VERMONT MEDICAL SOCIETY RESOLUTION
As Adopted by VMS Board November 8, 2023

Addressing Ethical Dilemmas in Some of CMS’s Pay for Performance and Value Based Care Programs

Resolved, that the Vermont Medical Society advocate to the Centers for Medicare and Medicaid Services (CMS) and Vermont’s federal delegation to the US Senate and House of Representatives that CMS’ payment reform programs meet the following standards:

1. For-profit corporations including but not limited to venture capital firms should be excluded from serving as contracting intermediaries in CMS-sponsored value-based care programs,

2. Medicare beneficiaries who enroll in the original Medicare program should not be unwillingly or unwittingly assigned to managed care or capitation systems that contract with corporate intermediaries, such as allowed in the ACO REACH and Primary Care First programs; rather beneficiary participation should be selected voluntarily by each individual patient;

3. CMS should encourage enrollment of historically underserved populations in Federally Qualified Health Centers, Rural Health Clinics and other programs organized to facilitate primary care and needed specialty care rather than in programs which impose financial disincentives to primary and specialty care;

4. Information provided to Medicare beneficiaries about contractual payment relationships that their clinicians may enter with CMS or third party intermediaries should be reviewed by a Medicare ombudsman, and important financial relationships in such contracts, including those that may create disincentives to providing care, should be disclosed in language that lay persons would find to be readily understandable;

5. Corporate entities that have been found to commit fraud or other deceptive practices of significant magnitude (i.e. > $100,000,000) should be excluded from participation in Medicare- or Medicaid-sponsored value-based care programs; and

6. A code of ethics should be instituted by CMS, prohibiting for a three-year period former high level CMS officials from assuming positions at industries they have been regulating.
And be it further resolved that the Vermont Medical Society advocate to the New England Delegation to the American Medical Association and to the American Medical Association that AMA Policy H-450.944, Protecting Patients Rights, be amended by adding the same six standards;

And be it further resolved that the Vermont Medical Society reaffirm it’s 2005 Policy Principles for the Development of Pay for Performance Programs (available at https://vtmd.org/client_media/files/vms_resolutions/final%202005%20p4p.pdf) with the following additions:

- Given that approximately 90% of the cost differential between the US and the other developed countries reflects high prices rather than an excessive volume of services, payment programs should refocus on evaluating and addressing the causes of conspicuously high prices of goods and services paid for by the Medicare program and other insurers in the US;

- Programs should not impose ethical conflicts on participating clinicians, such as clinicians facing significant financial loss when their patients require costly procedures; and they should be designed to protect patient access to necessary care, especially patients with expensive, complex illnesses;

- Care coordinators, social workers, and other mental health and substance abuse services targeted to at risk patients should be available to all primary care practices, regardless of whether practices have chosen to engage in financial partnerships with private sector Medicare subcontractors in value-based care programs;

See related:


