



Why primary care?

High-quality primary care provides comprehensive person-centered, relationship-based care that considers the needs and preferences of individuals, families, and communities.

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.

Significant investment in primary care is critical to maintaining access to affordable, quality health care in Vermont



Government Payments

Adjust for inflation annually



Primary Care Spend

Increase to 12% of Vermont's total health care spending



Payment Reform Support

Center payment reform on primary care



Workforce

Ongoing funding for primary care scholarships & loan repayment



Administrative Burden

Reduce administrative burden, especially prior authorizations

"I am a former dairy farmer now practicing family medicine in my home town of Newbury, Vermont for the past 8 years. 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. I hope my patients and I still have a functioning clinic in the coming years. Your advocacy for primary care is critical." - Melanie Lawrence, MD, MS, Newbury Health Clinic, Newbury, VT

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Policy Priority



**Sustainable
Government
Payments**

Background

Practices cannot wait for sustainable funding streams until payment reform matures. Practices must have predictable and sufficient funding from all payers, including Medicaid and Medicare. The COVID-19 pandemic and its aftermath have placed primary care under additional pressure between higher costs for labor and supplies; higher demand for services that are not paid for such as screening for respiratory illnesses and vaccine advice; and patients presenting with complex medical and mental health needs after delaying care during the pandemic.

There are 13 fewer independent primary care practices in Vermont since 2017. Hospital-owned practices have also closed after facing insufficient revenue to cover the costs of operating a primary care practice. Primary care practices are facing:

- **Inflation:** The consumer price index, reflecting real expenses facing medical practices such as fuel, electricity and wages, rose 6.5 % from December 2021 to December 2022.
- **Medicare cuts:** Practices received a Medicare cut of 2.0% in 2023 and currently face another 1.5% cut in 2024. Medicare already pays well below commercial fee for service rates. The Medicare physician fee schedule formula is flawed and is the only Medicare fee schedule that does not receive an inflationary adjustment. Adjusted for inflation, this means that Medicare payments under this fee schedule have declined 22% from 2001 to 2022.
- **Medicaid case rates higher:** With a pause on redeterminations, medical practices are seeing a higher percentage of patients with Medicaid coverage, lowering overall reimbursement.

Proposal

- **Fix Medicaid and Medicare's primary care fee schedules:**
 - Medicaid's Resource-Based Relative Value Scale (RBRVS) Fee Schedule should pay at 110% of the Medicare Physician Fee Schedule and, at a minimum, adjust annually by the Medicare Economic Index (MEI) inflation factor
 - Medicare's Physician Fee Schedule must incorporate the MEI annually
- **Payments support flexible modalities of care**
 - All payers should be required to reimburse at 100% of in-person rates for audio-only telehealth services

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Policy Priority



**Primary
Care Spend**

Background

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.

A 2020 report by the Green Mountain Care Board (GMCB) and the Department of Vermont Health Access (DVHA) determined that in Vermont, the percent of 2018 health care spending on primary care (claims-based and non-claims-based) was 10.2% overall, ranging from 24.3% for Medicaid, 9.2% for commercial payers to 6.5% for Medicare.

States that have mandated an increasing minimum percentage of health care dollars be spent on primary care services have achieved an increased investment in primary care, to over 12% in both Rhode Island and Oregon. Oregon's primary care spend requirement has been coupled with the creation of a primary care transformation office in state government.

Proposal

- **Increase percent of commercial payer spending on primary care services:**
 - Commercial insurers to raise their "primary care spend figure" by 1 percentage point per year until the percent of spending reaches 12% of overall spending, without adding to overall premiums and to not be accomplished through FFS increases.
- **Increase percent of Medicare spending on primary care services:**
 - Green Mountain Care Board and Agency of Human Services when negotiating Vermont's All Payer Model Agreement should require that Centers for Medicare and Medicaid Services/Medicare increase its percent of spending on primary care services over time.

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Policy Priority



**Center Primary Care
in Payment
Reform Models**

Background

Evidence shows that the dominant fee for service payment mechanism, in combination with the process CMS uses to set relative prices for primary care and other services in the Physician Fee Schedule, continues to devalue primary care relative to its population health benefit, resulting in large and widening gaps between primary care and specialty care compensation.

Fee for service payments can create barriers for primary care practices to move away from a biomedical, disease-focused model to one that addresses people's expressed needs and preferences, includes individuals and families more in their care, and responds to the multitude of factors that impact health, including the context of the community.

Primary care initiatives in Vermont are decentralized between the Agency of Human Services, Department of Vermont Health Access, Blueprint for Health, Vermont Department of Health Office of Rural and Primary Care, Green Mountain Care Board (GMCB) and the GMCB Primary Care Advisory Group, OneCare Vermont and their population health, prevention and pediatric committees, primary care specialty societies and more.

Proposal

- **Center Primary Care in Payment Reform Models**
 - The State must center primary care as the building block for our health care system as it renegotiates an All-Payer Model Agreement with CMS and considers hospital global budgets. Such models should be built with a clear eye towards mechanisms for integrating and investing in primary care. We must build off of and strengthen successful, existing multi-payer models in Vermont, including OneCare's Comprehensive Payment Reform (CPR) Program and Blueprint for Health.
- **Increase Upfront Investments to Support Practices Participating in Payment Reform:**
 - New participants in the CPR program, or other new payment reform models, must receive adequate investments to support the operational costs and resources necessary to make a smooth transition to value-based payment and practice redesign.
- **Coordinated Leadership**
 - Support the creation of a Chief of Primary Care at the Statewide level, such as the Green Mountain Care Board, who shall be responsible for coordinating efforts to evaluate, monitor and implement solutions to strengthen primary care delivery in Vermont.

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Policy Priority



Workforce

Background

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.

On October 15th, 2021 the Agency of Human Services submitted their [Health Care Workforce Development Strategic Plan](#) to the GMCB.

Proposal

- **Workforce:**
 - Support ongoing state funding for new VT Area Health Education Center (AHEC) Medical Student Incentive Scholarship for 10 Larner College of Medicine third-year and fourth-year medical students launched in summer 2021 to sunset in 2027.
 - Sustain increased funding for Vermont's primary care loan forgiveness programs beyond the current HRSA funding award
 - Support Teaching Health Center Graduate Medical Education Planning & Development Grant to establish a new rural family practice residency program in collaboration with Federally Qualified Health Centers and area hospitals
 - Advocate for Congressional changes to HRSA scoring, which disadvantages VT opportunities for loan repayment, public health service slots and residency (GME) programs
 - Fully fund initiatives to bolster the existing mental health workforce capacity through collaborative care models, such as the Vermont Child Psychiatry Access Program (CPAP)

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Policy Priority



**Administrative
Burden**

Background

In the summer of 2017, the GMCB conducted a Clinician Landscape Survey of over 400 Vermont clinicians to assess overall morale and the factors affecting providers' decisions to practice in hospital or independent settings. The results revealed that regardless of the employment setting or area of specialization, "paperwork, billing and administrative/regulatory burden" were among the most frequently cited sources of provider frustration and threat to practice success.

For every hour of physicians' clinical face time with patients, nearly 2 additional hours are spent on desk work – a recent time study revealed that during the office day, physicians spent 27.0% of their total time on direct clinical face time with patients and 49.2% of their time on EHR and desk work.

Despite a 2018 consensus statement on improving the prior authorization (PA) process jointly drafted by the American Medical Association, American Health Insurance Plans, BCBS Association and the American Hospital Association, 85% of physicians surveyed since the statement still report the burden associated with PAs as high or extremely high.

Proposal

- **Reduce prior authorization**
 - Act 140 of 2020 required private payers to establish "Gold card" pilot programs to reduce prior authorization. Those pilot programs must now be expanded so that all clinicians who have a 90% approval rating for their prior authorization requests can bypass the prior authorization process.
- **Payment reform efforts must be coordinated and multi-payer**
 - Practices cannot comply with many sets of payment and quality rules. Efforts to advance payment reform must include all payers with coordinated quality and administrative requirements.
- **Reform prior authorization**
 - Support additional prior authorization reforms identified by Department of Financial Regulation in its Act No. 183 of 2022 report: reduce the time to approve PAs, prohibit PAs for preventive services if already obtained that year; limit "step therapy," which requires patients to fail on medications before obtaining insurance coverage for another medication.