

Good morning committee members. My name is Kayla Davis, I am one of the Co-Executive Directors at Battenkill Valley Health Center in Arlington. We are the youngest and smallest FQHC in Vermont, serving Bennington County.

In the almost 12 years since our inception, we have grown from 7 employees and 1 physician - to 54 employees - with 5 medical providers, a dental department, a psychiatric nurse practitioner, and 5 therapists. We now serve more than 4,000 patients.

Our ability to grow strategically and in response to our community's needs has only been possible with access to debt financing. This has included mortgages, construction loans, cash secured loans, and lines of credit. The need in our community is still greater than we can meet, and our strategic plan includes the acquisition of additional space (through debt financing) and likely construction loans to renovate the space. We are also considering acquiring other practices, bringing those practices under our umbrella.

**Section 9525.a.2:** states that, "a transaction that involves financing the acquisition of a health care entity through the use of debt that will become an obligation of one or more of the health care entities that are party to the transaction" is prohibited.

We fear the broad language in this section may impact our ability to grow into what we need to be to serve our community.

This bill also imposes duplicate oversight on FQHCs.

Sections **9541.b and 9542** specifically.

FQHCs are regulated by the Health Resources and Services Administration of the US Department of Health and Human Services.

HRSA designed the FQHC system with built-in safeties to block private equity from being able to take over:

- Private equity requires control either through ownership, voting rights, or financial leverage...however, HRSA mandates that health center control stays with an independent, patient-majority board of directors.
- FQHCs cannot be owned or sold like a private company, any time federal funding is used to purchase or improve property, the federal government gains a federal interest in the property.
- Any dissolution or merger of a community health center requires that assets stay in the safety-net system.
- HRSA only permits affiliations if they serve a legitimate health center purpose and the health center retains ultimate control.
- HRSA prohibits private inurement and profit extraction. This means, no part of the organization's net earnings can benefit private individuals, compensation and contracts must be reasonable and defensible, and revenue must be reinvested in patient care.

- And ultimately, any change in control, even the change in CEO, must receive HRSA approval or risk the loss of grant funding.

We undergo annual financial audits, which are submitted to the Single Audit Clearinghouse which can trigger audit by OIG. We undergo annual reviews of our clinical, quality, and outcomes data through the UDS report, which are public. Anytime we expand a service line, add a new site, change our hours of operation, it must be approved by HRSA first, with assurance that the board has approved the change and will maintain control over the expansion.

Adding another layer of oversight will be administratively burdensome and may at times create conflicts between regulators.

While there are exceptions in certain sections of the bill for FQHCs, there are sections like **9533.f.4** where FQHCs are not excepted and the bill language as written cannot be conformed to given the structure of our organizations. For sections such as this we hope the committee will consider leaning into the work that VAHHS, VMS, and others have done.

The language in sections **9534.c.1 and 9534.c.5** as written could affect an organization's ability to manage visit durations in the primary care setting and limit our ability to manage provider privileges. While we in no way want to dictate clinical decision making, there is a need to set productivity expectations to remain financially solvent and grant clinical privileges based on experience, skills, scope of practice, and licensure. This is the responsibility of administrators to ensure access and quality of care.

And finally,

Section in **9521.8.E**, the definition of 'Health Care Services' includes technology associated with providing those services...to include electronic health records, software, claims processing, and utilization systems. These are not services, they are tools. Our access to these tools cannot be limited by the potential for private equity in those companies. We depend on an electronic medical record, Office 365, group purchasing agreements, etc. Without these services, the operations of our organizations will be paralyzed. And doing a deep dive into each of the business models is not administratively feasible.

Our health care system is financially fragile and access to services is extremely limited across our state. We are in a substance use disorder epidemic. We fear that this bill, as written, with overly broad language, will further limit our ability to grow and will place duplicate regulations on our organizations.

I appreciate the Committee's thoughtful questions, ensuring this bill does not have unintentional impacts on access across the healthcare system.