VERMONT ACADEMY OF FAMILY PHYSICIANS

Vermont Medical Society

Vermont Chapter
INCORPORATED IN VERMONT
American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

To : Chair Lyons and Members of the Senate Health & Welfare Committee
From: Jessa Barnard, Vermont Medical Society, jbarnard@vtmd.org
Date: February 29, 2024
RE: Support for S. 151 – Strengthening Primary Care & Prevention Services

Thank you for the invitation to testify. My name is Jessa Barnard, and I am the Executive Director of the Vermont Medical Society. I am here to testify not only on behalf of the Vermont Medical Society but also the Vermont Academy of Family Physicians and American Academy of Pediatrics Vermont Chapter **in favor of a number of provisions in S. 151 that strengthen primary care and prevention services**. In order of the bill, Draft 2.1 as presented yesterday:

Sec 1	**Health insurance rates and forms**	**Support**
Our organizations support additional transparency regarding the amount of premium dollars being spent by payers on their own care coordination programs. Since the State also supports care coordination centrally through the Blueprint it is important to gain a greater understanding of how payer efforts are complementary or duplicative of other statewide efforts.		

Sec 2	**Colorectal Cancer Screening**	**Support**
Our organizations support removing a fixed age from the requirement that payers provide no-cost colorectal cancer screening, and instead have state statute refer to national screening guidelines. Current state statue only requires screenings to be covered beginning at age 50, while United States Preventive Services Task Force Recommendations support beginning screening at age 45. In describing the importance of this recommendation, the USPSTF sites that 10.5% of new colorectal cancer cases occur in persons younger than 50 years and that incidence of colorectal cancer (specifically adenocarcinoma) in adults aged 40 to 49 years has increased by almost 15% from 2000-2002 to 2014-2016. Lowering the starting age of screening from age 50 years to age 45 years results in an estimated additional 2 to 3 cases of colorectal cancer being averted, an estimated 1 additional colorectal cancer death averted, and an estimated 22 to 27 additional life-years gained per 1000 adults. Rather than refer to fixed ages in state statute, the coverage requirement should be flexible enough to change with established clinical best practice. (Similarly, under the ACA, most private insurance plans are already required to preventive services that have a rating of A or B by the USPSTF – this would update state law in the same way.) See also Representative Kate McCann's testimony in support of a parallel bill in the House, H. 741, here.		

Sec 3 – proposed for removal	**Payment Reform**	**Support**
Proposed to be removed from bill – concept moved to Section Sec 11a(b). In concept, our organizations support participation by commercial payers in statewide health reform efforts. The more consistency there is between payers in terms of design of payment reform programs, goals and quality measures, the more opportunity there is for reform successfully improve care delivery, make a difference for patients, and reduce administrative burden on providers.		

Sec 4 & 5	**Minor consent; prevention and treatment**	**Support**

	of sexually transmitted infections	
Our organizations strongly support moving from a situation in which minors can only consent to STI *treatment* - after already contracting an STI - to allowing minors to consent to STI *prevention*. As explained by Dr. Eric Gibson when she testified to your Committee, in the last few decades, we have developed a number of preventive treatments for STIs. Dr. Gibson also referenced the evidence provided by the American Academy of Pediatrics, the Society for Adolescent Health and Medicine, the American College of Obstetricians and Gynecologists and the American Academy of Family Physicians regarding the importance of confidential treatment for adolescents with STIs. Fourteen other states have already expanded their minor consent laws to include prevention of STIs. We also support the conforming edits to update outdated reference in statute to "venereal disease" with "sexually transmitted infection."		

Sec 6	**Risk Based Capital Reports**	**No position**

Sec 7	**Increasing primary care spending allocation**	**Support – suggested edits**
A 2021 National Academy of Sciences, Engineering and Medicine Report found that 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. The National Academy Report found that 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. When assessed by DVHA and the GMCB in a 2020 Report, *Defining Primary Care and Determining Primary Care's Proportion of Health Care Spending in Vermont*, Vermont's total spending on primary care by payer (using 2018 data, including both claims and non-claims payments) was 9.2% for Commercial, 24.3% for Medicaid, 6.5% for Medicare - 10.2% overall across payers. The AHEAD Model will also require participating states to establish and meet an all-payer primary care investment target. A state can set their own definition of primary care for measurement or use a CMS definition. (See the CMMI NOFO pages 14-16). Given the need to align Vermont's goals on primary care spending with potential participation in the AHEAD Model, at this time our organizations support moving forward with next steps in setting a statewide all-payer primary care spend target and methodology with more input from regulators and interested parties. This approach would align with AHEAD, though not be dependent on participation. **We suggest replacing the current language in Section 7 with**: *The Director of Health Care Reform in the Agency of Human Services, in collaboration with the Green Mountain Care Board and with input from primary care clinicians, primary care professional associations, and other interested parties, shall report to the Governor and the House Health Care and Senate Health and Welfare Committees by January 15, 2025 a proposal for the process for setting a Vermont-specific all payer primary care investment target. In developing the proposal, the Director shall take into consideration design requirements to secure Medicare's participation in multipayer alternative payment models in Vermont.*		

Sec 8	**GMCB Purpose; Intent**	**Support in part/oppose in part**
We support the addition of the language that the GMCB's purpose focus on addressing per capita rates of growth though rate review and hospital and ACO budgets. We do not support the removal from GMCB purview of "patient and health care professional experience of care," workforce issues, and "achieving administrative simplification in health care financing and delivery," unless these are explicitly moved to AHS		

or another responsible regulatory body or otherwise embedded in the functions of the GMCB. While GMCB may not lead on these issues, it is important that GMCB regulatory decisions be informed by factors including professional satisfaction, workforce needs and administrative simplification.

Sec 8	**GMCB Nomination Process; Budget Review**	**No position**
Our organizations are neutral on these sections but do agree it would be helpful to clarify the timeline and process when a GMCB member seeks reappointment.		

Sec 8a (new from S.211)	**Mediation – Contract Termination**	**Oppose**
As we testified on S. 211, we are concerned about the unintended consequences of requiring all providers – including small or independent providers – to go through a mediation with the GMCB prior to nonrenewal of a health insurance contract. Providers may drop insurance contracts for many types of reasons, from excessive prior authorization denial rates and slow payments from insurers to closing their practice or no longer offering certain clinical services. Requiring all instances to go through mediation will add administrative burdens and costs to the health care system. It is also unclear the process, criteria and capacity for the GMCB to mediate such cases.		

Sec 8b (new) & 9	**Hospital Budgets**	**No position**

Sec 10	**Workers comp rate schedule**	**Support**
Vermont Statute (21 V.S.A. § 640 (d)) authorizes the Commissioner of the Department of Labor to set a fee schedule for medical, surgical, hospital and other services provided to injured employees covered by Workers' Compensation. Vermont's Workers' Compensation Fee Schedule set by rule has not been updated since 2006 leading to payments for office visits under this fee schedule falling well below current commercial rates, for example as low as 40% of one commercial payer's rate for certain office visits. VMS has been working with other interested parties, as well as the DOL, to discuss updates to the fee schedule and DOL is in the process of releasing an RFP to select a vendor to develop an updated fee schedule. However, just last week, an occupational medicine physician reached out to inform us that in the time since we have been in conversations with DOL regarding the fee schedule, one hospital has eliminated their Occupational Medicine Program and another has reduced clinic time, resulting in even less access to high quality occupational medicine in Vermont. Increasingly we hear from primary care and specialty practices that they are refusing to provide care to Workers Compensation patients. Studies have found that low fee schedules pared with the high administrative and paperwork burden of seeing patients covered by Workers' Compensation leads to low clinician participation and limits patient access to care. This section simply calls for updates to the fee schedule every two years.		

Sec 11	**Medicaid primary care rates**	**Support – suggested edits**
Our organizations strongly support sustained and adequate reimbursement for primary care services. As drafted, S. 151 pulls from past statutory language, including language that was included in Act 167 of 2022, calling for primary care professional services paid for by Medicaid to be reimbursed at 100% of Medicare rates. However, in the SFY2024 Budget, the legislature increased this primary care fee schedule to 110% of Medicare rates. In addition, there are several methodological shortcomings with benchmarking the professional fee schedule to Medicare: - Medicare's professional fee schedule does not include an inflationary adjustment, unlike many other Medicare fee schedules and - Medicare has been cutting this fee schedule over the past several years – it was decreased 3.37% in		

2024 and nearly 10% over the past 4 years, including in 2022.

To address these problems, the DVHA fee schedule could be benchmarked to a specific year, as proposed in S. 151. In addition, the fee schedule should incorporate the medical inflation factor that Medicare uses – the Medicare Economic Index (rather than the consumer price index). A report back on these rates would also be consistent with language currently suggested by the House Health Care Committee to include in the budget, asking DVHA to report on a methodology that would create a floor of reimbursement that would not decrease with Medicare rate cuts (Section D).

We suggest the following updated language:

"…in its annual budget proposal, the Department of Vermont Health Access shall either provide reimbursement rates for Medicaid participating providers for primary care services at rates that are equal to ~~100~~ 110 percent of the Medicare rates for the services in effect in calendar year ~~2022~~ 2021, with positive ~~Consumer Price Index~~ Medicare Economic Index inflation adjustment rates in subsequent years, or, in accordance with 32 V.S.A. § 307(d)(6), provide information on the additional amounts that would be necessary to achieve this rate. ~~full reimbursement parity for primary care services with the Medicare rates~~.

We are also comfortable removing the clause "with first priority to primary care providers" as we support all provider types, including specialty care services, working towards 100% of Medicare rates.

Sec 11a (new)	**AHEAD Model; Legislative Intent**	**Suggested Additions**

Our organizations appreciate the benefits of documenting legislative intent regarding participation in the AHEAD Model. The current language is largely focused on hospitals, and we request to expand the language to reflect the potential impacts of the Model on primary care practices, especially if this section is framed in terms of moving forward with the AHEAD Model if certain criteria are met.

We would like to thank the AHS Director of Health Care Reform for how much time and expertise she has spent explaining the Primary Care AHEAD Model to primary care practices and also how open AHS has been to hearing feedback and concerns from the primary care community. A Primary Care Workgroup has been meeting with AHS to both learn more about the model and provide feedback to the State. We encourage the Committee to review the Materials from the workgroup, available on the AHS website here. Of note, slides from December 15th crosswalk between the approximately $17 per FFS Medicare beneficiary payment that Medicare will make available to practices participating in the Model with Vermont's existing Blueprint and ACO payments (see slides 8-12). While $17 PMPM promises an increased investment by Medicare in primary care, we highlight several concerns with the Model:

- $17 PMPP is greater than most payments currently available to primary care, however this will only be linked to FFS Medicare patients, so the impact on each practice will be different – especially pediatric practices, which face losing all ACO payments while gaining very few dollars linked to Medicare payment. These payments are also not linked to Medicare Advantage plans, so as MA participation increases, payments to primary care will decrease.
- Independent practices participating in OneCare's capitated Comprehensive Primary Care program, stand to lose 105% FFS rates for "non core" services as well as a steady, predictable income stream. In our understanding, CMMI has held firm to not introducing a capitated payment model sooner than 2027.
- CMMI is currently indicating that the AHEAD Model will not count as an Advanced Payment Model under CMS's Merit-based Incentive Payment System (MIPS). MIPS ties physician's Medicare payments to their individual, group practice or alternative payment model (APM) score on reported and applicable: (1) quality measures, (2) cost measures, (3) health IT use and (4) practice improvement activities. Participating in OneCare Vermont has qualified as participating in an Advanced Payment Model and led to an exemption from MIPS. Critiques of MIPS include that is it costly, administratively burdensome, exacerbates health inequities, and hurts rural and independent practices. By one estimate, compliance

with MIPS costs $12,800 per physician per year and physicians spend 53 hours per year on MIPS-related tasks. These 53 hours are equivalent to a full week of patient visits.

- Regardless of the potential strengths of the Model, it will be disruptive for primary care practices – especially if it also comes with the end of a statewide ACO - leading each practice to need to assess the financial impacts of participation, adopt new administrative requirements such as entering contracts with CMMI and individual payers, and change quality/data collection methods and targets.

Due to these concerns, our organizations request the addition of the following language:

(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.

Sec 12	**Health care contracts; fee schedule; examining rates**	**Need more information/ Concerns**

This section would task the GMCB with collecting and reviewing a sample of insurer contracts and then provide the legislature with an update on the "methodology for increasing the transparency around health care contracts, including the standards and criteria that the Board intends to use for its reviews of health care contracts and fee schedules." Each health care practice has dozens of contracts with different payers – both those regulated by the State and not. We have concerns if the intent of this section is to task the GMCB with ultimately reviewing every contract between payers and health care practices. If so, what would this process look like? Does the GMCB have the capacity to take on this review? How much would this slow down the contracting process?

New in this draft, the bill also tasks the GMCB with examining reimbursement rates for different types of heath care professionals and lists a few examples. As with similar language in S. 211, we remain unclear of the intent and goal of this provisions. If the Committee is interested in updated information regarding equity in reimbursement we suggest being more specific, for example asking the GMCB to update the Act 159 of 2020 Report, which also built on reports regarding equitable payments going back to 2014.

Not in bill – Section 2 of S. 151 as introduced	**Blueprint PMPM Report**	**Support – suggest adding**

Our organizations request that the Committee implement the Act 51 of 2023 report completed by the Blueprint for Health regarding PMPM payments to patient centered medical homes. Act 51 called on the Blueprint to report on "…the amounts by which health insurers and Vermont Medicaid should increase the amount of the per-person, per-month payments they make to Blueprint for Health patient-centered

medical homes…." as well as to evaluate "potential mechanisms for ensuring that all payers are contributing equitably to the Blueprint on behalf of their covered lives in Vermont." The Blueprint for Health has now completed this report. The report finds that practices participating in the Blueprint have a demonstrated impact on healthcare utilization and costs – patients attributed spend less per year while having more primary care visits. At the same time, it costs practices between $13,000 and $16,000 per clinician for a practice to maintain certification as a patient centered medical home. In 2015, a paper studying PCMHs in Utah and Colorado found that practice costs to maintain PCMH recognition ranged from $3.85 to $4.83 per-patient per-month. The report concludes that to sustain the program, the legislature could create parity between Medicaid and commercial insurers by (1) Increasing the commercial insurer PCMH payment to $4.65 through a two-year increase of $0.83 in FY2025 and $0.82 in FY2026; and (2) With input from the Department of Financial Regulation, implementing legislative clarification of contributions by third-party administrators of self-funded plans and a renewed focus on engaging all commercial insurers in all Blueprint initiatives. We request that the Committee move forward with these recommendations in H. 151, consistent with a multifaceted approach to supporting primary care in Vermont.

Thank you for considering our comments on H. 151. Please contact me at jbarnard@vtmd.org with any questions.