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March 15, 2019

Senate Health and Welfare Committee
State of Vermont
115 State Street
Montpelier, VT 05633

Re: S.86 - S.53 - An act relating to increasing the proportion of health care spending allocated to primary care

Sent via email to msuttonsmith@leg.state.vt.us

Dear Chair Lyons and the Senate Health and Welfare Committee,

Bi-State Primary Care Association appreciates the opportunity to provide comment in support of S.53 - An act relating to increasing the proportion of health care spending allocated to primary care. In addition to supporting passage of S.53, we also support the amendment proposed by the Vermont Medical Society on March 14, 2019. We believe that their proposed changes provide important additional details around the framework for analysis that will improve the final result.

Established in 1986, Bi-State Primary Care Association promotes access to primary and preventive care services for all Vermonters through our network of members. This network includes federally-qualified health centers (FQHCs), rural health clinics, Planned Parenthood clinics, and clinics for the uninsured. Our members provide their communities with primary medical, dental, substance use disorder treatment, and mental health services, regardless of insurance status or ability to pay. We cover every county in Vermont. Our members provide these primary care services to 1 in 3 Vermonters, including 37% of Vermont Medicaid enrollees, 32% of Vermont Medicare enrollees, and the majority of uninsured Vermonters.

Strong primary care is critical to the overall health of individuals, families, and communities. For individuals, primary care:

- Provides a place to which patients can bring a wide range of health problems for appropriate attention, in most instances to be resolved without referral.
- Guides patients through the health system, including by providing appropriate referrals to other health professionals for needed services when necessary.
- Facilitates an ongoing relationship between patients and clinicians and fosters participation by patients in decision-making about their health and their own care.
- Provides opportunities for disease prevention and health promotion as well as early detection of problems.
- Builds bridges between personal health care services and patients' families and communities that can assist in meeting the health needs of the patient.

On a larger population level, we see the impact of strong primary care in both improving overall health and reducing costs. A healthier population allows for fewer lost productive days in our schools and at our Vermont companies. Decades of research, and peer-reviewed medical articles, demonstrate this fact. Studies have found that states with higher ratios of primary care physicians to population have lower smoking rates, less obesity, reduction in hypertension complications, and fewer hospitalizations across a broad range of conditions. An ongoing relationship with a single primary care provider produces a higher rate of accuracy in diagnosis. The correlation between better primary care and better overall health outcomes, including lower all-cause mortality, holds true when comparing countries and when comparing U.S. states and regions. Those countries with higher primary care and prevention investment have a healthier population. Strong primary care also enables us to maintain strong specialty care and emergency departments, as it prevents inefficient use of these services by patients who do not require them.

Even though Vermont leaders agree that primary care is essential, we do not have a strong understanding of the proportion of health spending that currently goes towards primary care or trends over time. Vermont needs an agreed-on framework to measure these investments and thereby build a stronger foundation for future policy work.

We recognize that primary care spending is difficult to measure. The Green Mountain Care Board's recent work exploring this measurement illustrates some of the challenges. For example, some definitions of primary care focus on who performs medical services, while others focus on the services themselves. Only some primary and preventive care services are attached to specific claims, others are bundled (or will soon be bundled) into capitated payments, while still others are paid through separate contracts or other vehicles. There are also challenges in capturing all of the supportive services that facilitate access to primary care for the most vulnerable Vermonters. Plus, when we apply the data to policy decisions, we need to understand how factors like demographics and geography affect appropriate baseline spending ratios – for example, younger populations will necessarily require more of some types of primary services than older ones. Beyond these questions, there is the fundamental issue that, for any of this information to be useful, we need broad agreement on framework and its consistent application, or we will not be able to compare information across groups or discern trends over time. Bi-State believes that this complexity indicates the need for an in-depth study incorporating guidance from key stakeholders and that S. 53 responds to that need.

Please let me know if you have any questions. I can be reached at gmaheras@bistatepca.org or 857-234-5171.

Thank you for your consideration,

Georgia J. Maheras, Esq.
Vice President, Policy and Programs