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Testimony on S. 285 for the Senate Committee on Health and Welfare
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Madame Chair, Members of the Committee, I want to thank you for the opportunity to provide testimony on S. 285, a bill to expand the Blueprint for Health, Moderate Needs Group services, and development of a global budget. These comments represent the perspective of Bi-State Primary Care Association members.

Bi-State Primary Care Association is nonprofit organization established in 1986 to advance access to comprehensive primary care and preventive services for anyone regardless of insurance status or ability to pay. Today, Bi-State represents 28 member organizations across both Vermont and New Hampshire. Our members include Federally Qualified Health Centers (FQHCs), Vermont Free and Referral Clinics, Area Health Education Center programs, and Planned Parenthood of Northern New England.

I would like to speak to a few sections of the bill, specifically Sections 1 – 4. First, I want to thank the legislature for looking at affordability and accessibility of health care. With sliding fees or no cost barriers to care, affordable and accessible care is at the heart of Bi-State members' mission. However, far too many Vermonters still struggle with paying for care or finding an appointment.

Sections 1 and 2 of S. 285 seek to address these challenges through the development of global budgets. Bi-State and its members are not opposed to the goals of global budgets; however, we recommend that the process for developing such a significant shift in the health care system should first focus on the next agreement with the federal government and also include health care providers in a central role. We make these recommendations for three reasons.

First, the state has a compressed timeline to develop a proposal for the next federal agreement following the current Vermont All-Payer Accountable Care Organization Model Agreement. The Office of Health Care Reform, which is leading this effort, has indicated that this October is the target deadline. Any development of a hospital global budget that involves Medicare will have to be done in the context of that proposal. Furthermore, any other reforms such as FQHCs pursuing value-based care models will need to understand how the next agreement would implement these new models. So, the conversation that needs to happen first – with provider and community input – is the development of the next federal agreement proposal.

Second, we are coming out of a once-in-a-century pandemic. COVID-19 has strained our health care organizations, our providers and staff are exhausted, and we are still working to understand the long-term implications of a disruption of this scale. The health care system needs to understand the full impact of delayed care on health and health service utilization, which modes of care will continue, and which will revert to pre-pandemic models. Significant transformations in the health care system, such as global budgets, should be approached with these considerations.

Third, the discussion on global budgets cannot happen in a silo. A successful hospital global budget will require robust primary care, mental health, and community services. Without these, global budgets could have a negative impact on hospitals' sustainability. For example, primary care with appropriate resources is needed to improve wellness, prevention, care management, and care coordination to reduce potentially avoidable, high-cost hospital care. Free and referral clinics provide a no-barrier point of entry to the health care system by providing care and connecting patients to primary care clinics. Federally Qualified Health Centers have long focused on social determinants of health and integrating oral health, mental health, substance use disorder treatment, school-based programs, women's health, and physical health. This whole person patient-centered approach is an important model that can support the goals sought through a global budget and needs to be part of the conversation.

On Sections 3 and 4, Bi-State members support the language that increases funding to the Blueprint for Health Community Health Teams and Quality Improvement Facilitators. This increased funding could also meet the goals set out in S. 244 to increase payer support for primary care. The Community Health Teams provide vital services to our members' patients by expanding on the FQHC's model of integrated whole person care. Quality Improvement Facilitators, previously known as Practice Facilitators, have had an important role in preparing practices for patient-centered medical home recognition and on-going quality improvement initiatives. As primary care increasingly looks to shift to value-based care, practices will need additional facilitated support to make necessary clinical transformations that best align with new payment models. This type of clinical transformation will be most effective if done across a clinic's full patient population, and not segmented by payer type. The payer-agnostic approach has been one of the enduring strengths of the Blueprint program.

I am happy to take questions on any of the above recommendations. Thank you again for the opportunity to testify.