Although the ACA significantly increased the number of people with insurance coverage, there are still over 27 million uninsured individuals and millions more who have difficulty affording care even with insurance coverage. Approximately 1 in 10 consumers report delaying or forgoing care because of cost. This number increases to 1-in-5 for people who report being in poorer health.¹⁶ Access is even more difficult for immigrant populations who may lack access to affordable coverage options or forgo seeking care because of fear that providers will report their immigration status to authorities.¹⁷ Between 2011 and 2016, the number of adults with high deductible health plans increased from 26 percent to close to 40 percent and individuals on these plans were more likely to delay or forgo medical care due to costs than individuals in traditional health plans.¹⁸

- **Consumers can't find and access a primary care provider**

Approximately 20 percent of patients report that they have no consistent source of health care and data from the Medical Expenditure Panel Survey shows a steady decline in the number of Americans who report having a personal relationship with a provider.¹⁹ The Health Resources and Services Administration estimates that over 84 million people live in areas where there is a shortage of primary care health professionals. This shortage is especially pronounced in rural areas where patients may have to travel long distances to visit the closest provider. Even when consumers are able to locate an available provider, there are numerous barriers to accessing that provider. For example, many providers do not offer services beyond normal business hours, making it difficult for people without paid sick leave to access care without fear of losing their jobs. Additionally, non-English speakers or people with disabilities often report difficulties finding providers who can accommodate their needs.²⁰ All of these barriers create an environment where it can be difficult for consumers to even get in the door to see a primary care provider.

One cause of these access issues is the shortage of primary care providers in the U.S. The Health Resources Services Administration (HRSA) estimates that by 2020 the United States will be short 20,400 primary care physicians.²¹ At the same time, an aging population will increase the need for

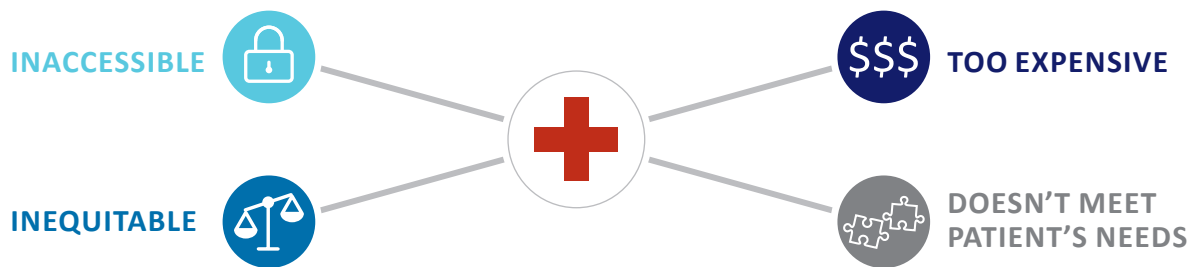
U.S. SPENDING ON PRIMARY CARE



PRIMARY CARE: 5-8%

more health care providers, including a pressing need for providers trained in geriatric care best practices. One major reason physicians cite for not entering primary care is financial concerns. Primary care providers in the U.S. are paid less than other specialties.²² This is partially a result of the fee-for-service system that favors specialists who perform high numbers of costly procedures, but also is affected by the actual amount payers will reimburse for the types of procedures primary care physicians perform. For example, the Medicare Payment Advisory Commission found that Medicare has underpriced primary care services, such as evaluation and management services, leading to disparities in provider compensation.²³

BARRIERS TO PATIENT CENTERED PRIMARY CARE



- **When consumers can access primary care, that care often doesn't meet their needs**

The average primary care visit lasts about 18 and one-half minutes, which is often inadequate for patients with multiple chronic conditions, numerous medications to manage, or complex social needs.²⁴ Although studies show that the majority of people with behavioral health needs seek care from their primary care provider, providers report that they have limited capacity for screening and treating behavioral health care needs.²⁵ Adults with physical or developmental disabilities often receive inadequate preventive care services.²⁶ Moreover, older adults with chronic health problems often receive care that is highly fragmented, incomplete and too often ineffective.²⁷

With growing recognition of the importance of social determinants such as access to housing and healthy food, systemic factors such as racism, the impacts of trauma on patients, and broader community needs, the primary care system has an important role to play as the first — and often the most consistent — point of contact patients have with the health system. However, currently most primary care practices are not prepared or equipped to screen patients for their social needs, refer them to services, provide trauma-informed care, or assess and respond to broader community health needs.

One major reason primary care does not often meet patients' needs is the fragmentation of the health system in the United States. While providers struggle to manage the different incentives, payment practices, and reporting requirements of different payers with little alignment, patients are left on their own trying to navigate a complicated health system and multiple providers who aren't communicating with each other. For example, in some states, Medicaid prohibits billing for behavioral health and physical health care services on the same day, making it financially impossible for a primary care practice to screen a patient for behavioral health needs and then provide a warm handoff to a behavioral health care provider on site. This lack of alignment and communication makes it more difficult to identify a patient's health needs and address them in a coordinated, comprehensive and timely manner.

This problem is exacerbated by the specific payment models used to reimburse primary care clinicians. The dominant fee-for-service model encourages providers to value the number of patients seen or procedures performed over adequate high-quality time interacting with patients. This creates a system where PCPs are paid less for valuable health services they offer such as lifestyle counseling and care coordination. Additionally, this system does not provide the flexibility needed to provide services that address the social determinants of health, services provided by community based providers, and care coordination activities. It also makes it hard for practices to afford the upfront investments that are often needed to implement more integrated, team-based models of care.

- **There are significant disparities in the quality of care patients receive**

There are also significant disparities in the quality of primary care received by patients of color, low-income patients, and LGBTQ patients. One study found that even when controlling for socioeconomic and health system factors, children of color experienced lower-quality primary care than white children in multiple areas including comprehensiveness and effective provider/patient relationships.²⁸ Quality measures relating to care coordination (for example, rates of preventable emergency department visits for asthma) are lower for low-income patients than for higher income patients and quality measures relating to disease control are lower for patients of color compared to white patients.²⁹ In addition, a large percentage of LGBTQ patients report instances of providers denying care, using harsh or harassing language, and blaming their sexual orientation for their illness.³⁰

CURRENT STRATEGIES HAVEN'T GONE FAR ENOUGH

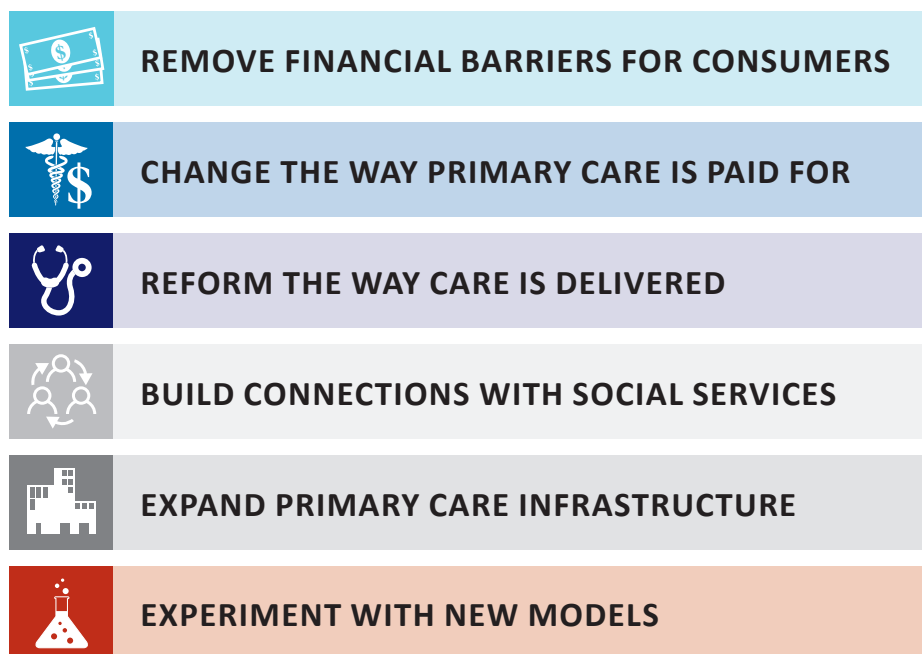
These problems are widespread and persistent, but they aren't new. Efforts have been underway to improve the primary care system in the U.S. for years. The National Health Service Corps and J-1 Visa programs aim to bring more providers into underserved areas by offering loan forgiveness for recent medical school graduates and work visas for physicians from outside the U.S. who agree to practice in an underserved community. The Affordable Care Act attempted to address financial barriers by improving access to insurance coverage and requiring coverage of preventive services with no cost sharing and made significant investments in the primary care workforce. It also created the Center for Medicare and Medicaid Innovation (CMMI) and spurred public and private payment and delivery reforms aimed at improving the value of care. Many of these efforts were specific to primary care including:

- **Patient-Centered Medical Homes (PCMH):** A PCMH is a coordinated, team-based model of delivering primary care in which the patient's primary care team is responsible for all of their physical and mental health care needs. There are a number of different payment models currently being tested by the Centers for Medicare and Medicaid Services (CMS) that could help support the long-term sustainability of these models.
- **Accountable Care Organizations (ACOs):** ACOs, which exist in the public and private spheres, are health care payment and delivery arrangements under which a set of providers agree to take on responsibility for the total cost of care of a defined patient population. These arrangements are often tied to achieving specific quality outcomes. While the design of ACOs varies from model to model, in theory, primary care providers in ACOs should play an important role in working to reduce unnecessary spending and improve health outcomes.
- **Comprehensive Primary Care (CPC)/ Comprehensive Primary Care Plus (CPC+) demonstration:** The CPC demonstrations are multi-payer models the CMMI are testing in select regions across the country. These models provide population-based care management fees and shared savings opportunities to primary care practices to allow them to provide more comprehensive, coordinated primary care services.
- **Direct Primary Care models:** Direct primary care models usually involve a patient or payer (such as an insurance company or Medicare) paying a primary care provider a set per patient per month price to provide a full set of primary care services to that patient. These types of practices are increasing in the private sector and CMS recently expressed interest in testing this type of model in Medicare and Medicaid as well.

While many of these efforts have seen some success, the pace of progress is slow and the efforts for improvement too often remain siloed and underfinanced. There are still a number of structural and financial barriers that must be broken down in order to truly place primary care at the center of our health system and make lasting and sustainable change.

Steps to a Transformed Primary Care System

Achieving the vision of a person-centered primary care system will not be a quick nor an easy task. Here, we lay out a menu of state and federal policy options that advocates can choose from based on their capacity and expertise, as well as the political landscape and individual state needs, to form an effective primary care advocacy agenda.



- **Remove financial barriers that prevent consumers from accessing primary care services:**
 - **Do away with Medicare co-pays for primary care services, such as chronic care management or additional time for serving patients with disabilities (Federal):** CMS has made significant strides in increasing Medicare beneficiaries' access to important primary care services by creating new and extended billing codes for chronic care management services and proposing new codes for the extra time and resources necessary to care for patients with disabilities. However, these codes still come with cost-sharing requirements for patients. Even small out-of-pocket costs have been shown to impede access to care.³¹ Congress should move towards eliminating the 20 percent co-pay for Medicare services related to chronic care management and services for patients with disabilities. These changes could first be implemented as demonstrations in order to evaluate their effectiveness and enable smoother large-scale implementation.
 - **Require first-dollar coverage of primary care services in high-deductible health plans (State or Federal):** The increase in high-deductible health plans means that many consumers face financial barriers to accessing cost-saving primary care services. To improve access, states and/or congress should pass legislation requiring high-deductible health plans to provide full coverage for designated primary care services. The American Academy of Family Physicians recommends that covered services include Evaluation & Management (E&M) codes for new and existing patients (99201-99215), prevention and wellness codes (99381-99397), chronic care management and transition care management codes.³²

- **Close the Coverage Gap (State and Federal):** Improving access to affordable insurance coverage also improves access to and use of primary care and preventive health services.³³ Although the majority of states have expanded access to Medicaid coverage under the Affordable Care Act, 17 states have not yet closed the coverage gap, leaving millions of low-income people without access to coverage. For the 17 states that still have not expanded Medicaid, closing this coverage gap should be a key policy priority.

At the federal level, Congress could encourage states to close the coverage gap by bringing the Federal Medical Assistance Percentage (FMAP) back up to 100 percent FPL for the first three years after a state expands Medicaid coverage. This would give newly expanding states the same financial benefit as those states that expanded in the early years of implementation of the ACA.

- **Ensure safety-net coverage for immigrant populations (State):** Although ensuring health coverage and access for immigrant populations, both documented and undocumented, is an issue that extends beyond primary care, ensuring that immigrant populations have access to basic primary care and preventive services can be an important first step towards expanded coverage and can help prevent more costly emergency room visits or chronic health problems down the road. States or localities could follow the lead of cities such as Washington D.C. and New York and set up a program that provides low-income residents who are ineligible for Medicare, Medicaid or ACA exchange subsidies, access to preventive, primary and prenatal care services.³⁴ Other strategies can be found [here](#) and [here](#).

- **Change the way care is paid for to better recognize the value of primary care**

- **Revise CMS policies for determining Medicare payments to primary care providers (Federal):** One of most direct and potentially impactful ways to improve payment for primary care services is by changing Medicare reimbursement rates. The current procedure for determining Medicare reimbursement rates favors specialty care and does not accurately reflect the value of primary care to the health system overall. This concern is shared by the Medicare Access and Payment Commission (MEDPAC).³⁵ Congress should follow MEDPAC's budget-neutral recommendation to provide an increase in primary care payments by instituting a per beneficiary payment to primary care providers while reducing payments for other, lower-value services in the fee schedule.
- **Advance innovative and value-based payment models in primary care:** The traditional fee-for-service reimbursement model has severely limited the ability of primary care providers to meet their patients' complete health needs. In order to provide care that is comprehensive, coordinated and continuous, primary care practices need payment structures that provide significantly more flexibility for them to utilize community based providers, address patient's social service needs, prioritize coordination and integration and make the upfront investments necessary to transform their practices. Additionally these payment models and associated quality measures and incentives should be aligned across payers to help reduce fragmentation in primary care.

Specifically, the Center for Medicare and Medicaid Innovation should:

- Test the American Academy of Family Physicians' Advanced primary care model that was recommended by the Payment Model Technical Advisory Committee (PTAC).
- Include primary care spending benchmarks in any population-based payment models it tests.
- Advance payment models that provide primary care providers with significant flexibility to address patients' needs and spend more time with patients, such as direct primary care models.³⁶

- Test models that support team-based care, including by providing flexibility to pay traditionally non-billable professionals such as CHWs and peer supports.
 - Focus on implementing multi-payer models that align incentives and quality measures.
- **Pass legislation requiring measurement of primary care spending at the state level and eventually setting a baseline for primary care spending (State):** Despite ample evidence that investment in primary care can improve health outcomes and lower health care costs, primary care investment has actually been decreasing in recent years. Between 2012 and 2016, spending on specialty care increased by 31 percent, while spending on primary care decreased by 6 percent. One way to measure system investment in primary care is to track the percentage of health care dollars spent on primary care services at the state level. This provides a baseline to track spending over time and measure the impact of various policy changes on primary care investment and can encourage payers to explore options for increasing primary care investment. Oregon passed legislation requiring payers to report their levels of primary care spending annually. Rhode Island went even further, requiring payers to raise primary care spending by one percent annually in order to have their rates approved. Between 2008 and 2012, primary care spending in Rhode Island increased from 5.7 percent to 9.1 percent and overall health care spending decreased by 14 percent.³⁷ Other states could consider enacting similar legislation.³⁸



- **Reform the way primary care is delivered so it better meets patients' health needs**

- **Improve Medicare beneficiary access to home-based primary care (Federal):** Congress should significantly expand and make permanent the Independence at Home program that allows Medicare beneficiaries to receive comprehensive, team-based primary care services in a home setting.
- **Allow same day billing for different providers in Medicaid (State):** Many states either prohibit or restrict the ability to bill Medicaid for services provided by multiple providers on the same day. This creates a barrier to effectively integrating primary care with behavioral or oral health services and negatively impacts a patient's continuity of care. States should update their Medicaid billing policies to fully allow for same-day billing.
- **Promote co-location of behavioral health and oral health services within primary care (State):** Providing behavioral health, substance abuse and oral health services on site can help improve continuity of care, ensure providers are communicating about a patient's care, and increase the chances patients will access necessary services. However, there are a number of barriers to co-locating services. In order to promote the co-location of primary care services, states should:³⁹
 - Simplify and streamline facility-licensing requirements to reduce the administrative burden on practices that want to provide co-located services.
 - Allow for Medicaid reimbursement of Health and Behavioral Assessment and Intervention Codes, care management services, warm handoffs/consultations, and bi-directional communication between physicians/clinicians.
 - Streamline patient consent requirements

- **Advance Community Paramedicine initiatives (State):** Community paramedicine can be an innovative way of expanding the capacity of the primary care system to reach people at home and after hours. Colorado launched a pilot program to provide direct primary care services and community-based prevention services using community paramedics in some select rural areas and used the pilot to learn more about the regulatory and reimbursement changes that would be needed to scale the model state-wide. Minnesota passed legislation defining community paramedicine and authorizing reimbursement. Other states should consider similar approaches to expand the use of community paramedicine.⁴⁰

- **Build out connections between primary care and social services**
 - **Promote and incentivize the ability of primary care providers to screen patients for their socioeconomic needs and refer them to appropriate services (State):** Because primary care providers often serve as the entry point into the health system for patients, they are in an excellent position to assess that patient's socioeconomic needs and help direct them to appropriate services. Through levers such as Medicaid ACOs or managed care contracts, states can promote social determinant screening and referrals by requiring a social needs screening or requiring health entities to partner with community-based organizations.⁴¹

 - **Strengthen the Health Home model so that it is better able to address the social determinants of health (Federal):** There are a number of changes that could be made to the Health Home model to strengthen its ability to identify and address patient's social and economic needs, including:
 - Add socioeconomic vulnerabilities (such as homelessness, food insecurity, etc.) to the list of chronic conditions that qualify a patient for eligibility in a health home
 - Include enhanced funding or lower the required state match for a portion of funding going to improve coordination with social service providers
 - Require community health workers, social workers and/or peer support counselors be included as part of the care team

 - **Promote models that directly integrate of primary care and social services at a single site (State):** Primary care practices, in particular community health centers and practices serving primarily low-income or under-resourced areas, should capitalize on their role as an entry point to the health and social service system by providing warm hand-offs or direct services on site. For example, the Codman Square health center in Massachusetts provides a variety of health care and non-health care services, including a food pantry, teaching kitchen, financial health services, and wellness and fitness center. States should establish funding mechanisms to support models of care that directly integrate social and economic support services into primary care practices through co-location.

- **Improve access to primary care by expanding the primary care infrastructure**
 - **Expand Scholarship and Loan forgiveness programs (Federal):** Currently 11 million people receive care from a National Health Service Corps-funded provider. Despite recent increases in NHSC funding, provider shortages remain and are poised to worsen in coming years. Congress should significantly increase investment in NHSC scholarship and loan forgiveness programs in order to increase the number of providers practicing in underserved areas.

 - **Improve and strengthen the Conrad 30 J-1 visa waiver program (Federal):** Under normal circumstances, physicians from other countries working in the United States on a J-1 visa have to return to their home country after two years and apply for another visa. The Conrad 30

program allows providers to continue working in the US after the two-year window if they agree to work in an underserved area for at least three years. The program places 800-1,000 physicians in health professional shortage areas every year, and many of them end up staying in those communities after the three-year requirement. In order to help address the primary care workforce shortage, we recommend increasing the number of waiver slots from 30 to 50, with the extra 20 added slots prioritized for primary care and mental health providers.

- **Establish a federal “pipeline” program to encourage middle and high school students in rural or underserved communities to enter into primary care professions (Federal):** Current efforts to attract providers to underserved areas, such as the NHSC or Conrad 30 program have been crucial in alleviating the physician shortage in the U.S., but they have some weaknesses. Retention in these programs remains low, with many providers leaving the area after their required terms of service, making it hard to develop long-term relationships with patients. Additionally, providers who come from outside of a community may be less trusted by members of that community or less prepared to deliver culturally competent care. One strategy that addresses these weaknesses is by encouraging members of underserved communities to enter the health field. There are a number of federal grants and programs that encourage health sector “pipeline” programs but they are often small, time limited, and aimed at college students who are already on health and science tracks. Congress should increase investment in pipeline programs aimed at middle and high school students in underserved communities and streamline the existing opportunities into a federal health professions pipeline program that is easier for potential grantees to find and navigate.
 - **Expand the number of Graduate Medical Education (GME) slots for primary care (Federal):** The number of medical school graduates is increasing faster than the number of available residency slots. In order to ensure a health care workforce that is prepared to meet growing demand, congress should increase the number of Medicare-funded GME residency slots by 3,000 each year over five years, with 75 percent of those slots reserved for specialties currently experiencing shortages, including primary care.
 - **Expand Medicaid reimbursement for Community Health Workers (State):** Community Health Workers (CHWs) can help relieve burdens on the primary care workforce, improve patient outcomes and advance health equity.⁴² States should pursue policy options that incentivize and promote the use of CHWs in primary care settings. This includes requiring CHWs on interdisciplinary care teams in Medicaid (if the number of CHWs in a state makes this feasible), authorizing Medicaid reimbursement for services provided by CHWS, requiring coverage of CHWs in private insurance, or specifically writing CHWs into legislations surrounding specific health programs at the state level (for example, Louisiana passed legislation designating the use of CHWS as outreach coordinators for patients in its Sickle Cell Patient Navigator Program).⁴³
- **Experiment with non-traditional primary care models that re-envision the way primary care is provided in the United States**
 - **Advance multi-payer medical home models (State):** A medical home is a team-based model of delivering primary care that is patient-centered, comprehensive, coordinated, accessible, and focused on improving quality and safety. In an effort to fully support the transformation of primary care practices into medical homes and ensure better alignment of payers and incentives, many states have tested multi-payer medical home models. Evaluations of these multi payer models have shown reductions in spending, reductions in ER use, improved patient access and health outcomes and improved access to preventive services.⁴⁴ Additionally, evaluations of these models have produced a number of important lessons learned for

implementing multi-payer medical homes that could potentially improve outcomes even further, including strong involvement from the state government and/or Medicare, aligning payers from the beginning, and finding common ground between payers and providers on key performance measures.⁴⁵ States should continue pursuing multi-payer initiatives to help transform primary care practices into medical homes.

- **Advance Universal Primary Care Initiatives (State):** Some states have explored initiatives that would ensure universal access to primary care. Vermont recently passed legislation to study how the state could implement a publicly financed primary care health system for all state residents. An initial study bill could direct an agency or stakeholder group to define what constitutes primary care, recommend how to make sure services universally available, and develop options for financing such a system. States would need to optimally adapt a universal primary care access bill to their specific provider, financing, and policy environment.
- **Promote the delivery of primary care as part of comprehensive, community-based models:** While primary care providers can screen patients for social and economic needs and serve as important links between patients and social service providers, their ability to move the needle on the social determinants of health will always be limited without extensive community involvement and integration. This involves re-imagining the primary site of health as the community, not the hospital or doctor's office. Initiatives like the Accountable Health Communities model piloted by CMMI envision primary care as a key player in a connected, community-based network of health and social service providers. Another promising model in this same vein is providing primary care services on site at affordable housing developments.⁴⁶ These types of models should be rigorously evaluated, funded, updated as necessary and scaled up. Additionally, they should include strong mechanisms for consumer and community engagement to ensure that the needs and desires of the community are central during development and implementation.
- **Promote community ownership primary care models:** Although not widespread, there are a few promising examples of primary care models that are community or cooperatively owned. These models have many benefits including improving access for populations such as undocumented immigrants who might lack access to traditional insurance, promoting person-centered care and community engagement, and providing care that is more culturally competent and centered on the needs of the community. They also represent an opportunity to shift more power over health care to patients and communities, opening up new opportunities for innovative care delivery that truly meets patients' needs. Some examples include Grameen PrimaCare in New York, which provides low cost health care to primarily immigrant women and comes out of a micro-finance model⁴⁷ and the SouthCentral Foundation, which is a community-owned health care organization owned, run by, and serving the Native Alaskan population. These models should be studied and where appropriate, funded and replicated in other communities.
- **Allow for reimbursement across payers for virtual primary care platforms:** A number of new health care companies, such as Lemonaid and Firefly are exploring ways to provide primary care services virtually, either exclusively or as a supplemental service to occasional in-person visits. This can include quick video consultations and medication prescribing for health needs that might not require a physical exam, as well as virtual care management or health coaching activities. Although these platforms might not be ideal for people with chronic conditions or those who need more extensive physical examinations, they can help improve access for people living in underserved areas, cut down on unnecessary ER visits, and free up primary care providers' in-office time to deal with people with more complex needs. Currently, most payers do not reimburse for such services and they are covered by patients entirely out of pocket. Exploring reimbursement for these services across public and private payers through targeted pilot programs could improve primary care access and efficiency.

Conclusion

A transformed health system that meets the health needs of all people must start with a re-envisioning of how we deliver and pay for primary care in the United States. Primary care serves as the gateway to the health system for many people and their source of consistent health system contact. If we can utilize primary care to catch chronic health issues or social needs early and address those needs in a coordinated and comprehensive way, it is possible to lower health care costs, improve health outcomes and patient satisfaction, and begin to tackle health disparities. However, there are a number of legislative, administrative, and cultural barriers to overcome before we can achieve this vision and it will take significant advocacy to overcome them. Advocates and policy makers who are working towards a truly patient-centered health system must begin to develop and advance a primary care policy agenda that will move us closer to this vision.

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@CCEHI
healthinnovation.org

COMMUNITY CATALYST
ONE FEDERAL STREET, 5TH FLOOR
BOSTON, MA 0211
617.338.6035