

House Energy & Commerce Committee
HEARING
May 25, 2005

Statement of Witness: **RODERICK V. MANIFOLD**, Executive Director
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SUMMARY

“We should not have to drive an hour and a half, one way, to take a child to see the doctor”. Beulah Wiley of the Community Action Program in Cumberland County said this in 1968 after she returned from taking a child to the doctor at the University of Virginia Medical Center. From that moment community activities began that culminated in the establishment of Central Virginia Community Health Center in 1970, now called Central Virginia Health Services.

Today that health center has grown to a ten-site family of health centers serving 18 counties and cities, serving over 34,000 people. It is still operated, as it was in 1970, by a board of directors made up of community members (63% of whom are CVHS patients) that are committed to its mission.

In recent years, under the President’s initiative to expand health centers, CVHS competed for and received a grant for a new access point in Charles City County, an expand medical capacity grant at two existing sites, and we also received a grant to add dental services in a health center that was previously providing only medical services. All of these additional services and sites would not have been possible without the HRSA grants awarded under the President’s Initiative.

At our center, Medicaid and Medicare are the two major payer sources for our patients. That being said, we do want to make one thing very clear: the prospective payment system (PPS) under Medicaid that Congress has given to health centers because of our unique place in the safety net is very, very important to health centers. Obviously, if the Medicaid PPS was tinkered with, health centers could suffer greatly. Within Medicare, the provision of pharmaceuticals to Medicare patients will be the largest contributor to better health outcomes for our health center Medicare patients since the inception of the Medicare program itself. We look forward to 2006 and we hope that the development of training and orientation programs and materials for seniors and for our caregivers will come in time for every Medicare recipient to benefit fully from this new service.

Statement of:
RODERICK V. MANIFOLD
Executive Director
Central Virginia Health Services, Inc.

Before:
House Energy & Commerce Committee
Subcommittee on Oversight & Investigations

May 25, 2005

In 1968 a staff member named Beulah Wiley of the Community Action Program in Cumberland County, Virginia returned from taking a child to the doctor at the University of Virginia Medical Center. She reportedly slumped down in a chair at the CAP offices and said, “We should not have to drive an hour and a half, one way, to take a child to see the doctor.” From that moment community activities (and I emphasize that word community) began that culminated in the establishment in 1970 of Central Virginia Community Health Center, located in Buckingham County and serving three counties.

Today that health center has grown to a ten-site family of health centers serving 18 counties and cities that are located from the Northern Neck of Virginia to the city of Petersburg, south to the North Carolina state line and west as far as Albemarle County and Charlottesville. Central Virginia Health Services, as it is called today, is the oldest community health center organization in Virginia and is celebrating its 35th year of operation in 2005. Last year Central Virginia served a diverse population of over 34,000 people in rural and urban sites across its many community service areas. It is still operated, as it was in 1970, by a board of directors made up of community members that are committed to its mission. In fact, as many of you may know, at least 51% of the

board members of a community health center must be consumers of the health center's services. Last year, 63% of our board members were users of our services. This community representation tempered with responsibility for the mission of the entire health center is one of the hallmarks of the health center movement. Being patients as well as leaders of the policy-setting board makes our members the best possible representatives of their communities and of the thousands of patients we serve.

As in the 1970's, poverty and lack of access to care are still primary reasons for the existence of Central Virginia and the many other health centers around Virginia and around the country. The high poverty rate, severe health care disparities, and the lack of access to the health care system are all reasons why health centers are needed in central Virginia. In the Central Virginia Health Services sites in 2004, for example, more than half (51%) of our patients were minorities, 30% were below the federal poverty guideline, and 31% were completely uninsured. These numbers of high need are not unusual for a community health center. In fact, in one of our urban centers, over 50% of our patients are uninsured and fully 70% are below the federal poverty guideline.

As you may know, community health centers do charge fees to all of these patients. These are not free clinics, because Congress in its wisdom set them up to collect fees on a sliding scale basis from each and every one of our patients. All consumers of our services participate in funding their community health center based upon their ability to pay. It gives them a kind of "ownership" of the health center in their community, and it clearly states to them that these services have a value. Last year Central Virginia Health Services collected from our various payer sources (not including the federal grant we

receive to assist the uninsured patients), 24% of our patient income from private insurance companies, 30% from Medicaid, 20% from Medicare, and 26% directly from patients' payments. As an example of those patient payments, we have a collection rate of over 95% from our Medicare patients for the services they receive from our providers. While these numbers are not the same in every health center, virtually all health centers work to develop a broad spectrum of payer sources, in addition to the HRSA grant.

In recent years, under the President's initiative to expand health centers, Central Virginia, has been able to expand services and add additional access points for care in many communities. We competed for and received a grant for a new access point in Charles City County, a jurisdiction with a minority population of over 75%. This grant helped to create a totally new health center with medical, dental and behavioral health services in a county that previously had one part-time private doctor serving the community only three half days per week and no dentists or psychologists. Additionally we received grants to expand medical capacity in two existing health centers, and we also received a grant to add dental services in a health center that was previously providing only medical services. All of these additional services and sites would not have been possible without the HRSA grants awarded under the President's Initiative and funded by Congress. And these grants have stimulated private foundations to provide funding for additional services to be provided in several of our existing health centers.

Of perhaps even more compelling interest to this subcommittee and your full committee, are some issues related to Medicaid and Medicare. Frankly, as a community health center director, I worry about these two major payer sources for our patients. Remember

that we health centers are the true safety net providers of primary care for many of our nation's most vulnerable citizens. And I mean, we really are working in the frayed bottom of that safety net. We live day to day, and we get very concerned when Congress begins to discuss cuts to the Medicaid program. We respect that your committee and the Medicaid Commission have a very difficult challenge in looking at reductions in the Medicaid program. That being said, we do want to make one thing very clear: the prospective payment system (PPS) that Congress has given to health centers because of our unique place in the safety net is very, very important to health centers. We know that our patients in that safety net will be our patients regardless of what sort of payment methodology is created here. Obviously, if the PPS was tinkered with, health centers could suffer greatly. In addition, if Medicaid primary care benefits are reduced, our patients will still need those services. We will just have to use the federal grant, which is designed to serve the many uninsured patients in our centers, to "subsidize" the Medicaid program and its patients. Furthermore, if Medicaid eligibility limits are lowered, and more patients are moved off the Medicaid rolls, we in health centers will still serve those patients, only they will then join the ranks of the uninsured. Reductions in benefits and/or eligibility levels for Medicaid will be a real double whammy to health centers and their patients, and could well bring about drastic reductions in programs and services-- exactly the opposite of the goal for the President's Initiative. At Central Virginia, our providers and staff know these patients very well, and we know that they will look to us for their care, regardless of whether they have Medicaid or not.

Also of interest to this subcommittee, of course, is the Medicare Part D program. The provision of pharmaceuticals to Medicare patients will be the largest contributor to better

health outcomes for our health center Medicare patients since the inception of the Medicare program itself. We look forward to 2006 and we hope that the development of training and orientation programs and materials for seniors and for us caregivers of seniors will come in time for every Medicare recipient to benefit fully from this new service. We know that CMS and other agencies are working to meet the deadline set by Congress for the initiation of this program. Please know that we in community health centers will do everything possible to assist in this monumental effort, because we truly know how important it is to the health of our individual patients.

I would like to tell you about another part of the community health center story in one of our communities: Farmville and Prince Edward County, Virginia. In the mid-1980's the Piedmont Health District serving these two localities and the surrounding counties had one of the highest infant mortality rates in the Commonwealth of Virginia. In 1985 Central Virginia Health Services, the Virginia Department of Health, and the federal government collaborated to open the Women's Health Center in Farmville. This OB-Gyn practice started small with one physician and a tiny group of support staff. The Health Center for Women and Families, as it is called today, now provides the only obstetric services in this rural community. Our center there has two full time OB-Gyn physicians, one full time family practice physician, and one part time nurse midwife doing deliveries in the local hospital and, along with a full time nurse practitioner, they also provide virtually all of the prenatal care for the community. This is a real success story for Farmville and the surrounding area. While several community hospitals in Virginia have recently closed down their labor and delivery service due to skyrocketing malpractice insurance and other factors, Southside Community Hospital, with our

assistance, has been able to not only keep its community obstetric program, but to make it grow and thrive. By the way, the infant mortality rate has gone down over the past twenty years and the community and its families are all the better for that positive outcome.

I would like to close with a story about the first community health center patient in Virginia. Dr. Mike Shepherd, a University of Virginia physician and the first physician of Central Virginia Community Health Center, recounts this story of opening day on the Friday after Thanksgiving in 1970. I have told it many times because I believe it illustrates why health centers are an absolute necessity in many communities around our country. A woman in her eighties was brought to the center by her family on that first day. She was being interviewed by the nurse taking her health history. The nurse asked the woman when was the last time she was seen by a doctor. The woman thought for a few moments and finally said, "Nineteen and twenty-three." And that is why health centers are needed. Here was woman who was not seen by a doctor for nearly 50 years. And, while we don't find many patients these days with such a long time between visits, we do know that we serve people who need us and who would not be seen if it were not for the health center in their communities.

House Committee on Energy and Commerce

Witness Disclosure Requirement - "Truth in Testimony"

Required by House Rule XI, Clause 2(g)

Your Name: <u>RODERICK V. MANIFOLD</u>		
1. Are you testifying on behalf of a Federal, State, or Local Government entity?	Yes	<input checked="" type="radio"/> No
2. Are you testifying on behalf of an entity other than a Government entity?	<input checked="" type="radio"/> Yes	<input type="radio"/> No
3. Please list any federal grants or contracts (including subgrants or subcontracts) which you have received since October 1, 1999: <hr/>		
4. Other than yourself, please list what entity or entities you are representing: <u>CENTRAL VIRGINIA HEALTH SERVICES, INC.</u>		
5. If your answer to question number 2 is yes, please list any offices or elected positions held or briefly describe your representational capacity with the entities disclosed in question number 4: <u>EXECUTIVE DIRECTOR</u>		
6. If your answer to question number 2 is yes, do any of the entities disclosed in question number 4 have parent organizations, subsidiaries, or partnerships to the entities for whom you are not representing?	Yes	<input checked="" type="radio"/> No
7. If the answer to question number 2 is yes, please list any federal grants or contracts (including subgrants or subcontracts) which were received by the entities listed under question 4 since October 1, 1999, which exceed 10% of the entities revenue in the year received, including the source and amount of each grant or contract to be listed:		
<u>SOURCE</u> <u>AMOUNT</u>	<u>SOURCE</u> <u>AMOUNT</u>	
2000 HRSA 3,623,149	2003 HRSA 4,655,534	
2001 HRSA 4,023,149	2004 HRSA 5,431,429	
2002 HRSA 3,900,259	2005 HRSA 5,219,343	

Signature: _____

Roderick V. Manifold

Date: _____

05-21-2005