# Community Health Centers: Can They Plug the Gaps in the Safety Net?
# Alliance for Health Reform
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**ED HOWARD:** My name is Ed Howard, I am with the Alliance for Health Reform. I want to welcome you on behalf of Senator Rockefeller and our board of directors to a program that explores the current and the potential role for community health centers in a very fast, changing healthcare system.

CHCs are aimed primarily at serving vulnerable populations; we are going to emphasis on those with low incomes. And wonder of wonders in this age they have historically received bipartisan support: under the George W. Bush administration the number of patients seen by CHCs doubled and under President Obama, and additional $2 billions, part of the American Recovery and Reinvestment Act of 2009, allowed CHCs to expand their operations and build some new centers.

Now all of that enhanced capacity is going to be needed to meet part of the expanding demand for healthcare expected in 2014 with the coverage expansions in the Patient Protection and Affordable Care Act. So, as CHCs move closer to the center of stage in the healthcare delivery system, we thought it was appropriate to take a closer look at their strengths and their challenges and how they are doing today and what the future looks like for this important part of our healthcare system.

We're pleased to have as our partner in today's program the Centene Corporation which contracts and provides Medicaid coverage in about a dozen states and operates a number of

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related services. We're happy to have Helen Bryson, who is Centene's lead liaison for federally qualified health centers and a former FQHC official herself as the co-moderator of this morning. Helen, let me turn it over to you.

**HELEN BRYSON:** Thank you, Ed. We are absolutely delighted to be here today as a sponsor and supporter of the Health Alliance Reform this morning. Centene is a Medicaid managed care company, headquartered out of St. Louis. We take a very unique and concentrated focus on providing services to Medicaid and Medicare recipients.

We found that health centers are an excellent partner because like health centers, we believe in providing healthcare and healthcare related services to the right group of folks at the right time, providing that locally in the best setting, and we found that the community healthcare setting is the perfect setting for our mission and for the members that we serve. We currently have over two million members in 18 states.

We absolutely respect the community healthcare centers, we believe in the perserverence and the fact that the community healthcare centers serve homeless, uninsured, underinsured, persons living with HIV and AIDS and migrant patients. So we strive every day to be the best corporate partner that we can be in providing those services. Thank you.

**ED HOWARD:** Thank you, Helen. A few logistical items in your packets, there is some important information including

biographical information about all of our speakers. You're also going to find PowerPoint presentations for those who have them and a lot more is available online at allhealth.org. There is a list of the additional materials in your kits.

There'll be a webcast and a podcast available tomorrow, thanks to our colleagues at the Kaiser Family Foundation and you can get that either at allhealth.org or at kff.org directly and within a week or so we will have a transcript on our website of this briefing.

The green question cards in your packets, please write whatever occurs to you that you need to find out from one of our speakers and will eventually fill out the blue evaluation form in your packets. Let me do my typical Centene footnote on the evaluation because particularly we're with our colleagues at Centene, we have a sensitivity to this.

Normally, about a fourth of you fill out the evaluations and we are very grateful for that. That's probably about average for a crowd like this, but in order to induce our higher participation rate, as we say, pay for our performance, if we can get 35-percent of you to fill it out, we are going to donate $50 to the City of Hope, which is a non-profit that I operate, it's a clinic service about 4,000 DC residents and Adams Morgan without regard of ability to pay and if 50-percent of you complete the evaluation, the donation to the City of Hope will be 100 bucks.

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So don't put any pressure on yourselves, fill out the blue evaluation form. Also, Zach Thompson on our staff told me I have to call your attention to the collection of letters and numbers in the lower left of the slide that you see up there has something to do with social media. I don't know what it means but he says you will and you can ask him if you don't understand. Those of you who are above whatever the cut-off age is.

Okay, enough housekeeping, let's get to the program. We have a terrific and knowledgeable group of panelists today with a broad range of experience and you are going to get a chance to listen to them make their presentations and then enter in to the conversation with them.

And we are going to start with Dan Hawkins, who is the Senior Vice President for public policy and research at the National Association of Community Health Centers, NAC. He is fairly new at NAC though he has been there since 1981. He's seen and been a part of a tremendous growth in the CHC presence and today we've asked Dan to sort of take stock on where the health centers are today, what they are doing now and in preparation for the full effect of the health care reform law. Dan, thanks for being here.

**DAN HAWKINS:** Thank you, Ed and good morning everyone. It is indeed a pleasure and an honor to be here today and I want to thank Ed and the Alliance and its supporters and

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especially the Centene Corporation for the great support they've shown for the work of community health centers and the people that they serve.

I will tell you I am older than dirt, and yeah I have been doing this for a long time, but the real folks who know health centers and work at every day, first of all the A Plus team are the folks you are going to hear from in a bit, who are on the front lines doing the work every day, that's the A Plus team.

And the A Team is my policy and research staff at NAC who would manage to commandeer what looks like about one and a half tables out there. Put your hands up so folks will know who you are. If you have questions after this is all over, ask the folks up here, ask the folks sitting at the tables there unless you want a seminar by Dan Hawkins. I tend to go on, but I will try to curb my enthusiasm here.

To begin with, because I suspect that most of you know at least something about health centers, maybe not a lot, my job, I think, is to give you kind of a grounding in what health centers are and where they are located, who they serve, what they do and the value they bring.

How many challenges they face as well. When I am asked to describe health centers, I like to do it in terms of the five basic characteristics. Together they make health centers sort of a unique ward of the health landscape. First of all,

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every single health center by law must be located in a high-need area.

These are called medically underserved areas and they are designated as such because they exhibit high poverty or high low income population, poor health status and generally a shortage of available providers. Number two, health centers provide comprehensive health and related services, not just a medical office. Most health centers provide medical but also dental oral health and mental and behavioral health services as well.

And then beyond that they provide a set of what we call enabling services that provide things like outreach, transportation, multi-lingual services or translators, things that break down the barriers and help people get into care. And then another set of enabling services like nutrition education, social work, job counseling, referral to other social service agencies and the like, help make the medical and dental care that the health centers provide, effective for the people they serve.

Number three, every health center in America is open to everyone and their community regardless of their ability to pay. That's important for those who can't afford to pay. But it also means that if there is an opening in a health center, my health center had a fabulous pediatrician and I had the mayor of the town and the CEO of the bank where we had our

money all wanted to bring their kids to be seen by Stan Fish, our pediatrician.

And the deal I cut with Stan is, as long as you never, ever, ever, turn away a poor kid, yeah, you can see them. He says I'll work extra hours. Good, that's fine. That's open to everyone regardless of their ability to pay. Number four, community boards. Every single health center in America is governed by a community board.

A majority of these members are active, registered patients get their care right there at the health centers. Kind of like the inmates running the institution. But this is the one place in America where this is healthcare of the people, by the people and for the people served.

And finally, health centers have to meet strict performance and accountability standards at the federal, state and local level for the services they provide. How are they done? I think reasonably well. They could always do better, and we are always looking to improve, but they provide top quality care.

The research has shown that health centers provide excellent care and especially the preventive care that they provide. They've had a major, major impact on health disparities, which are racial related, but they are also income related and insurance coverage related. And across all three of those classes, race, ethnicity, income, insurance coverage,

health centers have shown, as Jack Needleman from Harvard said once, a great researcher, he said there is no disparities inside the four walls of the health center, None.

It's when they need the specialty care referrals and the like, that the patients themselves and healthcare centers run into trouble. They show higher cost effectiveness, in fact the record shows that their overall costs of care for those who get care at a center are 24-percent lower than the overall total cost for those who get their healthcare elsewhere.

And that has amounted to a 20-percent, 24,000 a person almost [inaudible] 1800 a person per year savings on inpatient care, hospital emergency room use, specialty care, etc. 24 billion a year, actually, that number is a 2009 number. They also have had a significant community impact.

In fact, health centers employed 138,000 people across the country today and they have been credited with generating another 50,000 jobs in their local communities just by their presence there and their operations.

Their $12 billion annual budgets of which, by the way, a little over two and a half billion are federal grants, the rest are Medicare and Medicaid, private insurance, state and local payments, etc. and payments by the patients themselves because everybody is asked to pay something. Nothing is free in life.

As my consumer board members told me, if we give it away free, they won't put any value on it. So everybody's asked to pay something if they can. No one is ever turned away for inability to pay. The $12 billion in annual budgets generate $20 billion in economic activity and benefit for the low income communities they serve.

Obviously, bipartisan support as Ed mentioned, with the support under the Bush Administration, now under the Obama Administration, health centers have grown. A recent study and report, that was just issued a couple of weeks ago, shows in fact, that they perform better in many key quality measures than practice physicians.

That speaks to the level of quality, and there was an earlier report from GAO that talked about the quality of care at health centers, this is the latest record of the most comprehensive [inaudible] done a reviewed study of health center work. So what did health reform do for health centers? First of all, and most importantly, health reform affordable care act extends coverage to 32 plus million people across this country.

No one knows better than health centers other than the people themselves who were uninsured. What it's like being uninsured in America today. They deal with it 40-percent of their patients are uninsured. They struggle alongside their

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patients to try to get them the care they need and that is the most important benefit that health reform provides.

But Congress was pressured, they said, look we [inaudible] 32 million people, where are they going to get care? We need to invest some money in cost effective methods of getting care up to the very communities where these people live and work so they put $11 billion in the Affordable Care Act so they can expand health centers which would double the support for health centers, it's over a five-year-period and allow health centers to grow from the current 20 million patients served to 40 million.

Probably not in 2015, but shortly thereafter. It takes time to develop that capacity. You can have all the buildings in the world but if you don't have clinical staff to provide that care, Congress also invested in several key work force programs for health centers and additional health service workers by far the most important, and that is enough money to place another 17,000 physicians, nurse practitioners, PAs, nurse midwives, dentists, hygienists, psychologists and clinical social workers out there.

What are the reasons of the success of the health center model? I think I have mentioned several of them already. They are partnerships, they don't exist in the void and I am sure Henry and the other presenters here this morning will talk about the partnerships they have.

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They were built by the local community. This is one program that is all from the ground up. Not one health center in America was ever started out of Washington or out of the state capitol. It all came from an initiative in the local community. In the health centers world, it's their need for healthcare that determines how they relate to their communities more than any other thing.

And the limited federal grants, which average less than 18-percent of their budgets, provide the seed money that empowered these communities to do what they do so well. And that very directness and simplicity of the mission is what gives its overall strength.

I give you a final thought, a couple of weeks ago, [Inaudible] actually invented the principles of Chinese medicine said, well, you can read it, it's there. But this is what moves us and motivates us at health centers because we truly believe to serve the community is the greatest good of all. Are you going to introduce Laurie?

**ED HOWARD:** Let me do that, if I may, Dan. Thanks so much. Laurie Felland is the Director of Qualitative Research and a Senior Researcher at the Center for Studying Health System Change. She's the director of that center's signature project, by the way, community tracking study and she is a co-author of the excellent background paper on community health centers in your materials. Laurie's going to give us an

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understanding of how CHCs are financed among other things.

Laurie?

**LAURIE FELLAND:** Thank you, thanks for inviting me to this event and I want to thank the Alliance and Centene for hosting it. So I've been tracking community health centers for the past 13 years, again as I had said primarily through the community tracking study in which we followed 12 metropolitan communities and have been since 1996 and I won't try to name them all because I always forget one, but they are all listed in the briefing in your packet.

We were last in the field for the community tracking study in 2010. I've also done a number of other studies on safety net providers and looked at community health centers as part of those, just to name one right now. We are conducting a study of six communities in California and that is funded by the California Healthcare Foundation.

A lot of what I know about health centers comes from talking to people, like the people on the panel here, directors of health centers, directors of other clinics, safety net hospitals, other safety net providers and organizations. Community clinics increasingly have seen the benefits of becoming federally qualified health centers and there are a lot of benefits to that.

In addition to the federal grants, there is also cost-based payment from Medicaid and Medicare and I will talk about

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that a little bit more later. They can receive discounted pharmaceuticals, access to the national health service core physicians and malpractice coverage. So funding has increased over three fold since we started the community tracking study from about 750 million in 1996 to over 2.2 billion today and then of course more funding is coming with the ACA.

So organizations have increased from about 700 to about 1200 and it is sort of hard to really understand the capacity because so many of these organizations have multiple sites of care. So there's over 8,000 sites of care as well. Currently federal grants make up over about 23-percent of FUHC's total revenues so this isn't just federal money, as Dan mentioned, they're depending on other sources of revenues as well.

We've seen health centers grow and every time we go into the field, I'm always sort of amazed at how much they expand. A lot of them have expanded capacity and they are seeing more and more patients and more and more encounters and the need certainly seems to be out there.

In this last round of visits during the recession, we heard a lot about health centers seeing the so-called new poor, patients who haven't really used the safety net before, they haven't used community health centers, but they have lost their insurance, they lost their jobs, and were looking for a place to receive lower cost services.

There has also been a growth in mobile clinics and school-based clinics, I think these are sort of creative ways to expand capacity without necessarily a bricks and mortar facility and a way to reach new populations.

But there has been considerable variation in how federal funds have been distributed to health centers and how health centers have developed, so through the community tracking study, we see it in places like Boston and Miami, have an extensive set of health centers and they keep growing.

Some other places have lacked, Little Rock, Arkansas, has few sites of care, and places like Orange County has been growing in terms of their numbers but is still, when you look at the relative potential need in terms of the percentage of uninsured and the percentage on Medicaid there is a disparity across communities in the development of FQHCs.

You can see there is a table in the briefing in your packet that shows that listing. Part of the variation is based on the federal methodology, Dan talked about needing to be in a medically under-served areas and serving a medically under-served population and there is several criteria that go into that as far as the availability of primary care physicians and the percentage of the population that's under the poverty level, the percentage of the population that's over the age of 65 and infant mortality rate, that is sort of the current criteria.

What we hear from the communities doesn't always capture what they feel the need is and there has been some concern that some areas have been overlooked in their need for federal funding and another health center.

The other part of this is that health centers need to have state and local support to even get federally qualified status and a lot of them started out as clinics and they have to show over time that they are able to provide the various services that Dan mentioned and to be a comprehensive care provider.

They need help in doing that. They need help in showing that there is need in their community, conducting a needs assessment. They also need letters of support from their local policy makers, state policy makers and there is a lot of collaboration in communities helps the community health center association, tapping into other safety net providers and policy makers.

Also, a lot of state governments have provided direct funding so between state, local and private sources, that makes up about 15-percent of health centers total revenues. States have been increasing their support for health care centers over time as they've grown to help them cover the care for the uninsured especially.

We saw during the 2010 site visits that with the recession certainly and the state deficits that states have had

to cut back some of the tobacco settlement money some of it was general revenues. Also in some cases local governments, like in Seattle, provides some direct money to health centers and there has been some cut backs in some of those sources.

Another area that affected health centers is cuts in the Medicaid program itself, cuts in optional benefits such as dental care, health centers have really been expanding their capacity of dental services as these have been really difficult for low income people to get in their communities.

When the state cuts that benefit that is an added expense on the health center. Which leads me to the reliance on the Medicaid program. Medicaid [inaudible] are a growing proportion of community health center patients. When we started the CTS, Medicaid was about 31-percent and it's grown to about 39-percent of the total patients and it is also the same about 39-percent of revenues coming from the Medicaid program.

The cost-based reimbursement helps support that and is a really big part of the health centers revenues. I won't go into the history of how it changed over time, but it is a cost-based payment that takes into account the range of enabling services, transportation, language services as well as some of the other services provided, labs, pharmacy that are all don in sort of a one-stop-shop.

Also health centers really became proactive in Medicaid managed care in the late nineties when more and more states were moving to managed care. Health centers got a little nervous that they might lose their patients to other providers, so they have really been proactive in working with their state Medicaid programs to make sure that their payments are secure in terms of getting a wrap around payment if the health plan doesn't pay the full cost-based reimbursement that the state makes up the difference and also in terms of getting patients assigned to health centers and some health centers have developed their own Medicaid health plans.

We do expect an expanded role for health centers under reform. Certainly just because people get Medicaid coverage doesn't mean they will be able to find a provider, a private physician to treat them. Also a lot of the uninsured have relied on health centers and I think health centers are counting on them to keep coming to them once they have, this is their medical home and to keep seeing them.

A common mantra we heard among some community health center directors is that they really know they need to become providers of choice not providers of last resort. They are really working to improve their facilities and work on their efficiency and some of the things Dan mentioned. They are working on expanding and they do expect to see more patients

and the funds have been flowing from the ACA to help them do that.

Again, though I have noticed just in looking at some of the allocations, some of the communities that have pretty strong infrastructure that keep growing and those that have lagged are still struggling in terms of demonstrating the need and getting the support to get FQHC status.

Part of the ACA does include a committee to look at the criteria for demonstrating medical need in a community and those recommendations are out, we don't have a final rule on that yet, but it does look like there is some effort to take into account additional factors of barriers to care in a community to be more flexible or look at different measures to see if a community does need a new organization on site.

Also, I will just quickly say their involvement in payment models, health centers are starting to dip their toe into thinking about the ACO model certainly from the Medicare perspective, FQHCs don't tend to see a lot of Medicare patients currently it's usually in the single digits of their total patient population but they can be part of those, I think there will be a lot of interest in potential Medicaid ACOs that some states have been pursuing but there pretty nascent at this point.

I think there are some future challenges certainly ongoing federal, state and local budget short falls, we have

seen some of the cutbacks at the federal level already, the $600 million in 2011, so whether the grants can be maintained I think is a concern.

Also the cost-based reimbursement, whether the states and federal government can continue to maintain that. And of course at the local level support for demonstrating need and things. Also now we know some states can further discussion to whether they want to expand Medicaid or not, so health centers may have more uninsured if the state decided to not go that route.

They have been expanding and they may see that their expectations of their uninsured patients getting coverage may not come to fruition; I think that is a concern. I think the growing expectations health centers have taken on more and more as we've alluded to specialty care, dental care, helping people get insured, helping them enroll in coverage and I think it's been a good thing in their communities.

They have become more of a medical home, a one-stop-shop; I think we just need to make sure that it's not overburdening healthcare centers by expecting them to do everything. I just don't want people to forget about the other health centers and clinics out there that aren't federally qualified and some don't necessarily want to be, some don't want to meet the federal requirements.

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There are reporting requirements, some really just want to keep serving the uninsured and not get into collecting insurance and billing and things like that. I think sometimes there are misconceptions about the clinics out there, we've heard from some of them that their local policy makers or state policy makers assume they're getting federal money and they're not.

There is a distinction and some will want to continue with their current mission, it is becoming harder for them to do that especially as potentially private sources decline and other sources of revenue decline. I would just like to briefly acknowledge our funders for the community tracking studies site visits, the 2010 visits were funded by the Robert Wood Johnson Foundation and the National Institute for Healthcare Reform. Thank you.

**ED HOWARD:** Thank you, Laurie. Next we have three people for whom community health centers are not a subject of study, but rather a way of life and we have asked each of them to give us a flavor of the successes they've achieved and the challenges they face.

We're going to start with Henry Taylor who is the Executive Director of the University of Illinois Hospital and Health Sciences System and the Mile Square Health Center in Chicago and on the board of the National Association and he's got a generation's worth of experience of private and public

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advocacy for vulnerable populations. And let me just introduce the entire panel of CHC folks so that we won't interrupt the flow of that conversation.

Steve Shattls at the far end is the CEO of Valley Health Systems, and Integrated Community Health Center in southern West Virginia and southeastern Ohio. Valley Health Systems has more than 30 urban and rural setting locations the community health center network now meets health care needs of about 70,000 individual patients.

On my immediate left is Doctor Lisa Nicholas, she directs the Children's Clinic serving children and their families in Long Beach, California. She is, appropriately enough, a pediatrician. She's head of the Children's Clinic for more than 24 years and led it to a series of innovative advances, both clinical and managerial, so we are very happy to have all three of you with us and we are going to start with Henry Taylor.

**HENRY TAYLOR:** Good morning and thank you for having me out this morning. Thank you to Centene and thank you to the Alliance for Healthcare Reform. I am Henry Taylor, the Executive Director for the University of Illinois Hospital and Health Sciences System, U of I Mile Square Health Center. Mile Square in fact is one of the oldest community health centers in the United States.

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We have 11 community health centers in the Chicagoland area, five of which are located in Chicago proper, one in Cicero, five of those sites are regional sites that are large enough to care for large communities. Three are school-based sites and three are mental health sites that focus on the needs of patients with chronic mental illness.

Today I am going to take a different slant and talk about the opportunity and challenges we have, you heard Dan talk about care and the need for specialty care, the challenges we have in community health centers, getting patients linked to specialty care. We want to do it in a different framework and talk about how Telehealth has and is working to allow us to look at bridging the gap in providing care in the community.

It is important for community health centers in the health care industry changes across the United States that we find innovative ways to look at delivering care in the Chicagoland area and in community health centers. One of the major ways is to look at Telehealth and Telemedicine.

We're looking at it from a Telehealth perspective because we want to also look at those other enabling services that can be delivered through technology vantage point. In Telemedicine to look at some of the cumulative curative facts of care as well. We're looking at Mile Square Health Center, we're looking at developing two levels of telemedicine.

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One is to explore telemedicine from an intra perspective, with 11 sites you can imagine difficulty with having staff who have to go from one end of the city to the other to deploy services. So we are beginning to deploy Telehealth through which social service activities can be delivered through a web based technology and also to allow for some of our other enabling services to be delivered without the staff having to travel from one end of the city to the other.

That is important for us in terms of efficiency. The other piece of the discussion today will be focused on just the very medical perspective. Why Telemedicine? In a study that was performed in the UK, one of the largest studies in fact that involves over 6,000 patients of which 3,000 were patients with chronic disease was performed in a long term study which shows significant improvements in health outcomes by deploying telemedicine/telehealth.

It's from that vantage point that we felt it was important for us to build a telemedicine network within the Chicagoland area. We have developed was considered the ACT program, ACT access to care through telemedicine and it's primarily through an integration of other community health centers within the Chicagoland area that's built on the platform that already exists in the University of Illinois.

The University of Illinois is providing telemedicine services to the corrections department in the State of

Illinois. So is our process to embellish that technology to provide that telemedicine to community health centers within a network within Mile Square. For example, we are partnering with two other community health centers near North Corporation and Primecare to provide specialty care within the community.

Why specialty care? Specialty care is one of the hardest items for community health centers and for our patients to have access to. We have been looking at this for several years and what we recognize is that it's not a lack of specialists that's really the problem, at least in Chicago.

We know from region in region, region to region the issues are somewhat different. From our perspective, it's a maldistribution of technology, it's a maldistribution of specialists. Naturally, these specialists hover around major academic institutions like the University of Illinois, Northwestern Hospital and UFC University of Chicago.

So consequently you have to have some of your higher level of technical care being provided in these communities. Our perspective, our opportunity with the University of Illinois is to provide that technology in the community by linking them through telehealth. We want to provide increased access to specialists through the link of telemedicine.

We've launched our telepsych program which allows psychiatry services to be delivered from our location to other community health centers to the other community health centers

within our network. We are exploring the opportunities for providing telepsychiatry, teledermatology, cardiology, chronic disease and teleotolaryngology as well.

As we face this project, we also want to deploy telemedicine within our school link programs, our school based programs so that we can look at those childhood illnesses that are affecting our kids, and do some screenings in that environment as well.

There are two models of telemedicine/telehealth we are looking at today, we are exploring today one very focused is synchronize telemedicine where there is the face to face exchange just as you do with Skype with your provider, with your client, with your patient from a given location.

The other is asynchronous where you are able to store images that will be evaluated and assessed later on and the outcomes being delivered to the provider. So we are doing it both asynchronously and synchronously. Our goals are very simple, we want to improve access for our providers, our participating patients by 50-percent.

We want to provide improved access for the participating providers to specialty care services as well. And we want to improve diagnostic and treatment opportunities for these clinics who are part of our collaborative. We've started initially with two community health centers along with Mile

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Square to start this initial linkage; we have a total of 20 other health centers that are possibly able to line with us.

As a matter of funding, we've received our initial funding from The Chicago Community Trust. That has allowed us to launch this program we were looking at as a model for us to look at additional funding to provide this service throughout the Chicagoland area to other community health centers.

We're fortunate at Mile Square to be an academic community health center, which allows us to be able to leap into and to connect with specialized care. However, we want to ensure that we can do it more efficiently be providing that same opportunity to some of our colleagues.

It's been said before that having an insurance card does not give you access to care. It is important for us to look at solutions in health reform and solutions in our new health care model that allows it to be innovative and creative as well. Thank you.

**STEVE SHATTLS:** Thank you, Ed. Good morning. I would like to begin by thanking the Alliance for Health Care Reform and Centene for sponsoring this session and inviting me to participate. I am also very honored to participate in this event especially given the fact that the chair of the alliance is my US Senator, Senator Jay Rockefeller, who has been a huge supporter of the community health centers across this country

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for many, many years, not just those in West Virginia, as well as other access programs for health care across the country.

I'd like to start out by talking a little bit about health centers in general, particularly in West Virginia, to sort of give you a flavor of the landscape from on the ground. First of all, health centers are always on the edge. We don't have deep pockets.

We do what we can do with our resources so that we are able to provide service to the patients that demand service that need service in our communities. We collaborate, we are very open to working with all sectors of the population, in fact, one of my board members is the CEO of the state medical association and of course they represent private physicians.

Private physicians come to community health centers to try to link up with community health centers because they know they are the provider of choice. They have difficulty implementing EMRs, they have difficulties dealing with record keeping and providing outcomes.

We train medical students, we work with the health science schools, we have residents and we train residents and we also outreach to local and community pharmacies so we can provide access to low-cost medications for our patients and those are private businesses and I think that is really huge and something that needs to be understood that we are involved in collaborating.

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I just wanted to give you that flavor of it because today I would like to talk about a couple of items in West Virginia and at Valley Health Systems where I work. There is certainly a profile of our organization in your packet, I won't get into that.

But in West Virginia, we see health centers as a critical element not just to provide care to our patients but we also see it as economic development and I say that coming from the rural perspective. We have some huge healthcare needs.

The health indices in West Virginia are some of the worst in the country and not only are the health centers a critical factor because we serve 20-percent of the entire population of the state of West Virginia, that's 20-percent and we serve a third of the Medicaid recipients in the state.

So when we are serving one in five across the state, especially in rural communities and many of the communities around where I am, we're the economy we are the economic engine.

We're the employer that keeps the small business open. We're the employer that recirculates dollars, we think this is fairly typical of many rural communities throughout the country and that's why community health centers are so essential to many of the small rural communities in rural states.

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As you are probably aware, West Virginia has many of the worst statistics which I just mentioned, in fact, in 2009 a report stated that the area where I am in the Huntington/Charleston area where our base of operations is, was coined the highest incidence of obesity and depression subsequently we were the saddest and the fattest or the fattest and the saddest and that is pretty drastic commentary.

And it sort of sets the stage if you combine that with the substance abuse and addiction problems in southern West Virginia and our surrounding states, eastern Kentucky and Ohio that gives us an incentive to how are we going to improve access. How are we going to improve outcomes as we move forward in healthcare reform?

Given that as a backdrop and an opportunity to providers in West Virginia got together, 20 plus of the 29 health centers statewide we developed an incorporated managed care organization which decided as its mission to provide greater access to care, manage their own resources in Medicaid and not have folks in the private sector, private companies, take critical needed resources out of the state for their for profit companies.

We set up a for profit managed care organization and we are just pre-operational right now, but we've designed this so that we can partner because we do need the capital to get to

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the statutory reserve requirements our state insurance commission will require us to have before we can launch this.

Some other states have successfully launched community based and community health center owned managed care organizations and that's one of our objectives. Our initial start-up corporation, which is called the West Virginia Family Health Plan, still needs to be capitalized, but three months ago, we were working very hard and got our state legislature and the governor signed into law in April a Provider Sponsored Network Bill, which basically provides for automatic assignment of the Medicaid patients that we see to our managed care organization, which must be 51-percent owned by community health centers in the state and we think that is very dramatic particularly as we move forward into hopefully the expansion of Medicaid in West Virginia.

As I said, health centers serve a third of the Medicaid patients and if we have another 160,000 additional Medicaid recipients we can look at that also as economic development. We have our work cut out for us as a family health plan. We're looking for the capital, we're also discussing with HRSA a loan guarantee program so that we can go to commercial lenders with the support of the federal government possibly backing us up.

We're also talking and engaged in very careful and deliberate conversations with Medicaid experience, managed care organizations, insurance companies throughout the country that

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do have the resources and the assets and the management expertise to put us into business. They all recognize that we will have the 51-percent ownership.

We think this is critical because we do not want care and cost to be managed, we want care to be managed and we want resources to remain in the state and we also see this as good economic development. The bottom line is we're talking jobs in West Virginia if we get this up and operational.

We're also talking about being able to manage the care to a critically important population has some tremendous healthcare needs. Thank you again for the opportunity to be here and I look forward to your questions later. Thank you.

**ED HOWARD:** Thank you very much, Steve. Let's turn to Doctor Nicholas.

**ELISA NICHOLAS:** Good Morning, I know I am last on the docket here until the questions, so wake up. It's a pleasure to speak with you today. I want to thank Ed and the Alliance and Centene for inviting me here today and sponsoring this. It's a pleasure to come all the way from California to come and speak to you today. A little bit of background on me and the organization.

We were founded in 1939 and so we are a little bit unusual for a community health center. We did not become one until 2002 when we entered the FQHC world and we were only seeing children originally and then expanded to adults because

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really, in our community the majority of the uninsured were adults after SCHIP and the Medicaid program.

Long Beach is a community that is surrounded by ports, the largest ports, second in the world combined Port of Long Beach and LA and freeways so we have a big environmental issue with air pollution and our health so I am going to touch on that briefly. We are the most ethnically diverse city in the country of its size, under 500,000 people.

In our clinics alone there are 26 languages spoken. We have many challenges to face. I'm a pediatrician but I also have a degree in public health and I did a residency in preventive medicine, so I take the broad view of health similar to what Dan has alluded to. And I think that's why I fit so well in a community health center because it's more than working with one patient at a time.

It's really working with a patient in a context of their community and their family and their environment. Today I am going to talk about two areas, very disparate. One is the approach to chronic disease, specifically asthma. I am sure all of you in this room knows someone with asthma or personally have had asthma or have been touched by it in some way.

It is the most prevalent chronic childhood disease, chronic disease, and it is something that can be controlled. The other thing I am going to talk about briefly is

California's approach and our readiness for the Accountable Care Act coming in 2014 with the expansion of Medicaid.

As I said, Asthma is something that can be controlled. As we were seeing children in our clinic, we realized that it was the number one cause for hospitalization, ED visit and ICU admission that was unnecessary. We tried to address it in our own clinic setting, we developed different protocols when the patient would present with acute attack, we would start a certain medication that could keep them out.

We educated our doctors and we developed some health education material, but it wasn't enough. I recall a certain patient that we saw we knew him very well and knew the family, he was a young man with Down syndrome, and he was seen with one of our chief medical officer and excellent physician, he was on the right medications. The mother really understood what was happening, but he wasn't making progress.

Two things were revealed. One was the mother was a victim of domestic violence and until we could handle that and help her with that situation, she was not going to progress in treating her child's disease. But the second one was that we didn't realize what kind of environment he was living in.

One day the mother said to Doctor Chandler, do you think the mushrooms growing on the bathroom ceiling could have something to do with his not being able to control his asthma? And sure enough, mold is a trigger for childhood asthma and

until we could help him with that living situation, we weren't going to make progress.

We needed to treat not just the disease, we needed not to just treat the patient, but we needed to treat their psychosocial situation and their living environment. This led for us to develop an innovative program with funding from foundations like the California Endowment and the Robert Wood Johnson Foundation.

We embarked actually on two programs one within our own clinic and our own clinic population and one within our community which I led called the Long Beach Alliance for Children's Asthma. In that, we created a disease management team, we looked at the most innovative practices in the country. We redesigned our clinic flow and clinic system the way we enroll patients.

We did peak flow tests as a vital sign in the clinic. We trained our doctors and we trained all of our staff in what asthma is, how to treat it, what are the triggers and how to control it. We then engaged community health workers, we hired community health workers, some of whom were our patients previously and now they have health insurance.

We trained them in a validated program and they go into the homes, they assess the living environment of our patients whose asthma is poorly controlled. They only see the sickest of the sick. They do a very intensive intervention they give

them mattress covers, pillow covers, cleaning supplies, teach them how to control their environment, how to communicate with their doctor and give them an understanding of asthma that we aren't always able to do one on one in the room with a patient.

We've been extremely successful; we have lowered the admissions to the hospital, the ED visits, missed school days and missed work days importantly for their parents.

On the other hand, we also engaged with the community, the health department, the hospitals, community based organizations, the YMCA, and developed the Long Beach Alliance for Children's Asthma, which took a community-wide approach not only for the patient, but the physicians that treat those patients, our doctors and other doctors in the community and trained them is asthma care using the PACE program, which is approved by the NHLBI, it's now a validated program.

We've trained hundreds of physicians. We also trained the community to understand asthma and trained them in advocacy and we have changed some of the policies and processes in our communities.

We've helped clean up the air, trucks no longer idle at the port, the freeway expansion was actually moved so it wouldn't be right next to our patient's homes and we have been very active in that. We have augmented community health worker visits to those patients that are outside of our purview of the community. That has been our story with asthma.

We are now going to apply that to other chronic diseases and have already started with childhood obesity and diabetes. Let me talk briefly about California. In California, we are preparing for the expansion. We got an 1115 waiver to do so and we are currently enrolling our patients into the low income health program within our state.

Our clinic itself has enrolled almost 1,000 patients that in 2014 will be those that will be rolled on to Medi-Cal or Medicaid as you may know it. So we are getting prepared. Our exchange has been established at the state level and they are working on how they are going to approach this.

They promise us that it will be an administratively simplified program to enroll our patients and we're moving forward with this and looking forward to working and partnering with. Community health centers have been acknowledged and recognized for our role in working with our patients and partnering in understanding their environment, their culture and we will be seen as patient navigators and will help enroll the patients in that process. I look forward to answering any questions. Thank you.

**ED HOWARD:** Terrific, Thank you, Lisa and now we get the chance to hear from you or read what you have written. You have green cards that you can use to fill out questions, hold them up and they will be brought forward. There are

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microphones at either side of the room that you can use and someone obviously know how to use them.

This isn't personal; it's for everybody who stands at a microphone. Sir, if you will identify yourself and keep your question as brief as you possibly can so we can get through as many questions as we can. You've got the first word.

**STEWART GORDON:** I guess there's a proposal on the table or being discussed in the house to limit the use of 340B drugs to those who are uninsured. I was wondering, and I guess I direct this primarily at Dan and Steve, but the others are invited to respond. I was wondering to what degree you rely on the 340B drugs savings for the insured that you treat and what kind of an impact you think the proposal would have on your overall revenues.

**ED HOWARD:** And whoever starts this off, start by explaining what a 340B drug is.

**DAN HAWKINS:** That would probably be helpful. One of the many benefits that flow and they are federally authorized benefits that flow not just to health centers. In the case of the malpractice coverage that I think Laurie you mentioned under the federal to our claims act that's pretty much only for federally funded centers in fact, centers that are certified under Medicare and Medicaid as federally qualified health centers, we call them look-alikes but they don't get a grant, do not get FDAC coverage but 340B which was enacted in 1993 is

a drug discount program that requires manufacturers to make their pharmaceuticals available at a discount rate.

It varies, but generally it can get as high as 50-percent of retail to certain entities. That includes community health centers, are rural clinics in there? I think they are, rural health clinics, family planning clinics, disproportionate share hospitals, DISH hospitals and other entities that are certified by HRSA the same agency Health Resources and Services Administration that manages the health centers program, but 340B is its own program and all health centers are 340B sites.

The Affordable Care Act extended coverage to additional hospitals, children's hospitals and some others who had not been eligible for 340B discounts before. The one group of individuals for which the health centers cannot use the 340B discount is Medicaid enrolled individuals.

In those cases, the state and the federal government already get the Medicaid rebate for pharmaceuticals. Otherwise, 340B discounts can be used for uninsured people, for Medicare beneficiaries for privately insured individuals as well. I think it would be a real tragedy if it were restricted only for uninsured individuals.

As I mentioned 40-percent of the 20 million people served by health centers today are uninsured. But we've got 15-percent who've got private insurance and here's the irony, the 15-percent of our patients who actually have private

insurance, the insurers produce 6-percent of health center revenues. Why the disparity? I think the biggest reason, we don't know exactly.

I did tell Karen Ignagni one time that her members were the crappiest payers of all, but I was only pulling her leg. The reality is that most of those were private insurance and health centers, I'm going to call them WalMart workers. They've got high deductibles, limited benefit and high co-pay coverage.

If they're fortunate enough to have pharmaceutical coverage, it's usually pretty restricted. If health centers and other safety net providers were restricted from using the 340B discounts for those individuals, it would be tragic. In terms of the ability of the providers to meet the medication needs of their patients. We're very hopeful that won't happen. I'm unaware of anything that's proposed in the form of legislation to do so and I'm very hopeful that would not happen.

**ED HOWARD:** Steve, did you have something to add?

**STEVE SHATTLS:** I think Dan covered it all. It would be huge to our patient. It's part of the access problem, medications until 340B came along. You'd write scripts no matter if they were insured or not, they wouldn't get them filled. Now with the discount drug program under the 340B we

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have a reasonable assurance that they will be complying with their script and get it filled.

It is especially important in rural areas where we use the 340B contract pharmacies and those pharmacists in rural areas may just be the local, independent and they are dependent is part of the economy. It's also an economic issue as well.

**DAN HAWKINS:** It's about the survival of the small community pharmacies in rural areas. Just because the volume and the modest, I think, fee that they get for filling 340B pharmaceuticals. In most rural areas, the smaller community health centers, if you're big like Henry here, you've got your in-house pharmacy and that's the way it should be. That's the economics of scale. But if you are a small center or multi-site like Steve's 30 sites, a health center in a rural community, you're relying on those community pharmacies and guess what, Steve, they rely on you.

**STEVE SHATTLS:** Absolutely. Pharmacies would go out of business if they didn't have the 340B contracts through us.

**ED HOWARD:** I wonder if that changes in 2014 when most people will have a standard package of benefits that include a decent pharmaceutical benefit.

**DAN HAWKINS:** I'll say quickly, no. The simple fact of the matter is if you look at the experience in Massachusetts, and I know the center has and others have, health centers in Massachusetts 98-percent insured, but 22-

percent of health center patients in Massachusetts today are still uninsured.

We know that we are going to have 20 to 25 million people who will remain uninsured. In fact, if the cost of premiums goes up, it all dramatically, even in the exchange you said, you're going to have people who are going to exceed that 8-percent limit and not be able to afford, in fact, we may have some less than that, but still able to afford the coverage.

We know we're going to have millions of uninsured. People think it's all undocumented, no, it's only about a quarter of those who remain uninsured will be uninsured because they're undocumented. The other three quarters won't be.

In the experience in Massachusetts, was yes, there was a drop in the proportion of health center patients who were uninsured, but the number actually went up because health centers were among the few providers in Massachusetts who readily expanded access to care for both the newly insured and those who remained uninsured. I think the same is true and for 340B that the need is going to continue to be there.

**ED HOWARD:** I should have been more precise, though, because what I was [inaudible] was that assuming that the rule that is causing difficulty is one that restrict the 340B access to people who are uninsured. There will be a lot fewer of the other kind of people that cause the problem now. Is that not a good premise or is it?

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**DAN HAWKINS:** That may very well be the case, but I don't know with Henry or Steve or Lisa, have anything that you want to add on that. I think that still even those with private insurance, we're going to see what a bronze and silver policy looks like in terms of the coverage and the out-of-pocket costs. I would urge waiting to see how the situation shakes out before taking any precipitous action.

**ED HOWARD:** We have a bunch of questions that have been coming forward. Helen, you have been sorting through them.

**HELEN BRYSON:** I've tried to group these together. One of the things that it appears is that there is some interest in gaps in care. We know that community health care centers offer a wide variety of services, however, we are interested in behavioral health and how that is being addressed in the community health care centers and oral health. We know a lot of those programs are being affected by reimbursement and if you could share with us from your perspective what's going on in your health center, that would be great.

**HENRY TAYLOR:** I'll take the first stab at that. Let's take a look at mental health, which is a big issue for [inaudible] in the health care community center of business. We provide, as I stated earlier, mental health in each of our sites. Three of our sites specifically focus on mental health, chronic mental disease. We focus on chronic mental disease in connection with primary care.

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These are clinics that link the primary care with the psychiatric care. They're a couple of things we know are certain, this is by way of research and by way of our partnership with an organization called Thresholds, where they are responsible for taking patients from homelessness into housing. Many of these patients have mental illness.

We know to date is that patients with mental illness die much earlier than the average population, primarily because they get fair psychiatric care. The psychiatrists do not address the primary care. So from our [inaudible] it was important for us to bridge that gap by linking at the same visit the primary care and the mental health care at the same time.

This allows up to provide the intervention patients need to improve their health while looking at their getting the right medications and they're using the medications. That's a model that has worked rather well for us. We find that the gap in Illinois is where patients who are not chronically mentally ill, there's no coverage so you do find patients who are without coverage and not getting the care that they need, plus you have states, the state that has moved a lot of patients into the open market that go out that are uninsured and unattached to any care.

From a dental perspective, Illinois has just recently made some major cuts in the cares provided. In fact, dental

care is only provided on an emergent basis to adults. We continue to provide dental care to our patients. They of course provide dental care to the pediatric population.

It'll be interesting to see if the state will change this position once health care reform rolls out in 2014. This is all done due to budget short falls in the state of Illinois. So it may very well stay but that is the status in the state of Illinois.

**ELISA NICHOLAS:** We have done some very interesting and exciting things in the behavioral health arena. I think everyone realizes that mental health needs are profound in the low income community and something that we cannot address physical health without assessing their mental health issues. We now screen every patient that comes in for a physical once a year with a mental health screening.

We use the PHC, PHC 17 for children that looks at depression and attentiveness and anxiety and the PHQ 9 for our adult patients so we can identify the patients before they have severe mental illness problems and it really helps us to identify those things that patients would otherwise not reveal. We've had patients who had a brother killed and it showed up on the depression scale and they hadn't told the doctor with whom they had a relationship with because they just couldn't talk about it.

That's the first thing, we link them into our social workers and we have a psychologist on our team who's the director of behavioral health. Very exciting, this year we have two partnerships with mental health organizations, Pacific Agent Counseling Center who has got a grant from the county of Los Angeles to work with the severely mentally ill Cambodian population.

Long Beach has the largest Cambodian population outside of Cambodia. They suffer from tremendous mental health problems from what they went through in their homeland. We now are providing their health services and we have a Cambodian community worker that is working directly with them. With our homeless population, one of our sites is on a multi-service center and we've been involved with Mental Health America which is a premier leader in working with the homeless population.

They've created the village in Long Beach, we are now doing Under the Bridge medical outreach for those patients. The one challenge is that we can get no reimbursement for that, so if anyone has a solution for that let me know. We have a nurse practitioner that is working with the homeless populations and engaging them, examining them and bringing them into our site and we have had some real successes.

We have co-located therapists from a children's mental health provider that comes to our site and those relationships evolved really from [inaudible] Health Grant that we have from

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the bureau and are bringing together all the mental health providers in the greater Long Beach area that work with children to address problems of children with their families in our community.

The stigma is great, so I think the more we can do the more integrated health services we can do the better. With the dental, we've started dental varnishing the children under five in our clinic so we now have medical assistants that train the kids and they are actually much more cooperative than I would've imagined. They also do nutrition counseling which is extremely important and talk about sugary foods and sodas and not to put that in their bottles and helping families to get on the right track to prevent childhood obesity also.

**STEVE SHATTLS:** One of the things that we've been doing for the past 15 years, with the community mental health center in our service area that covers the same number of counties is looking at ways that we can collaborate and integrate over the course of this period of time we've co-located their therapists that are in our sites and indeed we found some resources so that we can put primary care providers in the behavioral health sites.

There are a lot of challenges with that, we've actually have gotten our boards and directors together to look at, maybe we could look at a full integration model of the two organizations. The biggest challenge seems to be aligning the

payments, the state of West Virginia has a special pool of money for the mental health industry, the community mental health centers that is specific to those mental health centers, behavioral health centers, subsequently over the past three years we've begun as a community health center ourselves developing our own behavioral health team.

In collaboration with the community health resources out there, but we've hired three psychiatrists, a couple of Ph.D. level psychologists and looking to expand that as we move forward in the next several years not knowing exactly what will happen with our integration efforts with the community mental health center. On the oral health side, we have a number of dental sites with six or seven dentists, but that's not enough to meet the demand.

It's really a health profession shortage issue in West Virginia. We have one dental school, it only produces a few dentists, most of the dentists that the school produces are going out of state.

Most dentists are going into practice where there are enough economic resources for them to make a very nice living. We have a huge access problem and I think what we're talking about here is access and oral health is a very difficult problem in rural areas across the country.

**DREW LEE:** Hi, my name is Drew Lee and I represent the American Medical Student Association. I just graduated from med

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school, actually Loyola right down the block from here, thank you. I actually spent a month at USC and got to visit Mile Square and everything so that was a good experience.

I guess this question is more directed to Director Taylor. You mentioned telemedicine, I was wondering what the technological requirements were on the user end in terms of if they need a computer, webcam, high-speed internet. And if they do, what kind of population is really using this or is able to use this technology in terms of getting their health care? Do you have any data on that?

**HENRY TAYLOR:** Very good question. Actually the technology for using telemedicine has really changed over the course of the past several years it's a lot more cost effective. As I am not a techie, I do have techie's who work on my committee who are developing the telemedicine platform for Mile Square. Right now, if I talk about mental health, right now that can be done on a secure network, face to face with just a webcam on top of your computer.

So consequently that's very low cost, very efficient and very efficient for the provider to do that as he sits at his desk and now has a schedule of patients who he will see electronically.

We're exploring the other components of the technology and how they are used, for example, there is a cardiology glove that you can buy that allows you to send images across the

universe for those readings to be done on camera. Those reports will come back to your provider.

From a cardiology perspective, we're really interested in just doing more in the way of screening, because we do know there is a high incidence of cardiovascular disease in the African-American male, Latino men, so if we can get in the community and just do screenings, we can identify patients who are at risk and get them into treatment.

So it does vary with the kind of and the degree of telemedicine you are going to deploy. Dermatology is also pretty easy to deploy because you are using a very high resolution camera to take a picture, and that picture is stored and you're able to save that for review later on by a provider who will then interpret those results.

So we're beginning to learn that, learn the technology and being able to put [inaudible] at our sides. Yes sir, [inaudible through] very much so in the following way one of that if you look at the greatest needs, when we surveyed our colleagues, the other FQHCs, who were interested in this, the things that lead us to the top was lack of access to mental health.

So being able to keep that patient at their home clinic, and have an experience where they have a visit with the physician at U of I without the distance, it's very cost-

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effective in that regard especially when there's so little access that's available to them.

To also be able to deploy dermatology in a way that says there's just not enough dermatology visits of access available for the needs we have in the community to have those stored and pay a provider to look at those later on and screen those images is very cost effective from our mind side as well. As we do our study, we'll have more information about really getting the data and add research to how much cost savings come out of it as well. Yes ma'am, [inaudible through]

**ED HOWARD:** Excuse me, we have these microphones that'll really help the people who are going to be watching the webcast.

**JEANETTE CALOWI:** My question was, what's the time period between the pictures getting taken and the results actually getting back to the patient?

**HENRY TAYLOR:** It depends on, there are several factors to consider. One, within the Mile Square network it really can be done the same day because we're all on the same medical record so we can upload images within our all medical record system. When we're deploying it with our other partners, we have not yet deployed dermatology to our other partners yet.

Those images, those results can be faxed or simply sent over a secure email so there are ways in which you do it more

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quickly than you might otherwise considered it in a standard environment. Does that help?

**CHRIS ANDERSON:** I'm curious about the connection between health care and law. I know there have been some new clinics that have been started in some of the major metropolitan areas where you actually bring lawyers into the clinic and they sit and they partner with the doctors so they are able to address some of the major issues that the families have and relieve the stress. And then by relieving the stress, you would lower some of the health care needs.

So, I'm wondering if there was, now with these news reports today about the plethora of new JDs we have out, I'm wondering if there's any thinking about expanding that cooperation.

**ELISA NICHOLAS:** We have a medical legal partnership and that was started originally by Doctor Barry Zuckerman an incredibly visionary pediatrician in the Boston area. We were very fortunate to partner in the last year with the Legal Aid Foundation in Los Angeles, The Los Angeles Legal Aid Foundation. They provide us with a lawyer, the lawyer is based at one of our clinic sites and it's a wonderful program.

We have flyers in our exam room and when we get the history of domestic violence or trying to get a restraining order or having trouble with their landlord we are able to say

we have this program for you and the families face lights up that there is somewhere they can turn to for this.

She will even go to court for them, so there are cases that she has actually gone to court for them. If it's something that she can't handle, they will refer them into the programs in LA county, Learning Right Center who will help with a school issue and some things like that so it's a wonderful program. It's sometimes a challenge to fund.

We're very fortunate that LAFLA has picked up the funding for this for the last year and I'm hoping they'll continue to do that. We have an Americore volunteer that coordinates that program, so that's a nice tie in through the Episcopal church it has a different name, that young woman has worked with us to be the coordinator for that program.

**DAN HAWKINS:** I was just going to add one thing, that the medial/legal partnership is something interestingly that come out of some of the same people - and I saw Elisa that you have a Reach Out and Read Program also—

**ELISA NICHOLAS:** Oh yes he started Reach Out and Read also.

**DAN HAWKINS:** Out of Boston Medical Center is really where the idea came probably less than 10 years ago. We don't know how many health centers have a medical/legal partnership, an MLP program, I'd estimate though it's somewhere around 75 to

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100. It is a great program for all the reasons that Elisa mentioned.

**KATE NEUHAUSEN:** Hello I'm Kate Neuhausen I'm a family physician and a Robert Wood Johnson Clinical Scholar. I've a follow-up question for Laurie and then I'd also like to hear Dan's thoughts—anyone else on the panel. Laurie, you had mentioned that many states were thinking about Medicaid ACO's and passing legislation and the community health centers were thinking about ways to get involved in these new payment models.

So I'm interested in your all's thoughts on what kind of role you see community health centers playing in delivery system reform and payment reform and how new models like Shared Savings and the ACO's might interact with the PPS cost-based reimbursement rate.

**LAURIE FELLAND:** I'll start. I think it's a very good question. Health centers I think are definitely interested and I've heard some directors say well they're already used to working obviously in a managed care environment, they're used to having a bit of a bundled payment, they have encountered base payments and so I think they feel that that is certainly a direction to go in.

They're seeing a lot of Medicaid patients, they're already working with safety net hospitals in their communities

so they feel they're already part of kind of an integrated delivery system, maybe it's not formal.

It is a good question as far as how then, would that affect their payment rates as they currently stand and I think it's important from a health center's perspective acknowledge the other services that they're providing. What about dental, what about specialty care, is that going to be part of some sort of global budget?

So I think that's a concern and that's something that they want to make sure is incorporated so that they're not losing out on a potential change there and that patients are getting those services whether they're at the health centers or part of somewhere else in the system.

**DAN HAWKINS:** What I can tell you is that the level of interests and concern for where the healthcare system is moving through the structure of integrated care, I said two years ago within months after the passage of the Affordable Care Act that ACO's were at that point, I considered them the hula hoop of health reform.

A fad that's here today and not will be gone tomorrow, what I do think the future of healthcare is, is vertically and horizontally in integrated healthcare systems providing a better healthcare experience and a more appropriate—I have to use the term patient focused, but person focused care as the future goes forward.

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In that context health centers have been highly interested in being part that development locally, I think what's happening is it is happening locally. We provide some technical assistance and response to queries and support and guidance and some training, my organization does, for health centers that want to consider either forming, that's almost been non-existent or participating in ACO's.

Keep in mind Laurie mentioned that health center patient population, the under-represented group is seniors. There are only 8-perncet of health center patients as opposed to any other demographic; low-income, minority, rural, et cetera uninsured Medicaid population.

All of those demographics health centers are disproportionately higher on, seniors they're lower on for reasons it's not easy to explain. Although the fastest growing age group of health center patients today are 45 to 64 year olds and we think they're going to age into Medicare as a health center patient and stay there.

Nevertheless with so few Medicare patients, a lot of what I'm hearing from health center folks is that they approach the hospitals who are the main drivers of ACO developments and find that the hospitals are less interested because they themselves, the health centers don't have that many Medicare patients. When it broadens to included privately insured and especially Medicaid patients you will see a much greater degree

of developments of participation and integrated care systems among health centers than I think we're seeing right now.

I want to say one other thing, it's really not about their payment system, they're on a perspective payment system which is limited already. In fact for the typical health center today, what's called their Medicaid PPS rate is about 80-percetn of costs. So it's not really—it started out as cost-based in 1990 but since 2000 it's been this perspective payment system that is slowly going this way even though health center costs per patient, per patient visit are rising at less than five-percent a year. The PPS is rising at two to three-percent.

It's really about risk. Health centers are safety net providers, the majority of whose patients are poor who have no margin really. Some might say they have a grant mentality, Henry would you say that? I don't think so. I think it's not a grant mentality, a dependence kind of mentality but it's a we're there for our community and we cannot engage in the kind of risky behavior that could drive us out of business, we don't have the resources to do that. That is the big unanswered question at this point in terms of where is the future of healthcare.

Health centers want to be part of integrated care, they all participate in managed care organizations hugely, but I think this notion of ACO they're not really certain of how it's

going to shake out. So they're holding their fire for the time being.

**ED HOWARD:** Maybe we could get some comment from our respective community health center folks about—and Elisa you talked a little bit about preparations for the ACA. What about the payment arrangements, what about arrangements with private insurers or for that matter the Medicaid ACO's that are starting to evolve as Dan said?

**ELISA NICHOLAS:** We haven't moved forward tremendously with the ACO, we have been partnering with our largest local hospital but it's a challenge. I think as Dan said, we want to kind of wait and we want to make sure that we have kind of an equal partnership and it's challenging when you're working with a hospital.

Our hospital's wonderful, they are our partner in many efforts but they have a very large infrastructure and a level of expertise and how to be strong when you're working with someone who is so powerful is a challenge. So we're being cautious about it.

**STEVE SHATTLS:** I think it's the same in our case, the hospitals have the Medicare population, the ACO's seem to be focusing on those individuals in the insured. Like I said earlier we are on the edge, the majority of our revenue sources are from the Medicaid program that's why our health centers in West Virginia have focused on in the past year, trying to

develop something that we can have some control on with a managed care organization that we have ownership in. So we're are steering clear of it but keeping our eye on it, we have not engaged at this point and time.

**ELISA NICHOLAS:** I just want to add one thing, I think what I'm hearing now is the hospitals talking about population health which I didn't hear before. I've been on the staff of the hospital for many years, I was Chief of Staff for four years at the Children's Hospital so I was engaged in their discussions.

They are coming around to what our view is about treating the whole patient in the context of the community, keeping them out of the hospital, making sure they're healthy so there's a discourse that has changed in the world of hospitals and healthcare. I think the community health centers have a lot to offer in that respect and I think we need to be at the table and try to advocate for those efforts and not have it taken over because many of us have been doing those efforts for these populations for a very long time and doing it very well.

**HENRY TAYLOR:** Our experience in slightly different in a university based system. We're beginning to learn more about ACO's, we have put through requests at the state level for ACO not only for Medicare but three's also Medicaid ACO in the state of Illinois, that contract is being deployed.

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From our lens at the University of Illinois one of the things we believe in that we think can be very beneficial is to put the patient in the most cost-effective environment where we can deploy care close to their environment, close in their neighborhood and do a good job, an outstanding job in delivering care in the community.

Then when the patient needs that hi-tech care; something very expensive, something very unique that care can be deployed at a university setting more appropriately. But clearly right now our discussions are slightly different; how do we proliferate more in terms of community, how do we ensure that patients are getting good quality population-based managed care in their community is part of our focus today.

But as Dan described we have been cautious, we are watching and learning as things move forward but we'll see how the tea leaves shake out in the time to come.

**BOB GRISS:** Bob Griss with the Institute of Social Medicine and Community Health. I'd like to pick up on the point that Elisa made that the community health centers are really in the forefront of some of the transformations in our health system. Including things like consumer-driven, many of us wished we were in healthcare systems that had a majority of consumers on the Board of Directors.

I'm wondering to what extend you are in a position to influence the standards of care for some of the preventative

services, the structures for accountability in healthcare delivery at a community level so that like you San Francisco study showed, if quality of care is actually superior in the community health center compared to solo docs in primary care?

Can those lessons really be used and benefit the whole community? Are some states actually using community health centers in a more generic way so that they have more middle-class folks at the community health center and that it not remain a safety net institution?

**DAN HAWKINS:** I guess that's me, and thank you Bob. There are places and actually Laurie could probably speak to at least a couple where health centers do play a more significant role than they normally play in the local healthcare system because of their volume and size and the respect that they have, but that's not everywhere Bob.

I think the extent to which health centers will be able to influence the development of both administrative and public policy around healthcare quality, healthcare organization and structure and effective healthcare delivery is going to vary community across communities based on their presence there.

Now I think with the resources that are in the Affordable Care Act, if those resources remain available and are deployed to expand care in communities across the country and hopefully rectify some of the imbalances that Laurie talked

about, the health centers will be—when they get to 40 million people, they will be a more significant presence.

I think they're dedication to quality improvements which has I think, if anything, even since the health disparities collaboratives only strengthened, only gotten more—I hate to say this Elisa but fervent on population health and quality improvements.

Nothing's perfect and health centers aren't perfect, we've got a ways to go to improve but they can be a driving force. If you will Bob, for lack of a better term, a morale force for healthcare quality that is focused on the individual and their well-being first and foremost. I remain hopefully, not convinced and not certain by any stretch, but I remain hopeful that that can happen. It won't be for lack of trying.

**LAURIE FELLAND:** I would just add that I think it will be interesting to watch what the subsidized population in the exchanges, people up to 400-percent of poverty getting subsidized coverage, it'll be private coverage and to see to what extent they are relying on health centers for their care.

I think that's an open question; will subsidized coverage and payment rates be very similar to Medicaid or will they be more similar to private coverage and that will affect the ability for people in those plans to see private physicians?

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Certainly in Massachusetts health centers play a big role in their key providers of people who are covered by the subsidized product in Massachusetts Commonwealth Care and so I think if that is any indication of what happens elsewhere, I think health centers will start to see people at a slightly higher income level.

**HENRY TAYLOR:** But I also wanted to take a few minutes just to shift the thinking just ever so slightly. When you speak of quality I think it's important to note that health centers that care for the poorest of the poor and the sickest of the sick. So when you think of the health outcomes that health centers have moved towards and you've seen the outcomes that were done by Stanford, that's no small measure.

I don't think people grasp Susie Jones who's homeless and that homeless person getting good healthcare and moving them into health is not like you're taking an average population individual who has access to good care, access to good transportation, access to good resources. You're taking a most vulnerable population, you're committing to changing the quality of their health.

I'm very proud to say and I'm very proud that there are studies that show not that I have to say it, the studies that show that health centers have in fact improved care for the population. Not average America but those Americans who have

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least of which we have today, that's enormous and it's often understated and I just wanted to say that today.

**ED HOWARD:** Helen has a couple more questions. Let me just say as we're getting to the last few minutes, a couple of things. One is, commercial we have a briefing on Friday and we're going to explore some related questions having to do with exchanges and their relationship with Medicaid in the post-Supreme Court decision era. Second, I want to remind you we have the slide up there now so you can't escape our desire to have you guide us by filling out the evaluation form in your packets as you listen to the last few questions.

**HELEN BRYSON:** So I know we're running really short on time so if we don't get to all of your questions the panelists will be around for a few minutes so please step up, say hello and ask your question.

These sets of questions deal with care coordination, we continue to talk about gaps in care and collaboration. We've talked about oral health or dental health and we've talked about behavioral health but can we also talk about the lack of vision and eye care services in community healthcare centers and how we're addressing those?

We know that there's some resulting or some contributing factors to health, can we talk about programs such as tobacco cessation? Then as far as collaboration, what's the role of—and I think Elisa you touched on this just a bit,

religion or faith-based organizations and how are we using those in our community healthcare centers? In 2007 HERSA urged FQHC's to engage in emergency planning act ivies with hospitals and other local providers. So can we touch on all of those?

**ED HOWARD:** We do all of those things.

**HELEN BRYSON:** I knew this panel could do it.

**ED HOWARD:** Steve's got stuff.

**STEVE SHATTLS:** I'd just like to talk about the eye care and vision. We've convinced an ophthalmologist in our community to take our sliding fee scale so we refer all the patients regardless of their ability to pay and he uses our sliding fee scale. So I think that's an important thing, you just don't know what might happen if you reach out and talk to folks in your community.

Sort of piggy-backing on that, in the Tri-State Huntington, Ashland and Ireton, Ohio, Ashland Kentucky area we deliver more babies, we provide more prenatal care than any other provider. So when you're talking about mainstream we are the provider of choice, our providers run labor and delivery, they're on the important committees in the hospital so we have achieved some of the things that you were talking about earlier in your question.

**ELISA NICHOLAS:** We have an ophthalmologist actually that we pay at our site and they see the diabetics for their retinal exams and the uninsured patients. The ones on Medicare

Managed Care all have optometry as part of their plan and they have ophthalmology if needed. As far as collaboration and community-based approach, my mantra is compliment not duplicate so whatever someone else can do I don't think there's enough resources for us to try to duplicate what others are capable of doing or doing well.

We also have several place-based initiatives for health, one for 0 to 5 through our First Five L.A. and then one through the California Endowment where many non-profits are working together to create solutions for our families especially low-income communities.

**HENRY TAYLOR:** From an optometric perspective, in the state of Illinois eye care is not paid for under the state public aid program. However as an institution as Miles Greer looks at our commitment to managing population-based care we have to provide that service so we do provide that service to both our adults and children. It's one a day a week so we do provide that care and they also get their glasses.

So if you look at how you position your organization to base and managed population-based care there are certain things that a patient must have access to so we ensure those things are covered through our own resources from the little revenue we make throughout the year. So that's how we respond to that issue.

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With regards to—some of the best community health centers I've seen in the nation, in fact some are faith-based and one down the street from me is [inaudible], very much faith-based so we're pleased that they exist and we partner with [inaudible] as well.

I think what Elisa said also, we don't want to duplicate things are already done very well in your community. One of the biggest needs we have right now is addiction care and one of the big issues we struggle with is how to manage addict care in the community. Although we partner, our needs are much greater than what we're able to deal with today to be very honest.

**ELISA NICHOLAS:** I think we're all shaking our head yes and we're just starting to partner with addiction care people in Long Beach and actually participating in some grants with them.

**HELEN BRYSON:** We know that we have the ruling from the recent Supreme Court decision and Dan, this question is actually for you. Can you give us your thoughts on states deciding whether to opt in and out of Medicaid and how does that impact other grant opportunities, whether it's the National Health Service Corps or other discretionary programs?

**DAN HAWKINS:** Sure, thank you Helen. It's timely you should ask that question because Friday the Ryan Community Health Foundation, through the Geiger Gibson Program at George

Washington University released its latest report. The report was focused on the impact that state-based decisions on whether or not to expand Medicaid will affect the ability of health centers in those states to serve not only those who would gain Medicaid but those who will remain uninsured, those who will be insured through the exchanges whether it's state operated or federally operated exchange.

That report which I thought was very well done, concluded that the difference—I talked earlier about health centers doubling in size over the next few years to 40 million people, one of the factors that will determine whether health centers get to 40 million or not will be this Medicaid Expansion.

If it doesn't happen, the difference is like five million people nationally in the proportion of folks, or the number of folks that health centers will be able to serve. Why? Because it's a matter of volume. Henry, Elisa, Steve can all tell you—and I from my own experience running a health center years ago, that when you bring in an additional provider, that next marginal provider you've got to have a patient population to serve them.

If you've only got grant funds and other support to care for uninsured people, you only have the capacity to grow at a certain level. If more folks come in who have third-party

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coverage and in particular Medicaid because it's PPS rate gets closest to cost, then health centers can grow that much more.

So the difference, even in the 10 states that have indicated that they're not going to expand Medicaid thus far, the difference is more than a million and a half people. So health centers, both because of their historic mission, purpose and focus and because they understand it's going to crucial to their own viability going forward are going to be I know, very, very actively engaged in working to convince their states that it is the right to do to expand the Medicaid Program.

And to help people most importantly, in their communities to learn about and enroll in either Medicaid or exchange coverage for which they qualify. That is going to be a crucially important test of whether we go forward as a healthcare system in this country or not.

**ED HOWARD:** According to a panel we ran at the Press Club last week with a bunch of experts ranging from Alan Weil at the State Health Policy Center to Michael Cannon from CATO, I think the general consensus was that you shouldn't put too much stock on the initial reactions that you're reading from state legislators and governors.

Let's take stock after the elections and see how that works out. Someone reminded us that it took a number of years for all that states to join doing Medicaid in the first place

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so if you're involved in advocacy you shouldn't give up on November 7th.

So we have come to end of our time, I want to thank you for staying with us and remind you that there are, thanks to the Centene Corporation's Healthy Nutrition Program, bagged lunches for you to take with you to eat wherever you can.

Also thanks to Centene for being involved in the planning and execution and leadership in this program. I want to ask you to help me thank our panel for what I think has been a very illuminating discussion on a very useful topic [applause].

[END RECORDING]

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