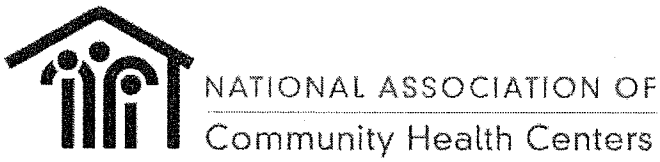

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Submitted to the Committee on Energy and Commerce
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Introduction

Chairman Waxman, Ranking Member Barton, and Distinguished Members of the Committee:

On behalf of the more than 1,200 community health center organizations nationwide, and the more than 18 million patients they serve, I want to thank you for your leadership in taking on this vitally important process, and for the opportunity to contribute to today's discussion. In Community Health Centers across the country, we witness the urgent need for fundamental health reform **every single day,** in our waiting rooms and exam rooms, and in the faces and struggles of our patients, who for too long have been left behind by our current dysfunctional health care system.

Let me begin with a broad outline of what health reform means to us in the health center movement, gleaned from our more than 40 years' worth of experience in caring for those who have been forgotten or left behind, and who have suffered immeasurably as a result. We believe that health reform should strive, first and foremost, to achieve universal coverage that is **available** and **affordable** to everyone, and especially to low-income individuals and families. We believe that coverage must be **comprehensive**, including medical, dental, and mental health services, and should emphasize **prevention and primary care**. And we believe that reform must also strive to guarantee that everyone – and especially those who are medically

underserved – has access to a **medical or health care home**, where they can receive **high quality, cost effective care** for their health needs.

Mr. Chairman, we believe that the plan developed by you and the Chairs of the Ways & Means and the Education & Labor Committees not only meets every one of those principles, but also takes great strides toward moving our nation much closer to achieving the equity and social justice in health care that has proven so elusive over the past century – and for that, Mr. Chairman, we commend you and the Members who worked with you on this history-making collaboration.

Community Health Centers strongly support the draft legislation's efforts to make health insurance coverage more affordable and more accessible to poor and low-income individuals and families – and in particular, its call to expand Medicaid to cover everyone with incomes up to 133% of the federal poverty level without restriction. These are the very people who most need the services and benefits offered through Medicaid – services like health and nutrition education, outreach, transportation, patient case management and language assistance, as well as dental care, mental health services and prescription drugs, that too often are not covered, or inadequately covered, under private insurance policies. This Medicaid expansion may well be the most important and essential features of your plan, Mr. Chairman, and for that we and so many others are grateful. At the same time, we urge you to take forceful steps to ensure that, as these Medicaid beneficiaries are potentially moved in the Health Insurance Exchange following implementation, they are fully able to continue receiving – as supplemental Medicaid benefits – these vital services that are and will remain vital to their health and well-being, even though these services will not be covered by their primary insurers through the Exchange.

We also appreciate the vital subsidies that this draft legislation would provide the lower-income individuals and families who are above the Medicaid eligibility level, not only to make coverage

affordable but also to eliminate barriers to care as well, through cost-sharing protections – and in particular by eliminating cost-sharing for vital preventive care.

In discussions about reforming the health care system, one element remains constant across all platforms and proposals: the need to invest in accessible, affordable, high-quality primary care for all as a down payment on a more effective and efficient health care system. Even before the current recession, a lack of access to affordable primary health care posted one of the most persistent challenges to our health care system. In our 2007 report, *Access Denied*, NACHC found that 56 million people lacked adequate access to primary care because of shortages of physicians in their communities. While even those with insurance coverage can be medically disenfranchised, it is the low income, uninsured, and minority populations that are disproportionately affected. These are the very populations that experience some of the most egregious health care disparities. **In an updated study released in March, we found that the number of medically disenfranchised has risen to 60 million people nationwide.**

This fact is unconscionable, as is the fact that in the wealthiest country on earth, more than 46 million people are uninsured. And yet it is clear that while vital, the expansion of insurance coverage can only take the country so far. From states and communities already experimenting with their own reform efforts, we know that federal, state, and local governments must continue investing in the health care safety net even if universal coverage is achieved. We also know that true progress in resolving this crisis entails removing all barriers to care, including provider shortages, the lack of insurance coverage, and cost, as well as geographic, linguistic, and cultural barriers. Most importantly, the increased demand for care that comes from expanding coverage must be met with an augmented primary care infrastructure.

Here again, Mr. Chairman, your plan delivers a solid response to this challenge: and we applaud you for its call to expand the highly-successful system of care that Community Health Centers represent through increased funding as part of the new Public Health Investment Fund. We also comment you for funding community-based prevention and

wellness programs, and for strengthening the work of state, local, tribal, and territorial health agencies, through the Fund as well.

Mr. Chairman, I have personally seen the power of health centers to lift the health and the lives of individuals and families in our most underserved communities. As a VISTA volunteer assigned to south Texas in the 1960s, I was asked by the residents of the poor farm-worker community I served to help improve access to health care and clean water, and assisted in the development of one of the country's first migrant and community health centers. At the request of community leaders, I stayed on and served as executive director of the health center from 1971 to 1977. That health center is still in operation today, and has expanded to serve more than 40,000 patients annually.

That community empowerment and patient-directed care model thrives today in every one of the country's 1,200 health centers serving more than 7,000 communities across America; I am honored to be able to share their success story and to detail how their growth from a small demonstration project in their early years to an essential element of our nation's primary care infrastructure today uniquely positions them to be key participants in a reformed health care system. I want to thank each Member of this Committee for your consistent, bipartisan support for health centers over the years, and your dedication to the all-important goal of providing affordable, accessible health care to all Americans. With your ongoing support, this cost-effective, high quality system of care will continue to expand toward our goal of eventually reaching every individual in need of a health care home and serving as the model and innovation leader for what primary care practice can become.

And I can assure you that your trust and your investment in health centers is being repaid handsomely every day. Literally dozens of studies – and research over the past three decades and up through this year – have concluded that health center patients are significantly less likely to use hospital emergency rooms or to be hospitalized for avoidable conditions, and are therefore less expensive to treat than patients treated elsewhere.[i] In fact, a recent national

study done in collaboration with the Robert Graham Center found that people who use health centers as their usual source of care have **41% lower total health care expenditures** than people who get most of their care elsewhere.[ii] **As a result, health centers saved the healthcare system up to $18 billion last year alone – more than 9 times the federal appropriation for the program, and better than $2 for every dollar they spent – and with new funding those savings will grow even larger.** The investment in primary and preventive care that federal and state governments make by paying health centers adequately actually *yields significant savings* to the health care system and to taxpayers as well.

As coverage expands, we must also ensure that patients have access to doctors and other health professionals who will treat them. The National Health Service Corps is a vital tool for health centers and underserved communities seeking to recruit new clinicians – and **the draft legislation would bring an historic investment to the NHSC and lead to thousands more providers choosing to practice in underserved communities**. In fact, the draft legislation takes powerful and forthright steps to confront the three most pressing shortcomings affecting today's health care workforce: the well-documented shortage of primary care professionals; the serious lack of diversity in the workforce; and the severe maldistribution of providers which victimizes underserved communities most of all.

Furthermore, in order to increase the pool of new health professionals entering primary care, health centers support **adequate and reliable primary care provider reimbursement** by all public and private payers to reflect the value – in system-wide cost savings and improved health outcomes – that primary care physicians and other health professionals provide. Here, too, your plan makes great strides in fixing a seriously broken payment system that has led to a significant and growing shortage of primary care health professionals – this, too, will be key to the success of health reform.

Health Center Participation in Public and Private Insurance

In the early 1990s, Congress instituted a health center-specific Prospective Payment System (PPS) to guide health center reimbursement under Medicaid, complementing the existing cost-based reimbursement structure under Medicare. The PPS structure ensures that health centers receive adequate payment through an all-inclusive per-visit payment rate that balances both higher and lower costs for all of the services provided to our publicly insured patients. We appreciate the Committee's leadership, as part of the Children's Health Insurance Program Reauthorization Act (CHIPRA) earlier this year, to align health centers' reimbursement under CHIP with the successful Medicaid PPS.

Medicaid and health centers have worked extremely well together to generate cost savings – averaging more than 30% per Medicaid beneficiary – and to improve patient outcomes. Compared to Medicaid patients treated elsewhere, health center Medicaid patients are 19% less likely to use the ER for avoidable conditions and have lower hospital admission rates, lower lengths of hospital stays, less costly admissions, and lower outpatient and other care costs.[iii]

In health reform, **it is critical that insurers enrolling people in underserved communities be required to include health care providers located there, and especially health centers and other primary care safety net providers, in their networks. In that regard, we applaud the Committee's inclusion of network adequacy standards for all Exchange-participating health plans, to ensure the participation of health centers and other essential community providers.** In addition, it makes sense to **align health center payments from <u>all</u> insurers** with the structure currently in place under Medicaid, to assure the continuity and quality of care that health centers have been proven to deliver. The PPS structure for health centers appropriately and predictably reimburses health centers for the comprehensive care they provide. Toward that end, we very much support the inclusion of requirements in the new public health insurance option that providers be paid no less than Medicare levels for the care they furnish; however, we urge the Committee to consider improving the bill further by including language from H.R. 1643, which would align the current Medicare health center payment methodology with the successful Medicaid Prospective Payment System. In fact, we believe that **the same should be**

ensured in any expanded insurance model, whether public or private.

Under a reliable and fair payment structure, and with full participation in the reformed health insurance system, health centers stand ready to provide low-cost, highly effective preventive and primary health care to millions more individuals and families in need. Reimbursing safety net providers like health centers appropriately for the comprehensive, coordinated care they provide will help to grow the primary care infrastructure - an essential step toward ensuring that investments in health reform translate into improved health and wellness for the nation.

Conclusion

Mr. Chairman, every health center administrator, clinician, community Board member, and patient witnesses the need for health reform every day, and we all strongly believe that reform must achieve universal coverage that is available and affordable to everyone, especially to low income individuals and families. As reform moves forward, we look forward to working with you to ensure that the final product also brings access to a health care home for every patient in need.

Thank you.

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[i] McRae T. and Stampfly R. "An Evaluation of the Cost Effectiveness of Federally Qualified Health Centers (FQHCs) Operating in Michigan." October 2006 Institute for Health Care Studies at Michigan State University. www.mpca.net. Falik M, Needleman J, Herbert R, et al. "Comparative Effectiveness of Health Centers as Regular Source of Care." January - March 2006 *Journal of Ambulatory Care Management* 29(1):24-35. Falik M, et al. "Ambulatory Care Sensitive Hospitalizations and Emergency Visits: Experiences of Medicaid Patients Using Federally Qualified Health Centers." 2001 *Medical Care* 39(6):551-56.

[ii] NACHC and the Robert Graham Center. *Access Granted: The Primary Care Payoff.* August 2007. www.nachc.com/access-reports.cfm.

[iii] Falik et al. "Comparative Effectiveness of Health Centers as Regular Sources of Care." 2006. *Journal of Ambulatory Care Management* 29(1):24-35. Falik et al. "Ambulatory Care Sensitive Hospitalizations and Emergency Visits: Experiences of Medicaid Patients Using Federally Qualified Health Centers." 2001. *Medical Care* 39(6):551-56.