




Statement of the Pennsylvania Association of Community Health Centers

to the Majority Policy Committee


Presented by
Cheri L. Rinehart
President & CEO

Pennsylvania Association of Community Health Centers
(PACHC)

Harrisburg, PA
Tuesday, October 25, 2011

I am Cheri Rinehart, President and CEO of the Pennsylvania Association of Community Health Centers (PACHC). PACHC represents and advocates for the more than 200 Community Health Center  sites across Pennsylvania, rural health clinics and other like-mission primary care providers and the patients and communities they serve. I appreciate the invitation to present today on behalf of the Commonwealth's safety net providers.

PACHC's testimony will focus on the following issues:

- ▶ A brief explanation of what a Community Health Center  is
- ▶ The important role Community Health Centers play in the Commonwealth
- ▶ Some health care and insurance cost drivers
- ▶ Health center experience with the uninsured
- ▶ Our recommendations on how the Commonwealth can help

What is a Community Health Center?

Community Health Centers, also known as federally qualified health centers or FQHCs, are non-profit community-based organizations. For more than 40 years, Community Health Centers have provided comprehensive, culturally competent, quality primary health care services to medically underserved communities and vulnerable populations, across Pennsylvania and the country. The goal of these health centers is to help the individuals they serve to get well and stay well so they don't require more costly emergency and hospital care.

Community Health Centers receive some federal grant funding to offset the costs of caring for the un- and underinsured. These grants are highly competitive, on average constitute less than 25% of an FQHC's funding and are rarely increased. For example, the most recent FQHC funding opportunity funded 67 new FQHC sites across the nation and there were more than 800 applications. Generally, if an FQHC expands its services or capacity it must ensure that it can do so without additional federal funding.

A Community Health Center/FQHC is distinguished from other primary care providers in a number of ways, including:

- F**ees based on **ability to pay**. FQHCs must offer a sliding fee scale for those with incomes less than 200 percent of the federal poverty level. We are not free clinics.
- Q**uality health care for **all**. FQHCs are open to all and must meet federal reporting, performance and accountability requirements.
- H**ighly competent **health professional team**. FQHCs offer other services to help patients stay well, such as case management, pharmacy, lab testing, social services and translation, as well as behavioral and dental services.
- C**ommunity **control** to ensure they are responsive to their patient population. At least 51% of people serving on the governing board of an FQHC must be patients served by the FQHC.

FQHCs are NOT:

- Federal organizations. They are private non-profit community organizations that receive limited federal grant funding to offset some of the costs of caring for the un- and underinsured. In exchange for meeting the stringent requirements of the Community Health Center Program they receive fairer Medicare and Medicaid reimbursement and their employees are covered by the Federal Tort Claims Act for medical liability.
- State-supported organizations. Although many states help subsidize the care Community Health Centers provide to the un- and underinsured because it prevents higher costs to the healthcare system, Pennsylvania's support to FQHCs is limited to the Community Challenge Grant program, even though these health centers are seeing an ever-increasing number of individuals without insurance.

FQHC services include prevention and wellness services as well as management of acute and chronic medical conditions. In addition to primary medical care across the lifespan, FQHCs also offer access to dental and behavioral health services as well as discounted medications, either on site or through arrangement with a pharmacy. Many FQHCs in Pennsylvania are already recognized Patient Centered Medical Homes and many more are working to achieve that recognition. Many Pennsylvania Community Health Centers have already implemented an electronic health record and almost all are somewhere in the process of doing so.

The Important Role Community Health Centers Play in Pennsylvania

Community Health Centers comprise the largest network of primary care providers, both in the Commonwealth and in the nation. Across the nation, there are FQHCs in every state and they serve more than 20 million people in more than 8,000 locations. In Pennsylvania, there are more than 200 FQHC sites in rural and urban areas, with locations in 45 of the commonwealth's 67 counties. Sixty percent of Pennsylvania's health centers are located in urban areas and 40 percent in rural areas. Last year, these health centers served more than 700,000 Pennsylvanians.

Community Health Centers are required to serve a medically underserved area or medically underserved population. Pennsylvania's Community Health Centers have a patient base that is 68 percent Medicaid and uninsured and 93 percent of the individuals they serve have incomes at or below 200 percent of the poverty level. The Commonwealth's Community Health Centers directly generate 3,200 jobs and indirectly support an additional 1,700 jobs in regions that are most impacted by the current economy. FQHCs in Pennsylvania have an overall economic impact of over \$500 million.

Despite predominantly serving poor individuals with higher risks and more chronic and comorbid conditions, multiple studies have shown that FQHCs provide cost effective, high quality care, have excellent patient outcomes and save the health system significant dollars.

Rural health clinics (RHCs) are also an important part of the healthcare safety net. There are currently 59 RHC sites in rural areas of Pennsylvania. The major ways RHCs differ from FQHCs are:

- They are limited to non-urban locations of medical underservice
- They must employ a non-physician provider (physician assistant or nurse practitioner) at least 50% of the hours they are open
- They can be for-profit or not-for-profit
- They can be freestanding or connected organizationally to another provider, such as a hospital
- Their services are generally limited to medical (i.e. most do not offer dental or behavioral health care)
- They have no board of director requirements nor data reporting requirements
- They may limit their services to specific age groups and do not have to provide services across the lifespan

RHCs serve an important role in many rural underserved areas of Pennsylvania that may not have the resources or population to support the more comprehensive FQHC, but are no less in need of access to quality primary health care services.

What Drives Health Care & Insurance Costs?

The acceleration in health insurance premiums and healthcare costs can be attributed to a number of factors but high among these is chronic disease. In its groundbreaking study, “An Unhealthy America: The Economic Impact of Chronic Disease,” the Milken Institute details the enormous financial impact of chronic disease on the U.S. economy – not only in treatment costs, but lost worker productivity – today and in the decades ahead. It also describes the huge savings possible if a serious effort were made to improve the health of Americans.

In the Milken study, Pennsylvania ranks among states with the highest impact of chronic disease, with only five states ranking higher. According to the study, nearly 7.8 million cases of seven common chronic diseases were reported in Pennsylvania in 2003. The cost of treating these conditions, without taking into consideration the many secondary health problems they cause, totaled \$13.6 billion in 2003. These conditions also reduce productivity at the workplace, as ill employees and their caregivers are often forced either to miss work days or to show up but not perform well. The Milken study estimated the impact of lost workdays and lower employee productivity at \$50.5 billion annually in economic loss in Pennsylvania.

On our current path, Pennsylvania will experience a dramatic increase in chronic disease in the next 20 years. But there is an alternative path. According to the Milken Institute study, by making reasonable improvements in preventing and managing chronic disease, we can avoid over 1.7 million cases of chronic conditions and these improvements in preventing and managing chronic disease could reduce future economic costs of disease in Pennsylvania sharply, by 27 percent (\$45 billion) in 2023. And the impact on economic output *compounds* over time.

This is where Community Health Centers come in. Several research studies demonstrate that health centers yield substantial cost savings to the health care system by reducing emergency department visits, hospitalizations, and other avoidable, costly care. The studies indicate that Community Health Centers currently save the health system more than \$1,200 per person through efficient delivery of needed care. A new study from the George Washington University, *Strengthening Primary Care to Bend the Cost Curve: The Expansion of Community Health Centers Through Health Reform*, finds that the expansion of health centers will contribute to even higher savings.

Community Health Centers and the Uninsured

According to data from the Health Resources & Services Administration (HRSA), Pennsylvania's FQHCs added 111,000 new patients from January 2009 through December 2010 and provided nearly 400,000 more patient visits during that two-year period than the prior year. Pennsylvania FQHCs provided care for nearly 30,000 additional uninsured individuals during that time period.

PACHC maintains a toll-free line, 1-866-944-CARE, to help connect individuals with health care. On average, we respond to 200 calls a month. When the dissolution of adultBasic was announced, call volume went up to more than 900 calls a month and the callers were often desperate. Many of these individuals are unable to afford or obtain coverage at the time they need it most.

Also, as many are aware, insurance is not equivalent to access. Those who are insured require a provider willing to accept that insurance to have access to health care beyond the emergency department. For many individuals insured by Medical Assistance and some of those who were insured by adultBasic, the only option is their local Community Health Center. Fortunately, that is a good option. For those who were covered by adultBasic and received their care at an FQHC, the good news is that it is unlikely they experienced a disruption in access to care—as I mentioned earlier, one of the central tenets of the FQHC model is that these health centers are open to all, regardless of ability to pay. What is good news for a patient, however, is not good news for the Community Health Center as they will continue to provide health care to the individual, but not receive reimbursement for that care.

Again, FQHCs that expand services or number of people served must generally do so without additional federal grant funding and FQHC Look-Alikes do not receive any federal grant funding to offset the cost of care to the un- and underinsured even though they must meet the same requirement of being open to all, regardless of ability to pay. The Commonwealth's FQHCs provided **\$88.3 million** in uncompensated care in 2009, the most recent year for which data is available. That is likely to rise significantly based on what we have heard from individual health centers about the sharp increases in the number of uninsured they are serving. For example, in York County, 548 people were on adultBasic and the Community Health Center there had 76.3% enrolled as patients; in Franklin County the FQHC has seen nearly 90% of those who were insured by adultBasic enrolled as patients; and in Tioga County, the health center saw 65% of those enrolled in adultBasic as patients. Most of these patients are now uninsured and are adding to the uncompensated care burden on Community Health Centers. FQHCs are also seeing many of the more than half a million people who were on the adultBasic waiting list.

Another significant impact on this healthcare safety net and the people they serve as a result of the increased number of uninsured individuals is diminished access to specialists. Community Health Centers work very hard to connect the people they serve who require specialist consultation with those services. This is often difficult even when the individual has insurance and can be almost impossible when they do not. This access, or lack thereof, can mean the difference between a medical condition being stabilized or frequent costly visits to the emergency room. Jim Kelly will discuss the approach Lancaster County has adopted to help address this challenge.

Some hospitals and health systems provide what is called a “Community Benefit Grant” to their local FQHC because they recognize that an effective health center can reduce the burden of uncompensated care on the hospital. Hospitals challenged by reductions in funding and an increased number of un- and underinsured individuals may no longer be able to provide this support to their local health center, further increasing the burden of uncompensated care on the health center and health system.

A recent Harvard Medical School study found that nearly 45,000 people die in the United States each year in part because they lack health insurance and cannot get good care. Those without insurance are also less likely to get preventive care and often delay care until a condition becomes serious. Serious also means more expensive to the healthcare system and those of us with insurance subsidize the cost of care for those without—either directly through higher insurance premiums, or indirectly through lower wage increases because our employers are paying more for our health insurance coverage. We are all paying for the healthcare costs of the uninsured.

What Should be Done?

What can Pennsylvania do to support the Community Health Center program and improved access to affordable primary health care?

- 1- **Expand Pennsylvania’s existing Community Challenge Grant program** administered by the Pennsylvania Department of Health. During the last application cycle, of 43 applications submitted, there was only funding for five. Those five grants supported 33 FTEs who provided access to care through more than 100,000 visits to the vulnerable populations they serve, reducing reliance on the emergency department.
- 2- **Reduce administrative burden** by requiring evaluation of the impact of legislation and policy changes, prior to implementation, on these critical safety net providers who are serving the Commonwealth’s most vulnerable citizens. For example, the new Department of Public Welfare adult dental benefit changes will have a significant impact on many health centers and the people they serve, not only because of the reduction in covered services, but also because of the increase in administrative burden the new policy creates. Mr. Kelly will offer more detail on that impact.
- 3- **Help us to resolve the issue of payment for delivery of babies with DPW.** The department has proposed to pay a health center its prospective payment system (PPS) rate for deliveries (on average, \$120) while non-health center clinicians are reimbursed approximately \$1200 for the same service. Should the policy be implemented, health centers will stop doing deliveries and for two health centers alone, that translates into more than 2,000 women showing up at the emergency department when they go into labor.

- 4- Create an Uncompensated Care Fund for Community Health Centers** or some other way to provide some state support of the uncompensated care financial burden carried by the Commonwealth's health centers. A number of other states provide similar support through uncompensated or indigent care pools or funds or line item funding to health centers and we would be happy to provide more information.

As the legislature moves forward, PACHC recommends the following principles to ensure access to high quality, cost-effective health care within state budget limitations:

1. Pennsylvania has a responsibility to ensure access to quality health care for its low-income and vulnerable citizens.
2. Policies should support "right care, right time, right place" health care, delivered in the most cost efficient and cost effective way without sacrificing quality.
3. Policies should support every person having a "health care home," so that care management, continuity of care and outcomes can be optimized and costs best controlled.
4. Changes should support a strong health system foundation of local access to quality primary health care that is community-based, culturally competent and patient centered to help individuals become and stay healthy and become partners in staying well and controlling costs.
5. Cost-benefit analysis of proposed program cuts is essential to evaluate their long-term impact on costs to the healthcare system and the Commonwealth.

Insurance is important, and so is access. Pennsylvania's healthcare safety net is already strained by a challenged economy with its concomitant increase in the number of uninsured, many of whom have chronic conditions that are destabilized because they are unable to afford appropriate treatment and medication. Whether the support the Commonwealth provides is through an adultBasic-like product or more affordable private insurance through an insurance exchange or through an uncompensated care fund, it is important that the Commonwealth support access to care for those who need it and are unable to pay for it. The choice is to provide support to help individuals get and stay well or pay later when their conditions become emergent and high cost. PACHC believes the former is the more fiscally sound approach.

Thank you for the opportunity to testify. My colleagues, Jim Kelly and Elaine Herstek will now speak to the experience of their individual health centers and communities.