PENNSYLVANIA ASSOCIATION OF COMMUNITY HEALTH CENTERS

House Health Committee and Professional Licensure Committee Hearing

Joint Informational Meeting on Improving Access to Healthcare.

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March 7, 2024

Good afternoon, Representative Frankel, Representative Burns, Representative Rapp, Representative Metzgar and members of the House Health and House Professional Licensure Committees. We thank you for the opportunity to discuss how we can all work together to improve access to healthcare and how Community Health Centers work as part of the safety-net network to provide critical services to individuals across the Commonwealth who might otherwise have difficulty accessing care.

Thank you for the opportunity to provide an overview of the important role Community Health Centers play in Pennsylvania and some of the issues that must be considered and addressed as we work together to improve access to health care across Pennsylvania.

Background

In speaking on behalf of the Commonwealth's Community Health Centers, I will take a moment to provide context. The Pennsylvania Association of Community Health Centers, or PACHC, represents Community Health Centers (also known as federally qualified health centers or FQHCs) throughout Pennsylvania. Community Health Centers compose the largest network of primary care providers in both the state and the nation. These health centers are held to nearly 100 federal requirements to gain and maintain their status as Community Health Centers – some of which include minimum number of hours of operation, quality assurance standards, and locations in an underserved area. Community Health Centers improve health equity and offer access to quality primary medical, dental, behavioral health care, vision and other health-enhancing services for individuals and families. Health center services include primary medical care, behavioral health care, oral health care, prenatal care, cancer and other disease screenings, immunizations, pharmaceutical services, enrollment assistance, and many others.

Community Health Centers are open to all, including privately insured, Medicare, Medicaid, and the uninsured, and currently serve one in 13 Pennsylvanians. If a patient is uninsured, the cost of services provided by the health center is based on the patient's family size and income through a sliding fee discount program. Our average patient is working poor – an individual who is employed but their employer is unable to provide insurance, or it is too costly for the individual.

There are 53 community health center organizations serving Pennsylvanians, with more than 430 FQHC sites in 54 of the Commonwealth's counties operated by these non-profit community organizations. You will find Community Health Centers in both rural and urban underserved areas of the Commonwealth. In aggregate, Community Health Centers provide quality care to almost one million Pennsylvanians every year. Many of these individuals would have difficulty accessing health care without their local FQHC. Community Health Centers also often serve as the first line of surveillance and response to public health needs, especially for the most vulnerable.

The Health Center Program and model of care has a history exceeding 50 years and has enjoyed bipartisan support throughout that history. Multiple studies have validated that although Community Health Centers serve more individuals challenged by the social determinants of health, like poverty, and with complex medical conditions, they do so both effectively and cost efficiently. A recent study by George Washington University concluded that the health care system saved $1,760 annually for everyone who has a Community Health Center as their medical home. If we extrapolate that number times the 890,000 individuals served by Pennsylvania's Community Health Centers, these critical providers are saving the health care system—and consequently, the Commonwealth and taxpayers—**more than $1.74 billion dollars annually.**

Community Health Centers are only able to be located in rural and urban areas that are federally designated as Medically Underserved Areas (MUAs) or Health Professional Shortage Areas (HPSAs)—areas of highest need. Community Health Centers are successful in part because of the federal requirement that these non-profit community-based organizations have a patient majority board. That is, at least 51 percent of a Community Health

Center's governing board must be patients of the health center to keep the Community Health Center responsive to their community and community need.

Primary Care in Crisis

Primary care is in crisis. On Feb. 28, 2024, the Milbank Memorial Fund published their second annual Scorecard[i] that highlighted the systemic lack of support for primary care in the United States, which is harming people's health and weakening the US health system. Despite the overwhelming evidence that access to primary care improves population health, reduces health disparities, and saves health care dollars, support for primary care continues to dwindle. As a result, the average life expectancy in the United States continues to stagnate, and health disparities in preventive services and other basic primary care services persist. The primary care workforce is not growing fast enough to meet population needs.

The number of primary care physicians (PCPs) per capita has declined over time. While the rate of total clinicians in primary care, inclusive of nurse practitioners (NPs) and physician assistants (PAs), has grown over the past several years, it is still insufficient to meet the demands of overall population growth, a rapidly aging population with higher levels of chronic disease, and workforce losses during the pandemic. The number of trainees who enter and stay on the professional pathway to primary care practice is too low, and too few primary care residents have community-based training. In 2021, 37% of all physicians in training began their residencies in primary care, but many of them go on to specialize and don't ever practice primary care. More than half of residents with the potential to enter primary care subspecialized or became hospitalists instead. In 2020, only 15% of primary care residents spent most of their time training in outpatient settings where a majority of the US population receives their care. Fewer than 5% of primary care residents spent most of their training with the most underserved communities in the United States.

Pennsylvania's community health centers employ 509 physicians, 370 nurse practitioners and 130 physician assistants. These primary care practitioners account for 1.6 million patient visits a year. However, that's not nearly enough providers to cover the need. The recruitment of physicians, nurse practitioners, and physician assistants, along with mental health professionals, dentists, and other skilled health care professionals is key to caring for Pennsylvanians now and into the future.

Primary Health Care Practitioner Program

That is why it is imperative that the General Assembly support an increase in the Primary Health Care Practitioner Program (PHCPP). Programs like PHCPP become even more critical to ensure we have a viable health care workforce to meet the demand for health care services in the short- and long-term.

The PHCPP funding allows organizations across Pennsylvania to train and place clinicians in underserved communities, provide technical assistance to primary care clinicians and health care facilities across the state, and support the Commonwealth's network of safety-net providers. The line item also supports the state's Primary Care Loan Repayment Program, which offers funding for educational loan repayment to primary care clinicians practicing in underserved communities. This program acts as a financial incentive for the recruitment and retention of physicians, dentists, mental, and behavioral health professionals, and other primary care clinicians in areas that lack access to primary care. It also helps Pennsylvania health care employers compete with other states to secure clinicians to practice in the Commonwealth. This comprehensive programming supports clinicians serving hundreds of thousands of Pennsylvania patients in need of access to quality, affordable health care to help them get well and stay well.

Unfortunately, each year there is a delay in getting the funding to those clinicians due to a combination of the lengthy budget approval process and the arduous application process that is managed by the Pennsylvania

Department of Health[ii]. The following barriers impact access to and participation in the program, per the PHCPP Request for Application (RFA)[iii]:

1. In order to do business with the Commonwealth of Pennsylvania (Commonwealth) practitioners selected for an award are required to enroll in the Student Assistance Program (SAP) system. Applicants may enroll by selecting "Non-Procurement" at https://www.budget.pa.gov/Services/ForVendors/Pages/Vendor-Registration.aspx.
2. Grant funds will be distributed at the end of each year of the service commitment. The LRP will send approved Grant payments directly to the practitioner (not to the student loan lender).
3. State Taxability – Student loan repayments or the forgiveness of student loan debt received as an inducement to enter or as a result of employment in a certain profession or field are considered taxable compensation for Pennsylvania personal income tax purposes according to the Pennsylvania Department of Revenue. By comparison, recipients of loan repayment through the federal National Health Service Corps do not pay tax on their loan repayment dollars.

Funding for Community Health Centers

Health Centers across Pennsylvania are continually faced with narrowing margins and increased costs throughout their organizations. In addition to covering the cost of caring for the uninsured and to make up for inadequate Medicaid reimbursement, Community Health Centers are facing additional unfunded costs for a myriad of services that are needed to comprehensively care for their patients. At the same time, attacks on the 340B program are decreasing saving through this program; inflation is increasing the costs of goods and services; and increasing workforce challenges are directly impacting the ability to provide care. When we are not there to provide care, the alternative is a much more costly emergency department visit and, often, hospital stay. There are also additional costs associated with telehealth services. Community health centers quickly embraced telehealth services at the beginning of the pandemic. The use of telehealth is now a critical part of part of the care being delivered in both rural and urban communities. Nowhere is telehealth more important than in the delivery of behavioral health services.

Throughout the pandemic and moving forward, Pennsylvania's Community Health Centers have taken care of Pennsylvania's most vulnerable populations and have filled in the gaps to serve as the state's public safety net for much of this population, across both rural and urban settings. The chart below highlights the unfunded costs Pennsylvania Community Health Centers encounter to just care for the uninsured population in Pennsylvania.

FQHC Patients	**Uninsured Patients**	**Average PPS Rate[iv]**	**Unfunded Care**
992,412	129,609	$216.46/Visit	$28,055,164
FQHC Visits	**Uninsured Visits**	**Average PPS Rate**	**Unfunded Care**
3,585,864	468,314	$216.46/Visit	$101,371,248

Pennsylvania's Community Health Centers need financial support to assist them in covering the costs of providing care to uninsured Pennsylvanians and to assist in covering many of the additional unfunded costs. These include Community Health Workers, transportation, care coordination, technology costs, etc. To date, community health centers have never received direct state funding through the state budget to support the unfunded care they provide. Pennsylvania is one of only four states that do not fund FQHCs.

Primary Care Preceptorship Program for Community Health Centers

PACHC supports SB 817, the FQHC Primary Care Workforce Initiative. Introduced by Senator Brooks, SB 817 is based off a key program initiative implemented in Ohio. The legislation seeks to ensure that Pennsylvania is

training and incentivizing primary care, dental, and behavioral health students to learn, live and work in Pennsylvania and serve our underserved populations with affordable, quality health care IN their local communities. The legislation helps to bridge the gap between Pennsylvania's state-based medical, dental, nursing, and other schools and Pennsylvania FQHCs by creating the infrastructure to allow them to offer preceptorships to students who are training for careers as primary care clinicians, dental providers, and behavioral health professionals.

Nurse Practitioners Full Practice Authority

PACHC supports HB 1825 and SB 25 to grant full practice authority to nurse practitioners (NPs), increasing access to care for the people of Pennsylvania. Community health centers across Pennsylvania employ more than 300 nurse practitioners who account for more than 750,000 patient visits per year and who contribute to our positive outcomes--quality of care that is validated by publicly available data. We are confident from our experience, and the experience of 29 other states where NPs already hold full practice authority, a formal collaborative agreement with a physician is not a prerequisite to these professionals providing quality care. It is becoming harder to find a supervising physician, which limits access to care.

Credentialing

PACHC also supports HB 1510, which would require health care practitioners and insurers to use the Council for Affordable Quality Healthcare (CAQH) system for credentialing, limit the credentialing period to 45 days for complete applications and streamline the process for health practitioners practicing in multiple locations. Community health centers routinely face delays with the credentialing process, particularly with the Medicaid Managed Care Organizations. When a health center can find and hire a practitioner, the credentialing process may take up to 6-12 months. During this time the practitioner may be providing care due to high patient need, but the community health center might not receive any reimbursement for the care provided. This puts the community health center at financial risk. We fully support a mandatory, centralized, standard credentialing system for all health care providers to ensure timely access to care and reimbursement for services provided.

> *Here's an example of the broken credentialing system from one community health center: The credentialing process for new providers takes an unreasonably long amount of time. Since 2020 we have experienced wait times of 6-12 months for our new providers which has hindered our ability to meet the increased demands of our community. We are currently losing a dentist who was hired immediately after residency because she feels she isn't able to practice her clinical skills enough to progress as a new dentist. Our organization struggles to find funding that supports the salaries of uncredentialed providers for 6 months. As the Chief Dental Officer of my organization, I have had to sacrifice my administrative time to compensate for lost productivity during the credentialing period. This has created further problems for my department within the organization. I understand there is a time-limit for insurers to complete a provider's credentialing. I've experienced MCO's going well beyond the time-limit, then retro-activating the credentialing to a time that is compliant. Since we are not informed about which plans will retro-activate credentialing we are left to assume none will.*

Mobile Units

In 2023, PACHC conducted a survey with support from our national association regarding Pennsylvania mobile units and identified that 15 of the 50 Pennsylvania FQHC organizations operate one or more mobile units. These mobile units offer a wide variety of services including preventative services, primary care, dental, enabling services, outreach and enrollment, immunizations, and pediatrics. Community health centers use mobile units to meet communities where they are by offering services at community events, schools, health fairs, homeless shelters and encampments, and low-income housing. Based on the survey, the average cost to operate per unit per month in Pennsylvania is $82,936.29. Additionally, hiring and training staff was identified as the greatest challenge to operating a mobile unit, further highlighting how the workforce shortage impacts access to care. Many health centers struggle to sustain their mobile units. If payers could offer value-based incentives for service

provided on mobile units or make eligibility for collecting payment more flexible, it would ease the overall financial burden of maintaining these very expensive units.

School-Based Health Clinics

There are 10 FQHC organizations operating one or more school-based health clinics (SBHC) in the commonwealth, accounting for nearly half of the 30 individual SBHC sites in Pennsylvania. School-based health clinics provide access for children to receive primary health care and other services where they are: in school. Research has shown that SBHCs increase access to health care, decrease emergency room use, and improve school attendance and academic achievement. In West Scranton Intermediate School, at the SBHC operated by The Wright Center for Community Health, parents can join their child's appointment via telehealth, thus eliminating transportation and time off work barriers to care. Community integration is foundational to FQHC operations; therefore, Community health centers are well-suited to operate school-based health clinics. Hannah Penn Center, an SBHC operated by Family First Health in York, has been an example of excellence in this space for 26+ years. Through generous funding from a variety of partners, Hannah Penn Center provides school physicals, immunizations, mobile dentistry, primary care, and care navigation while being fully integrated with the school culture and activities. Hannah Penn Center even employs a Health and Wellness Coach that is embedded in school activities and promotes wellness, health, and disease prevention across the school community.

SBHC services are valuable assets to ensuring access to care, however, they are expensive and difficult to sustain without adequate funding. For example, West Virginia funds 160 SBHCs, the majority of which are operated by FQHCs. West Virginia SBHCs provide care to more than 45,000 students and provide access to care to more than 85,000 students. With an investment in FQHCs to provide access to students and their families through SBHC, Pennsylvania could become a national leader in school-based health and ensure access to care for families who need it most.

Maternity Deserts

Many patients served by Pennsylvania community health centers face disparities in social determinants of health, including decreased access to care, financial instability, and limited social support. These barriers put many FQHC birthing people at risk for poor health outcomes. The maternal death rate in the United States in 2020 was 23.8 deaths per 100,000 live births, which was higher than in 2019.[v] In the Pennsylvania Maternal Mortality Review: 2021 Report, the pregnancy-associated mortality ratio across the state was 82 deaths per 100,000 live births.[3vi] For non-Hispanic black patients, this number was 163 deaths per 100,000 live births, which was two times higher than non-Hispanic white patients.[3]

One factor contributing to poor outcomes for birthing people is lack of accessible hospitals with maternity units. With rural hospitals closing across the state, and maternity units closing in urban hospitals, pregnant individuals are left to travel long distances for care. These closures have a negative downstream effect on prenatal care availability in Community health centers who often partner with hospitals to provide the full complement of maternal care. Community health centers are a safety net provider providing prenatal services to vulnerable populations, regardless of their ability to pay. Often, this includes patients who are uninsured and ineligible for Medicaid. Community health centers fill the gap to provide prenatal services for these patients, however, many Community health centers are not outfitted with the capability to provide anatomy scans. Patients end up having to be referred to outside organizations where the cost is prohibitive. Uninsured pregnant women should have presumptive eligibility for Medicaid throughout the course of pregnancy and for 12 months after to improve access to prenatal services and improve patient outcomes. Additionally, continued support of evidence-based programs such as Nurse Family Partnerships[vii] and Healthy Start[viii] is important to allow families access to prenatal and post-partum care through home visits.

Oral Health Access

According to 2023 federal shortage designations, Pennsylvania has 174 individual Dental Health Professional Shortage Areas (Dental HPSAs)[ix]. Pennsylvania ranks tenth among states for most people living in dental HPSAs in the country. A lack of dental providers, including dentists, dental hygienists and dental assistants, across the state necessitates the recruitment of atypical health settings for dental care. With more than 2 million Pennsylvanians living in a shortage area, it is critical that medical settings begin doing more to prevent oral health disease as is often done through integrated care in Community health centers. These services must be incentivized by payers.

Another important factor in the workforce shortage is the lack of dental providers willing to accept Medicaid insurance. Only 8% of the general dentists in Pennsylvania accept all forms of Medicaid, leaving nearly 1.5 million children who rely on Medicaid with very few dental providers to choose from. Community health centers participate with all Pennsylvania Medicaid plans, leaving them as the primary provider of choice for Medicaid beneficiaries. In a poignant example, one small Pennsylvania FQHC is serving patients from 19 rural counties because of lack of access to dentists who will accept Medicaid. Statewide, the number of dental providers in non-rural areas compared to rural areas is 15 to 1[x].

Licensed Social Workers

In Pennsylvania, social workers and counselors require 3,000 hours in direct supervised clinical practice to qualify to sit for their Licensed Clinical Social Worker (LCSW) or Licensed Professional Counselor (LPC) exam. For many graduates in the social work and counseling field this can be quite difficult to achieve while working full time, often raising a family, and finding the time and supervision to complete the required 3,000 hours. For community mental health providers who operate under the policies and guidelines of OMHSAS, it is allowed for an individual working on their licensure hours to bill for encounters under the supervision of an LCSW or LPC for Medicaid. As you know, FQHC providers serve the Medicaid population and many individuals in Pennsylvania are unable to access mental health treatment. Allowing Community Health Centers to hire and bill for staff who are actively working on their direct clinical hours and are under the required supervision would help to reach the many individuals actively seeking care.

Community Health Workers

A Community Health Worker (CHW) is an individual who contributes to improved health outcomes in the community where they reside and/or where they share ethnicity, language, and life experiences. Community Health Workers proactively serve as a liaison between communities and healthcare agencies, provide guidance and social assistance to community residents, advocate for individuals and community health, provide referrals, follow up services for care, and so much more. These individuals are key to providing care in a community health center, but there is currently no reimbursement for their services under the Medicaid state plan. CHWs are incredibly important as community health centers work to assist the populations they care for address to not only their health care needs, but to also address their social determinants of health.

Social Determinants of Health

Health disparities persist throughout rural and urban Pennsylvania and across the nation, and the COVID-19 pandemic has underscored and magnified this reality. Residents across Pennsylvania die prematurely and live with a poor quality of life due to social, economic, service environment and physical environment factors, which are the social determinants of health.[xi] Figure 1 outlines examples of the social determinants that cause these harms.

Figure 1

Social Determinants of Health

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	Quality of care
Medical bills	Playgrounds	Higher education		Stress	
Support	Walkability				
	Zip code / geography				

Health Outcomes
Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

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Social determinants of health, including education, socioeconomic status, social supports, access to services, systemic racism and oppression, racial segregation, and housing have contributed to different health outcomes for Pennsylvanians. That's why it is so important for policymakers to look beyond the traditional rural health care barriers that we have all been working to address, and to also look at health care through another lens: Why people may not be able to access the care that is available.

Technology

The pandemic in general had a tremendous impact on health care. One of the biggest positives is that the pandemic has advanced the use of telehealth and technology in providing health care services much faster than we thought possible, and with quality outcomes. Community Health Centers have found telehealth to be extremely helpful in reaching those patients that have not been able or did not want to leave their house and for those struggling with increased mental health issues due to the pandemic. But the increased use of telehealth alone cannot fill the gap in rural health care. Telehealth is a terrific example of how an individual's Social Determinants of Health can impact an individual's access to care and how policymakers have an opportunity to break down those barriers to that same care.

In advocating for telehealth services, it has regularly been cited that this type of technology assists in addressing two common Social Determinants of Health – transportation and provider availability/specialists. However, as health care providers expanded the use of telehealth to meet the needs of their patients during the pandemic, they quickly realized that the technology was able to help overcome other barriers as well, such as linguistic and cultural competency, geography, childcare, employment, transportation, income, food insecurity, and support systems, to name a few.

But barriers to use the technology remain. A key component of telehealth, particularly in rural Pennsylvania, is the ability to provide care through an audio-only option. Many patients don't have access to the technology to conduct a virtual telehealth visit or do not have access to broadband to conduct such a visit. Even if they have the technology and broadband access, they cannot afford the technology or data plans that are needed. A solution is that telehealth, including audio-only services, needs to remain an option for patients to choose how their health care is delivered. The cost for providers to deliver telehealth services is equal to or greater than the cost to deliver in-person care. To deliver telehealth services, providers must invest in HIPAA-compliant technology and employ additional staff to coordinate the virtual meetings. The costs for the practitioners remain the same. Acknowledging that broadband is essential to success in the Commonwealth, it is crucial, not only for

Pennsylvania's Broadband Development Authority to address the lack of reliable broadband, but to find solutions to ensure that everyone is able to afford, access and utilize the technology.

Rural Homelessness: Research has found that homelessness in Pennsylvania rural areas has increased at greater rates than in urban areas in recent years. This increase has been most dramatic for unsheltered homeless and homeless veterans. A 2015 study[xii] found that among homeless individuals in rural Pennsylvania, nearly 24 percent had a disability, 27 percent experienced mental health challenges; 12 percent had a physical disability; and 10 percent had a chronic health condition. Pennsylvania's rural homeless must overcome challenges related to the lack of public transportation in rural areas and the geographically dispersed employment opportunities, health care providers, and social services. To better address rural homelessness in Pennsylvania, a strategy should be implemented to coordinate services and provide a rural focus on prevention.

Conclusion

Thank you for the opportunity to discuss our thoughts on health care and we hope that they help to provide background information for future discussions of healthcare needs. As shared earlier, Community Health Centers have had bipartisan support for more than 50 years, and there is good reason for that. The Community Health Center model is one that is not only community-responsive, but improves access to quality health care, treats individuals in a holistic way by serving as their one-stop health care home, improves health equity, and saves the health system substantial money by helping individuals get well and stay well. This network of non-profit organizations across our Commonwealth is making a difference in lives and health status every day. We are glad to answer any questions you may have or provide you with additional information. Questions after the hearing may be directed to me at eric@pachc.org.

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[i] The Health of US Primary Care: 2024 Scorecard Report — No One Can See You Now, https://www.milbank.org/publications/the-health-of-us-primary-care-2024-scorecard-report-no-one-can-see-you-now/

[ii] Pennsylvania Primary Care Loan Repayment Program (LRP), https://www.health.pa.gov/topics/programs/Primary%20Care/Pages/Loan-Repayment.aspx

[iii] PHCPP Request for Application (RFA): https://www.health.pa.gov/topics/Documents/Programs/Primary%20Care/RFA%2067-171.pdf

[iv] PPS Rate: Under PPS, Community health centers are paid a predetermined rate, that encompasses reimbursement for all services. provided during a single visit, and it is adjusted. annually for inflation.

[v] Hoyert DL. Maternal mortality rates in the United States, 2020. NCHS Health E-Stats. 2022. DOI: https://dx.doi.org/10.15620/cdc:113967

[vi] Pennsylvania Department of Health. Pennsylvania Maternal Mortality Review: 2021 Report. Accessed February 10, 2023. https://www.health.pa.gov/topics/Documents/Programs/2021%20MMRC%20Legislative%20Report.pdf

[vii] Nurse-Family Partnership - Helping First-Time Parents Succeed, https://www.nursefamilypartnership.org/

[viii] Healthy Start Factsheet, https://mchb.hrsa.gov/sites/default/files/mchb/about-us/2023-mchb-healthy-start-factsheet.pdf

[ix] Dental Health Professional Shortage Areas, https://data.hrsa.gov/default/generatehpsaquarterlyreport

[x] A Study Pursuant to House Resolution 68: Rural Dental Health, https://lbfc.legis.state.pa.us/Resources/Documents/Reports/733.pdf

[xi] The State of Our Health: A Statewide Health Assessment of Pennsylvania, January 2021, https://www.health.pa.gov/topics/Documents/Health%20Planning/SHA%20Complete%20Report_2021.pdf

[xii] Feldhaus, H. S., and Slone, A., 2015. Homelessness in rural Pennsylvania, https://www.rural.palegislature.us/documents/reports/homelessness-2015.pdf