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Dear Chair Lyons and Members of the Senate Health and Welfare Committee,

Thank you for hearing from Blue Cross and Blue Shield of Vermont on the proposals in S.244 an act relating to strengthening primary care and primary care providers. While we are all striving to improve and reform our state health care system, our approaches differ. Three proposals in this legislation concern us particularly; requiring equivalent payment for audio-only health care to in-person or audio-visual visits; mandating that all payers increase their primary care payments to 12% of total health care spending; and requiring the GMCB to have a primary care physician on staff.

Audio-only Telehealth

Blue Cross and Blue Shield of Vermont recognizes that audio-only telephone care bridged a critical gap during the COVID-19 pandemic. In the long term, however, we have significant concerns about promoting audio-only care as a substitute for either audio-visual telemedicine or in-person care. The concerns we expressed to DFR and the workgroup last summer are primarily focused on the quality and value of audio-only care, and particularly the health equity implications of this modality on low income and rural Vermonters. This recent publication, Rethinking the Impact of Audio-Only Visits on Health Equity in The Rand Blog from December 2021 is an excellent summary of these issues and cites the latest research on audio-only care.

The RAND article discusses:

- How ongoing delivery of audio-only visits can reduce the quality of care among low-income populations and contribute to health disparities.
- It references studies have shown that clinicians can miss visual cues and struggle with establishing rapport with patients, and the visits are shorter. Additionally, patients report lower satisfaction and comprehension rates—which is a critical concern for patients following medical advice.
- Even as new data emerge about the quality of audio-only visits, it is clear that some patients are largely getting more evidence-based, tested medical services (which are in-person and video visits) while low-income patients are getting this untested service of audio-only.
- Cervical cancer screening rates, child weight assessment and counseling, and depression screening and follow-up at FQHCs declined with telehealth (predominantly audio-only) use.
- Telehealth experts have pointed out that failing to rein in audio-only visits risks escalating costs and creating a two-tiered system in which affluent patients get video and in-person visits and low-income patients get telephone calls.

These are direct quotes from the RAND study. The note that is particularly concerning is that “generous parity reimbursement for audio-only visits may be creating perverse incentives to deliver substandard care to the most under-served.”

When we implemented the emergency rules for telehealth, audio-only services were included using the same codes as audio-visual visits. This was done primarily to make it easy for providers to understand and implement these changes quickly and avoid programming changes to our claims system. Therefore, our data cannot identify which claims are for telephone calls only, and which are for audio-visual telehealth visits. The data that is so critical for analyzing the impacts of this policy didn't begin until January 1 of this year.

One of the key components in DFR's audio-only regulation is requiring separate and consistent coding for telephone calls across all payers. This Vermont-specific data will allow evaluation of how telephone calls are being used by providers. Currently, we cannot review the usage without an in-depth audit. With the analysis of the new coding, we should be able to see if a telephone visit is often followed up by an in-person visit, or if these are being used to notify patients of test results after a visit, and what other types of services are being delivered over the phone.

Finally, it is very difficult to establish a "basis of comparison" for audio-only care because there are so many variables involved, even when narrowly focused on the payment rates. Every payer – Medicaid, Medicare and all the commercial payers have negotiated different rates – so 100% of the audio-visual or in-person rate is not consistent for any of the services.

DFR did a remarkable job navigating all of the stakeholders' concerns during the workgroup and has plans to evaluate the data and research each year as more information becomes available. They built a comprehensive plan and the proposal in this bill undercuts their work.

12% Primary Care Spending

Blue Cross supports primary care providers, and like you, we believe that primary care is the backbone of wellness and a strong primary care system is essential. This proposal to mandate that 12% of health care spending on primary care is a blunt attempt to increase revenue to primary care practices, and despite assurances that this will not increase premiums, fee-for-service payments, or overall health care expenditures, the money must come from somewhere.

Blue Cross commercial ratepayers have participated and paid into all of the State's health care reform efforts. Additionally, Blue Cross has our own programs and policies designed specifically to support primary care.

- Commercial insurance policies pay more overall for health care services than government payers across all types of health care including primary care. Congressional Budget Office Medical Prices Report.
- We contribute on behalf of our members to the Blueprint program which largely benefits primary care practices.
- Blue Cross was the first, and for a long time the only commercial payer who participated in the All Payer Model and collaborate with OneCare VT contributing to the PCP support programs and care coordination payments, and Blue Cross is the only payer to persuade self-funded employers to participate in the program.

- Blue Cross plans are designed with lower co-pays to encourage people to use primary care services
- Blue Cross non-standard plan designs allow for PCP visits with no out of pocket costs, which is intended to eliminate financial barriers to primary care access.
- We additionally undertake our own collaborations with primary care practices. Two *recent* examples are:
  1) The Vermont Blue Integrated Care program is an agreement with primary care practices that allows them flexibility and additional funding through value based payments. We believe this will result in better outcomes for our members as well as the provider.
  2) A second project with the Plainfield Health Center will establish them as the first trauma-informed/trauma-trained FQHC in Vermont.

Blue Cross is doing more than any other private insurer in the state to support primary care. There are a number of reasons why these efforts aren't born out in the Act 17 report that are technical, but important.

Primary Care Spending Analysis

The Act 17 Primary Care Spending Report was an interesting and useful exercise to try to measure the proportion of primary care spending in Vermont, but the 12% is an arbitrary number plucked from Rhode Island. There are several important issues with the definition and measurement of primary care. Blue Cross contributed an Appendix (pages 26-27) to the report to highlight several findings when we analyzed our own data separately.

BCBSVT Primary Care Spending - 2018 Analysis

a	b	c	d	e	f
BCBSVT	All PCP Claims	PCP Claims & Defined PCP Services	Non-Claims PCP Spending	**Total Primary Care Spending**	Total (if Medical Rx excluded from the denominator)
Children <18	23.6%	13.2%	4.6%	**17.8%**	19.1%
Adults 18+	16.9%	4.8%	1.5%	**6.3%**	7.3%
All Members	**17.5%**	5.5%	1.8%	**7.3%**	8.4%

- Blue Cross internally uses a broader definition of primary care (column b), and we include both primary care services provided by a specialist and non-primary care services delivered by a primary care provider. Blue Cross estimated that 17.5% of our spending, excluding non-claims based spending such as Blueprint, immunizations and value-based payments is for primary care broadly.
- The most important finding is that the percentage of primary care spending by payer is strongly influenced by the covered population. Children and older Vermonters utilize primary care services more frequently, and the percentage of claims spending on primary care is

directly related to the population that is covered. Spending for people under age 18 is 17.8% using the Act 17 definition.

- Blue Cross, and many commercial payers, have fewer members under the age of 18 and very few over 64 compared to government payers so naturally our primary care spending is lower. As a state, Vermont's population is skewed towards the older end, with fewer children, so the percentage spent on primary care may reflect demographics more than the results of health policy efforts.

There are several ways to increase the percentage of spending on primary care, but the definition in the Act 17 report excludes the second method below:

1) Increase the utilization of primary care
2) Increase the types of services received in the primary care setting
3) Increase the reimbursement for primary care services

The Legislature has enacted contradictory policies around primary care and some that undermine our efforts toward reform. As you know, primary care services are provided in both hospital-owned and independent primary care settings. In 2018, approximately 48.1% of primary care service spending was delivered by a provider affiliated with a hospital, while the remaining 51.9% of the spending was at an unaffiliated provider.

The **UVMMC FY18 Hospital Budget Order (page 6 item C)** ordered an adjustment to the evaluation and management codes (E/M) paid to academic medical centers. This was in response to the Payment Differential and Provider Reimbursement Report, **Act 85 (2017)** § E.345.1. Beginning 1/1/2018 UVMMC's professional reimbursement was reduced by 35%. The overall primary care spending calculation is 4% lower in 2018 than in 2017 due specifically to this policy change.

Simultaneously you are considering the hospital sustainability and Global Hospital Budget proposed by the GMCB. There is considerable conflict between how to manage hospital sustainability and shift resources to primary care. These types of health care reform initiatives shouldn't be siloed from each other.

Commercial rate payers are being inundated by contradictory reform efforts. The goal should be to maximize affordability and increase access to quality care. These multi-faceted efforts are increasing commercial insurance costs for hospital care, primary care and through health reform initiatives. Proposals being considered in the House would limit our leverage to negotiate against drug manufacturers for the lowest prices through PBMs. Considerations by the GMCB would expand benefit coverage by including hearing aids. Another bill being considered by your committee would expand the Blueprint program—all of these proposals shift the ballooning cost of health care onto the narrow shoulders of an ever shrinking commercial pool and makes health care increasingly unaffordable for those middle income Vermonters. We fundamentally know that it is simply too expensive today for people who pay the premiums and out-of-pocket costs. None of the proposals being actively considered now will make health care more affordable for Vermonters.

Primary Care Physician on GMCB Staff

Section 8 requiring the GMCB to hire a primary care professional on staff will just increase the cost of health care regulation – which is yet another cost billed back to commercial rate payer's premiums. The GMCB already has the Primary Care Advisory Group that meets monthly to advise on policy. They also have the ability to hire consultants whenever they need expert support.

Response to Committee Member Questions

The bullets below are responses to some of the questions about payer-provide contracts that were asked during the testimony last week:

- The Department of Financial Regulation has oversight over contracts and can and has reviewed our provider contract provisions.
- The Legislature in 2020 explicitly gave the GMCB authority to request information about payer-provider payment rates in Section 6 of Act 159 (H.795) – this is the bill that required the hospital sustainability planning among other information.
- Finally, the contracts will tell you nothing about the medical coding. Information about how codes are used and billed are included in our payment policies that are available online and are transparent and open to the public.

Thank you for considering our concerns,

Sara Teachout, Corporate Director, Government and Media Relations