Senate Finance - 4/23/15
Testimony of Amy Cooper, Executive Director of Health*first.*

Good afternoon, I'm here to address the Pay Parity provision in Section 16 of S135. Just to be clear - Pay Parity is about equitable reimbursement for services, not about salaries or gross compensation. Some independent physicians are on salary, some hospital-employed physicians are on salary. The issue here is how private health insurers re-imburse independently-owned practices differently than hospital-owned practice for providing the same services. We also are not advocating that all payments for be raised to the rates charged by UVMMC, only that the money in the system for professional fee be allocated fairly, which may cause some adjustments up and down. Healthfirst would not object to adding a requirement in the bill that insurers achieve this parity in a cost neutral way.

Hospital-owned practices are paid 2-3 times more than independent practices for physicians providing the same service. Unsurprisingly, this has resulted in hospitals buying up physician practices, in order to profit from this arbitrage, and indpendent physicans selling their practices to hopsitals to remain afloat: **From a patients perspective, one day they are seeing their dermatologist in independent practice whom BCBS pays** ($109) for a skin biopsy, the next week the independent practice becomes UVMCC owned and now BCBS is paying $349 for the same physician providing the same service. The payment differentials are just as stark for normal office visit services ($78 for CPT code 99213 paid to an idependent practice versus $177 paid to a uvmmc owned practice, $117 verus $261 paid for a 99214, etc.). Keep in mind these are <u>professional service fees only</u> - facility fees are separately paid to hospitals to support emergency rooms and overhead, etc. and are not at issue here

I have testified in front of this committee before. To add to what I've said previously, I would like to focus on how parity parity legislation, as proposed, coheres with the State's long-term payment reform goals, how the patient experience of care is different in independent practice, and what motivates physicians to remian in independent practice.

While it is tempting to say let's let the GMCB deal with this issue in a system-wide way, we fear that any solution devised and then implemented by the GMCB in 2-3 years may be too late. Less than 30% of phyisicians in Vermont remain in independent practice, whereas nationally that figure is 60%. I can name at least four independent specialty care and four independent primary care providers who are seriously contemplating closing their businesses, selling to the dominant hospital group, or leaving the state within this calendar year. I mention this to underscore how critical we believe it is that this issue be addressed now, through the legislation you have in front of you.

As much as we are hopeful true reform takes hold, there is real possibility that all-payer payment model is not achieved here in the near term. Healthfirst is involved

in meetings on the ground with other provider groups from the "coalition of the willing" working tirelessly and frantically to get an application together for CMS to review regarding an all payer model. But CMS may not accept it, and if they do, all the stakeholders may not remain engaged enough to effectively implement it. These are real risks to effective implementaion of a new payment system.

Those risks aside, the pay parity language in Sec 16 coheres with the 'Payment Principles' outlined by the GMCB in any case. These are that payment be: 1) Fair 2) Reasonable 3) Transparent 4) Logical 5) Related to Cost and 6) Not necessarily equal. The language in Section 16 currently allows for differential payments based on participation in quality or value-based payment programs, the scope of the legislation is also limited to professional fees, which again allows for unequal total payments to providers through separate, revenue streams - facility fees, graduate medical education payments, and disproportionate share payments, etc. all going to hopsitals. Interestingly, the idea of pay parity for physician services, regardless of the practice ownership model, has already been assumed and imbedded in the all-payer payment model that these stakeholder groups are together working on.

Back quickly to the idea of how the patient experience of care is different in an independent practice, and what will be lost if we continue to allow private insuers to reimburse independent practices less... Let me use the example of a pregnant woman seeing a physician in independent practice at Matri health care For Women in South Burlington. Currently, the physician does pre-natal ultrasounds in her office and talks to the patient the whole time and tells them what she see. If the practice were to get absorbed by UVMC, patients could no longer can have their ultrasounds in the office because UVMC protocol demands they make a separate appointment to go to the fetal diagnostic center, where they won't be seeing their own doctor, and where the ultrasounds cost much more. Additionally, the ultrasounds in a medical center are often done by sonographers who aren't allowed to tell the patients during the scan what they are seeing. This is just one example of how the patient experience of care is different, and arguably worse, when an independent practice is absored by a large medical center. The same sort of examples hold in cardiology, family medicine, opthamology and other specialties.

Lastly, to address what motivates independent physicians to continue in independent practice in Vermont, despite the difficulties. I'll read this short letter from one of our members:
I have been in practice in Vermont for 25 years. Over the years, many of my colleagues have given up trying to survive as independents. Those of us trying to continue as independent practitioners continue to do so, because we believe that we provide a unique, valuable, and personalized service to our communities. There are numerous reasons why it is critical for the future of health care in Vermont to maintain viable choices for our patients - this includes hospital employed practices as well as independent physicians. We, in independent practices are basically small enterprises that can innovate and problem solve on a level that would be virtually impossible in a "top down" situation you would find in a hospital employed

system. Imagine a world with Shaw's, but no Richmond Market; a world with Walmart, but no Aubuchon's; Budwieser, but no Switchback; Microsoft, but no Mac; Folgers, but no Green Mtn coffee; Green Giant, but no Pete's Greens.

This is what the future of health care in Vermont may look like if we don't take measures to address the issue of pay parity for indpenedent practices in timely manner.