HEALTH FIRST

Date: April 10, 2025
To: Chair Alyssa Black and members of House Health Care Committee
From: HealthFirst, Susan Ridzon, HealthFirst Executive Director, sr@vermonthealthfirst.org
Re: Testimony on Sections 2 and 3 of S.126

Thank you for the opportunity to testify today. For the record, I'm Susan Ridzon, Executive Director of HealthFirst, an independent practice association representing approximately 215 clinicians working at 62 physician-owned primary care and specialty care practices located across Vermont.

In general, we strongly support efforts to control Vermont's hospital spending and to implement a fair and transparent payment/pricing method. Current methods and policies are driving high value independent providers out of business. When these practices go away, access and affordability worsen. Some points to consider:

- The professional fees paid to independent clinicians often are much lower than those paid to hospital-employed physicians. These differences are *independent* of facility fees, which independent practices do not get.
    - Example: The professional fee paid to a hospital-employed cardiologist was almost 2.5 times higher than what was paid to an independent cardiologist for the same service, performed in the same location. In addition, the hospital receives facility fees. A patient needing a coronary stent could pay almost a $900 more, depending on whether an independent or hospital-employed cardiologist is on call at the time.

- Payer reimbursement is the only source of fee for service revenue for independent practices
    - Rates are largely "take it or leave it" and have not kept pace with ever-increasing costs
        - Clinicians essentially have to take a pay cut and/or cut staff, or see more patients – which is not always feasible - to keep practice solvent
    - Medicare rates have decreased every year since 2021 and 33% overall since 2001
        - Many other payers base their rates on Medicare, so those rates are also declining
    - Independent practices get no revenue from facility fees, 340b programs, encounter rates, 330 grants, graduate medical education
        - Extremely difficult to recruit staff when better resourced entities can offer richer compensation packages

- Independent practices are disadvantaged in other impactful ways as well:
    - They are not tax exempt, so they are paying higher prices for supplies, property taxes, etc.
    - Most are forced to buy health insurance on the exchange with few options for relief from very high and ever-increasing premium prices
    - Independent practices are not considered eligible employers for Department of Education Loan Forgiveness program, making it very difficult to recruit clinicians when they can have their loans forgiven if they work at a hospital or FQHC

- The reference-based language in Sec 3 in S.126 is welcome but GMCB already has the authority to

institute RBP, a type of rate setting. The bill would be more impactful if it also included language that requires redirection of resources into high value services such as primary care. Community-based primary care practices need a stable, simple and predictable funding source. Ideally, funding includes both fee for service and capitated payments.

Comments on Specific Sections

Section 2

- **We suggest speeding up the implementation timeline.** We suggest implementation by 2027, earlier if possible, for at least the one or two hospital(s) responsible for the bulk of Vermont's spending. Our system is already in severe crisis due in part to inaction, and we must make meaningful changes now. We understand that the work requires a heavy lift and needs to be thoughtfully implemented. However, it's our hope that GMCB's existing hospital budget process, and the extensive work hospitals and other stakeholders have done in preparation for the AHEAD model will allow for an earlier implementation.

Section 3

- (e) (1)
    - **Suggest clarifying language & intent.** Talks about purpose of RBP is to contain costs and move health care professionals toward a site-neutral pricing structure. These are two different approaches, so the goals/intent are unclear. Do you want to lower costs, level the playing field, both, other goals?
        - Is the intent of RBP and site-neutral pricing language to get to a Medicare-benchmarked price and apply that same rate to all providers/facilities offering the service, regardless of site of care?
            - If yes, would this include non-hospital providers such as independent clinicians, ambulatory surgery centers, etc.?
            - If no, how would reference based pricing help with the intent language in Sec 3 18 V.S.A. § 9376 (a) that states the intent "to eliminate the shift of costs between the payers of health services to ensure that the amount paid to health care professionals is sufficient to enlist enough providers to ensure that health services are available to all Vermonters and are distributed equitably."
        - Consider adding "price transparency" as one of the goals.
        - To what fee schedules, services or items would RBP apply to? What about facility fees? What will prevent prices for items/services not subject to RBP from increasing to offset price limits on other services?

Thank you for the opportunity to weigh in on these sections. Please get in touch if we can offer additional information from the perspective of independent practices.