

**TESTIMONY COVER SHEET
FOR**

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Testifying on behalf of the
Michigan Primary Care Association
2525 Jolly Road, Suite 280
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*Before the House Committee on Energy and Commerce
Subcommittee on Oversight and Investigations*

May 25, 2005

Summary:

- Federally Qualified Health Centers (FQHC) provide medical homes to residents of medically underserved communities. Michigan's health centers deliver comprehensive primary care in more than 140 Michigan communities and neighborhoods to more than 425,000 persons. Michigan's 29 FQHC organizations form an essential component of the state's safety net for health care services.
- Several studies have demonstrated that health centers save the Medicaid program more than 30% in annual spending per beneficiary due to reduced specialty care referral and fewer hospital admissions and FQHCs save by helping to prevent unnecessary usage of the emergency room. Studies have indicated that Medicaid beneficiaries who sought care at health centers were 22% less likely to be hospitalized for potentially avoidable conditions than beneficiaries who obtained care elsewhere. Michigan's 29 FQHC organizations currently care for 10% of all Medicaid enrollees for less than 1% of the physician services budget.
- Michigan FQHCs view the implementation of the Prospective Payment System (PPS) as a huge success and support efforts by the State Medicaid Agency to act as a guardian on behalf of the public good. The PPS has allowed Michigan FQHCs to plan for the future with a predictable budget and it has created incentives to innovate and implement cost-saving programs such as the 340(b) drug pricing program.
- As Congress moves forward on considering ways in which to reform Medicaid, it is critical that it recognize the important role health centers play in their communities and the unique relationship between these centers and the Medicaid program. And lawmakers must appreciate that changes in Medicaid that could be construed as minor could actually have devastating impacts on health centers. For example, the elimination of dental services for Medicaid adults in Michigan in 2003 is still causing tremendous stress to health centers in the state since the need for these services has not dissipated.

**Testimony to the Subcommittee on Oversight and Investigations
Committee on Energy and Commerce
U.S. House of Representatives
Washington, D.C.
Wednesday, May 25, 2005
2:00 pm**

**Presented by,
Kim Sibilsky
Michigan Primary Care Association**

Good Afternoon. My name is Kim Sibilsky and I am here representing Michigan's Federally Qualified Health Centers (FQHC), which include community, migrant, homeless health centers. I am the Executive Director of the Michigan Primary Care Association (MPCA). The MPCA is a nonprofit organization developed to promote, support and develop comprehensive, accessible and affordable, quality primary health care services to everyone living in Michigan. Representing organizational providers and affiliates of community-based primary care centers in the state, we provide a myriad of services, including health professional recruitment, clinical support and technical assistance services, education and training as well as helping organizations become a Community/Migrant Health Center or other primary care delivery model.

Thank you for this opportunity to speak with you today.

Federally Qualified Health Centers (FQHC) provide medical homes to residents of medically underserved communities. Michigan's health centers deliver comprehensive primary care in more than 140 Michigan communities and neighborhoods to more than 425,000 persons.

Michigan's 29 FQHC organizations form an essential component of the state's safety net for

health care services. We are committed to providing high quality, comprehensive health care services to federally designated medically underserved areas and populations.

As FQHC organizations, we provide a comprehensive set of primary care services and enabling services to all people, regardless of their ability to pay. Our clinics not only provide care to families, they also provide care to high risk and special populations including people with changing insurance coverage and those with chronic conditions and disabilities. Research has repeatedly shown that these groups cost the system a disproportionate share of available resources and we are committed to providing them with the best service in a cost-effective manner.

To address the cost of health care, we must ensure that necessary services are available, are delivered by the most appropriate provider, and are accessible in the most cost-effective setting, at the right time. By regulation, only communities lacking such access qualify for a Federally Qualified Health Center. These regulations focus on two different, but equally important issues: 1) a severe shortage of primary care providers for the entire community; and/or 2) a severe shortage due to primary care physicians refusing to provide essential care to populations in need.

Research shows that you can reduce the cost of health care by increasing access to preventive and primary care services. It follows that a reduction in health care costs will result in a reduction in the number of uninsured persons. Yet the cost of health care continues to grow and the growing number of uninsured and underinsured people in Michigan and across the country is directly contributing to the growing number of Medicaid eligible people. This results in a

burgeoning Medicaid budget. Figures calculated from the Current Population Survey and Claritas, a data clearinghouse, indicate that more than 250,000 or 24.7% of Michigan's low-income residents lack basic health insurance. Looking at all income levels, 1.1 million or 12% of Michigan's residents and 45 million or 15.6% nationally are uninsured.

Unless an uninsured person is fortunate enough to live in a community with an FQHC or a free/charity clinic, they have few options other than their local hospital's emergency room. Reports indicate that 58% percent of the 106,000,000 annual visits to hospital emergency rooms across the country are described as inappropriate. In a new study published in Health Services Research; entitled, "Availability of Safety Net Providers and Access to Care of Uninsured Persons" (Hadley J. and Cunningham P., October 2004) finds that FQHCs are more cost effective because they improve access to primary care for the uninsured and underinsured and reduce emergency room visits and hospital stays.

Michigan completed a study in 2001 which looked at preventable hospitalizations, those for which timely and effective ambulatory care can help reduce the risks for common problems such as asthma, diabetes or dehydration. High rates of preventable hospitalizations in a community signal potential barriers to care including lack of sufficient primary care resources. The review estimated that we had over 240,000 preventable hospitalizations which resulted in almost 1.3 million unnecessary inpatient days of care.

Michigan's Medicaid program covers 1 out of 7 citizens. We continue to experience record levels of enrollment as a result of our slow economic recovery. With such high Medicaid enrollment numbers and low state revenues, the pressure is on to identify cost savings. FQHCs

stand ready to be a part of the answer. Several studies have demonstrated that health centers save the Medicaid program more than 30% in annual spending per beneficiary due to reduced specialty care referral and fewer hospital admissions and FQHCs save by helping to prevent unnecessary usage of the emergency room. Studies have indicated that Medicaid beneficiaries who sought care at health centers were 22% less likely to be hospitalized for potentially avoidable conditions than beneficiaries who obtained care elsewhere. Michigan's 29 FQHC organizations currently care for 10% of all Medicaid enrollees for less than 1% of the physician services budget.

Federally Qualified Health Centers (FQHC) applaud the work of Congress to protect the federal funds provided to help care for the uninsured and underinsured. From the beginning, Congress recognized that without mandating a payment system that provided sufficient resources to the FQHCs to care for Medicaid clients, federal dollars may be shifted away from the uninsured. Previously, this meant cost-based reimbursement. On January 1, 2001, the Prospective Payment System outlined in the Medicare and Medicaid Beneficiaries Improvement and Protection Act of 2000 was implemented across the country. This was a historic moment in our program's history. For Michigan FQHCs, not only did this allow them to plan for the future with a predictable budget, it created incentives to innovate and implement cost-saving programs such as the 340(b) drug pricing program. FQHCs welcomed and continue to support efforts to maximize the use of limited tax dollars at both the state and federal levels. The Prospective Payment System is key to these efforts.

Under the Prospective Payment System, each FQHC is assigned a prospective payment amount calculated from their reported 1999-2000 costs. While states have implemented the system in slightly different ways, they all are required to adjust the rates annually by at least the Medicare Economic Index (MEI). These adjustments have averaged around 2.7% over the last four years, way below the medical inflation rate. Even with these modest adjustments, Michigan FQHCs view the implementation of the Prospective Payment System as a huge success and support efforts by our State Medicaid Agency to act as a guardian on behalf of the public good. We have to work within a budget and we understand that both the State and federal government have to do the same.

The Prospective Payment System reimburses the FQHCs and FQHC ‘look-alikes’ on an encounter basis. FQHC encounters combine the cost of the face-to-face visit with a provider and the cost of ancillary services such as immunizations, on-site lab and x-rays, translation, and nutritional counseling provided during the visit into one payment. People not directly involved in the FQHC program often mistakenly believe that we are paid higher rates for office visits than private physician offices. In reality, private physician offices usually do not provide the scope of services we do and when they do provide some of these ancillary services, they often do not incorporate these services into their practice without a means to receive payment.

Michigan would like to draw your attention to how crucial the Prospective Payment System is to FQHCs. We recognize that through the waiver process, states regularly request the ability to waive their obligation to provide FQHCs with payment according to the Prospective Payment System. This waiver activity has the potential to jeopardize the entire system. For example, when

the State Children's Health Insurance Program was created, recognition of our payment system was not included. At the time of development, we anticipated that the enrollees would be relatively inexpensive to care for given that they were children. To our surprise, Michigan created a SCHIP waiver program for childless adults with incomes below 35% of the federal poverty level. This program is referred to as the Adult Benefits Waiver. As you can imagine, this is a very different population than the one we, and we believe Congress, envisioned. Adults enrolled in this program often have multiple conditions including chronic illness, substance abuse, and mental health issues. Many of them are very transient, moving from shelter to shelter or reside on the street. Without recognition of our Prospective Payment System, programs such as Michigan's Adult Benefit Waiver threaten the FQHCs' ability to protect the federal dollars for the uninsured persons in our communities. Because of the demographics of the target population, most private providers do not wish to enroll in these provider networks. As a result, more than half to two-thirds of the Adult Benefit Waiver program enrollees are patients of FQHCs. Recognition of our payment system would protect the financial viability of our nation's health centers and the federal funds provided for the uninsured.

I would like to ask for your assistance as you and your colleagues begin to evaluate the Medicaid program to remember the Federally Qualified Health Centers. Changes that could be construed as minor could have devastating impacts on our system. For example, the State of Michigan elected to eliminate dental services for Medicaid adults on October 1, 2003. This saved relatively little general fund dollars (\$9.2 million) and would impact few providers given the relatively small number of private dentists enrolled in the program. What they did not understand is that the Federally Qualified Health Centers accounted for the majority of dental care currently being

provided to the Medicaid adults. The elimination of Medicaid adult dental is still causing tremendous stress to our system since the need did not disappear, just the payment.

Everyone is struggling with how to pay for our Medicaid system. We must remember the interplay between publicly-funded coverage and the uninsured. When you restrict enrollment in public programs, the cost of providing care does not disappear and the savings are not absolute. People will eventually receive the care they need. It may not be in the best and most cost-effective location, at a time when the progression of illness can be headed off and the most expensive care prevented, but in the end, anyone can walk into a community hospital and receive some level of care. Our goal as providers is to squeeze any waste out of the system that we can. We believe a sizeable amount of waste exists simply from the vast amount of paperwork required of health care providers, the lack of connections between different components of the health care delivery system, and the mobility of our population. I would like to talk to you today about two opportunities that Michigan's FQHCs have embraced to help us address some of these challenges – the chronic disease collaboratives and technology.

Federally Qualified Health Centers are uniquely positioned to embrace change. Our administrators are particularly adept at stretching dollars, our clinicians are mission-oriented and employed by the centers, our Boards of Directors are made of a majority of users of the clinics and therefore personally committed to their continuation, and the federal government is an important partner with resources that go beyond the financial. With the support of the Bureau of Primary Health Care, the FQHCs have undertaken a major shift in how chronically ill patients

are cared for and given the responsibility for their own health. Many positive changes have occurred as a result of the Chronic Disease Collaboratives. Some of these are listed below:

- Michigan Health Centers in the Chronic Disease Collaboratives have experienced drastic reductions in the severity of diabetes among their patients. The Hemoglobin A1c, a lab measurement used to gauge the severity of diabetes, has increased by 26% from the when the centers began to implement the model in 1999 to April 2005.
- Presently there are over 5,463 Michigan patients being tracked related to cardiovascular disease. The Chronic Disease Collaborative aims to reduce blood pressure which leads to reduction in complications associated with cardiovascular disease. To date, despite an influx in the number of new patients enrolled, the program has demonstrated a 5% overall increase in the number of patients with a blood pressure less than 140/90.
- In addition to tracking diabetes and cardiovascular disease, the Michigan health centers are spreading the care model to other chronic diseases including cancer, depression, asthma and a perinatal pilot project.

As a State Primary Care Association, we are working to educate our state policymakers about this program and in fact have a proposal pending with the State of Michigan that will draw many different provider types into providing care using the chronic care model including Critical Access Hospitals, community hospitals, independent and provider-based Rural Health Clinics, private physician offices, Medicaid Health Maintenance Organizations, and community-based coverage programs. This model has tremendous potential that is just beginning to be broadly

appreciated such as improvements in patients' depressive symptoms, percentage increases of patients receiving appropriate treatment for chronic conditions and the ability to track measurable improvement in meeting nationally accepted guidelines. We are committed to providing assistance and sharing our lessons learned in order to see the impressive results in improvement of health status and reduction of health disparities in Michigan that we have experienced in health centers nationally.

Finally, in light of the national interest in moving health care to the electronic age, I'd like to speak with you concerning Michigan health centers' innovation in information technology supported by the Bureau of Primary Health Care of HRSA, VirtualCHC. VirtualCHC is an Application Service Provider (ASP) designed by MPCA which delivers application functionality and computer services to many users via the Internet or a private network. VirtualCHC houses software appropriate to health centers, including a number of choices of practice management, general ledger, Microsoft Office Suite and many others, making them available to health centers via the Internet.

As I mentioned earlier, electronic health records represent an opportunity. They are key to our efforts to improve the quality of care through better and more regular monitoring of patient/provider adherence to clinical guidelines and to eliminate duplication of services/testing/treatment. Implementing electronic health records is a large front-end expense for centers purchasing the software, equipment, training and lost productivity. VirtualCHC provides a way to help minimize that initial investment by giving them a viable alternative to developing and implementing complex systems themselves. Finally, because VirtualCHC is

Internet based, there are no geographic limitations in health centers selecting or being supported by VirtualCHC. As a result, VirtualCHC has serviced health center clients in Michigan, Missouri, Massachusetts, Alaska and the Virgin Islands. With Community Health Centers, the future really IS now.

Thank you for this opportunity to talk with you. If there are any questions, I would be pleased to answer them at this time.

House Committee on Energy and Commerce

Witness Disclosure Requirement - "Truth in Testimony"
Required by House Rule XI, Clause 2(g)

Your Name: <u>Kim E. Sibilsky</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	No
3. Please list any federal grants or contracts (including subgrants or subcontracts) which you have received since October 1, 1999:		
4. Other than yourself, please list what entity or entities you are representing: <u>Michigan Primary Care Association (MPCA)</u> <u>National Association for Community Health Centers (NACHC)</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 of MPCA</u> <u>PAST BOARD MEMBER, NACHC</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	No <input checked="" type="checkbox"/>
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>F.A. TO CMHCs AND HOMELESS, HRSA, DHHS 4/05-3/06 \$640,224.</u>		

Signature: Kim E. Sibilsky Date: 5/19/05