To: Senate Committee on Health & Welfare
From: Jessa Barnard, Vermont Medical Society, jbarnard@vtmd.org
Date: April 16, 2024
RE: H. 721, An act Relating to Expanding Access to Medicaid and Dr. Dynasaur

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Good morning and thank you for the opportunity to testify regarding H. 721. I am the Executive Director of the Vermont Medical Society, Vermont's largest physician and physician assistant membership association, representing approximately 2900 physicians and PAs from around the state, both primary care and specialists, and at all practice settings.

In 2020, our Board of Directors reaffirmed the Vermont Medical Society's principles of health reform and statement of need for universal coverage.[1] The statement reads, in part:

RESOLVED that the Vermont Medical Society reaffirms its support as stated in 1992, 2003 and 2005 for universal access to comprehensive, affordable, high quality health care centered on an increased investment in primary care, reduced administrative burden and public health interventions that address the social determinants of health.

Based on our position in support of universal coverage, the VMS Board has adopted a position in favor of Section 7 of the bill, expanding the MSP program, which would make traditional Medicare coverage more affordable for Vermonters**.**

Our Board also stated an interest in exploring expansion of the Medicaid program for more Vermonters. In concept, more Vermonters covered by Medicaid could result in administrative simplification and help provide Vermonters with coverage that is more comprehensive and with lower out-of-pocket costs than commercial coverage.

However, our Board had a number of questions with the proposal to expand Medicaid coverage and believes that further study and analysis of these issues is critical before moving forward with expansion. **Therefore, we strongly support the technical analysis in section 4 of the bill.** Questions include:

What coverage do these individuals already have? How many will be added in each of the expansion categories (young adults up to age 26, pregnant individuals, adults ages 26-64)? Are they uninsured or insured through employment-based coverage or QHP plans? Would individuals have the choice to not select employer-based coverage and receive Medicaid? What impact would switching from current coverage to Medicaid have on the federal dollars available to Vermont, potential cost sharing assistance and reimbursement rates to providers? What rate should such services be reimbursed at to make up for individuals who may be switching from

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[1] https://vtmd.org/client_media/files/2020%20Reaffirming%20VMS%20Principles%20of%20Health%20Reform%20%20Statement%20of%20Need%20for%20Universal%20Coverage_Final.pdf

commercial plans to Medicaid? As your committee is aware, inadequate reimbursement rates for both specialty care and primary care in the Medicaid program could further exacerbate access issues, including wait times for services, and threaten the viability of Vermont's health care practices. So, what would make an adequate reimbursement rate? The study will compare current Medicaid rates to various Medicare benchmarks as well as average commercial rates.

This is based on the following data points:

Medicaid is currently the lowest payer for most services. While Vermont Medicaid currently reimburses at 110% of Medicare rates for certain primary care services provided by specific provider types the remainder of services including all specialty care services are reimbursed at around 85% of Medicare. And, Medicare rates are far below commercial. Commercial insurance rates are on average 143% of Medicare rates for physician (professional) services – with ranges depending on the analysis from 118 -179%.[2] Other state public option programs have acknowledged that reimbursement rates must be set closer to commercial rates to ensure access for patients and participation by providers.[3]

Toward the end of Committee deliberations and after taking witness testimony, the House Health Care Committee did move forward with H. 721 expanding coverage to young adults ages 18 & 19 and pregnant women up to 312% FPL. While we support the concept behind this immediate expansion of coverage, we do have concerns with the financial impact on the clinicians and facilities caring for them. **We request that the Committee include in H. 721 reimbursement for comprehensive prenatal, labor and delivery, postpartum, other reproductive health care services, and psychiatric services under the enhanced primary care rate paid under the RBRVS fee schedule, rather than only study this option under the technical analysis**. **Further, it should be explicitly clarified that OBGYNs can attest to providing primary care services to qualify for the enhanced rate.**

As you know, existing birth facilities in Vermont, neighboring states and other rural states are already struggling to stay open. Vermont has the lowest birthrate and number of births per year in the country.[4] As examples:

- The obstetrics unit at Springfield hospital closed in 2019, requiring many women to travel up to an hour for services.
- 9 out of 16 rural hospitals in New Hampshire have closed their labor & delivery units since 2000 – largely due to financial pressures and declining birth rates – doubling the driving time to the nearest L&D unit: urban.org/research/publication/following-labor-and-delivery-unit-closures-rural-new-hampshire-driving-time-nearest-unit-doubled
- See national coverage by Kaiser Health News, emphasizing that with high Medicaid coverage and low numbers of births, hospitals in rural states are struggling to continue

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[2] https://www.kff.org/medicare/issue-brief/how-much-more-than-medicare-do-private-insurers-pay-a-review-of-the-literature/

[3] https://www.chcf.org/wp-content/uploads/2021/03/StatePublicOptionsComparingModelsAcrossCountry.pdf. For example, in Washington State, aggregate provider reimbursement was set at a cap of 160% of Medicare rates, with reimbursement floors for primary care physicians at 135% of Medicare. Colorado appears to have set rates at 155% of Medicare with variations by hospital type. And a study in Oregon under the analyzed carrier-led model, provider reimbursement would be benchmarked to a state-determined blended rate, estimated at 145% of Medicare.

[4] https://www.cdc.gov/nchs/pressroom/sosmap/fertility_rate/fertility_rates.htm

obstetric care, which must be available 24/7: https://khn.org/news/article/how-low-can-they-go-rural-hospitals-weigh-keeping-obstetric-units-when-births-decline/

H. 721 would increase the number of births per year covered by Medicaid by approximately 657 per year,[5] a not insignificant percentage of our approximately 5100 births per year.

Reproductive health care providers are also struggling. As Planned Parenthood testified to the House Health Care Committee, 5 health centers recently closed across the state (Newport, St. Albans, Bennington, Middlebury and Hyde Park) and they are facing a $ 3.9M deficit in their 2024 budget.

Therefore, if the State moves forward with the expansion populations as included in H. 721, the following services should be included in the enhanced rates for primary care services, as well as clarification that OBGYN providers can attest to being primary care providers:[6]

Common contraception care codes:
58300- IUD Insertion
58301- IUD Removal
11981- Implant Insertion
11982- Implant Removal
11983- Implant Removal and Re-insertion
55250- Vasectomy

Most common psychotherapy codes:
90832 - Psychotherapy, 30 minutes with patient
90834 - Psychotherapy, 45 minutes with patient
90837 - Psychotherapy, 60 minutes with patient
90833 - 30 minute psychotherapy add-on to an E/M visit
90836 - 45 minute psychotherapy add-on to an E/M visit
90838 - 60 minutes of psychotherapy add-on to an E/M Visit

Most common prenatal (antepartum) & delivery care codes:
59400 (Routine obstetric care, vaginal delivery)
59409 (Vaginal delivery only)
59410 (Vaginal delivery and postpartum care)
59510 (routine obstetric care, cesarean delivery)
59514 (Cesarean delivery only)
59515 (Cesarean delivery and postpartum care)
59610 (Routine obstetric care, vaginal delivery, after previous cesarean delivery)
59612 (Vaginal delivery only after previous cesarean delivery)
59614 (Vaginal delivery and postpartum care after previous cesarean delivery)
59618 (Routine obstetric care, cesarean delivery, after previous cesarean delivery)
59620 (Cesarean delivery only after previous cesarean delivery)
59622 (Cesarean delivery and postpartum care after previous cesarean delivery).
59425 & 59426 – antepartum visits only

Thank you for considering our feedback on H. 721. Please don't hesitate to reach out with any questions to jbarnard@vtmd.org.

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5 https://legislature.vermont.gov/Documents/2024/WorkGroups/House%20Health%20Care/Bills/H.721/Witness%20Testimony/H.721~Stephanie%20Barrett~Department%20of%20Vermont%20Health%20Access%20-%20Fiscal%20Estimates%20for%20Medicaid%20Coverage%20Expansions~2-22-2024.pdf

6 See current description of qualifying providers and codes here: https://www.vtmedicaid.com/assets/provEnroll/EPCPAttestForm.pdf