Rebecca Buck

From: Oxfeld, Ellen D. <oxfeld@middlebury.edu>
Sent: Friday, March 16, 2018 11:05 AM
To: Rebecca Buck
Subject: peer reviewed materials on primary care fiscal impact
Attachments: S.53~Deb Richter~References~1-12-2018.pdf; S.53~Allan Ramsay~Testimony~1-12-2018.pdf

Dear Ms. Buck: Would you be able to make this email available to Senator Kitchel and the other members of the Appropriations Committee today? They are taking up a bill this afternoon (S53) for which the attached information is pertinent.
Ellen Oxfeld
Middlebury, Vermont 05753

Dear Senator Ktichel,

Thank you so much for talking to us about S53 this morning. You asked about peer reviewed articles on the fiscal impact of Universal Primary Care. Attached is an annotated bibliography compiled by Dr. Deb Richter on primary care access. A number of the peer reviewed articles summarized here contain research results on the ways in which access to primary care without barriers can help contain health care system costs.

I have also attached a presentation by Dr. Allan Ramsay, formerly of the Green Mountain Care Board, that details some of the evidence on why investment in primary care will have a positive fiscal impact (with reference to peer reviewed source material as well).

I hope this might be useful.

Sincerely,
Ellen Oxfeld

REFERENCES

1) "Is General Practice Effective? A Systematic Literature Review. Scandinavian Journal of Primary Health Care". Engstrom S, Foldevi M, Borgquist L. 2001;19:131–44
http://www.ncbi.nlm.nih.gov/pubmed/11482415
RESULTS:

> Primary care contributed to improved public health, as expressed through different health parameters, and a lower utilization of medical care leading to lower costs. Physicians working in primary care, in comparison with other specialists, took care of many diseases without loss of quality and often at lower cost. The organization of primary care was important in respect of reimbursement by capitation, more group practices, higher personal continuity, and having generalists as primary care physicians.

CONCLUSIONS:

> To compare the effectiveness of primary care and specialist care is a complex task and there are limitations in all studies. However, we have found evidence that increased accessibility to physicians working in primary care contributes to better health and lower total costs in the health care system. It is also clear that studies with evaluation of how to most effectively organize primary care are far too few. There is an extensive need for future research in this area, a suitable task for collaborative research between the Nordic countries.

2) "Medicare costs in urban areas and the supply of primary care physicians." Mark DH, Gottlieb MS, Zellner BB, Chetty VK, Midtling JE. Journal of Family Practice. 1996;43:33–9.
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2690145/#b118
RESULTS:

> The average Medicare Part B reimbursement per enrollee was $1283. After adjusting for local price differences and county characteristics, a greater supply of family physicians and general internists was significantly associated with lower Medicare Part B reimbursements. The reduction in reimbursements between counties in the highest quintile of family physician supply and the lowest quintile was $261 per enrollee. In contrast, a greater supply of general practitioners and non-primary care physicians was associated with higher reimbursements per enrollee.

CONCLUSIONS:

> These results add to the evidence than an increased supply of primary care physicians is associated with lower health care costs. If this association is causal,

it supports the theory that increasing the number of primary care physicians may lower health care costs.

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3) "Continuity of Care: Is It Cost Effective?" Raddish M, Horn SD, Sharkey PD. American Journal of Managed Care. 1999;5:727–34
http://www.ncbi.nlm.nih.gov/pubmed/10538452
RESULTS:

There were 12,997 patients followed for more than 99,000 outpatient visits, 1000 hospitalizations, and more than 240,000 prescriptions. Increasing the number of primary or specialty care providers a patient encountered during the study generally was associated with increased utilization and costs when HMO and patient characteristics were controlled. The number of specialty care providers also increased as the number of primary care providers increased. The incremental increase in pharmacy costs per patient per year with each additional provider ranged between $19 in subjects with otitis media to $58 in subjects with hypertension.

CONCLUSIONS:

Continuity of care was associated with a reduction in resource utilization and costs. As healthcare delivery systems are designed, care continuity should be promoted.

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4) "The Political Economy Of U.S." The singular lack of balance between primary and specialty care has serious consequences for health care in the United States. Lewis G. Sandy, Thomas Bodenheimer, L. Gregory Pawlson, and Barbara Starfield. s. [Health Affairs 28, no. 4 (2009): 1136–1144; 10.1377

http://content.healthaffairs.org/content/28/4/1136.full.pdf+html

ABSTRACT:

Compelling evidence suggests that the United States lags behind other developed nations in the health of its population and the performance of its health care system, partly as a result of a decades-long decline in primary care. This paper outlines the political, economic, policy, and institutional factors behind this decline. A large-scale, multifaceted effort—a new Charter for Primary Care—is required to overcome these forces. There are grounds for optimism for the success of this effort, which is essential to achieving health outcomes and health system performance comparable to those of other industrialized nation.

5) “THE IMPACT OF PRIMARY CARE” SHI,L , Scientifica, Volume 2012 (2012), Article ID 432892, 22 pages
http://www.hindawi.com/journals/scientifica/2012/432892/

ABSTRACT:

Primary care serves as the cornerstone in a strong healthcare system. However, it has long been overlooked in the United States (USA), and an imbalance between specialty and primary care exists. The objective of this focused review paper is to identify research evidence on the value of primary care both in the USA and internationally, focusing on the importance of effective primary care services in delivering quality healthcare, improving health outcomes, and reducing disparities. Literature searches were performed in PubMed as well as “snowballing” based on the bibliographies of the retrieved articles. The areas reviewed included primary care definitions, primary care measurement, primary care practice, primary care and health, primary care and quality, primary care and cost, primary care and equity, primary care and health centers, and primary care and healthcare reform. In both developed and developing countries, primary care has been demonstrated to be associated with enhanced access to healthcare services, better health outcomes, and a decrease in hospitalization and use of emergency department visits. Primary care can also help counteract the negative impact of poor economic conditions on health.

6) The Patient-Centered Medical Home’s Impact on Cost and Quality
Annual Review of Evidence 2014-2015 Published February 2016
https://www.pcpcc.org/sites/default/files/resources/The%20Patient-Centered%20Medical%20Home%27s%20Impact%20on%20Cost%20and%20Quality%2C%20Annual%20Review%20of%20Evidence%2C%202014-2015.pdf

Key points from this year’s evidence review include:
1) Controlling Costs by Right Sizing Care:
Advanced primary care is foundational to delivery system transformation — medical home initiatives continue to reduce health care costs and unnecessary utilization of services

2) Aligning Payment and Performance:
Payment reform is necessary to sustain delivery system changes, but alignment across payers is critical for health care provider buy-in

3) Assessing and Promoting Value:

Measurement for PCMHs must be aligned and focused on value for patients, providers, and payers

7) "Primary Care: A Critical Review Of The Evidence On Quality And Costs Of Health Care", Friedberg, M, Hussey,P , Schneider, E, Health Affairs, Vol 29, no.5, https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2010.0025

Conclusion:

Whatever policy interventions emerge from the recently enacted health care reform law, health system attributes that have grown over decades are unlikely to reorient themselves swiftly toward primary care, even in the face of strong incentives. Our reading of the evidence suggests that these systems exert a powerful influence over the care that individual providers deliver to their patients. In the absence of targeted efforts to reorient local health systems and enhance the capabilities of primary care providers, simply expanding the number of primary care physicians may miss a crucial opportunity to improve health care delivery in the United States.

On the other hand, based on the existing evidence, the determined pursuit of primary care as a health systems orientation is likely to have beneficial effects on the quality, outcomes, and cost of U.S. health care.

Universal Primary Care: Questions
And why it is so important for Vermont!

Allan Ramsay, MD

Family Physician and Medical Director, People's Health and Wellness Clinic, Barre, VT

Vermont Coalition of Clinics for the Uninsured

Member, Green Mountain Care Board

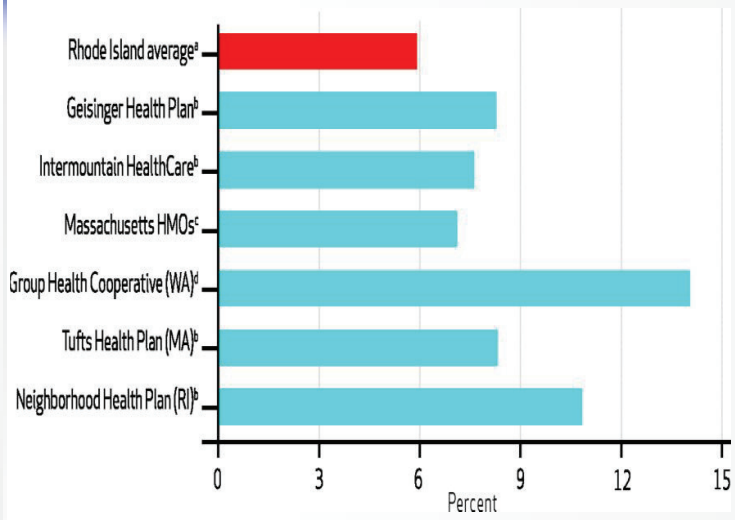
2011-2016

Will UPC improve Vermont's current health care reform efforts?

- - **Value:** Every study has confirmed that specific investment in primary care improves quality and reduces cost.
- - **Patient centered**: UPC legislation gives Vermonters more voice in how the delivery system evolves through their elected officials.
- - **Goals:** Universal Primary Care is compatible with and will complement the goals of OneCare and the all payer model.
- - **Unique**: UPC will attract primary care clinicians because it recognizes them as unique and valuable in the health care system.

Is there small state financial evidence to support a universal primary care program?

(Koller, et al. Health Affairs 2010;29:941)



- RI mandated an increase in PC spending from 5.4% to 8% from 2007-2011
- This led to an 18% drop in total spending (a 15 fold ROI)
- The legislature next required commercial insurers to increase the proportion of medical expense allocated to PC by 1% per year 2011-2014.
- Results are not yet available.

Is there evidence in Vermont that increased primary care spending is beneficial?

- A study of FQHC Medicaid claims in 13 states confirmed total cost of care was reduced 24% (15% in Vermont)
- UVMMC testified at the 2017 hospital budget hearings about the effect of increased investments in primary care
- A 62% increase in new patient visits since 2014 led to a decrease in ED utilization rates from 15.5 per 1,000 patients to 14 per 1,000 patients
- The Blueprint was only a first step in supporting primary care

What does a financing plan for UPC in Vermont look like?

- A Primary Care Trust Fund is established (model legislation has been proposed in Rhode Island.)
- An accountable state agency implements the trust fund program (AHS and DVHA)
- Accountable care organizations in the State establish and report their primary care spend rate
- The GMCB regulates and oversees the primary care spend rate
- The legislature establishes rules for funding the Trust (hospitals, insurers, ACOs in the State are assessed x% of their total projected medical spending for the Trust)

(Remember-most of the estimated $200 million annual investment in UPC was based on claims- money that Vermont is already spending!)

Do we have operational capability for a universal primary care program in Vermont?

- Enrollment of primary care clinicians- employed, independent, FQHC
- Quality measurement
- Primary care benefits and claims (PC payment reform workgroup, DVHA/Medicaid)
- Data analysis and reporting (VHCures/APCD)
- Overall performance evaluation (GMCB, Legislature)
- Medical necessity determination (prior authorization pilots)
- Grievances and appeals (DFR)

Why should Vermont try to implement a universal primary care program?

- We have a unique delivery system model
- We have unique payment model initiatives
- We have a health care regulatory authority (GMCB)
- We have financial regulation (GMCB, DFR)
- Our current reform initiatives do not address access to health care for those who are uninsured or underinsured
- If the APM is not sustainable we have no Plan B for health care reform

Is Universal Primary Care a way to address the primary care workforce crisis?

- The way to achieve the goal of a strong primary care workforce is to recognize that primary care is unique
- Without a solid primary care workforce we will not achieve increases in quality or moderation in the growth of health care costs.
- A recent Dartmouth medical school survey has convinced me relying on an accountable care organization or the all payer model alone will attract primary care clinicians to Vermont

Universal Primary Care (S.53) sends a message that <u>would</u> attract clinicians