Is Colorado Ready for a Primary Care-based Health Care System?

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Presented by the Department of Family Medicine and the Colorado AHEC System
Why Health Reform Now?

“We suffer from a fiscal cancer... the real problem is health care costs”
U.S. Comptroller General David Walker
60 Minutes March 4, 2007

"We can't allow the cost of health care to continue strangling our economy."
President Obama April 15, 2009
The Curve We’re On

Spending on Health Care as a Percentage of Gross Domestic Product Under an Assumption That Excess Cost Growth Continues at Historical Averages

Source: CBO
Sources of Growth in Projected Federal Spending on Medicare and Medicaid
Health Care Spending

- 16% of the US Economy ($2.3 trillion)

BUT

- From 2000 – 2005 healthcare devoured nearly 25% of our Economic Growth

- Now consumes 1/3rd of Federal and State Taxes
What’s Happening in DC?: Federal Trends worth keeping an eye on

MedPac recommending primary care bonus payments for primary care services. Primary-care-focused practitioners are those whose specialty designation is defined as primary care and/or those whose pattern of claims meets a minimum threshold of furnishing primary care services. The Secretary would use rulemaking to establish criteria for determining a primary-care-focused practitioner.

The Congress should establish a budget-neutral payment adjustment for primary care services billed under the physician fee schedule and furnished by primary-care-focused practitioners.

2A

The Congress should initiate a medical home pilot project in Medicare. Eligible medical homes must meet stringent criteria, including at least the following capabilities:

- furnish primary care (including coordinating appropriate preventive, maintenance, and acute health services),
- conduct care management,
- use health information technology for active clinical decision support,
- have a formal quality improvement program,
- maintain 24-hour patient communication and rapid access,
- keep up-to-date records of beneficiaries' advance directives, and
- maintain a written understanding with each beneficiary designating the provider as a medical home.

2B

Less than 18 months ago, President George W. Bush had blocked similar bills by congressional Democrats, labeling the proposed expansion of the State Children's Health Insurance Program as a step toward government-run health care.

But with Democrats now firmly in control of the White House and Congress, the party's leaders easily pushed through a $33 billion bill that is expected to provide government-subsidized insurance to 4 million mostly low-income children.

That would reduce the number of uninsured children in America by about half over the next 41/2 years and boost the number covered by the program to 11 million.
“Policy makers should also consider ways to use some of the Medicare subsidies for teaching hospitals to promote primary care. Such efforts in medical training and practice may improve our future supply of primary care clinicians and thus increase beneficiary access to them.”

Medicare Payment Advisory Commission, 2008
“Overhaul of the health care system must not only provide for universal coverage but also for more primary care doctors and nurses to ensure that an insurance card actually gives the holder access to treatment.”

Rep. Henry Waxman

Hearing: Making Health Care Work for American Families: Improving Access to Care
March 24, 2009
Lessons from its peers –
State-level Health Policy reform

- Near neighbors and reform: Utah
  - March 2009, Governor claims ‘major’ reform achieved through 4-part legislation
    - NetCare (HDHI available to all Utah)
    - Mandatory employer coverage
    - Malpractice reform
    - HIT – Single swipe insurance technology pilot model for...?
The crisis of primary care physicians

MRS. J. LOOKED baffled and hurt. I had just explained that I would no longer be her primary care doctor. I was leaving the field after just three years. "I have had three different primary care doctors over the years ago, Massachusetts enacted perhaps the care experiment in American history, bringing courage to the commonwealth with Paul Revere To make it happen, Democratic lawmakers and Gov. Mitt Romney, a Republican, made an expedient choice, deferring until another day any serious effort to control the state's runaway

16.03.2009

Now Playing in Massachusetts: Health Reform, the Sequel

Since enacting its sweeping health care reforms a few years ago, Massachusetts has reduced the percentage of its population without health insurance to less than 3 percent. That is, by far, the lowest rate in the nation. But you hear a lot of criticism of the Massachusetts reforms, particularly from my friends on the left. And one of the primary criticisms is that the state hasn't done anything to control costs.
Apples & Oranges?:
Colorado and Massachusetts

- Percent uninsured 2003-04
  - Children: 7.6% (120,000)
  - Adults: 12.7% (709,000)

- 2008
  - 3% uninsured; 27-31% trouble with Access

- Colorado uninsured 2006-07
  - Children: 13.8% (174,000)
  - Adults: 20.4% (631,000)

http://www.kff.org/uninsured/upload/7451_04_Data_Tables.pdf
2008 Massachusetts Health Insurance Survey
Apples & Oranges?:
Colorado and Massachusetts

- Geographies
  - A large metropolis + dense ‘rural’ West
  - Rocky Mountain Urban Corridor + a huge swath of isolated rural... MA has no Western Slope.
- Demographic and Socioeconomic differences
  - Avg education, Per capita GDP
Need to build Primary Care Capacity Now

- So, with a higher per capita GDP, fewer uninsured and less rural-urban separation, Massachusetts has struggled mightily to guarantee comprehensive primary care access for its population.

- Why?
National Trends for Physician Workforce

- National workforce trends
- Updates on School expansion, residency expansion
National Trends for Physician Workforce

- National workforce trends
- Updates on School expansion, residency expansion

Shortage of Doctors an Obstacle to Obama Goals

By ROBERT PEAR
Published: April 27, 2009

One proposal -- to increase Medicare payments to general practitioners, at the expense of high-paid specialists -- has touched off a lobbying fight.
Primary Care Workforce

- **97,752 family physicians/general practitioners**
  - 1 for every 3,081 persons
- **92,257 general internists**
  - 1 per 2,443 adults
- **48,930 general pediatricians**
  - 1 for 1,548 children and adolescents
- **238,939 primary care physicians**
  - 1 for every 1,260 persons
Physician Specialties to Population Ratio 1980-2006
(Physicians per 100,000 persons)
Is it a Primary Care Shortage?

- **Problems:**
  - **Distribution**
    - Still concentrated in desirable areas
    - Relative shortage in underserved and rural areas
    - True for physicians, NPs and Pas
  - **Scope**
    - Primary care physicians performing non-primary care tasks to remain solvent
What lies ahead: Will there be a Primary Care Shortage?

- What’s to come:
  - Substantial decline in US student interest
  - Increased reliance on international students
  - Increased interest in specialization and alternative careers
  - Contraction of training programs
  - Majority of PAs now subspecialize; NPs?

- Current physician expansion effort not promoting primary care
Grow Medical Schools:
COGME said 15%; AAMC said 30%

First Year MD and DO Enrollment in 2013 is Likely to be more than 5,500 (28%) Higher than in 2002

<table>
<thead>
<tr>
<th></th>
<th>2002</th>
<th>2013</th>
<th># and % Increase</th>
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<tbody>
<tr>
<td>MD</td>
<td>16,488</td>
<td>19,909</td>
<td>3,421 21.0%</td>
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<tr>
<td>DO</td>
<td>3,079</td>
<td>5,227+</td>
<td>2,148 69.8%</td>
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<tr>
<td>Combined</td>
<td>19,567</td>
<td>25,136</td>
<td>5,569 28%</td>
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Source: 2007 AAMC Dean’s Enrollment Survey
2007 AACOM Enrollment Survey
## Student Interest

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>General Internal Medicine</td>
<td>2.0%</td>
</tr>
<tr>
<td>Med/Peds</td>
<td>2.7%</td>
</tr>
<tr>
<td>Family Medicine</td>
<td>4.9%</td>
</tr>
<tr>
<td>General Pediatrics</td>
<td>11.7%</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td><strong>21.3%</strong></td>
</tr>
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</table>

K. E. Hauer et al. Factors Associated With Medical Students' Career Choices Regarding Internal Medicine *JAMA* 2008;300(10):1154-1164
Erosion of Primary Care Training Capacity

- Since 1996 GME cap was put in place in 1996, positions in the annual student Match have fallen by
  - 57% for primary care internal medicine
  - 34% for primary care pediatric positions
  - 18% for family medicine
- Actual Family Medicine positions fell 2.7% between 2002 and 2006
Reliance on International Medical Graduates

Change in Number of IMGs in Training 2002-2006

- Decline in interest among US graduates
- Growth of subspecialty positions

Source: JAMA Medical Education Issues, Ed Salsberg, AAMC
Proportion of third-year internal medical residents becoming subspecialists or hospitalists is growing

Note: MedPAC June 2008

Grow Residency training:
COGME said 27,000 by 2015

- 2002 – 2007
  - Allopathic grew 8% 23,443 – 25,171
  - Osteopathic grew 14.8% 2849
  - Now nearly 28,000 positions

Primary care losing ground: GME

- Between 2002 and 2007
  - Residency positions grew +7.9%
  - Subspecialty positions grew +24.7%
  - Primary care positions grew +2.3%
  - Family Medicine positions fell -2.8%

  However...the estimated number of graduates going on to practice primary care fell 15% (from 28.1% to 23.8%)

Specialty positions rose 24.7% 2002-2006
Primary care by 2.3%
Family Medicine fell 2.7%
ACGME subspecialty rose 33% 2001-2008
Over same period, family medicine lost 37 programs
In the Match, since 1996
FM lost 18%
PC IM lost 57%
PC Peds lost 34%
M. H. Ebell. Future Salary and US Residency Fill Rate Revisited. *JAMA.* 2008;300:

Income Disparity affects Choice
True in 1989, true now
Is that a surprise?
Progress of the Physician Payment Gap

- Diagnostic Radiology
- Orthopedic Surgery
- Primary Care
- Family Medicine

Year:
- 1979
- 1981
- 1983
- 1985
- 1987
- 1989
- 1991
- 1993
- 1995
- 1997
- 1999
- 2001
- 2003

Annual Income:
- $0
- $50,000
- $100,000
- $150,000
- $200,000
- $250,000
- $300,000
- $350,000
- $400,000
- $450,000
Unintended Consequences of Resource Based-Relative Value Scale Reimbursement

“Medicine’s generalist base is disappearing as a consequence of the reimbursement system crafted to save it – the RBRVS”

Poor Alignment of Payment Policy with Distribution

- Convergence of proposed Medicare cuts and Shortage redesignations 2008—threatened 24% payment reductions in some rural/underserved areas
- Loss of Physician Scarcity Area bonus 2008
- Revisited in COGME 18th Report
2008 Potential Medicare Payment Reductions
Maps provide a way to explore variation in Colorado’s physician distribution (Physician per 10,000) - Specialty by Specialty (PC then ALL then FM)
<table>
<thead>
<tr>
<th>COUNTY</th>
<th>GRADUATES</th>
<th>STATE</th>
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<tbody>
<tr>
<td>Denver</td>
<td>775</td>
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<tr>
<td>Arapahoe</td>
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<td>Jefferson</td>
<td>263</td>
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<td>Boulder</td>
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<td>Salt Lake</td>
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<td>Utah</td>
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University of Colorado School of Medicine Graduate "Footprint"

Concentrations along the FRUC, in Western Slope
Other Schools with Footprint in Colorado (collaborators?)

- Nebraska
- New Mexico

<table>
<thead>
<tr>
<th>State</th>
<th>Access Ranking</th>
<th>Net Donation, 91-01</th>
<th>Supply/Demand, 91-01</th>
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<td>0.547020818</td>
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University of New Mexico
University of Nebraska
Colorado has nine primary care residency programs that train 56 primary care residents per year. Of these, 80%-90% are from out of state medical schools and 65-75% remain in Colorado after their training.
Residency Retention by State

Colorado 39.1%; PC = 44.4%
Residency Training

- Family Medicine Footprint
Family Medicine Residencies in Colorado = 9
Retention rates > 60%, despite >70% coming from out of state
Notice Western slope, footprint
Exempla-St. Joseph Family Practice Residency Footprint (Regional)

Source: AMA Master File 2006

Legend:
- Exempla-St Joseph Family Practice Footprint (70%)
These two maps were made from the Health Professional Shortage Area Wizard.
Role of NPs & PAs

- Important, but distributing much like physicians
2008 Colorado Physician Assistant by County

Legend
- Physician Assistant

Physician Assistant
- 35 - 283
- 6 - 34
- 3 - 5
- 1 - 2
- 0

Data Source:
1. CMS National Provider Identifier (NPI), Nov. 2008
2. 2007 Census Population Estimate
2008 Colorado Nurse Practitioner by County

Legend
- Nurse Practitioner

Nurse Practitioner
- 11 - 408
- 4 - 10
- 2 - 3
- 1
- 0

Data Source:
1. CMS National Provider Identifier (NPI), Nov. 2008
2. 2007 Census Population Estimate
Health Center Capacity

- **Massachusetts**
  - 43 CHCs
  - 430,000 patients (grew to 482,000 in 2007)
  - 1 in 13 people in Massachusetts

- **Colorado**
  - 14 CHCs
  - 396,000 patients
  - 1 in 12 people in Colorado

Targeting Resources

- HPSAs
- MUAs
- Rural
- Former PSAs
- Obvious staffing deficits
What Enhanced PC Could Do

- Potential cost savings
- Potential morbidity, mortality reduction
Insuring Everyone

- Massachusetts cost model
  - Cost of care for all people (60 million) currently without a usual source of care (MEPS)
    - $125 billion - $145 billion

- Enhanced PC cost model
  - Give everyone cost of Top 5 states: Save $70 billion
  - Give everyone cost outcomes of Community Health Centers: Save $450 billion
Greater numbers of primary care physicians per capita is associated with lower cost care

EXHIBIT 9
Relationship Between Provider Workforce And Medicare Spending: General Practitioners Per 10,000 And Spending Per Beneficiary In 2000

Spending per beneficiary (dollars)

8,000
7,000
6,000
5,000
4,000

1 2 3 4 5
General practitioners per 10,000

SOURCES: Medicare claims data and Area Resource Files, 2002

Baicker and Chandra, Health Affairs April 2004
Greater numbers of family physicians per capita is associated with lower cost care.
Market doesn’t absolve Schools

- Rural birth – 2.4 x rural practice
  1.8 x Family medicine
- Public Medical School
  1.8 x FM and Rural
- Interest in Serving Underserved
  3 x an FQHC
  4 x Rural Health Center
- Inner City, Rural and Primary Care
  Clerkships and Electives Matter

Factors Affecting Medical Student and Resident Career Choices. Graham Center 2009. Funded by the Josiah Macy Jr. Foundation
Medical Schools can choose and train students to produce

• More Primary Care
• More Rural Access
• More Access for Underserved

Despite the Market
Title VII

- Significantly increased perceived quality of primary care clerkships, electives
- Increased likelihood of FM and rural electives
- Title VII interacted/enhanced effects of debt and scholarships
- School exposure increased specialty choice, residency exposure increased NHSC
Recommendations

- More debt for service
- Decrease disparities in physician income
- Change admissions: students more likely to choose primary care, rural practice, and care of the underserved
- Shift training: community, rural and underserved settings
Recommendations

- Support primary care Departments & Residencies--teaching, mentoring
- Reauthorize and revitalize Title VII
- Study how to make rural areas more likely practice options, especially for women
- New Medical schools: public and rural
Meeting Colorado’s Physician Workforce Needs: Options and Ideas

Pre-Medical School Factors
- Birth place
- Intent to serve state’s needs (e.g. primary care, rural)
- In-state students
- Age/Race of applicant
- Previous experiences (service, maturity)

Medical School Factors
- Targeted medical school expansion strategies
- Community rotations and preceptorships (e.g. AHEC, primary care)
- Institutional mission to care for underserved, areas of need
- Public medical school

Residency Factors
- Need-based training & tracks (e.g. Obstetric, procedural, rural)
- Program commitment to Ohio’s underserved
- Location (e.g. Rural, Community-based)
- Primary Care residency

Placement and Retention
- Practice start-up subsidies
- Loan repayment
- Opportunity for continuing education

Colorado Physician workforce: sufficient, composed & distributed to meet populations needs
So, Is Colorado Ready for a Primary Care-Based Health System?

- Readying the Home and its occupants
  - *Cards* for all would-be occupants: If fiscal reality and the need to address the needs of 800K, not 100K as is currently proposed, can meet
  - *Hosts* adequately distributed, composed and trained in full spectrum, new model practice
  - *Homes* in all corners of Colorado, outfitted for transformative primary care
So, Is Colorado Ready for a Primary Care-Based Health System?

- You tell us...
Extra
A BILL FOR AN ACT

CONCERNING MEASURES TO INCREASE THE AVAILABILITY OF HEALTH RESOURCES IN DESIGNATED AREAS IN COLORADO, AND, IN CONNECTION THEREWITH, CREATING THE PRIMARY CARE OFFICE IN THE PREVENTION SERVICES DIVISION IN THE DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT TO MAXIMIZE STATE AND FEDERAL PROGRAMS THAT PROVIDE HEALTH RESOURCES.

Bill Summary

(Note: This summary applies to this bill as introduced and does not necessarily reflect any amendments that may be subsequently adopted.)