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January 31st, 2020

AHS Medicaid Policy Unit
280 State Drive, Center Building
Waterbury, VT 05671-1000

Submitted via e-mail to AHS.MedicaidPolicy@vermont.gov

Thank you for the opportunity to comment on proposed changes to the Vermont Medicaid Next Generation Model (VMNG) ACO Program regarding attribution methodology, GCR 19-084.

Bi-State Primary Care Association is a 501(c)3 nonprofit organization, formed by two health and social service leaders in 1986 to expand access to health care in Vermont and New Hampshire. Today, Bi-State represents 31 member organizations across both states that provide comprehensive primary care services to over 300,000 patients at 142 locations. Our members include federally qualified health centers (FQHCs), clinics for the uninsured, rural health clinics, Area Health Education Center programs, and Planned Parenthood of Northern New England. In 2020, nine of eleven Vermont-based FQHCs are participating in the ACO for their Medicaid populations.

We support the proposed policy change to the new attribution model for the VMNG ACO Program, and we believe that it will support several key goals of our members.

Through their status as FQHCs, our members take responsibility for the health of their entire communities. They are charged with accepting all patients regardless of insurance status or ability to pay; providing preventive care within their community; designing strategic plans that match broad Community Health Needs Assessments; investing in services that increase access to primary and preventive care for community members who might experience barriers to care. An ACO attribution model that focuses on being part of the community and is not restricted by existing relationships with individual providers matches this mission.

The change in attribution also supports an underlying premise of the Next Generation ACO model, which is that engaging more people in health care earlier leads to higher quality outcomes and lower overall cost. We have a goal of reaching a time when every Vermonter sees a primary care provider regularly. Until that time, there will always be a population we are bringing into primary and preventive services after a gap in their care history – this attribution change reflects where we are in that process.

The proposed policy change helps with the stress our providers feel in running operations with different populations in different payment structures. FQHCs are part of the front line in providing preventive care and bringing new patients into primary care, to do their job well they would engage relatively more patients who do not meet the test for an existing relationship with a primary care provider. Their systems for paying for these patients have fallen outside of the ACO model. The new attribution system would bring these patients within the core structure of value-based payment.

As with any change to the ACO framework, it is important to undertake this change in a way that engages all providers across the network. It is also important to note that changing the underlying payment structure to support bringing new people into primary care will not be sufficient if we do not also provide investment for practice change in pursuit of that goal.

Thank you for your consideration of these comments.

Sincerely,

A handwritten signature in black ink, appearing to read 'H. Labun', with a long horizontal line extending to the right.

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