525 Clinton Street
Bow, NH 03304
Voice: 603-228-2830
Fax: 603-228-2464

BI-STATE PRIMARY CARE ASSOCIATION
SERVING VERMONT & NEW HAMPSHIRE

61 Elm Street
Montpelier, VT 05602
Voice: 802-229-0002
Fax: 802-223-2336

Bi-State Primary Care Association
Testimony on S. 290
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Helen Labun
Director of Vermont Public Policy

Bi-State opposes S.290 for reasons that other groups will likely echo:

- The resource cost of implementing these new requirements
- The idea that this proposal collects a lot of data without necessarily providing new insight into the health care system
- The concern that it's disruptive to health care reform efforts

I'm going to highlight some areas that are of particular concern to Federally-Qualified Health Centers, which Bi-State represents.

FQHCs provide primary and preventive care to almost 30% of Vermonters. We lead community-based health efforts across Vermont and bring in federal funding for preventive care. Our organizations are a critical part of health care reform.

As you have heard before, including from the Rural Health Services Task Force, FQHCs are heavily regulated at the federal level – the FQHC designation comes with 100 additional requirements, plus several layers of administrative oversight.

- Every 3 years FQHCs must apply for their funding as part of a competitive service area grant process
- Halfway through the 3-year contract there is a 3-day site visit from federal project officers with an intensive audit
- Every year FQHCs spend months collecting and submitting UDS data which tracks quality, patients served, community needs, financial information, and staffing information. This is reviewed nationally and posted publicly

The federal regulators exercise strict oversight. For example, if your FQHC bylaws say that the Board will meet once every month, and there's a late January snowstorm that leads to two meetings in February instead of one in January and one in February, you are considered out of compliance.

This federal regulation comes on top of an overall atmosphere of health care provider concern about administrative burden. National studies and local anecdotes show that today primary care doctors spend as much time filling out forms about patients as they do engaging with those patients. Plus, every new project or attempted innovation comes with its own set of rules, evaluations, and data tracking. This makes the work of primary care less appealing, leads to lower current provider satisfaction and adds to the difficulty in attracting a new generation of primary care providers.

So, FQHCs are very hesitant to have state-added administrative burden like what we see in S. 290.

But I also recognize that the question isn't just whether someone is paying attention to individual FQHC performance, it's whether the state has access to the information they need to assess the health care system as a whole. This information we're providing to the federal government *is* available to state entities should they wish to review it, and Bi-State is happy to work with any organization on data access and evaluation.

A specific example of where this problem comes into play in S.290 is the section on Designated Agencies that would have Preferred Provider Organizations come under organizational budget review by the Green Mountain Care Board. Two of our FQHCs would be directly affected by this inclusion, and others are concerned about the precedent it sets. When FQHCs participate in specific programs with the Vermont Department of Health, they anticipate that will include review of performance and how they spent the funds for that program. To bring their entire organization into a new regulatory structure as part of program participation is unreasonable. **Bi-State recommends striking Preferred Provider Organizations from that section.**

Another way that S.290 adds to concerns about regulatory burden is in its timing. FQHCs have been participating in health care reform in different stages and approaches for years – we currently have 9 of 11 Vermont FQHCs participating in the Next Generation ACO model, several of which are new this year and others are expanding which the payers for which they participate. As FQHCs expand their participation, but still remain short of reaching full scale, they are essentially running several businesses at once, each with a different payment system. We know that this feels very tenuous and will for several years to come until they all have experience working in this new model.

Our Vermont-level change is happening as the federal Health Resources & Services Administration, HRSA, is also moving FQHCs into a new way of doing business, introducing their own framework for value-based models. We're busy preparing our members for that switch.

The current phase of the ACO work is part of a contract that goes through the end of 2022. This timing correlates roughly with the HRSA changes. To have the Legislature make sweeping regulatory change in 2020 and 2021 feels a lot like having the rug pulled out from under us. We are already dealing with the uncertainty of this extensive reform work and to know that the regulatory system surrounding it can change quickly midstream is disheartening. **We recommend that any changes, if they do happen, be timed for the end of the current ACO contract period.**

Another question raised by these proposed changes is how the Legislature supports tools that are already in place. For example, the contracting section of S.290.

From a policy perspective, when our members come to us with contract concerns it's roughly in one of two categories. The first is when a member believes a specific contract they've signed with a payer is wrong. The upside of all the regulation I described in the beginning of this testimony is that there are also specific rules around how FQHCs are reimbursed and what services they are supported to provide. If a member believes their specific contracts do not match these guidelines, we can review and bring the dispute to the Department of Financial Regulation for resolution.

The second category is entering into a new *type* of contract - something that will affect multiple FQHCs and that is outside of our previous experience. So, for example, as OneCare Vermont began to enroll

FQHCs, Bi-State recognized this as a new type of contract and hired a national law firm with experience in this field to look at the whole class of Next Generation ACO contracts for Vermont FQHCs. They were able to suggest a template and some broad refinements to the contract structure. This type of targeted input from expert analysts is very useful and also very different than creating an ongoing function at the Green Mountain Care Board.

If the committee is concerned with how contracts are working, Bi-State would welcome a conversation with a more detailed problem statement and a consideration of tools already available to solve the problem.

Which brings us to the final point and sort of an overarching theme to Bi-State's concerns.

Vermont is a leader in the national effort to change how we pay for, and how we deliver, health care. As a nation we're trying to move towards a value-based payment system and Vermont figured out pretty early on that we needed to coordinate all payers in the system to reach the scale where health care providers could make their decisions based on that value-driven model.

A lot of the specific issues that are coming up right now are symptomatic of the fact that as reform efforts mature, we're entering new territory in health care regulation. I'm thinking of the primary care investment report that asks how to measure primary care specific investment in a value-based world, or the conversation about preventive care and how to reconcile the investment in generational changes with a financial timeline that measures results by one or two years, or the question about how payment reform designed to contain the growth in total cost of care gets translated back into reducing what individuals pay for health insurance . . . These are not Vermont questions. These are national questions.

It makes all the sense in the world for Vermont to engage more nationally in the conversation about health care reform and the appropriate regulatory system for that reform as we move closer to value-based payment. We built the best system we could prior to our current phase of work, we are accumulating on the ground experience today, and soon we'll be looking at how to move into the *next* phase of work; it isn't wrong to be asking whether what we have is what we want looking to 2023 and beyond. But we aren't going to come up with the right answer by sitting here and brainstorming possible changes amongst ourselves. We need much more detailed problem statements and we need to avail ourselves of national resources and expertise. **If we were to move forward with S.290 as it is currently written, we'd be pulling a lot of resources out of the system that might otherwise have been put towards tackling the bigger questions of Vermont's role as a leader in health care reform.**

Bi-State Primary Care Association is happy to participate in a conversation about the regulatory system for health care and how that supports reform efforts. However, we feel that S.290, as currently drafted, does not provide the appropriate framework for that conversation.