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ACCESS TO HEALTH CARE FOR HARD-TO-REACH POPULATIONS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH
FOR FAMILIES AND THE UNINSURED

OF THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED SECOND CONGRESS

SECOND SESSION

ON

S. 773 and S. 1227

JUNE 30, 1992

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ACCESS TO HEALTH CARE FOR HARD-TO-REACH POPULATIONS

TUESDAY, JUNE 30, 1992

U.S. SENATE,
SUBCOMMITTEE ON HEALTH FOR FAMILIES
AND THE UNINSURED,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 2:33 p.m., in room SD–215, Dirksen Senate Office Building, Hon. Donald W. Riegle, Jr. (chairman of the subcommittee) presiding.

Also present: Senators Rockefeller, Chafee, and Durenberger.

[The press release announcing the hearing follows:]

[Press Release No. H–37, June 23, 1992]

RIEGLE ANNOUNCES HEARING ON AVAILABILITY OF HEALTH CARE PROVIDERS, SUBCOMMITTEE WILL EXAMINE BILLS DESIGNED TO IMPROVE ACCESS

WASHINGTON, DC—Senator Donald W. Riegle Jr., Chairman of the Senate Finance Subcommittee on Health for Families and the Uninsured, Tuesday announced a hearing on access to health care for those living in areas where doctors and treatment centers are in short supply.

The hearing will be at *2:30 p.m., Tuesday, June 30, 1992* in Room SD–215 of the Dirksen Senate Office Building.

"I am holding this hearing to examine innovative ways to improve the delivery of basic health care services for hard-to-reach populations. In some parts of this country, shortages of physicians or primary care clinics, or long travel times for hospital care may be barriers to needed primary care," Senator Riegle said.

"Witnesses will present testimony on S. 773, a bill that Senator Chafee, the Ranking Minority Member of the Subcommittee, has introduced to increase access to medical care for underserved populations. In addition, they will comment on comprehensive health care reform proposals, including HealthAmerica, a bill I introduced with several Senate colleagues, which expand delivery of primary health care," Senator Riegle said.

OPENING STATEMENT OF HON. DONALD W. RIEGLE, JR., A U.S. SENATOR FROM MICHIGAN, CHAIRMAN OF THE SUBCOMMITTEE

Senator RIEGLE. The committee will come to order. Let me welcome all those in attendance this afternoon. I would indicate that as we meet this afternoon, we also have an important debate under way on the Senate floor.

So, that creates a little bit more time pressure on all of us than would be the case with an early morning hearing. So, I will try to be mindful of that as we move through our statements and questions today.

We are holding this hearing to examine ways to bring primary health care to people who are considered to be medically under-

served. These are populations that lack access to basic health care because they cannot afford the care, or they live in areas that have limited health care services.

And I want to commend my colleague, Senator Chafee, for introducing his bill, S. 773, which provides assistance to health centers that care for people who are medically underserved and helps with the development of new facilities under the Medicaid program.

Our witnesses today will discuss Senator Chafee's bill and other innovative ways to provide health services for populations with special needs.

Our first witness today will discuss a report published by the National Association of Community Health Centers on the lack of access to basic health services nationwide.

This report found that in my own State of Michigan, over 15 percent of the population lacks adequate primary care, such as immunizations and prenatal care. And that, of course, in the State of Michigan, is a number of citizens—nearly 1.5 million people.

For low-income uninsured Americans, the cost of basic health care is a luxury that is simply beyond their reach. It ought not to be, but it is. Others may have Medicaid or Medicare, but they have trouble finding a provider who will treat them, or they cannot afford to pay for the services that are not covered by those programs.

Other underserved individuals face language or cultural barriers to care or live in an area where health care resources simply do not exist.

Community health centers, school-based clinics, hospital out-patient clinics, local health departments and other facilities are all struggling to meet the health needs of underserved populations, often with shrinking budgets of their own.

Twenty-five community and migrant and homeless health centers in Michigan serve tens of thousands of Michigan citizens each year. Funded as they are through a hodge-podge of grants and public programs, these health centers which serve our most vulnerable populations are sometimes the most financially vulnerable health care providers.

Senator Chafee's bill goes a long way to help support and expand the network of health facilities that bring primary care to underserved areas.

We must relieve the burden on both public and private providers of health care by ensuring that everyone in the country has health care coverage for themselves and their families.

We must invest in education and recruitment of more primary care providers to practice in these underserved areas, and we must encourage innovation in the delivery of services so communities can best meet the health needs of their respective populations.

I am deeply committed to meeting the urgent health needs of our people through comprehensive health care reform. Health America, a bill that I have introduced with several Senate colleagues, would provide universal access to health care for all Americans.

It also, importantly, provides additional funding for community health centers. Other innovative ways to improve access to vital primary and preventive health care services are also an essential part of health care reform. With that, let me yield to Senator Chafee.

OPENING STATEMENT OF HON. JOHN H. CHAFEE, A U.S. SENATOR FROM RHODE ISLAND

Senator CHAFEE. Mr. Chairman, first, I want to thank you very much for convening this hearing today. I appreciate that. What we are dealing with, as you noted in your statement, is access to health care in underserved areas and specifically with legislation, S. 773, which I introduced last year.

With or without comprehensive health care reform legislation, which both you and I are committed to, this is an issue that has to be addressed. Now, we are often faced with the question, what good is a Medicaid card if nobody will accept it?

One of the major reasons the Medicaid program has not realized its potential in providing health care to low-income individuals is that it is viewed as an insurance program.

The reality is that the Medicaid program is not an insurance program, it is a component of our public health system. And until we recognize that and coordinate Medicaid with other public health programs, particularly in underserved areas, I think we are wasting both time and money.

Now, in 1989, Congress took the first step to integrate our public health system through the establishment of the federally qualified health centers. Last year I was joined by several of my colleagues in introducing S. 773, which I believe is the second step in this effort.

My legislation will provide necessary capital through the Medicaid program to allow health centers to serve more Medicaid and uninsured patients.

Funds under this program can be used to recruit and train personnel to purchase necessary supplies and equipment, to increase the types of services provided, to serve more people in existing facilities, and to expand the new sites and satellite sites, for example.

Today's witnesses will describe some of the problems in medically underserved areas, both urban and rural—something you just touched on, Mr. Chairman, in your statement, and something you are familiar with in your own State of Michigan.

I believe that we have got to recognize that there is a shortage of health care professionals in some areas, but, also, that there is an unwillingness on the part of providers to accept Medicaid patients in some areas and in some instances.

And, as you also pointed out, we have got these socioeconomic barriers, we have got cultural and language barriers, drug and alcohol abuse, AIDs, and other factors, such as violence and the availability of food and shelter; all of these play a key role in determining health status.

Now, why do I believe that the federally qualified health centers are where our dollars are best invested? Community health centers and other community-based providers have a proven track record—something you and I are both familiar with, as are many other members of this committee—in overcoming these barriers that I just mentioned. These providers are often over-burdened and have limited ability to expand to additional patients.

Many States have recognized the inter-dependence of Medicaid and other public programs and have implemented strategies in which the Medicaid agency and public health departments, commu-

nity health centers, and other providers join together, and I look forward to hearing more about that today.

Some will argue that the bill should be expanded to include other community-based providers and should require a level of coordination.

Now we have the money coming from the Federal Government straight out to the community health centers. Some say there should be more coordination with the State Medicaid agency. Maybe so.

The need for this program is especially relevant, given the recent movement to expand Medicaid managed care. Community-based providers play key roles in successful Medicaid managed care plans in many States. Private HMO's are often reluctant to accept Medicaid patients because they are considered high risk.

S. 773 can provide community health centers with necessary capital to expand the number of people they serve. I firmly believe this legislation is an important component of any health care reform proposal, regardless of the direction we take.

Health insurance alone will not solve our problems. I think that is one of the key points I would like to make today. These socioeconomic barriers to care will not be eliminated simply by giving everybody a Medicaid card, or a health insurance card.

If we design a health care system which guarantees only health insurance but ignores these other barriers, namely availability, I do not think we have done our job properly.

So, with or without reform, we have got to find ways to integrate Federal health programs and to strengthen the health care infrastructure in medically underserved areas. I believe this program is a step in that direction. Again, I thank you Mr. Chairman, and look forward to hearing from the witnesses.

Senator RIEGLE. Very good, Senator Chafee. Thank you. Our first witness today is Daniel Hawkins, who is the director of policy research and analysis with the National Association of Community Health Services. He will be discussing a recent report he co-authored called "Lives in the Balance," which provides a thorough analysis of the problems of medically underserved people here in our country.

He is accompanied today by Mr. Mickey Goodson, with the Georgia Association for Primary Health Care, and by Dr. Tim Palmer, who is a private practice physician from a rural Georgia community, and they will be available to answer questions as well.

Mr. Hawkins, we welcome you and your colleagues. We will make your full statement a part of the record, and we would like your summary comments now.

STATEMENT OF DANIEL R. HAWKINS, JR., DIRECTOR OF POLICY RESEARCH AND ANALYSIS, NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS, WASHINGTON, DC, ACCOMPANIED BY MICKEY GOODSON, EXECUTIVE DIRECTOR, GEORGIA ASSOCIATION FOR PRIMARY HEALTH CARE, ATLANTA, GA, AND DR. TIM PALMER, A PRIVATE PRACTICE PHYSICIAN FROM THE STATE OF GEORGIA

Mr. HAWKINS. Thank you, Mr. Chairman, and Mr. Chafee and Mr. Durenberger. My name is Dan Hawkins, and I am director of

policy research and analysis for the National Association of Community Health Centers, which represents the more than 700 community migrant and homeless health centers, which serve some 6.3 million medically underserved Americans in communities all across the country.

Now, these centers, and other non-federally assisted community directed health clinics are collectively known as federally qualified health centers under the Medicare and Medicaid provisions, added under the leadership of Senator Chafee and the other Senators here present, in 1989 and 1990.

In most of the communities in which they are found, these centers are the key and often the only preventive and primary care access points for community residents, and, in particular for those who are low income and who either lack insurance, or who have coverage through Medicare and Medicaid.

These Americans are called medically underserved precisely because they are people who cannot get care when they need it, when it makes the most sense, when it can keep them healthy, or treat a problem before it becomes serious and costly.

In recent years, as economic and health problems have combined to increase the numbers of medically underserved, fewer and fewer health care providers have been willing to care for these individuals, or are even trained or equipped to do so, given their now more complex social and health conditions.

Thus, the problem of medical underservice has become one of the most pivotal health policy concerns of the day. But how big is this problem, how widespread, and where is it most pressing? Equally important, what can be done about it?

To answer these questions, we set out to determine in a way that, to our knowledge, has never been done before, the problem of medical underservice in America: the critical lack of access to primary health services which affects millions of Americans because of their economic situation, their health status, or their geographic isolation from providers of those services.

The special report already mentioned, "Lives in the Balance," which I co-authored and which was released earlier this year, provides details in the findings from our study. The report assess medical underservice by using a combination of economic, health status, and physician supply measures.

Let me briefly review the most salient findings and our conclusions, then I will be happy to answer any questions.

The report found in 1990, 43 million Americans—one out of every six Americans—were medically underserved, either because they lived in counties that scored poorly on measures of health and well-being, or in counties that scored poorly on physician supply measures, or a combination of the two. In all, a total of 51 million Americans were at risk for medical underservice.

These Americans who were medically underserved span all ages and live in literally all parts of the country. More than one-third, or 14 million, are children aged 18 and under, and another one-fifth, or 9 million, are women of child-bearing age.

We found medically underserved Americans living in every State except Alaska. The numbers ranged from a high of 6.4 million in California, to a low of 30,000 in Vermont. They were 17 percent of

all U.S. residents, and their proportions ranged from a high of 33 percent of the population in Mississippi, to a low of 3 percent in Nebraska.

Twelve States had more than 1 million medically underserved persons, including, as you have mentioned, Mr. Chairman, Michigan, as well as the States of Alabama, New York, Florida, Georgia, Pennsylvania, and Texas.

Six States with the most significant medical underservice problems are Alabama, California, Georgia, Louisiana, New York, and Texas. Each of these States had more than 1 million persons who were medically underserved, and each had medically underserved populations that exceed 20 percent of their total population.

The report found more than 2,100 U.S. counties out of somewhat over 3,000 that are classified as medically underserved, again, either because of poor health measures, a shortage of physicians, or both.

Every State except Alaska had at least one underserved county, with Texas having the greatest number at 191. A total of 554 counties were classified as double jeopardy counties because they scored poorly on both the health status and physician supply measures. These double jeopardy counties are considered the most severely underserved of all.

I might note that the counties we identified as medically underserved had illness and death rates that were more than twice as high and economic and demographic measures that were nearly twice as bad as other non-medically underserved counties, including low birth weight and tuberculosis rates that were 50 percent higher, and vaccine-preventable disease rates that were eight times higher than the average for non-medically underserved counties.

Our study shows that the crisis of medical underservice most often stems from the fact that in thousands of communities across this Nation, services are not actually accessible to the people who need them most.

Certain areas in States and communities clearly stand out, but this study also makes clear that no part of the Nation is immune from this problem.

Because so much medical underservice occurs in counties with a seemingly adequate supply of physicians, the study makes clear that simply insuring everyone for medical care, and even increasing physician supply, will not cure the problem.

While improving the availability and accessibility of health care is no substitute for the health insurance coverage we will all need at one time or another in our lives, neither can insurance alone give all Americans a doorway into the health care system which not only lets them in, but welcomes them.

And along this line, many studies have shown that efforts designed specifically to furnish care to underserved populations have made significant gains in the overall health of the communities they serve. These include the federally qualified health centers, as well as other comprehensive primary care programs offered by hospitals, health agencies, and other local organizations.

They all contain certain key characteristics: especially strong community involvement; strategic locations and hours; afford-

ability; and services geared to and appropriate for the populations served.

Mr. Chairman, the bill under consideration today introduced last year by Senator Chafee would accomplish this purpose by making up to $2.8 billion available over the next 5 years for the development of new and expanded federally qualified health centers in areas where they are most needed.

We have estimated that if the Chafee bill were enacted into law, more than half of this Nation's medically underserved people—24 million in all—would have access to care through a health center by the year 1997.

But I would be remiss, Mr. Chairman, if I did not also note that your bill, S. 1227, also contains provisions remarkably similar to those of Mr. Chafee's, all within the context of a universal health care plan, and to express our deep appreciation to both of you for your insight and leadership on this issue.

As the Nation tackles the issue of health reform, the study makes clear that a central part of any viable reform plan must be development of comprehensive primary care services in all underserved communities.

The question is not whether the Nation can afford to do so, but whether it can afford not to. For without such an effort, the long-term goals of health reform will never fully be realized. Thank you.

Senator RIEGLE. Thank you very much.

[The prepared statement of Mr. Hawkins appears in the appendix.]

Senator RIEGLE. I am going to ask a couple of questions, go to Senator Chafee, and then give Senator Durenberger more time so that he can make any opening comments and also ask whatever questions he wants to ask today.

Let me say, I appreciate your noticing that we had provisions in Health America. We tried to make Health America irresistible to Senator Chafee, so we drew heavily on his insight and his experience in that area.

Senator CHAFEE. Very tempting. Very tempting.

Senator RIEGLE. We do not quite have him in the boat yet, but we are trying to reel him in as best we can. Your report presents dramatic information on the problem of medical underservice in the United States, with almost 43 million people lacking access to basic health care services, and about 1.5 million in my home State of Michigan.

Without a major overhaul of our Nation's health care system, do you see this problem increasing over time, and what impact will this have on our Nation's health care system generally?

Mr. HAWKINS. Well, clearly, right now we are adding more than 1 million people to the ranks of uninsured Americans each year, and that number is certain to increase as health care costs continue to skyrocket.

More and more employers, especially small employers and individuals, find the cost of insurance coverage completely unaffordable, and the cost of care out-of-pocket to be impossible. What clearly would happen in that kind of a situation is significant increase in the number of individuals who find themselves reduced

to seeking care through inappropriate providers of care, such as hospital emergency rooms.

Already in Detroit and other major urban areas throughout the country, and in rural areas as well—hospital emergency rooms find themselves unable to provide the most fundamental critical trauma care that they were established to provide because they are overwhelmed with patients who need basic primary care and do not have anyplace else to turn.

It is clear to me that, unless we do something to deal with both the system of care in this country—there are those who would argue that we do not have a system, in fact—and to do something about making the care accessible to individuals and providing some form of coverage for necessary services, within the next few years, the system, which is already on the verge of collapse, will collapse, in fact.

Senator RIEGLE. And is it not fair to say, too, in health care, eventually an unmet need is going to have to be met. I mean, if the person is going to survive, they will show up at an emergency facility if the situation is dire enough.

Do we not end up paying sooner or later for health care problems? The longer we wait and postpone intelligent care or preventive care we end up paying more later when there has been great hardship put into the picture as well?

Mr. HAWKINS. Yes. You know, we all remember that great commercial on TV with the oil filter guy who said, "You can pay me now, or you can pay me later." It is no more true than in health care today.

Senator RIEGLE. Yes. But should it not read, you can pay me a smaller amount now, or you can wait and pay me a larger amount later.

Mr. HAWKINS. Absolutely.

Senator RIEGLE. Is that not the way it should read?

Mr. HAWKINS. That is exactly true.

Senator RIEGLE. Very good. Senator Chafee.

Senator CHAFEE. Thank you, Mr. Chairman. Some have asked why I believe that community health centers are so critical in this debate and question how they differ from other providers.

Could you, for our benefit and for the benefit of the record, explain how community health centers differ from other providers in terms of services and of locations? And I am not just talking about hospital emergency rooms, I am talking about average physicians, and so forth.

Mr. HAWKINS. I would be happy to do so. As a matter of fact, I am pleased to have at my side today an individual who has for 15 years engaged in the private practice of medicine in a rural Georgia community, and who wants to turn his practice into a community health center precisely for the reasons that make health centers an appropriate mechanism to look at for providing care to not only underserved populations, but all populations.

When I am asked that question, I tend to define health centers in terms of four fundamental characteristics. One, they are located in the areas where they are most needed. By law, they can only be located in areas that are designated as medically underserved.

That means that we are not going to be willy-nilly, Johnny Appleseed-style trying to develop these centers in every community, even where they might not be needed, but specifically where they are most desperately needed, communities where there are large low-income uninsured and publicly insured populations who do not have access to care.

Secondly, they provide comprehensive preventive and primary care services. They meld the best of the preventive and primary care service components together into one.

So, because they do not have an incentive to see people time, and time again, their fundamental focus, because they operate in effect off of a global budget system, is to fundamentally work within the limited resources that they have available to them on an annual basis. Their incentive is to keep healthy and out of the clinic, not necessarily coming back time, after time for episodic care.

The comprehensive services they provide include prenatal/perinatal care, as well as the delivery and post-partum care; they provide after-hours coverage; their physicians must be on staff at local hospitals; they must admit and follow patients in the hospital when they are needed.

They are a linkage, a door into the health care system. I describe it not as a second tier of medicine, but a second door that says, y'all come in, in 62 different languages.

We do not care whether you are homeless, whether you are a farm worker, whether you are middle-class, whether you are a banker; we do not care. Y'all come in and you are welcome here, we will provide the care that you need.

The third characteristic is affordability, with charges based on one's ability to pay. Where an individual has the ability to pay through private or public coverage or the ability to pay out-of-pocket, then they are charged accordingly. Where they do not have that ability, the charge is discounted or they are not charged at all.

Fourth, and finally, the centers are accountable to the community that they serve. Structurally, the health centers must have a policy board that sets policy for this operation, a majority of whose members are patients of the service itself. This ensures input from the community, responsiveness to community needs, and accountability to the community served.

I think that best describes the structural and functional way that health centers are different from other providers. I might add, many, many public health agencies, many hospital out-patient departments today functionally operate in much the same fashion.

And these characteristics are shared by many non-federally funded community clinics, as you recognized, Mr. Chafee, in the provision on federally qualified health centers which recognizes those entities; not just the community health centers, but others as well.

Senator CHAFEE. Certainly we in Congress strongly believe in the efficacy of community health centers. They have a wonderful reputation here.

In your testimony I was shocked by your statement that 51 million out 250 million people are at risk and underserved.

Mr. HAWKINS. Are at risk.

Senator CHAFEE. Now, have you been able to get doctors for your community health centers? That has been a constant problem—challenge, I will put it that way. Has it not?

Mr. HAWKINS. Yes, it has. There are over 3,600 physicians working at health centers across the country today and there is no doubt that they are perhaps the resource that is most in short order and yet most necessary to secure, without which a system cannot function.

They are the health professionals, the physicians, the mid-level providers—nurse practitioners, nurse midwives—the dentists, et cetera, who are needed.

But there is a plan in place for that, as well; a plan that already is in effect in communities across this country, including in the State of Georgia, where more medical students are being encouraged to practice and to train in primary care rather than in specialty care.

We need to completely revamp our health professions education system, and there is almost unanimous consent on the need to do that: to focus more on primary care; to move more of that training into the community to give them that experience as part of their training.

Senator CHAFEE. Is there any forgiveness for Federal loans if you work in a community health center?

Mr. HAWKINS. There are several critical programs that are important, the National Health Service Corps, perhaps being the most critical. Its scholarship program, which provides assistance to medical students and asks them to pay it back in service after their training is over; and the loan repayment program at the Federal level.

Senator CHAFEE. I will just take a couple of minutes. If I have gone to a medical school and have substantial loans, I suppose those would be private loans from a bank. Would they not?

Mr. HAWKINS. Yes, typically.

Senator CHAFEE. All right. Now, let us say I owe $15,000 to the bank, or make it $30,000 for my medical education.

Mr. HAWKINS. The average is closer to $100,000.

Senator CHAFEE. All right. I will stick with $30,000. Now, is there some system whereby if I sign up with a community health center in Georgia I would be excused, or what happens there? And, first of all, I assume that would be a private loan. That would not be a loan I have gotten from the Federal Government.

Mr. HAWKINS. No. Most of those are through commercial banks and institutions who have made those loans. I am going to answer very quickly.

There is a program called the National Health Service Corps Loan Repayment Program that would allow an individual, in return for each year of practice in a community health center or in an underserved community, designated where they have been assigned, to secure repayment of those loans at the rate of $20,000 to $30,000 a year.

The genius of the program is, not only does it operate at a Federal level, but it also provides limiting funding on a matching basis to States, Georgia is one of the States that picked it up and has, now, a complementary State loan repayment program which does

exactly the same thing. And they work hand in hand together to concentrate on those efforts.

Senator CHAFEE. Even though I had had no previous tie with the Federal Government while I was going through medical school.

Mr. HAWKINS. That is correct.

Senator CHAFEE. I had not enlisted in any program, public health service, or whatever it might be.

Mr. HAWKINS. It is not necessary. You can sign up at the end of your training, the very last day of your training. In fact, in some cases, individuals who have finished their training, been in practice for a year or two, and are unhappy with their practice, still loaded with all that debt, having to pay it back, have actually come back in and said, if I sign up now, is it too late, and the answer is no.

Senator CHAFEE. Thank you very much. Thank you, Mr. Chairman.

Senator RIEGLE. Senator Durenberger.

Senator DURENBERGER. Yes. Mr. Chairman, I would ask that my statement be made a part of the record.

Senator RIEGLE. Without objection, so ordered.

Senator DURENBERGER. I want to thank the two of you for the really tough work you do in this committee, for your commitment to expand access to health care and also for this hearing, which I think will help us—certainly will help me—understand more about the breadth of the problem. I also want to thank Mr. Hawkins and the gentleman from Georgia for coming.

I have a theory that just because this Federal program works does not mean it is the best way to go about doing it. If I look in my State of Minnesota, I can tell you about the wonderful things that are being done on the West Side of St. Paul by 37 doctors who are working for about $37,000 apiece per year.

I can take you around my community and verify everything you said, Mr. Hawkins, about how the community health centers work, and it is terrific. We want to look at how to keep people healthy, how to deal with impossible problems, how to get three, or four, or five people with five different language limitations to get services in a clinic. This is the place to go.

What is bothering me, I suppose, more than anything else as I listen to you describe what a community health center is, is location. It is low-income, basically disadvantaged persons. My question is, why should we settle for this two-tiered access to preventive care and primary care if, in fact, we could do something like taking the burden of medical assistance off of State and local government.

Perhaps we could say right here in this place we are going to guarantee access to medical care in America to everybody who needs it and we are going to deal with the affordability issue, but we want the State of Georgia, and the State of Minnesota and the local communities to take on the responsibility for eliminating these 2,100 underserved areas, but they can do it their way.

That is my instinctive preference, if I want community-based health. I look at the example of public education and I compare that to what you were saying about this kind of public health, and I see all the similarities—it is going to be close to the folks, it is going to concentrate on preventive rather than on treatment.

You did not talk about education and that sort of thing, but it is implied in what you say and what you do. You talk about affordability. There is no financial barrier to get into the public schools in this country.

Then you talk about accountability to the community. Now, we do not have a majority of parents sitting on school boards, but we have a process through which the community is represented in the delivery of public education.

And I ask myself, why does the United States of America not have that kind of a system rather than one that gets built here or in the Labor Committee on specific Federal programs and never quite seems to make the mark?

Mr. HAWKINS. Yes. I think the real answer to the question goes back over a century to when we allowed health care to separate itself from public education as a service and a responsibility of local communities, and allowed it to develop and pursue a path until this day where it is a private-sector business.

Although, I would hasten to add, that we see this model, not the brand-name community health center, but the generic community-based, community-responsive clinic, if you will, as a private-sector alternative.

And Dr. Palmer can speak much more eloquently to this, because he has made a decision to literally go to work for the community. He is one of those private physicians that you speak of who has a desire to serve, but sees the best way to do that within the function and structure of an organization that takes all of the administration—billing, accounting, personnel management—responsibilities off of his shoulders, allows him to practice medicine, and, by the way, holds him accountable for the quality of care he provides as well because of that tension that is always there between the community, on the one hand, which has its own sense of needs that they want the system to be responsive to, and the Federal or State officials, on the other hand, who provide some funds and resources for this and want some accountability as well, in return.

Senator DURENBERGER. Well, maybe Dr. Palmer can respond. But my question, is why do you have to join a public clinic in order to do this?

Why does your community not buy services from you? I mean, you maintain your medical practice and you do your primary care and your prevention on contract with your local community. Why do we have to segregate preventive and primary care services into some publicly-owned clinic over here, and say, for your secondary and tertiary care you have got to go over there?

Mr. HAWKINS. Would you mind terribly if I just let him answer?

Senator DURENBERGER. Yes. All right.

Dr. PALMER. Well, my understanding of a community health center, that is not what you are doing. It is not a federally funded clinic. It has a federally funded grant, but it is not a federally funded clinic.

It is a clinic that is non-profit that is run by the board of directors in that community. And I have had problems with that in the community when we were talking about this that some people are against that.

I am against socialized medicine because I do not think the government can do it. But I also do not think the private sector can do it, either. I think it is going to take a marriage of the two. And if that will ever happen, that is what is going to have to happen for it to work.

I got involved in this because I am chairman of the State Medical Education Board in Georgia and we give scholarships to medical students who then go back to towns of 15,000 or less.

And we have a coalition of people, including the Joint Board of Family Practice, the Primary Care Centers, about 10 organizations that put together something called "Medical Fair." We bring 40 communities together with about 140 medical residents. And over the past 10 years we have put 225 physicians into rural areas that are underserved.

In this process, the loan repayment program came about. Now, we give their students about $4,000 a year to go to school to come back to a town of 15,000 or less to practice on a year-for-year payback, so they end up paying back 4 years.

But when the loan repayment program came about, that meant, as Senator Chafee said, that you get a position right now, you have got somebody that owes $20,000 or $30,000, and you can pay him $20,000 a year to go back to a small town, then you do not have to wait for them to get through school.

So, what we did in Georgia is we made our State Medical Education Board scholarship recipients also eligible for the loan repayment program because we had a group of doctors ready to go back to small areas, but the loan repayment program was targeted at even more underserved areas. And, in 10 years, we have put 225 positions in those places and only 7 percent have left. So, we have been working together on this. This did not just come about on a fluke.

But when we started giving scholarships to the community health centers, I had to find out what a community health center was. So, that is how it started.

I went to Albany, GA, where Dr. Jim Hotz has a very good model of the community health center there. And I came away from there wondering why we could not do that in Swainsboro, because it seemed to me a perfect concept. I have a private practice. It is a successful private practice. I have a partner. We do a lot of Workman's Comp and a lot of young people.

But what I have found is, they do not have insurance. They work at a shirt factory, and their wife works at a shirt factory and they pay for day care, and they cannot afford insurance.

So, I end up having to treat them a little different than I do somebody that has insurance or can pay, and I am tired of that, for one thing. And I feel helpless over it.

So, when I saw this system, what you have to do is you have to go into the community. We talk about having a medical system, we do not have a medical system.

In my own county, when we met with the Department of Human Resources and the Health Department, it is the first time those two had even sat down and talked together. You have a lot of independent players in the health community, but you do not really have a system where they are working together.

When you are writing this grant, what you do is you meet with all the health care providers, you tell them what you have got, what each one is able to do, what your needs are, and then you apply for the grant and tell them how you are going to take care of those needs.

And it seems to me that every community is different, so every community is going to have a different amount. You know, if you give everybody an insurance card, what have you accomplished? You are going to have a certain number of people over here at the health department taking care of people, you are going to have a lot more procedures run because it is being paid for. It has not really accomplished anything.

Senator DURENBERGER. Great. I appreciate that response. Thank you very much.

Senator RIEGLE. Gentlemen, thank you very much. It has been very helpful. And if we have additional questions for you, we will submit them to you so you can respond for the record.

Mr. HAWKINS. Thank you.

Senator RIEGLE. Thank you. We will next hear from a panel of witnesses who will present different State perspectives on this issue. Let me introduce the members of the panel. They are: Carol Herrmann, who is the commissioner of the State of Alabama Medicaid Agency, and vice chairman of the State Medicaid Directors Association from Montgomery, AL; Dr. Deborah Klein Walker is the assistant commissioner of the Massachusetts Bureau of Family and Community Health, and is also regional councillor with the Association of Maternal and Child Health Programs. She is here today from Boston.

And Dr. David Smith is commissioner of health for the State of Texas. He is here from Austin, representing the Association of State and Territorial Health Officials. And we are delighted to have Senator Rockefeller here with us, too, now. Let us begin. Carol, why do you not start?

STATEMENT OF CAROL HERRMANN, COMMISSIONER, STATE OF ALABAMA MEDICAID AGENCY, AND VICE CHAIRMAN, STATE MEDICAID DIRECTORS ASSOCIATION OF THE AMERICAN PUBLIC WELFARE ASSOCIATION, MONTGOMERY, AL

Commissioner HERRMANN. Thank you, Mr. Chairman. Members of the subcommittee, we appreciate the opportunity to speak with you about efforts under way in Alabama and throughout the country to improve access to health care, especially for the uninsured and for those who depend on Medicaid for their care.

I am sure I speak for all the States when I say we truly appreciate the attention Congress is focusing on the issue of access. This emphasis is necessary and deserved because the problem is so great.

At the same time, we are making progress in building better systems of care at less cost. Alabama is a good example of a State that has stretched its limited resources with excellent results by joining forces with the private sector.

We first looked to the private sector because our resources were so scarce. After many satisfying and successful experiences, we dis-

covered that public and private partnerships work much better than the public efforts alone.

We are working with the private sector to establish systems of high-quality managed care; to increase outreach to children and pregnant women; to recruit more Medicaid providers; and to improve the program in ways that encourage greater participation by physicians.

We are proud of many of our programs and initiatives, but one in particular, our Maternity Waiver Program, deserves a close look. The waiver has become a model on a nationwide level for four other States and has earned widespread praise.

The program is one of many we have undertaken to attack our high infant mortality rate. In the course of 1 year, we brought our infant mortality rate down from 12.1 deaths per 1,000 live births to 10.9.

The waiver is a managed care system for pregnant women. The key is a primary provider who is responsible for the woman's care from as early as possible in her pregnancy until after the baby is born.

The primary provider can be almost any entity capable of putting together a network of total health care. In some waiver areas, the primary provider is a county health department, in others, a hospital or private foundation.

To form a coalition of care, the provider contracts with doctors, nurse midwives, hospitals and clinics, both public and private. Social workers or nurses are employed as case managers who assure that the patient receives all needed health care and social services.

Now operating in 38 of the States' 67 counties, the waiver has reduced the need for neonatal intensive care, has reduced the number of readmissions to the hospital in the first years of life, and has reduced costs for diagnostic tests and premature births.

For this year and last year, we estimate savings through the waiver to total $1.4 million. This program is clearly demonstrating that better care can cost less, and it highlights the achievements that become possible when the public and private sectors work together toward common goals.

Similar achievements are demonstrated by other initiatives, such as our healthy beginnings program, which provides incentives such as coupons and groceries to encourage early and continuous prenatal care. There are other examples.

To make health care available to as many children and pregnant women as possible, we have out-stationed over 100 eligibility workers throughout the State to take applications and to determine eligibility as quickly as possible.

The workers are housed not only in federally qualified health centers and county health departments, but also in public and private hospitals.

Working with a task force of physicians, including many in private practice, we have reduced paper work and red tape, making it easier for physicians to serve low-income patients.

One of our most exciting developments is an on-line eligibility verification system which provides immediate information to our providers on a wide range of eligibility and payment issues. We have recognized the unique problems of accessibility in rural areas

by establishing an urban and rural differential in the fees paid for obstetrical care.

We are successfully encouraging more obstetricians and pediatricians to participate in Medicaid. Recently, the new President of the Academy of Pediatrics Chapter in Alabama has challenged each pediatrician in the State to take 10 percent of their practice in Medicaid clients. All of these efforts are helping to make health care more accessible to low-income children and pregnant women.

In Alabama, we are committed to the concept of managed care and we are working to develop systems of managed care for more populations. In doing so, we will undoubtedly link our efforts with those of the private sector because we see great value in that partnership.

We support Congress in its placement of greater stress on coordination of care. As this committee and all of Congress struggle with our health care dilemma, I encourage you to consider any proposals in light of their long-range benefit for States, such as Alabama, with low per capita incomes and very limited funds for health care and social services.

Also, I urge you to consider any proposals in light of whether they will provide equal access for all. We should not encourage the development of separate systems of health care for different populations based on income.

I thank you for your attention. With your help, I believe we can continue to improve access to health care for all of our citizens.

Senator ROCKEFELLER. Thank you very much, Ms. Herrmann.

[The prepared statement of Ms. Herrmann appears in the appendix.]

Senator ROCKEFELLER. Dr. Smith, do you want to go ahead, sir?

Dr. SMITH. That would be fine. Actually, in an effort to have collusion and cooperation, I wondered if she wanted to come and work for me in Texas next year as the Medicaid program is coming over to the Texas Department of Health. We can talk about that later.

Senator ROCKEFELLER. You can negotiate right now. [Laughter.]

STATEMENT OF DAVID R. SMITH, M.D., COMMISSIONER OF HEALTH, STATE OF TEXAS, AUSTIN, TX, ON BEHALF OF THE ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS

Dr. SMITH. Well, thank you very much. It is certainly my privilege to address the committee on this critical issue. I think one of the things I see, having been also a National Health Service Corps scholar myself and practiced in south Texas, and, for a short period of time, also, a Federal employee working here in Washington.

Senator ROCKEFELLER. Could I just interrupt you, and not to have the light count against you? Where were you born, and what made you go into the National Health Service Corps?

Dr. SMITH. I went to school in Cincinnati, the University of Cincinnati College of Medicine. And because of my wife's collected debt that both accrued during University of Cincinnati College of Medicine and Cornell undergrad, first we were committed to go into primary care, secondly, as we were committed to make a difference and not end up in some sub-specialty forum. We ended up in Brownsville, TX, during that period of payback. I guess you could

say we were the "Southern Exposure" couple. We got very involved in that community.

Actually, I had a position to go back to the University of Pennsylvania, Children's Hospital of Philadelphia, which is where I had trained in pediatrics to do anesthesia and critical care pediatrics.

After seeing what was going on in the Rio Grande Valley, particularly the colonias and the plight of the migrant seasonal farm workers, elected not to go back and stayed in public health at that point.

In 1987, I came to Washington to work as the chief medical officer for the Community Migrant Health Center Program, later as a deputy division director for the Health Care for the Homeless Stuart B. McKinney Act, and the Comprehensive Perinatal Care Program.

I was then asked to go back to Texas to work for Ron Anderson at Parkland Hospital and set up a new program called "Community-Oriented Primary Care." That program is very much patterned off the model of community migrant health centers, but puts a bit more of a public health flair to it. Then I was requested to be Commissioner of Health, so I really have had a tough time keeping a job.

Senator ROCKEFELLER. God bless you.

Dr. SMITH. Thank you. Well, as the Senators well know, we have an illusion right now of a health care system. We have a medical system and not a health system.

It is not based upon the principles of paying up front, as we have already heard. It is over-priced, it is reactive. We are very enamored with the issues of catastrophic and resurrection medicine.

One of the things that someone said to me a few days ago in a health analogy utilizing cars and the kind of cars we built, we still have a gas-guzzling Oldsmobile Rocket 88 out there and we seem to be content with that. We do not want to put systems in place that would front-load health care, where we would invest in people in the front end.

One of the best examples I could give to this committee is really a question that I would pose to you, "If we cannot fix measles?" Right now in this country, we have had several major outbreaks of measles.

It is one of the most simple, fundamental things that we could do is to eliminate vaccine-preventable disease. We almost had done that during the early 1980's. We have seen a scourge come back on this country and it has been a costly one.

All of us would sit here today and love to have a vaccine which would prevent everything from AIDs, to substance abuse, to teenage pregnancy, but, folks, it would not be enough.

The delivery system we have now is not well positioned, we do not have the folks trained in a manner that allows them to do preventive care or to deliver those vaccines.

We need to ask ourselves, if we cannot fix measles, then what are we all about? It is one of the points I am going to make, particularly as we look at Medicaid as a tool to pay for prevention and develop an armamentarium which can front-load this system. I will now make some specific comments.

There is another scourge at the front door that I think is also predicting doom for us if we do not change our approach to health care, and that is tuberculosis. Here is another disease that now is coming back that we thought we had also licked.

Tuberculosis, is bringing with it a different story which relates to its ability to develop resistance to antibiotics. We are seeing the story told in Newsweek and other reputable journals that we have multiple drug-resistant tuberculosis. Folks, this is a bacteria that you can catch in church.

In fact, one of the frightening things about it is that it can be spread during choir practice. If you receive or encounter multiple drug-resistant tuberculosis, it can be just as deadly in a shorter period of time than HIV.

My question to us is, what are we doing on the front end? Why do we not have the systems in place in communities to blend prevention screening, surveillance, primary care and treatment? We do not at this present time, we continue to be reactive.

Our approach to funding is tragic.

The appropriate analogy is the Clue Game. We put everyone into the dining room, we throw in the rope, the gun, the knife, the candlestick holder, and we put in tuberculosis, moms and babies, AIDS, substance abuse, and we turn the lights out, and we decide whoever can get out gets funded.

This is not the solution right now for health care. We need to have a comprehensive approach. Prevention needs to be part of that strategy. If it is not, we are not going to see cost containment.

We need to take a hard look at models such as community-oriented primary care and not just in the sense of those being supported through Federal dollars. My own State health department is making a major effort to develop a bureau of community-oriented primary care which builds and blends the best of public health and primary care; front loads the system, invests in the community, accountable for outcome. The system must be patient-centered and patient-valued and allow the community to provide feedback to the center on those services and tell us whether or not we are doing the job. As public health physicians we must also determine whether or not we have made any difference in the outcomes of those patients; not just the usual approach of turnstile medicine to count the number of people that go through the turnstiles, but to find out whether they are any bloody better off for having seen us.

States are undertaking these efforts. I am one of those States—as Dan Hawkins referred to earlier—that has over 170 counties out of 254 that are underserved, and the numbers are going in the wrong direction.

I will take as many community health centers and migrant health centers as I can get, but, in the meantime, I am going to have to try to find scarce State resources—and we are facing a $6 billion deficit—to try to build capacity and infrastructure in those communities.

I need, in fact, to blend and do the things that we have talked about earlier and make sure that I front load that system with some capacity dollars that I have at the State level.

The point to be made here is that States are also looking at this model and going to the communities. We cannot split dollars or our

efforts and not make sure that these efforts are also rewarded with such things as cost-based Medicaid and some of our other grant programs that we have currently within the Federal Government.

I think the things that we need to be doing are the following. I think we have to demand that we have a health model and not a medical model, and we have to determine that we are going to be willing to pay for it. We have to blend primary care and public health.

That means taking responsibility for the larger community, also looking at outcomes of what we do, and also recognize that it is not just federally supported programs that are providing these services.

We need to, thirdly, recognize the vast need for expanded capacity. I think all of us can be positioned to be reimburse under Medicaid, but we, first, have to get there and develop that capacity.

Finally, we need to recognize that we have to front load this system, and Medicaid is one way we can do that. Traditionally, we have a series of non-reimbursable health services such as immunizations, pap smears, breast self-examination, nutrition services, outreach.

Those things are what make community health centers and community-oriented programs unique. Those are the non-reimbursable services that probably make as much difference as the medical services that we currently have in place.

Also, we need to look at the opportunity to fund services, such a case management. They should be put in the reimbursable category rather than the grant categories, which make them very fragmented.

And I will just close with saying and forcing that point, we have case managers right now who can case manage tuberculosis and another set case manage moms and babies, another set case manage immunizations, and another series case manage school-aged children, but they cannot cross over.

We have case managers case managing case managers, not people. We need to have that as a reimbursable service so there can be a continuum of services.

I think if we package preventive services and services such as case management which have been traditionally non-reimbursable, we can help not only systems such as community and migrant health centers, but also the public sector and the private sector that would like to enrich their practices. And for our efforts, I think we will see an improvement of outcomes. Thank you.

Senator ROCKEFELLER. Thank you very much, Dr. Smith.

[The prepared statement of Dr. Smith appears in the appendix.]

Senator ROCKEFELLER. Dr. Walker.

STATEMENT OF DEBORAH KLEIN WALKER, Ed.D., ASSISTANT COMMISSIONER, BUREAU OF FAMILY AND COMMUNITY HEALTH, MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH, AND REGIONAL COUNCILLOR, ASSOCIATION OF MATERNAL AND CHILD HEALTH PROGRAMS, WASHINGTON, DC

Dr. WALKER. I am the assistant commissioner from the Massachusetts Department of Public Health. I am here today to represent the Association of Maternal and Child Health Programs, which is

a national non-profit organization representing State public health programs funded by Title V of the Social Security Act, or the Maternal and Child Health Services Block Grant.

The mission of our association and the Title V block grant is to assure the health of all mothers, children, adolescents, and families.

The testimony we have submitted presents our views on care for mothers and children in underserved areas, a description of Title V programs and their impact on the medically underserved, examples of innovative Title V programs in different States, comments on S. 773, and a request to increase the Title V authorization as a way to improve care.

The greatest percentage of uninsured individuals in this country are women and children, the very population served by the Title V block grant.

The majority of this money goes to States to fund direct services for mothers and children, with a special focus on low-income families, families with limited access, and families with children with special health care needs.

These State Title V dollars are used to fund local providers, either via contracts to community health centers—which is the case in my State of Massachusetts—or by supporting directly the operations of State or local public health-run clinics.

Our Title V needs assessments across the country in 50 States identify barriers to care other than the financial ones. These barriers to care include: provider shortages; lack of transportation; lack of translation services; attitudinal differences; lack of knowledge and awareness of services on the part of clients and providers.

In every State, there are innovative programs which blend Title V dollars, Medicaid, and private-sector programs, and, in many cases, community health center programs.

More recently, there have been many innovative programs with Medicaid where Medicaid has been used to reimburse services delivered through Title V agencies. Examples of this are in Rhode Island, Michigan, Utah, Missouri, and you have heard some today in testimony.

In addition to direct services funded by Title V, it is important to point out that Title V services at the State level build and maintain systems of care at the community level.

In other words, Title V provides the public health infrastructure or the glue which holds together the MCH services at the local and community level.

These kinds of services include: needs assessment and planning; maintenance of data for accountability; population-based surveys; program monitoring and evaluation; health promotion and prevention activities; interagency collaboration and networks; quality assurance and standards setting; technical assistance and supports to communities.

We are very pleased to be here today as we support the intent of S. 773 and the things that it proposes to expand—the number of providers in underserved areas; provide funds for training and recruitment; renovation of facilities; purchase of services; opening new sites—are all very much needed and will help to alleviate many of the non-financial barriers of care.

We would strongly like to recommend, however, that there be an increase in the percentage of dollars that would go for non-federally qualified health center organizations. This would actually help many of the Title V programs in the States across the country to apply and use some of these dollars.

Finally, we would like to point out and suggest that there may be a simpler way to solve some of these issues related to the underinsured in the mothers and children population, and that is to use the mechanism already in place through the Maternal and Child Health Title V authorizations.

In fiscal year 1992, Title V had appropriated $650 million, with an authorization ceiling of $686 million. We would like to request an authorization of $750 million for fiscal year 1993, with a phase-in up to $1 billion in fiscal year 1995.

We actually, from our own recent survey in the 50 States, identified many unmet needs, so there are many ways that this money could be spent and would help to close this gap.

I and my colleagues in the Association of Maternal and Child Health Programs across the country support your efforts to help mothers and children receive needed health services. We look forward to working with you to achieve this goal. Thank you.

Senator ROCKEFELLER. Thank you, Dr. Walker, very much.

[The prepared statement of Dr. Walker appears in the appendix.]

Senator ROCKEFELLER. We will start the questioning with Senator Chafee.

Senator CHAFEE. Thank you very much, Mr. Chairman. First, I want to thank the panel. The legislation I have is oriented toward expanding community health centers, although I am open to other suggestions beyond that. What other types of providers should be included in this program? Do you have any specific suggestions on that, Dr. Smith, Ms. Herrmann, Dr. Walker?

And one of the questions that comes up is, should you accept anybody regardless of their ability to pay? Earlier we had some testimony from a previous witness who talked about the community health centers, anybody could come in. And then, of course, there is a scale for payment. Give me your thoughts. Why do we not start with you, Ms. Herrmann; you were first up.

Commissioner HERRMANN. Well, I believe very strongly that at the community level we can develop systems of care in a more organized cost-efficient manner, so the more the decisionmaking process is put down on the community level, the better product Congress is going to get.

If you are designing a package of services that you want a community to provide, if you have an idea in mind, obviously, through this bill of what you want to happen, we ought to have the flexibility to then look at the community providers.

In our State, what we are working with now in our primary health care system, with our primary health care providers, with our public health department and Medicaid is building our rural hospitals, because they must diversify or die, in essence.

So, instead of wasting the property, wasting the utilization of space and resources with that hospital, we are working with them to become, in essence, a community health provider using the public health department where appropriate, and each plays its part.

But it is a much more coordinated campus-type system of care, including putting eligibility workers on site for both health and social services.

Senator CHAFEE. So, you would have somebody in there who would be able to tell a woman about the WIC program, for example.

Commissioner HERRMANN. Well, we do that now. We cross-train all of our eligibility workers, so a Medicaid eligibility worker will always raise WIC as an issue, and vice versa, with our social services.

Senator CHAFEE. All right. Why do we not try Dr. Smith now? Go ahead. Thank you very much, Ms. Herrmann.

Dr. SMITH. I very much agree. I think the services need to be positioned in the community. I think what you have right now is a number of entities out there that are doing the same thing.

In other words, public health departments, local and State right now, are trying to build capacity that very much mimics a community-based model. Again, a lot of us are using terms like community-based, community-responsive care, community-oriented primary care; a whole host of things.

What they do is very similar. They have local ownership, they are based on need. And that is something we have not talked about. A lot of us drive these systems, obviously, based on need and the number of underserved. I have 4 million in my State that are uninsured, one of the largest numbers and largest percentages.

Senator CHAFEE. Yes. But I think one of the points that we want to remember here—and I will just take this as a given; maybe you can argue with me—on the community health centers, I usually figure that about 50 percent of the cost is paid for through the Federal Government through Medicaid or Medicare, and the balance is made up of contributions by the local community, State, and so forth.

As you envision it, would you continue to charge? Suppose somebody comes in, he is a worker, he has got a job, no insurance where he works, but nonetheless can pay something, would you charge him?

Dr. SMITH. Yes, we do. Almost all of the systems I am familiar with and the ones that we are putting in place through the public health departments, while many cannot have a governing board, an advisory board, what they do is have a sliding fee scale that is based upon the ability to pay.

In some cases, obviously, people cannot pay. There is a concept of one-stop shopping in that WIC, psycho-social services, comprehensive public health preventive services and primary care are delivered, and there is continuity into a hospital setting.

Again, I think the generic model of community health centers has been picked up by a lot of folks. If you look, and sound, and quack like a duck, you are probably a duck. And I think a lot of folks have decided it is a good model. They are calling it many things.

In some cases where there are not 330 dollars, or 329 from the Federal side, we are using State dollars to get them started like in our State, but otherwise they look very similar. Again, I will take as much 330 money as I can get, or 329.

In the meantime, I have 170 counties that need those services. So, again, we are going to look very similar, but the money is going to come not from Federal coffers, but from State coffers.

Senator CHAFEE. One of the things you indicated in your testimony was that the case managers cannot cross over. Why is that so? You are the boss of the system, can you not——

Dr. SMITH. Actually, those decisions are probably coming from this house. Those are determined by Federal dollars that have restrictions that we have to be accountable for for full-time equivalents based upon the disease grant we have either from the Centers for Disease Control——

Senator CHAFEE. Is that in the categorical nature of the grants?

Dr. SMITH. Yes.

Senator CHAFEE. If somebody is dealing with heart disease they cannot get over into tuberculosis?

Commissioner HERRMANN. It is called targeted case management, which is the only way Medicaid can reimburse for case management services under the Federal laws and rules and regulations.

Dr. SMITH. Yes. But the case management I pay for under the preventive services blocks in TB and others is very categorical by disease. And where we want to put out comprehensive systems in the communities, I have got to use State dollars to get case managers that can blur the lines. And that is what we are doing.

Senator CHAFEE. Dr. Walker.

Dr. WALKER. I think my colleagues have made the point that our association would agree with that many people are supportive of this concept of the community-based services like you would see in the community health center.

But we recognize that there are not enough of those, nor will there be in the near future, even with, I think, support of bills like this. So that there are other public health clinics—we have not mentioned school-based health clinics here, too—that are in the community providing much-needed services to these populations. And we would like to make sure that these types of services are also funded.

Senator CHAFEE. I must say, I got very nervous when Ms. Herrmann talked about hospitals, because one of the virtues, as I see it, of the community health centers is they are not emergency rooms, and they do not have all that tremendous overhead. And, indeed, one of the virtues of the community centers, I have always thought, is that they keep people out of the emergency rooms.

Our Catholic Hospital in the inner city has had to close its emergency room. It has just been overrun. They could not take care of the people pouring in there; they could not afford it.

And it seemed to me, one of the tragedies was that our community health center system was not broad enough to expand to take these people who were improperly—not consciously—going into the emergency room. So, when you mentioned hospital, I got very nervous.

Commissioner HERRMANN. I will explain that. Because when they first approached me with this idea—we have a task force of rural hospital administrators that we are working with—and this is specifically for rural Alabama, we have not taken it into the few

urban areas in Alabama—but where you have a hospital that is needing to close beds, is needing to give up space, that community does not have an existing community health center or federally qualified health center and you are looking to either build or put in a community center, that building—and many times they have doctors' offices that are unused space—serves as an excellent campus for a community health-type service.

Now, what it will do is get those people who the only place they can get care now, even primary care and preventive services, is that emergency room, instead of them walking into the emergency room, they could be told the clinic is two doors down, Mrs. Smith, take your children and go there. We can get you care right on the spot.

Not only can we get you health care services, but we will make sure you understand what else is available in the State of Alabama, either Federal or State, and we will immediately make you eligible for Medicaid. Here is the form, fill it out. We have a computer there. We key it in, and it is all done that quickly and in that kind of a comprehensive setting.

Absolutely, the goal is to get people out of the emergency room. It is to get them out of the hospital and keep them out of the hospital. But it is a perfect campus setting and it is a perfect environment to put all of the coordinated services into one location.

Senator CHAFEE. Mr. Chairman, thank you.

Senator ROCKEFELLER. Dr. Smith, I remember a couple of years ago I was looking at the community health center situation, and it just seems to me in my mind that I was struck by two things. One, is that Montana, at the time, had none. And I thought that Texas, at the time, had something like two.

Dr. SMITH. No. I think they have got about——

Senator ROCKEFELLER. 28 you have now.

Dr. SMITH. 27 or 28.

Senator ROCKEFELLER. Yes. But even so, what do you do? I know in West Virginia, which is about 1/30th the size of Texas, we have 32 of them and we still cannot make health services user-friendly enough fast enough over a long enough period of time. What do you do?

Dr. SMITH. Well, we are hoping that we do get expansion so we can get, as I said not facetiously, we would love to have more 330 and 329 dollars. Because, again, I have 254 counties and 170 that are underserved, even with the 27 heath centers.

Senator ROCKEFELLER. Well, what do you do?

Dr. SMITH. Well, what we are doing is retooling the State Public Health Department. We are going to try to develop general revenue resources and combine that with Medicaid where we can in Title V to expand capacity in those communities.

We are looking at taking some of our 115 closed rural hospitals and making them into primary care community health centers instead of what they were in the past.

Senator ROCKEFELLER. With what money?

Dr. SMITH. Well, the little bit of money that we are trying to get through disproportionate share money that came in from Medicaid from general revenue; we are going to ask for an expansion in general revenue from the State, which is not going to be easy, but we

have to do something; we are going to use Title V, which has been very effective, at least for moms and babies, for us to expand capacity, and then get them in a mode where they can do billing for Medicaid, and, under the option, also doing cost-based reimbursement.

We are just putting band-aids and bubble gum into it and trying to get it to stick together. We cannot meet all the needs. As you know, the border is an awesome area for us, and we have grossly insufficient capacity for a very young population.

Senator ROCKEFELLER. It is absolutely amazing to me that there would be only 28. And then you talk about how many hospitals closed?

Dr. SMITH. 115.

Senator ROCKEFELLER. I mean, that is incredible. And, of course, my concept of a community health center is a very user-friendly exshoe store—not quite that—in a shopping center somewhere where people feel free to go. I mean, a hospital is an enormous cost.

Dr. SMITH. Right. What we are looking is to create that same milieux. We are going to use those buildings, or part of the building so we do not have to build bricks and mortar.

But the concept is put in place community-oriented primary care community heath centers. We are using the same model as CHC's, but what we are going to do is try to use some of those buildings that are now closed that we could open up and use a part of them.

Senator ROCKEFELLER. Yes. Well, you have a very sympathetic Governor.

Commissioner HERRMANN. Excuse me. I apologize. But transportation is going to be a problem. In rural areas where our problem is so acute, they are going to have to get in an automobile and drive somewhere.

And if we can put everything in one campus without having to rebuild a community, then it actually provides easier access. There may not be a store front in a central area, and this may be the only central area in a rural community.

But I think what we are missing, too, is that all of look at community health centers and federally qualified health centers as a name. They exist, but not by those names.

In many of our States where we are struggling to put together, as you said, a band-aid—and I would argue that it is even more than a band-aid—some of the systems of care that the States are developing are very good, very innovative programs.

Senator ROCKEFELLER. But you have been effective, have you not, on infant mortality? What has happened, from where to where?

Commissioner HERRMANN. Our infant mortality rate, in 1986, was 13.3 deaths per 1,000 live births. This year, it is 10.9. Yes, sir.

Dr. SMITH. The Parkland program, which is driven off a hospital that decided it should not be building any more central capacity, but has no Federal dollars except for reimbursement under Medicaid, has some staggering results right now, particularly in its school-based systems where they have seen a drop in adolescent mortality for the entire West Alice area—the denominator, not just the kids that are served.

The hospital utilization has declined, average length of stay when they are hospitalized declined. Actually, reimbursement when they were increase because they got them on Medicaid through having out-stationed case workers and eligibility determination.

And, most significantly, teen-aged pregnancy went from 14.8 per 1,000 to 7.9 in that system. And, again, they have real outcomes. They are not community health centers in the way they are funded, but they are functioning in the same way.

What Parkland has decided to do is build yet three more, and our State health department is looking at mimicking that model in other areas of the State where we do not have a Parkland.

Senator ROCKEFELLER. Yes. Please.

Dr. WALKER. I would just like to say, Massachusetts is a State is kind of an enigma in some ways in the way it delivers services. We do not have public health clinics, except in the big cities of Springfield and in Boston. We basically rely on a community health center network, of which about half are federally qualified. That is the service delivery system for us. That is where the Title V dollars go.

In those communities in Massachusetts, and there are some in those areas where there are none, then we might support a community health center type looking entity that would be related to a community hospital, or some other kind of group practice with physicians coming together. And our infant mortality rate is seven. We have made the year 2000 objectives.

And it is not only because of the infrastructure that exists, but also because of the systems issues we talked about, about using the leverages for getting physicians to come into the community; the outreach, the links we have done with Medicaid where Medicaid has given us dollars to fund outreach workers; to do things in communities of color; to make all our materials translated into seven languages so that people can understand them, and going beyond just the financial barriers, which, once you have broken those—because our State has made a commitment to pay for prenatal care for all women, regardless of their economic status or their residency status but we found that that did not do it alone, these other barriers are key.

Senator CHAFEE. The other variance being language?

Dr. WALKER. Language. Attitude on the part——

Senator CHAFEE. The outreach.

Dr. WALKER. Outreach, lack of transportation, attitudes, also, on the part of providers at every level in terms of what it like to be from a different culture, understanding different cultures, how you translate that into nutritional packages for WIC. And, also, the issue of just making your services available so that people in the community know they are there.

And we found that big outreach PSA campaigns do not do it, you have to get to that street level and have leaflets available in Haitian, Creole, and Spanish, and go to the neighborhoods where those women are at that community level.

Dr. SMITH. It is one of the things, if I could, in public health we are trying to bring back concepts such as outreach and public

health nursing. We want to see those in those community health centers.

Again, historically, public health and primary care and even medicine went two different directions. The models we are trying to propagate is to actually put public health also into that primary care model to take responsibility for community in the sense of the denominator, not just the users, but also put in some traditional public health services so they got real one-stop shopping, which we have also not wanted to do.

We have historically felt that, this is sort of our area of expertise and we will maybe keep a separate infrastructure. That is not going to work. So, what we are trying to do is to blend that traditional public health role right into that primary care and build those kind of strategies.

Senator ROCKEFELLER. Let me ask Dr. Walker. You be the statesman here for the moment. Well, you are all statesmen here, but it is just a question of turf. You say, and I agree, that both the MCH block grant and funding for the federally qualified health centers deserve increase funding.

You note in your testimony that flexibility in the Title V program allows for resource allocation and program development that compliments—and, to use your word—leverages other public programs like the FQHC's.

So, in a sense, we are all in this together. Now, you are in a unique position, and you have just provided us with some of this information, on the best strategies to improve outcomes and protect children and adolescents.

So, before you answer me, let me, for the record, again, make a statement. There are a lot of shared goals and responsibilities between MCH programs and community health centers. And you are working together to ensure that services are not duplicated and resources are maximized.

This is not a matter of turf, but of shared responsibilities. What is your view of the balance that we need to strike between the joint responsibilities of the federally qualified health centers and the Maternal and Child Health Programs?

Dr. WALKER. All right. I think that is a very good question, and I think it does have to be a partnership going forward. I really see the role of the State Title V agency—which is the public health agency, the piece relating to mothers and children—to have this larger responsibility.

In fact, it is within the Federal statute for looking at the total system of care for mothers and kids with all of these different pieces. One piece is to provide direct services, but there is more than that.

So, a major player within your State or whatever your entities are delivering that direct service, our goal is to build systems of care at the community level that will be community-based, family-centered, empowered by the consumers, and high quality.

When you have a community health center which is a very viable, tremendous, wonderful way to do that at a community level, our role is to work and support that at the community level.

In other communities where there may not be those, we would help to support the development of those, or we would support the

development of whatever entity it was, but all would have that same goal going forward. So, it is very much in a partnership role.

But I really feel that the State, as a public health system, is responsible for seeing how all these pieces go together and help support communities where they are not there.

I think we are responsible for accountability to you and to the State for what is happening to mothers and kids, and a lot of those pieces that, in fact, community health centers can help you do at the local community level, but they cannot do the whole State or Federal role. So, it is an interactive way of putting it together. They are very important together.

Senator ROCKEFELLER. Comments?

Dr. SMITH. Well, I think she has stated it accurately. What we are going to be doing with Title V and the 330's, is, again, I am going to try to create some capacity where I do not have any.

If I have a health center, then what I am going to be seriously looking at is to invest there and not create duplicative systems. I should take my other resources, if there is a cost savings, and go into the next town where I have nothing. And, in that case, if all I can do is moms and babies through Title V and some Medicaid, that is exactly what I am going to do.

But what we are going to be looking at is pushing our resources into the community, whether they be Title V or any other block, and make sure we invest in some of these viable systems. And I am very pleased to be able to invest and want to invest in increased investment in the CHC's.

At the same time, I have got to also look at where I do not have anything, so that is probably where I will use Title V and some of our other preventive block grants.

Senator ROCKEFELLER. If you awakened tomorrow morning and read—where do you live?

Dr. SMITH. Austin.

Senator ROCKEFELLER. What is the big paper there?

Dr. SMITH. Statesman.

Senator ROCKEFELLER. If you read in the Austin Statesman that all pregnant women and children through the age of 18 were covered by health insurance, would you start your day out happily?

Dr. SMITH. No. I would be scrambling, because I have no one to deliver them or give them prenatal care. But I would sure like the job and opportunity to find it.

Senator ROCKEFELLER. John, do you have anything further?

Senator CHAFEE. I do, Mr. Chairman, have a couple of questions. My legislation provides assistance to federally qualified health centers. And you have indicated that you would like it broadened to cover situations such as yours.

Let me put a twist on that. Why have the centers that you are talking about, the delivery systems you are talking about, not qualified as federally qualified health centers? What do you have to do, or what should I do to change this? We want to work with you. We do not want this just to go to certain centers, we want to help people. Why have your centers not qualified?

Dr. SMITH. There are several areas. Again, I can even cite the example of what Parkland did, which was basically a similar setup,

and actually contracted and gave dollars to some of the 330's to let them do more.

The biggest issue for them was they had a governing board which was established by the county commissioners, which is the board of managers for the hospital district.

The area that they would require a waiver is under governance. Otherwise, they did everything else; they even had advisory boards. But they did not have fiduciarily-placed boards that were responsible for the operation and budgeting.

Dr. WALKER. That is one. The other thing is, sometimes it is hard for public health clinics, the Title V clinics, especially in rural areas and other areas, to be open 24 hours a day, or have on-call 24 hours a day. So, the have to scramble to make some of those connections the way it is now written, in addition, being open 7 days a week.

I also feel like in our State we are helping some of these centers apply for the money. It is a lot up front to get enough consultant fees together to do the application to be qualified. I mean, I think that should be put on the table, too, in terms of some of the resources, even streamlining the process for becoming——

Senator CHAFEE. Well, wait a minute. They have to pay money to hire somebody to obtain the grants?

Dr. WALKER. Yes. In our experience in our State, to qualify to become a center you need to go through an extensive application process. Some of the pieces of it are very good. I mean, having a needs assessment, putting it all together in all the legal ways.

We find that for a local struggling entity, whether it is a Title V clinic, a public health clinic, or a community-based organization that is just getting it together, knows there is a need and wants to go for it, they do not usually have the skills to put that together with a lawyer and the needs assessment person.

Senator CHAFEE. We ought to make that easier.

Dr. WALKER. We have actually used some of our Title V dollars to help people do that. That is the kind of infrastructure things we are talking about we feel responsible to do. But I do not feel it should take that much.

I think an estimate might be anywhere from $15,000 to $25,000 per site to get the application in. So, that is a barrier that does not help, but it is really these other barriers of all the pieces, including the boards and the 24-hour coverage.

Dr. SMITH. I would just, if I could, Senator, say something about 24-hour coverage, which is why, I did not mention, and having been a pediatrician and neonatologist on the border, I am not as willing to let that one go, because I want to make sure patients do have continuity and they can get into a hospital.

I have seen so often in my State where we can do everything and deliver them to the threshold, and we cannot get them over. So, I think that is a noble thing. The biggest problem we have is governance.

Senator CHAFEE. Well, just a comment. I thought what you said about outcomes research was very important. A very quick question. Who said, in their State they brought down teen-aged pregnancy by 50 percent? That was remarkable.

Dr. SMITH. That was in west Dallas. Correct.

Senator CHAFEE. Well, how did you do that? What did you do?

Dr. SMITH. Well, it is a 23-year-old Title V Children and Youth Project. It is the oldest demonstration program in the United States. I should not remind anybody of that in Washington; they will probably get de-funded.

But it is a school-based program that has been there with comprehensive education, including sex education and health care, that has been in place for 23 years, well accepted by the community and by the children and their families, has been very aggressive in comprehensive health, reproductive health, and sex education.

And the results have paid off, not just in the kids served. I think the exciting thing about west Dallas is it was the entire catchment area, not just the users in that population.

It is a remarkable story, because west Dallas is the poorest standard statistical community in Dallas, at $4,800 per year per capita, and it is about 50 percent African-American, 50 percent Hispanic, and it is the largest housing project in the United States.

Senator CHAFEE. When you say it was brought down by 50 percent, you mean from 23 years ago?

Dr. SMITH. Actually, that was a 10-year figure. It was 10 years ago. That drop was in the last 10 years.

Senator CHAFEE. And, finally, a very quick question just for my own edification. Ms. Herrmann, you indicated, I think, that you had 115 rural hospitals close. Did they close because of decline in population, or easier transportation to better facilities, or for financial reasons that they just could not support themselves because of, perhaps, a combination of the previous reasons?

Commissioner HERRMANN. Actually, Texas had 115 hospitals close, but Alabama and Texas followed each other for 2 years in the number of hospitals closing. Some of ours were lack of need, some of them needed to be closed. The majority of them were closed for financial reasons.

Senator CHAFEE. But they were closed because of financial reasons, that is, because the population demand had declined?

Commissioner HERRMANN. Correct. When the population declines and hospitals close, it still leaves the elderly and the Medicaid population without services. And that is why we are looking forward to a coordinated system of care with all of our components in using those campuses to provide primary and preventive services.

Senator CHAFEE. All right. Thank you very much, Mr. Chairman.

Senator ROCKEFELLER. Thank you, Senator Chafee.

Senator CHAFEE. I want to join you in thanking the panel.

Senator ROCKEFELLER. Yes. I do, too. I would go on, but I have a clinical nurse specialist from West Virginia who has a 5:00 o'clock plane to catch. And it is written in the Constitution that she cannot miss it, so I have to go to the next panel. Thank you very, very much.

Our final panel consists of Rochelle Boggs, from Parkersburg, WV, on behalf of the American Nurses Association, although you will not be necessarily talking about nurses' agenda.

Ms. BOGGS. Just briefly.

Senator ROCKEFELLER. And Ms. Rivera, who is the senior health specialist of the Children's Defense Fund, and I am sorry I have not met you before. Ms. Boggs, do you want to start?

STATEMENT OF ROCHELLE L. BOGGS, R.N., M.S., C.C.R.N., C.S., PARKERSBURG, WV, ON BEHALF OF THE AMERICAN NURSES ASSOCIATION

Ms. BOGGS. Thank you. Mr. Chairman and members of the subcommittee, I am Rochelle Boggs, a clinical nurse specialist from Parkersburg, WV. I work in a collaborative practice with a general surgeon. In addition, as a volunteer in the community, I serve as the clinical director of the Good Samaritan Clinic, Inc., a free clinic serving the medically indigent population in our area. I am also a board member for the West Virginia Nurses Association, and a Member of the American Nurses Association (ANA).

I appreciate the opportunity to come here today to discuss the services provided by nurses in health care, as well as my own experiences in providing health care in rural areas. I would like to summarize my written statement and ask that a complete copy of my remarks be entered into the record.

America's 2 million registered nurses, working in a variety of settings, deliver many of the essential health care services in the United States. Because we are there 24 hours a day, 7 days a week, we know all too well how the system succeeds for some, yet falls short for many.

We see people on a daily basis who are denied or delayed in obtaining appropriate care because they lack adequate health insurance or are unable to pay for care. These people often postpone seeking health until they appear at the hospital emergency rooms in advanced stages of illness or with problems that might have been treated earlier in a less costly fashion, or, more appropriately, prevented altogether with earlier diagnosis and treatment.

Delayed access to needed and appropriate health care is associated with problems of increased morbidity and mortality, as well as increases in cost, time away from family and work, and increased utilization of health care resources.

For the past 3 years, under the leadership of ANA and the National League for Nurses, nursing has worked to develop a plan which encompasses our best vision of a health care system for the future.

To date, in addition to ANA's state and territorial associations, 64 national nursing and health-related organizations have endorsed this proposal for health care reform entitled "Nursing's Agenda for Health Care Reform." Together, these organizations represent approximately 1 million of the Nation's 2 million registered nurses.

We believe that expanding the principle of provider choice to include all qualified health care providers must occur to improve access to quality health care, particularly to the underserved and unserved populations.

Now, I would like to tell you a little bit about what I do as a volunteer in my community, which is a different approach to health care. I serve as the clinical director of the Good Samaritan Clinic, Inc. in Parkersburg, WV.

We were founded by a group of concerned nurses, physicians, local business people and ministerial alliance people in our community. We opened this free clinic on September 29, 1991. The patients that we serve we ensure that those people are referred into

those programs, do not include Medicaid or Medicare eligible patients.

The population that we do serve are people who are truly the indigent of our area who have nothing. They fall through all cracks in the system. They meet the Federal poverty guidelines to qualify for services in our clinic.

To date, we have had approximately 1,300 patient contacts. We are open two evenings a week from 5:00 o'clock until the last person has received care. We have no more people in line, and we are totally funded by volunteer donations. Everything in our clinic has been donated; including trash bags, toilet paper, et cetera. Everyone in our community has donated to some extent. A good example of this is the health care providers, predominantly nurses and physicians, who volunteer to work at this clinic. They leave their place of business at 5:00 o'clock and come to the clinic, without having had supper. The local restaurants provide dinner to these health care providers free of charge so they can have something to eat since they are there until 10:00 and 10:30 at night.

We see mostly people between the ages of 21 and 45. However, we do see some patients that have Medicare. The reason that we see these people is the medications that they are on many times come to a cost of $200–$300, and they need these medicines to survive.

So, we will take care of them as far as handing out the medications. We have a volunteer pharmacy that is staffed by a licensed pharmacist. All the drugs are provided free of charge by pharmaceutical companies. We dispense approximately $1,000 worth of medications on a weekly basis.

The types of problems that our patients present to us are largely depression and crisis intervention situations. We have some people that come with many, many ailments and complaints, and when you really pin them down as to the problem, they tell you that they are lonely, that they feel that they are nobody's nobody, and they need to know that someone cares.

Those are the types of things we see. Sometimes it gets very depressing. When they leave, sometimes they ask us for a hug. We give them a hug, send them on their way, tell them to come back and we will provide whatever it is they need.

I just want to summarize by saying that there are several things that our clinic needs. We have ran out of space. We only have three rooms. We do not have enough advanced practice nurses. We only have five in the five-county area, and only one of them comes to the clinic, and that is myself.

The rest of the nurses at the clinic are registered nurses with varying levels of education. Therefore, we find we are really shorthanded. If we had more advanced practice nurses we could take care of more patients.

We need to be open more days a week. If we had the funding to hire advanced practice nurses, we could achieve this. And, also, we need to buy a building because we do not have adequate space.

The other thing that we are concerned about regarding advanced practice nurses in West Virginia is the fact that we do not have a Medicaid-friendly system to enter our provider status.

This is a very major problem, and it is very frustrating to the nurses in our State. Advanced practice nurses need to be directly reimbursed for their services under Medicaid in order to enhance the availability of health care for the unserved and underserved populations.

I would just like to say, in closing, that ANA commends the subcommittee for its leadership in this time of health care crisis. Mr. Chairman, we are pleased that the subcommittee is holding this hearing on access to health care in underserved areas.

We hope this issue continues to be discussed, that all legislative options will be thoroughly considered, and that effective legislation will be enacted to improve access to health care. I appreciate this opportunity to speak to you as a representative of ANA and the nurses in the State of West Virginia. Thank you, and may good health be with each of you.

Senator ROCKEFELLER. Thank you, Ms. Boggs.

[The prepared statement of Ms. Boggs appears in the appendix.]

Senator ROCKEFELLER. Ms. Rivera.

STATEMENT OF LOURDES A. RIVERA, ESQ., SENIOR HEALTH SPECIALIST, CHILDREN'S DEFENSE FUND, WASHINGTON, DC

Ms. RIVERA. Good afternoon, Mr. Chairman, Mr. Chafee, and Mr. Durenberger. The Children's Defense Fund is pleased to have this opportunity to testify before you today in support of S. 773, which would provide better access to primary and preventive health care services for low-income children and their families.

CDF is a national public charity which provides long-range and systematic advocacy on behalf of American children. Our organization pays particular attention to the needs of low-income, minority, and disabled children.

For children, it is the primary health services, prenatal care, immunizations, health examinations, and ongoing basic medical, dental, vision and hearing care that will make a big difference in their lives and health.

It is these basic services which all industrialized nations but the United States and South Africa assure for all children and pregnant women. It is the lack of these services, combined with tragically high child poverty rates, which are primarily responsible for the Nation's shameful international child health rankings.

S. 773, if enacted, will help to ensure that medically underserved communities have access to health care by expanding the capacity of federally qualified health centers to provide quality primary and preventive health care services where they are most needed.

FQHC's have an impressive track record in serving hard-to-reach populations. These are the urban, rural, low-income, non-English-speaking and migrant families, as well as families with children with disabilities, and employing outreach case management and service strategies that are appropriate for the communities in which they are located.

Most importantly, FQHC's have provided the most basic and needed primary and preventive health services, as well as specialty out-patient services and case management services that link families with other programs.

While this legislation does not address all of the health care system's shortcomings, it moves us in the right direction in strengthening our health care infrastructure.

All Americans must be able to obtain good quality primary and preventive care from providers that are accessible to them. These additional resources are desperately needed and will provide an essential complement to any national health care reform that guarantee health insurance coverage for all Americans. Thank you, Mr. Chairman.

Senator ROCKEFELLER. Thank you, Ms. Rivera.

[The prepared statement of Ms. Rivera appears in the appendix.]

Senator ROCKEFELLER. Senator Chafee.

Senator CHAFEE. Mr. Chairman, first of all, I want to congratulate your fellow West Virginian.

Ms. BOGGS. Thank you.

Senator CHAFEE. I am very, very impressed with what Ms. Boggs is doing.

Senator ROCKEFELLER. Well, I am going to send over an article in the Parkersburg News about her. I mean, this is an incredible person. And somebody says, I tell you, we look like a Tin Lizzy, but we give Cadillac care.

Ms. BOGGS. That is true. And please remember, I did not do this, by any means, alone.

Senator CHAFEE. Well, you certainly are a key force there, and I want to join others there in a salute to you for what you are doing. This particular center, what would you have to do to qualify as a federally qualified health center, do you know?

Ms. BOGGS. Well, it is our understanding, we have been looking at some long-term grant money to obtain this new building. It was our understanding that we had to be in operation 32 hours a week, and that is virtually impossible with an all-volunteer staff; most everyone works full time.

So, we look at that as a problem. We need to have paid staff to stay open longer and serve more people. That was our understanding in order to apply for some type of a Federal grant.

Senator CHAFEE. The other thing, I may have missed it in your testimony, and I skimmed through it to see whether I heard correctly. Is a very substantial portion of your clientele there, did you indicate, because of depression and for mental reasons rather than physical reasons? Was I incorrect in gathering that from what you said?

Ms. BOGGS. I did say that. They do come with physical ailments, such as with complaints of headaches, back aches, breast lumps; multiple, multiple problems, many of them.

And when you look at this person in front of you with 10 or 15 complaints, you say to yourself "where do we start?" So, sometimes you just look them in the eye and you say, "what can we do for you here today?" And sometimes they look at you and say, "I need a hug. I need to know somebody cares."

So, you realize that their most pressing issue may not be the physical problems that they say they have. Those are types of people that we see. However, we also see a substantial number of diabetic problems, high blood pressure problems, those types of things.

Senator CHAFEE. Now, in your particular clinic—if I can call it that—you would not have somebody there who would, for instance, be qualified to advise them on WIC programs or something like that. Is that true?

Ms. BOGGS. No. We do. We have social workers there. We work with the community. The resources that are there in the system we do not duplicate. We try to get people back into the system if they have fallen out. We do have people that come with the medical card. We do not refuse to see them. We will see them that evening, and then we will plug them back into the system.

We have two hospitals that cooperate. They will see patients if we need to send them for X-rays, lab work, whatever. We have some 75 physicians that participate in our program; approximately half of those are sub-specialists that have actually done surgery on our patients at no charge. It is a real community effort.

Senator CHAFEE. How do you know whether somebody can pay or cannot pay, and if they can pay something, do you make a charge?

Ms. BOGGS. Mr. Chafee, we look them right in the eye and we say, "what do you make?" And if they tell us and it meets the Federal poverty guidelines, they see us. It is just that simple.

Senator CHAFEE. I see. All right. Thank you very much, Mr. Chairman. I will have a question for Ms. Rivera in a minute. I just wanted to get squared away on that.

Senator ROCKEFELLER. Senator Durenberger.

Senator DURENBERGER. Yes, Mr. Chairman. First, I want to thank both of you for your testimony. More than that, as you have both indicated, you are here representing a whole lot of people who have preceded you and who are in the field in all of our States having the experiences that you spoke to here today, and I thank you for that.

Earlier in the afternoon, I said I was a bit bothered by the sort of two-tier implications that are built into a system in which those who are, in one way or another, by income or location or something, outside of the mainstream of the privately delivered employer-insured insurance system.

In other words, so many Americans buy both their health and medical services with a Blue Cross card or something like that, or parents have enough money that they can afford to get their kids' shots.

The community health centers and other community institutions like them have been designed to fill a growing void in this system. I worry that we perpetuate the void in some way by perpetuating a particular solution.

I prefaced my remarks earlier by saying the solutions in my State are all terrific people, just as they are in your State. They work harder, they work longer and they work for less by way of material reward than anybody else. They are the kind of people I would want taking care of me and my family.

I am just sharing this concern that somehow or another we perpetuate a separate solution for one group of people from the others. I have not reached any definite conclusions and I keep seeking help with this.

I keep coming to the point where I say, I wish the communities of America would make the same commitment to health that they make to education, because the two are so related and they are so important.

From conception, or even before you contemplate pregnancy, all the way to about age 16, we just make a community, and a family, and a neighborhood commitment to our kids. We drag their parents in and make them be involved and responsible, too. But we do not do that in health care. It keeps bothering me a lot.

I would love to see an America in which the communities made that kind of commitment, and, in exchange for that, the national government, which seems to do some of these other things better, would make a commitment to ensure universal access to medical care for every single American regardless of where they are located, and regardless of its cost.

I wonder if either of you would care to speak to your own personal feelings about either the lack of community commitment to public health in general or whether there are not perhaps better solutions that we ought to be looking towards as a nation than just expanding community health centers and related activity.

Ms. RIVERA. It would be ideal if everyone had access to exactly the same type of private providers. However, even if you were to provide every child or every person in America with the same exact insurance card, because of the barriers that exist—language, people need child care to take care of their kids, location, needs for transportation—that will not be possible.

We still need an infrastructure that is there to provide the types of quality care that these folks in these communities need. I mean, it would be ideal for everyone to have the same access to the same providers, but I just do not see anytime in the near future how that is going to be possible.

Right now you have 40 percent of all children who do not have employer-based health insurance, and the children on Medicaid cannot find providers to see them for all sorts of reasons. So, that is why you do need these community-based providers.

Senator DURENBERGER. Do not get me wrong, I do not argue against community health centers. My community solution would be community health centers, without all of the red tape that has to be built into all of these laws. That would be the model. But it would be up to the community to decide what works best in that particular community.

Ms. BOGGS. I find that I spend a great deal of time educating, and it often seems that I cannot do enough. It would be nice to see education on good health habits, start very young, and then I think that in long-term we might see some changes in health care.

Senator ROCKEFELLER. Ms. Boggs and Ms. Rivera, we just had a vote that went off. Actually, it turns out that it is your transportation that leaves at 5:00 o'clock, not your plane.

Ms. BOGGS. That's right.

Senator ROCKEFELLER. So, you have nothing to worry about. Your clinic, as I understand it, is on the second floor.

Ms. BOGGS. Yes, sir. It is.

Senator ROCKEFELLER. And so, automatically that means you cannot be federally qualified because there is no accessibility for the disabled. Is that right?

Ms. BOGGS. That is my understanding. That was a building that was donated to us by physicians to use, and it is the only thing that we have been able to obtain.

Senator ROCKEFELLER. Yes. See, that is so utterly fascinating to me. I sent the newspaper article over to Senator Chafee, but here you are just doing unbelievable things, with other people. I mean, just absolutely the way the world ought to work. Then you get done in, so to speak, by the fact that you are on the second floor.

Ms. BOGGS. We looked at that really critically before starting out and then we said, "if we do not just start doing this, we will never get started."

Senator ROCKEFELLER. Yes.

Ms. BOGGS. So, we are just going to start and see how far we can go. And it is still going; we are still there.

Senator ROCKEFELLER. Yes.

Ms. BOGGS. The other thing, we had a computer donated to us. We are generating statistics through the ICD–9 coding for disease processes and also the CPT, or Current Procedural Terminology codes looking at those procedures generated by nurses versus those procedures generated by physicians, and then the diseases that coincide with people coming to our clinic for contacts.

The other thing is, we code people according to their employment status, and we look at the amount of homeless that come in there. This has just been going on since September, so we have not generated a lot of statistics yet. However, we know we are the only free clinic in West Virginia generating this kind of information, and we think we are going to find some very interesting information or data.

Senator ROCKEFELLER. Let me just ask both of you. Then, gentlemen, we probably have to go vote and probably close the hearing, too, at that point. It is curious in a way, because there is a little turf war between Maternal and Child Health Care, and then the federally qualified health centers and the rest of it.

But you come in and you want to get a little bit of help here, a little bit of help there and you scratch, and you pull, and you get something in the law but it does not get funded.

I mean, basically, if you both had your druthers, if we were just going to work at the American health care system, what would you do, taking a larger look, in 3 minutes?

Ms. BOGGS. Well, if I look at it from my volunteer clinic viewpoint, it would be to let us serve those people in our communities with as few restrictions as possible. When I look at my so-called real job, there are so many restrictions, so many paper-type generated things. Just to get reimbursement is sometimes a nightmare. And in the clinic we just do not have any of that to fool with. People come, they give care, they leave. They are happy, they are so glad that they have served someone.

It is just there is not a lot of—I hate to say this here in this room—hassle from other people, I guess. I do not know how to say it. We need the money without a lot of strings attached, I guess. And I do not think that it may be possible.

Senator ROCKEFELLER. Again, actually, this is just sort of an interesting phenomenon. Was there a camera in the room? Was there? Oh. Because it is just sort of interesting to have lights in the room but no camera.

Senator CHAFEE. Mr. Chairman, I have one quick question.

Senator ROCKEFELLER. Go ahead. I mean, the lights went off and I felt so much happier.

Senator CHAFEE. Ms. Rivera.

Ms. RIVERA. Yes.

Senator ROCKEFELLER. Well, John, could I just do one quick one?

Senator CHAFEE. Yes. I am sorry.

Senator ROCKEFELLER. Ms. Rivera, if you wanted to take a larger look at the health care system, this nickel and diming, coming and fighting for this or for that, what would Children's Defense Fund do?

Ms. RIVERA. Well, in a nutshell, I think we would guarantee every child and family a means to pay for health care services and then provide them with a place to go that is accessible to them to get their health care services. And I think that is the bottom line.

Senator ROCKEFELLER. Senator Chafee.

Senator CHAFEE. This is particularly directed to Ms. Rivera. Some suggest that if we had universal health insurance that we would not need the expansion of these federally qualified health centers or community health centers, or whatever we want to call them—let us just call them federally qualified health centers—that everybody would have national health insurance and universal access. What do you say to that?

Ms. RIVERA. Well, even if everyone in this country had the same insurance card, that does not mean that everyone has a place to go to get their health care. An insurance card or a means to pay for the health care does not mean anything unless you have a place to go that is quality and accessible to you. So, you need both.

Senator CHAFEE. Well, I am glad you said that, because that is the answer I wanted to hear. [Laughter.]

Ms. RIVERA. Happy to oblige.

Senator CHAFEE. Delighted you came today. I very strongly believe that. It is one thing to have a card, but unless you have got somebody to go to, it does not do you any good.

Ms. RIVERA. Exactly.

Senator CHAFEE. And that is true in our inner cities, that is true in our rural areas. And that is why I feel strongly about it, regardless of what happens. This is not an either/or. I very strongly feel we should go ahead with the expansion of these community health centers and I want to thank both of you very, very much for coming.

Ms. BOGGS. Thank you.

Ms. RIVERA. Thank you.

[Whereupon, the hearing was concluded at 4:23 p.m.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED

PREPARED STATEMENT OF ROCHELLE L. BOGGS

Mr. Chairman and Members of the Subcommittee, I am Rochelle L. Boggs, RN, MS, CCRN, CS. I am a clinical nurse specialist from Parkersburg, West Virginia. I work in collaborative practice with a general surgeon. As a volunteer in my community, I serve as the Clinical Director of the Good Samaritan Clinic, Inc., a free clinic serving the indigent population of Parkersburg and the surrounding five county area. I helped to found that clinic which opened on September 29, 1991. I am also a Member of the Board of Directors of the West Virginia Nurses Association and a member of the American Nurses Association (ANA). Thank you for the opportunity to appear before this Subcommittee to discuss access to health care in rural areas.

The American Nurses Association is the only full-service professional organization representing the nation's two million nurses, including nurse practitioners, clinical nurse specialists, certified nurse midwives and certified registered nurse anesthetists. ANA advances the nursing profession by fostering high standards of nursing practice, promoting the economic and general welfare of nurses in the workplace, projecting a positive and realistic view of nursing, and by working closely with the U.S. Congress and regulatory agencies on health care issues affecting nurses and the public.

A number of important steps have been taken recently to improve access to primary health care for people in our nation's rural areas. For example, in the 101st Congress, ANA was pleased to have the opportunity to work closely with Senator Daschle and others to achieve enactment of the "Rural Nursing Incentive Act." That proposal, which was included in the Omnibus Budget Reconciliation Act of 1990 (Public Law 101–508), allows nurse practitioners and clinical nurse specialists who practice in rural areas to receive direct reimbursement under Medicare. We are also grateful to Chairman Bentsen for the work he has done to expand Medicaid coverage for women and children. ANA looks forward to continuing to work with members of the Finance Committee and other Members of Congress to build on these measures to improve access to the health care system.

Access to high quality, affordable health care is of concern to millions of Americans—not only to the over thirty-seven million who are uninsured, but to the growing number of currently insured who fear that changing or losing their jobs will result in loss of coverage because of pre-existing conditions, or that the skyrocketing costs will make their dependent's coverage or their own out-of-pocket health care costs unaffordable.

America's two million registered nurses deliver many of the essential health care services in the United States today in a variety of settings—hospitals, nursing homes, schools, home health agencies, the workplace, community health clinics, in private practice and in managed care arrangements—nurses know first hand of the inequities and problems with our nation's health care system. Because we are there—twenty-four hours a day, seven days a week—we know all too well how the system succeeds so masterfully for some, yet continues to fail shamefully for all too many others.

We see people on a daily basis who are denied or delayed in obtaining appropriate care because they lack adequate health insurance or are unable to pay for care. These people often postpone seeking help until they appear in a hospital emergency room in advanced stages of illness or with problems that could have been treated earlier in less costly settings or, more appropriately, prevented altogether with earlier treatment or prevention services.

Delayed access to needed care is associated with problems of increased morbidity and mortality as well as countless hours of lost productivity in the workplace. Infants and children, pregnant women, the frail elderly, people with persistent health problems, rural and inner city residents and minorities are disproportionately represented among these most vulnerable uninsured groups. Their complex and diverse needs are not met by the existing system.

Nursing is concerned by the failures in our current health care system. More than 30 million people have no health insurance and millions more are critically underinsured. Our health care system is oriented toward expensive medical interventions, rather than essential health services designed to promote and maintain health. As a nation, we have failed to develop appropriate ways to allocate available health care resources and services. Unfortunately, the burden of the reality of the failures of our health care system are disproportionately felt by vulnerable segments of our nation's population. This includes the very young, the very old, the poor, the illiterate and those who live in rural and frontier communities and low-income urban communities.

America's nurses believe that it is time to frame a bold new vision for reform—one that keeps what works best in our current system, but casts aside institutions and policies that fail to meet present and future needs—a plan that addresses the triad of problems that exist in the current system: **inequitable and limited access, soaring costs and inconsistencies in quality and appropriateness of the care delivered.**

For the past three years, under the leadership of American Nurses Association (ANA) and the National League for Nursing (NLN), nursing has worked to develop a plan which encompasses the profession's best vision of a health care system for the future. To ensure that all areas of specialty practice and unique geographic differences were sufficiently represented in the development of this plan, ANA convened a special task force of nursing experts. They evaluated the current health care system in the United States, as well as those of other nations, and subsequently developed a plan for reform that is uniquely American.

To date, in addition to ANA's state and territorial associations, 64 national nursing and health-related organizations have endorsed this proposal for health care reform, entitled **Nursing's Agenda for Health Care Reform.** Together, these organizations represent approximately one million of the nation's two million registered nurses.

Many other highly respected and qualified groups have also studied the growing crisis in health care and have come forward with reform proposals of their own. Unfortunately however, many of those plans have focused primarily on the problems of the high cost and the financing of health care services. Nurses believe that framing the problem that narrowly will not result in solutions that will adequately achieve the desired outcome: **universal access to affordable and timely health care that is appropriate, necessary and that ultimately results in the improved health status of all.**

Nursing defines the health care crisis problem in terms of the need to **restructure, reorient** and **decentralize** the health care system in order to **guarantee access to services, contain costs and ensure quality.** Fundamental restructuring must occur because patchwork approaches have failed. Health care reform must be comprehensive, and not limited to addressing only one or two components of the problem. Nursing's proposal does not define the problem only in terms of the uninsured or underinsured; rather, it **addresses the health care needs of the entire nation.**

Nursing's Agenda for Health Care Reform calls for building a new foundation for health care in America while preserving the best elements of the existing system. Influencing the direction of health care reform is a complex, demanding task. Nurses know, however, that in order to preserve the health and well being of our country and its people we must make important, fundamental changes in *how, where and to whom* care is delivered.

Today, America's two million nurses are united in urging that the nation's health care system be cured . . . and cured **now.** We must reshape and redirect the system away from overuse of the expensive, technology-driven, hospital-based models we currently have. **A balance must be struck between high-tech treatment and prevention.** It is nursing's belief that the system must emphasize and support health promotion and disease prevention and show compassion for those who need acute and long-term care.

We believe that **expanding the provider of choice principle to include all qualified health care providers must occur to improve access to quality health care.** Nurses are an essential component of the health care system. Nurses are frequently the first and sometime the only point of contact for the consumer and

the health care system. Restrictive reimbursement laws have created an illness-oriented, hospital-based health care system that revolves around the interests of institutional and physician providers. We believe that both private and public insurers should expand coverage to include nurses and other qualified nonphysician providers. Freedom of provider choice laws can save the health care system money by reducing visits to emergency rooms and or other specialists who may be high cost providers. Studies have shown that nursing services can reduce the utilization of hospitals, emergency rooms and nursing homes and can reduce the costs of laboratory services and save physician time (Harrington, 1990 and Feldman, 1987). Nurses' style of practice has also been shown to be cost-effective to the consumer through increased compliance to treatment (Office of Technology Assessment, 1986).

After studying nurse practitioners at the request of the Senate Committee on Appropriations, the Office of Technology Assessment issued its findings in December 1986 that indicated that nurse practitioners clearly play legitimate roles in the health care system and have made important contributions to meeting the nation's health care needs by potentially reducing health care costs, improving the quality of health care services, improving the accessibility of health care services, and increasing the productivity of medical practices and institutions. This study concludes, "Federal third-party payers could be more in step with new and evolving payment practices by liberalizing coverage payment restrictions" for the services of advanced practice nurses. In addition, it asserts that direct payment to these providers is likely to improve health care for segments of the population that are currently not being served by our health care system.

In addition, a balance must be maintained between treatment of illness and promotion of health. Practically, that means valuing and incorporating as an integral part of health care delivery the health education and counseling roles which are an essential component of nursing practice. The incorporation of these roles into practice has increased patient/consumer ability to manage their health status to achieve improved health outcomes, especially for those with multiple or chronic illnesses.

To improve access and reduce costs, **consumers must have more responsibility in making decisions.** Health care must be made a more vital part of individual and community life, and controls must be placed throughout the system to reduce spiraling costs.

Among the basic components of "Nursing's Agenda for Health Care Reform" are the following:

- **universal access for all citizens and residents provided through a restructured health care system;**
- **a federally-defined standard package of essential health care services financed through public and private plans and sources including preventive, pre-natal, well-child, mental health, acute and short duration long-term care services** provided through either:

—**a public plan,** based on federal guidelines and eligibility requirements, which would provide coverage for the poor and create the opportunity for small businesses and individuals to buy into the plan. This public plan would be administered by the states in order to anticipate the health care needs and changing demographics of the population. Copayments and deductibles would be eliminated for those under 100 percent of the poverty level and reduced for those between 100 and 200 percent of the poverty level; or

—**a private plan** provided through employment which would offer, at a minimum, the nationally standardized package of essential services. This package could be enriched as a benefit of employment, or individuals could purchase additional services. If employers did not offer private coverage, they would be required to pay into the public plan for their employees.

—a shift in focus to provide **a better balance among treatment of disease, health promotion and illness prevention** such as coverage for:

—immunizations;
—prenatal care;
—health screening which has proven effective in preventing costly and devastating disease (e.g., colorectal and testicular exams, pap smears, and mammograms).

- the **phase-in** of essential services, starting with pregnant women and children under six years of age, and continuing with the vulnerable populations who historically have had limited access to our health care system.
- enhanced consumer access to services **by delivering primary health care in community-based settings;** the new system would facilitate utilization of the

most cost-effective providers and therapeutic options in the most appropriate settings;

- Steps to reduce health care costs such as:

—required usage of **managed care** in the public plan. Private participation in managed care plans would be encouraged by reduced consumer cost-sharing and federal prohibitions of state barriers.
—ensuring consumer access to a **full range of qualified health care providers** (including nurse practitioners);
—providing early **treatment and prevention service at convenient sites, such as schools, the workplace, and other familiar community settings;**
—**reducing defensive medicine and unnecessary practices;**
—**controlled growth of the health care system** through planning and prudent resource allocation; and
—elimination of unnecessary **bureaucracy and decreased administrative requirements through the use of uniform claim forms and electronic billing;**

- utilization of **case management** for people with continuing health care problems to promote active participation in their care and reduce fragmentation of the health care system.
- **public and private funding for long-term care services of short duration** and a provision for **public funding of extended care to prevent personal impoverishment.** This proposal will require more **shared personal and community responsibility for care.** It will prevent impoverishment due to extended long-term care needs. It will require use of new creative financing ideas, such as individual health accounts, similar to Individual Retirement Acts (IRAs) and home equity loans.
- **insurance reforms** are required to ensure improved access to coverage, including community ratings, affordable premiums, reinsurance pools for catastrophic coverage and other proposals to assist the small group market.
- access to services are ensured by **no payment at the point of service and elimination of balance billing** in both public and private plans.

While we would like to see reform of the health care system occur as quickly as possible, we recognize that it may be necessary to implement these fundamental changes sequentially. We believe it is necessary that the first priority should be the immediate coverage of all pregnant women and children under six years of age, and those individuals who have traditionally had limited access to health care services.

ANA commends the Subcommittee for its leadership in this time of health care crisis and is pleased that a number of members of the Subcommittee have introduced bills that propose a variety of different approaches for reform of the health care system. This will ensure that this issue is comprehensively discussed and that all options are thoroughly considered.

There are several key features and principles of *"Nursing's Agency for Health Care Reform"* that are very similar to provisions contained in several comprehensive health care reform bills that have been introduced in the 102nd Congress.

ANA is particularly pleased that S. 1227, "Health America" and *"Nursing's Agency for Health Care Reform"* share several key components. Both include public responsibility for insuring universal access, to a federally defined standard package of essential health services as well carefully thought out incentives for every individual to assume greater self-responsibility for health care. In addition, both build on the existing employer-based health insurance system that exists today and advocate a better balance between treatment of disease and illness prevention.

ANA believes that this legislation accurately targets removal of financial barriers to health care as a major goal of comprehensive health care reform. S. 1227 provides a comprehensive health care reform package that will extend access to a core of health care services for those who currently experience financial barriers to health care. In addition, it proposes a balance between public and private payors to allow meaningful choices by employers, providers, and consumers of health care.

ANA is pleased to note that a number of members of the Senate Finance Committee have introduced bills that propose a variety of approaches to improving access to health care in rural areas. ANA commends Senator Chafee for his bill, S. 773, to create and expand federal health centers in medically underserved areas.

During the 102nd Congress, ANA has been working closely with Senator Daschle on his bill (S. 1842) to provide direct Medicaid reimbursement to nurse practitioners and clinical nurse specialists. This legislation expands the provision enacted as part of the Omnibus Budget Reconciliation Act of 1989 (Public Law 101–239) which provided direct Medicaid reimbursement to certified pediatric and family nurse practi-

tioners. The goal of S. 1842 is to promote provider choice and permit all nurse practitioners and clinical nurse specialists to be directly reimbursed under Medicaid, thereby enhancing the availability and quality of health care for our nation's unserved and underserved populations.

At the present time, many Medicaid recipients are being forced to forego essential health care services because physicians and other health care providers are not available to them. S. 1842 recognizes that better utilization of nurse practitioners and clinical nurse specialists will help to fill those gaps in our health care system by increasing access to quality care.

At the present time, many people in rural areas are being forced to forego essential health care services because physicians and other health care providers are not available to them.

One of the primary components of *Nursing's Agenda for Health Care Reform* is to enhance consumer access to health care services by delivering primary health care in community-based settings, and from my direct experience, I know how critical this can be for those who might otherwise have no access to the health care system. The closest medical center is located in Charleston, West Virginia, approximately 70 miles away from Parkersburg; and the closest Veterans Hospital is located in Clarksburg, West Virginia, approximately 50 miles away.

In my volunteer position, I serve as the Clinical Director of the Good Samaritan Clinic, Inc., a free clinic for indigent populations which we opened on September 29, 1992. The purpose of this clinic is: (1) to meet the health needs of the noninsured and financially indigent population; (2) to triage people into the appropriate community health services in order to be more cost-effective in the utilization of health care resources; and (3) to offer different levels of health care, provide follow up and ongoing care. We primarily serve patients between the ages of 21 to 45, the vast majority of whom do not have a high school education. With this population we find the major clinical problems include depression and social habits that contribute to poor health.

As a clinical nurses specialist, I would say that my primary function in the clinic is health education and crisis intervention. First, we act as a triage point and channel people to appropriate federal health programs that they are qualified to use. We are careful not to duplicate services that are already available in the Parkersburg area. Therefore, we ensure that Medicaid and Medicare eligible patients are referred into those programs. The same is true for young pregnant women; we ensure that they are sent to the appropriate Title K and other federal support programs that are designed to meet their needs. We provide direct services to those patients that do not fit into any of these categories.

The clinic was founded entirely with private individual donations. At the present time, we are housed in a building donated by the local electrical company. We have a 17-member volunteer board made up of nurses, physicians, local business people and ministerial alliance. In addition, the staff of the clinic is all-volunteer. Health care services are provided by nurses, including advanced practice nurses and physicians, while social workers concentrate on resource management. In addition, we have a volunteer pharmacy which is staffed by a licensed pharmacist. All the drugs are provided free of charge by pharmaceutical companies. Approximately $1,000 worth of pharmaceutical products are dispensed weekly. Because the clinic is open during evening hours—from 5 PM until the last patient has received care—local restaurants have begun to provide dinner to the health care providers free of charge. In addition, we have a dental clinic which is open twice a month and a psychiatric clinic is open once per week.

Since our opening, some important statistics have been generated. To date, we have had approximately 1300 patient contacts. Our physicians have performed approximately 20 to 30 major surgeries. During the past six months, there has been a growing trend for entire families to come to our clinic for their health care needs. Only three percent of our patients are homeless. We have identified four major barriers impacting upon the care in our rural area. The first barrier effects the potential employment of the population we serve. One of the services that we provide are routine physicals that enable people to obtain jobs. We have found that one of the barriers to employment in our area is the inability of people to pay for routine physical examination—needed in many occupations as a condition of employment. Complete examinations including laboratory and radiological services can cost up to $150. By providing routine physicals at no charge, we have enabled a number of people to rejoin the workforce.

We have identified basic education about preventive health care as a barrier to good health. For example, we have a family with five children that visited the clinic throughout the winter months with ailments such as colds and flu. The health staff found that one of the reasons that the children were getting sick was that they were

not wearing proper clothing to accommodate the environmental conditions. The nursing staff developed, with this family, a specific plan of care detailing measures such as putting on a winter coat with scarf and mittens to help to minimize their health problems. It is this basic type of preventive measure that needs to be taught to many of the less educated members of our society. Often, the staff and other people associated with the clinic will provide coats and other types of clothing who can not afford them.

As a clinic that serves a five country area, transportation can be a barrier to access to health rare. We estimate that the average travel time to our clinic for many of our patients is 35 to 45 minutes. Despite this distance, we have been surprised that the clinic's existence has spread quickly by word of mouth and that people do make it to our clinic. However, we would like to be able to purchase a van to enable those who do not have access to transportation to be able to get to our clinic.

A third barrier is money. Through private individual donations and volunteer staff, we have come as far as we can. However, we are unable to address all the unmet health needs in our area. At the present time, our building is too small (we only have three examining rooms) and we are only able to be open two nights per week. Our goal is to purchase a larger building and hire advance practice nurses on a full-time basis. We are currently reaching out to private foundations to obtain funding to meet these needs.

The fourth barrier is lack of professional health care providers. Ideally, we would like to have advanced practice nurses on staff five days per week. This is a problem since the demand far outweighs the supply. We only have three advanced practice nurses located in the five country area served by our clinic. Further funds are needed in order to attract more nurse practitioners and clinical nurse specialists to our area as well as to support the advanced practice nursing programs currently operating in our State. I, myself, receive calls on a continuing basis inquiring as to whether I would like to relocate to our neighboring State, Kentucky, to serve as an advanced practice nurse. However, I love what I do and would not consider moving.

Mr. chairman, we commend the Subcommittee for holding this hearing and attempting to find solutions to improving access to health care in rural areas. We appreciate this opportunity to share our views with you and look forward to continuing to work with the you as comprehensive health care reform is developed. Thank you very much.

PREPARED STATEMENT OF SENATOR DAVE DURENBERGER

I'd like to commend the witnesses who have come to testify today. They, and their counterparts all across the United States, are engaged in the most difficult challenge of serving individuals who are often overlooked in our society—the migrant worker, the homeless person, the urban and rural poor.

I think it Is critical to point out, at the outset, that health is much, much more than medical care. Health must be broadly defined to include public health issues, medical or acute care, and long term or chronic care.

When we look at health in this way, we discover that health is on the front page of the newspapers every day. The health of the public includes substance abuse, teen pregnancy, homelessness, hopelessness, and violence. (Refer to Washington Post article, entitled "Gun Violence Called Health Emergency.")

It is clear from the testimony submitted today, and from what we all know from reading the papers, we as a nation have an enormous health problem to solve. The federal government cannot solve the problems alone, nor can the states, or for that matter communities or Individuals. It must be a collaborative effort.

This is particularly true because of the severe budgetary constraints we face at both the federal level and in the states. Our health care spending Is already going through the roof, yet we have so much more to accomplish. We must get more for less—in other words, we must be more productive.

To tackle the issues productively takes bold new thinking about how best to allocate responsibility to solve this problems—among individuals, among communities, in the private sector, and In government.

I know that Senator Chafee sincerely wants to solve the problems of access to health care. He and the cosponsors of S. 773 have determined that the way to go about it is through infusion of new federal dollars in community health centers and other entities that provide services.

However, before we simply pour more federal dollars In the present system, we should step back and see if there are better, more efficient, indeed more productive ways to meet the challenges before us.

As we all know, federal dollars come with federal strings, in the form of rigid requirements, rules, and regulations. States exhaust a lot of resources simply trying to manage their way through federal red tape In order to qualify for federal funds. Just talk to state officials burdened by the waiver process for Medicaid alone. The proliferation of separate federal programs all aimed at helping underserved individuals leads to waste, duplication, and often, lower quality services.

What we need to do, I think, is look at what each level of government does best—local communities, states, and the federal government. I bet most state and local officials would agree that the federal government's rules can act as roadblocks to successful services. Local communities have unique needs, special populations, and different resources to tap.

In my view, we need to seriously re-examine issues of intergovermental relations in order to address this problem. I think we should consider devolving many of the federal health programs back to the states. We have so many federal categorical grant programs, mostly coming from the Labor Committee, haven't been able to get a complete list of them.

Don't misunderstand me. By devolution I do not mean fewer services for people. I propose that we consider a swap—the federal government should take over the costs of access to MEDICAL services, i.e. the Medicaid program, and the states should undertake to provide the infrastructure for delivery of services, and responsibility for Issues of public health Including preventive care and health promotion. This the states could do without all the federal strings.

The federal government now pays for about 60% of the Medicaid program. We might as well go all the way and federalize it. Relieved of the backbreaking burdens of Medicaid financing, I believe that states could be more creative, flexible, and more effective at the community level than any uniform federal program.

I realize that this is not a simple process. Many of the federal categorical programs and other programs for the underserved have different histories, different structures, different advocates and beneficiaries. This is not a task to undertake lightly.

But we do not need more of the same kind of thinking as we have done in the past. We are at a crossroads in health policy. Before i vote to expand federal programs, even very fine and necessary federal programs, I want to inquire more deeply into better alternatives based on federalism principles.

Prepared Statement of Orrin G. Hatch

I want to thank the Chairman for holding this important hearing to continue our examination of how best to increase access to, and availability of, quality health care for underserved populations throughout our nation.

Today, we reach underserved areas through the community and migrant health centers. They serve some of the most vulnerable populations, such as migrant and seasonal farmworkers, women with inadequate prenatal care, as well as individuals suffering with AIDS and the growing deadly scourge of tuberculosis.

We must consider how to provide for the fiscal and human resources that will make these health centers successful. This means that we will need to examine reimbursement and the funding for public health service programs.

Moreover, we must begin to look at new incentives to foster careers in primary care and to examine current policies and practices in the federal system that may affect the supply of appropriately trained primary care health professionals in rural areas. I am told that there are many towns in this country that are lucky if they have access to a physician one day a week.

I commend you for holding this hearing I look forward to learning from our witnesses about some possible solutions to the problems facing us. Thank you.

Prepared Statement of Dan Hawkins

Mr. Chairman and Members of the Subcommittee: My name is Dan Hawkins; I am Director of Policy Research and Analysis for the National Association of Community Health Centers, a Washington-based association representing the more than 700 community, migrant and homeless health centers, which serve some 6.3 million medically underserved Americans in communities all across the country. These centers, and other non-federally-assisted, community-directed health clinics, are collectively known as Federally Qualified Health Centers under provisions added to the Medicare and Medicaid statutes in 1989 and 1990. In most of the communities where they are found, these health centers are the key, and often the only, preven-

tive and primary care access points for community residents, and in particular for those who are low income and who are uninsured or have coverage through Medicare or Medicaid.

The health center programs were established more than a quarter-century ago, to make their primary and preventive health services accessible to precisely such individuals and families. At the time of their founding, they were heralded as "break-through health" care providers whose purpose would be to care for those about to gain coverage under the new Medicare and Medicaid programs—if, indeed, as organized medicine had threatened, private providers would refuse to serve them—and for the millions of low income people who, because of qualifying restrictions, would remain uninsured.

A term was coined to describe these Americans: they were called the "medically underserved." Simply put, they are people who can't get care when they *need* it, when it makes the most *sense,* when it can keep them *healthy* or treat a problem *before* it becomes serious and costly. Estimated at more than 50 million in 1965, their number declined over the next 10 to 15 years, as Medicare—and even Medicaid—found increasing acceptance among private providers and the number of uninsured Americans dwindled. By 1980, the medically underserved population was estimated at only 21 million.

But then things began to change for the worse—in many ways quite dramatically. Over the past decade, two separate recessions and a major shift in our country's economy have combined to nearly double the number of uninsured Americans, while the ranks of the poor swelled by almost 50 percent; these economic upheavals left more Americans homeless than at any time since the Great Depression; economic and political troubles abroad brought millions of new Americans to our shores, most of them fluent only in their native language; more than 1 million people have been infected with the incurable HIV virus; and rates of teen pregnancy, substance abuse, and violence—whether personal, family, or community—have shown startling increases. All of these changes have had a profound impact on health care providers, and on none more so than those whose mission is to care for the medically underserved. At the same time, payers of health care, both private and public (and especially the federal government), substantially revised the ways in which they pay for care, trying to rein in runaway costs. Most importantly, they refused to pay for costs other than those associated with care furnished to their insureds. This, in turn, effectively ended the long-standing tradition in which providers—from hospitals to private physicians—would care for even limited numbers of people with no or inadequate insurance, and would shift the costs to other payers. Fewer and fewer health care providers were willing to care for these medically underserved Americans, or even trained or equipped to do so, given their now more complex social and health conditions. Thus, the problem of medical underservice in America has become one of the most pivotal health policy concerns of the day; but over the past decade no one had bothered to determine the size or scope of this problem, and the methods used to measure underservice had quickly become obsolete.

How *big* is this problem today, how *widespread,* and *where* is it most pressing? Equally important, what *can* be done about it? To answer the first question, we set out to determine—in a way that, to our knowledge, has never been done before, the problem of medical underservice in America—the critical lack of access to primary health services—which affects millions of Americans because of their economic situation, their health status, or their geographic isolation from providers of those services.

A Special Report entitled **Lives in the Balance: A National, State and County Profile of America's Medically Underserved,** which I co-authored and which was released earlier this year, provides details on the findings from our study. Let me briefly review the most salient findings, the methodology we used, and our conclusions, and then I'll be happy to answer any questions you may have.

THE STUDY METHODOLOGY

Our report assesses medical underservice by using a combination of economic, health status, and physician supply measures. We employed a multi-step methodology to arrive at its estimates of how many Americans are medically underserved, at the national, state and county level.

- First, using data from the United States Census Bureau's Current Population Survey, for each state and county we estimated the number of "at-risk" residents. These include: (a) persons with family incomes below 200 percent of the federal poverty level ($26,800 for a family of four in 1991) who are uninsured; (b) Medicaid enrollees under age 65; and (c) Medicare enrollees with family incomes below 200 percent of the federal poverty level. Their low incomes and ei-

ther total lack of, or inadequate, health insurance coverage place these individuals at significant risk for primary care underservice.

- The report then uses *two specially-designed measures of underservice:*

—The *first* is a composite measure of the overall health of each U.S. county, using a range of county-level health and demographic indicators collected by the federal government, which are commonly used to measure health and well-being. These include: health indices such as rates for low birthweight births, infant mortality, vaccine-preventable diseases, tuberculosis, and deaths from pneumonia and ischemic heart disease; and demographic data such a per capita income, unemployment rate, and minority population percentage. Counties that ranked in the lowest 25 percent on either low birthweight, illness rates for vaccine-preventable diseases, or a composite of health and demographic measures were considered underserved.

—The *second* measure identifies the number of U.S. county residents who, even if apparently in reasonably good health, live in areas with an inadequate supply of primary care physicians and can thus be considered underserved. We selected a physician-to-population ratio of 1800:1, as the threshold for determining underservice. This ratio is 50 percent worse than the "ideal" average used in many parts of the health care industry; and it is 50 percent worse than the current national average of 1158:1.

Using these two alternative measures, we then determined how many counties are medically underserved under one or both measures.

- Once we identified the medically underserved U.S. counties, we then estimated the number of at-risk persons living in each county, and aggregated the numbers to both state and national levels.

THE REPORT'S KEY FINDINGS

- Our report found that, in 1990, 43 million Americans—1 out of every 6—were medically underserved. because they members of a group of at-risk persons who live in counties that score poorly on measures of health and well-being, physician supply, or a combination of the two. In all, *a total of 51 million Americans were at risk for medical underservice.*
- Americans who are medically underserved span all ages and live in all parts of the country.

—14 million—over 33 percent—are children under 18 and 6 million are children under age six.
—More than 9 million—1 in 5—are women of childbearing age.
—One quarter—10.1 million—are elderly or disabled Medicare beneficiaries.
—And more than 3 out of 4—33.5 million—reside in urban areas.

- The overwhelming majority (95 percent) of medically underserved Americans are underserved because *they live in counties whose health and demographic measures place them in the lowest 25 percent of all U.S. counties,* rather than as a result of living in areas with an actual shortage of physician supply. In these communities, the apparently adequate supply of medical care nonetheless appears to be inaccessible to large numbers of low income residents.
- We found medically underserved Americans living in every state except Alaska.

—Their numbers range from a high of 6.4 million in **California** to a low of 30,000 in **Vermont.**
—They constitute 17 percent of all U.S. residents, and their proportions range from a high of 33 percent of the population in **Mississippi** to a low of 3 percent in **Nebraska.**

- Twelve states each had more than 1 million medically underserved persons, including **Alabama, California, Florida, Georgia, Illinois, Louisiana, Michigan, New York, North Carolina, Ohio, Pennsylvania and Texas.**
- Two states—**Mississippi and Louisiana**—had medically underserved populations exceeding 30 percent of their total populations, and in 10 others—including **Alabama, Arkansas, California, District of Columbia, Georgia, New Mexico, New York, Oklahoma, Texas, and West Virginia**—the medically underserved population exceeded 20 percent of their total populations.
- *The 6 states with the most significant underservice problems*—whether measured in terms of the number of underserved, the proportion of the population which is underserved, or both—are **Alabama, California, Georgia, Louisiana, New York, and Texas.** In 1990, each had more than one million persons

who were medically underserved, and each had medically underserved populations exceeding 20 percent of the total population.

- *Our report found 2147 U.S. counties, out of a total of 3080, that are classified as medically underserved,* either because of poor health measures, a shortage of physicians, or both.

—Every state except Alaska had at least one underserved county, with **Texas** having the largest number, at 191.
—In three states—**Delaware, Hawaii, and Louisiana**—every county was medically underserved, while 19 states had more than 75 percent of all counties so identified.
—*Number-wise,* rural underserved counties outnumbered urban counties (1,586 rural versus 561 urban). In terms of *persons,* however, three-quarters of all underserved persons lived in urban counties.

- A total of 554 counties—1 out of every 6 U.S. counties, and 1 out of every 4 medically underserved counties—were classified as "double jeopardy" counties, because they scored poorly on both the health status and physician supply measures. *These "double jeopardy" counties are considered the most severely underserved of all.*

—*Half* of all **Louisiana** counties were double jeopardy counties, as were *third* or more of the counties in five other states—**Alabama, Delaware, Georgia, Mississippi, and South Carolina.**
—While most of these counties (84 percent) were rural, their 4.8 million medically underserved residents were divided nearly evenly between urban and rural residence.

These are the most salient findings from our study and report. There are some, no doubt, who may disagree with those findings, and even with the methodology we used. However, I should point out that the counties we identified as medically underserved had:

—illness and death rates that are more than twice as high; and
—economic and demographic measures (poverty, unemployment, etc.) that were nearly twice as bad

as those for non-medically underserved counties, including low birthweight and tuberculosis rates that averaged 50 percent higher, and vaccine-preventable disease rates that were 8 times higher, than the average for non-medically underserved counties. Moreover, we believe that, if anything, the methodology we used actually under-counts the number of medically underserved Americans, for three reasons:

- First, as noted above, it does not include privately insured Americans with incomes below 200 percent of the federal poverty level, even though we believe there is strong evidence for their inclusion.
- Second, we did not include some 3 million not-at-risk (that is, non-low income individuals living in counties identified as having a physician shortage.
- Third, the methodology omits counties that scored well on both the physician-to-population ratio and on the health status measures, but that nonetheless have pockets of poor and underserved persons. Virtually all counties have "at-risk" low income residents who, on an individual basis, face significant health threats. If these threats become severe enough—or if several physicians retire, die or move away—the county can easily slip into medical underservice. *Thus, in a real sense, no part of the country is immune from the threat, if not the reality, of underservice.*

CONCLUSIONS

Our study shows that the crisis of medical underservice most often stems from the fact that, *in thousands of communities across the nation, services are not actually accessible to the people who need them the most.* Lack of health insurance, or the refusal of providers to participate in Medicaid or Medicare, is compounded by cultural and language barriers, inaccessible hours and locations, and staff who are not skilled in the provision of comprehensive medical care to low income persons facing extraordinary health risks.

Certain areas, states and communities clearly stand out in terms of the severe access problems their residents face. *But this study also makes clear that no part of the nation is immune from the problem.* While a sizable proportion of the medically underserved reside in rural areas, this study underscores how critical the medical underservice problem is for millions of Americans residing in urban communities, in the shadows of some of the world's greatest medical institutions and in

the midst of counties of great wealth. We pay for their underservice in countless ways—the loss of healthy and productive citizens, unnecessary illness, disability and death, and extraordinarily high medical care costs.

Because so much medical underservice occurs in counties with a seemingly adequate supply of physicians, *this study makes clear that simply insuring everyone for medical care—and even increasing physician supply—will not cure the problem.* While improving the availability and accessibility of health care is no substitute for the health insurance coverage that we all will need at one time or another in our lives, neither can health insurance alone give all Americans a *doorway* into the health care system which *not only* lets them in but *welcomes* them, *regardless* of their circumstances or needs.

To be sure, health care reform is *essential,* and needs to happen soon; and we believe that any reforms, if they are to be successful, *must* ultimately remove every American from the ranks of the uninsured and get health care costs under control. But if that is as far as health reform goes, then the job will not be done. For at that point, there will still be millions of people all over America, who will have some form of health insurance, but no place they can use it.

It is evident that the issue is not simply the *availability* of medical care but its *content, character,* and *appropriateness* for the patients who need it. The highest quality clinical medical care alone will not cure the ills of underservice. *A different approach to medical care itself is needed.*

Along this line, many studies have shown that *efforts designed specifically to furnish care to underserved populations have made significant gains in improving the overall health of the communities they serve. These include the Federally Qualified Health Centers,* such as the community and migrant health centers, as well as comprehensive primary health programs offered by local community organizations, hospitals and health agencies. These community programs share certain key characteristics, especially: strong community involvement; strategic locations and hours; affordability; and services geared to and appropriate for the populations they treat.

In effect, these programs successfully recruit doctors and other health care providers to underserved communities, and link those doctors with the people who need their care. *Service settings like these are among the lowest cost to develop.* These programs have learned to operate with high levels of efficiency, often because their funding is so scarce. And the scarcity of that funding is today a pivotal concern, because today—after more than 25 years of effort—these community health programs serve about 9 million people in all, or only 20 percent of the 43 million Americans who need their care. At this rate of growth, the centers will reach just *50 percent* of the country's medically underserved people in the year 2037—45 years from now—and that assumes no further increase in their numbers over that period!

We are most pleased, Mr. Chairman, that the bill under consideration today, S. 773, which was introduced last year by Senator Chafee, would accomplish this purpose by making up to $2.8 billion in new funding available over the next 5 years for the planning, development and operation of new and expanded FQHCs in areas where they are most needed.

We have estimated that, if the Chafee bill were enacted into law, more than half of the nation's medically underserved people—24 million in all—would have access to care through a local health center by the year 1997; in effect, the Chafee bill would support the development of health care services for some 15 million underserved people who currently have no place to turn for care when it's needed. Moreover, the legislation would ensure that these centers are established only where they are needed, are focused especially on the underserved families they are intended to serve, and are directed toward providing in particular the services that their patients need. In this way, the Chafee bill would put in place the critical provider network that will be *essential* to ensure the success of any national health care reform effort. *And we especially wish to commend Mr. Chafee for his foresight in linking this effort to the current Medicaid program, thus providing an assured level of federal support for the necessary development activities.*

I would be remiss, however, Mr. Chairman, if I did not also note that your Health for All Americans bill, S. 1227, also contains provisions remarkably similar to Mr. Chafee's, all within the context of a universal coverage plan, and to *express our deep appreciation to both of you for your insight and leadership on this issue.*

As the nation tackles the issue of health reform, this study makes clear that a central part of any viable health reform plan must be support for developing community-based comprehensive health care in all medically underserved communities. The issue is not whether the nation afford to make health service development a priority for all Americans, but whether it can afford *not* to. Without such an effort, the long term goals of health reform in the U.S. will never be fully realized.

PREPARED STATEMENT OF CAROL HERRMANN

INTRODUCTION

Mr. Chairman, members of this Subcommittee, I am Carol Herrmann, Commissioner of the Alabama Medicaid Agency and Vice Chair of the State Medicaid Directors' Association of the American Public Welfare Association. I appreciate the opportunity to speak with you today about efforts underway in Alabama and across the country to improve access to care for low income and uninsured people. Because of the decisions you are called upon to make, it is important for this Subcommittee to be well acquainted with the many responsible and successful activities states are undertaking to improve access to health care for all populations, but especially for those with no health insurance and those who depend on Medicaid for their care. In Alabama and other states, the Medicaid agency has taken the lead in bringing the provider community and the private sector together with state, county, and city agencies to design innovative and efficient systems of care. We are developing coordinated systems of managed care that deliver a high quality of service while controlling cost growth. Toward this end, states need the continuing support of Congress.

THE ALABAMA MATERNITY WAIVER PROGRAM OPERATION

Alabama's maternity waiver offers a prime example of a system of managed care that joins the public and private sectors together in an effort to give a high quality of service to a specific population—in this case, pregnant women. Since the maternity waiver began in 1988, our program has become a model for other states and has received acclaim within the state and across the country. The primary goal of the waiver program is to develop coordinated systems of health care in order to achieve better pregnancy outcomes. In order to operate the program we must seek waivers of various parts of the Medicaid statute, such as freedom of choice.

The problem of infant mortality has been long entrenched in my state. Alabama's infant death rates have been well in excess of national rates. In 1987, for example, Alabama's rate was 12.2 deaths per thousand births while the national average was 10 per thousand. In 1990, two years into our maternity waiver program, the Alabama rate had dropped to 10.9 per thousand. While we still have much work to do, we believe our waiver program has been instrumental in reducing the rate of infant mortality. The program has four specific objectives: reducing infant and fetal mortality; reducing the frequency and severity of handicaps associated with premature and low birthweight infants; reducing the need for neonatal intensive care; and improving the overall cost-effectiveness of services.

One of the unique aspects of our program is that providers must agree to work together before a geographic area (a county) can be brought into the program. For a county to become part of the waiver program, one coordinating provider must have established a network or coalition of providers of sufficient size and specialties to provide a full array of obstetrical and other health services to Medicaid-eligible pregnant women. These provider networks include individual doctors and hospitals as well as local health departments and federally qualified health centers. Currently, 28 of Alabama's 67 counties are participating and that number will grow to 38 on July 1 of this year.

Within each county, a primary provider is designated to coordinate all of a pregnant woman's health care needs in addition to her needs for social services. Since it is unlikely that any single primary provider will have all the resources necessary to provide total care directly, the primary provider must develop subcontracts with other providers such as physicians, tertiary care hospitals, and other community providers. The ultimate responsibility and accountability for quality service remains with the primary provider. Primary providers are paid an expanded global fee per client, while many of the ancillary services are paid by Medicaid on a fee for service basis (such as laboratory, drugs, emergency services, referrals to non-OB specialists, transportation and family planning). The global fee includes payment for delivery, care coordination and prenatal care visits among other things which would otherwise be paid separately.

The Medicaid Agency selects primary providers based on stringent criteria encompassing access, accountability, subcontracting arrangements, adherence to care standards, and licensure requirements. Primary providers must provide or arrange for antepartum and postpartum care, care coordination, delivery, and treatment of conditions that may complicate pregnancy. The primary providers are responsible for conducting medical and psychosocial risk assessments and providing a variety of information to clients. In order to receive the expanded global fee, the primary provider must assure that women seen during the first trimester receive a minimum

of eight prenatal visits. Clients first seen during the second or third trimester must receive a minimum of seven or six prenatal visits respectively. Alabama also requires rigorous adherence to quality assurance and client grievance procedures on the part of primary providers.

RESULTS OF THE MATERNITY WAIVER PROGRAM

A key result of our maternity program has been an increase in providers participating in Medicaid. Prior to implementation, Medicaid eligible women had trouble accessing services. As a result of the waiver, there are now enough medical personnel participating to meet the Medicaid demand in waiver counties. An independent evaluation of our program found that it increased the likelihood of clients receiving local prenatal care by approximately 50 percent.

Improving access to local services has many positive effects. The evaluation found that prior to the waiver program, Medicaid women received an average of three prenatal care visits as compared to nine visits for waiver-enrolled women since 1990. Even though the state's minimum program standard for prenatal visits for women participating from their first trimester is eight visits, the median number of visits for these women in the program is 12 visits. The standards for prenatal visits for women enrolling in the second trimester is seven, but the actual median number of visits for these women in the program is ten. This speaks to the success of the program and the commitment of the provider community to make the program successful.

The waiver program has had positive effects on decreasing the probability of low and very low birthweights and has reduced utilization of neonatal intensive care. Use of postpartum family planning also has significantly improved for women in the program. In addition, improved access has led to cost savings in Alabama. We estimate that during the first two years of the program we saved or avoided costs of approximately $2.7 million, while effective preventive care saved an estimated $1.4 million in years three and four.

Alabama is very proud of its Maternity Waiver Program, which is due for its second waiver renewal this year. I would like to take this opportunity to stress one theme common to all states, that waivers for programs such as our care coordination program, which have proven successful in meeting objectives of improved access and cost effectiveness, should not need renewal every two years. Waiver renewal is a time consuming process for both states and the Health Care Financing Administration. To that end, I would like to acknowledge strong state support for S. 2077, introduced by Senators Moynihan and Durenberger among others, which would make coordinated care programs, such as Alabama's, regular Medicaid state plan options.

OTHER STATES' INITIATIVES

While I am most familiar with the Alabama waiver program, there are many other states involved in developing, or expanding, a service infrastructure that more adequately meets the needs of Medicaid clients as well as uninsured clients. Like our maternity waiver, these efforts involve work with providers, the private sector and other state agencies. State Medicaid agencies are also very involved in improving enrollment of potentially eligible people through outreach campaigns conducted in conjunction with other state and local agencies and the private sector.

Many states in addition to Alabama have focused on case management and care coordination for specific populations, notably pregnant women. States such as New York, North Carolina, Michigan, Maryland, Idaho, South Carolina, Florida, and West Virginia among others, use a range of providers-public health departments, clinics and private practitioners-to coordinate care and services. The service package in these programs is often enriched to provide a range of necessary care to better assure healthy births and improved child health.

There are also many notable media outreach campaigns such as those in Alabama, Utah and North Carolina, where Medicaid, public health and the private sector (television, radio, print media, and business of all types) work together to encourage attention to early prenatal care and create awareness of Medicaid coverage. Alabama's Healthy Beginnings program reaches about one-third of all pregnant women in the state with incentives to encourage early and continuous prenatal care.

State Medicaid programs have also worked with various entities and agencies to directly recruit private practitioners. In Maryland, Medicaid, public health, and maternal and child health programs work jointly to recruit obstetric providers. West Virginia Medicaid and public health departments work together to improve provider retention and participation. Washington, Colorado, and California have worked with provider associations to enhance speciality and/or generalist practitioner participation in the Medicaid program.

In other states such as Texas, Kansas, and New Hampshire, the Medicaid fiscal agent has taken on responsibility for encouraging provider participation and retention in the program through visits with providers, troubleshooting provider complaints, and outreach efforts.

Finally, 33 states, including Alabama, have Medicaid managed care programs to improve access for Medicaid clients. These programs range from full risk, fully capitated programs using traditional health maintenance organizations and community providers such as FQHCs, and partially capitated programs that enroll physician networks and FQHCs, to primary care case management systems where individual physicians enter into agreements with the state to better manage client health care needs in a fee for service system.

State Medicaid agencies have worked and continue to work aggressively to improve client access and to expand the role of preventive care in the Medicaid system. The states and programs I have mentioned here do not constitute an exhaustive list of activities but are simply a sample of the types of programs that are on-going in a variety of states.

WORK THAT REMAINS; HOW TO EXPAND ACCESS

Arguably, there are many ways to expand access—from some type of reform of the health care system that would assure the availability of health care coverage to all members of society to reforming the system of incentives in medical education and medical practice that would help assure greater numbers of general practitioners and improve geographic distribution of providers. Outside of substantial changes in part or all of our current system, improvements can be made in the Medicaid program and resources can be allocated for increasing the capacity of public community providers such as federally funded clinics and public health departments.

The legislation introduced by Senator Chafee (S. 773) builds on the latter approach, to expand the Public provider service capacity. The Chafee legislation brings attention and focus to the critical issue of developing adequate service delivery structures and raises the issue of how best to do this. In general, I believe state Medicaid agencies would support the overall concept of S. 773 to improve service infrastructure.

I think it is important to note that Medicaid programs have begun to use their resources to improve access in underserved areas. Among these efforts to expand the service delivery system, some of the most innovative and successful initiatives across the country depend heavily on participation by the private sector. The Medicaid focus in many states has been to try and develop or expand the private sector service delivery system. Development of private and public sector infrastructure are both important and state goals, objectives, and resources will determine which method a state will choose. In some states, the goal will be to try to mainstream Medicaid clients into a private delivery system. In other states, or areas of states, there may be no private sector upon which to build therefore public sector development is the only alternative. The emphasis on private sector development results, in part, from the financial constraints states are facing. Development of a public sector infrastructure can be more costly than encouraging involvement of the private sector in programs for Medicaid and the uninsured.

The issue of service delivery systems has become a very important issue for states as they struggle with improving access to care. In Medicaid, states have begun to explore how to use reimbursement rates to improve private sector participation in underserved areas, building on experience using reimbursement rates to influence patterns of care or treatment. Reimbursement rates have been used to influence drug prescribing and dispensing patterns, and have been applied to some medical procedures to encourage greater use of certain lower-risk procedures for example. Building on this experience, states have begun in recent years to use reimbursement rates to try and influence the delivery system. Alabama and other states have begun to pay higher rates to rural providers (notably obstetricians) to encourage participation in underserved rural areas. Alabama and other states pay global obstetrical rates to reduce provider administrative burdens and thereby encourage participation. New York has increased selected fees related to physician treatment of clients with AIDS because these clients were experiencing access problems related to their illness. States are also beginning to look at their institutional reimbursement rates to see if there are ways to encourage development of a specific infrastructure to treat the growing population with tuberculosis.

In general, state Medicaid programs are working to improve access by improving the service infrastructure in a variety of ways. It is clear that there is much more to be done and that state Medicaid agencies have not yet explored all the potential of selectively using reimbursement rates to address infrastructure problems. State

agencies support efforts at the federal level to help in this effort. Given the work that states are undertaking, it is important for any federal strategy to allow flexibility for states to direct their resources in ways that best address the needs of Medicaid clients, the insured and the uninsured at the state and local level.

On a much more specific matter related to S. 773, state Medicaid agencies need to be assured that the money for FQHC expansion coming from Medicaid program funds would not affect the funding for the actual entitlement program in years of entitlement funding shortfalls. This has become a greater concern as the federal dollars at the end of the last three fiscal years have been in short supply. his July, states will receive a fourth quarter federal grant award equal to about 35 percent of the need for the quarter because spending during the year was in excess of what was estimated or allocated. We do expect receipt of the full grant award by the end of the federal fiscal year, as has occurred in the last two years. These end-of-year shortfalls lead to some concern about the potential impact of mixing an entitlement program and an appropriations program into one funding stream and the effect one may have on the other in years of shortfall. We would like to work with this committee to assure that any potential problems are avoided.

CONCLUSION

State Medicaid agencies are very interested in looking at new ways to expand access to low income clients served by the program. Indeed, states are actively pursuing a variety of strategies to promote greater access to the program and to providers of care. We remain willing to work with this Subcommittee toward the common goal of improving the Medicaid financing and delivery systems.

Thank you for the opportunity to speak with you today.

PREPARED STATEMENT OF LOURDES A. RIVERA

Mr. Chairman and Members of the Finance Committee:

The Children's Defense Fund (CDF) is pleased to have this opportunity to testify before you today in support of S. 773 which would provide better access to primary and preventive care services for low-income children and their families. CDF is a national public charity which provides long range and systematic advocacy on behalf of American children. Our organization pays particular attention to the needs of low-income, minority, and disabled children.

We would first like to commend the members of this committee for your leadership in expanding access to health care. Through concerted, bipartisan effort and strong leadership, this committee has made major strides over the past several years in improving access to health care for low-income pregnant women and children through a series of vitally important reforms in the Medicaid program. While Medicaid has significant shortcomings as a source of health care coverage, its contributions to the health and well-being of children and women of childbearing age have been enormous.

In great part as a result of this committee's work, Medicaid will reach an additional 4 million children and half a million pregnant women each year by the end of this decade. Improvements in the Medicaid enrollment process will assure swifter access to benefits. Improvements in the Medicaid's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program make Medicaid the single most comprehensive child health insurance program, public or private, ever to exist in the United States. In addition, the improvements in Medicaid and Medicare's support for community and migrant health centers and other community-based health providers located in medically underserved areas will assure the availability of urgently needed funds to expand and improve primary health care services for millions of Medicaid beneficiaries and other low-income families. We applaud the committee's efforts that have led to these accomplishments.

As important as these changes have been, however, they alone do not suffice. During the 1980's, every key measure of maternal and child health in the United States worsened, failed to improve, or improved at a slower rate than in previous years. As a result, the United States has fallen behind many countries with fewer resources on important health indicators such as infant mortality, prenatal care, and low birthweight. Every year, nearly one million infants start life at a disadvantage because their mothers did not receive early prenatal care. More than 250,000 babies are horn at low birthweight, needing advanced medical technology to survive, and often facing high risks of disability or developmental delays. And 40,000 infants die each year—half of whom would have lived to see their first birthday if the United States had the same infant mortality rate as Japan.

A frightening indication of America's failure to ensure its children's health is the low rate of immunization against preventable diseases among infants and toddlers. At a time when other nations have improved their immunization rates dramatically, studies suggest that fewer than half of the infants and toddlers in many urban areas are immunized fully. In fact, a recent study of nine major cities by the Centers for Disease Control (CDC) found that only 10 to 42 percent of the children starting school in 1991 had received appropriate preschool vaccinations on time. Compared with other nations, the United States ranks seventeenth in the world in the percentage of one-year-olds fully vaccinated against polio. When the proportion of nonwhite infants is compared to overall rates of other nations, the United States ranks seventieth, Behind countries such as Burundi, Nicaragua, and Trinidad and Tobago.

Not surprisingly, the United States has seen a resurgence of preventable childhood diseases, including measles, mumps, pertussis (whooping cough), and rubella. Between 1988 and 1991, a nationwide measles epidemic struck nearly 60,000 Americans, mostly preschool children. At least 130 people died and more than 8,000 were hospitalized.

Lack of adequate health insurance is one of the major reasons why our nation is failing to ensure every child a healthy start. Yet, the structure of health services in the United States poses barriers even for families that are insured, leaving millions of Americans stranded in communities where they have little access to doctors, hospitals, or health clinics. Because access to service cannot be assumed even when insurance (either public or private) is present, one of the things we must do is to develop and maintain sources of health care in medically underserved areas that have a shortage of physicians and clinics.

More than 43 million Americans, half of whom are children and women of childbearing age, live in medically underserved areas. For these families, getting routine prenatal care, getting children vaccinated, or getting a sick child to the doctor—if they can afford it—may be next to impossible because there are simply too few doctors, clinics, and other health care providers to serve them. According to a report done by the National Association of Community Health Centers, more than one in five residents in the District of Columbia and 11 states (Alabama, Arkansas, California, Georgia, Louisiana, Mississippi, New Mexico, New York, Oklahoma, Texas, and West Virginia) are medically underserved.

The lack of private health services in medically underserved communities has placed an extraordinary additional burden on public health programs across the country already strained by deep budget cuts and the additional demands imposed by deepening poverty, decreasing insurance coverage, and increasingly complex health crises such as AIDS and substance dependencies. During the height of the measles epidemic in Los Angeles, for example, the demand for vaccinations was so great that many families lined up at 6:00 am. so they would not be turned away.

Finally, many children, even those with health insurance coverage and adequate health services in their communities, still face numerous barriers that keep them from getting what they need to grow up healthy. Among these barriers are logistical and attitudinal problems with the health care system itself. Far too often, low-income families that need to take a child to the doctor must overcome problems like inadequate and expensive transportation to hospitals or clinics, a lack of child care for the child's siblings, health care providers who do not speak a language other than English, and health care providers who are reluctant to treat low-income or Medicaid patients. Doctors, for example, repeatedly refuse to even see low-income pregnant women with substance dependencies.

For children with disabilities, it is indeed a challenge to meet their multiple needs. All too often, it is up to parents to wind their way through the maze of health services, social services, and special education programs their children need. Low-income families, strained to the limit of their resources, face nearly impossible challenges.

Unless there are strong efforts to expand and sustain sources of comprehensive, community-responsive health care where they are needed, America's more than 30 million medically underserved citizens will continue to be deprived of essential, effective, and cost-effective services.

For children, it is the primary health services—prenatal care, immunizations, health examinations, and ongoing basic medical, dental, vision, and hearing care—that will make a difference in their lives and health. It is these basic services which all industrialized nations but the U.S. and South Africa assure for all pregnant women and children. It is the lack of these services, combined with tragically high child poverty rates, which are primarily responsible for the nation's shameful international child health rankings.

S. 773, if passed, would help to ensure that medically underserved communities have access to health care by expanding the capacity of Federally Qualified Health Centers (and similar community-based services) to provide quality primary and preventive health care services where they are most needed.

FQHC's have an impressive track record in serving hard to reach populations (such as urban, rural, low income, non-English Speaking, and migrant families, as well as families with children with disabilities) and employing outreach, case management, and service strategies that are appropriate for the communities in which they are located. Most importantly, FQHC's have provided the most basic and needed primary and preventive health services, as well as specialty outpatient services, and case management services that link families with other programs.

With additional resources, existing FQHC's will be able to expand their services, allowing them to reduce their long waiting lists for new appointments, and establish satellite programs, such as in school-based sites. New FQHC's and other community-based clinics also will be placed in urban and rural areas that presently have little or no medical services.

With the infusion into medically underserved areas of facilities and personnel that are properly trained and equipped to serve the communities in which they are located, many of the access problems can be alleviated. Women of childbearing age will have a place to go to maintain good reproductive and overall health, leading to better birth outcomes. Children will have health care providers who can immunize them. And all children, particularly children with special health care needs, will have access to a provider who can render primary care services and case management services to ensure that any specialty health care or social service needs are met.

While this legislation does not address all of the health care system's shortcomings, it moves us in the right direction in strengthening our health care infrastructure. All Americans must be able to obtain good quality primary and preventive care from providers that are accessible to them. These additional resources are desperately needed and will provide an essential complement to any national health care reforms that guarantee health insurance coverage for all Americans.

PREPARED STATEMENT OF DAVID R. SMITH

Aesculapius, the Greek god of medicine, had two quarrelsome daughters: Hygeia, the goddess of health, known for preventing illness and Panacea, the goddess of cures, known for treating illness. They began life as equals, but eventually Panacea was given preference. Society came to value the immediacy of relieving the suffering of the sick more than the less obvious, long-term benefits of maintaining health.

The status of the two sisters became more and more disparate. Without Hygeia's full beneficence, more people became sick The demand for Panacea's services exceeded her capacity to heal. The price for her help soon outstripped many patients' ability to pay.

These goddesses embody the age-old competition between medical/or curative care and disease prevention, still much in evidence today. This sibling-like rivalry has left us with a disjointed, fragmented health care system—a system unresponsive to the needs of our communities. Our current system is out of balance. It fails to take advantage of the human and economic savings that can be realized by avoiding illness. And, it fails to offer sufficient treatment capacity to meet the needs of the sick. In short, it fails to provide adequately for the public's health.

Examples of Panacea's failures abound. In Texas, lack of capacity to provide medical/or curative care is illustrated by the following:

- Of the state's 254 counties, 105 (with a total of 1.4 million residents) are designated Health Professional Shortage Areas (HPSAs). Portions of the populations of another 19 Counties also are designated HPSAs.
- The total populations of 170 counties are designated as Medically Underserved Areas. Nearly 3 million Texans reside in these counties. An additional 56 counties have areas or populations which are medically underserved.
- Some 56 counties have no hospital.
- There are no physicians in 20 counties. Another 23 counties have only one primary care physician.
- More than 3 million Texans had no medical insurance in 1989. Of those living below poverty level, more than 42 percent were uninsured.

Likewise, Hygeia's failures are apparent. In Texas, the sad consequences of inadequate health maintenance and preventive health care can be measured by these statistics:

- More than 9,200 cases of measles, a Vaccine-preventable disease, have been reported since 1989.
- One-third of Texas women giving birth receive little or no prenatal care.
- Infant morality for black Texans is 14 per 1,000 live births.
- The percent of Texas infants with low birth-weights has been on the rise since 1985.
- More than 15,000 cases of tuberculosis are being treated in Texas. Some 2,525 new TB cases, the highest annual total since 1975, were reported in the state in 1991, including 139 cases of drug-resistant TB.
- Some 15,872 cases of AIDS have been reported in Texas. The estimated number of HIV-infected Texans is 73,000.

We can no longer afford a health care system based on sickness rather than on health—one in which the imbalance between primary care and prevention leaves both modes incapable of fulfilling Americans' health and medical needs.

The popular health care reform debate becomes meaningless, unless our system has the capacity to care for those who currently lack access to the system. Even if we issue every medically indigent American a magic plastic card labeled "National Health Care Insurance," the needs of many would go unmet.

Solving the health care problem in America must begin by building capacity—for both primary care and prevention. S. 773 is a good start it provides funding to increase the primary care capacity of community health centers and federally qualified health centers. Hygeia's realm of prevention, however, is somewhat shortchanged.

Congress cannot afford to neglect the need to expand capacity in preventive health care or to miss the opportunity to correct the ancient inequity between treatment and prevention or the opportunity to create a new vision which links primary care and public health.

State and local health departments as well as community health clinics provide medical/or curative care to the medically indigent and medically underserved throughout the nation. Historically, community clinics focused on treatment, while state and local public health clinics focused on prevention. Today, that delineation is less clear. Health departments are the sole source of medical/or curative care in some communities, while more and more community health clinics are realizing the value of offering preventive services to their patients. We should acknowledge this change and nurture it. It could be the beginning of a long-term reconciliation between Panacea and Hygeia.

Attempts at such a reconciliation are not without precedent. The concept of integrated care has been labeled "one-stop shopping," community-responsive medicine and Community Oriented Primary Care (COPC).

COPC minimizes fragmentation by reducing barriers such as transportation and by co-locating related services, such as laboratory; pharmacy; radiology; health education; Women, Infants, and Children (WIC) services; and immunizations, in one site. It is a way of practicing medicine that blends traditional primary care with preventive public health

While, primary care focuses on the individual patient or "user" and does not assume responsibility for the health status of the community at large, COPC is driven by the defined need for health services identified within the target community. By combining obstetrical, gynecological, pediatric, and adult medicine with preventive public health services such as immunization and communicable disease control, COPC pro-actively aims to reduce the incidence of diseases that can lead to costly hospital care.

The COPC concept has had successful application in this country. The National Institute of Medicine reviewed seven case studies in a report published in 1983. The case studies spanned both urban and rural practice settings as well as programs with academic affiliations. Not all of these systems had every aspect of COPC, but all had defined their target community and were providing directly or indirectly a wide array of related health services such as outreach, mental health, translation services, and immunizations.

In Dallas, Texas, Parkland Memorial Hospital has implemented a large COPC program supported in part by county taxes. The program focuses health services to six at-risk communities in Dallas County that were identified in a county-wide needs assessment conducted by Parkland. The program is affiliated with the University of Texas Southwestern Medical School. Physicians working in these health centers are granted faculty status by the university and provide attending coverage on the inpatient units of Parkland Hospital. This arrangement enables the COPC program to provide continuity of care for the practice and inpatient settings. The program operates five health centers that handle in excess of 110,000 patient visits an-

nually and has resulted in significant improvements in the health of the community, including reductions in emergency room admissions, the incidence of teenage pregnancy among Hispanics and African-Americans, and death rates for adolescents.

Parkland Hospital's COPC program is & local response to the national health care problem. The need for such a response to this Nation's health care deficiencies has never been more apparent, and never more desperate.

Community-responsive care is well positioned to fulfill this need. Medicine responsive to the needs of the community reflects an attempt to move beyond the current maze of disjointed programs which fail to capture and maintain individuals in a comprehensive care system The concept of "one-stop shopping," recently promoted by the United States Public Health Service to describe a model of prenatal care for this country, is also an appropriate model for health care in general.

The success of community-responsive medicine will demand the preparation of physicians and other health professionals who can recognize the evolving needs of society and respond with effective preventive and therapeutic measures. it will require health care providers who can function beyond the limits of categorical programs, and face head-on the sexually active teenager who is homeless, out of school, alcohol-abusive, and at risk for AIDS.

The Federal government must lead. Federal support—one barometer of national health priorities-for service delivery has grown only sparingly over the last ten years, while dollars for research have expanded substantially. Similarly, aside from the growth in Medicaid expenditures, the majority of which still go toward catastrophic and long-term care, Federal Department of Health and Human Services expenditures for primary care service delivery show negligible growth in the past decade after correction for inflation Therefore, the funding attached to S. 773 is particularly welcome. Preventive services such as.

- childhood immunizations
- cholesterol screening
- prenatai and maternity care
- colon screening
- family planning
- adult/elderly vaccinations
- mammogram
- limitcd dental health care
- pap smears
- adult and child preventive health visits

and traditionally non-reimbursable services such as nutrition education, outreach, case management and overall health education should be mandated as reimbursable services in Medicaid. There should be no *wiggle room*—these related health services are cost effective and should be supported in statute. This would be a critical positive statement in health care reform.

This Nation has a vested interest in the health of its citizens as we speed toward the twenty-first century with an aging population, a potential shortfall in our labor force, and the next public health crisis which will test our system of care. We must protect our investment by building local health care capacity wherever it is needed. For the health of our citizens, for the future of our labor force, and for the economic imperative to curb the uncontrolled growth of health care costs, we also must change the fractured way health care is delivered in America.

I urge Congress to end the wasteful discord between Aesculapius' daughters, to reunite Hygeia and Panacea by building capacity in both preventive and therapeutic medicine and by promoting the concept of Community Oriented Primary Care.

PREPARED STATEMENT OF DEBORAH KLEIN WALKER

Good Afternoon. My name is Deborah Klein Walker. I am the Assistant Commissioner of the Bureau of Family and Community Health in the Massachusetts Department of Health and Region I Councillor for the Association of Maternal and Child Health Programs. AMCHP is a national non-profit organization representing state public health programs funded in part by Title V of the Social Security Act, or the Maternal and Child Health Services Block Grant. The mission of these programs and of AMCHP is to assure the health of all mothers, children, adolescents and their families.

I am pleased to have the opportunity to present to the Finance Subcommittee on Health for Families and the Uninsured, the Association's views regarding access to care in underserved areas. Our members' experience in planning, delivering and monitoring health care services for this population tells us that financial barriers are not the sole factor limiting access to care or contributing to poor health status. Our testimony will include a discussion of these barriers to care, a description of the Title V program's mission and their impact on the medically underserved, and the importance of the public health system in assuring access to care. We will give

examples of innovative Title V programs that have improved access to care, comment on S. 773, and outline the need for an increase in the Title V authorization level as a way to improve access to care.

More than 30 million Americans do not have health insurance. The greatest percentage of that group is women and children, those served through the Title V block grant program. Title V of the Social Security Act (SSA) has authorized the Maternal and Child Health (MCH) Services program since 1935. The goal of this public health program is to improve the health of all mothers and children consistent with national health objectives established by the Secretary of DHHS.

The majority of Title V funds are provided to states to assure effective MCH policies and programs, especially for: low-income families; families with limited access to care; and families with children with special health care needs due to chronic or disabling conditions. A portion of the funding is set aside at the federal level to support research, training and demonstration projects. A new set-aside program established by OBRA '89 and funded for the first time this year will support six types of projects, including those to improve provider participation in public programs, better integrate services, and increase home visiting. These projects can expand program capacity by addressing non-financial barriers to care such as transportation, poverty, chronic illness, and lack of available providers.

Through funding to local providers or by directly operating programs, state Title V programs support the availability and accessibility of community health services especially for Medicaid insured, uninsured and underinsured families in rural and urban settings. Title V-supported programs provide prenatal care to over half a million pregnant women, or well over one-third of births to low-income women. Over two and a half million children receive Title V-supported preventive or primary health care, including immunizations, well-child exams and referral or treatment for minor illnesses. Nearly one-half million children with chronic illnesses or disabilities receive specialized health and family support services, including diagnostic, treatment and follow-up services, as well as case management or care coordination services.

State Title V programs are mandated to develop family-centered, community-based, coordinated care systems for children with special health care needs. State programs are also developing community-based networks of preventive and primary care that coordinate and integrate public and private sector resources and programs for pregnant women, mothers, infants, children and adolescents. Three-fourths of the state programs have supported local "one-stop shopping" models integrating access to Title V, the WIC food program, Medicaid and other health or social services at one site. All state Title V programs support some home visiting services, although these services are extremely limited in many states due to funding constraints.

State Title V programs conduct needs assessments to identify health problems, assess service gaps and barriers, and target resources. State programs develop and implement health education, health promotion and disease prevention strategies, such as seat belts and bicycle helmets to prevent injuries. States develop standards to assure quality care, monitor services, and provide training and technical assistance to providers on emerging health problems and on new clinical and service approaches. These activities are examples of those which develop and maintain the public health infrastructure, upon which is the foundation for the service delivery system.

Title V is the "glue" for a variety of other public programs that finance care, or target specific health problems or population groups. Coordination with related federal health, education and social services programs is mandated in the Title V legislation. Coordination with Medicaid has greatly intensified in recent years, with MCH programs providing the technical expertise and the service delivery systems to ensure that expanded Medicaid eligibility and benefits translate into improved access to services, and to improved health status. OBRA '89 required state MCH programs to identify and assist eligible infants and pregnant women in obtaining Medicaid and to establish toll-free information lines to help parents locate Title V and Medicaid providers. MCH programs use multi-program application forms, conduct on-site presumptive eligibility determinations, use outstationed Medicaid workers, and conduct outreach. Title V programs also work with Medicaid to develop standards for EPSDT and enhanced prenatal services, provide case management for Medicaid clients, recruit providers, and evaluate services.

There are many examples of state efforts to coordinate with Medicaid for the purpose of improving access to care and maximize the Title V dollar to expand services to the uninsured. In my own state of Massachusetts, Title V and Medicaid work closely together to implement the Medicaid eligibility expansions, establish standards and certification requirements, and to support services in Healthy Start and the Perinatal Community Initiatives Program. The PCIP promotes and funds cul-

turally and linguistically compatible services to high risk pregnant women and their families. In addition, the community health centers serve as the infrastructure for the delivery of the large majority of Title V primary and preventive care services.

In Iowa, as in a number of states, there is an agreement between the State Department of Public Health and the Medicaid agency for the provision of an enhanced package of prenatal care services by the Title V program to Medicaid enrolled women. The enhanced package includes nutrition and case management and is reimbursed by the Medicaid agency. Since approximately 90% of all Title V prenatal care patients in Iowa are Medicaid enrolled, the reimbursement allows the Title V program to direct their monies to assure provider capacity for services to women, infants, children and adolescents without health insurance.

The Rhode Island RIte Start program provides risk reduction services and childbirth education classes for Medicaid eligible pregnant women and comprehensive prenatal care to uninsured women. The Utah Medicaid agency contracts with the state Title V program to reimburse Title V for the provision of case management services for Medicaid enrolled children with special health care needs. Title V providers in Missouri contract with the state Medicaid agency to provide case management for all children enrolled in EPSDT. In these states, children are receiving cost-effective services, barriers that interfere with a family's ability to access care are decreased, and the Title V dollars are being rechanneled to serve those otherwise without care. In almost every state these types of innovative arrangements are being crafted to stretch public resources so that more individuals can receive services.

State Title V programs also coordinate with and frequently administer categorical public health programs targeted to specific causes of morbidity and mortality. These include immunizations, and programs to prevent and treat such problems as lead poisoning, STDs, HIV/AIDS, substance abuse, and tuberculosis.

Title V programs similarly coordinate with and often are directly responsible for family planning, WIC, and early intervention programs for children under age three. In areas where community and migrant health centers are also in place, Title V programs are working to assure that services are coordinated and not duplicated. Flexibility in the Title V program allows for resource allocation and program development to complement, extend and leverage other public programs, as well as private resources for health care delivery and financing. Together, these resources make up the public infrastructure, or fabric, for MCH services. Today that fabric is wearing thin and has holes in it through which too many women, children and families fall. Health care reform and bills such as S. 773 have the potential to make major repairs. But financing alone won't assure that women and children and are covered.

Unless we incorporate services and activities known to improve birth outcomes, protect children and adolescents from preventable disease, injury, disability, and death, promote healthy development and improve family functioning, and make them universally available, health care reform will not live up to its promises for women, children and adolescents. Data systems, needs assessment, public planning processes and reporting related to the health of women, infants and children are important components of these services. Accountability for planning, coordination and quality assurance for MCH services should rest with public health agencies, working jointly with community agencies and providers.

Another important function of the infrastructure is to assure the adequate distribution and mix of preventive, primary and specialty care providers and to encourage the appropriate use of non-physician providers, such as nurse midwives and practitioners, and supervised lay health workers. This provider mix includes support for regional systems of care such as high risk perinatal and neonatal care. Provisions for health systems infrastructure are particularly critical to women and children with more extensive needs for health and related support services due to such factors as poverty and chronic illness or disability. These activities go well beyond the services provided by individual practitioners to their patients, and are the cornerstone to cost containment and disease prevention.

AMCHP supports the intent of S. 773, to increase access to medical care for underserved populations. The provisions in the bill which expand the number of providers in medically underserved areas and allow funds to be used for recruitment and training of staff, renovation and expansion of facilities, purchase of supplies and equipment and opening of new sites, can help to alleviate non-financial obstacles to care. We are particularly interested in seeing that the 10% set-aside for non-FQHC organizations be increased to enable Title V programs to participate in a more significant way. Title V-supported programs provide a substantial amount of prenatal, preventive and primary care, and the essential components of the health system infrastructure, but are not in most cases FQHCs. FQHC requirements that care be

available 24 hours/day, 7 days/week often may be difficult to meet, given current staffing limitations.

A simpler and perhaps more straightforward way to increase the availability of care to women and children is to increase the authorization level of the Title V Maternal and Child Health Services Block Grant program and to support adequate appropriations for FY 1993 and beyond.

A recent survey of the state Title V programs by AMCHP found that 96% of the programs indicated an increased demand for prenatal care and for pediatric care. States attributed the increase in demand for services to unemployment, lack of health insurance, and expansions in Medicaid coupled with a decline in private providers accepting Medicaid. Collaborative efforts between Medicaid and Title V to meet EPSDT screening targets, for example, result in the identification of more children in need of Title V services. Expansions in Title V service capacity and outreach, and expansions in other programs, such as SSI, WIC, and Part H of the Individuals with Disabilities Education Act (IDEA) were also cited as factors contributing to additional referrals for health services.

Reports from the Carnegie Foundation (Ready to Learn: A Mandate for the Nation), the National Commission on Children (Beyond Rhetoric), the National Vaccine Advisory Commission (Access to Childhood Immunizations: Recommendations and Strategies), and the National Commission to Prevent Infant Mortality have echoed the need for increased support for MCH services. The administration's budget also calls for a modest 4% increase. This is a step in the right direction, but not a big enough step to meet the needs of women and children today, or in the coming year.

Title V programs support clinics in medically underserved areas, and are often the sole source for care for low-income women and children. The Title V program was appropriated $650 million for FY 1992, with an authorization ceiling of $686. We are requesting that the Committee support an authorization ceiling of $750 million for FY 1993, with a phase in to $1 billion for 1995.

AMCHP and many of our colleagues in the public health and women and children's services arenas firmly believe that specific attention must be devoted to policies, resources and proposals ensuring that families have access to and utilize services that will promote their children's health. Improved financing of care is a necessary but not sufficient step toward that goal. To comprehensively reform health care and to assure that health care services are universally available, especially in areas that traditionally have been underserved, explicit attention must be devoted to the infrastructure of health services, and to financing services for those with special needs. An increased authorization for Title V and adequate appropriations would be a major step in the right direction.

We have been gratified to share our efforts to date with you today, and stand ready to work with you to better address the health of women and children in the future.

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