



HEALTH REFORM: SAFETY NET WORKGROUP
Monday, August 16, 2010
North Carolina Institute of Medicine, Morrisville
1:00 – 4:00
Meeting Summary

Attendees

Workgroup Members: Chris Collins (co-chair), Ben Money (co-chair), Jason Baisden, Anne Braswell, Charles Bregier, Kellan Chapin, Robin Cummings, Brian Ellerby, Katie Eyes, Elizabeth Freeman, Tom Irons, Susan Mims, Chip Modlin, Connie Parker, Marilyn Pearson, Joy Reed, Steve Slott, Karen Stallings, John Torontow, Ramon Velez, Kristin Wade

Steering Committee Members: Marti Wolf

Staff: Kimberly Alexander-Bratcher, Thalia Fuller, Paul Mandsager, Sharon Schiro, Pam Silberman

Interested Persons: John Dervin, Lee Dixon, Tracy Linton, Tammy McLean, Mary Piepenbring, John Price, Chris Skowronek, Jeff Spade

Welcome and Introductions

Chris Collins, MSW, Deputy Director, Office of Rural Health and Community Care Co-Chair

E. Benjamin Money Jr., MPH, Chief Executive Officer, North Carolina Community Health Center Association, Co-Chair

Ms. Collins and Mr. Money welcome participants, gave introductions, and asked workgroup members and participants to introduce themselves.

Overview of health reform and structure of the health reform workgroups and workgroup charge

Pam Silberman, JD, DrPH, President & CEO, North Carolina Institute of Medicine

Dr. Silberman gave an overview presentation of the main provisions in the Patient Protection and Affordable Care Act (“Affordable Care Act or ACA”) and the structure of the health reform workgroups. Click here to view the presentation: [Health Reform overview](#).

Overview of Workgroup’s specific provisions from the Affordable Care Act and the Health Care and Education Reconciliation Act of 2010

Kimberly Alexander-Bratcher, MPH, Project Director, North Carolina Institute of Medicine

Ms. Alexander-Bratcher gave a more detailed presentation of the health reform provisions related to Safety Net. Click here to view the presentation: [Workgroup overview](#). Click here to see the specific sections of the Affordable Care Act which the workgroup will review: [ACA Safety Net provisions](#).

Selected comments/questions:

- Q: Payments to Community Health Centers (CHCs) matching Medicaid payments: Does the PPACA maintain the cap on Medicaid payment? A: Payments must at least match prospective payment rates. Payments are based on 2000 rates and then increase every year. CHCs get paid higher rate than fee for service. The ACA provides an opportunity for CHCs to have different payment source.
- Distinction between appropriations (funded) and authorizations (not yet funded) in the PPACA.

Update on health reform implementation for the Safety Net (NC)

John Price, Director, Office of Rural Health and Community Care

Mr. Price gave an overview of the Office of Rural Health and Community Care implementation efforts focused on the federal health reform provisions. He specifically discussed the National Health Service Corps and Health Professional Shortage Areas (HPSA). Click here to view the presentation: [Office of Rural Health and Community Care](#).

Discussion:

- Health Professional Shortage Areas:
 - [HPSAfind.gov](#): lets you find facilities, areas and counties where loan repayment is available.
 - If something is not designated as HPSA (Health Professional Shortage Area) it does not mean it is not underserved at a county, population or facility level. Office of Rural Health (Rockville, MD) makes decisions about HPSA designations and can be asked to reevaluate them. Applications have to be done for each type of covered specialty: primary care, dental, and mental health. Designations have a lot to do with contiguous counties and areas, distance and travel time.
 - The PPACA requires the US Department of Health and Human Services to issue new rules with a comprehensive methodology to designate medically underserved populations and health professional shortage areas (Sec. 5602)
- National Health Service Corps:
 - The penalties for dropping out of the federal loan repayment program could make providers very hesitant to sign up. In NC individuals have to apply for federal loan repayment before state funds. There is no penalty if

- a provider moves between HPSA sites or between HPSA designated locations in different states.
- Under ARRA there was a pilot test to do loan repayment for part time providers. It was previously only available full time repayments. The PPACA continues to allow professionals working part time to qualify for loan repayment.
 - The Office of Rural Health (ORH) serves as a place where individuals can make connection to the National Health Service Corps (NHSC). The ORH helps recruit certain types of professionals eligible for loan forgiveness (i.e. primary care, dental and psychiatric physicians, dentists, nurse practitioners, and physician's assistants), but not others (i.e. psychologists, marriage and family therapists, licensed professional counselors, and licensed clinical social workers). However, the ORH can help these individuals apply for NHSC loan forgiveness if they agree to practice in a HPSA. The Office of Rural Health does track individuals who receive NHSC funding and they have helped place.
 - State Loan Repayment Program
 - State program provides loan repayment for full time and part time providers. If individuals are eligible for federal loan repayment, they are not eligible for state funds.
 - Under PPACA, state programs are no longer taxable for federal tax purposes or for state employment tax.
 - From national perspective is NC unique in recruiting providers? Other states have been doing loan repayments. Office of Rural Health recruits primary care providers.

E. Benjamin Money Jr., MPH, Chief Executive Officer, North Carolina Community Health Center Association

Mr. Money gave an overview of the North Carolina Community Health Center Association (NCCHCA) implementation efforts focused on the federal health reform provisions. He specifically discussed the Community Health Center expansion and New Access Points. Click here to view the presentation: [NC Community Health Center Association](#).

Discussion:

- New Access Points (NAPs): The two year project period means that if the full amount is received by an organization (\$650,000), the organization must have ramped up to serve 4,333 new individuals by the end of two years. The program has a road map for decreasing funding over time. There is a preference for funding new sites of existing organizations because of their track record at success. NCCHCA is actively encouraging existing centers to expand, but they can only expand to one new site.

- These are highly competitive applications. There is a lot of pent up demand for money.
- For the first time collaboration is a point of emphasis, but there is only one lead applicant.
- Applications that have other local dollars (not just Medicaid, Medicare, private insurance) to leverage federal dollars are considered favorably. Organizations that can bring many new individuals into services are also viewed favorably.
- It is difficult for public agencies (e.g. health departments) to receive federal health center funding. Projections suggest that only 18 public entities will receive funding.

Connie Parker, Executive Director, NC School Community Health Alliance

Ms. Parker gave an overview of the North Carolina School Community Health Alliance implementation efforts focused on the federal health reform provisions. She specifically discussed the School-Based Health Center expansion and potential funding opportunities. Click here to view the handout: [NC School Community Health Alliance](#).

Discussion:

- There are currently 55 School-Based Health Centers (SBHC) in North Carolina.
- A \$100M federal funding opportunity is expected in early 2011 (FY 2010 and 2011 dollars) for equipment and capital improvements.
- Community Health Centers are able to apply for operational funds to support SBHCs through [HRSA-11-017 for New Access Points](#).

Jeff Spade, FACHE, Vice President, NCHA, Executive Director, NC Rural Health Center

Mr. Spade gave an overview of the North Carolina Hospital Association safety net programs and implementation efforts focused on the federal health reform provisions. He specifically discussed the 340B Discount Drug Program expansion to Critical Access Hospitals and other hospitals. Click here to view the handout: [NC Hospital Association](#).

Discussion:

- Applications have been requested and received for Critical Access Hospitals to join the [340B program](#)
 - It is estimated that between 20 and 25 new hospitals will be added to the 340B program through changes in the PPACA
- Rural Hospital Flexibility Program (FLEX) is not addressed in PPACA.
- How is the sliding fee scale set up in academic centers? NCIOM does have a website, [NCHealthCareHelp.org](#) that lists the organizations, services, whether or not they accept sliding fee scale, and many other helpful details. The site lacks good numbers from hospitals and information about hospital outpatient clinics. It

is an attempt to collect numbers about who received care in what areas. It is most widely used in helping patients find free and reduced care.

Discussion of Workgroup goals

Safety Net Goals

- Issues, questions, and ideas to discuss and build on:
 - 1) How should we encourage all appropriate communities to be designated as Health Professional Shortage Areas (HPSAs)? Do we need new money or legislation?
 - 2) There are lots of types of providers who are not actively recruited by the Office of Rural Health and Community Care. We need to take advantage of loan repayment for other provider types (i.e. mental health providers)
 - 3) What can this workgroup do to help Community Health Center applications for funding be successful?
 - 4) What can this group do to help School-Based Health Centers?
 - 5) There are hospital community benefits requirements in the legislation. We may need updates from hospitals about what they are doing but they may need help to do community benefit assessments.
 - 6) We may also want to learn more about how Triple Aim program (overview by Jeff Spade) is aimed at low income and uninsured. It may be a focus for Centers for Medicare and Medicaid (CMS) innovation grants and CMS focus in general.
 - 7) We need to keep eye on other potential funding through ACA to find other needs for organizing community collaborations or emergency collaborations.
 - 8) How do we encourage safety net providers to cover gaps that are still going to exist after the expansion of health insurance coverage? That may be more of long term focus of this workgroup.
 - 9) We also need to think about where money that is now going to the uninsured will go and what it will be used for once the numbers of uninsured shrink in 2014. How is the existing safety net funding going to be invested after ACA is completely rolled out?
 - 10) There is an expanded need for primary care providers and demand for primary care providers. (This will be a focus of the [Health Professional Workforce workgroup](#).)
 - 11) Are there efforts that could be undertaken now to help prepare collaborating organizations and communities for successful applications?
 - Education for safety net organizations and providers about expected proposals and applications
 - 12) What is needed to prevent emergency departments from being completely overcrowded and overwhelmed?



- 13) There is a need for health care organization administrators (not just providers). ECU is setting up an educational track for administrators.
- 14) The cuts in funding for hospitals through ACA will be substantial. There will be significant changes in reimbursement which will lead to substantial changes in how hospitals will have to operate.

The next meeting of the Safety Net Workgroup will be held Wednesday September 15, 2010 at 9:00 AM at the NCIOM offices in Morrisville.