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Testimony on S. 244 before Senate Committee on Health and Welfare

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Thank you, Madam Chair, Members of the Committee, I first want to thank you for your continued support of primary care and the opportunity to discuss S. 244 and provide Bi-State's members' perspective.

Bi-State Primary Care Association is 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, Area Health Education Center programs, and Planned Parenthood of Northern New England.

Role of Primary Care

Robust primary care is essential to the transformation of health systems in Vermont. FQHCs who serve 1 in 4 Vermonters are an important part of that primary care foundation. However, for FQHCs to continue to offer the level of services they currently provide AND to serve in this transformational role, funding needs at a minimum to cover the cost of care. This bill, S. 244, takes an important step in that direction.

Core to primary care's role is improving population health, coordinating care across multiple health and community partners, and treating the whole person by including the social factors that affect their well-being. Bi-State members serve this role for all Vermonters, but especially for uninsured, underinsured, and vulnerable populations. For example, FQHCs offer sliding fee scales based on income and family size. Health centers also integrate mental health services, substance use disorder treatment, and oral health services along with primary care. Planned Parenthood offers access to critical family planning and reproductive health services, and the Free Clinics, which are funded by state grants, do not have any cost-sharing barriers to care. These clinics along with Referral Clinics act as important entry points to the health care system, including connecting Vermonters to primary care homes.

FQHCs have been leaders in addressing social determinants of health. I toured our member sites when I first joined the Bi-State team and saw shelves in waiting rooms filled with food, baby diapers, and other supplies available to anyone at no cost. Many of our members are working to address food insecurity by providing supermarket gift cards, running a grocery store, or supporting cooking classes.

The Health Resources Services Administration (HRSA) requires that FQHC patients make up over half the membership of an FQHC Board of Directors. Therefore, governance and leadership of FQHCs have strong commitments to patient-centered care and engaging in their communities. Health centers also have robust relationships with their regional hospitals and designated agencies. Many FQHCs have school-based programs that support physical, oral, and mental health. Another service offered is translation services, which is important for including minority groups in the community. This focus on the person and the community is a key part of the FQHC model and improving population health.

FQHCs have long participated in the state's health care reform efforts. They are engaged with the Blueprint for Health initiative in multiple ways. All FQHCs are recognized as patient-centered medical homes (PCMHs) and work with the community health teams. Most members offer Spoke services, and many members participate in the Women's Health Initiative. Currently nine of the state's FQHCs participate in one or more payer programs with OneCare Vermont.

Quality of care is important to Bi-State members. FQHCs must meet HRSA's stringent quality and operation standards to continue their status as an FQHC. They also meet the National Committee for Quality Assurance standards (NCQA) for PCMH recognition. Bi-State staff works hard with partners at the Agency of Human Services (AHS) and with Vermont Information Technology Leaders (VITL) to meet the quality and reporting needs of our members. Our fantastic data team has been a leader in using linked claims and clinical data in quality improvement efforts with FQHCs.

Audio-Only Reimbursement

Regarding audio-only, Bi-State supports parity in reimbursement. We have come a long way since the initial and rushed shift to telehealth in early 2020 – consent is now required for an audio-only service, and practices have more clarity around implementing telehealth. We also do not know how clinical care models will evolve following the pandemic. It is not realistic to think we will snap back to the care models of 2019, and what follows 2021 is uncertain; therefore, giving providers the flexibility to provide clinically appropriate care in ways that meet patient needs as we understand the new normal will be imperative.

Specific to FQHCs, Centers for Medicare and Medicaid Services (CMS) recently issued a clarification on FQHC Medicaid billing for audio-only telehealth services. CMS views audio-only as a service modality not a separate service type. Therefore, if a service is included in the Medicaid Prospective Payment Systems (PPS) encounter rate and the state does not explicitly exclude audio-only, CMS has stated that the service is eligible for the full encounter rate, and that CMS will cover the federal match for the full encounter rate. We are working with the Department of Vermont Health Access (DVHA) on what this clarification means for Vermont Medicaid, but I offer this as a federal perspective on audio-only.

Bi-State will be happy to work with the Committee and partners on implementing this flexibility and parity while ensuring patient protections.

Increased payment to primary care and Medicaid rates

Bi-State and its members also support a greater proportion of health care spending supporting primary care for two reasons.

One, funding for primary care needs to cover the cost of care. Based on data from 2016 and 2019, the average cost per visit across all our members in both years was $30 to $40 higher than the PPS reimbursement rate for that visit. And since 2019, costs have only risen with inflation and labor pressures. FQHCs have also taken on additional services, including public health activities, to meet the needs of patients, communities, and federal regulations. The PPS encounter rate has not been updated to reflect these new services. Even increasing the 2021 Medicaid PPS encounter rate by 5% will still leave reimbursement below the average 2019 cost of services.

Speaking of inflation, federal statute requires that Medicaid FQHC PPS encounter rates increase annually at the Medicare Economic Index (MEI) inflation rate. For 2021, this rate was 1.4%, which is well below the rising cost

of labor and operations. In 2018, Medicare adopted an FQHC-specific inflation factor – the FQHC market basket. CMS uses this inflation factor annually to adjust the Medicare PPS encounter rate for FQHCs. This rate has historically been 0.5-1.0 percentage point higher than the MEI. While the 2021 FQHC market basket rate of 2.4% is still less than the growth in wage and salary increases, it would be an improvement over the MEI rate.

Second, funding needs to be sufficient for primary care to continue its central role in improving population health and shifting health care utilization away from high-cost services, a role consistent with Vermont's stated health care reform goals. The comment I often hear from members is that primary care is consistently asked to do more with less or by being more efficient. However, we are not going get spending across the health care system on a sustainable trajectory simply through more efficient primary care. Instead, primary care needs the flexibility, tools, and resources to increase access, provide clinically appropriate care to its patients, and engage with partners across the care continuum to improve Vermonters' health.

Currently, FQHC reimbursement from Medicaid is not included under the Medicaid primary care rate increases found in the Budget Adjustment Act (BAA), the FY2023 budget, or in section 6 of S. 244. We would ask to work with the Senate Health and Welfare Committee to include language in S. 244 specific to the FQHC reimbursement rate. We are also interested in working with the Committee and provider partners on how Section 4, Increasing Primary Care Allocation, would apply to FQHCs.

Thank you again for the opportunity to testify on behalf of Bi-State members. I am happy to answer any questions.