HEALTH FIRST

Date: February 29, 2024
To: Chair Lyons & Members of Senate Health & Welfare Committee
From: Susan Ridzon, HealthFirst Executive Director, sr@vermonthealthfirst.org
Re: S.151 Comments, draft 2.1

Thank you for the opportunity to testify on the S.151, draft 2.1. We are commenting on behalf of our 62 physician-owned primary care and specialty care practices located across Vermont. We are neutral or not informed enough to comment on sections that are not specifically mentioned below.

Section 2: HealthFirst **supports** the updates to colorectal cancer screening coverage by insurers. However, we **suggest** that the language be edited as below so that it captures all of the U.S. Preventive Services Task Force permitted strategies (current Task Force permitted strategies in brackets included for your information):

(b) Insurers shall provide coverage for colorectal cancer screening at a minimum in accordance with U.S. Preventive Services Task Force guidelines, including:

(1) providing an insured with the option of:

(A) one colonoscopy every 10 years (if not high risk); or

(B) another USPFTF highly recommended screening strategy.

(2) for an insured who is at high risk for colorectal cancer, colorectal cancer screening examinations and laboratory tests as recommended by the treating physician.

Screen all adults aged 45 to 75 years for colorectal cancer. Several recommended screening tests are available. Clinicians and patients may consider a variety of factors in deciding which test may be best for each person. For example, the tests require different frequencies of screening, location of screening (home or office), methods of screening (stool-based or direct visualization), preprocedure bowel preparation, anesthesia or sedation during the test, and follow-up procedures for abnormal findings.
Recommended screening strategies include:

- High-sensitivity guaiac fecal occult blood test (HSgFOBT) or fecal immunochemical test (FIT) every year
- Stool DNA-FIT every 1 to 3 years
- Computed tomography colonography every 5 years
- Flexible sigmoidoscopy every 5 years
- Flexible sigmoidoscopy every 10 years + annual FIT
- Colonoscopy screening every 10 years

Sections 4 & 5: HealthFirst **supports** the language allowing minors to consent to services for prevention of Sexually Transmitted Infections (STI), as well replacement of "venereal disease" with "sexually transmitted infection".

Section 7: HealthFirst **strongly supports** increasing the percentage of healthcare dollars allocated to primary care. We suggest that the level and type of spending be aligned, or at least not compete with, the primary care spending targets outlined in the AHEAD model should the state determine that participation in AHEAD will improve healthcare affordability and accessibility. It may be necessary to increase primary care fee-for-service payments to providers to meet the AHEAD primary care spending targets so you may want to delete or amend (B) on line 6 of page 6.

Section 8: HealthFirst **does not understand** the intent of removing items (3), (4), (5) on page 7. Will another entity be responsible for these elements?

HealthFirst is **neutral** on the proposed GMCB nominating and appointment process changes though we **support** increased clarity and transparency around the process.

Section 8a, page 10: HealthFirst **has concerns** about the language requiring GMCB mediation prior to termination or non-renewal of contracts between healthcare providers and payers. What issue is this intended to solve? How will providers know of this requirement? This could burden small practices and put them at a disadvantage. Sometimes the only reasonable recourse to a payer/provider dispute is to exit a payer network so we appreciate that the mediation is intended to be non-binding.

Section 8b, pages 10-11: Adding hospital global budget methodology development to the GMCB's duties **makes sense** to us given the possibility of AHEAD model participation.

Section 10: HealthFirst **strongly supports** this language requiring regular updates of the Worker's Compensation fee schedule. The current fee schedule is almost two decades old and needs to be updated to reflect the costs of providing care for Workers Compensation patients.

Section 11: HealthFirst **strongly supports** the intent to ensure that Medicaid reimbursement is an adequate percentage of Medicare and contains inflationary adjustments for both primary care and specialty care providers.

We do have **concerns** with Medicaid aligning to Medicare. Medicare's Physician Fee Schedule (PFS) is based on a flawed formula, does not include any inflationary adjustments,

and has declined each year for the past three years. Adjusted for inflation, Medicare's FPS has decreased 30% from 2001-2024. We suggest that if Medicaid is to be tied to a percentage of Medicare, that a floor be set and an inflationary factor equal to the prevailing year's Medicare Economic Index (MEI) be applied. We suggest the MEI rather than Consumer Price Index be used because it is specific to medical practice cost inflation. Additionally, the percentage of Medicare floor for primary care could be set to at least 110% of the 2021 Medicare Conversion Factor of $36.09, instead of 2022 as currently listed in the draft, as 2022 included a 4% cut from the prior year. We suggest at least 100% of 2021 Medicare as the floor for specialty care.

Section 11a: HealthFirst is unclear of the intent of this section and question whether it is necessary when the State may not participate in AHEAD. However, if the section remains, we recommend adding language that reflects the significant disruption to practices that will result from the ending of the All-Payer Model, and from the potential switch to the AHEAD model.

We agree with VMS' overview of the AHEAD model impact that is outlined in their comments on this bill. We also support adding the language they suggested as below:

> *(a)…If the State of Vermont is selected, it is the intent of the General Assembly that the State participate in the Model beginning on January 1, 2026, provided the Model is determined to be beneficial in addressing the State's goals of improving affordability, access to care, quality of care, health equity, and hospital and primary care sustainability.*
> *…*
> *(C) It is the intent of the General Assembly that any agreement entered into between the State and the federal government for Vermont's participation in the AHEAD Model:*
> *…*
> *(4) Acknowledges the fragility of our primary care system and the need to hold harmless or increase investment in all types of primary care practices including independent and pediatric practices currently participating in Vermont's existing payment reform activities such as OneCare Vermont's Comprehensive Payment Reform (CPR) and Population Health Management Payments.*
> *(5) Does not increase administrative burden on primary care practices for, by example, subjecting them all to the Medicare's Merit-based Incentive Payment System (MIPS), and adequately supports practices in completing the fiscal analyses, contracting, quality/data and other administrative requirements necessary for participation.*

Additionally, HealthFirst suggests that we include language that includes that outlined in (a), (4) & (5) as the State considers a path forward from the All-Payer Model, whether or not that

path includes AHEAD. The State must take steps to support and hold practices harmless from the transition to a different model.

Section 12: HealthFirst is unsure of the intent of having GMCB review contracts but is open to the possibility. What is the goal of these reviews and what will the GMCB be looking for? Would practices have the ability to share contract grievances with the GMCB and would the GMCB address those grievances on the practices' behalf?

HealthFirst **strongly supports** the language pertaining to examining and identifying opportunities to increase reimbursement equity and we **recommend** that GMCB leverage reimbursement data already available from payers and hospitals as a result of federal price transparency laws.

We also want to express our **deep disappointment** that we are still at the stage of looking at fair reimbursement when numerous bills and reports already exist on this topic such as Act 54 (section 23), Act 143 (section 5), Act 85 (section 345.1), to name a few. We've been talking about this for at least a decade. We need to move past the examination and reporting stages and actually **address** the reimbursement inequities and unlevel playing field. It is this unlevel playing field that has led to more physicians becoming hospital employed so that now only 1 in 4 physicians are independent when it used to be 3 out of 4. The continuation of these inequities has negative consequences for our practices and, importantly, they also cause our system to be more expensive and consolidated. Our network stands ready to help figure out a solution to this problem.

Addition after 2/29/24 testimony: We agree with VMS' suggestion to add language from the Act 51 of 2023 report prepared by Blueprint regarding Blueprint PMPM payments to patient centered medical homes.