Strengthening Vermont Primary Care

Patrick Flood, Julie Wasserman, & Mark Hage

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1. Fixing and strengthening primary care is long overdue. The neglect of primary care has gone on so long it will require substantial efforts to meet the current and future needs of Vermonters.

2. Meeting the needs of our primary care system cannot be done in isolation. We must integrate other services and solutions, such as community mental health services, home health care, and hospital financing.

   As we plan for improvements in salary, loan repayment and working conditions for primary care physicians, we acknowledge we must address the same issues for nurses and mental health professionals.

3. We acknowledge not all of these recommendations fall under the jurisdiction of the GMCB, but we believe the Board can and should develop a comprehensive plan for primary care and that the Board has authority over spending in hospitals.

4. There is plenty of money in the health care system, but we are not spending it wisely or efficiently. The GMCB received reports from Mathematica and the Berkley Research Group declaring that Vermont hospitals are spending substantial amounts of money (10-34% of inpatient care) on "avoidable care," and 26% to 41% in unnecessary emergency room care. **Even at the lowest end of "potentially avoidable," we are talking about roughly $350 Million dollars.** This money can be redirected to prevention, primary care, and community-based services.

5. Annual, targeted reductions in potentially avoidable care should be set and incorporated in the GMCB's annual Hospital Budget Review. As part of the Hospital Budget Review process, hospitals will be charged with identifying the sources of potentially avoidable care and devising solutions on how to substantially reduce them, in collaboration with community partners including primary care physicians, community mental health staff and home health personnel. Subsequent steps should include approaches on how to reallocate savings to less costly community-based settings.

6. Analyze primary care expenditures and resources by Hospital Service Area and use this data to identify gaps in provider resources, service delivery, and access to care.

7. Subsequent initiatives should include the establishment of a Primary Care Budget for HSAs.

8. Address the acute shortage of primary care physicians by instituting measures related to salary, loan repayment and working conditions for current and new physicians.

9. Raise Wages
   a) Close the pay equity gap between primary care physicians and specialists.
   b) Close the pay equity gap between and among primary care physicians practicing in different settings.
   c) Raise primary care physician salaries by $10,000 per year for each of the next five years.

10. Loan Repayment
    - Provide $50,000 per year in loan re-payment to each new physician willing to relocate to and practice in Vermont for at least ten years. Average annual cost of $1.39 million over nine years to recruit 10 physicians per year bringing 50 primary care physicians to Vermont.

11. PMPMs
    - Institute a PMPM of $60-$100 for Independent primary care physician practices to cover the administrative and team-based staffing costs that are insufficiently covered by current rates. This approach resembles the special rates provided to FQHCs and would foster equity. DVHA could disperse these PMPM payments directly to the providers as it currently does with its Value-Based Incentive Fund. The Blueprint is also an option for dispersal since it made payments to participating practices for years prior to the inception of the ACO.

12. Increase the number of future physicians in each graduating class at UVM Medical School who will practice family medicine or primary care, and expand the number of in-state residency slots. We understand that just 8 students from this year's UVM graduating medical class chose family medicine; at Dartmouth, the number was 5. Both classes have roughly 100 students.
    - Launch a "25 by 30" campaign, where 25 percent of each UVM Medical School graduating class will chose primary care by the year 2030. If necessary, the Vermont Legislature must compel UVM Medical School to do this.

13. Establish a task force of primary care physicians to identify lower priority or burdensome administrative tasks for elimination. The state and insurers should adopt these recommendations, and a process for receiving any necessary permissions from CMS should be included in the APM 2.0. Eliminate prior authorization for primary care. Eliminate quotas for daily visits.

14. To correct the imbalance in funding and rate increases between hospitals and primary care, implement global hospital budgets with reference-based pricing benchmarked to Medicare rates. Reference-based pricing standardizes wildly varying hospital prices for the exact same service and addresses hospital market leverage. Savings can be redirected to primary care and community-based services,

15. All Payer Model 2.0

    The above recommendations should be incorporated into Vermont's APM 2.0 agreement with CMS, including additional initiatives to:

    - Ensure adequate access to primary care.
    - Address the affordability crisis through specific proposals.
    - Expand community mental health and home health services.

    If implementing or funding any of these recommendations requires regulatory flexibility from CMS, the state should make that request in the new APM agreement. For example, if reducing the administrative burden on primary care physicians requires a relaxation of documentation requirements for Medicare or Medicaid, the state should make the request as part of the new APM agreement.