Date: April 21, 2021
To: Senate Health & Welfare Committee
From: Susan Ridzon, HealthFirst Executive Director
Re: S.120, S.132

HEALTH FIRST

Thank you for inviting me to testify on S.120, an act relating to the Joint Legislative Health Care Affordability Study Committee, and S.132, an act relating to health care reform implementation.

S.120

We support S.120 and we thank the bill sponsors and the Committee for working to advance it. We agree that healthcare affordability is a critical issue for both patients and employers. We also agree that there is a shortage of healthcare providers, especially in primary care, and any solution must include investment to strengthen and expand the number of healthcare providers. We strongly support examination of the efficacy of Vermont's All Payer Model and whether an alternative would be more effective in improving affordability and access. We believe the current model falls well short of its goals and should not be renewed without significant changes that strengthen and expand primary care and improve healthcare costs and access for Vermonters (see our comments to GMCB regarding APM renewal, included as part of this memo). We also support the inclusion of a broad spectrum of stakeholders in the evaluation process, including Vermont residents and small business owners who shoulder much of the burden of increasing health care costs.

S.132

We support many of the presumed tenants of S.132, such as transparency, fairness and increased access to primary care and hearing aid services. We appreciate you putting forth a bill that aims to address these issues.

We support the transparency provisions in the bill; in general, we support transparency in the healthcare system, including price transparency. We appreciate the bill's attention to the administrative costs of the ACO, in particular the cost of administrative salaries. However, we wonder if linking the salary to primary care physician salaries might have the unintended consequence of limiting an ACO's ability to recruit a candidate with the skills needed for success. In addition, such limitations may make Vermont less attractive to other ACOs looking to do business here. We are in favor of competition as we believe it helps to improve quality, lowers cost and expands the healthcare choices available to Vermonters. More important than salary data is the ability of Vermonters to realize a clear Return on Investment (ROI) for their money. If an ACO or another model is achieving positive results that can be clearly measured and felt by Vermonters, then the cost of salaries is likely money well spent.

The provisions of the bill related to contracting seem partly aimed at ensuring fair payments for different provider types. We support measures to achieve this goal. Our current system is a seemingly state-sanctioned near monopoly that unfairly stymies competition and has narrowed Vermonters' choices while increasing costs. An examination of the financial modeling in the 2021 hospital budget process clearly demonstrates this. As noted by Green Mountain Care Board Member

P.O. Box 2124, South Burlington, VT 05407-2124
802-878-8811 (voice) 802-419-4810 (fax) contact@vermonthealthfirst.org www.vermonthealthfirst.org

Tom Pelham in his 2021 UVMMC budget decision dissent (pages 15-17), Vermonters' healthcare dollars are mainly going to one entity at the expense of the viability of the community hospitals and other community-based providers. Charges and price increases awarded to those with market power fuels the increase in health insurance rates that individuals and employers face each year. We support a system that distributes our finite healthcare dollars in a transparent and fair manner and isn't ruled by market dominance. The bill's provision of having the GMCB review every contract might be aiming to get at this issue. Though we applaud this presumed intent, we have concerns that GMCB review of every contract is not practical and is unlikely to achieve the desired equity. It may be simpler to require basic contracting guardrails and/or allow providers to form collective bargaining groups for the purpose of negotiating with payers.

On the issues of price transparency and market dominance, we recommend that the legislature utilize the available price transparency data to help inform and direct healthcare reform efforts. As of January 1, 2021, CMS mandated that hospitals publish price transparency data on 300 shoppable procedures. In addition, GMCB will be releasing a price transparency report that is driven off of VCURES and discharge data. We suggest that over the Summer, the Joint Fiscal Office explore the use of these two data sources to make the best use of this long sought and awaited market information.

We support the provision related to inclusion of specialty care in healthcare reform efforts. In addition, we suggest that you include language that directs the ACO or other health reform effort to encourage the use of lower cost sites of care when appropriate. Our current model doesn't seem to consider this, so many Vermonters are paying hospital prices for care that doesn't need to be done in a hospital. Encouraging the use of and bolstering the viability of independent practices and independently owned facilities will ensure Vermonters have continued access to these high value choices.

Lastly, we strongly support the provisions related to hearing aids and exploration of two primary care visits without cost sharing. As this committee is aware, out of pocket costs can be a deterrent to patients seeking primary care services early in the course of an illness when interventions are generally less costly. Removing this barrier to primary care makes sense and will result in future cost savings. However, we have concerns that our diminishing primary care workforce won't have the capacity to provide these needed services. Accordingly, we suggest that the exploration also includes an assessment of the ability of Vermont's primary care network to support the change, with the knowledge that Vermont needs to do significant work now to address the current primary care crisis to ensure Vermonters' needs will be met.

In summary, we support the concepts of transparency, fairness, and increased access outlined in S.132. However, we are skeptical that the bill will have a meaningful influence on affordability and access, while also ensuring that the way that we finance healthcare will fairly support an array of healthcare choices for Vermonters. In addition, the bill suggests that Vermont will continue with an ACO model. We do not believe this should presumed, given the ACO's lackluster performance to date. We believe Vermont should allow itself the flexibility to entertain other potential models of payment reform. Given the timing of the new federal Administration, Vermont is in a unique position

to entertain creative and novel solutions to improve our healthcare system to the benefit of all Vermonters.

About HealthFirst

HealthFirst is Vermont's independent practice association representing 64 physician-owned primary care and specialty practices located across ten counties in Vermont. We estimate that approximately 85-90% of the independent practices in Vermont are HealthFirst members.

HealthFirst Feedback to the GMCB re: the All Payer Model

March 26, 2021

Susan Barrett, Executive Director, GMCB
Alena Berube, Director of Health Systems Policy, GMCB
Ena Backus, Director of Health Care Reform, State of Vermont

Dear Ms. Barrett, Ms. Berube and Ms. Backus:

As a member of the Green Mountain Care Board Advisory Committee, I am writing to provide feedback on the All Payer Model (APM), specifically with regard to the negotiation for a new agreement. We were asked to discuss what is currently working in the model, and whether and/or how the State of Vermont should proceed to enhance health care reform efforts. The current model falls short of its goals and should not be renewed without significant changes that strengthen and expand primary care and improve healthcare costs and access for Vermonters.

To assess how the model is working, I found it interesting to review the description of the All Payer Model on the GMCB website. As stated, if successful, the All Payer Model should reduce the cost of care, improve the quality of care, and improve the health of the population, all on a foundation of enhanced preventive (i.e. primary) care. To date, there have been minimal improvements in these areas despite the significant shift of financial resources to the ACO. The money would be better spent on primary care where there is ample evidence that investments result in a long-term decrease in medical costs[1].

The APM description also suggests that the majority of patients are operating in a capitated system, whereby the practice or provider is receiving an adequate per-member per-month (PMPM) payment that allows them to drastically change or improve their model of provider care. Only 6 of our 26 (23%) primary care practices are part of this capitated system. This is partly because the capitated rate would cause many of our practices to lose money, threatening their viability. In addition, many smaller practices lack the office staff or resources to invest in the ACO without a tangible return.

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[1] Jabbarpour Y et al. Investing in Primary Care: A State-level Analysis. Robert Graham Center. July 2019. https://www.graham-center.org/content/dam/rgc/documents/publications-reports/reports/Investing-Primary-Care-State-Level-PCMH-Report.pdf

For practices that are participating, approximately 30% of patients are eligible, while the other 70% remains in a fee-for-service (FFS) system. Additionally, while there were initial incentives to enroll in the pilot version of the program, those financial incentives have gradually decreased so that the program may now be financially detrimental to many practices. The end result is that there are very few, if any, practices who are able to make any structural changes in the way they provide care. Real change is unlikely unless at least 65% of a practice's patient panel is included in a model. Our current model is unlikely to get there as there is little to entice self-insured employees to sign on.

Many primary care providers (PCP) were hopeful that the APM, with its stated goal of enhanced primary care, would increase funding to primary care at a level commensurate with its value. While there have been small increases in funding through the care management payment, primary care continues to be grossly underfunded. Independent primary care practices are particularly challenged as payer reimbursements are their only source of income. Commercial rates have been stagnant for years and there is no ability to negotiate. Medicaid reimbursements are insufficient and, in fact have decreased for primary care. This is particularly challenging for practices with high Medicaid populations, which includes all our pediatric practices. The All Payer Model does not address any of these financial concerns. In fact, the model actually compounded the problem when it put a portion of practices' upfront payments at risk and tied to factors largely out of their control. There must be a sufficient PMPM floor that is not at risk that practices can rely on to sustain their practices. Primary care practices currently do not receive PMPM levels that are high enough to permit risk without jeopardizing practice viability. Each of these challenges has resulted in a decline in the number of independent primary care practices (we've lost 15 since 2015, most in rural areas). Continued loss of independent practices will further increase cost and decrease access for Vermonters. Any model that aims to control healthcare costs should be supporting and embracing these high value options.

With regard to cost and quality, our independent practices demonstrated through our previous ACO that they routinely provided high quality, lower cost care than hospital-owned practices.[2] Studies have demonstrated time and again that when a hospital acquires an independent practice, health care costs increase and health care quality decreases[3][4]. As such, it is imperative that independent practices continue to be a key player in meeting the stated goals of lower costs and higher quality.

In addition, we strongly championed the opening of the Green Mountain Surgery Center (GMSC), which offers a high quality, lower cost alternative to a costly hospital visit for many patients. Such centers align with the stated goal of ensuring that Vermonters are provided "the right care, at the right place, at the right time". It seems that a system with a stated goal of improving quality and reducing cost would strongly support this independent system. To date, that support has been largely absent. If

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[2] Vermont's ACO Shared Savings Programs: Results and Lessons Learned 2014-2016. Green Mountain Care Board. December 2017.
https://gmcboard.vermont.gov/sites/gmcb/files/FINAL%20Year%203%20Shared%20Savings%20Program%20Results%2012%2019%202017%20to%20GMCB%20FINAL_DVHA%20update.pdf

[3] Capps C, Dranove D, Ody C. The Effect of Hospital Acquisitions of Physician Practices on Prices and Spending. Institute for Policy Research Northwestern University. February 2015
https://www.ipr.northwestern.edu/documents/working-papers/2015/IPR-WP-15-02.pdf

[4] Short MN, Ho V. Weighing the effects of vertical integration versus market concentration on hospital quality. Published online February 2019.
https://journals.sagepub.com/doi/full/10.1177/1077558719828938

the model did support such lower cost networks, it's likely that more self-insured employers would be interested in joining, as they would be able to pay less for healthcare.

One area that the APM has succeeded is in the enhancement and standardization of care coordination. This was care that many PCP practices had already been providing but in a more informal manner. The incentive payments for practices to hire care coordinators have helped many PCP's to be able to provide this care coordination for Vermonters at highest risk. However, the required documentation tool provides little to no benefit while increasing the workload of the care coordinator, resulting in decreased efficiency.

As the State of Vermont looks to negotiate another waiver, it is paramount that it reviews its own stated goals of the higher quality, lower cost and improved population health, and determine what structural supports are needed. As stated above, we believe the following is needed in any model.

1. Increase payments to primary care. For health care reform to truly change the way care is delivered, there needs to be a substantial increase in primary care funding. In addition to supporting existing primary care practices, reform efforts need to directly address the worsening primary care provider shortage and use aggressive and creative strategies to entice more primary care providers to join their ranks.

2. Support lower cost sites of care such as independent practices. Any model that wants to reduce cost, improve quality, and ensure access needs to include and support independent health care providers.

3. Include a Return on Investment (ROI) analysis when evaluating the success of the APM. We've seen reports on performance on total cost of care, scale targets, quality measures and shared savings but nothing seems to consider the savings/perceived benefits relative to the cost of the program. To not include such an analysis almost ensures that Vermonters won't get their money's worth out of the program.

4. Improve quality reporting to practices. Practices need to be aware of their own performance on quality measures. While measures can be uniform across the health service area or State, actionable quality data should be reported regularly to practices so that they can target quality improvement efforts.

5. Listen to consumers. Legislators and the GMCB should hear not only from practices and health care systems, but from employers and consumers who are shouldering the burden of insurance premiums and high deductibles.

In summary, the performance to date of the current healthcare reform falls short of its stated goals and we do not believe the State should move forward with the model without significant changes. Vermonters will not gauge the success of healthcare reform efforts by a cost growth trend of 0.1% less than the national trend. Rather, success will be evaluated on an increased ability to see their primary care provider when needed, a decrease in their insurance premiums, or a reduction in their out-of-pocket medical costs. If we are unable to achieve those goals with the current program, then it is time to look at alternative models of reform.