Vermont Medical Society

To: Senate Committee on Health & Welfare
From: Jessa Barnard, Vermont Medical Society
Date: April 21, 2021
RE: S. 120 & S. 132

Thank you for allowing the Vermont Medical Society (VMS) to testify this morning regarding S. 120 and S. 132. VMS is the largest physician membership organization in the state, representing over 2400 physicians, physician assistants and medical students across all specialties and geographic locations.

In setting the stage for testimony on both bills this morning, I would first like to distinguish efforts aimed at increasing health care coverage and efforts aimed at payment and delivery system reform. Both efforts are complementary and in fact necessary to work together as you cannot typically afford the cost of expanded health coverage without efforts to manage spending and ensure quality of care. We see S. 120 primarily aimed at exploring options for financing and expanding health care coverage while S. 132 addresses Vermont's model of payment and delivery system reform.

Comments Regarding S. 120

Overall, VMS supports the intent of S. 120. Since 1992, VMS has supported and advocated for Vermonters having "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."[1] Vermont clinicians share the frustration and heartbreak that patients experience when they cannot afford a recommended plan of care or don't even seek care in the first place due to their out of pocket costs. In 2019, VMS adopted a policy to advocate for approaches to address health insurance products with high patient deductibles and out of pocket costs.[2]

VMS supports exploring federal funding available to expand coverage options, while also maximizing and implementing options already available to make coverage more affordable, such as the expanding premium tax credits available under ARPA.

[1] https://vtmd.org/client_media/files/2020%20Reaffirming%20VMS%20Principles%20of%20Health%20Reform%20%20Statement%20of%20Need%20for%20Universal%20Coverage_Final.pdf
[2] https://vtmd.org/client_media/files/vms_resolutions/2019%20High%20Ded.%20Health%20Plans_Final.pdf

VMS does have several specific suggestions regarding bill language.

First, VMS does have concerns that (C)(2) as currently drafted will distract from the overall purpose of the bill to explore ways to expand access. The All Payer Model has and will continue to be extensively studied and evaluated. We suggest a change in wording from

> *(2) the efficacy of Vermont's All-Payer Accountable Care Organization Model and the changes to the Model that would be necessary to make health care more affordable for Vermonters or whether an alternative model may be more effective;*

To:

> *(2) a review of the role of payment and delivery system reform in minimizing health care cost growth and coordinating with coverage reform.*

Second, you have heard from a number of witnesses regarding S. 120 that simply having health coverage does not translate into access to health care services. You have also heard extensive testimony that access to primary care services is foundational to any future direction of our State's health care system. In fact, Patrick Flood stated that "coverage is no good" if you can't get in to see your doctor or if there aren't enough primary care clinicians. Therefore, VMS believes it is crucial to add to the bill that the Commission examine as one of their charges:

> *(6) payment rates and program design options for public option programs under (5) that would ensure fair and sustainable payments for health care providers and provide patient access to care, especially primary care.*

Comments Regarding S. 132

VMS supports the sections of S. 132 that would expand hearing aid coverage (Sec. 12) and study eliminating cost sharing for two primary care visits (Sec. 19). A number of primary care clinicians testified on S. 245 last session in favor of eliminating copays for primary care services. While the Affordable Care Act eliminated cost sharing for preventive services, it did not address other primary care services, including chronic care management. This has led to many patient and clinician concerns. Reducing financial barriers to accessing primary care could have the following positive changes:

- Patients would not delay care for acute problems, or avoid care for chronic problems
- Primary care practices could provide medical services during preventive/wellness visits without patients worrying about the extra costs, or practitioners worried about not being paid.
- Patient satisfaction would increase and overhead costs at PCP offices would go down due to less billing, fewer delayed payments and collection letters.

VMS has concerns with a number of other provisions currently included in the bill.

Section 3 – Oversight of ACOs

(a) (1) VMS would oppose this section of it requires the collection or reporting of participating primary care providers' salaries to compare against ACO administrators' salary.

(2) Coordination with Blueprint: While VMS supports improved coordination of care coordination services across the state, we are not sure that this language will improve care coordination. Instead, VMS suggests that as part of the insurance rate review process, insurers

must report to the GMCB on their costs and staffing to provide internal care coordination services, with the goal of ultimately decreasing duplication of care coordination programs across the state.

Sections 4 & 7 - Distribution of Shared Savings
VMS opposes the shift from the ACO to the GMCB in determining the amounts of value-based payments or shared savings that are distributed to ACO-participating providers. As the GMCB stated in its testimony, an ACO is a provider-led, voluntary organization, and changes must "ensure we are attracting providers to value based care programs, and that these programs continue to work for providers and most importantly Vermont patients." VMS believe that the ACO is best positioned to work with its provider members to determine, based on factors such as quality results, participation and type of providers, how to distribute value-based payments or shared savings. Shifting this one element of the program away from the ACO would undermine one of the fundamental structural elements of an ACO model.

Section 6 – Access to Records
This section states that the ACO shall provide to the Office of the Auditor "all records of the accountable care organization, and any affiliated entity…." VMS would oppose this section to the extent that "any affiliated entity" could be interpreted to mean any practice or provider choosing to be a member of the ACO network. This could open the records of hundreds of private medical offices to review by the State Auditor.

Sections 8-10, Provider rate/contract review
VMS fully supports fairness and equity in contracts between insurers and clinicians. However, we are concerned that the approach taken in S. 132 may inadvertently give even more power to insurance companies in this process rather than increase fairness. Small clinician offices may contract with dozens or even hundreds of health insurance companies. It could completely overwhelm a small practice to follow the requirement to submit each of these contracts to the Green Mountain Care Board for review. Further, it is unlikely that for each of these contracts small practices will be able to effectively make their case that contracts or rates should be adjusted – in contrast to insurance companies who will likely have staff fully dedicated to this process. VMS suggests replacing a contract review regulatory process with the ability for small practices to more effectively work together in negotiating contracts and rates with insurers. VMS suggests amending existing statute, 18 VSA § 9409 in the following way:

> *18 V.S.A. § 9409. Health care provider bargaining groups*
> *(a) The Green Mountain Care Board may approve the creation of one or more health care provider bargaining groups, consisting of health care providers who choose to participate. A bargaining group is authorized to negotiate on behalf of all participating providers <u>with health insurers as defined in § 9402</u>, the Secretary of Administration, the Secretary of Human Services, the Green Mountain Care Board, or the Commissioner of Labor with respect to any matter in this chapter; chapter 13, 219, 220, or 222 of this title; 21 V.S.A. chapter 9; and 33 V.S.A. chapters 18 and 19 with respect to provider regulation, provider reimbursement, administrative simplification, information technology, workforce planning, or quality of health care.*

Thank you for considering our comments on S. 120 and S. 132. We look forward to working with your Committee as you work on the complex and important issues that the bills raise.