Memo:	House Appropriations Committee
From:	Vermont Medical Society, Vermont Academy of Family Physicians & American Academy of Pediatrics Vermont Chapter
Date:	March 15, 2018
Re:	Primary Care Case Management Fee

The Vermont Medical Society (VMS), the Vermont Academy of Family Physicians (VTAFP) and the American Academy of Pediatrics Vermont Chapter (AAPVT) are very concerned about the proposal included in the Governor's FY19 Recommended Budget to eliminate the $2.50 Primary Care Case Management(PCCM) per member per month payment to primary care practices, which would result in a $3.3 million cut statewide.

The Department of Vermont Health Access (DVHA) has stated that this payment is a lower priority primary care investment, as it is not actually tied to providing case management services or payment reform activities. We asked both of our independent and hospital-based physicians and physician-assistants to let us know their understanding of the PCCM payment, what they use the funding for and what impact the cut will have on their ability to deliver primary care to their patients.

In the interest of giving you comprehensive comments, please pardon the volume of this document. Here are their responses organized **regionally.**

Thank you for considering these comments. We respectfully request the Committee restore the funding in order to maintain primary care services across the state and to encourage primary care physicians to want to practice in Vermont in the future. Please let VMS, VTAFP and AAPVT know if you have any questions regarding our member's comments at jsudhoffguerin@vtmd.org.

Bennington

Judy K. Orton, MD, FAAP - Southwestern Vermont Health Care, Bennington, VT
*"**The funds are used to support extra hours for my care manager**. Through the Blueprint she only has 8 hours/week with 8 - 12 of these hours/month spent in required meetings and training so not directly available for direct care management. I am able to add 6 extra hours/week paid by my practice for these services. She helps patients with prior authorization (for specialty care for our children with special health needs) - physician appointments, testing, therapy, transportation. She arranges and moderates care management team meetings for patients.*

If these funds are not available, the care manager's hours would be cut. The number of care management meetings would decline (thus the number of patients served by these). These meetings are important as it gets all the team members together in one place to discuss current status and health

goals with the family. The family is able to communicate more effectively to get their needs met in a more efficient, complete and cost effective manner. Care might be delayed as the process of obtaining the PA's would take longer with less paid work hours available."

Caledonia

Melanie Lawrence, MD, MS - Newbury Health Clinic, Newbury, VT
"I am a former dairy farmer now practicing family medicine in my home town of Newbury, Vermont for the past 8 years. I trained at UVM and then did my residency at Dartmouth also getting my master's degree from The Dartmouth Institute in Health Care Quality and Improvement. I serve mainly low-income families in a small private practice that focuses on family health and education, team-work and preventative care. We manage on a shoe-string for a budget, but love what we do. I am the only physician and have two medical assistants and one person doing full-time billing/insurance work. The proposed $2.50 PMPM Medicaid cut makes it even less likely that we will be able to provide care for our neediest families and patients. Or for doctors like me to remain in business. Newbury Health Clinic scores in the highest categories for NCQA - medical home measures, wins awards for our pediatric and adolescent immunization rates, does outreach to schools and already get reimbursed at a much lower rate than the surrounding FQHC clinics. We provide high quality care but when 51% of our office visits are Vermont Medicaid - it risks the well-being of patients, patient access and the viability of primary care in rural Vermont if such a cut is implemented.

We use the funding for care coordination - helping patients get set up with counseling services, transportation, help them negotiate referral processes particularly around pediatric issues with impaired or limited parents. *If funding is cut, patients will have less access to services and support. I will not have the funding to provide as much care coordination. Ultimately, if cuts continue, I will need to retire early because it is not worth the headaches associated with doing the care I love to do when I have to fight so hard to make payroll.*

We are all struggling in a challenging political and economic environment. I so appreciate the work you do and your consideration of my concerns. I will keep this short but hope my patients and I still have a functioning clinic in the coming years. Your advocacy for primary care is critical and I hope you reject this proposal."

Chittenden

Joseph F. Hagan, Jr, MD, FAAP - Hagan, Rinehart and Connolly Pediatricians, PLLC Clinical Professor in Pediatrics, UVM College of Medicine
*"**We are absolutely using these funds for case management. Take these funds away, we will certainly be less able to provide these services**. Case management is a significant cost to a practice in time and personnel. In the big picture, the satisfaction of cases well-managed is a significant salve preventing clinician burn out. Taking this funding away is anti-primary care, anti-ACO, and will lead to less trainees choosing Vermont for primary care and will encourage earlier retirements."*

Paul Reiss, MD, FAAP – Evergreen Family Health, Williston, VT
"It is my understanding that these funds were formerly at $5.00 PMPM for primary care recognizing that the Medicaid patient population requires substantially more resources for PCPs in terms of care management and case management due to an increased burdens of negative social determinants of health.

When the ACA increased the Medicaid fee schedule to Medicare rates for two years, starting in 2014, the Vermont Department of Health Access cut the Management fee to $2.50 PMPM, without discussion or input from providers. When the ACA primary care bump was removed, the fee was not increased back to $5.00. This sequence was the last straw causing loss of Franklin county Pediatric practices, and hardship on others. The $2.50 PMPM currently is not enough $ for the services needed from primary care practices to work with their communities to care for this population. The entire FQHC network exists primarily to help care for the Medicaid population because it is underpaid outside of FQHCs. Removing this $ makes this untenable situation worse.

The Blueprint payments to primary care practices are acknowledged by the Blueprint staff and stakeholders to be woefully inadequate for the Medical Home services and certification that is required of primary care practices. The attribution numbers are far less than the actual practice populations for Medicaid, many payers and employers including UVMMC and other hospitals do not pay into the Blueprint, and the payments are may not be even enough to cover the activities required to be certified as Medical Homes to participate.

The One Care ACO Medicaid payment is currently only available to a select number of hospital service areas. OneCare has not invited all PCPs to join. So there is not option for many practices to make up any of these payments. Further, FQHC and independent practices are NOT able whatsoever to raise fees or incomes from commercial payers, and most are running at maximum efficiency and lowest possible overhead already.

We have a shortage of primary care physicians. Patients cannot find a primary care physician in many parts of the state. Our office accepts new patients, but uses a long waiting list to accommodate new patients. There are practices that will not accept Medicaid patients because the Medicaid fee schedule is far below other payers. Even if the reimbursement rates were higher, practices face the burden of a sicker population that takes more resources to manage. Every year our practice discusses whether we take Medicaid patients. The discussion becomes harder each year as we struggle to pay staff appropriately, and physicians continue to take personal pay cuts.

*Most efforts at health care reform emphasize the need to attract more primary care physicians**. Without a comprehensive, specific effort to reform and improve Medicaid payments in other ways, this isolated, specific, unconnected cut to payments to the fragile primary care network will create an ever more tenuous situation.***

Carol Joy Gardner, D.O. - Preventive Medicine, Colchester, VT
"As one of the last few solo practitioners, it is a real challenge to stay in business. Federally funded hospitals and community health centers receive nearly twice as much insurance re-reimbursement. Any more cuts will likely force us to cut staff, other EHR supports, etc. We hope the Department realizes that us Family Physicians are working against all odds with the costs rising and less reimbursement. Please consider the struggles us GP's are trying to deal with already."

Essex-Orleans

Thomas A. E. Moseley, M.D., FAAP - Pediatrician, Newport, VT
*"**The proposed elimination of the $2.50 per member per month payment for Medicaid patients to a primary care practice is one more barrier to accessibility for our most vulnerable patients** which sadly, is a common suggestion to save money in tight times. The lack of parity in payments for Medicaid vs*

*insurance covered patients is already great. To further increase that disparity is short sighted and will make it more difficult for Medicaid patients to receive care. To maintain access and choice for Medicaid patients, there must be recognition that practices must cover their costs to continue to exist; reducing this payment either means that practices must limit slots for Medicaid patients in favor of better paying insured patients or reduce services for everyone. T**he Medicaid per member per month payment covers the salary and benefits of a registered nurse in my practice**."*

Franklin

Rick Dooley, PA-C Clinical Network Director, HealthFirst, St. Albans, VT

*"At our HealthFirst staff meeting this morning, we were discussing the Governor's budget. As you are probably aware, within that budget is the removal of the $2.50PMPM Primary Care Case Management payment for Medicaid patients. Based on just our HealthFirst membership, we estimate that this will **result in an annual loss of about $250,000 to our pediatricians, and $350,000 in revenue to all of our combined HealthFirst [independent] practices**. Given the high percentage of Medicaid patients in pediatrics, coupled with the shortage of pediatric practitioners and the relatively recent closing of a number of pediatric practices in Franklin County because of chronic Medicaid underpayment, we feel that **a reduction in Medicaid payments in any form will be detrimental to the Primary Care base in Vermont**."*

Lamoille

Laura Norris, MD, FAAP – Cambridge Family Practice, Cambridge, VT
*"I was very disheartened to hear that the Governor intends to cut funding for Primary Care. Our Family Practice in Cambridge, Vermont is an independent practice, a rarity these days, struggling to keep afloat amidst the perpetual changes to our finances. At this time, every bit of money that we receive goes back into the system. We practice now, as we always have, in a fashion that is most favorable to the patient. **Our team-based approach incorporates case management within the scope of the care that we provide. The PMPM monies doled out by Medicaid are folded into the system allowing us to provide well-rounded services to our patients**, rather than being set aside for a particular aspect of case management. In fact, most all of our encounters require an element of care coordination and management anyway.*

If the funding were to be cut, our services would suffer. We do not have luxury of generating a safety net of funds by charging such things as facility costs, nor do we have the buffer of the high priced specialist fees to support our practice, as those who work for larger institutions. Essentially, we fully depend on every penny allotted to us by the piecemeal system that constitutes our current mode of compensation. With less income we would have to reduce our salaries, a tricky thing in a rural area where it is difficult to maintain a competitive wage, or we would have to cut the staff despite our essential need for each one of them.

It would be a crime to see our practice go out of business as a result of the rising costs, plummeting payments, and random withholds and fines. If primary care goes under, the cost of medical care will become astronomical as patients will turn to the Emergency Room and specialists for their primary care needs. This will certainly alter the Governor's budget in a very unfavorable way. Now is the time to find ways to improve primary care funding, not reduce it. If the health of our state is to be improved, the foundation of this lies with primary care."

Susan Miller - Family Practice Associates, Cambridge, VT
*"**This would result in an $18,000 loss of revenue for our (independent) practice. As PCPs, case management or perhaps a better term would be patient care, is what we use this funding for**. The impact could be limiting our patients based on type of insurance, something we have not done for 42 years and an idea we do not support; or worse-case scenario closing our doors. It is an effort to remain solvent. One might say let the big ACOs take over – unfortunately with maneuvers like this that will occur."*

Windham

Val Rooney, MD, Pediatrics – Just So Pediatrics, Brattleboro, VT
"The PCCM funds are used to help with the following:

- ***Clinician and staff phone calls to patients**. This is not billable time, but answering patient's questions, reassuring patients, assessing patients, etc. are all ways to keep patients out of costly treatment center, like emergency rooms.*
- *Administrative time to create the infrastructure to create and allow for effective primary care. This time is used for **pre-visit planning and chart review prior** to patient's arrival at the clinic. This time is spent in reviewing the patient's allergy and medication list. To come up with the plan of care for that visit, including what medication refills and immunizations are the patient due for. What tests have they had and what do they need. A review like this, can save patients and the system a great deal of money and can keep patients healthy. None of this work is billable.*
- *Time that the Practice Manager spends **creating standing orders and triage protocols**, so that staff can be better equipped to help answer patient questions. Not billable, but keeps patients healthy and keeps costs down.*
- ***Referral tracking**. Non-billable time spent making sure that patients are scheduled for consults with Psychiatrists, Endocrinologists, Behavioral Health Therapists, Nephrologists, etc. Again, not billable, but works to catch problems early and tackle them while they are manageable.*

Windsor

David Park, M.D. - White River Family Practice, White River Junction, VT
*"I'm one of the partners from White River Family Practice in WRJ. **This PMPM payment is really important for us to maintain two key positions in our office: 1) community care nurse**-- our community care RN, Lisa Paquette, is tasked with managing our highest-risk population, identified by several indicators, the most important of which are low health-confidence measures and frequent hospitalizations/ER visits. She actively contacts these patients to reconcile meds, coordinate follow-ups after discharge, and check in with their condition to minimize chances of readmission. Since establishing this position in our office, our patient's readmission rates have decreased significantly.*
***2) mental health coordinator**-- Gretchen Curtis is a social worker employed by the Clara Martin Center, and we pay for her to come to our office every Thursday to meet with any patients in need of finding psychiatric care. She does some counseling and also has an inside knowledge of local counselors/providers for those who need to find someone with whom to establish longer-term care. Removal of this PMPM payment would significantly and negatively impact our ability to fund these positions in our clinic. We would likely have to eliminate at least one, if not both, positions were this cut to be approved."*

Dr. Rebecca Foulk MD, Pediatrics, South Royalton, VT
"Primary care in Vermont is at a critical juncture: In 2016, 29% of primary care physicians were 60 years of age or older, and many were planning to retire or reduce hours within the next twelve months at the time of the survey. While the number of specialists in Vermont is growing, the number of primary care providers is shrinking, due in large part to the huge debt that most medical school graduates are carrying and the disparity in income between specialists and generalists.
Any measure that cuts funding for primary care practices will put many in an ever more precarious position; a measure that cuts funding to practices with a high percentage of Medicaid recipients might put some in an untenable position.

Our pediatric practice sees about 60% Medicaid patients. We have three pediatricians, one of whom is still paying off medical school debt 10+ years out of residency, and one of whom carries about $400,000 in debt, and is just a few years out of residency. The third is on the verge of retirement. Both of the younger doctors are working at salaries far below what they could make had they gone into a subspecialty practice, and below what they could make working for one of the big medical centers. They do this because they are dedicated to community health and service to underserved populations. As part of our practice's commitment to our surrounding communities, we pioneered a school-based clinic over 23 years ago, which now offers medical, dental, and mental health services in eleven schools. The two younger pediatricians both spend some time in the school clinics; the practice subsidizes this work.

We also employ a full time mental health counselor, who splits time between the school clinics and the office, and two nurses, one of whom functions as our care coordinator. She works four days/week, and three of those are taken up with her care coordination work, which includes meeting with families to address the social determinants of health such as food insecurity, housing, mental health challenges, and substance abuse, as well as coordinating with schools to advocate for children with special needs in their educational settings.

***The $2.50 PPPM payment that we now receive enables us to employ the RN care coordinator, and to maintain the important connection with the schools. Without these funds, we would have to reduce care coordinator hours significantly. As things stand now, even with the funds, we are having to reassess our presence in the schools due to the cost**. Without the funds, we would surely have to withdraw medical services and some of the mental health services from the school setting, which in many cases would mean that the neediest children would be the ones to go without care.*

Vermont needs to enact measures to strengthen our primary care system. In order to attract new providers, and to retain those already here, funds need to go to ensure adequate compensation. There should be more state programs of debt repayment or forgiveness. Funds should be diverted from insurers and specialists to primary care providers, or in a few more years the system will fail the majority of Vermonters who live outside of Chittenden county."