Testimony of Mr. Greg Nycz
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To the Senate Special Committee on Aging

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Chairman Smith, Senator Kohl and Members of the Senate Special Committee on Aging:

My name is Greg Nycz and I am the Executive Director of Family Health Center of Marshfield, Inc. We are a federally funded community health center. Last year we cared for over 45,000 low-income patients who reside in or around our 8,228 square miles service area, which is located in north central Wisconsin.

Let me begin by stating my deep appreciation for your collective efforts to proactively identify improvements in our system of care for the many vulnerable Americans who seek assistance through our nation's Medicaid programs. I have spent 34 years working to improve access to care for vulnerable populations. I was pleased to learn of your effort to pursue a more challenging, and potentially more rewarding, path than simply cutting Medicaid funding. As I understand it, you are seeking approaches that the federal government might take in combination with states and the private sector to improve the existing health care system in ways that add value not just to those in Medicaid programs, but also to those whose taxes finance that assistance.

As the Director of a federally funded community health center, I would also like to thank you for your support in expanding the capacity our nation's community health centers, who work as front line providers to meet the health care needs of our nation's most vulnerable residents. With the support of Congress and the President, we have had the opportunity to expand, and the privilege to now serve, over 14.1 million Americans from clinics located in over 5,000 communities across our nation. Because our focus falls largely on those with limited incomes, our collective efforts are very much aligned with your Committee's initiative. Our own experience in north central Wisconsin demonstrates that over time people with limited incomes frequently experience different combinations of private insurance, public insurance, and episodes of uninsured status. In two recent samples of uninsured patients who had been screened and determined not to be eligible for Medicaid we found that 17% in the first sample and 20% in the second sample became eligible for Medicaid within the year.

If we are to add value for taxpayers and also protect and promote health for our neighbors with limited incomes, we must manage their care more effectively across the continuum of financing systems. I believe this is best achieved by strengthening the primary care infrastructure in this country and fully capitalizing on the value of the "medical home" concept. By that I mean having a primary care provider that knows you and your circumstances and undertakes to be your primary point of contact in the health care system. If the same physician or clinic is caring for a privately insured diabetic patient through a period where that patient lost all insurance, and if that patient subsequently becomes eligible for Medicaid there is a greater likelihood that his or her diabetes will be better controlled upon entering Medicaid than it would have been if the individual had to rely on emergency room care during their uninsured episode. The likelihood that the illness would be well managed during an uninsured period would be even

higher with the increased accountabilities and attention to quality improvement associated with the unique partnership that exists between the federal government and individual communities under the community health center program.

My first suggestion to the Committee is that in your deliberations you please consider the importance of trust in your own relationship with your personal physician and ask yourself how important trust is in the healing process and how much more important trust becomes as one's disease burden increases. I believe part of the backlash against managed care among more affluent populations stemmed from the frequent disruptions in the patient/provider trust relationship that occurred as competing managed care firms sought to move market share from one provider panel to another in exchange for better contracting provisions. For Medicaid eligibles covered under private managed care firms, such dislocations can be even more burdensome and the loss of Medicaid eligibility may equate to a loss of access and a return to reliance on emergency room care. As you seek to make greater use of many of the very positive aspects of managed care for highly vulnerable populations, greater attention should be paid to exploiting synergies possible in linking medical home concepts to third party care managed care initiatives. Community health centers are well suited to partner with managed care firms for this purpose, in part because of legislation passed by Congress establishing federally qualified health center status under Medicaid and Medicare, and Congress's extension to FQHC's of federal best prices in the acquisition of pharmaceuticals under Section 340B of the Public Health Service Act.

Second, as you look to future, I would also encourage the Committee to invest in new knowledge generation that supports the articulation of best practices in optimizing health and functioning for special needs populations. An important consideration is whether it is better to employ the tools of managed care at the provider level or at a third party payor level. The answer will depend on the degree to which the delivery system is integrated and the level at which it has adopted health information technologies. In the future with fully developed electronic medical records and the full integration of genetic information, will people in this country be more comfortable with all of this personal information being available to the treating provider at the time of service or to a third party managed care insurer? The reality is, we have a diverse country with widely variable levels of delivery system integration. As you seek to harness the potential of managed care for the Medicaid special needs populations, there will be opportunities to gain experience with point of care management, third party management and hybrid systems, using state Medicaid programs as natural laboratories.

A third issue I would like to raise relates to the privatization of Medicare and Medicaid in the post Part D era. There is a loss of purchasing power that occurs when you move from state to private payment of pharmaceuticals under managed care. For young adults and children, this slippage is more easily made up by efficiencies in managed care because pharmaceuticals represent a smaller percent of their overall health care costs. However, special needs populations have a proportionately higher need for pharmaceuticals and the loss in purchasing power is much more difficult to overcome, potentially creating barriers to entry for managed care firms. As the Committee considers more fully integrating the special needs populations into capitated managed care, please consider these differences. A number of options seem available to overcome this problem. For example, the federal best price arrangement could be extended to Medicaid patients covered under managed care arrangements. If this is too

difficult to achieve politically, perhaps it could be limited to just Medicaid special needs populations. Alternatively, pharmaceuticals could be carved out of the managed care arrangement and continue to be paid by the states. Although there may be initial concerns about disaggregating benefits, technical solutions are available to maximize the joint cost saving potential of state purchasing power and quality management expertise of managed care firms. An example of this approach is the excellent system created by the Employee Trust Fund in the State of Wisconsin. They have carved out pharmacy benefits from their managed care contracts and consolidated purchasing power within an employer-sponsored insurance environment. The system was set up to provide customized turnaround passing all relevant data on prescription transactions back to the appropriate HMO for care management purposes. The system is geared to meet the managed care contractors needs be they for 24-hour or two week turnaround. It has generated significant savings to payors. More information on this innovative program can be obtained by contacting either Eric Stanchfield (608-266-0301; eric.stanchfield@etf.state.wi.us) or Tom Korpady (608-266-0207; tom.korpady@etf.state.wi.us).

My final point is one that is all too frequently forgotten at all levels. We should work to end the historic neglect of oral health in low-come populations. The Surgeon General referred to this as a silent epidemic of dental and oral diseases, pointing out that oral disease is disproportionately borne by the poor of all ages.[1] In children, oral pain has negative impacts on ability to learn, with estimates of up to 51 million school hours lost each year due to untreated oral health problems.[2] Productivity and earnings are impacted when low-income parents of sick children must cope with their pain and suffering and deal with the frustration of having no place to take them, which is all too often the case. Untreated dental disease can damage self-esteem and impact nutrition. In adults, poor oral health reduces employment prospects in many service related industries.

There is a growing body of evidence that links dental disease to systemic health problems. Dental disease, specifically periodontal disease which is characterized by chronic infection of the gums, may be linked to cardiovascular problems, difficulty in controlling blood sugars in diabetic patients, miscarriages, prematurity and low birth weight babies in affected pregnant moms and respiratory illness in institutionalized older adults. Access problems within the Medicaid population regularly results in visits to emergency rooms and urgent care centers that are not equipped to address the underlying disease process and are limited to prescribing medicines for pain and infection.

I would urge the Committee to embrace the need to address oral health as a key component in better managing the care of our vulnerable citizens on Medicaid. Wisconsin, I am proud to say, has a great history of providing comprehensive Medicaid benefits including adult dental. Unfortunately, low payment levels, coupled with paperwork burdens and high no-show rates, have prompted most dentists across the State to reduce or eliminate Medicaid patients from their panels. Wisconsin has attempted to deal with dental access issues in both its Medicaid fee-for-service and managed care programs. Unfortunately, a solution has not been found in either. The situation is critical. The latest figures I've seen indicate that the proportion of Medicaid recipients receiving dental care in any given year has fallen to the low 20% range.

While quick solutions to this problem seem elusive, Congress has taken steps to begin to address this problem through its support of the ongoing expansion of community health

centers. Subsequent to the Surgeon General's report on oral health, there has been a renewed commitment by health centers, fueled in part by the dollars provided through Congressional appropriations, to more fully integrate oral and mental health with medical care.

Health centers have a lot to offer in the form of efficient management of the health care needs of vulnerable populations within the fee-for-service environment because their financing mechanisms afford the opportunity to supply enabling services critical to improving and maintaining health. Historically, Medicaid claims data reveals that health centers provide care that is of equal or greater quality than that provided by more traditional provider types.[3] A host of studies have concluded that health centers save states money in their Medicaid programs. According to one recent study, preventable hospitalizations in communities served by health centers were lower than in other medically underserved communities not serviced by health centers.[4] Patients in underserved areas served by these centers had 5.8 fewer preventable hospitalizations per 1,000 people over three years than those in underserved areas not served by a health center[5]. Furthermore, Medicaid beneficiaries in five states who received care at health centers were less likely than other Medicaid beneficiaries to be hospitalized or visit emergency departments for ambulatory care sensitive conditions (ACSC) that are avoidable through timely primary care.

Several other studies have found that health centers save the Medicaid program 30 percent or more in annual spending per beneficiary due to reduced specialty care referrals and fewer hospital admissions.[6] Based on that data, it has been estimated that for FY2004 health centers saved almost $3 billion in combined federal and state Medicaid expenditures.[7] The continued expansion of the health center program holds the potential through the medical home concept of generating even greater savings. While the definitive cause and affect studies are not yet complete, it is likely, based on existing evidence, that the growing integration of oral health professionals into the health center workforce will yield additional savings through reductions in emergency room visits for previously untreated oral disease, as well as potentially significant medical care offsets if the early indications from research hold true regarding the impact of untreated oral disease on cardiovascular, respiratory, diabetic and birth outcomes.

In January 2006, the *Journal of Obstetrics & Gynecology* published an article entitled "Progressive Periodontal Disease and Risk of Very Preterm Delivery.[8]" The authors were reporting on a prospective study of obstetric outcomes entitled "Oral Conditions and Pregnancy." In their concluding comments, the authors note that their findings "indicate that maternal periodontal disease progression during pregnancy may, in part, contribute to deliveries at less than 32 weeks of gestation and that the maternal periodontal disease progression merits further consideration as a potential risk factor for neonatal morbidity and mortality." Consider that some of the highest cost cases in health care involve preterm births. Consider also that periodontal disease is easily treated. Think about the proportion of births that are financed by Medicaid. In Milwaukee, WI 58% of the birth cohort in 2004 were financed through the Medicaid program. While the Committee's focus may be on the other end of the age spectrum, capitalizing on program savings in any lifecycle strengthens and adds value to our nation's Medicaid program.

A key question is when to act when a growing body of scientific evidence is increasingly suggestive but inconclusive. The decision to take action should normally be predicated on

weighing the relative risks against the relative benefits of the action. Since the action contemplated with pregnant women with periodontal disease is the application of standard evidence based treatment for periodontal disease, there is no downside and the potential exists for the upside to soar beyond simply improved oral health to include possible significant improvements in birth outcomes with attendant reductions in medical care costs. This should be motivation enough for us to act. Wisconsin's health centers are currently planning an initiative that will help to raise awareness among those treating pregnant women about this issue and to provide them with a priority referral source for treatment through our network of health centers.

In closing, I would urge the Committee to: 1) recognize the importance of establishing a patient/provider trust relationship and protect that relationship for vulnerable populations; 2) don't limit your possibilities to third party level managed care interventions; 3) find a way to retain the states purchasing power for pharmaceuticals; 4) consider the Surgeon General's report and the growing body of scientific evidence that increasingly supports the notion that oral and systemic diseases are linked; 5) consider the mounting evidence on health center quality and efficiencies and recognize that the health center model represents a highly effective way of managing the combined medical, mental and oral health care needs of our most vulnerable residents; and 6) embrace the continued expansion of health centers as a key strategy to expand and extend managed care to our nation's Medicaid populations.

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[7] NACHC calculation, using FY 2004 Medicaid spending per enrollee (for children and non-disabled adults only), accessed from CMS website (www.cms.gov).

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