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Testimony on S.151, Draft 3.2, before the Senate Health and Welfare Committee

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Madame Chair, Members of the Committee,

Thank you for the opportunity to provide comments on S. 151, draft number 3.2. I am providing comments today on behalf of Bi-State Primary Care Association members. As I mentioned, these written comments are updated from my verbal comments, which were based on draft number 2.1.

Bi-State Primary Care Association is a 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, and Planned Parenthood of Northern New England.

The first section that I would like to address is Section 7. Primary Care Investment Target; Report. We are supportive of all efforts that increase investment in comprehensive and integrated primary care. Bi-State and its members would be pleased to participate in an initiative aimed at developing a proposal for an all-payer primary care investment target. Including the perspective of federally qualified health centers, free and referral clinics, and Planned Parenthood clinics will address a variety of ways that Vermonters access and receive primary and preventive care. Furthermore, each of these providers receive payments for the services in different ways, which should be considered and incorporated into how Vermont invests in primary care.

The second section is Section 11. Medicaid Budget. As currently written, Section 11 would have no impact on Medicaid reimbursement to FQHCs. Federal statute lays out the minimum rates that state Medicaid programs must pay FQHCs. While Bi-State, FQHCs, and DVHA continue to work on updating FQHCs' minimum required rate to reflect their current scope of services and populations served as intended by federal law, the legislature could set a state minimum. A couple options the legislature could consider would be fully funding the alternative payment methodology presented by DVHA in its October 16th report to the legislature or setting a state minimum payment for FQHCs at 125% of higher of the Medicare FQHC PPS. Of note, the Medicare PPS rate covers a narrower scope of services and providers and is therefore generally lower than the Medicaid PPS rate, which is why we recommend setting the minimum at 125% or higher of the Medicare PPS.

The final section I will comment on is Section 12. Green Mountain Care Board; Health Care Contracts, Fee Schedules; Report. While Bi-State supports an analysis of reimbursement rates with the goal of increasing equity across health care providers and health care settings, we recommend that the analysis also consider the regulatory and quality reporting requirements of those providers. Primary care, while generally receiving lower reimbursement rates, often bears the highest reporting burdens. For example, FHCHs must report on Blueprint quality measure, PCMH recognition standards, and HRSA's Unified Data System (UDS) measures (which include quality, patient demographics, financial, and workforce data), and host regular onsite visits from HRSA to ensure compliance with FQHC operational and quality standards. The variation in the regulatory and quality reporting requirements should be evaluated as part of improving equitable reimbursement policies.

Thank you again for the opportunity to comment on S.151, Draft 3.2. I am happy to answer any questions.