Community Health Centers: Saving Money, Saving Lives

United States Senate Committee
on
Health, Education, Labor, and Pensions

March 2, 2023

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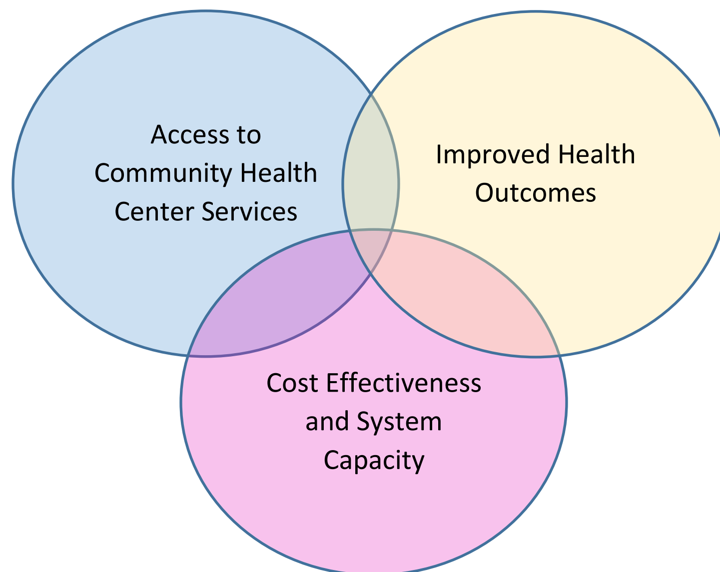
Introduction:

Good morning, Chairman Sanders, Ranking Member Cassidy, and Members of the Committee, and thank you for the opportunity to testify about the important work of Community Health Centers and the incredible value they deliver to this nation. My name is Sue Veer, and I am the President and CEO of Carolina Health Centers, Inc. (CHC), a Federally Qualified Health Center (FQHC) that serves as the primary care medical home for 25,770 patients in the rural area of South Carolina known as the Lakelands. I also have the privilege of serving on the Executive Committee of the National Association of Community Health Centers (NACHC) and the Board of Directors for the South Carolina Primary Health Care Association.

My career in health care spans 35 years and includes working in community hospitals, a major academic medical center, private practices, and now, the community health center world. Though my work environment has varied, the one constant has been my strong commitment to advocating on behalf of patients and their families – a commitment to ensure that everyone, regardless of demographic or socio-economic circumstances, has access to appropriate and effective health care that is delivered with dignity and compassion. When I discovered Community Health Centers in 2001, I found my career home and the perfect fit for my commitment to patient and family-centered care and my training in business and organizational development.

When I joined the health center movement, I discovered unlike other health care settings in which I had worked, the approach to patient care is not episodic or limited to what can be addressed within the walls of a traditional medical practice. Our health centers care for and manage their patients across not just the continuum of care, but often, the full spectrum of their lives. We provide comprehensive primary and preventive care, and address social determinants of health by tackling difficult challenges like homelessness, joblessness, domestic violence, parenting skills, food insecurity, transportation, and so much more. Community Health Centers embody the concept of whole-person care, producing immeasurable value in those patients' lives and across the health care delivery system. Let me illustrate:



As the Venn diagram illustrates, access to the programs and services at a community health center drives more appropriate and effective use of health care services and results in improved health outcomes. This, in turn, results in cost-effectiveness and increased capacity within the health care system. Where access, quality, and cost-effectiveness intersect lies the value proposition for Community Health Centers. As acknowledged in the announcement of this hearing, Community Health Centers save (and improve) lives[1] and save money, and those savings accrue not just to the health centers but across the entire delivery system.

I would be remiss if I did not include comments about the overall economic impact health centers have on their communities. The following data are from a study on Value and Impact prepared by Capital Link, and highlight the Carolina Health Centers, Inc. 2020 economic impact:

Savings to the Health Care System:	**Economic Stimulus:**	**Vulnerable Populations**
24% lower costs for health center Medicaid patients	456 total jobs - 256 health center jobs - 201 other jobs in the community	24,843 total patients served - 95.2% of patients are low income - 57.2% identify as an ethnic or racial minority - 10,133 are children and adolescents - 1.2% are veterans - 1.3% are agricultural farmworkers
$22 million in savings to Medicaid	$53 million in total economic impact from current operations - $34.5 million in direct health center spending - $28.6 million in community spending	
$42 million in savings to the overall health system	$7.9 million in annual tax revenues	

[1] Saving lives is listed first intentionally. Though we are committed to and work diligently to ensure cost effective care, our primary mission is the health and well-being of the patients and communities we serve.

	- $1.4 million in state and local tax revenue - $6.5 million in federal tax revenues	

The National Association of Community Health Centers (NACHC) can provide national as well as state-by-state economic impact data.

Overview of Carolina Health Centers, Inc.

Carolina Health Centers, Inc. (CHC is a Federally Qualified Health Center (FQHC) that serves as the primary care medical home for 25,770 patients in the rural area of South Carolina known as the Lakelands.

CHC's primary service area covers 3,708 square miles and includes the 7 rural counties of Abbeville, Edgefield, Greenwood, Laurens, McCormick, Newberry, and Saluda. Established in 1977, CHC now operates 12 medical practice sites, two community pharmacies, and provides agricultural farmworker health services during the growing season.

CHC's 12 medical practices include nine family medicine practices, two pediatric centers, and one practice site that includes both a family medicine and a pediatric practice. One of the family medicine practices operates as a faith-based practice and is aligned with a wide variety of community ministries to facilitate referrals. Agricultural farmworker services are provided during the growing season at our family practice location in the rural community of Ridge Spring in Saluda County.

CHC has served as something of a pioneer in demonstrating the impact of integrating comprehensive early childhood services into the pediatric medical home. For over 25 years, we have included child development professionals and evidence-based home visitation programs as part of our model of care. I plan to discuss these programs' contributions to value delivered later in my comments.

Behavioral Health and Substance Use Disorder (SUD) services are provided through a combination of in-house behavioral health specialists and collaboration with the Beckman Center for Mental Health Services, the local office of the SC Department of Mental Health. CHC directly employs six integrated behavioral health professionals, and a Beckman Center counselor is located at one of our practice sites. We also coordinate with the Beckman Center for psychiatric services. In addition, we are in the early stages of implementing an agreement to serve as a Designated Collaborating Organization for the Beckman Centers' Certified Community Behavioral Health Center (CCBHC) and will be assigning an Advance Practice Registered Nurse to provide primary care services at four of their locations throughout the service area.

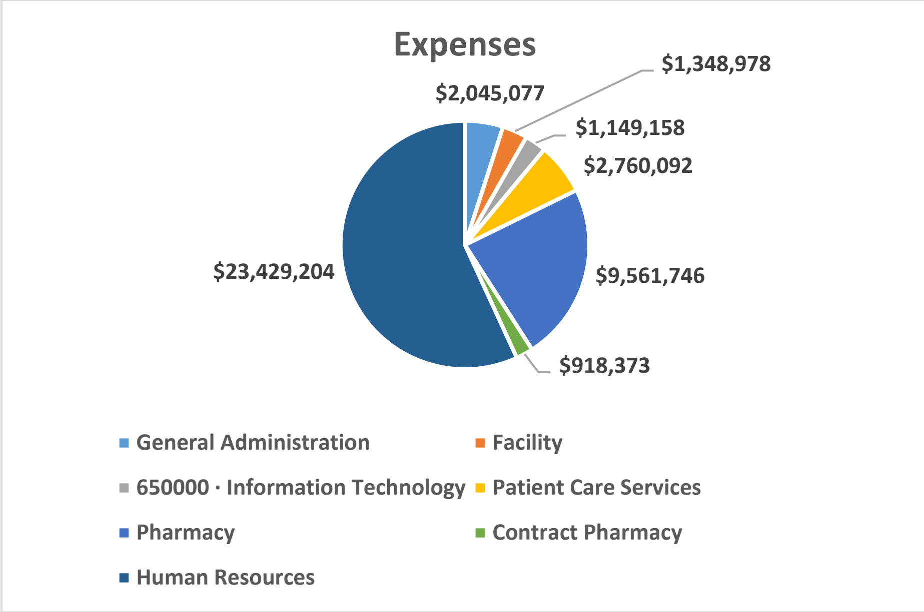
Meeting the escalating need for Behavioral Health and SUD is a particular challenge due to the lack of 3rd party reimbursement or any other source of funding. While the South Carolina Department of Health and Human Services recently adopted new reimbursement guidelines for FQHCs to expand the types of billable providers, in a non-expansion state, few adults have Medicaid coverage; consequently, these enhanced rules only benefit the pediatric population. We estimate that as high as 80% of our adult behavioral health visits have no source of 3rd party reimbursement. This challenge extends to the need for expanded SUD services. CHC has at least five medical providers interested – in fact anxious to provide Medication Assisted Treatment (MAT); however, our ability to add the behavioral health resources necessary to support MAT is limited by the lack of funding or 3rd party reimbursement.

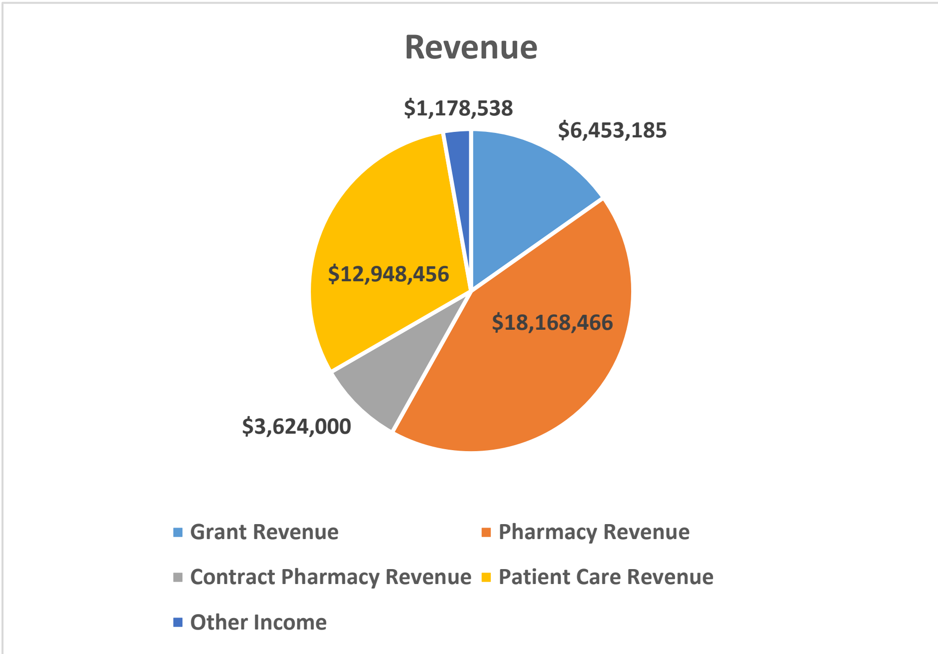
CHC Department of Pharmacy includes two entity-owned community pharmacies, both of which are open to the general public as well as CHC patients. We are a 340B covered entity and 340B purchased inventory is used for only established patients of CHC and only for those prescriptions that emanate from CHC's medical practices and HRSA Scope of Project. The 340B program enables us to offer deeply discounted prescription medication to our patients living at or below 200% of the federal poverty level. To ensure access for our patients given our large and very rural service area, the pharmacy operates a daily courier service that delivers prescriptions for established CHC patients to our outlying medical practice sites. We also provide mail-order medications and implemented home delivery within a limited range during COVID. We also provide prescriptions through several contract pharmacy arrangements, which are necessary due to both geographic barriers and limited payer networks, especially related to specialty drugs. In addition to operating a dispensing pharmacy, clinical pharmacists serve as part of the patient care team, assisting with patient and staff education and medication adherence.

Oral health care is provided through a network of contacted dentists with CHC providing a subsidy for low income uninsured and underinsured patients.

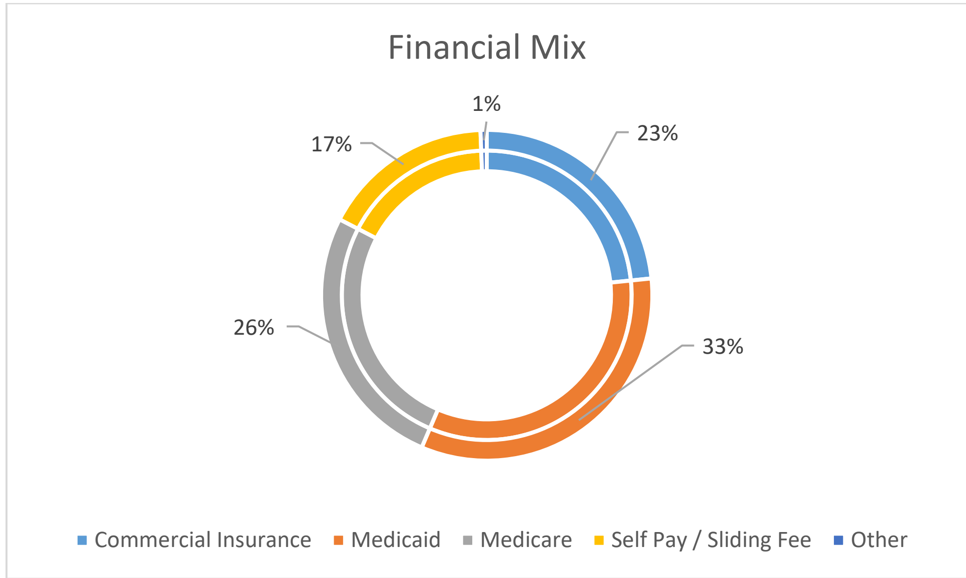
Like most health centers, CHC provides an array of enabling services to promote patient access and the effective use of the health centers services. Those include outreach, community education, transportation support, translation, and referrals to community resources. We have a comprehensive Quality and Population Health Department focused on optimizing the health of the patients we serve through care coordination and case management. The work of this department will be discussed later in my comments.

For the current fiscal year (June 1, 2022 - May 31, 2023), CHC has a total operating budget of $41,212,627, and projected revenue of $42,372,645, for a year end operating margin of 2.7%

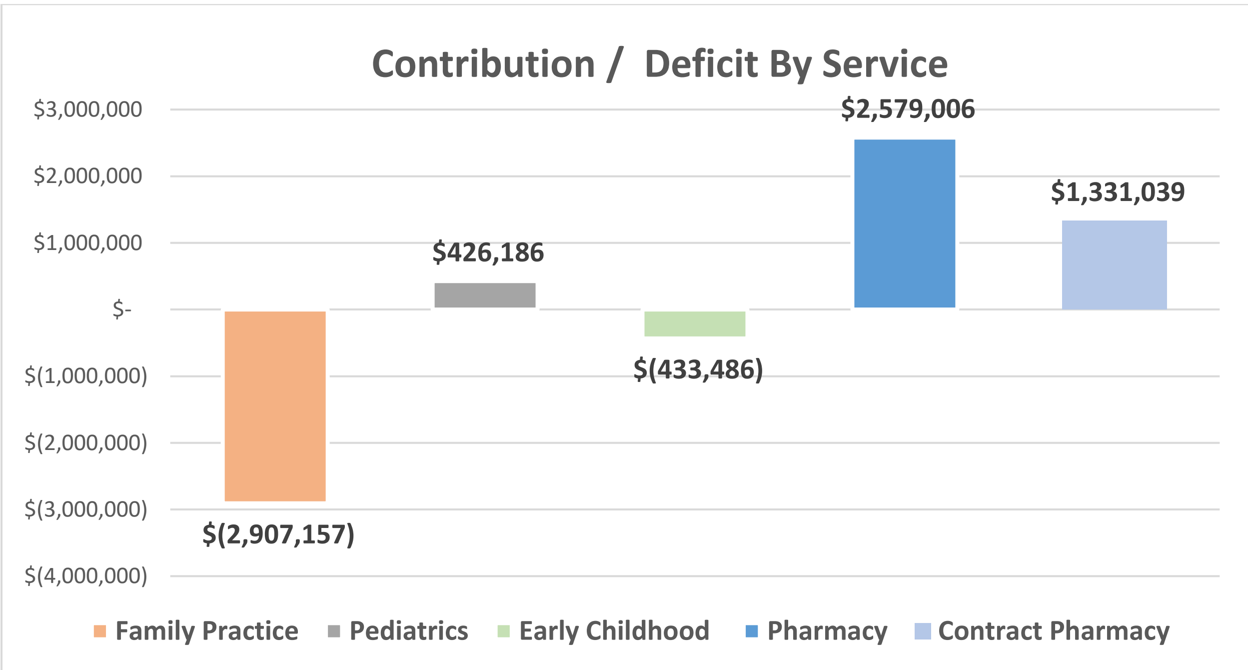




The 12-month Revenue Analysis below reflects a healthy payor mix with 33% of the patients covered by Medicaid and 26% by Medicare; however, it is important to point out that this does not reflect all health centers nor represent the total picture for CHC. It is important to point out that represents the aggregate of all patients across all CHC practice locations. First, that includes pediatric patients which make up over 30% of CHC's total patient population, and 95% of which are covered by Medicaid or private insurance. Measuring in the aggregate also does not account for the variation across practice sites, with many of our smaller rural sites having a significantly higher self-pay patient population – with two practice sites as high as 43%.



The previously mentioned lack of 3rd party coverage for adult family medicine is clearly reflected in the analysis below of contribution versus deficit to the operating margin:



CHC employs a total of 319 employees; however, that number does not reflect the vacancies resulting from current workforce challenges.

Having provided a substantial overview of Carolina Health Centers, Inc., I would like to focus the remainder of my comments on three specific initiatives that make a significant contribution to CHC's ability to effectively manage the care of our patients and deliver on our commitment to value.

Integrated Models of Care:

The primary care medical home model at Carolina Health Centers, Inc. (CHC) is built on a belief that, in order to improve the health of individuals and build healthy communities, the care we provide must extend well beyond the traditional medical practice and include integrated programs and services that address the social determinants of health. Three areas of integrated care that I mentioned earlier are Behavioral Health and SUD, Pharmacy Services, and Early Childhood Services. While all of these contribute significantly to providing quality and cost-effective care, I would like to focus here on Early Childhood Services, as it is a bit unique to CHC and a focus of growing interest among the Community Health Centers.

CHC's largest pediatric practice, The Children's Center, was born out of the vision of a group of pediatricians at the Greenwood Genetics Center. They believed that, in order to positively impact the health and well-being of future generations, the work of pediatrics must extend beyond the walls of the traditional pediatric model. These pediatricians formed a community-based non-profit organization focused on Early Childhood Development and helped leverage state funding for CHC to open The Children's Center over 25 years ago. For many years these two organizations were co-located and worked collaboratively to meet the needs of our shared patients and families. Then in 2009, the boards agreed to merge the organizations, creating a Department of Early Childhood Services within CHC.

Today, the Department of Early Childhood Services (ECS) operates four evidence-based models, three of which include a home visitation component. They also provide a range of care coordination to ensure that families with need but not meeting any specific program eligibility can access assistance. All of these programs are voluntary.

The four evidence-based programs and their goals are described below:

<u>Nurse Family Partnership (NFP)</u> – is a home visitation program staffed by bachelors prepared registered nurses, that serves low income, first time mothers starting early in pregnancy and continuing until the child's second birthday. The goals of NFP include:

- Improve pregnancy outcomes by teaching/encouraging mothers to engage in good preventive health practices including thorough prenatal care;
- Improving diet;
- Eliminating the use of habit-forming substances;
- Improving child health and development; and

- Improving the economic self-sufficiency of the family by supporting parents in the planning of future pregnancies, continuing their education, and finding employment.

Healthy Families America is a home visitation program of Prevent Child Abuse America. Families in need of services are identified through a risk assessment given at the 2-week well child check-up. Risk factors include low income, single parent, first child, 18 years-old or younger, Spanish speaking only, high/school or less educational level, late/no prenatal care, expressed concern about parenting lack of a support system, past history of child abuse/neglect, or a history of mental illness, domestic violence, and/or substance abuse. The goals of Healthy Families America include:

- Prevent the abuse and neglect of children in communities;
- Strengthen parent-child relationships;
- Promote healthy child development; and
- Enhance family well-being.

Parents as Teachers is a program that helps parents embrace and develop their role as the child's most influential teacher. Similar to the Healthy Families America program, families in need are identified through a risk assessment at the 2-week well child check-up. The goals of Parents as Teachers include:

- Supporting the parent's role in school readiness;
- Promote optimal early development; and
- Enhance the learning and health of children.

Healthy Steps is an evidence-based interdisciplinary pediatric primary care program that integrates child develop specialists into the pediatric care team to promote healthy development. Healthy Steps has an emphasis on low income and otherwise vulnerable families and the goals of the program include:

- Providing support for common and complex concerns including behavior, sleep, feeding, attachment, parental depression, social determinants of health, and adapting to life with a baby;
- Identifying when children are (and aren't) meeting developmental milestones;
- Connecting families to additional services as needed; and
- Fostering patient centered care and the appropriate and effective use of health care services.

Care Coordination is an essential role in ECS as it ensures that no family is left without resources to assist them with special needs or in navigating the health care system. The pediatric care team often refers families who are known to use emergency services for episodic care, or require referrals to specialists or other services within the community.

Early Childhood Services (ECS) have immeasurable impact for the families served, as well as across the health care delivery system. On more than one occasion, Nurse Family Partnership home visiting nurses have identified preterm labor, preventing the possible death of mother or baby, or preventing a premature delivery resulting in a long and costly stay in a neonatal intensive care unit (NICU). The Healthy Families America and Parents as Teachers staff share countless stories of parents who have ended abusive relationships, eliminated toxic substances from their lives, gone back and finished high school, and even completed college degrees. CHC's pediatric providers often share stories about the work of the Health Steps child development specialists positively impacts their patients, noting that these families are the most adherent to both well-child care protocols as well as treatment when needed for episodic and chronic illnesses. These families are also less likely to use an emergency department or urgent care for ambulatory sensitive conditions that are more appropriately treated in a less costly setting of care.

These success stories speak to the impact on the health and well-being of these families, but behind the scenes is the story of the resources that have been saved, not to mention the contribution these families are now making in the community.

Three of the four evidence based programs provided by CHC's Early Childhood services Department are funded (in part) by the Maternal Infant and Early Childhood Home Visitation program; however, a portion of the cost for these programs must be covered by CHC's operating margin.

Recently, the Health Resources and Services Administration (HRSA) released a Notice of Funding Opportunity that will enable more Community Health Centers to incorporate Early Childhood Development into their medical home model. I appreciate and applaud HRSA for helping to move the needle on this important work that can impact so many lives, build healthier communities, and drive the appropriate use of our health care resources.

Quality and Population Health/ Value-based Reimbursement

The Quality and Population Health Department at Carolina Health Centers, Inc. (CHC) has developed over the past ten years to now include eight professionals whose roles focus on managing how CHC patient access and utilize the health care system in order to optimize the benefit to the patient and ensure appropriate and effective use of healthcare resources.

The responsibilities of this cadre of case managers care coordinators, and quality and population health specialists include closing gaps in care, which means working directly with patients to ensure that they are receiving recommended primary and preventive care and screenings. Often for low income, uninsured, and underinsured patients, this includes working with other providers and community organizations to arrange for free or low cost screening services. Closing gaps in care is closely related to meeting Healthy Effectiveness Data and Information Set (HEDIS) measures that have been established by the National Committee for Quality Assurance (NCQA). Through the work of CHC's Quality and Population Health Team does to close gaps, we have saved lives through early detection and intervention for a myriad of potentially life threatening and definitely life changing conditions. Early detection and intervention results in far more cost effective care saving money across the entire continuum of care.

Another focus for CHC's Quality and Population team is evaluating patterns of high utilization of emergency departments, urgent care, and specialty care. Staff are able to identify these patterns of high utilization using reports provided by the managed care companies whose beneficiaries are assigned to a primary care provider (PCP) at CHC. Through outreach, education, and care coordination services, we are often able to alter a life long and even multi-generational pattern of inappropriate use of health care services, resulting in significant and long-term savings to the health care delivery system. Often times, this also results in better care management and improved health outcomes.

Care coordinators and case managers also work with complex patients to connect them to needed specialty care and social services and follow up with those patients assigned to a PCP at CHC, but who have never established care as a new patients. This is important for the patient, but also because the managed care companies attribute responsibility for care of those patients to the assigned PCP.

The results of this work are documented and measurable, and for Carolina Health Centers, Inc. and thirteen other health centers in South Carolina, have the potential to return benefit in terms of value-based reimbursement by the Medicaid Managed Care Organizations (MCOs).
In January of 2008, fourteen of South Carolina's community health centers formed an Independent Practice Association (IPA) called Community Integrated Management Association (CIMS). The partners in CIMS are clinically and financially integrated in order to develop collaborative clinical protocols that support improved health outcomes, and to develop value-based reimbursement agreements with the MMCOs. As of this date, the CIMS heath centers have value-based agreements with four of the MMCOs and are working to develop similar agreements with Medicare plans as well as Market-based plans.

Basically, the value-based agreement measure performance in two ways. The first is based on the % of beneficiaries assigned to the practice that meet all of the plans selected quality measures, which may be HEDIS measures or other measures assigned by the Medicaid agency. The second is how the health center performs in terms of the Medical Loss Ratio (MLR) in the aggregate for all beneficiaries assigned to a PCP at that health center. MLR is a measurement of the amount of the MCOs capitation that is directed to health care services. MLR is reported in total as well as broken into composite parts representing different categories of care such as primary care, pharmaceutical costs, inpatient, and emergency care. In evaluating MLR through the lens of both quality and cost effectiveness, a MLR that is too low – i.e. below 80% - may indicate that the beneficiary is not receiving adequate care; while a MLR that is too high – i.e. 90% and above may indicate that the beneficiaries assigned to that PCP are not using health care resources in a cost effective manner. Because it encompasses all direct health care expenses, MLR is an excellent measure of the impact Community Health Centers are having on both quality and cost effectiveness.

Because CIMS is clinically and financially integrated, value-based reimbursement (or shared savings) paid by the MMCOs are based on the aggregate performance of all partner health centers; however, CIMS distributes those value based payments to the partnering centers based on their individual performance. Carolina Health Centers, Inc. (CHC) is in the top three performing partner centers, largely due to the investment that has been made in developing our Quality and Population Health team. The image below is an example of a report that is generated for CHC in the CIMS Quality Dashboard.

CLINVIEW® Worklist (MLR) | CIMS | UDS REPORTS | ROSTERS | CLAIMS | MLR | GAPS IN CARE | EMR | GEO MAPPING

Facility Name: Carolina Health Centers | MCO_MLR: HealthyBlue | Quarter: 4 of 18

MLR	AVG MBR MTH	AVG COSTS	AVG PREMIUM	AVG ER	AVG IP	AVG OP	AVG RX	AVG PCP
89.6%	6,470	$261	$291	$16	$66	$49	$55	$87

Carolina Health Centers | HealthyBlue | Select a YearMonth (ATC) | 4 of 18 selected in Quarter (Healthy Blue) | Select a PCP (ATC)

MEDICAL LOSS RATIO
Worklist

Facility Group	MCO Name	Quarter	HBR	Member Months	Total Cost	Premium	Inpatient	OP ER	OP Non ER	RX	PRF PCP	PRF Non PCP
CarolinaHealth	HealthyBlue	202104	86.1%	6,624	$242	$281	$49	$16	$35	$59	$25	$55
CarolinaHealth	HealthyBlue	202103	87.2%	6,515	$262	$301	$57	$18	$31	$60	$34	$57
CarolinaHealth	HealthyBlue	202102	90.0%	6,503	$261	$290	$64	$16	$36	$55	$31	$55
CarolinaHealth	HealthyBlue	202101	95.2%	6,238	$280	$294	$95	$13	$30	$47	$29	$62

It is an excellent demonstration of the impact CHC has across all segments of the health care delivery system. Through Quality and Population Health management we are savings lives and saving money.

Laurens County Community Care Center (LC4)

is an excellent example of how Community Health Centers are able to partner with other provider organizations to increase access to primary care in a community and save money. LC4 was established in 2009 when Laurens County Community Hospital (now the Laurens County

campus of Prisma Health) was building a new emergency department. In their needs assessment they determined that over 60% of the ED utilization was related to non-emergency care that could be treated in a less costly health care setting. Through a dynamic partnership, the space vacated when the new ED was completed became a family medicine practice site of CHC. LC4 is located within the walls of the hospital, immediately contiguous to the new ED. Though patients are still treated in the ED for episodic, non-emergent conditions, those without an established source of primary and preventive care are referred next door to LC4 where the majority become established patients. Previous studies indicate a significant reduction in ED utilization for nearly 70% of the patients that establish a medical home with CHC. Reduced use of emergency services for ambulatory sensitive care has been recognized as one of the top strategies for reducing cost in our health care system and that savings has become a reality at LC4. Of note, 43% of the established patients at LC4 are self-pay, which suggests that these patients added to the financial burden in the ED. We are also saving and improving lives as we reduce the use of episodic care in favor of a comprehensive and integrated primary care medical home.

Closing:

Chairman Sanders, Ranking Member Cassidy, and members of the committee, I would like to close by thanking you, as well as all Members of Congress for your recognition that Community Health Centers essential to the health and well-being of communities across this nation, and for you long standing, bipartisan support that has enabled us to grow and stand in the during the past three difficult years.

I recognize that Congress is facing significant challenges in terms of fiscal policy and deeply appreciate the attention that is being paid to the needs of Community Health Centers, our patients, and the communities we serve.

I will leave you with my thoughts about what is important to me as health center leader.

I have alluded to significant challenges in terms of workforce development, lack of funding for behavioral health and SUD, and the inflationary pressure we have all experiences. There is unmet need across CHC's service area that clamors to be addressed. Community Health Centers are deteriorating and could benefit from capital funding. However, what is critical to me as a health center leader is funding that is sustainable, predictable, and fully supported now and into the future. Support for long-term, sustainable, and predictable funding enables me to confidently lead my health center into the future and empower the amazing team at CHC to continue the work of saving lives and saving money.

Thank you.