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To:
Senate Committee on Health and Welfare

From:
Helen Labun
Director of Vermont Public Policy
Bi-State Primary Care Association

April 20th, 2021

Thank you for the opportunity to comment on behalf of Bi-State Primary Care Association regarding S. 120 and related topics in health care reform.

Primary care practices rely on payment reform to allow us to better serve our patients and communities. The fee-for-service structure reflects an outdated care model. It incentivizes an ever-greater volume of costly medical services, drives up overall health care costs, and fails to support a holistic approach to care that would prioritize upstream prevention over downstream treatment. Value-based, prospective, capitated payment models can provide both revenue stability and also flexibility in designing care to best serve the needs of our communities. For Federally Qualified Health Centers, flexibility is particularly important. This payment model would support more frequent patient engagement in managing chronic conditions, assistance with social determinants of health such as food and transportation, coordination around transitions in care setting, and basic funding for care teams that reach beyond the clinical staff.

Moving from fee-for-service to value-based payment methods goes beyond running the numbers to calculate new reimbursements.

Successful reform efforts require alignment between payers. Having a half dozen different payment models prevents meaningful change to how care is delivered. Successful payment reform also happens hand-in-hand with delivery reform, to implement new, more effective care models that are supported by new payment methods. Support for new delivery models includes funding, but also other benefits such as federal waivers, data sharing and analysis, and coordination with other practices. Coordination includes the ability (and incentive) for hospitals to invest in upstream interventions. We also need support for the infrastructure that allows us to change care models, for example through telehealth, remote patient monitoring, and other tools. A critical element in all of this work is stability in the state's vision for moving forward in health

care reform. Bi-State hears regularly from our members that lack of a sense of a shared goal and extreme uncertainty in the future limits their ability to invest in change.

The All Payer Model creates a framework where state initiatives can align with federal investments. It allows us to access federal funding for programs like the Blueprint and SASH, and to negotiate new payment structures for Medicare beneficiaries. This arrangement also accesses critical federal waivers. For example, without this agreement, Chittenden County residents would be ineligible to participate in telehealth, as they are in an urban county. Without an ACO structure, hospital investment in primary and preventive care would be prohibited, and we could not share data and support teams. As a practical matter, with only 624,000 residents, not all of whom receive their care in Vermont, it would be difficult to design an actuarially sound prospective payment system or global budget system without all payer types and all provider types participating in a common effort.

The COVID-19 pandemic highlights the need for these changes. Our members have experienced significant disruptions in patient volume and have needed to find new ways to serve their patients. COVID-based changes also include a rapid increase in demand for non-clinical services, such as assistance in food access.

Finally, payment and delivery reform are a necessary foundation to any efforts the state undertakes to reduce health insurance premiums or subsidize insurance plans.

The All Payer Model does not directly address premium costs or pharmaceutical costs; it contains the growth of the total cost of care and it can reduce drug costs by shifting the focus from treatment to prevention. We recognize that this structure leaves the Legislature looking for additional policy options. We support reducing health care insurance costs for individuals. However, if Vermont were to decelerate payment and delivery reform efforts while accelerating direct intervention in premium costs, we would place the state on a path to pour increasingly more funds into a broken health care payment structure. We do not believe that S. 120 as currently presented reflects this reality, but rather throws a brake on health care reform at a time when progress is more important than ever.

Thank you for considering our testimony.

Sincerely,

Helen Labun
Director, Vermont Public Policy
Bi-State Primary Care Association