HEALTH FIRST

Date: August 15, 2024
To: GMCB, AHS, Dr. Hamory and the Oliver Wyman team
From: Vermont HealthFirst, Susan Ridzon, Executive Director, sr@vermonthealthfirst.org
Re: Act 167 Recommendations

On behalf of our 131 primary care and specialist care physicians practicing in 62 physician-owned practices across Vermont, we offer the following feedback regarding the recommendations presented during the community engagement process on hospital sustainability (Act 167 of 2022). We appreciate the significant effort exerted by Dr. Hamory and his team throughout this process, as well as by GMCB and AHS. Overall, we appreciated several of the recommendations highlighted in Dr. Hamory's presentations. We also found key details and points to be missing. We request that you consider incorporating our feedback into your final report and implementation plan.

- **Cleary define the vision**. What do we want Vermont's healthcare system to look like in the short, medium, and long term? How will it serve Vermonters? How will it function? How will it be financed? Who will shepherd the system through the many changes needed?
- **Emphasize role of high value services, such as primary care.** The crucial role of primary care in a high value healthcare system is undisputed. The recommendations should clearly outline how primary care, and other high value providers such as home health, practitioner-owned practices, and other community providers and services will be expanded and supported.
- **Acknowledge and address the challenges faced by non-hospital-based providers.** Community providers face many of the same operational and financial challenges as hospitals. Workforce recruitment & retention, needed infrastructure improvements, and increased costs are also major issues for independent practices. In addition, there is an unlevel playing field for independent providers driven by both federal and state policies and system consolidation. Some examples:
    - Federal payment policies and other federal policies mentioned in Dr. Ge Bai's recent testimony on medical debt to the US Senate (see pg. 3 – tilting the playing field in favor of large players).
    - Independent practices are not considered eligible employers for the Department of Education Loan Forgiveness program, while FQHCs and non-profit hospitals are. This means that clinicians saddled with medical training debt are highly incentivized to work at an FQHC or a hospital system rather than an independent practice. This puts independent practices at a huge disadvantage when trying to recruit clinicians.
    - Vermont's policies and regulatory authority have historically embraced a consolidated and hospital-centric system, compounding the challenges facing

independents. For example, Vermont has a very broad and onerous Certificate of Need law that effectively discourages the creation of lower cost sites of care.
    - Independent practices have few options for healthcare insurance for themselves and their employees other than the state's health exchange, where there have been double-digit premium increases every year since 2020. Bound by payers' largely "take it or leave it" reimbursement levels, already lean independent practices don't have the luxury of raising prices or decreasing expenses to cover such increasing costs. They are essentially on a path to insolvency.

- **This unlevel playing field contributes to Vermont and the U.S. losing high-value, nimble, and personalized sites of care**. This further exacerbates our state's affordability and access challenges as Vermonters are forced to seek care in higher cost hospital settings. Since 2019, 21 of our independent practices have closed.
    - One third were primary care practices. Others offered important specialty care services at a lower cost such as OB/GYN, general surgery, and interventional spine.
    - 11 closures were due primarily to unsustainable reimbursement levels.
    - 2 independent surgeons closed alleging that referrals were stymied by intentional or unintentional incentives by hospital-employed physicians to keep referrals primarily "in-house" (2 different surgeons and hospital service areas mentioned).
    - 8 closures resulted from physicians retiring and no one to replace them because the unlevel playing field makes it very difficult to recruit physicians into independent practice.
    - Others moved out of state for various reasons, e.g. high cost of living, family.

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Feedback on specific Oliver Wyman (OW) Recommendations from 7.8.24 GMCB Meeting

OW Recommendation 1: "The endgame for population health is movement of care out of the hospital and shift of hospitals to more intensive care" (and centers for complex surgery).
We agree! Vermont's system is currently too hospital centric and needs more high value options for care. We need our hospitals but let them focus on the care that requires a hospital. Let's have most everything else be provided by properly resourced community providers and entities.

OW Recommendation 2: Help reduce costs in hospital care by collaborating for group purchasing for supplies, health insurance, benefits, etc. It would be very valuable if independent medical practices, and potentially others, could be included in such
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collaborations, particularly for health insurance. Very costly small group premiums are an enormous risk to independent practice sustainability.

OW Recommendation 3: "Increased support for all PC providers and MH/SA services."
We agree primary care providers and mental health and substance abuse services need more support, and recommend:

- Much higher PMPM payments for primary care or a blend of capitated and FFS payments that reflects the value of primary care and all of the work that they are doing.
- Enhanced support through existing programs like the Blueprint for Health. This could range from more CHT support, higher PMPM payments and/or covering the cost of NCQA PCMH certification, quality measurement, etc.
- Increased support for recruitment and retention of clinicians and practice staff with specific support for independents to offset Department of Education Loan Forgiveness policy and relative inability of independents to match wages of better resourced entities like hospitals and FQHCs. Some support can be achieved through existing recruitment and retention programs.

OW Recommendation 4: "Expand non-hospital-based access and treatment options" such as free-standing diagnostic facility for radiology/ultrasound and free-standing ASCs.
We appreciate the mention of lower cost ASCs vs higher cost OSCs and HOPDs and think repeal or major reform of CON laws would help to encourage, rather than discourage, formation of these lower cost sites. We also recommend:

- Encouraging ownership by non-dominant entities and at lower non-hospital ASC pricing to help lower prices and loosen grip of consolidated entities.
- Promoting value-based insurance design that will drive care to the highest value sites.
- Offering options for lower interest loans, helping to procure building sites, using part of ASC revenue to augment primary care reimbursement, and helping to recruit independents to invest in and/or practice at lower cost sites of care.

OW Recommendation 5: Utilize community pharmacies for certain primary care related services.
While pharmacies are an essential part of our health care system, we would rather see investments in primary care and PCMHs, so care isn't further siloed and fragmented. In addition, if non-independent pharmacies are meant as "community" pharmacies, pushing services to those pharmacies could end up strengthening the large, profiteering, non-local companies whose vertical integration results in them controlling much of the US healthcare system (to the detriment of patients and providers in many cases).

OW Recommendation 6: "Tight alignment of financial incentives among all participants."

We agree in concept but have questions: toward what goal(s) specifically beyond promoting access and appropriate use of resources? Who do you mean by "all participants"? There are many perverse incentives that drive up cost and do not benefit patients. The money needs to be followed to identify and correct such misaligned incentives across the system.

Thank you for taking the time to review our feedback. Please reach out if you have any questions or request additional input from HealthFirst.