Vermont Medical Society

To: House Health Care Committee
From: Jessa Barnard, Vermont Medical Society, jbarnard@vtmd.org
Date: April 9, 2025
RE: S. 126 – Overview of Fee Schedule Methodologies

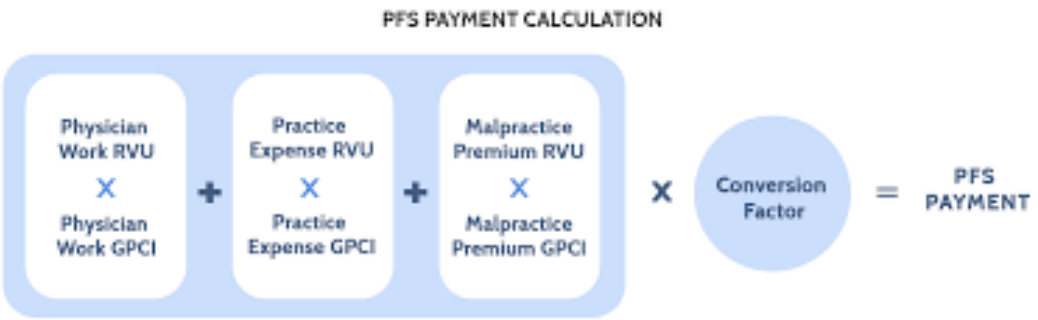
Good morning. I am the Executive Director of the Vermont Medical Society, Vermont's largest physician and physician assistant membership association, representing approximately 3100 physicians and PAs from around the state, both primary care and specialists, and at all practice settings. Thank you for the invitation to testify to provide background information regarding payments under professional services fee schedules.

We are focused on professional fee schedules under fee-for-service reimbursement. So, this picture will not focus on:

- Capitated payments (global budgets, capitated primary care programs)
- Value based payments (like in some of Blueprint for Health, OneCare Vermont programs. MIPS)
- Bundled payments
- Facility fees/facility fee schedules
- Hospital inpatient and outpatient rates

Medicare

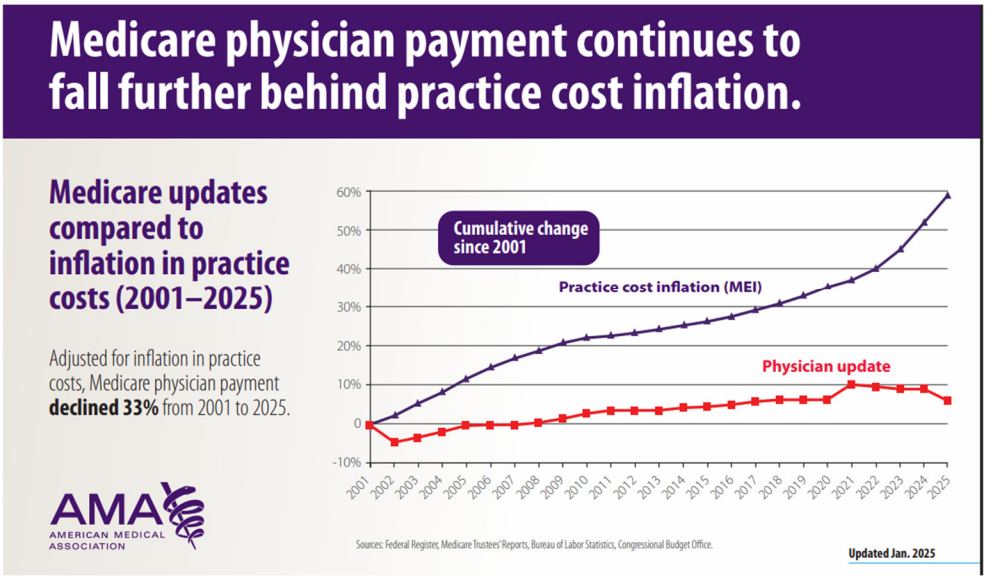
Medicare Physician (Professional) Fee Schedule (PFS) Rates are determined by a formula that multiplies work and practice expenses (RVUs) by geographic adjustments (GPCIs) and then by a dollar "conversion factor" to get the dollar amount paid for a service. See the following

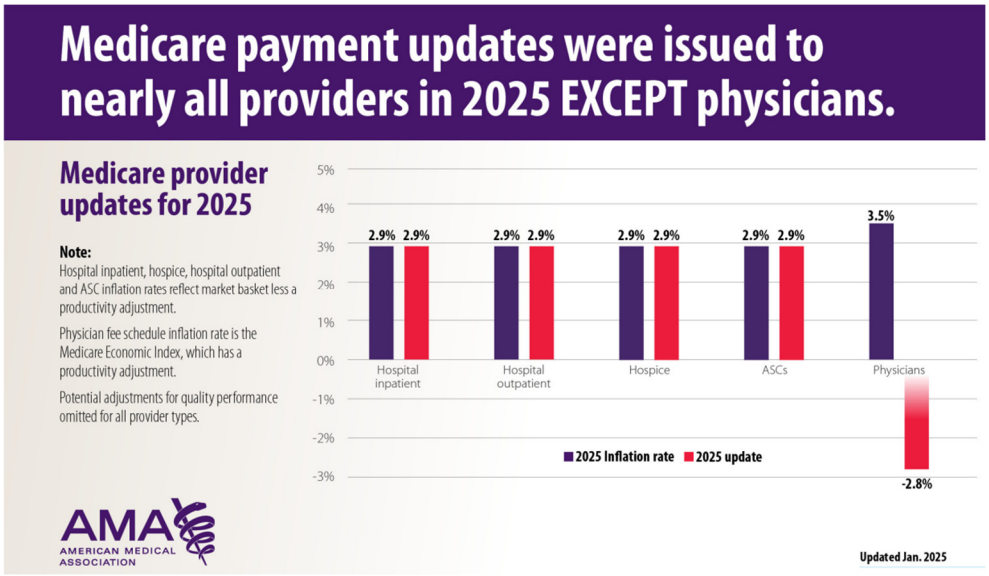


Example: CPT Code 10021- Fine needle aspiration

1.03	+	0.426	+	0.121	x	$33.8872	=	$53.44

These rates are set in an annual rulemaking process by CMS. Currently, the Medicare PFS is statutorily required to be budget neutral – this means that as adjustments are made in one part of the fee schedule formula there need to be commensurate decreases elsewhere – typically this means increases in the RVUs lead to decreases in the conversion factor.[1] The consequence of the current Medicare formula is that Medicare has made year over year overall fee schedule cuts to professional services since 2021 – for example, a cut by 3.4% in 2024 and another 2.83% in 2025. The Medicare PFS is also the only Medicare fee schedule that does not receive an inflationary adjustment. Putting these factors together, Medicare payments under this fee schedule have declined 33% from 2001 to 2025.





Medicaid

Medicaid's professional fee schedule – the Resource-Based Relative Value Scale (RBRVS) also goes through a rulemaking each year to align with current Medicare Relative Value Units

[1] See further description here: https://www.kff.org/medicare/issue-brief/what-to-know-about-how-medicare-pays-physicians/

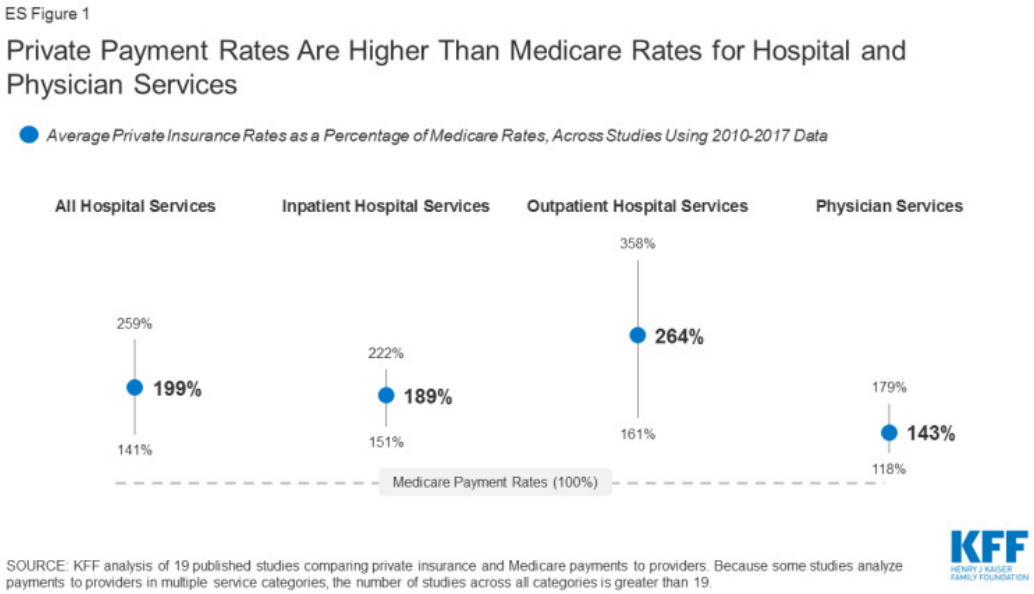
(RVUs) and geographic adjustments. Medicaid then applies its own primary care and specialty care conversion factor.

Using these conversion factors, as of 2025, Medicaid reimburses at 115% of Medicare rates for certain primary care services provided by specific provider types and the remainder of services, including all specialty care services, are reimbursed at approximately 89.5% of Medicare rates.[2]

If Medicaid adopted Medicare's conversion factor, as it did for several years when aiming to benchmark to 100% of Medicare rates, it would lead to the year over year Medicare cuts being adopted in Medicaid's fee schedule Learning from this experience is why VMS supports the language in S. 126 Section 3(e) allowing the Board to opt to update reference based prices "in the future based on a reasonable rate of growth that is separate from Medicare rates."

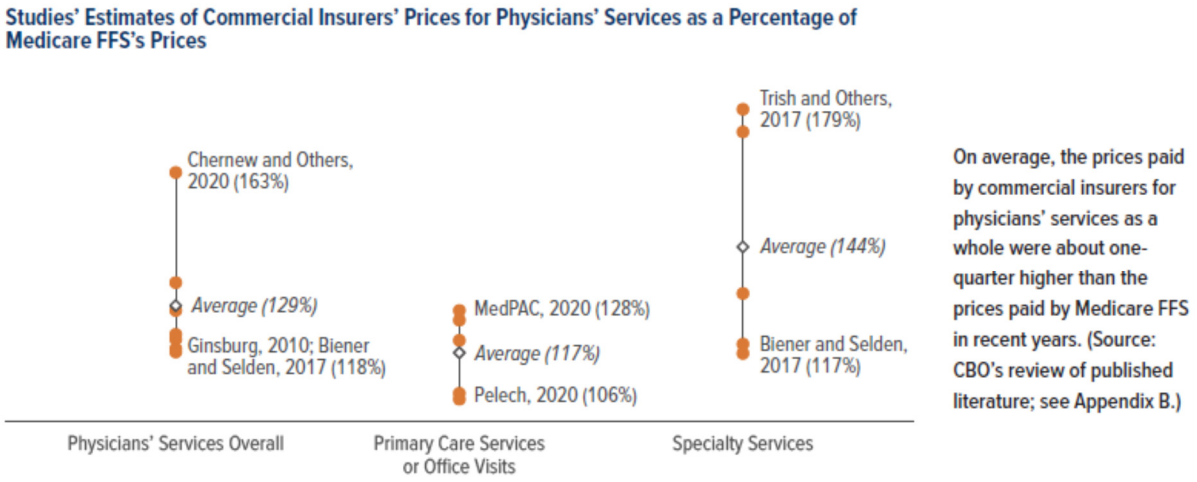
Commercial

Commercial insurance rates are negotiated between individual payers and providers – often with one "community fee schedule" offered to all smaller providers. On average, commercial payers pay for professional services at approximately 143% of Medicare rates – with ranges depending on the analysis from 118 -179%. According to a recent CBO analysis, they are approximately 117% for primary care services and 144% for specialist services.



Source: https://www.kff.org/medicare/issue-brief/how-much-more-than-medicare-do-private-insurers-pay-a-review-of-the-literature/

[2] https://humanservices.vermont.gov/sites/ahsnew/files/documents/25-007-F-GCR-RBRVS-Rates-CY2025.pdf



Source: January 2022 CBO Report: *The Prices That Commercial Health Insurers and Medicare Pay for Hospital Physicians' Services*

State public option programs that have benchmarked rates have acknowledged that reimbursement rates must be set close to commercial rates to ensure access for patients and participation by providers. For example, in Washington State, aggregate provider reimbursement was set at a cap of 160% of Medicare rates, with reimbursement floors for primary care physicians at 135% of Medicare. Colorado appears to have set rates at 155% of Medicare with variations by hospital type. And a study in Oregon under the analyzed carrier-led model, provider reimbursement would be benchmarked to a state-determined blended rate, estimated at 145% of Medicare.[3]

Feedback on Specific Language of Sections 2 & 3 of S. 126

Based on our experience with the fee schedules described above, our comments on sections 2 & 3 of S. 126 are as follows:

- **Section 2**
  - Support the timelines - GMCB and providers need time to seek sufficient input and design the methodology
- **Section 3**
  - Support GMCB weighing the factor listed to determine reference-based prices
  - Support the guardrails the GMCB must weigh in determining whether to continue reference based pricing, including a reduction in services
  - Support removing, or at a minimum, additional clarity in section 3(e)(5) regarding establishing reference-based pricing for non-hospital services.
    - Which services/provider types do you want included? Professional medical services like primary care or other services such as mental health, home health?
    - Which payers do you want included – commercial or Medicaid?
  - Suggest replacing this with a more holistic approach to alternative payments for primary care services:

[3] https://www.chcf.org/wp-content/uploads/2021/03/StatePublicOptionsComparingModelsAcrossCountry.pdf

- **Language needs to accompany funding in order to continue our State's commitment to alternative payment models for primary care**. Simply increasing fee for service funding mechanisms does not enable primary care to provide the best patient-centered, creative care models clinicians and patients have been receiving and seek to continue. Reference-based pricing is simply based on developing a state set price – and primary care is currently depending on the flexibility of alternative funding models. **We ask that the bill also direct that:**
- *The Agency of Human Services 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 in consultation with a stakeholder group including primary care providers, primary care associations, primary care administrators and health care finance experts shall develop an all payer alternative payment program for primary care practices, which may include a per member per month or capitated methodology, shall apply to both adult and pediatric patients, shall support practices to at least the same extent as Primary Care AHEAD, and shall not add to practice administrative or data collection burden.*

We would look forward to working with the Committee as you continue your work on S. 126. Please don't hesitate to reach out with any questions to jbarnard@vtmd.org.