Thank you for the opportunity to comment on the Draft Public Transit Policy Plan.

Established in 1986, Bi-State Primary Care Association promotes access to primary and preventive care services for all Vermonters through our network of members. This network includes federally qualified health centers (FQHCs), Planned Parenthood clinics, and clinics for the uninsured. Our members provide their communities with primary medical, dental, substance use disorder treatment, and mental health services, regardless of insurance status or ability to pay. We cover every county in Vermont. Our members provide these primary care services to 1 in 3 Vermonters, including 37% of Vermont Medicaid enrollees, 32% of Vermont Medicare enrollees, and the majority of uninsured Vermonters.

As cited in the draft plan, providing basic mobility for Vermonters that allows them to access essential services such as primary health care is a key goal for the state. Also as recognized in the plan, there is a growing consensus that a key part of our health is the ability to access not only health care providers but also activities that facilitate wellness, such as healthy food and positive social interaction. We support these priorities.

We know that transportation is a key barrier for Vermonters, and particularly rural Vermonters, in accessing health care. A 2019 survey conducted by VPR / VT PBS found that when Vermonters can't access health care they need, 31% say difficulty reaching the location is a significant factor. That's more than the national rural resident average, where 23% say travel is a barrier to care, according to the Robert Wood Johnson 2018 rural life survey. In the aggregated Community Health Needs Assessments for Vermont hospitals compiled by the Green Mountain Care Board (June, 2019), transportation was the number one barrier to care listed by key stakeholders – 80% of stakeholders identified this as a major barrier, significantly above the next most commonly cited barrier which was the inability to pay out of pocket expenses (54%) followed by difficulty navigating the health care system (49%). The State Health Improvement Plan (2018) also cites this critical need. An additional nuance, supported by the trends outlined in this transit plan, is that accessing health care centers is not only a matter of accessing health care, but also one of accessing employment, as health care is the largest and fastest growing sector of our economy.

Bi-State's members have a long history of working with their patients to overcome barriers such as transportation. In fact, FQHCs are required to assist in transportation as part of their operating agreement with the federal Health Resources and Services Administration (HRSA) and they are measured on their performance as part of what HRSA terms Enabling Services. We do not believe this report's characterization of transportation as an "afterthought" for our providers is fair or supported by evidence.

Our members go beyond the basics in helping access services such as transportation. For example, Springfield Medical Care Systems launched an innovative new program in 2012 called "Health Transit." This program involved collaboration with Springfield, VT area community partners, including the Blueprint for Health-supported Community Health Team, to develop an algorithm that could be used to help patients and family members overcome a variety of

transportation barriers. It was presented to VTrans and eventually evolved into the Rides to Wellness pilot now being trialed in Windsor and St. Johnsbury.

It is our understanding that Springfield's pilot was originally funded by the Fanny Holt Ames and Edna Louise Holt Foundation, then folded into their baseline 330 grant funding through a HRSA program that is no longer offered. As this transit plan points out, best practices for providing the funding to address social determinants of health, such as transportation, are still evolving. The shift towards value-based payment is part of the answer. However, the ultimate goal of value-based payment is to contain health care costs while delivering better health outcomes, not to shift the financial burden for public and social services onto the health care sector. We believe that these investment patterns require a deeper conversation that covers the broader system of social determinants of health and how different funding sources work together. We would welcome an opportunity to look more closely at this important issue.

One important support system for transportation assistance has been Medicaid non-emergency transportation funds. We are grateful for this support. At the same time, we would welcome a dialogue that looks at whether the current structure matches realities of our Medicaid patients' lives and, in particular, the lives of people who are working or reentering the workforce. Two examples that our members use to illustrate the potential disconnect are:

- Transportation needs to be arranged to and from the home, which limits the ability of working Medicaid recipients to utilize the service. This restriction becomes particularly onerous in Substance Use treatment and Medication Assisted Treatment programs. Our understanding is that DVHA is piloting a new project to consider the transportation needs of Substance Use Disorder patients in particular and we welcome those results and opportunities to expand the pilot.

- Restrictions on the age of children that can accompany parents becomes difficult when parents need appointments outside of working hours, which often means outside of the school day, and cannot bring school age children with them. Again, this policy may not adequately reflect the fact that many Medicaid recipients are currently employed or support Medicaid recipients on the road to full time employment.

We also continuously look for ways to reduce administrative burden related to these services. We look forward to continuing to collaborate with the state to address these types of concerns.

Another critical strategy for reducing the transportation barriers to health care is to reduce the number of times Vermonters need to travel *at all* to health care appointments. Technology may provide part of the solution. Vermont already recognizes telemedicine (live video feeds between provider and patient) as a reimbursable alternative for an in-person patient visit. However, some commercial providers only reimburse these visits at half the normal rate and Medicare does not recognize FQHC clinicians as telemedicine providers, limiting the utility of that tool for our members. While we work on finding solutions to telemedicine bottlenecks, other telehealth tools are extremely promising for reducing unnecessary visits. Remote patient monitoring could allow clinicians to track patients with a range of conditions and check in more frequently (but with less travel) on their health; allowing brief eVisits through platforms other than live video feed (as is

now recognized by Medicare) would make this tool more broadly useful including to patients who can't access highspeed broadband; reimbursing eConsults (provider-to-provider communications) has significant promise for allowing more health issues to be handled through primary care without additional specialist visits. In existing eConsult systems, the opportunity for a primary care provider to bring in a specialist opinion *before* making a referral has led to dramatic reductions in unnecessary visits – ConferMED reports 69% of eConsults resulted in an avoided unnecessary specialist visit, AristaMD reports 74%, our colleagues in upstate New York who have started using these systems report that the 70-74% estimates appear accurate.

All Vermonters benefit from reducing unnecessary travel related to health care, health care providers benefit from being able to more efficiently use their time, and the environment benefits from fewer vehicle miles traveled. For example, UVM Medical Center estimates that in 2018 their early-stage telemedicine video visit programs avoided 47,000 driving miles, 1007 hours of driving time, and 6.6 tons of CO2 emissions. These estimates appear as part of the Rural Health Services Task Force's telehealth recommendations. As this transit report points out, technology has opened up more avenues for managing transportation challenges than ever before. We support a statewide effort to effectively implement the most promising telehealth tools as a strategy to support patients, providers, and travel reduction goals.

Bi-State Primary Care Association would welcome participating in an ongoing conversation around transportation as part of health care. In addition to the recommendations already specified in this draft public transit policy plan, we support:

- Looking more critically at the intersection of health care funding and social determinants of health – either beginning with the Rides to Wellness program as a case study, or with transportation included as a core focus within a broader initiative.
- Reviewing how Medicaid transportation policy matches today's needs.
- Pursuing more options for how to avoid unnecessary travel, including through strategic use of telehealth tools.

Thank you for your review and consideration of these comments.

Sincerely,

Helen Labun
Bi-State Primary Care Association