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Written Testimony on Committee Bill 25-0907 – Draft 1.3 for the Senate Committee on Health and Welfare
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March 13, 2025

Madam Chair, Members of the Committee, thank you for the opportunity to provide comments on Committee Bill 25-0907 – Draft 1.3. We submit these comments knowing an updated draft is forthcoming, and therefore some comments may not longer be relevant, but wanted to share our thoughts.

Addressing the cost of health care and how resources are allocated is an important task. Bi-State Primary Care Association and our members are committed to expanding access and reducing barriers to comprehensive primary, mental health, substance use disorder, and oral health care for Vermonters. Efforts that increase resources for and investment in these services are important for curbing growth in the overall cost of care, reducing potentially avoidable high-cost care, and improving the health of Vermonters.

Regarding the specifics of Committee Bill 25-0907 – Draft 1.3, Bi-State's response falls into three main categories: 1) recognition that payment reforms should also address what we pay for in health care, 2) recognition of the unique payment structure for Medicare and Medicaid payments to FQHCs, and 3) concerns about any increase in administrative and reporting burden. Please see the bullets below for additional details.

- The payment reform approach that this bill relies on is reference-based pricing and describes that the "purposes of reference-based pricing are to contain costs." While the overall cost of health care in Vermont is a significant concern, we also need to think about how and where we are spending the money in the health care system. Sectors of the health care system, such as primary care, mental health, home health, and long-term care need more funding, not less.

  Bi-State recommends including language that expands options for payment reform methods, particularly for non-hospital providers, and includes approaches, where appropriate, that aim to contain costs while promoting investment in cost-effective primary and preventive care and care management.

- FQHC's receive bundled encounter rates from Medicaid and Medicare. The methodology for both is established in federal statute with the Centers for Medicare and Medicaid Services (CMS) determining the specific Medicare rate each year. Further the Patient Protection and Affordable Care Act (PL 111-148) sets forward a payment methodology for marketplace plans to set FQHC payments. Given the technical nature of FQHC payments, Bi-State has concerns that the provision stating the Board "shall implement referenced-based pricing for nonhospital services" is overly broad and could lead to reimbursement approaches that do not align with the FQHC care delivery model or could come into conflict with federal statute and regulations for FQHC payments.

  Bi-State recommends that the bill exempt FQHCs from rate setting for non-hospital services given the unique nature of FQHC rates unless rates are voluntarily developed in collaboration with FQHCs.

- FQHCs are federally regulated by HRSA with intensive reporting requirements[1]. Bi-State has concerns that some of the provisions included in the current bill could lead to additional regulatory oversight and reporting requirements at the state level. This outcome would lead to additional administrative burden and potentially conflicting regulatory obligations.

  Bi-State recommends that any reporting requests be limited to publicly available data reported to HRSA by FQHCs and that the bill recognizes the primacy of federal regulatory oversight and obligations.

[1] https://bphc.hrsa.gov/compliance/compliance-manual