To: Senate Health & Welfare Committee
From: Jessa Barnard, Vermont Medical Society, jbarnard@vtmd.org
Date: March 12, 2025
RE: Senate Health & Welfare Health Care Reform Committee Bill 25-0907

Good morning and thank you for the opportunity to testify regarding committee bill 25-0907 now that we have had an opportunity to review the full language. 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 have already testified in your Committee regarding the need to support primary care in order to achieve the goals of the bill to move Vermont forward with achieving high-quality, cost-effective care. I will not repeat my testimony from February 19th or Jon Asselin's testimony from Primary Care Health Partners except to remind you of our asks to the appropriations committees that the 2026 primary care funding cliff must be addressed including the:

- **A $5,514,308 primary care funding gap due** to the loss of Population Health Model (PHM) Program funding for all OneCare Participating primary care practices and the Comprehensive Payment Reform independent primary care prospective payment program.

- **$10.8 million in lost payments to Blueprint for Health** Community Health Teams, Patient Centered Medical Homes and the SASH program.

- **Loss of the Blueprint for Health Pilot Expansion Program that invested Medicaid dollars in expanded Community Health Team staff** at primary care practices.

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. In addition, primary care funding is already largely driven by Medicaid and the Agency of Human Services' work with the Blueprint for Health. Designing a primary care payment methodology is more appropriately housed in AHS rather than the GMCB. Further, any referenced-based pricing methodology developed by the GMCB is still a fee for service mechanism – 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.

Our comments on current sections in the proposal follow below:

Section 1 – Hospital Budgets and Payment Reform

- (b)(5): VMS has concerns with referenced based pricing being developed by 2025. This does not appear realistic since rulemaking also has to take place. VMS agrees with VAHHS to **slow the timeline** and implement as a pilot.

Section 2 – Payment Amounts – subsection (e), Reference-based pricing

- (e)(1): **VMS requests clarification** regarding which payers a reference-based pricing methodology developed by the GMCB will apply to – is this only for state-regulated commercial payers? "Payer" does not appear to be defined in this chapter. "Health Insurer" is defined as only commercial payers. VMS agrees with VAHHS that GMCB should **consult with providers** as well as payers in developing referenced-based pricing and **supports legislative guardrails** that will trigger ending referenced-based pricing.

- (e)(2): If reference-based pricing is moving forward, **VMS strongly supports this paragraph but would request that it be strengthened** by not allowing it to be optional for the Board to decide to separate from Medicare rates in the case that Medicare rates are decreased, especially as referenced-based pricing is expanded from hospital services to professional and/or non-hospital services. Medicare implemented a 2.8 percent cut to its professional fee schedule on January 1, 2025 following across-the-board cuts in 2021, 2022, 2023, and 2024. In fact, between 2001 and 2025, Medicare professional services payments, adjusted for inflation, have declined 33%.[1] Professional services must be adjusted each year based on the Medicare Economic Index measure of inflation.[2] Otherwise, the GMCB could simply be importing a broken Medicare fee schedule – as we have seen impact the Medicaid professional fee schedule year after year.

- (e)(4), regarding setting referenced-based pricing for non-hospital services, we question the feasibility and GMCB capacity of implementing reference based pricing for all non-hospital services at this time, **and oppose the inclusion of non-hospital services** at this time. **It is unclear the range of services** this could include – independent primary care and specialty care practices? All non hospital professional services? Dental care? Mental health care? How would information

[1] https://fixmedicarenow.org/sites/default/files/2025-01/Medicare%20Gap%20Chart_2025.pdf

[2] Published each year by CMS at https://www.cms.gov/data-research/statistics-trends-and-reports/medicare-program-rates-statistics/market-basket-data (See "Actual Regulation Market Basket Updates," line 64-65)

be gathered regarding existing rates and a benchmark be established? **We also reiterate our question regarding the range of payers** this will apply to and assume it only applies to private payers, in which case many of these services largely rely on payers outside the scope of GMCB regulation. We support the goal of increasing a reference-based price for primary care services, although believe this should **apply to all locations of providing primary care, not only non-hospital services**.

Section 3 – Hospital duties

- Agrees that GMCB already receives data on administrative costs and salaries
- (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).

Section 4 – Budget review

- (b)(7): **VMS strongly believes that hospitals should have incentives to invest in the spectrum of primary and preventive services regardless of whether those services are provided by the hospital or by non-hospital providers.** VMS also supports the bill being more specific regarding the types of incentives that would be helpful for the GMCB to implement. We recommend the bill state:

  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. 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 believes this section should be more broadly worded and also coordinate with ongoing work by the Vermont Program for Quality in Healthcare and the new Statewide Health Care Delivery Plan and Advisory Committee**. VMS suggests rewording to: *The Board, in consultation with the Vermont Program for Quality in Healthcare and in alignment with the goals of the Statewide Health Care Delivery Plan, shall establish measurements for hospital costs, quality and access.*

Section 6 – Statewide Health Care Delivery Plan

- (b)(2) & (3): Unfortunately, VMS does not believe that a plan can "Ensure access" to all types of health care services and that these sections are not necessary, as section (b)(4) already calls for a review of appropriate allocation of health care resources and services and (6)(A) calls on the plan to identify gaps in care.

Section 7 -Health Care Delivery Advisory Committee

- VMS supports the comments of VAHHS that the legislation should identify specific organizations or sectors that should be represented and allow the

organization to identify the appropriate representatives. VMS recommends looking to Act 26 of 2019 that created the Rural Health Services Task Force as a model.[3]

Section 9 – ACO Capabilities

- As stated at the outset of our testimony, retaining capabilities for payment reform is critical for primary care. **VMS believes that this work should primarily be housed with the Agency of Human Services, including DVHA and the Blueprint for Health, not just the Blueprint for Health**. Those capabilities would more accurately be stated as "**comprehensive payment reform and quality data measurement and reporting,**" rather than related to electronic health records.

Sections 10 & 11 - Positions/Appropriations

- As stated in our prior testimony, VMS has concerns with investing significantly in policy and regulatory staffing when direct services are struggling every day and primary care practices are closing sites around the State. We ask the legislature to first direct any available funding to care delivery rather than building administrative infrastructure; then look to redeploying staff and funding that was being used to oversee the All Payer Model.

Thank you for considering our feedback on your draft Committee bill. 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.

3 https://legislature.vermont.gov/Documents/2020/Docs/ACTS/ACT026/ACT026%20As%20Enacted.pdf?_gl=1*z45gau*_ga*MjExMTUwNzE2LjE2OTQxOTY3Mzc.*_ga_V9WQH77KLW*MTc0MTcyMzc0Mi4yMjkuMS4xNzQxNzIzODgzLjAuMC4w