HEALTH FIRST

Date: April 29, 2025
To: Chair Alyssa Black and members of House Health Care Committee
From: HealthFirst, Susan Ridzon, Executive Director, sr@vermonthealthfirst.org
Re: Suggested language for select sections of S.126

Thank you for the opportunity to suggest language for S.126. Our suggestions focus on clarifying intent and language and on strengthening primary care.

Page 6, lines 3-16

(e) Reference-based pricing.

(1) The Board shall establish reference-based prices that represent the maximum amounts that hospitals in this State can charge ~~health insurers in this State shall pay to hospitals~~ for items provided and services delivered in Vermont. The purposes of reference-based pricing are to contain costs, and to increase rational pricing and transparency across the system. The Board shall consult with health insurers, hospitals, other health care professionals as applicable, the Office of the Health Care Advocate, and the Agency of Human Services on ways to approach reference-based pricing in an effort to achieve all-payer alignment on design and implementation of the program.

Recommend editing site-neutral language in section 3 (e)(1) and putting it in its own section:

Section ? –Site-Neutral Pricing

The Board shall ~~and to~~ move health care professionals toward a site-neutral pricing structure. A site-neutral pricing structure is one where provider professional fees are the same per CPT code and does not differ by location or ownership of the practice. Site-neutral pricing also will apply to fees charged by healthcare facilities, such as facility fees. ~~while also allowing t~~ The Board may ~~to~~ differentiate prices among health care ~~professionals~~ facilities based on factors such as demographics, population health in a given hospital service area, payer mix, acuity, social risk factors, and a specific ~~health care professional~~ facility's role in Vermont's health care system.

Page 6, lines 17-21

(2)(A) Reference-based prices established pursuant to this subsection (e) shall be based on a percentage of the Medicare reimbursement rate, or other

benchmark(s) deemed appropriate by the Board, for the same or a similar item or service, provided that after the Board ….*no change to the rest of (2)(A)*.

Page 7, lines 19-21

C) The Board, in collaboration with the Department of Financial Regulation, shall monitor the implementation of reference-based pricing to ensure that any decreased prices paid to hospitals result in commensurate decreases in health insurance premiums and/or increased investment in cost-effective services such as primary care, mental health care, and home health. The Board shall post its findings regarding the alignment between price decreases and premium decreases annually on its website.

Page 8, lines 7-13 ***We agree with most of VMS's suggested language in their 4/18 testimony (bottom of page 1 to page 2)***

(5) The Agency of Human Services, in consultation with the Green Mountain Care Board, shall develop by January 1, 2026, a per member per month payment rate and methodology to maintain 2025 funding rates for 2025 primary care practice participants in the All Payer Model primary care programs. By January 1, 2027, the Agency of Human Services and the Green Mountain Care Board, in consultation with a stakeholder group including primary care providers, primary care associations, GMCB Primary Care Advisory Group, primary care administrators and health care finance experts shall develop an all payer alternative payment program for primary care practices which shall include a per member per month or capitated methodology, in addition to fee for service payments. The payment methodology shall apply to both adult and pediatric patients and shall support patients to at least the same extent as primary care AHEAD, and shall not add to practice administrative or data collection burden. ~~may implement reference-based pricing for services delivered outside a hospital, such as primary care services, and may increase or decrease the percentage of Medicare or another benchmark as appropriate, first to enhance access to primary care and later for alignment with the Statewide Health Care Delivery Plan established pursuant to section 9403 of this title, once established.~~