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An act relating to a universal, publicly financed primary care system

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What is primary care?

- “Primary care means health services provided by health care professionals who are specifically trained for and skilled in first contact and continuing care for individuals with signs, symptoms, or health concerns, not limited by problem origin, organ system, or diagnosis, and includes pediatrics, internal and family medicine, gynecology, primary mental health services, and other health care services commonly provided at federally qualified health centers.”

Act 54, Sec. 18

Universal Primary Care: Why Now?

- Impact of Federal cuts mostly affects primary care
- Shortages already existing in primary care workforce will be even worse in a few years
- When catastrophe hits there are no quick fixes
- ACO/All Payer does not address access or coverage

Possible Federal Cuts

- Elimination of Federal Subsidies likely to increase uninsured and underinsured
- Cuts to FQHCs will affect primary care
- Defunding of CHIP
- Medicare cuts due to PAYGO
- Impact of the tax bill

Source: JFO 2018

Primary Care physicians are witnesses to the health effects of cost sharing

"Over the years, I have seen people die when their initial illness could have been
cured by a simple office visit and a 20 dollar antibiotic prescription. In one
typical example, a 50 year old man developed pneumonia. Because of his fear
of the cost, he waited to seek treatment. He waited until he needed an ER, and
ICU and a transfer to a UVM where he was on a ventilator in an ICU for a week
before he died. Setting aside the emotional cost of this barrier to healthcare,
which was extreme in this case, the financial cost of his treatment was also
extreme. It was orders of magnitude greater than it would have been had the
barrier to primary care been removed. Universal primary care seems an obvious
solution to this aspect of the problem." Dr Marion Bouchard

“I kept thinking it was my asthma and I would get better”

A 50 year old working Vermonter came in to see me after struggling to breathe for 4 days She had health insurance through her job but she told me she was worried about the deductible.

Her oxygen level was very low and she could barely remain upright.

After a brief exam it was clear she had suffered a massive heart attack. She spent 3 days in the ICU and was eventually discharged . She now has irreversible heart damage which will significantly shorten her lifespan. Had she come in when her symptoms first appeared she might have avoided heart damage .

Two patients same diagnosis,

- Two additional patients were experiencing the same symptom of having trouble swallowing solid food. One was uninsured, the other had insurance but with a high deductible. Both waited more than a year to seek treatment due to worrying about the cost. By the time they sought care both had Stage 4 esophageal cancer. Both died soon after being diagnosed.

ACO/All Payer does not address access

- Its goal is to improve quality and outcomes and to reduce unnecessary care
- It has to function in a health care system where tens of thousands of patients have co-pays and deductibles which can impede access to care
- This can erase any savings and actually lead to increased costs
- Universal Primary Care is essential for the ACO to reach its goals

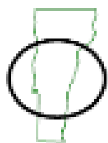
Shortages in Primary Care Workforce

- Aging of primary care workforce-More than 1/3 of primary care physicians are over the age 60 in 2014, this is particularly affecting internists.
- Aging of the population increases need for more primary care capacity
- Burnout affecting primary care more than other specialties

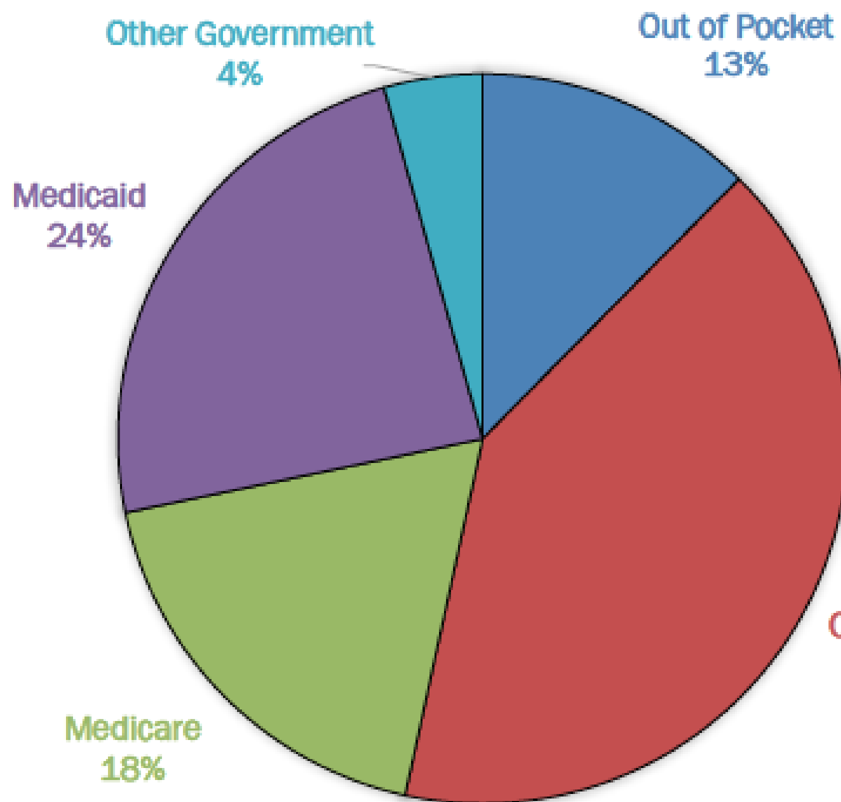
Source: : AHEC

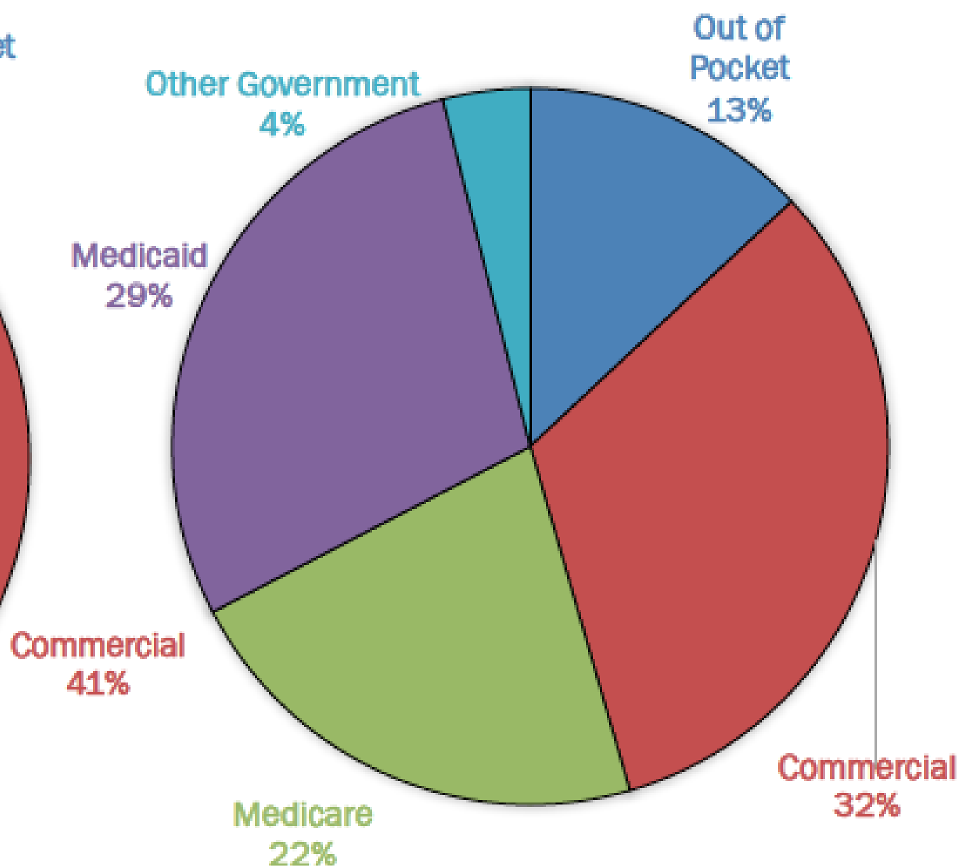
2015 Vermont Resident Analysis

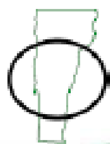
Provider services purchased: in and out-of-state - $5.7 billion



2015 Vermont Resident Analysis

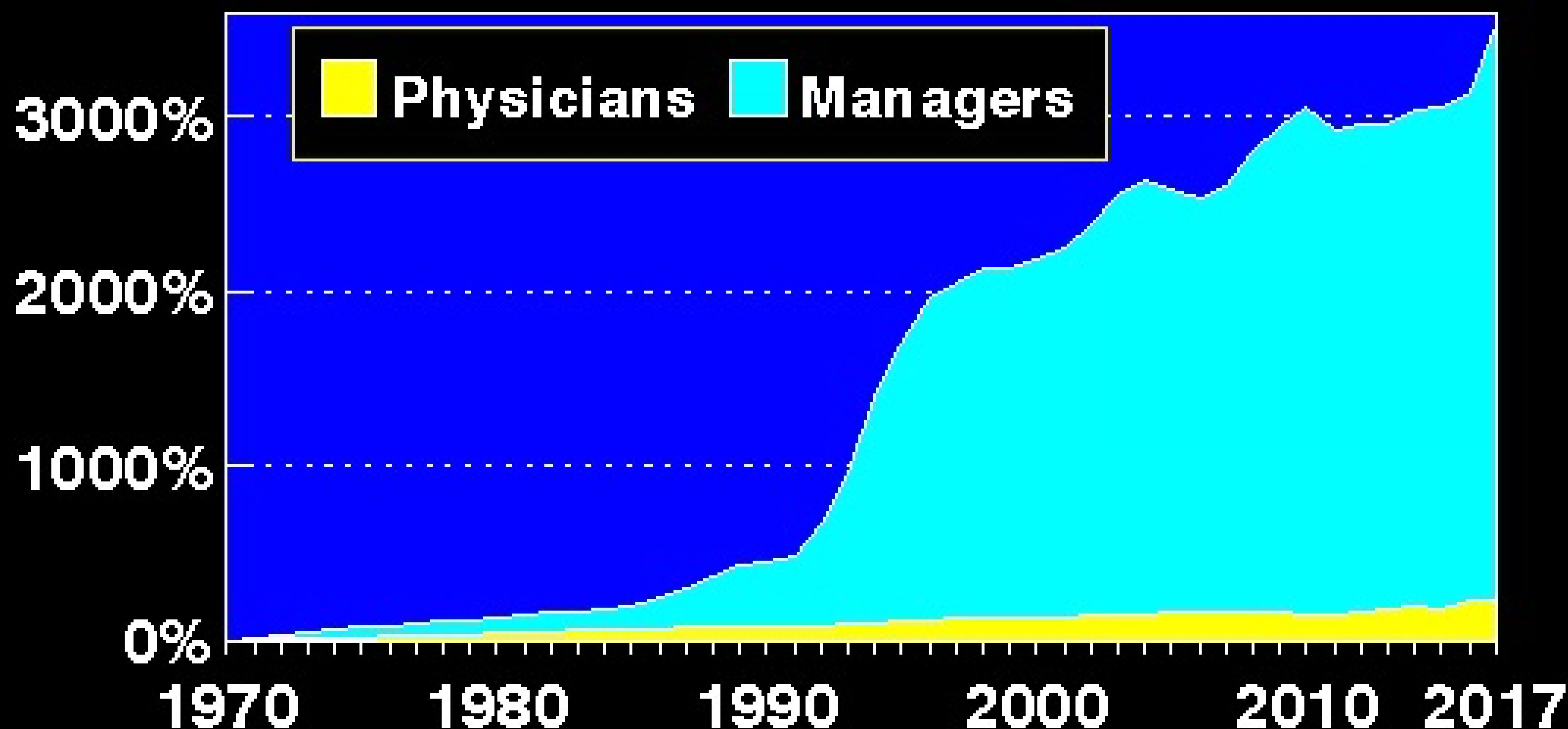






VERMONT
GREEN MOUNTAIN CARE BOARD

Growth of Physicians and Administrators 1970-2017



Source: Bureau of Labor Statistics; NCHS; and Himmelstein/Woolhandler analysis of CPS
Note - Managers shown as moving average of current year and 2 previous years

Vermont	COST & UTILIZATION	additional outcomes	payment model
Vermont Blueprint for Health[58] ***Published:*** *Population Health Management*, September 2015 ***Data Review:*** *Review of annual outcomes from 2008-2013* *Study evaluated cost, utilization, access and quality of care measures*	• Participant expenditures were reduced by −$482 PMPY* ($p<.001$) • Reduction in inpatient (−$218 PMPY*; $p<.001$) and outpatient hospital expenditures (−$154 PMPY*; $p<.001$) • Increase in expenditures for dental, social, and community-based support services ($57 PMPY*; $p<.001$) • Total annual reduction in expenditures was $104.4 million • Medical expenditures decreased by approximately $5.8 million for every $1 million spent on the Blueprint initiative • Reduction in inpatient discharges reduced by 8.8 per 1000 members ($p<.001$) • Reduction in inpatient days reduced by 49.6 per 1000 members ($p<.001$) • Significant reduction in standard imaging, advanced imaging, echography	• Higher rates on 9 of 11 effective and preventive care measures • Higher screening rates for breast cancer and cervical cancer ($p<.001$) and appropriate testing for pharyngitis ($p<.001$) • Participants with diabetes had higher rates of eye testing and LDL-C testing ($p<.001$) • Participants had significantly higher rates of adolescent well-care visits ($p<.001$)	**Fee-for-service + capitated payments** *"Two payment reforms were implemented to support PCMH and CHT* operations:* • *a **capitated** payment that went directly to the practice based on its NCQA PCMH score* • *a **capitated** payment that went to the administrative entity in each service area to operate the CHT*"* Vermont Blueprint for Health is a **multi-payer** initiative that participates in the MAPCP demonstration

Source: The Patients Center Medical Home's Impact on Cost and Quality, Feb 2016

Primary Care : Why Is this so important ?

- Primary care practices provide 50- 60 percent of all daily patient contacts in the US.

- **Primary care provides most of the care to most of the people most of the time**

Source: U.S. Centers for Disease Control and Prevention. (2010). National ambulatory medical care survey: 2010 summary tables,
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Value of Primary Care

- It is the only sector of health care that has been shown to improve population health
- Increases life expectancy
- Lowers infant mortality
- Lower rates of all causes of premature mortality
- Lower heart disease mortality
- Lower cancer mortality
- Lower premature mortality from asthma and bronchitis, emphysema and pneumonia,

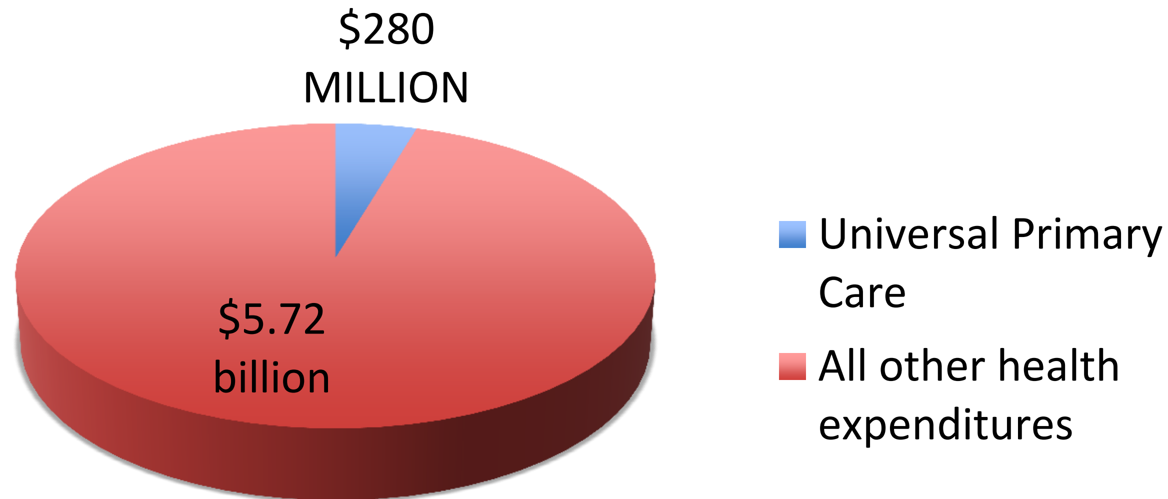
SOURCE: Contribution of Primary Care to Health and health Systems
http://www.commonwealthfund.org/usr_doc/Starfield_Milbank.pdf

Patients with a Regular Primary Care Provider as Their Usual Source of Care:

- Are more likely to receive recommended preventive services
- Their care is associated with better quality
- They have better health outcomes
- They live longer
- They utilize care less often
- Their health care costs are lower
- They have greater rates of satisfaction with their overall health care
- They have lower rates or Emergency room visit for non-urgent conditions.
- They have lower rates of hospital admissions
- They have fewer low birth rate babies
- They have lower infant mortality rates
- They get earlier detection of colon, breast and skin cancer

Source: **Primary Care: A Critical Review Of The Evidence On Quality And Costs Of Health Care**
http://content.healthaffairs.org/content/29/5/766.full

UNIVERSAL PRIMARY CARE IS A SMALL INVESTMENT FOR A LARGE RETURN



Vermont Health Expenditures 2017 (est.)

2017 Estimated Total Claim Cost of the Program

			2017 Estimated Total Claim Cost of Program		
Market	**Estimated Members**	**Universal Primary Care Coverage**	**Status Quo**	**Universal Primary Care with Cost Sharing**	**Universal Primary Care without Cost Sharing**
Commercial	296,400	Primary	$103,944,000	$102,464,000	$150,040,000
Military	14,400	Excluded	$0	$0	$0
Federal	14,400	Primary	$4,905,000	$4,905,000	$6,215,000
Medicaid	150,500	Primary	$107,371,000	$107,371,000	$107,371,000
Medicare	140,800	Secondary	$0	$0	$11,382,000
Uninsured	13,100	Primary	$5,527,000	$5,496,000	$6,921,000
Total	**629,600**		**$221,747,000**	**$220,236,000**	**$281,929,000**
Compared to Status Quo				**($1,511,000)**	**$60,182,000**

VERMONT
HEALTH CARE REFORM

How much $ will need to be publicly financed?

	Costs (2017)	UPC with Cost-Sharing	UPC with No Cost-Sharing
A	Medical Claims (netting out Medicaid $)	$113 million	$175 million
B	Administrative Cost Estimate (7%-15%)	$8-$26 million	$12-$35 million
	TOTAL BASE COST (Claims + Admin)	**$121-$139 million**	**$187-$210 million**
C	Provider Reimbursement Increases (modeled 10%-50% increases as possible options)	$25-$135 million additional	
D	Other costs	Identified by AOA and JFO for further study if moving forward	

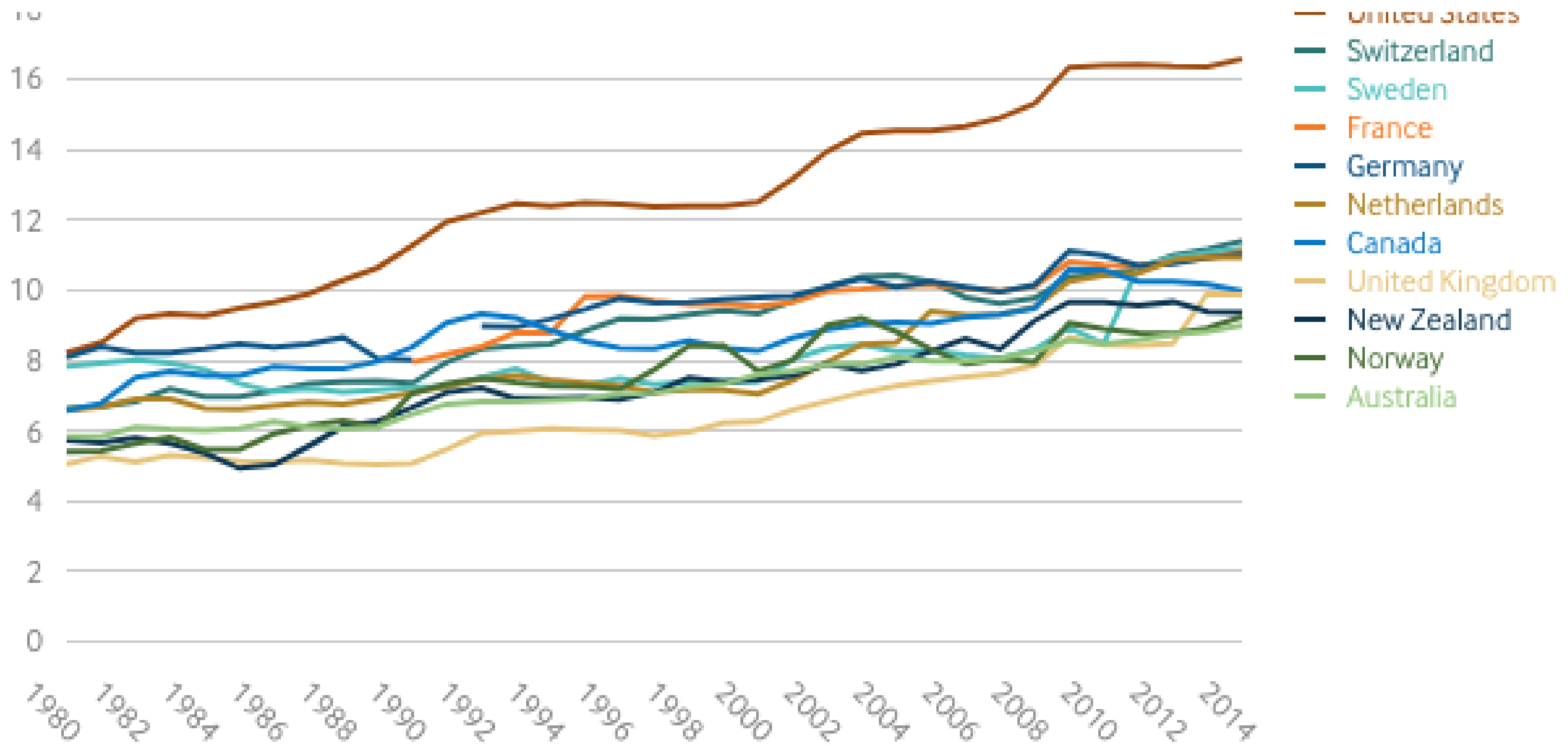
VERMONT
HEALTH CARE REFORM

Impact of UPC on Primary Care Workforce

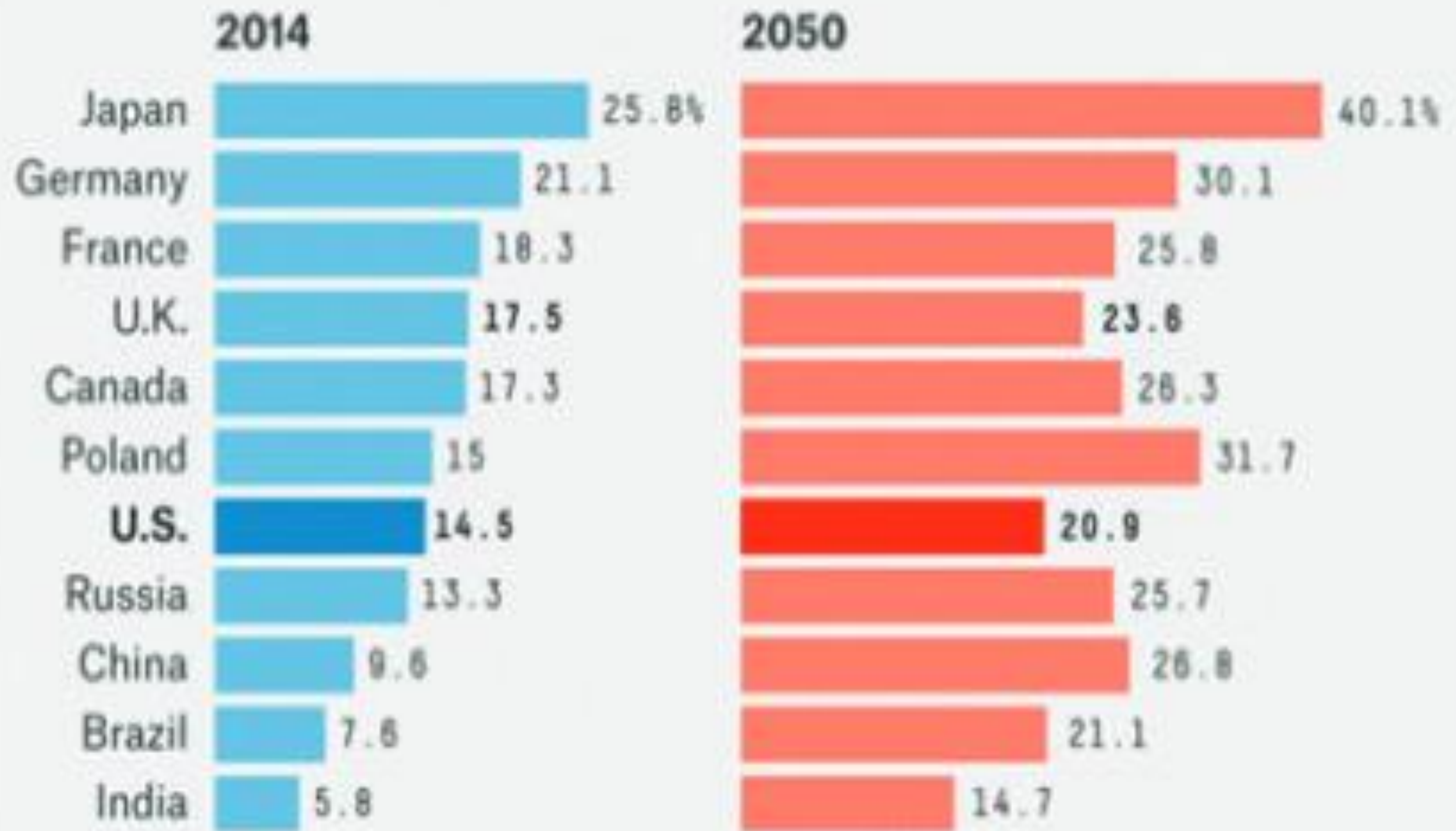
- Guaranteed coverage means predictable income
- Improves the conditions of practice
- Encourage migration of primary care docs and NPs to VT

ADDITIONAL DATA

Health Care Spending as a % of GDP-1980-2014



Notes: GDP refers to gross domestic product



Source: U.S. Census Bureau International Database

Table 1a: All Primary Care Practitioners by Discipline

Discipline	No. PCPs (2013)	No. PCPs (2016)	No. FTEs* (2013)	No. FTEs* (2016)	Supply to Benchmark FTEs* 2011	2012	2013	2016
PHYSICIANS (MDs/DOs)	**559**	**520**	**492**	**458**	**-35**	**-20**	**-12**	**-46**
APRNs, CNMs, PA-Cs (combined)	**267**	**305**	**185**	**220**	**-5**	**7**	**17**	**52**
Advanced Practice Registered Nurses (APRNs)	150	186	101	133				
Certified Nurse Midwives (CNMs)	34	32	21	20				
Certified Physician Assistants (PA-Cs)	83	87	62	67				

Table 1b: Total of Primary Care Practitioners Statewide

Discipline	No. PCPs (2013)	No. PCPs (2016)	No. FTEs* (2013)	No. FTEs* (2016)	Supply to Benchmark FTEs* 2011	2012	2013	2016
PHYSICIANS (MDs/DOs)	559	520	492	458	**-35**	**-20**	**-12**	**-46**
APRNs, CNMs, PA-Cs (combined)	267	305	185	220	**-5**	**7**	**17**	**52**
TOTAL STATEWIDE	**826**	**825**	**677**	**678**				

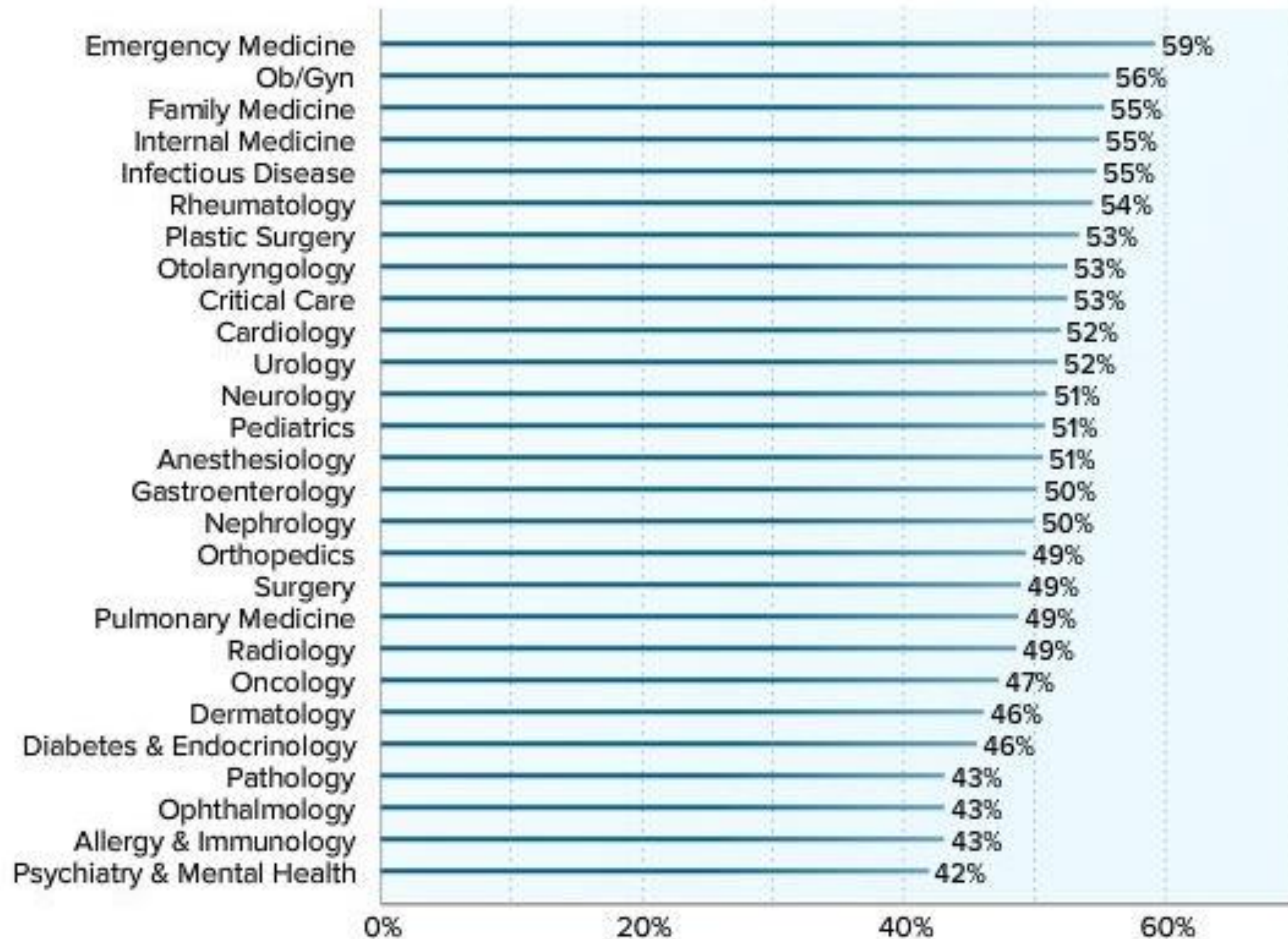
Table 2: Primary Care Physicians by Specialty

Primary Care Specialty	No. PCPs (2013)	No. PCPs (2016)	No. MD/DOs in FTEs* (2013)	No. MD/DOs in FTEs* (2016)	Supply to Benchmark FTEs* 2011	2012	2013	2016
Family Medicine	242	228	212	198	**-6**	**-2**	**8**	**-5**
Internal Medicine	130	121	117	112	**-58**	**-60**	**-59**	**-64**
Obstetrics-Gynecology	78	64	71	60	**6**	**13**	**13**	**3**
Pediatrics	109	107	93	88	**24**	**29**	**26**	**21**
TOTAL STATEWIDE	**559**	**520**	**492**	**458**	**-35**	**-20**	**-12**	**-46**

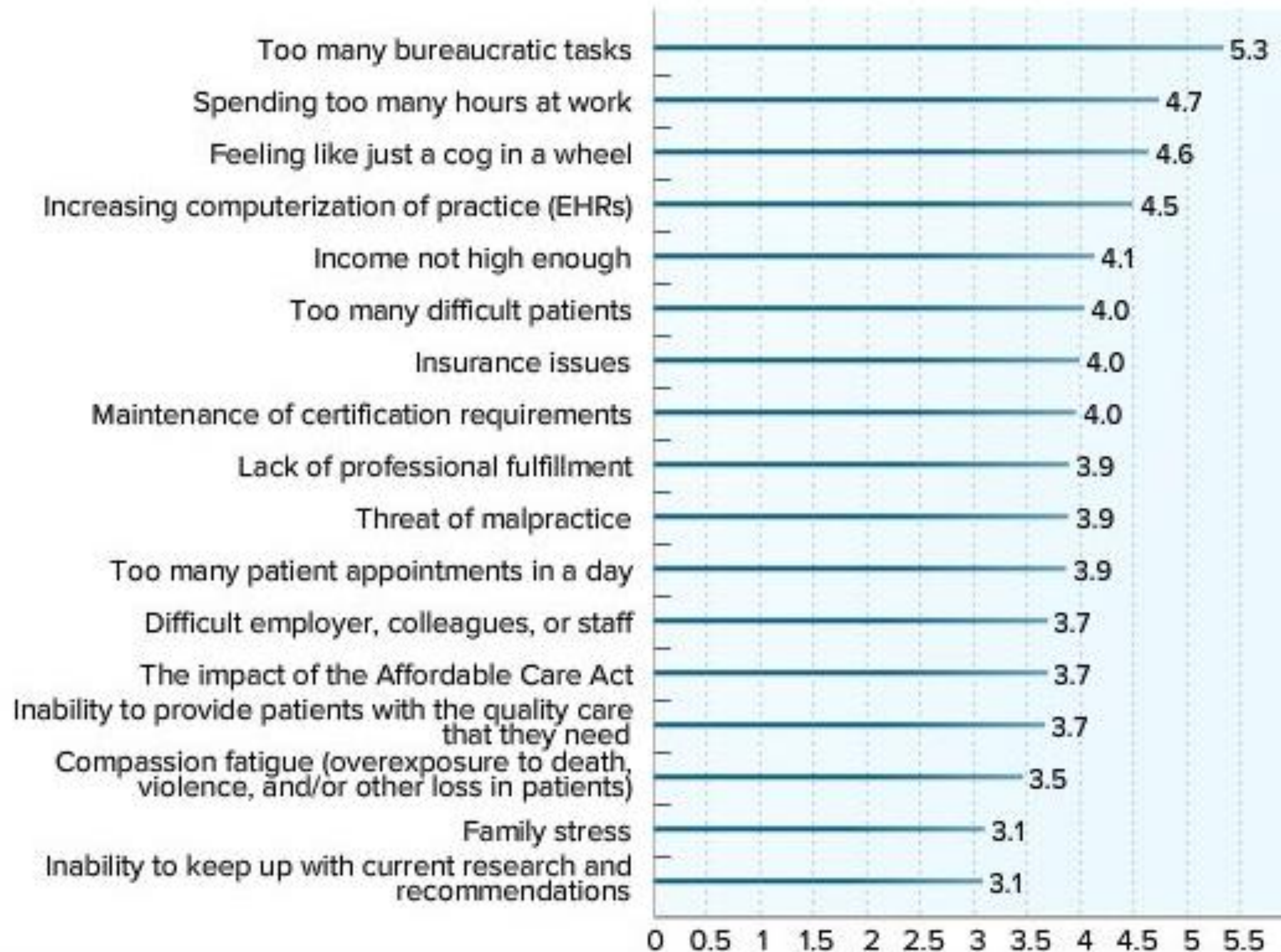
*small discrepancies are due to rounding

workforce shortage

Primary Care Workforce 2016 AHEC



Source: Medscape Lifestlye Report 2017



Souce:Medscape Lifestyle Report 2017

Benefits of Primary Care

- Studies show that an increased supply of primary care physicians is associated **with lower health care costs**
- Patients in **poor health** living in **primary care shortage areas** were twice as likely experience a preventable hospital admission
- Patients living in primary care shortage areas **are less likely to get diagnosed early** and experienced a lower 5 year survival rate from breast cancer

SOurce"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
"Preventable Hospitalizations in Primary Care Shortage Areas. An Analysis of Vulnerable Medicare Beneficiaries.
Archives of Family Medicine"Parchman ML, Culler SD.. 1999;8:487–91
"Associations of physician supplies with breast cancer stage at diagnosis and survival in Ontario, 1988 to 2006". Gorey KM, et.al.: *Cancer*; 2009 Aug 1;115(15):3563-70

VERMONT HOSPITAL COSTS

Total spending on hospital costs in VT
$2.2 billion (2015)

Have increased $ 1 BILLION in the past
10 years

VERMONT HEALTH CARE COSTS: 2015

Vermont is spending 18.7 % of GSP on Health Care

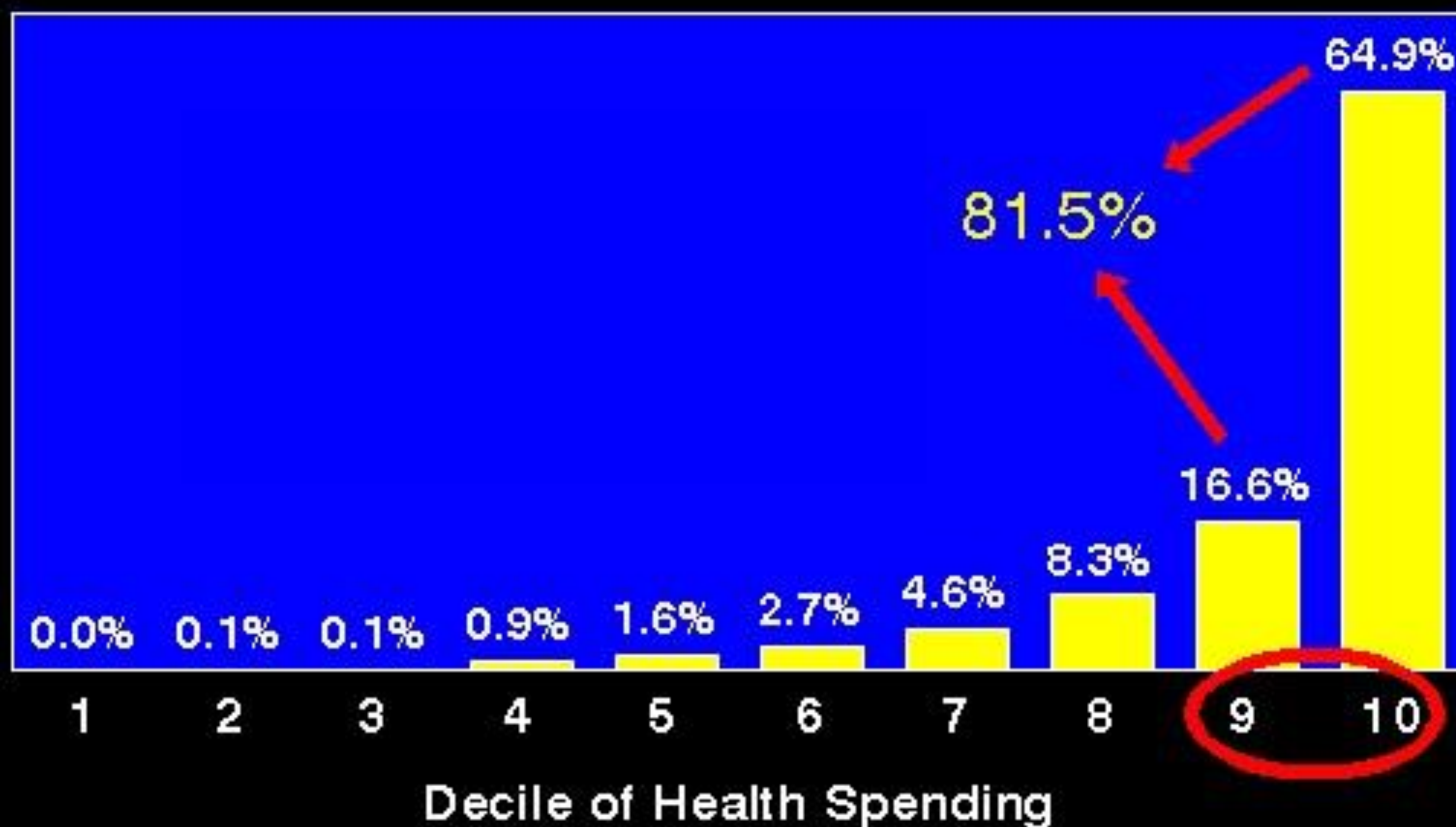
Per person costs $9112

Total spending $5.7 billion

Source: GMC Board 2016 Expenditure Analysis

A Few Sick People Account for Most Health $s

Percent of Total Spending for Each Decile Among Non-Institutionalized Americans



Source: JAMA 2016;316:1348