Hannah Rabin testimony Senate Committee on Health & Welfare April 7, 2021

I have been a family doctor in independent practice in Vermont for more than 20 years, currently at Richmond Family Medicine where I am one of 3 family doctors. We work also with 3 family nurse practitioners and 3 part-time psychiatric nurse practitioners. We take care of nearly 10,000 patients and see about 1200-2000 patients per month for everything from health maintenance "check ups" with focus on screening, immunizations, and other prevention to chronic disease management and acute care for injuries and illness.

Just over a year ago, with the start of the Covid-19 pandemic we quickly shifted our practice to incorporate care for patients with Covid symptoms, evaluating and testing patients outside in a tent and finally in a trailer that remains our respiratory clinic where we can evaluate symptomatic patients, test and monitor patients who have Covid whom we are managing as outpatients. We scrambled for PPE which was in short supply. We continued to see some patients in person in our clinic but shifted to telemedicine for many visits in the early months of the pandemic and even continuing to some extent now.

I testified last year before this committee that our participation in OneCare helped to stabilize us financially during that time when we saw fewer patients in the transition to telemedicine, and when we saw our revenues from fee-for-service drop, even as the number of phone calls from patients increased. Additionally we benefited from the Payment Protection Program loan/grant and stabilization grants from the State of Vermont and the Department of Health and Human Services. This funding helped us to retain and pay all of our employees, including those who needed to be out of work to care for children or for their own health needs during the pandemic. Fortunately none of our employees contracted Covid and now all our clinic staff are vaccinated.

What has become clear to me is that although we were able to stabilize and keep our staff employed, and our clinic functioning to take care of our patients over the first year of the pandemic, the future of primary care in Vermont looks uncertain. I do not see that we are on a path forward to keep primary care robust and able to serve the needs of Vermonters. My concerns have to do with the overwhelming burden on primary care providers, the degree of burn out and the difficulty of attracting and retaining good clinicians in primary care. The pandemic has highlighted this but it was a trend that long preceded the pandemic.

Unfortunately, I do not see OneCare which was Vermont's answer to the quest for an all payer model as a solution to this problem.

Because of the particular role of primary care --from managing prevention to being the first stop for diagnosis and treatment, to coordinating care and supporting patients as they navigate a complex medical system--there is a whole clinical team approach required. Much of the work of this care and coordination happens within the clinic and is "behind the scenes". In primary care we know that every hour spent seeing patients involves another hour of work by that clinician--responding to messages from patients, making phone calls, looking up results, coordinating care with other doctors, with visiting nurses, with therapists, with teachers, documenting everything in the chart. I spent 15 minutes yesterday on the phone with Blue Cross trying to get a prior authorization for a CT scan for a patient. Staff in my office are often on hold, even for a couple of hours, to try to get prior authorizations for needed medications or tests. In a "fee-for-service" system much of this work done by doctors as well as the work done by other clinical staff is unfunded by the payers. In a capitation system like OneCare there is an attempt to pay for this work, but in fact, there is little understanding by OneCare about the care coordination we do and have always done, and there are additional administrative burdens and documentation requirements for participation that make little clinical sense and add time and cost to our clinic. Additionally, in the capitation model where a certain number of patients are attributed to a clinic and a per-member-per-month fee is assigned, shifts in patients from one practice to another might not be captured in those payments, and perhaps more importantly, if we add another service or another clinician after the beginning of the year, we have costs associated with those additions but there is not a way that OneCare has come up with to increase the per-member-per month payment to account for the additional services for the patients. We brought on a new psychiatric nurse practitioner in January to help care for our patients' mental health needs and are hoping to hire a new family nurse practitioner to help care for new patients and to ease the workload of our current clinicians. But without a clear way to increase funding as we increase our clinical capacity, it becomes difficult to grow to meet the needs of our patients and to be able to retain clinical staff at risk of burn-out.

We don't get clear accounting from OneCare about attribution of patients or how the per member per month amount is derived or even, in our monthly statements

what those numbers are. Perhaps in a large hospital system with financial experts, OneCares accounting for services makes sense but to us with our clinical focus, even with a very competent practice manager trying to get explanations from OneCare, the accounting remains opaque and that troubles us. An example of this is that we have not seen an increase in our monthly payments from OneCare from last year to this year which we would have expected with the new participation of Blue Cross which is one of the largest payers and the decline of fee for service as we shifted from that method of payment to OneCare per member per month capitation payments for those patients with BlueCross insurance. The specifics of attribution and per member per month payments are not listed on the monthly statements.

OneCare also now requires that we participate in the financial risk of the organization and at the end of the year we will find out if we will owe money back to OneCare if the whole Clinical Service Area which includes other primary clinics (none of which we have control over) has been more expensive than they anticipated.

I still love to go to work, and feel it is an extraordinary privilege to care for my patients. I like the small clinic model because we really know our patients and can be responsive to the needs of our community. I love working with my colleagues at our clinic which feels like a sort of family. Being small enabled nimbleness and cohesiveness which allowed us to respond quickly, safely and to meet the needs of our patients and our staff from the very start of the pandemic. We know that we are providing high quality and lower cost care and that this value is important for Vermonters, but we also know that to keep going we need a system of funding that does not add to our administrative burden and a revenue stream that we can count on so that we can keep our doors open and ultimately so we can attract and retain clinical staff to do this important work.