

Health Reform: Safety Net Workgroup
Wednesday, September 15, 2010
North Carolina Institute of Medicine, Morrisville
9:00 – 12:00
Meeting Summary

Attendees

Workgroup Members: Chris Collins (co-chair), Ben Money (co-chair), Anne Braswell, Kellan Chapin, Cindy Ehlers, Brian Ellerby, Katie Eyes, Elizabeth Freeman, Chuck Frock, Lin Hollowell, Tom Irons, Connie Parker, Marilyn Pearson, Steve Slott, Karen Stallings, John Torontow, Ramon Velez, Kristin Wade

Staff: Kimberly Alexander-Bratcher, Pam Silberman

Interested Persons: Kristen Black, Lynne Bolden, Anne Cohn, Laura Vincent Darby, Lee Dixon, Tammy Eldridge, Christine Kearsley, John Price, Jim Robinson, Maggie Sauer, Chris Skowronek, Michael Utecht

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 welcomed the group and the participants introduced themselves.

Safety Net Organization Overview

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

Ms. Alexander-Bratcher gave an overview of safety net organization in North Carolina. There are many types of safety net organizations, including federally qualified health centers (FQHC), local health departments and other clinics, designed to provide care to the uninsured for reduced or no cost. Safety net organizations can include primary and preventive services, access to specialty services, pharmaceutical services, dental services, behavioral health services, and hospital services. Her presentation can be found here: [Safety Net Organization Overview](#).

Selected questions and comments:

- Comment: The reason FQHC Medicaid numbers are low is because there are so many more private providers accepting Medicaid. North Carolina has more capacity for private providers to accept Medicaid patients than other states. Because of this capacity, converting uninsured persons to Medicaid may cause problems for FQHCs by leaving them with a higher proportion of uninsured patients due to new Medicaid patients leaving FQHCs for private providers.
- Comment: When we insure more people with Medicaid, a lot of them will go to private providers. This switch will put pressure on some community health centers to raise the bar on quality.

- Comment: We had challenges in medical education clinics with people leaving; but when the hospital opened free standing clinics that take all payers, the people who moved to insurance stayed.
- Q: Is public health providing primary care or are they getting out of primary care? A: Some health departments are getting out of primary care. The health departments have been providing more primary care in the last 5 years, but will probably be reduced in the next 5 years as more people become insured and more FQHCs are created.
- Comment: Catawba County gave up primary care and shifted to a private provider. They lost a school-linked health center because private providers do not back up school-linked centers. There are 3 school-linked health centers in Buncombe County supported by public health. As primary care moved to FQHCs, it was a struggle to continue to support school-linked centers.
- Comment: Federal support for school-based health centers waned in the last administration, but there is more support in this administration.

Areas in State of Greatest Needs

Mark Holmes, PhD, Assistant Professor, Department of Health Policy and Management, Gillings School of Global Public Health, University of North Carolina at Chapel Hill

Dr. Holmes gave a presentation about the areas of North Carolina with the greatest need and use of safety net organizations. The eastern portion of the state has very high poverty and uninsured rates which makes many eastern counties “high need” counties. The second part of his presentation focused on how Health Reform would change the characteristics of the uninsured after 2014. North Carolinians who are uninsured after 2014 will be slightly older, have higher incomes and there will be a higher percentage of undocumented persons in this group. His presentation can be found here: [Areas in State of Greatest Needs](#).

Selected questions/comments:

- Q: Why won't low income people who are eligible for Medicaid enroll? A: Some people aren't eligible because they are either undocumented or are here in the US for less than 5 years. Others may not know they are eligible or may choose to not enroll.
- Q: What about the make-up of the pool of enrollees? A: We may end up with a pool of more high-cost individuals who choose to enroll if those with better health choose to not enroll.
- Comment: FQHCs are trying to recruit healthy individuals into FQHCs.
- Comment: Eligibility and enrollment will be simplified in 2014. There will be fewer young adults and an increase in 24-44 year olds.
- Comment: The percentage of noncitizens who are uninsured will fall; however the percentage of US citizens who are uninsured will be cut in half. There will be a huge gain in insurance among citizens.
- Comment: Two “buckets” of non-citizens: those who are here without documents and those who have documents. Undocumented persons receive no benefit under ACA while those who are documented can receive subsidies through HBE (if eligible).

Documented persons can also qualify for Medicaid.

- Q: What is the difference between Mark's estimates and the DMAs? A: Mark is only looking at uninsured who will enroll in Medicaid. DMA looks at all the new Medicaid eligibles (including some who were previously insured through other insurance coverage).
- Comment: As a medical provider, there is a difference between urban and rural poverty.

Workgroup Discussion

- What are the areas of the state of greatest unmet need and how can we work together to strengthen the safety net in these communities?
- What role will safety net organizations play in helping to enroll the uninsured into health insurance products (Medicaid, NC Health Choice, private insurance)?
- Will there be sufficient provider capacity (private providers, safety net providers) to meet the health care needs of the uninsured as they gain insurance coverage?
- What role will safety net organizations play in continuing to serve people without insurance coverage?

The workgroup discussion included the following themes:

- sustainability
- provider mix
- organizational roles
- quality improvement, cost containment, efficiency, and health outcomes
- patient triage – intake centers do first history (physician extender), and then help link patients into care
- systems of care
- access
- health education
- co-location of community health centers with emergency departments
- community collaboration
- access barriers for Medicaid (to be presented in October)
- provider capacity
- role of minute clinic – connecting various access points to medical homes
- Health Professional Shortage Area designation
- National Health Service Corps loan repayment options for primary care and behavioral health providers
- team approach to care
- new models of care (to be presented in October)
- reimbursement and sustainability
- workforce (billing changes and policies for LCSW, LPC, other mid-levels)
- technical support and guidance for communities interested in FQHC status
- FQHC Executive Management track in East Carolina University Department of Public Health (Chris Mansfield, PhD)
- retiring providers – strategic plan to recruit for safety net providers, NC Medical Society/NC Medical Board – considering mentorship for providers who have stopped providing primary care, but want to get back into providing primary care

Public comment period

Comment: Definition of need

- point of access versus Health Professional Shortage Area
- discrepancy between what providers think they are doing for charity care and what practice managers show (reporting measures)
- believe numbers are higher for private providers
- national numbers not focused on National Health Service Corps and Community Practitioner Program practitioners

Comment: actual need in Brunswick or New Hanover is higher than represented, access problem for uninsured

- before collaborative work -2 free clinics (1-2nights per week)
- free clinics now 5days/week and 1-2night/week, 16 new patient/per month;
- IT needs
- free clinics may change identity, urgent care for indigent program