Vermont Medical Society

**To:** Senate Health and Welfare Committee
**From:** Jessa Barnard, Executive Director
**Date:** February 9, 2020
**RE:** S. 244, Strengthening Primary Care and Primary Care Providers

**The Vermont Medical Society** is the largest physician membership organization in the state, representing over 2400 physicians, physician assistants and medical students across all specialties and geographic locations. The mission of the Vermont Medical Society is to optimize the health of all Vermonters and the health care environment in which Vermont physicians and physician assistants practice medicine. **VMS strongly supports S. 244 and efforts to strengthen primary care in Vermont.**

VMS supports efforts to strengthen support for primary care in Vermont because high-quality primary care is the foundation of a high-functioning health care system and is critical for achieving health care's quadruple aim: enhancing patient experience, improving population health, reducing costs, and improving the health care team experience.[1]

Primary care is unique in health care in that it is designed for everyone to use throughout their lives—from healthy children to older adults with multiple comorbidities and people with disabilities. High-quality primary care provides comprehensive person-centered, relationship-based care that considers the needs and preferences of individuals, families, and communities.

However, primary care is currently struggling. Numerous reports have highlighted the workforce challenges facing primary care, from an aging workforce to an increasing cost of medical education to frozen federal dollars for graduate medical education and burnout among existing clinicians. In Vermont, primary care FTEs per 100,000 population decreased from 80.2 to 69.6 between 2008 and 2018, 31% of primary care physician are over age 60 and 15% are planning to retire or reduce hours in Vermont within 12 months.

VMS supports the specific sections of the bill for the following reasons:

### Sections 1-3: Parity of Audio-Only Telephone Services

Providing parity for audio-only telephone services is the only way to accomplish the goals of Vermont patients having equitable access to primary care services in their medical home, and achieving useful outcomes for studying the use of audio-only services over the next year.

- Audio-only connections offer critical access to healthcare services for patients who face barriers that might otherwise cause them to delay, defer, or cut short medical treatment.[2]

[1] National Academies of Sciences, Engineering, and Medicine 2021. *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care.* Washington, DC: The National Academies Press.
[2] Vermont Program for Quality in Health Care, Report: Audio-Only Telemedicine & Clinical Quality Recommendations, October 20, 2020; available at https://legislature.vermont.gov/assets/Legislative-Reports/Audio-Only-Telephone-Services-Working-Group-Report-v2.pdf

- There are a number of patients for whom technological barriers make an audio-visual connection impractical including broadband access, affordability, computer equipment, comfort with technology and patient preference.
- Audio-only reimbursement addresses equity issues: research shows that rates of those who lack digital access are higher among those with low socioeconomic status, those 85 years or older, and in communities of color.[3]
- Under 8 VSA § 4100l, plans must only provide coverage for services that are determined by the plans to be "medically necessary, clinically appropriate" health care services to be delivered remotely and plans are limiting coverage to services they have determined can be provided without an in-person visit. Not all phone encounters are billable and appropriate billing practices must be followed. See for example BlueCross BlueShield's policy, that lists only 27 services that are reimbursable using telephone: https://www.bluecrossvt.org/documents/telephone-policy-publication-12422
- Vermont law now in effect requires patient consent for all audio-only visits.
- A VMS member survey in November 2021 revealed that Vermont health care practices are not experiencing a cost savings as part of implementing audio-only services and many practices report that providing services over the phone requires more time including: working with patients to determine if audio-only is appropriate, helping patients get situated in a new way of connecting with their clinicians, longer appointment times talking through each patient concern and checking that nothing has been missed, more time spent documenting the encounter and more follow-up time by staff to call patients separately to coordinate prescriptions, referrals or other follow-up care
- In response to the July 2021 order issued by DFR requiring reimbursement of "at least" 75% for audio-only services, both MVP and BCBSVT have issued policies stating that they will reimburse at 100% for services provided by mental health providers but at 75% even when the same services are offered by primary care providers.[4] At a time when primary care clinicians are providing a large percentage of mental health and substance abuse care and when the state is working to encourage treatment of MH/SUD in the mental home through Hub and Spoke and other efforts, this is counterproductive.

We ask that the Committee return Vermont's policy to reimbursement at parity for health care services delivered by telephone.

### Sections 4 & 5: Increasing Primary Care Spending Allocations

A 2020 Milbank update on how states are increasing their primary care spending[5] found that states such as Rhode Island, Oregon, Connecticut and Pennsylvania that are setting primary care spend targets are investing in primary care for two reasons:

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[3] Roberts ET, Mehrotra A. Assessment of Disparities in Digital Access Among Medicare Beneficiaries and Implications for Telemedicine. JAMA Intern Med. 2020;180(10):1386–1389. doi:10.1001/jamainternmed.2020.2666; see also the recent HHS data brief finding that video telehealth rates were lowest among those without a high school diploma (38.1%), adults ages 65 and older (43.5%), and Latino (50.7%), Asian (51.3%) and Black individuals (53.6%): https://aspe.hhs.gov/reports/hps-analysis-telehealth-use-2021

[4] https://www.bluecrossvt.org/documents/telephone-policy-publication-12422
2021-64-telehealth-coding-and-reimbursement-updates-for-vermont-providers.pdf (mvphealthcare.com)

[5] https://www.milbank.org/2020/11/how-states-are-increasing-their-investment-in-primary-care/

- research indicates that countries with health systems that invest more heavily in primary care relative to other types of care compare favorably on multiple performance dimensions, and
- primary care physicians continue to be among the lowest paid physicians across all specialties, making it difficult to attract new physicians to primary care.

A 2021 National Academy of Sciences, Engineering and Medicine Report found that people in countries and health systems with high-quality primary care enjoy better health outcomes and more health equity, yet in the United States primary care is under-resourced, accounting for 35 percent of health care visits while receiving only about 5 percent of health care expenditures nationally.[6]

The National Academy Report found that states that have mandated an increasing minimum percentage of health care dollars be spent on primary care services have achieve an increased investment in primary care, to over 12% in both Rhode Island and Oregon.

We urge Vermont to follow Rhode Island and Oregon's lead and to build off of the 2020 DVHA and GMCB Report that assessed Vermont's spending on primary care[7] and set a target of 12% spending on primary care services. In the DVHA/GMCB Report, the total spending by payer (using 2018 data, including both claims and non-claims payments) was 9.2% for Commercial, 24.3% for Medicaid, 6.5% for Medicare - 10.2% overall across payers.

Ways to increase spending on primary care that is not fee-for-service includes support for the Blueprint for Health's Patient Centered Medical Home program, Community Health Teams, Spoke program, and Women's Health Initiative and other value-based payments. This approach complements the work of the Committee with S. 285 and strengthening the Blueprint for Health. The Committee may want to add some parameters around how payers can accomplish this increase, such as increased investment in the Blueprint, or other statewide programs that invest in primary care practice support and redesign.

### Section 6: Increasing Medicaid Primary Care Payments

VMS appreciates the work of DVHA to professionalize and standardize DVHA's fee schedules and to align the RBRVS fee schedule with Medicare. We also appreciate the commitment of DVHA to achieve primary care rates of 100% of Medicare rates in the 2022 Budget Adjustment and 2023 State Budget and the statement of principle in S. 244 that DVHA should continue to meet 100% of Medicare. Medicare undertook major revisions to its fee schedule in 2021 to revalue primary care services, especially Evaluation and Management office visit codes. Implementing these updates within Medicaid's RVRVS fee schedule for 2022 results in a long-needed increase to Medicaid payments for primary care.

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[6] National Academies of Sciences, Engineering, and Medicine 2021. *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care.* Washington, DC: The National Academies Press. https://doi.org/10.17226/25983.

[7] https://legislature.vermont.gov/assets/Legislative-Reports/Act-17-Primary-Care-Spend-Report-15-January-2020_Final.pdf

However, we also recognize that aligning the fee schedule with the Medicare fee schedule can have its drawbacks for specific services. For example, over the past several years this has led to decreases in primary care payments, specifically to reductions in vaccination administration rates (2017- 2019) and to primary care visit rates (2020-21).

In addition, in seeing the breakdown of the amount of the overall proposed 2022 Medicaid RBRVS fee schedule update, which just became available to VMS in January, only 36% of the fee schedule increase is directed to primary care physicians and nurses.

Therefore, while we agree with 100% of Medicare as a starting point and support the language that is in S. 244, VMS asks that in addition DVHA and the Committee work with primary care providers when developing the fee schedule to ensure this formula is leading to meaningful investment in primary care, avoids year over year decreases to primary care, and that it adjusts for inflation over time.

### Sections 7&8: Chief Clinical Officer for Primary Care

As this Committee is well aware, the Green Mountain Care Board is responsible for regulating hospital budgets and health insurance rates, implementing the ACO/All Payer Model and embarking on completely new ways of paying providers. While health reform in Vermont is predicated in part on primary care and prevention reducing more expensive or avoidable care it is not always clear how these regulatory levers are all moving in that same direction. A CMO for primary care will have their eye on and can advise the Board members regarding how hospital budgets, insurance rates, ACO budgets and the APM agreement with Medicare move our state towards a primary care and prevention-focused model. Similarly, the National Academy Report finds that implementing a plan for high-quality primary care requires coordinating primary care activities and cites that Oregon's primary care spend requirement was coupled with the creation of a primary care transformation office in state government.[8]

The sections of S. 244 work together to increase investment in, and support for, primary care being available over time to serve as the foundation of our health care system. We ask for your support in moving the bill forward.

[8] https://www.oregon.gov/oha/hpa/dsi-tc/Pages/index.aspx