Thank you. For the record, Ena Backus, Director of Health Care Reform, Agency of Human Services.

We appreciate the work of the committee in the updated version of S.285 to acknowledge the importance of including community-based providers in health care system redesign.

Over the last two years, the State of Vermont and the Agency of Human Services have been partnering with providers across the health care system to respond and adapt to the unprecedented global health pandemic.

We are proud of the ways that our system has come together to ensure care for the sick including those with COVID-19, to establish a statewide network of testing centers, provide large scale vaccination opportunities, and much, much more. Vermont has one of the lowest rates of death due to COVID-19 in the country, owing to this spirt of collaboration.
Today we can clearly see some of the ways that the health care landscape in Vermont, and the country, has been altered by the pandemic. Two key examples are:

1. We recognize that one of the non-COVID risks of the pandemic is delays in preventive care and treatment; people are now arriving in the health care system with more acute need for care because of these delays in preventive care.
2. Workforce shortages stemming from the pandemic are particularly acute in the health and human services system where there is no substitute for the human beings who are essential caregivers.

As we turn to recovery and revitalization after these two years of COVID-19, we are implementing the workforce development strategic plan and investing in short, mid, and longer-term strategies to address significant workforce challenges in the health and human services system. Similarly, our approach to health care reform will be necessarily informed by the impact of COVID-19 on the system of care.

However, I want to take this opportunity to expand on the concerns we've previously articulated about how the bill as written is providing significant resources and support for hospital global payments when it is also essential that any system redesign and subsequent proposal for an all-payer model agreement include accountability for total cost of care and not only the care and services delivered by hospitals.

#1 The Agency has been clear that the predictable, prospective payment models that Medicaid put in place prior to the pandemic created some stability during the pandemic. When visits to health and human services providers sharply declined in the early days of the novel infectious disease, the fee-for-service revenue generated by these visits also fell away. For providers who were participating in predictable prospective payment models, the steady Medicaid revenue provided some stability during this challenging time.

#2 We also support exploring hospital global payments because this model, depending on its design, may provide stronger incentives to redesign care and to support upstream strategies that impact health and wellbeing and move toward value-based care.
But I want to be very clear, hospital global payments in isolation can have unintended consequences. Hospital global payments alone can result in inappropriate shifting of hospital-based services to outpatient settings that are not covered by the global budget--for example, discharging a patient to another care setting before clinically appropriate. Furthermore, in Vermont where patients travel between hospital services areas frequently and regularly to access care, a system of hospital global payments in isolation would require complicated and frequent recalibration of budgets. For these reasons, I urge the committee to consider that support be provided not only for hospital global payment design but also for the design of a total cost of care accountability structure that includes health care expenditures beyond hospital only services.

As we explore a next potential agreement with Medicare to participate in an all-payer approach in Vermont, we need to ensure that we are using our resources to explore not just hospital global payments but also the potential for broader global budgets inclusive of community-based providers, and again, that our plan includes a strategy for total cost of care accountability and that this plan incentivizes the health care continuum to work collaboratively across service types to deliver high quality care in the least costly, most appropriate settings. Vermont's All-Payer Model agreement includes accountability for the total cost of care and services, both hospital and non-hospital services. Maryland, another state that has implemented hospital global payments also has a total cost of care accountability model in companion to hospital global payments. It is this total cost of care overlay that creates incentives for care to be delivered in the most appropriate settings and to ensure that care is not withheld.

As the Director of Health Care Reform, I, and the Agency of Human Services must approach health care reform through the lens of the full care continuum, both upstream and downstream, not just from the perspective of hospitals. If resources are provided to inform Vermont's future health care reform direction these resources should steer towards a comprehensive plan for reform, inclusive of a total cost of care approach, rather than an approach that is siloed to hospitals alone.

As you know, in my position I am required to coordinate health care reform initiatives across state government and with the Green Mountain Care Board. When it comes to exploring frameworks for a potential next agreement with the federal government, the responsibility is coordination between the Green Mountain Care Board and others and to ensure that a plan for a future federal agreement includes an approach to total cost of care.

Third, concern, which I believe the Green Mountain Care Board with Agree with: The Green Mountain Care Board's purview does not extend across the health and human services care continuum and yet providers have to work together across care settings for care redesign to be successful. The Director of Health Care Reform in the Agency of Human Services is more ideally situated to ensure that the approaches and frameworks that we explore are inclusive of care and

services across the continuum and that the resources that we have to promote integration are appropriately brought to bear in the health care reform context. For example, the Blueprint for Health Patient Centered Medical Home program which is funded today, in part, through the All-Payer agreement with CMS has been and will continue to be a critical component of how Vermont invests in and supports primary care—a successful shift away from fee-for-service reimbursement does and will continue to rely on a strong primary care approach. We urge the committee to incorporate these important considerations into S.285.

Lastly, my fourth concern: as Chair of the Health Information Exchange Steering Committee, we'd like to propose an alternative approach to harness claims, clinical, and social determinants of health data to support the Steering Committee's ongoing work to promote one health record for each person. This is a path on which the Steering Committee has already embarked and we can report that we have tested the integration of Medicaid claims data with clinical data in the HIE. Because there are already established tools within the HIE to create an integrated, longitudinal record we do not think it is necessary to also create an Enterprise Master Patient Index. Here is a proposed alternative for the committee to support this work:
The Health Information Exchange (HIE) Steering Committee shall continue its work to create one health record for each person that integrates data types to include health care claims, clinical, mental health and substance use disorder services data, and social determinants of health data. In furtherance of these goals, the Health Information Exchange Steering Committee will include a data strategy in its 2023 Health Information Exchange Strategic Plan to merge claims data in the Vermont Health Care Uniform Reporting and Evaluation System (VHCURES) with the clinical data in the HIE.

With that I will close my testimony and express my gratitude to the committee on your continued interest in hearing from me and will take any questions. I will submit my written testimony.