Ohio Association of Community Health Centers
Testimony on Substitute House Bill 49 – Senate Finance: Health and Medicaid Subcommittee
May 17, 2017

Chairman Hackett, Vice-Chair Tavares, and Members of the Senate Finance - Health and Medicaid Subcommittee, my name is Julie DiRossi-King, Chief Operating Officer of the Ohio Association of Community Health Centers (OACHC). Thank you for this opportunity to provide testimony on Substitute House Bill 49.

The Ohio Association of Community Health Centers (OACHC) represents Ohio's 49 **F**ederally **Q**ualified **H**ealth **C**enters and FQHC Look-Alikes (more commonly referred to as Community Health Centers, or CHCs), providing care to more than 670,000 Ohioans in over 280 care sites. Community Health Centers are non-profit health care providers that deliver affordable, high quality and comprehensive primary care to medically underserved populations, regardless of insurance status.

For more than 50 years, Community Health Centers provide integrated whole person care, often times providing **dental, behavioral, pharmacy, vision and other needed supplemental services under one roof.**

Health Center patients are among the nation's most vulnerable populations – people who are isolated from traditional forms of medical care because of where they live, who they are, the language they speak, and their higher levels of complex health care needs. And yet, Health Centers produce positive results for their patients and for the communities they serve while their **costs of care rank among the lowest, saving billions of dollars for taxpayers**.

Community Health Centers have a proven record of delivering high-quality, low-cost health care, coupled with a strong presence in vulnerable/highest need communities – including impoverished urban neighborhoods, small towns and rural counties where poverty and unemployment are historically high.

Quality Coverage and Care for all Ohioans

We commend the preservation of coverage of all individuals under the age of 65 and up to 138% of the Federal Poverty Level. We also applaud the continuation of the current Adult Vision and Dental Medicaid Programs, particularly because its impact directly coincides with the overall health of our low-income children and families as well as it is vital to the sustainability of Ohio's established health care delivery systems in our underserved communities.

Day in and day out, Ohio's Community Health Centers see the tremendous need for greater health care coverage across our state. **Extended Medicaid eligibility levels are directly associated with the enhanced ability of safety net providers like Community Health Centers to invest in capacity, increase access, and better meet the needs of patients and our communities**.

Health Centers have seen many previously uninsured patients become Medicaid enrollees and access primary and preventative primary health care services at a greater rate than before-the health center

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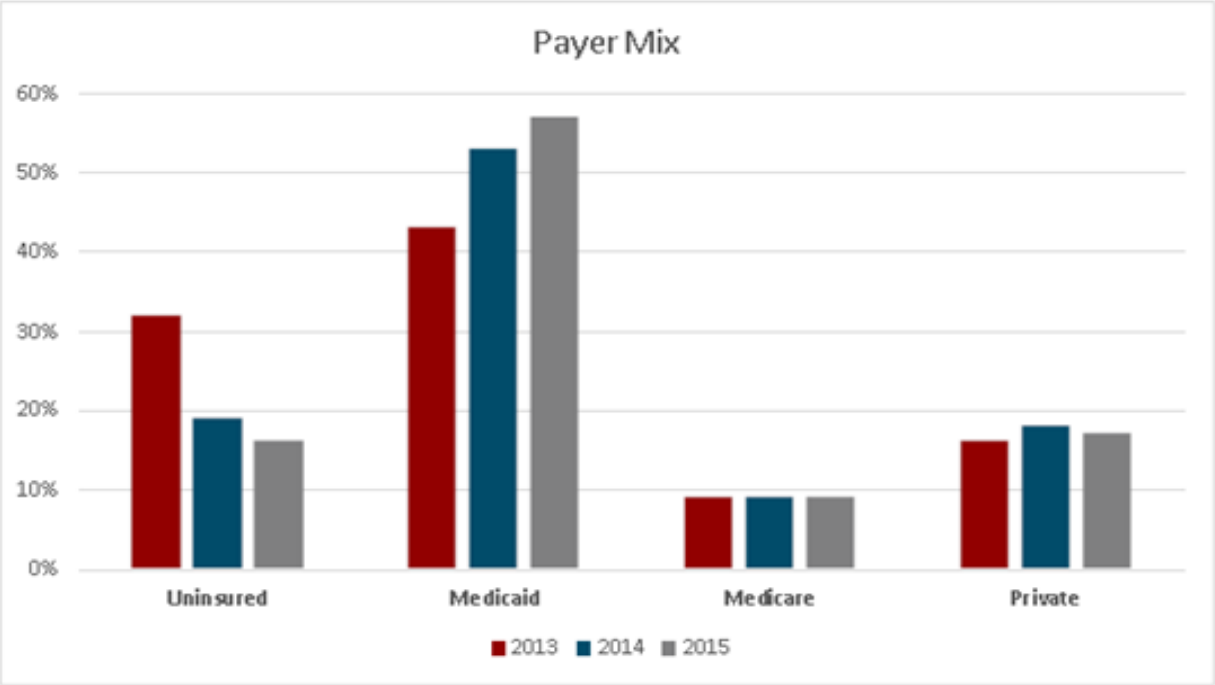
experience reflects the results of Ohio's Group VIII study released last year. Thanks to a greater number of patients accessing coverage, **Health Centers have invested in more patient capacity through a greater number of locations, expanded hours of operation and higher staffing levels for clinicians and other personnel**.



2013-2015 Ohio Community Health Centers Statistics | Medicaid Expansion Impact:

- 13% increase in patients
- 11% increase in access points (Health Center sites)
- 20% increase in dental sites
- 22% increase in Health Center staff/jobs
- Over 80% of Health Centers now offer MAT

For Community Health Centers, increased coverage has meant hiring more staff, standing up more places to access care, and more people seeking care for chronic conditions at the right time, and in the appropriate primary care setting. Without the continuation of that coverage, the gains made in the state regarding access to quality primary care will be in jeopardy.

We believe that providing health care coverage to additional people will save the state money over the long term and immediately begin to change the lives of many Ohioans. **People without insurance who don't have access to primary and preventative care get more sick, do not treat their chronic diseases and end up costing the entire system far more than if they were covered and managed through Medicaid and sought appropriate care at the right time and in the appropriate cost-effective primary care setting.**

Moreover, in a recent *American Journal of Public Health* study, the authors found that Community Health Centers save, on average, $2,371 (or 24%) in total spending per Medicaid patient when compared to other providers, mainly due to patients having fewer ER visits and reduced spending on

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inpatient and specialty care. This represents a tremendous cost-savings that Health Centers generate across the health care delivery system for a comparatively modest investment. Community Health Centers deliver results through the effective management of primary care and chronic disease management, notably in the form of lower total spending.

Included in Sub. HB 49 are provisions requiring the Group VIII population be one of the following; over 55, in school, employed, medically fragile or in alcohol or drug treatment. We understand and respect the General Assembly's wish to monitor Medicaid spending while serving the most vulnerable. We respectfully request the Senate give consideration on broadening these requirements such as including those actively seeking employment, those with mental health diagnosis and broaden treatment to include those on a waiting list or just completed treatment. According to State Health Rankings, Ohio is the 40th healthiest state in the nation, we can't afford to take steps backwards. We need to ensure quality coverage for Ohioans.

Fighting Ohio's Opioid Epidemic

According to a report published in 2016 by the Centers for Disease Control and Prevention (CDC), 78 Americans die every day from opioid overdoses. In 2014, six out of every ten drug overdose deaths involved opioids. Further noted by the report is that, as the number of prescription opioids sold in the U.S. almost quadrupled between 2000 and 2014, the number of deaths due to opioid overdose also quadrupled. Coupled with a surge in heroin overdoses, prescription opioid pain relievers are a primary factor in the increasing rate of deaths due to drug overdose. And in Ohio specifically, **unintentional drug overdoses caused the death of 3,050 Ohioans in 2015, making it the leading cause of injury-related death.** Further, the number of overdose deaths has increased by approximately 20% in each of the last 2 years.

A bright spot for Ohioans was the extension of coverage through the Medicaid Program. Ohio's Community Health Centers have been supported as such to improve and expand the delivery of substance abuse services in an integrated primary care/behavioral health model with a specific focus on Medication-Assisted Treatment (MAT) of opioid use disorders in underserved populations. Currently, **more than 80% of Community Health Centers** offer this critical treatment to curb opioid misuse and abuse, coupled with intensive counseling services. In large part, this **growth and focus is because of the resources and access that the extension of Medicaid has offered** to both Health Centers and those fighting the disease of addiction.

We applaud the investment to combat this terrible tide of addiction. This, along with the reauthorization of the Medicaid Program in Ohio, will allow Community Health Centers to remain fully engaged to offer addiction treatment services, along with physical health care, that those fighting this addiction so desperately need so they can focus and stay on the recovery path.

As Community Health Centers position themselves to be at the forefront of the fight against opioid abuse in underserved communities, several key factors - operational and cultural - must be considered in order to properly address substance use disorders. At the top of this list is workforce shortages.

Support and Growth for Front Line Providers

According to the American Academy of Family Physicians, various studies and projections show a current and predicted worsening primary care physician shortage. With nearly 209,000 primary care physicians in 2010, the United States will require almost 52,000 additional primary care physicians by 2025. Coupled with the United States not only facing a shortage but also a maldistribution of primary care physicians, this deficit is of particular concern given that the elderly population continues to grow,

and **many rural, poor, and minority communities remain medically underserved**. However, fewer medical school graduates are choosing primary care as a specialty today than in the past.

The above statement is true not just for physicians, but for many primary care providers. Progress is being made to find students, but there is a growing shortage of clinical sites in which to train them. Recognizing that need, Community Health Centers, along with the Administration and the General Assembly, created the FQHC Primary Care Workforce Initiative (PCWI) during the FY16-17 operating budget.

This line item, housed in the Department of Health, is **the only primary care workforce strategy in the state.** The funds are used to provide a stipend to the Community Health Centers who bring on primary care students (medical and dental students, APNs, PAs, and behavioral health) for a rotation to expose students to advanced Primary Care Medical Homes in practice and provide a standardized, high-quality educational experience. Checks and balances are built into the program to ensure quality clinical rotations are provided in that only Community Health Centers nationally recognized as a Patient Centered Medical Home are eligible to participate, and the stipend to the Health Center is only awarded if the student has a quality experience and rates their experience 4 out of 5 or higher in their student evaluation. This Program helps account for the loss of productivity associated with precepting. The data for the first year of the program is below, and while data is not yet available for year two (which concludes at the end of SFY 17), all indicators are that it will significantly exceed these numbers, projecting 1200+ primary care students (bringing the biennium total to 2000+ students precepted).

PCWI Year 1 Data Summary (July 1, 2015-June 30, 2016):
883 Total Students Precepted

- 423 Medical students
- 275 Advanced Practice Nursing Students
- 101 Dental students
- 59 Behavioral Health students
- 25 Physician Assisting students

Ohio's Community Health Centers stand ready to expand access to high quality, affordable primary and preventive care to underserved Ohioans, and bring needed health care professionals who will stimulate economic activity in some of our most economically hard-pressed communities.

HB 49 As Introduced reduced funding for the program (ODH Line 440-465) by 10% from the current biennium ($2.43M per FY, compared with the line fully funded at $2.68M per FY) for the PCWI. Substitute House Bill 49 now applies the across the board 1.5% cut to this line, bringing down the total funding to $2.38M per year for the upcoming biennium. We estimate these cuts to mean more than 200 fewer primary care students will receive their clinical rotations in Ohio's Health Centers over the coming biennium. Now, more than ever before, we must grow our primary care workforce, not remove capacity to do so in this workforce shortage area, particularly for Ohio's most underserved areas.

We applaud the House for striking language from the As Introduced version that served as an additional mandate to the PCWI Line. This language would have mandated dollars be diverted from the PCWI line to implement new recruitment and retention activities, over and above the PCWI. The Department shared with us their intention to divert dollars from the PCWI Line to support dentist loan repayment. While we fully support the goals of recruitment and retention, and specifically loan repayment programs that incentivize providers to work in underserved areas, there are existing and supported Loan Repayment programs better suited for this purpose, and as such, we respectfully request this mandate

remain struck. It is important to note, Sub HB 49 doubles (100% increase, from $20 to $40 – Line 67128 of Sub HB 49) the funding that flows from dental licensure registration fees to finance the Ohio Dentist Loan Repayment Program. Diverting funding from the PCWI Line to support dental loan repayment is duplicative, and potentially harmful to the stability of the PCWI program. This mandate language has no limits as to how much funding can be diverted away from PCWI to other recruitment and retention activities, and as such, causes strong concern with regard to the viability of PCWI.

On behalf of Ohio's Community Health Centers and the patients and communities served, we are asking the Senate evaluate programs individually rather than apply across the board cuts, and prioritize programs that provide a return on investment. As we outlined above, we strongly believe PCWI will expose students to advanced primary care, train them appropriately, and bring them back to our most depressed areas in Ohio to practice. As such, we are asking to be restored to the As Introduced funding level.

Value-Based Primary Care Payment

As Ohio elevates care coordination and increasing quality outcomes through value-based payments, the Comprehensive Primary Care (CPC) Program is vital for our success. CPC was built 4+ years ago via the Ohio State Innovation Model (SIM) grant and is an investment in primary care infrastructure intended to support improved population health outcomes. CPC is a patient-centered medical home program, which is a team-based care delivery model led by primary care practices that comprehensively manage patients' health needs.

Currently, 20 Ohio Community Health Centers comprising 57/92 participating sites in CPC 2017 with most Medicaid/primary care providers envisioned to enter CPC in 2018. The goal of CPC is to empower practices to deliver the best care possible, both improving quality of care and lowering costs. Unfortunately funding for CPC was abolished in Substitute HB 49. Eliminating CPC returns Ohio to the model in place for several decades, and we need coordinated, comprehensive, team-based care - the CPC model to move Ohio forward in terms of quality and lower costs.

By eliminating CPC, Ohio will lose $90M in federal funding already authorized for the program. The state must also repay $9.3M to the federal government for ending CPC early, and forego significant savings generated by successful implementation. Abolishing CPC could bring devastating consequences. We respectfully ask the Ohio Senate to restore this pivotal Program.

Summary

In closing, as we think about reinventing our health care delivery system to emphasize prevention and primary care, and push to deliver more cost-effective and patient-centered comprehensive care, Community Health Centers are uniquely positioned to continue to lead this transformation and make it a reality. We look forward to partnering with the Administration and the Ohio General Assembly to keep Ohio healthy. On behalf of our 49 Community Health Centers and 670,000+ patients served, I appreciate the opportunity to provide testimony on Substitute HB 49. Please contact me at jdirossi@ohiochc.org; 614.884.3101 ext 226 with questions or further information.

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