House Committee on Health Care
April 17, 2022

Rep. Lippert (Chair)
Rep. Donahue (Vice Chair)
Rep. Houghton (Ranking Member)
Rep. Cordes (Clerk)
Rep. Burrows
Rep. Cina
Rep. Goldman
Rep. Long
Rep. Page
Rep. Peterson

Clare Neal (Committee Assistant)

Thank you for the opportunity to provide written testimony on S.285 – An act relating to health care reform initiatives, data collection, and access to home-based and community-based services.

I agree with Sen. Lyons and Michael Fischer, the current system is not working:

- Premiums on VT health connect marketplace start at $700 for families that don't qualify for subsidies (like mine)

- Preventative care like physical therapy and exercise classes are unaffordable and therefore not accessible to common folks

Furthermore, we should recognize that activities and resources that affect 80% of health quality outcomes (such as food, housing, education, wealth, etc.) are NOT currently part of the healthcare system. Nor does this reformation bill explicitly including them as part of services or quality metrics that are covered under hospital payment/analytics models.

Find below my signature, specific amendments I would propose.
Thanks again,

~Wichie~
Wichie Artu – Health Equity Consultant and Data Systems Expert

SECTION 1 | Value-Based Payment Design

In traditional value-based models, fee-for-service is supplemented by bonuses based on quality outcomes. It also includes penalties for hospitals that perform as the bottom 25%. In an environment where hospitals struggle to meet quality metrics due to insufficient resources, we should explicitly prohibit resource allocation penalties for not meeting quality metrics.

In (3), we are proposing to use market-based metrics as benchmarks for growth in the health care industry. While I agree that benchmarks should be established, I would propose to explicitly require an analysis of existing biases and assumptions within these algorithms. For example, a sampling base with a disproportionate number of abled people would lead to biased benchmarks against people with disabilities.

SECTION 2 | Community Engagement

(a) When we engage with "one or more consultants with expertise in community engagement", I'd like to draw attention to VDH's HECE team (Health Equity and Community Engagement Team) who have been doing tremendous work in filling health service gaps for our most vulnerable populations. I would recommend they get explicitly included as one of the stakeholders brought in to give advice on engaging our communities and addressing on-the-ground health needs.

(a)(1) "facilitating patient-focused, community-inclusive plan" doesn't explicitly include patients or asks for community collaboration in the design of that plan. Many a times throughout the pandemic, the government has designed the "plan" and THEN included community members. There have been several reports, including that of the Governor's Racial Equity Task Force, that suggests the community be involved in designing plans before it gets pushed through; community representatives should have a say before resources are allocated. This should be explicit.

(b)(1) If we are to extract information from people in the community engagement process, this should be compensated. Asking under-resourced community members to provide free labor is inconsiderate – and should be construed as a form of slavery (i.e. free labor).

(b)(2) Health administrators – such as those involved in the revenue cycle (e.g. registration processes and denial claims analysts), should be included in the engagement of those "who have direct experience with … aspects of Vermont's health care system".

(c) As we "strengthen" the role of primary care, it is important to recognize the oppressive nature of western medicine as the established supreme and traditional way of providing primary care. Strengthening should explicitly involve input especially from indigenous communities. Furthermore, it is important to remember that in primary care, the following communities are traditionally ignored and not catered to their particular needs: Deaf and hard of hearing (i.e. no interpreters available), LGBTQ+ community (i.e. competency around STDs, varied body part inventories, and more), and poor folks (sensitivity to environmental and societal conditions).

SECTION 9 | 18 VSA 9375 amendment

(e) If reports are to be able to be read by the public, testing groups are needed before publication.