Testimony from Katie Marvin MD

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Regarding S. 126 - An act relating to health care payment and delivery system reform

Thank you for the opportunity to speak to this group on health care reform, specifically bill S.126. I am a family doctor in Morrisville, Vermont, where I have worked in an FQHC in full spectrum primary care for 16 years. I have also worked across the street at Copley Hospital, a Critical Access Hospital helping with obstetrics and pediatric services. I have been active with the Vermont Academy of Family Physicians, the GMCB Primary Care Advisory Group, and am the current President of the Vermont Medical Society.

The Primary Care Advisory Group was created by the legislature in 2018 and then continued by the GMCB to provide "input, advice or recommendations" on the topics of primary care to our state leadership. Over the past 7 years this group of advanced practice providers and physicians in primary care across the state have shared our stories and concerns in meetings every other month. I can testify that the messages from this group, while they come from a variety of stakeholders, have been consistent, and it comes of no surprise to us that we are in a financial health care crisis.

Every day I talk with patients who are unable to afford or access the care they need, yet we have exorbitant health care costs in Vermont. This paradox is critical – how do we curb costs and improve care? Act 167 in the fall, recent VT Digger articles on the welfare of community clinics, as well as the testimony this week by Jessica Holmes of the GMCB all echo the same alarms that primary care providers have been sharing for years. This system is not sustainable. This complex problem will require a multifaceted approach, strong evidence to make decisions, and a foundational primary care base.

Our primary care practices of all types – private practices, hospital owned, and FQHCs – need support. Those of us on the ground, doctors, nurse practitioners, physician's assistants, and the teams of nurses, Community Health Teams, and staff who support us, are seeing as many patients as we possibly can, both due to patient demand, and to keep our clinics afloat, but this pace leads to burnout, hurried care and recruitment challenges. Bill S126 attempts to reform our health care delivery system. Our goals must be to reduce the cost burden of medical care, AND improve patient health, by improving access, lowering expenses, making systems more efficient and staying evidence based.

Primary care is the ONLY field of medicine that has demonstrated superior results in all areas and must be involved as we implement necessary changes.

If I were to create a list of priorities, I recognize that it would be from my lens, with the inherent bias of my role in a community FQHC. You will, no doubt, receive asks and lists from others, each of whom have their own lens. Which is why it is so important that the legislature and GMCB and other partners work together with common goals, and with a commitment to using EVIDENCE to guide their decisions. In medicine, we work very hard to make evidenced based decisions. Your task is no different with high stakes, as you weigh the health care options and subsequent costs.

My list of priorities relate to Bill S126, health care reform, and the immediate need to address cost.

1) Make sure decisions are evidence based. Where are the greatest costs? What are the risks of specific proposed changes? What are other states or nations doing to improve care access and decrease costs? What do your medical leaders across all fields suggest? Ask: Bravely follow the evidence to reorganize care – where it is given, how it is reimbursed, and who is responsible.

2) Primary care funding. Robust primary care is a critical component to a better health care system. Payment reform might look different for different practice types, and I can speak further on this. But, the bottom line is that without adequate funding we cannot recruit or pay nurses, providers, or staff. The spend rate for primary care has been at 5-10% (depending on payer) without improvement. It is unrealistic to think that primary care can survive as a critical foundation without significantly better funding. Payment rates are increasing by double digits for insurers or hospital budgets, but primary care rates have decreased! Ask: Requiring the primary care spend rate to climb, even by 1% per year to a goal of 15%, would have a dramatic effect across the board.

3) Improved PCAG involvement with policy development. Act 167 was developed by the GMCB to decrease costs, and members of the PCAG were interviewed during the process, but not involved in the conclusions or recommendations. Most primary care providers were very concerned with recommendations to significantly alter services of our small, rural hospitals. These centers of care are essential to community health. Questions such as: should we be measuring net patient revenue? Or cost? What is the value of a service that is not making money, but essential to community care? What other cuts were considered? Ask: Could PCAG be more involved with GMCB policy development?

4) Primary care payments for high level care and procedures. A fee for service model reimburses more complex care and procedures done by the PCP, however the "flat rate" for Medicare and Medicaid visits in the FQHC setting does not. So, if I see a patient for an hour and perform procedures (GYN, derm, ortho examples), I am reimbursed the same amount as seeing a patient for 5 minutes for a cold. How FQHCs are paid and the need for rate increases was recently discussed in VT Digger. Ask: Developing additional payments to incentivize FQHC providers to keep these cases, and not refer them due to lack of time, would be beneficial.

5) Patients should be seen at the appropriate level of care. In many cases, and for a number of reasons, some patients go to the emergency department or a specialist for something well within our wheelhouse. This costs more and clogs the pathway to that higher level of care. Sometimes I end up managing a very complex case that tests my skill for months until the patient can be seen by a specialist. Another paradox. Asks: Improving "right place" medicine would reduce cost and reduce the wait times. Developing more phone consults provider-to-provider for specialty services would also help rural PCPs reduce unnecessary referrals and costs.

6) Every dollar spent was at one point a medical order or prescription. This starts with providers. Are providers considering this? Do they work to reduce redundancy? Is there any incentive to NOT order a test or medication? In primary care, we see labs and imaging orders done at one facility and then repeated at another facility… just because…. Some technologies may be able to bridge electronic medical records reduce redundancies, but

they must be easy and reflexive. Transparent reference-based pricing may help, but only for insured payers. Ask: We need health care policy experts to research best practice to decrease health care costs nationally.

7) Capitated payments for primary care PANEL management. People think about the visits we see, but not about the behind the scenes work I do at night managing the care our patients need outside of their visits. This is mostly unpaid work, a huge source of burnout, and really important. The medical home is the central hub of health care, and we make sure that our patients are getting the labs, specialty care, or hospital follow-ups they need. Payment reform must also account for this workload for all practice types.

8) Build a Pipeline. I have often been told "if only there were 20 more of you to help primary care out in all of these small towns". That is exactly why Maple Mountain was created – to build a residency to train new doctors in rural Vermont where they will stay to practice. This program and other scholarship programs to support PAs, NPs and nurses must be funded if we want to rebuild our pipeline for the future.

9) Technology: smart electronic medical records, AI for note writing and chart management, and a state system like VITL to bridge EHRs across the state would significantly reduce the time spent looking for information, create ONE spot to look for data, reduce medication errors (due to multiple prescribers who work in different settings), and as stated above, reduce redundancy of orders when a patient goes from one location to another. Patients cannot believe that this does not already exist.

10) Smart spending. The gap in funding caused by the AHEAD model brought forward a concern for funding Blueprint programs. I cannot work without this support staff, and they enable me to see more patients with higher quality visits. Our Community health teams have led Vermont a national leader in the outpatient management of Opiate Use Disorder. Funding Blueprint is an example of a high ROI, great investment for our state. We need to continually look at expenses and consider their greater impact.

Our primary care providers want health care to be better – more available, less expensive and high quality. We want to help work with our State leadership to find sustainable short and long term solutions. I think we can do this! Thank you!

Katie Marvin MD