TESTIMONY ON S.53
Senate Health & Welfare Committee
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My name is David Reynolds and I am testifying on S.53 as an interested citizen, not representing any organization. I was asked to testify on the "need to prove with hard data and experience that primary care is an investment that saves money in the long term." I have that proof based on over 40 years of experience devoted to expanding primary care and proving its cost-effectiveness. In 1976, I established the first Vermont network of community health centers (a.ka. federally-qualified health centers - FQHCs) in the Northeast Kingdom, and subsequently, conducted doctoral research on community health center cost, quality, and effectiveness. Later, as Senator Bernie Sanders' senior health policy advisor, I negotiated the provisions of the Affordable Care Act that led to the largest expansion of community health centers in the program's history.

In preparing my testimony, I reviewed the "Report on Universal Primary Care" prepared in November of 2016 in accordance with Act 172 of 2016, Section E.100.10. I was surprised to read:

> No studies directly exploring the cost savings attributable to universal access to primary care were found in the literature. (page 3)
>
> . . . there is no precedent for universal primary care . . . (page 5)
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> A total of 13 studies investigated the cost savings from a primary care intervention in the US. (page 7)

The report ignored the largest & longest-lived primary care delivery systems in the US. Community health centers (FQHCs) have a 52-year history of well-studied effects in providing not only universal, but importantly, comprehensive primary care in the communities they serve and achieving significant cost-savings in doing so. Today, almost 10% of all Americans, and 25% of Vermonters, in every county of the state, receive universal, comprehensive primary care at their FQHC. Echoing goals in S.53,

> They (FQHCs) are required to provide care to all residents regardless of insurance status. They provide free or reduced-cost care based on the ability to pay.[1]

In terms of their comprehensiveness, the NACHC report also notes:

> Health centers provide a comprehensive array of services tailored to their community needs and generally not found in other primary care settings. Health centers provide dental, behavioral health care, and pharmacy services. They also provide services – such as transportation, translation, case management, and health education – that facilitate access to care and make health care more culturally and linguistically appropriate . . .

Regarding cost-savings, a report from George Washington University[2], estimating the impact of FQHC expansion under the Affordable Care Act, found that in 2009, health centers' users had *total* health care costs that were $1,262 less than non-users. Extrapolating this to Vermont's total population, minus those already patients of health centers, would result in a savings of approximately $637,000,000.

This is consistent with other studies since 1975 and in a variety of states. Without much effort, I found a few examples demonstrating this, just from the Geiger Gibson/RCHN Community Health Foundation Research Collaborative at George Washington University:

> Health care services provided at Indiana CHCs ("I-CHCs) are less costly than health care services provided at other outpatient settings. In Indiana, expenditures per I-CHC patient were $1,529 compared with $2,924 at other outpatient settings, resulting in a savings of $1,395 per patient.[3]

[1] From a summary of research findings in "Community Health Centers: The Local Prescription for Better Quality & Lower Costs," page 7, National Association of Community Health Centers (NACHC), March, 2011.
[2] Ku, Leighton, et al, Department of Health Policy, George Washington University, "Using Primary Care to Bend the Curve: Estimating the Impact of a Health Center Expansion on Health Care Costs," pp. 7-8, September, 2009
[3] Dor, Avi, et al, Department of Health Policy, George Washington University, "Community Health Centers in Indiana: State Investment and Returns," July, 2009

> On average, total annual health care spending for North Carolina patients served by health centers was 62% less than for patients with similar health status and demographic characteristics served in other ambulatory care settings.[4]

And, in a national study:

> Compared to those who received care from other types of providers, and after adjusting for their underlying differences, children cared for by CHCs had annual health care costs about 35% lower than other children ($1,133 if all children used CHCs vs. $1,751 if all children used other providers).[5]

Given this proven cost-saving and their ability to provide both universal and comprehensive primary care, I believe an expansion of FQHC sites in Vermont could achieve even more than S.53 seeks to do. Furthermore, in my estimation, it could do it easier and quicker.

First, such expansion would address some of the JFO concerns with implementing S.53. Since FQHCs exist, there would be no need to establish and pay for a new state administrative structure or payment system. Payment mechanisms already exist for FQHCs under Medicare & Medicaid. There would be no need for a waiver from Medicare or Medicaid, nor for state dollars to have to supplement Medicare payments to primary care providers. Such state supplements were estimated to be over $11 million dollars without cost-sharing in the "Report on Universal Primary Care," submitted by the Agency of Administration. There are no ERISA implications or roadblocks.

[4] Richard, Patrick, et al, Department of Health Policy, George Washington University, "Bending the Health Care Cost Curve in North Carolina: The Experience of Community Health Centers, August, 2011.
[5] Bruen, B. & Ku, L., Department of Health Policy, George Washington University , "Community Health Centers Reduce the Costs of Children's Health Care," June, 2017.

Second, FQHCs only need to obtain a change in scope for their service area from DHHS in order to expand, as long as additional federal funding is not requested. When first established, they must be in a medically-underserved area, but then are free to expand to other areas.

I believe expansion of FQHC sites statewide would fit well with the all-payer model, and can offer cost-savings to providers and patients not possible by an ACO. Indeed, a statewide ACO would be wise to support and link with this effort since it can help reduce costs of operations and lessen risk. For one example, FQHC providers do not pay for malpractice insurance; they are covered by the federal government under the Federal Tort Claims Act.

In addition to health care system benefits, statewide expansion of FQHCs has benefits for both medical providers and their patients. While eliminating the expense of malpractice insurance, provider practices would also be relieved from the burdens of administering their practice. (Combining administration of small practices under an existing FQHC would create economies of scale, further reducing system costs.) Since FQHCs are charged with meeting local needs and conditions, providers integrated within a FQHC would be able to influence and achieve a broader array of services than they are able to now. For their patients, there would be access to lower costs for prescriptions, access to dental care offered on a sliding scale, and a range of ancillary services that address the social determinants of health.

My problem with S.53 is that, while it has a worthy goal of expanding primary care, I believe that, in asking the state to further subsidize patients and practices, it basically maintains the status quo. Universal coverage does not equate to comprehensive primary care, which is what will have the greatest impact on costs, as proven by FQHC research. I believe there needs to be a return on investment, a quid pro quo, if the state is to invest further in primary care.

I would propose a legislative approach that would designate "state-qualified health center areas (SQHCAs)," eligible for FQHC expansion. Basically, this would be the communities in Vermont which do not have a FQHC. Existing medical practices in these areas would have the option of joining a FQHC network voluntarily or remaining independent. If independent, current reimbursement would continue. Much like the reasons for their federal support in underserved areas, expanded FQHCs would be eligible to apply for a state grant to cover sliding scale-eligible users and non-reimbursable support services in the SQHCAs, should federal funding not be possible.

While a formal financial analysis is needed, it is my strong belief that the cost of this to the state would be far less than anticipated in the Agency of Administration's 2016 "Report on Universal Primary Care." And, in fact, the savings might well exceed the cost outlay, based on extensive, well-grounded research on FQHCs and the cost-saving features available through FQHCs. So, yes to universal access, but let's make it comprehensive through a proven vehicle.

Thank you for the opportunity to testify.