



Community Health Centers and State Health Policy: Issues and Ideas for Improved Collaboration

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January 17, 2008

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NATIONAL ACADEMY *for* STATE HEALTH POLICY

- Non-partisan non-profit dedicated to helping states achieve excellence in health policy & practice.
- Conduct policy analysis and research, interactive forums for problem solving and assistance
- Work with, across executive & legislative branch officials and program administrators
- Offices in Portland, ME & DC



A Guide to a few acronyms

- HRSA-Health Resources and Services Administration
- BPHC- Bureau of Primary Health Care
- FQHC – Federally Qualified Health Center
- CHC- Community Health Center
- DRA- Deficit Reduction Act of 2006

Health Care Safety Net Providers (Source: Institute of Medicine)

- Deliver a significant level of health care to uninsured, Medicaid, and other vulnerable patients.
- IOM report focuses on “core safety net providers.” These providers have two distinguishing characteristics:
 1. either by legal mandate or explicitly adopted mission, they offer care to patients regardless of their ability to pay for those services; and
 2. a substantial share of their patient mix are uninsured, Medicaid, and other vulnerable patients. Core safety net providers typically include public hospitals, community health centers, and local health departments, as well as special service providers such as AIDS and school-based clinics. In some communities, teaching and community hospitals, private physicians, and ambulatory care sites fill the role of core safety net providers.

Health Centers: Five Basic Characteristics (Source: NACHC)

- Location in high-need areas
- Comprehensive health and related services (especially 'enabling' services)
- Open to all residents, regardless of ability to pay, with charges prospectively set based on income
- Governed by community boards, to assure responsiveness to local needs
- Held to strict performance/accountability standards for administrative, clinical, and financial operations

Health Centers Reach High Proportion of MCH Populations (*Source: NACHC*)

Health Care Home for 16 Million Americans

- **1 of 5 Low-income Uninsured Persons (6.4 million)**
- **1 of 9 Medicaid/CHIP Recipients (5.7 Million)**
- **1 of 4 Low-Income Children (5.9 million)**
- **1 of 5 Low-Income Births (400,000)**
- **1 of 10 Rural Americans (7.9 Million)**
- **1 of 7 People of Color (10.2 Million)**
- **800,000 Farmworkers, 800,000 Homeless Persons**

NASHP's National Cooperative Agreement with HRSA-BPHC

- States making policy decisions and implementing programs that have implications for FQHCs
- Federal funding, requirements, relationships can mean state policy makers/administrators not as aware of issues/implications for FQHCs
- Need for information, analysis, and dialogue to better inform decisions


NASHP's National Cooperative Agreement with HRSA-BPHC

- Provide info and TA to state policy makers about access and the health care safety net, especially FQHCs
- Provide opportunities for dialogue, to increase understanding and build effective working relationships
- Analyze and provide information on federal policy changes which affect access and the safety net, especially FQHCs
- Collaborate with other national organizations focused on the safety net

NASHP's National Cooperative Agreement with HRSA-BPHC

Competitive selection of 6 teams of Primary Care Associations (PCAs) and Primary Care Offices (PCOs)

- Alaska
- District of Columbia
- Hawaii
- Massachusetts
- Michigan
- Mississippi



Top State Policy Issues Identified by PCA/PCO Teams and NASHP Academy members

- Health care reform implications for safety net/CHCS-overriding concern
- Workforce
- Reimbursement in Medicaid and SCHIP
- Oral health, mental health
- Health information technology
- Performance measurement and improvement

Issues and opportunities in the Deficit Reduction Act changes in Medicaid

- States have option of benchmark plans that may change coverage for services provided by safety net
 - New packages may not align with what safety net providers/FQHCs provide, creating financing issues
 - New focus on disease management and wellness may present opportunity to expand education and case management

Issues and opportunities in the Deficit Reduction Act changes in Medicaid

- **DRA and other state reform changes may affect how people use safety net/FQHCs**
 - Could affect benefits for all Medicaid
 - Increased co-pays, ability to refuse service for non payment could drive people from other providers to FQHCs
 - Citizenship documentation also may drive more to safety net/FQHCs *and* diminish enrollment of eligibles and therefore affect revenue

Issues and opportunities in the Deficit Reduction Act changes in Medicaid

- Recognizes role of health centers, offers collaboration opportunities
 - Enrollees must have access to FQHCs
 - \$50M grants to states to encourage use of appropriate care settings over ERs
 - Emphasis on community placement of elderly and disabled, new option for covering disabled children create opportunities to improve community health services for the disabled



Views from the Trapeze: Workforce and the Safety Net in Reform Context

- NASHP visited New Mexico and Massachusetts to learn more about workforce issues in range of state reform contexts
- Met with PCOs, PCAs and other state officials to talk about reform, workforce and how safety net is both affected by and part of the solution to workforce shortages

Views from the Trapeze: Workforce and the Safety Net in Reform Context

Findings:

1. CHCs face workforce challenges from front office to providers to executives
2. State policymakers and CHCs need ongoing communication to deal effectively with key policy issues
3. Workforce, access and the safety net have not been an integral component of state health reform planning, and they merit early and explicit attention
4. Even “universal” health reform will leave some uncovered while potentially increasing needs for providers

Views from the Trapeze: Workforce and the Safety Net in Reform Context

Some promising approaches:

- Training and development programs for both front line workers and executives (MA)
- Enhancing role and use of community health workers (MA)
- Integrating recruitment and placement programs (NM)

Collaboration between States and Health Centers Yields Results: AK

- Alaska Frontier Initiative funded rapid growth of CHC program (from 2 centers serving approx. 12,000 people, to 24 serving over 80,000)
- PCA and PCO jointly led planning, designations, community development, TA, moral support
- Half of the orgs. funded are tribal entities
- Frontier Extended Stay Clinic (FESC) demonstration projects. Examines effectiveness and appropriateness in certain remote locations
- PCO annually proposed this initiative, PCA advocated for enabling legislation and funding

Collaboration between States and Health Centers Yields Results: DC

- Training and technical assistance to support health centers such as self-learning materials; career development tracks; and infrastructure support
- Emergency preparedness including: the Bioterrorism Preparedness Program; the Emergency Operations Template (customizable for individual CHCs)
- Quality measurement and improvement

Collaboration between States and Health Centers Yields Results: HI

- PCO & PCA collaborated with Dental Assoc., Dental Hygienists Assoc., Medicaid, dental insurers, & community leaders on oral health task force.
- Led to state legislation for a new dental license, called community services licenses, in 2004.
- Licenses may be used to practice dentistry in FQHCs, Native Hawaiian health Systems Centers, or post-secondary dental auxiliary training program. May be obtained without state exam.
- Community service license significantly improved recruitment of dental professionals for CHCs.



Collaboration between States and Health Centers Yields Results: MA

- Statewide Health Disparities Collaborative recognized by HRSA as a federal equivalent
- Improved readiness of centers to address and participate in Emergency Preparedness and utilize incident command center strategies
- Expansion of Women's Health Network Services and access to mammography units and services
- Expanding capacity for dental services through community health services
- Strategies to focus on community health centers as primary care homes for low income patients to improve care, expand access in health care reform.

Collaboration between States and Health Centers Yields Results: MI

- Agreement to extend some of savings assumed through a Family Planning Waiver to Michigan's FQHCs to expand capacity around women's health, to meet the growing demand for primary care
- Collaborated with Medicaid to assure that Medicaid Managed Care plans serving the Detroit area were aware of services offered by and benefits of working with FQHCs when serving Medicaid enrollees

Collaboration between States and Health Centers Yields Results: MS

- MS Access for Rural Care (MARC) is a model because of unique relationship between PCA and PCO. Together recruited 128 primary care providers for CHCs & rural hospitals. Also developed and implemented a state loan forgiveness program for primary care
- From 2002-2006 had a joint contractual position for a research specialist.
- MS Qualified Health Center Program (MQHC) provides increased access to preventative and primary care services for uninsured or medically indigent patients.

Conclusion

- State health policy environment, especially in context of health care reform, is changing, creating risks and opportunities for health care safety net
- Ongoing communication between state policy makers/administrators and the community health community is essential to deal effectively with policy change

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