To: House Health Care Committee
From: Jessa Barnard, Vermont Medical Society, jbarnard@vtmd.org
Date: April 16, 2025
RE: S. 126 - An act relating to health care payment and delivery system reform

Good morning and thank you for the opportunity to testify regarding S. 126. 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. We appreciate the opportunity to testify regarding additional sections of S. 126. We have consolidated our feedback by section, below, realizing you are currently focusing on Sections 4-6.

Section 2 – Reference Based Pricing – Board Duties

- Support the timelines in the bill as passed the House. While we recognize and appreciate the urgency to address health care costs, the GMCB and providers need time to seek sufficient input and design the methodology of reference based pricing.

Section 3 – Reference Based Pricing – Payment Amounts

- (e)(1): Support more clarity and/or definition regarding what is meant by site-neutral – does this mean between hospital and non-hospital providers or between hospital types. Suggest more clarity regarding weighting site neutrality vs differentiating prices based on the factors listed.
- (e)(2)(A): Recommend allowing more flexibility in terms of what benchmark is selected, such as a percent of average commercial rates. Payers such as public option plans and state Workers' Compensation programs benchmark not just to Medicare but blended commercial rates. Support 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."
- (e)(2)(C): Suggest more flexibility of uses of decreased pricing based on reference-based pricing – such as reinvestment in other provider types.
- (e)(4): Support the guardrails the GMCB must weigh in determining whether to continue reference based pricing, including a reduction in access to care or quality.
- (e)(5): Support removing, or at a minimum, additional clarity in section 3(e)(5) regarding establishing reference-based pricing for non-hospital services.
    - **Suggest replacing this with a more holistic approach to alternative payments for primary care services**:
    - *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.

Section 4 – Hospital duties

- (a)(7): VMS agrees with previous witnesses that GMCB already receives data on administrative costs and salaries in the hospital budget process
- (a)(8): VMS questions the distinction between "clinical leadership" and "employees who deliver health care services directly to hospital patients." Many "clinical leaders" including physician and nursing leaders of departments, programs or units both have a managerial role and well as see patients at the bedside. We also question how this definition is different from paragraph (7) and (17) and how the GMCB will use this data in ways different from data already available to it.
- (a)(9): VMS supports the request that hospital submit any proposals for ways in which the hospital can support community based providers, workforce needs and social determinants of health. Nothing in this paragraph requires additional investment or directs spending, and hospitals are largely already engaged in these activities.

Section 4 – Budget review

- (b)(7): VMS believes that hospitals should have incentives to provide the spectrum of primary and preventive services**.** VMS also supports the bill being specific regarding the types of incentives that the GMCB should implement.
    - We support the language that: *Revenue derived from primary care, mental health and substance use disorder services shall not be counted towards hospital net patient revenue or any state total cost of care target developed.*
    - **We suggest adding***: Any reference based price methodology developed that applies to such services shall be set at a benchmark to encourage the delivery of such services.*
- (e)(1): Quality measures: VMS supports coordinating quality metrics with ongoing work by the Vermont Program for Quality in Healthcare and the new Statewide Health Care Delivery Plan and Advisory Committee.
- (e)(2)(A): Reduction in services: appears inconsistent with wanting hospitals to manage costs, transform delivery and being more administratively efficient to add a new, complex review of reduction or elimination of services.
- **Suggest adding to this section**: a requirement that as the Board move to reference-based pricing and global budgets that they transition away from regulating based on net patient revenue. By combining volume with cost, net patient revenue as a metric can serve to disincentive providing access rather than directly address costs.

Section 7 – Contracts

- VMS recommends removing this section. VMS is unclear of the intent behind or utility of requiring any provider to provide a contract to DFR or the GMCB. VMS believes that DFR and the GMCB can already request contract information – such as rates paid – directly from payers.

Section 8 - Health Care Delivery Plan

- (b)(4): VMS has for years supported setting a statewide primary care spending target. A primary care spending target is also required under AHEAD. If the Health Care Delivery plan moves forward, VMS supports retaining the setting of a primary care spending target.

Section 9 – Health Care Delivery Advisory Committee

- VMS supports retaining broad provider input on any health care delivery advisory committee.

Section 10 – Integration of Data

- (b)(5): VMS supports a focus on ensuring interoperability of health care data. VMS does not believe it is feasible or affordable for the state to move to one EHR, however it is critically important to improve interoperability of our EHRs and data systems, so that data is available, can improve care, and reduce redundant services.

Section 12 – ACO Capabilities

- VMS does believe that retaining capabilities for payment reform is critical for primary care. VMS supports AHS continuing its work on comprehensive payment reform and quality data measurement and reporting.

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