To: Senate Health & Welfare Committee
From: Jessa Barnard, Vermont Medical Society, jbarnard@vtmd.org
Date: January 24, 2024
RE: S. 211 – Health Care Reform and Duties of GMCB

Good morning and thank you for the invitation to testify regarding S. 211. I am the Executive Director of the Vermont Medical Society, Vermont's largest physician and physician assistant membership association, representing approximately 2900 physicians and PAs from around the state, both primary care and specialists, and at all practice settings.

VMS represents individual clinicians – physicians and PAs – not their practice sites, facilities or health care institutions. Therefore, my comments on S. 211 are focused on the experience of individual health care professionals trying to take care of their patients. And many health care professionals do find Vermont's health care regulatory structure confusing and difficult to navigate. For example, members of the GMCB Primary Care Advisory Group struggle to understand why the GMCB doesn't have or use regulatory levers to do more to reduce prior authorization, address a shortage of primary care clinicians or increase primary care reimbursement – things that would make a difference in their day to day practice, many of which are also highlighted in the Act 167 initial feedback.[1] To add to the confusion, DFR recently testified that they are not the correct home to help drive a reduction in prior authorization, either. Leaving practitioner with a feeling that no one is in charge of improving the practice environment. VMS would support additional clarity and consistency in which entity in Vermont is lead on some of these day to day practice issues.

As discussed in your walk-through of S. 211, VMS does strongly support moving several sections of S. 151 forward along with any sections of S. 211. I will reference those sections below.

Section 1: **Neutral** on moving these activities, however, would want to ensure that whichever entity is determining and evaluating "health care professional satisfaction" and other items listed has the staffing and expertise to meaningfully engage in this activity.

Section 3 (and 5 & 6): **Unsure the intent** of the added language of providing for/promoting/ensuring "equitable" reimbursement. Does this mean between provider types (i.e. hospitals, independent practice, FQHCs, DAs, etc) even those not regulated by the GMCB and have very different reimbursement types? Or does this mean within provider types (critical access hospitals vs academic medical centers)? Without more of a definition and criteria, it is difficult to assess the impact of this addition on different provider types and potentially adds

[1] https://gmcboard.vermont.gov/sites/gmcb/files/documents/OW%20Presentation%20to%20GMCB%2017%20Jan%202024%20Final.pdf

confusion with other sections of the bill. For example, Section 5, page 9 uses the term "sustainable payment." VMS supports instead keeping existing statutory language such as "*It is the intent of the General Assembly to ensure payments to health care professionals that are consistent with efficiency, economy, and quality of care and will permit them to provide, on a solvent basis, effective and efficient health services that are in the public interest.*"

Section 4: **Oppose** removing task for GMCB of reviewing effectiveness of existing requirements for health care professionals unless this is explicitly moved elsewhere.

Section 5 (page 10): **Comfortable** removing approval of Health Care Workforce Strategic Plan – however it seems important for GMCB to still be aware of workforce needs in crafting any regulatory decisions.

Section 8: **Support** the Board adopting rules to certify Medicare-only ACOs.

Section 9: Mediation prior to nonrenewals of contracts: VMS is **concerned** about 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.

Section 10: Alignment of credentialing and quality measures: VMS **strongly supports** alignment of both credentialing and enrollment criteria and quality measures with CMS. These would be extremely helpful measures to reduce the paperwork burden in health care. In 2018, VMS adopted a policy statement urging more streamlining of the credentialing process, as credentialing with health plans – in addition to licensure – can cause some of the biggest delays to having a new clinician quickly able to see patients.

Section 11: VMS has **concerns** with adding data on "provider productivity" to the hospital budget review. It is unclear the intent of this new language, and what metrics would be used to determine "productivity." In addition, the ongoing push for greater productivity and shorter appointment times is one of the factors leading to primary care clinician burnout and dissatisfaction.[2] Similarly, simply "churning" more patients through may also run counter to the goals of payment reform and global budgets, which should allow more flexibility in length and types of appointments in order to meet patient need rather than productivity metrics.

Section 12: Same **concern** with "provider productivity," as above, and **questions** about adding the considering of spending across sectors of the health care industry – where would the GMCB seek this data, especially from nonregulated entities, would this impact the administrative burden on small entities to provide data, and what impact would this ultimately have on regulatory decisions?

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[2] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6957654/

Section 17: VMS has **concerns** with all mergers, affiliations and divestments needing to be reviewed and approved by the Attorney General's Office or GMCB. Small practices may affiliate or merge when in particularly precarious financial situations. Several small primary care practices moved from hospital-based to independent or FQHC in the past few years. VMS is concerned that the expense and regulatory burden of needing to go through a review of these types of transactions would mean these small practices would simply close.

Section 18: **Questions** regarding the intent and implications of this section – while supportive of the ultimate goal to have integrated clinical and claims data.

VMS does strongly <u>support</u> a number of the sections of S. 151, which the Committee discussed integrating into S. 211 during walk through. A number of these provisions provide important support to primary care and prevention services in Vermont.

The sections VMS supports moving into S. 211 include:

- Section 2: Blueprint Patient Centered Medical Home payments – report already authorized and written but now can implement recommendations
- Section 3: Ensuring Medicaid rates for primary care are adequate percent of Medicare rates
- Section 4: Increasing the percentage of health care dollar spending going to primary care – this integrates with the AHEAD Model
- Section 5: Regular updates to the Worker's Compensation fee schedule
- Section 6: Gold carding/reduced prior authorization
- Section 7: Preventing STIs in minors
- Section 9: Updates to colorectal cancer screening

We would be happy to offer additional testimony regarding any of these sections at your convenience.

Thank you for considering our testimony and please reach out to me at any time with questions to: jbarnard@vtmd.org.