HealthFirst

Independent Practice Association

H.583 – An Act Relating to Health Care Financial Transactions and Clinical Decision Making

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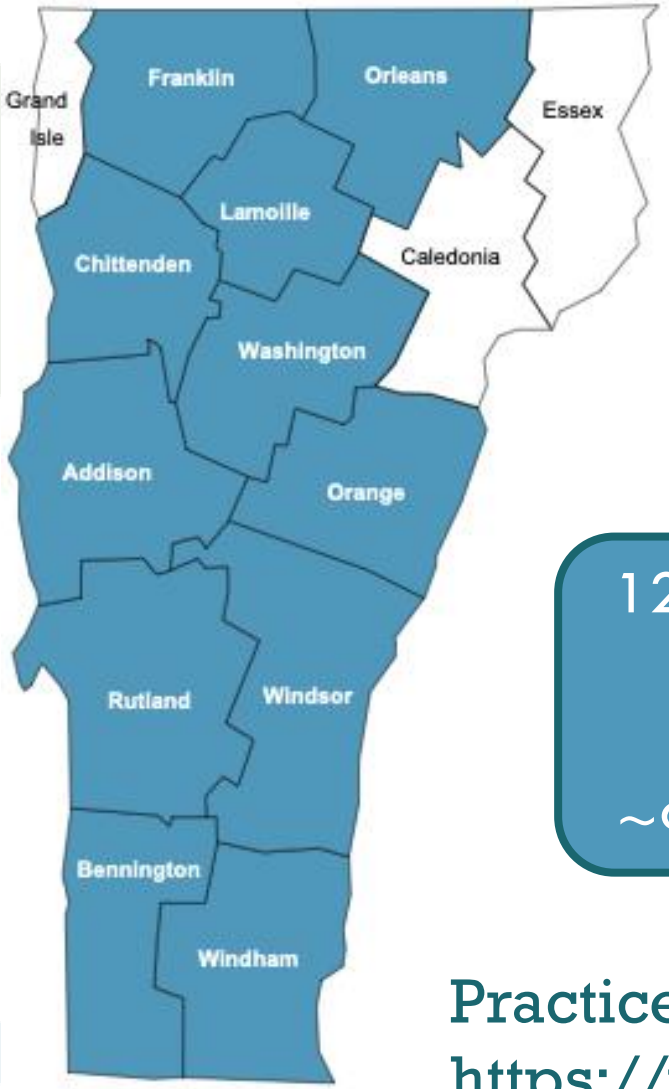

66 primary & specialty care practices in 11 counties

21% Direct Care or Concierge

127 primary care clinicians caring for ~90,000 patients

108 specialists offering 25+ specialty care services

Green Mountain Surgery Center

VermontEyeLaser at New England Vision

Vermont Diagnostic Imaging

Practice directory:
https://vermonthealthfirst.org/directory.php

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Our members overwhelming agree: Patient care comes first and should not be influenced by private equity, profits, or other factors.

In fact, this is why many choose independent practice despite the challenges – because they want more control over their patient interactions.

We understand wanting to do something about PE. Bad behavior should be stopped whether it's coming from PE or other entities, including non-profits.

Questions

How will this bill affect:

- Practices participating in a PE backed Medicare ACO?
- Practices participating in a payer contract through HealthFirst?
- HealthFirst as an organization?
- A clinician's ability to sell their practice to other clinicians?
- A practice's, HealthFirst's, or the state's ability to participate in NECHC?
- A practice's ability to contract with a PEO, MSO, or be part of an AHP?
- A practice's ability to outsource common tasks like RCM, IT, recruitment, etc?
- The ability to use debt to start, expand, or improve a practice/facility?

Questions (con't)

How will this bill affect:

- A practice who chooses not to contract with MA or any payers?
- A practices' legal expenses? Privacy/anti-trust concerns? Burden?
- Investment in independent practices & facilities?
- Other non-hospital facilities like infusion centers, labs, etc, who are primarily owned by private business owners/investors but not private equity or clinicians?
- And more….e.g. is it retroactive? Should GMCB have access to info on non-regulated entities?

Suggestions / Thoughts

- Supportive of prohibition of exploitative non-competes & unreasonable non-disclosures
- Narrow, simplify & clarify language & intent
- Focus on capturing truly bad behavior, not ordinary & benign business practices
- As you go through the bill ask:
  - How will this affect viability of current/future independent practices & facilities?
  - How will this affect competition?
  - How will this affect workforce?
  - How will this improve VT's access and affordability crises?
  - What other ways can we support practices so that PE isn't seen as only option?
- Explicitly state that independent clinician-owned practices & facilities, and IPAs are not the intended targets

Suggestions / Thoughts

- Apply requirements evenly across healthcare entities.
  - Dr. Song: "There's way more consolidation that's not PE, PE is just one version of ownership of hospitals and physicians." Why is the bill only targeting problematic behaviors by PE?
- Add language that explicitly allows:
  - Clinician to clinician practice sales
  - Independent to independent mergers
  - Loans or financing used for recruitment, technology updates, facility improvements
  - Shared clinical or administrative services arrangements
- Scale reporting based on size & risk; reduce burden
  - Exempt practices & facilities attesting to not engaging in prohibited transactions
  - Use info from SOS filings rather than requiring separate reporting
  - Simplify & allow confidential reporting of sensitive financial info for those needing to report