



**Health Centers at the Launch of the Coverage
Expansion**

The Commonwealth Fund

Alliance for Health Reform

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ED HOWARD: Good afternoon, my name is Ed Howard, I am with the Alliance for Health Reform and on behalf of Senator Rockefeller, Senator Blunt, our Board of Directors, I want to welcome you to today's program on how well prepared federally qualified health centers – FQHC's are for major health system changes that are afoot. And by the way, FQHC is one of those essential – it's not an acronym actually, it's a collection of letters, but whatever it is, you have to know what it means to be able to negotiate the next hour and 45 minutes.

Now, I am informed reliably that there are some differences between Democrats and Republicans on health policy issues. Melinda told me this. But there is a rare area of agreement that FQHC serves a vital purpose in getting access to primary care and more to the 20 million or so Americans every year. Now, President George W. Bush moved to double the number of centers during his tenure in office. Congress added funds for those centers in both the Affordable Care Act and the stimulus package in addition to the regular appropriations under the statutes governing the centers. And now we have the coverage expansion underway that is bringing new customers, new challenges to these federally qualified centers. They face fiscal and physical uncertainties and the health of some of the most vulnerable people in the country depend on how those uncertainties are resolved.

Now, today we are going to take a close look at the experiences of two exemplary FQHC's and take a broader look at the issues facing all of them. Now, you can infer, I think correctly from their titles, that Federal Health Policy Decisions will have substantial impact in how well these challenges get met. We are very pleased to have as our partner today, the Commonwealth Fund, nearly a century old philanthropy established originally in New York and now a strong Washington presence to promote the common wheel, the common good and we are doubly pleased to have as co-moderator from the Fund, Melinda Abrams, who is the Vice President in charge of their program on healthcare delivery system reform. She is also coincidentally and fortunately a nationally known expert in this field and by the way, a leader in putting together the new survey by the Fund of FQHC's that is being released today and you have material about that. I welcome Melinda back to the chair here and we are looking forward to having you help to frame the issues for us today and tell us a bit about the results of the new survey – Melinda?

MELINDA ABRAMS: Great, thank you very much, Ed and thanks to the Alliance and all of you for being here today. So as Ed mentioned, just by kind of quick background and there are other people on this panel who could also provide this breadth of perspective, but just wanted to kind of remind everyone that the nation's community health centers play a critical role in our primary care safety net, as our primary care safety net in the United States. And as of 2012 there were about 1200 federally qualified health centers serving more than 21 million patients through 8500 sites. And so the majority of their patients are uninsured or publicly insured and when you look at them, more than 84% of their patients earn under 200% of poverty. So again, really treating kind of our low income and middle income patient population. The Affordable Care Act, as Ed

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mentioned, has the potential to increase demand for our nation's FQHC's because of the major coverage [unintelligible] target low and middle income Americans.

So the Commonwealth Fund conducted a survey in the summer and fall of 2013 and it is a survey of FQHC leaders. Primarily completed by either executive directors or chief medical officers and it asked them about – kind of their views. And their views on what they perceive to be some of the challenges in 2014 with the new coverage provisions taking effect. It did also ask them to report on current shortages. It also asked them about a number of other questions about their current capacity. So what we are releasing today is two briefs from this national survey. We had about a 60% response rate. We asked the universe and we got 60% response back, to report on, again, their capacity both in terms of kind of their technology, but also in terms of the personnel. So just quickly, just saying that when we asked these health center leaders about what they perceived to be some of the challenges in 2014, a number of them are concerned about physician shortages. An overwhelming majority, as you can see. But it's not just on the physician side, it's also with nurse practitioners and physician assistants. Again, just to be clear, this is their perceived concerned. This was last summer. So it's not saying that as of right now that these are shortages, this is kind of what keeps them up at night. I think that is the way to think about it. But when we did ask them, well, tell us about budgeted positions where there are vacancies. So positions that you have budgets for that you are trying to fill. A majority of them do report that there are shortages of primary care physicians and nurse practitioners and physician assistants. So they are reporting current shortages. A couple of things about that. They also report shortages of mental health providers as well as bilingual personnel. The Commonwealth Fund did this survey in 2013, but we also did a survey – a very similar national survey in 2009 and as many of you may know, if you follow the health center issues, that clinician shortages is a long standing concern. This is not a new problem and when we compared it to 2009, it's relatively consistent. So this is just something to note. So yes, there are shortages, but it's not necessarily worse, so take that for what it's worth.

In light of the anticipated influx of new patients as a result of the Affordable Care Act and in light of the concerns about personnel shortages, FQHC's are actively working on ways to prepare for new patients. As you can see here, whether it's hiring and training staff to apply for health insurance coverage, more than half of them are working on integrating behavioral health. Many are also working, more than a third or about a third, are working on hiring new clinical staff. So yes, there are these concerns, but they are actively working on trying to address them.

So as I said, in addition to kind of the personnel issues and capacity, we also asked these health center leaders to report on their capacity in terms of information technology. What we found was that we saw more in terms of the adoption of electronic health records – we saw a huge increase, tremendous increase, more than double, where it was 49% of health centers reported that they had an EHR in place in 2009. It's up to 93% in 2013. And it's not just about having the wires and the hardware in their sites, but actually about using

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them. And so we also asked about their functionality. Everything from kind of tracking lab results, preventive care reminders, alerts if there is going to be a medication interaction. A number of things. Whether or not you can sort patients by condition or medication and things like that. We have 13 – and of the percent of FQHC's that have advanced capacity, as you can see here, is also an incredible increase from what we saw in 2009 – from 30% to 85%.

Now, that is not to say that this was easy. As any of you know who look at information technology adoption in healthcare and you look at whether its office based practices or federally qualified health centers, but this was a survey of federally qualified health centers. A lot of them talked about challenges such as the training of the staff, lost productivity, the costs of maintaining the system and the usefulness of some of these templates to manage the entire population. Either they are not just the population of empanelled patients, but also kind of across the community. So there are certainly challenges.

What we don't have, which I just wanted to kind of give you a quick preview to, what we don't have in the briefs that are being released today, but future data that will come out from this survey, is that while we see that there is this perception and view and concern about their personnel capacity and ability to kind of retain their staff, when we also asked them about ability to provide access, same day or next day, we actually found that there was pretty good access. And this is again, just reporting what you currently can offer your patients. So 62% of our health centers said that they can usually – the patients can receive telephone advice after hours. Over half can receive care – can receive an appointment either same day or next day. And 22% can easily obtain specialist procedures for their Medicaid patients. So there is definitely some work to do, continues to be an ongoing issue around access to specialty care.

So what does all of this mean and why do we see this tremendous increase on the information technology and what is all of this in terms of the personnel issues that we found? Again, I want people to walk away with a sense that health centers are a critical part of the safety net. We do expect them to see more patients and they will continue to need help to attract primary care providers and other clinical personnel to those centers. And that it's maybe partially about the kind of personnel, but it's also maybe about new models of care, that a lot of them are working on. Such as expanding telehealth and telemonitoring as well – so that is another way of expanding their capacity and working in teams such as we find with patients at our medical homes or with health homes.

Another piece and Leighton will get into this in a minute is that the trust fund, which is the health center trust fund is 11 billion dollars and the Affordable Care Act to support FQHC's in anticipation of their increased demand, is set to expire in 2015. We just need to ask ourselves whether or not there is adequate support, continued support for health centers and whether or not they have adequate stability to continue to meet the needs of

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new patients and expanded patients, because they will also continue to see the remaining uninsured.

The integration with behavioral health is critical because such a large proportion of their patient population have mental health and substance abuse issues and a lot of this is being addressed through the health home provision of the Affordable Care Act and maybe kind of considering – and how important that provision is and that program is for the states that have taken that on.

I think the other thing is, no question, the adoption of HID is quite impressive and I think it shows that the value of kind of the targeted federal funding, as well as the financial incentives that have been focused on community health centers, have really made a difference. But there are still gaps. These gaps are not exclusive to FQHC's, but the gaps really are about interoperability from within the center to those outside of the center, as well as also patient access. Patient portals, patient access to their records. So there is still more work to do.

So these are just conclusions and implications from our survey, but our panel today is actually going to be talking about a broader range of issues, I'm really excited to hear them. And these will be some of the questions for us to kind of – for them to consider and for them to answer in terms of projecting what they see as some of the impact of projecting coverage expansions and how the federal investments have affected their operations, challenges they see moving forward and what can federal officials do to make it easier for them to fulfill their missions and successfully meet the needs of their patients.

I did not do this alone and I would like to really recognize my colleagues at the Commonwealth Fund who helped analyze and write these briefs, but also an external technical expert panel who provided invaluable guidance to the Commonwealth Fund as we developed the survey. So Ed, I will pass it back to you.

ED HOWARD: Okay, thanks very much, Melinda. Just a little bit of housekeeping before we get to our speakers. There are, as there always are, a treasure trove – I guess it is a treasure trove of materials in your packets on this subject including a list of some things that aren't in your packets but if you go online to allhealth.org, you can hit the link to get to each of those that are on that list. There are biographical sketches of each of our speakers that will provide you more background on exactly who they are. There will be a video recording of this briefing available on the Alliance website at allhealth.org in a couple of days and a couple of days after that, a transcript that will allow you to peruse every word that you have heard. The kits also contain a card, a green card, that you can use to write a question on at the appropriate time and there are microphones where you can go to voice your question at the appropriate time. And a blue evaluation form that we, as always, would be delighted if you would take the time to fill out so that we can improve these briefings and respond to the needs that you have for briefings on topics and speakers that will serve your purposes. If you are tweeting and we would encourage

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you to tweet, the #healthcenters will do it for you. With that, I think we can get to the program.

We are going to start, if we can, with Leighton Ku, if I can find him on the panel. He is a professor at George Washington University, he directs the Center for Health Policy Research there. He is one of the countries leading experts in among other things, coverage for vulnerable populations and Medicaid and the healthcare safety net, all of which will serve him well in mastering and conveying to you information on the topic at hand today. And today we have asked him to identify some of the major issues facing FQHCs in this time of rapid expansion of lower income Americans with coverage and also share with you and us some of the insights from his examination of what has been happening in Massachusetts with health centers since its expansion of coverage in 2006. Leighton, welcome back, happy to have you with us.

LEIGHTON KU: Thank you very much. Thanks to the Alliance and the Commonwealth Fund for having me. I realize the title, Critical Issues Facing Community sounds a little dire. It occurs to me that my feeling has been about community health centers for a long time, is sort of like in the TV show MacGyver or maybe 24 is the correct analogue today, you know, you find yourself in a pit with alligators and you think, this is the end. And then somehow the hero pulls out a ballpoint pen and some bubble gum and maybe there is a friend who manages to figure out a way to escape and save the day and in the end, I'm often impressed the community health centers are amazingly resourceful and ingenious and through good leadership, manage to make what seems like a dire situation into a happy ending. So certainly that is what I hope.

Let me start. What I'm going to talk about today is a few points mentioned the insurance expansions, we know are leading to an increase in the demand for primary care services at the release by the newly insured and that health centers play a central role in filling that need and at the same time, they continue to serve the uninsured. Another thing that is important is that this is a good thing because health centers can help reduce medical expenditures. There are some areas where things are still a little unclear, so whether there are relationships between health centers and the new health insurance exchanges is still a little murky. Medicaid expansions help health centers and will help them expand their capacity, but as Melinda mentioned just a moment ago, there are some worries about a potential funding cliff after 2015.

So this is a slide that shows what happened in Massachusetts before and after Chapter 58, which is it's big health insurance reform and of course much of the federal reform was designed to emulate what happened in Massachusetts. So what we see is after that time. Massachusetts health centers have served another 200,000 people, so really sort of stepped up to take on capacity. In addition, during that time, the percentage of patients who were insured at health centers fell from around 36% to around 20%. Now, they are still serving a lot of uninsured patients. The uninsurance rate in Massachusetts is around 4%, so it's still serving a disproportionate share of the uninsured. But the fact that

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there was growth in Medicaid, there was growth in that yellow patch which is called Commonwealth Care, which was sort of the analogue to the health insurance exchanges, really led to the ability for health centers to expand capacity and to fill in the slack. So not only were they commonly called safety net providers, they were also a safety valve for the system.

Now, one of the reasons that we think that this is a good thing is because health centers, to the extent that they are providing good quality primary care to people who otherwise would have difficulty getting that, the evidence suggests that they actually save money. So this was a study that we did that basically looked at, what were the annual medical expenditures for people who went to community health centers, versus those who did not? And what we found is that actually, total medical expenditures – so this is hospital expenditures, ER expenditures, total ambulatory care expenditures, drug expenditures, were about one quarter less for people who went to health centers, suggesting that they can have a profound effect in helping to bend the cost curve down by providing better primary care to people who otherwise just wouldn't get it.

So one of the new landmark parts of the Affordable Care Act are the creation of the health insurance exchanges and as well as the Medicaid expansions. Health centers have been dealing with Medicaid for a long time. The health insurance exchange is still sort of a new relationship. Under the Affordable Care Act, qualified health plans are those insurance plans that operate under the exchanges, must contract with some quote, unquote “essential community providers” and CHC’s are some of those essential community providers. It doesn’t say how many exactly. In addition, there is some flexibility in negotiating what the payment rates are for the community health centers. It’s still not completely clear how many health centers have obtained contracts with qualified health plans, therefore let them serve the patients of those – of the health centers and in addition to that, at least the anecdotal information suggests that the payment rates are often low and well below the rates that they expected to get, which are equivalent to the sorts of payment rates in Medicaid, which are actually pretty good for health centers. One of the things that these leaves is an additional problem that in many cases, many of the new insurance plans that patients have, have relatively high deductibles. So health centers still will subsidize care and offer a sliding fee scale for people. What this means is that essentially speaking, they may have a privately insured patient, but they still have to underwrite the care and effectively, from the perspective of health center, it’s like this person is uncompensated care patient. So they are still bearing uncompensated care cost, regardless of the fact that now they have a patient who is insured.

To talk a little about health center financing and of course on one hand, this may put some people to sleep, on the other hand, money is always a popular topic in Washington, I know that. So health centers are funded by what is called Section 330 of the public health service act. And they are the core funding for health center funding. However, health centers get funding from a variety of sources of which Medicaid is the largest source. The two work together and actually act synergistically to improve the capacity of

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health centers to improve their capacity to serve uninsured and low income patients. The Section 330 funds, the core grant funds, fund infrastructure, they help directly support care for the uninsured, but they also help fill in gaps that are left by insurance payments that are not adequate. And so most insurance payments at health centers are less than the actual cost of providing care; partly because health centers provide a relatively rich set of packages including social services, enhanced services, to help their needy patients. So the grants end up supporting both the insured and the uninsured patients. Now, what has happened in the Affordable Care Act is that it was anticipated there would be a need to build up the infrastructure of community health centers to serve patients who are low income patients in areas that were underserved across the country. So it built in mandatory funds under a trust fund to supplement the regular appropriations. However, those trust funds expire at the end of 2015. What this means is there is a funding cliff that will begin in 2016 and if the Section 330 appropriations aren't¹ increased to compensate for the loss of the mandatory funds, there could be some serious issues and we will talk about that in a moment. And then I know Michelle Proser will also talk a little about this.

So Medicaid expansions play a big role here, Medicaid expansions will add revenue and by doing this, help the health centers not only serve for Medicaid patients, but also more uninsured patients, more Medicare patients, more exchange patients. So one of the net effects is that in addition to this, this is where things work together. About half the states are expanding Medicaid; about half the states are not. If more states expanded Medicaid, health centers would be able to serve more patients, particularly the patients in the states that are currently not expanding them.

So this is from some analysis that some colleagues of mine did just recently that looked at the 2012 case loads in Medicaid and found that of people who are currently being served as uninsured patients in Medicaid, about 2.3 million of them appear to be eligible in the opt out states. That is the states that aren't expanding Medicaid, about 2.9 million are eligible for either Medicaid or the health insurance exchanges and the states that are expanding Medicaid. The thing that is really important to note is that black section. So there are 1.1 million people who would be eligible if the state had expanded Medicaid to the 133% of poverty level. If the state does not expand Medicaid, these 1.1 million people will remain uninsured, they will remain, therefore uncompensated care patients for the health centers and in addition, they are going to have the problems getting specialty care that Melinda was just talking about in her prior presentation. The others will be eligible for either the premium subsidies under the Affordable Care Act for the exchanges – many of them will get health insurance coverage. They are not all going to get covered and on the expansion states, again all of those 2.9 million will be eligible for either the health insurance exchange subsidies or Medicaid, once again maybe not all of them will get coverage, but at least there is the potential for them to get into coverage.

So where I'm going to wrap up is talking about what we think this has in terms of implications for our ability to serve people. As Melinda mentioned in the last official data that we have available, there are about 21 million patients being served at health centers

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in 2012. So what this graph shows is a comparison, so the reason there are the stack bars is the blue bars are the states that we think are expanding Medicaid. The yellow or the green bars are the states – the patients in the states that we don't think are expanding Medicaid. Our current projection is that based on funding for 2014, the number of patients that can be served is more like, over 25 million. So in fact, we will be able to pick up around four million additional patients in health centers, so that will really go a long way in serving the primary care needs of newly insured people and again, out there are a lot of people who are already insured that have problems getting access simply because they live in remote or underserved areas. If the grant funding level is low, that is, if the appropriations do not compensate for the loss of the mandatory funds or the VACA, these case loads could plummet. So the third bar says that in 2020 we would expect around 20 million patients could be served. That is, we lose about – more than five million patients, getting close to six million patients who were served this year, would not have services, would not be able to get care in 2020. Actually, it occurs before that, we just drew our projections out to 2020 because of the low grant levels. If on the other hand, grant funding continues to grow, not necessarily as rapidly as it has just recently, but still maintaining a modest growth rate after 2015, we can actually get to the point where health centers will be serving about 35 million patients, so it could really make a big dent in meeting the primary care needs of patients all across the country. The last two bars show what happens if the states that are not expanding Medicaid, expand Medicaid instead. So we find that that increases furthermore the capacity in those states, that a potential combined with the high grants, actually they could reach 36 million patients. So this would make a big difference, particularly in those states that are not expanding patients, to help meet the needs of Medicaid patients and the uninsured patients. So health centers can go a long way to meeting the primary care needs of the vulnerable low income patients. On the other hand, that is very much at risk if the mandatory funds are not replaced in some manner shape or form in 2016. Thanks.

ED HOWARD: Thank you Leighton. Before we hear from our next speaker, I neglected to mention that the briefing is being carried live on C-SPAN 3, so you can both tell your colleagues about it by email so that they can tune in, if you would and I would remind anyone who is watching on C-SPAN 3, that they can follow along including with the speaker slides by looking at them on allhealth.org's website, so that you can get a better sense of what is being presented right here.

Now, we are going to turn to a couple of folks who have an intense familiarity with the challenges and the chances to help that FQHC's present, because they run them. First we are going to hear from Vernita Todd, who is the CEO at the Heart City Health Center in Elkhart, Indiana. She knows her way around the world with non-profit organizations generally as well. She is a long time consultant to non-profits in a range of management issues and she faces many challenges at Heart City, including integrating the full range of services to a diverse and growing population and managing those new technology services that Melinda was talking about that are needed to operate effectively and deliver quality care and we are delighted that you could join us today, Vernita.

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VERNITA TODD: Well, thank you Ed and Alliance and Commonwealth for having me here. For you, for giving up your Friday afternoon. I guess if Leighton said that he is going to compare us to 24, I'm Jackie Bauer. We can get you access to healthcare, but if you are in a pit of alligators, you might be on your own. So just keep that in mind, we are not all things to all people.

So I am here today to share with you a little bit about comprehensive overview of community health centers and they gave me 600 seconds. So I'm going to do a little bit of a synopsis of the slides that you saw, certainly there will be time for questions afterwards. But hopefully, there will be enough substance in the slides so that when you go home and you are making those – or giving input to those all important funding and policy decisions, you will have something to look back on as we talk about today. So the presentation again, will get started.

They asked us to share a little bit about Heart City Health Center. We are in Elkhart, Indiana, a population of about 51,000. Our health center sees a little more than 10,000 people a year, which is not very much when you are considering my colleague Brooks down the road, but represents 20% of our city's population. So we are safety net provider serving a large group of friends within the Elkhart community. And we have the requisite medical, dental, behavioral health and an onsite pharmacy, which is a great benefit for our patients. We are more than excited to announce that we are opening a second clinic on June 3rd that we were able to do thanks in part by a grant during the Affordable Care Act, a new access point. So 3500 additional Elkhart residents will have access to a medical home coming June 3rd. I would note to you that since that press release went out to our community, we received 15-20 calls a day from people who are trying to get access and who need care and this is before we asked the hospitals to open the gate, so we know that once they are referring folks, that that 3500 number will fill up pretty quickly. The slide indicates that 47% of low income families do not have access to a primary care provider and that low income is \$44,000 for a family of four or less.

A little bit about our patient population. I think it mirrors many of the slides that Melinda showed earlier. We do have a very large Medicaid population; over half of our patients we serve are on Medicaid. 77% fall at or below 100% of poverty and we serve a very diverse patient population. Elkhart, Indiana is one of the more diverse communities when it comes to Hispanic and Latino families. Largely due to the RV industry and the opportunity for work in that area. Elkhart got the dubious distinction in 2009 of having the highest unemployment rate in the country, prompting a visit from the President at the time. I'm happy to say that we have bounced back, but recovery looks different, jobs look different, most are part time. Many are victim to automation and so it doesn't look exactly like it did before and we are still having people have difficulties. The thing I would point out to you is 44% of our patients are kids under the age of 12. So while the need for access still exists for adults, what we are finding is we have a large patient population of children because there are very few Medicaid providers in our community.

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This slide needs to be updated. I'm so proud to announce that yesterday, Indiana Governor Mike Pence announced the expansion or a desire to expand access to low income families. Notice I didn't say he expanded Medicaid. He would probably be very happy with me for that. But he did expand access to low income families using what we have now, the Healthy Indiana Plan. They are actually calling it HIP 2.0. So while there are some financial obligations for the folks that are involved and not making it a free access to care like Medicaid is, we believe it's a great – or I believe after a quick review of something that was released yesterday, that it is a good compromise between fiscal responsibility and access to care for the families that are the most vulnerable. The plan calls for – if you are doing a basic plan, no actual monthly premium, but you have a co-pay on every service. Or the more robust plan which includes a monthly premium based on family size and income at a max level of \$25 a month. So will be interested to see how Indiana responds during the public comment period and hopefully be ready to provide care for those families starting January of 2015. What we know is that that increased access is going to – or the need and demand, is going to play some capacity challenges. I just mentioned we are the only safety net provider, many don't take Medicaid. The compensation rate is comparable with HIP so we could face that same issue with Medicaid.

So the heart of my presentation is a little bit about HIT, a primary care and the patient centered medical home. And what this slide shows you is the increased need for the primary care provider kind of to be the keeper of knowledge and data, as well as the person that helps the patient navigate through what can sometimes be a complex healthcare system. If you live in it, you understand it. If you just need to access it because you are sick, it can be a tough thing to understand. So while we are here, we implemented an electronic medical record to allow us to do this. To be able to not only guide the patients to the referrals that they needed, but to be able to bring together and reconcile the information so that somebody had a big picture of what was going on in that patient's life.

I would say our use of technology – we were one of the health centers in 2009 who had just started the HER or electronic health record implementation. We went from a practice management system in 2009 and in 2011 went live with the electronic medical record. What we learned quickly is it's not a Panacea; it's not that GE commercial where all the specialists are in the audience and they are screaming about this is what happened. When I say it's not a Panacea, it's a great system. It does help you. But with the lack of other providers having electronic medical records technology, it's a little antisocial. So we have information, but the information is not coming back to us. The other thing that I would tell any of my colleagues and all of you who are impacting policy, is that buying the system is just the first of 100 costs. Getting the hardware and the software is important. Getting it maintained and providing support, because let's face it, if on a paper record system, circle, circle, circle, go on. Circle, circle, circle, go on. On an EMR, if your computer goes down, it's a very different world. And yes, you may be able to go back to

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that circling an encounter on a paper, but then someone is responsible for going and putting all that information back into the electronic medical record so that we are still keeping that information.

I would also say that not many providers in our community have adopted yet. Our local hospital has and we are very fortunate to have built an interface with them. But there are three hospitals that patients utilize in our community.

Let me just say on this last slide, meaningful use of the EHR does not equate to better outcomes alone. This is a shared responsibility. We can certainly become more efficient and effective and have better information, but it is a partnership with the patient to equate to better outcomes, not simply an alert or the ability to function more effectively.

I won't share much on this slide, but it talks about meaningful use, which is some of the financial incentives that are available to all health providers who adopt an electronic medical record. And so there is more information on here. We are doing the Medicaid meaningful use, which is roughly 63.5 in incentives. What we found out though is, as Melinda mentioned about the recruiting shortage, that we do bring on new providers whose providers former work places have attested to some portion of meaningful use. So they don't come to us with the ability to generate the level of incentive for any new provider coming in.

Just a little bit about the money, because I know everybody cares about that. We were able to get about a \$55,000 grant from the federal government through HERSA for the implementation of a patient portal – excuse me, a patient management or tracking software. But if you look at the yellow line, that is the amount that we have invested in EHR since we started in 2009. \$861,000. So it's costly. We just need folks to know that going forward.

A little bit – it's not as easy as Wi-Fi, so that is self-explanatory. But the IT challenges, the biggest ones we face is personnel costs tend to be the highest for all health centers, but I can guarantee you they are not high because we have a bunch of IT experts on staff. Most of the folks that we utilize are part of our care teams. They are clinical related. So not having that expertise in-house makes it difficult for us to deal with the myriad of changes that occur, as well as to make sure the system is as robust as it can be so that we are always ready to move forward. The maintenance and support cost, if I have said that once, I have said it 30 times and so that is why it's on this slide again.

I will just end with just a couple of things about delivery system improvements using the EHR. We were very fortunate in July of 2012 to have received a level three patient centered medical home designation from the National Committee on Quality Assurance. We are darn proud of that because we had to work very hard to do it. But at the heart of it all, what it meant was, how were we better serving our patients? What are we doing that is making a difference, how are we a team? The medical community can create patients

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who are dependent, who believe they go in, you tell them what to do and they go home. Therefore if they don't get better, it's your fault. What we realized, it's a team concept and the patient is at the center of that. Meaning they have control over what happens. Some of things that we are talking about, improvement for our chronic disease patients, our understanding, you have to meet them where they are. And reasonable care plans that they have to have things that are accessible to them. I hear a lot about, reach out to your patients and do text messaging and all different ways to get a hold of them and our patients say, look, I have a limited amount of minutes and I'm not going to let you use those up reminding me about patient visits. So when you recognize, you've got to know your audience. You've got to know who you are dealing with. You have to be willing to meet them where they are, not where you want them to be. And so, these are some of the things that we are working on as far as delivery system.

My 600 seconds has been up, so I'm going to just end with these three slides that show that 8% of the patients are typically in this Kaiser triangle, considered multiple chronic conditions. Almost 20% of our patients have more than one chronic disease. So when you hear us say, health centers, our patients are sicker, this is what we are talking about. Think about it. An uninsured patient who finally accesses care has probably delayed going to see about it. And so by the time they do get to us, we are dealing with more complex disease states and things that folks need to do.

This is the comic relief that ends the presentation if it wasn't so serious. So when we adopted the PCMH, we thought it was simplistic. These seven steps, you do that and you will be a better provider, you will provide better care and this is what it actually looked like because every step generated 15 more steps and 15 more questions and things that we had to do. But being Jackie Bauer, we did it. And so I will just leave you with this, this is what our staff says to themselves and in our management meetings every day. This is why we exist. That one who has health has hope and one who has hope has everything. And we believe that is why community health centers make such a difference in communities that we serve. Thank you!

ED HOWARD: Excellent. Thanks very much, Vernita. Actually, she who has the clicker has everything. We are going to make it an instrument now in the hands of Brooks Miller who is the head of the Jordan Valley Community Health Center in Northeast Missouri. In fact, the only CEO the center has had in its 11 years of existence. Mr. Miller has 30 years of healthcare experience; he is using all of that as his center expands to meet the needs of the uninsured. Vernita mentioned that he does have a high volume of business in his center. So he is trying to meet the needs of the uninsured, of Medicaid beneficiaries, of other vulnerable groups in the Jordan Valley and he's trying to help us learn a little bit more about that. Brooks?

BROOKS MILLER: Thank you, Ed. I too appreciate the opportunity to be here today and appreciate the invitation from the Alliance to participate. As Ed had mentioned, I have 30 years experience as an executive director to the community health center and so

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when I was invited to attend this, they asked for me to summarize that within five minutes and touch on the high points of my career. Most of my staff would say that that is probably three minutes too long, but we will see what we can do. It's another interesting fact, my youngest son, Joseph, had the opportunity to do an internship out here with our national association and I commend the national association, they represent us very well out here in Washington DC and really do a great job. But at any rate, I had the opportunity to talk to Joe and I said, son, I have been invited to attend the Alliance for Health and do a presentation, sit on a panel. And he said, you know, I had the opportunity to go to something like that last year and he said, that is the real deal. And he quickly followed that up by, why did they ask you? So I tell you what, this might be the intermission time for you today. If you need to get up and step out, this could be it and Michelle would follow-up.

But it is a real opportunity and always a pleasure for me. It's been a wonderful career, I moved to Springfield, Missouri, and there is a little correction with that and that is in the Southwest corner of the State of Missouri, the Show Me state. When I first got to Springfield, we were a new start program. I had the ability to operate out of the backseat of my pickup truck and my checking account for the first three months and it shows you how barren we were to begin with. There was a lot of opposition to our program when we first established. We turned in three previous grant applications, none of which were refunded. The fourth one, however, was. When I got to Springfield, I felt like that our growth down there may be very limited, so I opened up our first healthcare clinic in a 4500 square foot strip mall of which I intended for 3000 to be medical administration and 1500 to be dental. Five years ago, we moved into the facility that is shown on your screen there. That particular building is 70,000 square foot. It provides a full array of services. We are very blessed, as Vernita had mentioned, primary care, behavioral health and oral health services out of that building. We also have a very dynamic WIC program that is operated through that center and it's the largest WIC program in the State of Missouri and it's done in conjunction with the Green County and Springfield Health Departments. And so we are really proud of that relationship and that affiliation. This building was a blighted factory when we bought it. It only had about a third of a roof, it was a tractor part distribution center. It was key to us because it sat centrally to the population that we chose to serve in the Springfield area. And so after five years, we had the opportunity to expand it once again – and let me get the clicker here – this year, we are in the process and on June 26th of this year, we will be expanding that piece of property or that clinic in particular. We will be relocating our family practice, urgent care, pain management, behavioral health into the building. In addition, we will be expanding somewhat our oral health program. Jordan Valley is unique in that we are somewhat divided evenly between oral health and primary care as far as patients go. And the reason for a large part of our success and growth has been because the emphasis we placed on oral health from the very beginning. Once completed, we will have a total of 120 medical exam rooms, 40 dental offices, we will have central sterilization located within that, we will have an expanded pharmacy and an expanded behavior health. In addition, what is unique I think to this particular – our particular program here, is that we do have our own surgery center

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where we do a significant amount of oral surgery on a daily basis. We also have a pediatric dental residency program that is operated in conjunction with Luther Medical Center out of New York. We are in our second year of that program and we will have eight residents rotating through our program indefinitely.

We also have a mobile program. We have five mobile units. We have three of these particular trucks, which are single exam rooms and optometry. In addition, we have two large vehicles where we operate our oral health programs from. We service 21 schools outside of Springfield. Springfield has a population of 250,000, I believe it is, but once you get out of the direct city into our five county service area, it becomes very rural. Access to care is very limited and so its – we have been able to develop this very robust program and it's worked out quite well for us. In addition to the schools we serve, you can see there that we also work with the county jails and nursing homes, which prevents a hardship for that.

I will also say that we have three satellite clinics. One came online in 2009. Hollister and Republic clinics will come on this year and are a part of the funding that we received through new access points. Each side of those will have four to eight medical exam rooms and four to eight dental rooms. Since moving into the new building, and that is the most accurate information I can provide with you, going back to 2009, you can see there the number of users within our program as well as the number of patient encounters generated. And then what we anticipate through the Affordable Care Act will transpire to additional users of our program as well as encounters. You can see we had a slight dip in 2013. In speaking to my staff, we have numerous excuses why that occurred. However, in fairness, we have had a significant transition of medical providers during the past year, which I think truly, get attributed to that as well as some service changes that we took into consideration for the year. So we do anticipate with the opening of the new building this year, we will be back on a growth rate as experienced in that chart.

This is an extremely important slide and I draw your attention to this and if I can figure this – this is where Jordan Valley is a little bit different. Our total grant income only makes up 9% of our budget and routinely across our programs, that is a small amount of funding and I'm very proud of that in one degree, but you can see that we have generated revenue here that is the blue cycle, which is predominantly Medicaid, which will be shown on the next slide. But one of the things that really does concern me is that when we talk about funding of health centers, it can't only be about the grant because there are – especially many of the new start programs that have just started up, it is the reimbursement methodology that many of us live on and develop our programs around. And so, we need to be consistent in our message that – how important the revenue stream is for our programs. Let me go real quickly to the next slide and show you that Medicaid for us is 60%. If we ever get into Medicaid expansion, this will go down and we anticipate by going onto the exchanges, this 12% is going to increase and that is where our additional revenue should come from. My concern with that and I caution you here about this, is to a degree, health centers are being pushed into a private sector model

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rather than a community health model. And I truly do believe that the focus or the treatment of disadvantaged patients is very different depending upon your social economic class. That is just a caution I have. Now, if I go back to this, one thing I want to show you is that our revenue is, on an annual basis, just short of 29 million dollars a year. So far we are privileged to be caring a 1.2% margin, which if you did the math, it is about \$347,000. While it's always good to be in the black, putting that into perspective, our two week payroll is about \$430,000 a year. So you can see that we operate on a very thin line and there are a lot of variables that impact us on a daily basis.

While we have not passed Medicaid expansion in the State of Missouri, we have been the beneficiary of a significant amount of resources that have come within our program throughout the state. We have also had in just the most recent application process, we have been awarded four new sites, so very positive things, expansion of services are taking place and that will bring us up to, I believe, 27 health centers throughout the state of Missouri.

Vernita touched on this; I won't take much time with it. Medical homes is something that we are working with. I'm not certain of Vernita's perspective. My concern with the medical home, I think it's an excellent philosophy for patient care. My concern is the expense related to it. I think it is particularly important for children to be within this model and that they have access to all these different support services. But once again, it is just – it is very labor intensive and very expensive and we have to be willing to make the investment if that is truly what we are interested in. Missouri was the first state that began participation with the medical home. Our state primary care association, Joe Purley serves as Director of that, is very aggressive and progressive. We leveraged one million dollars of our resources to obtain nine million dollars through the Affordable Care Act, to implement this program. Here is one little mistake, the IPA, which we just recently implemented, which stands for the Independent Practice Association, rather than Integrated. Even though Integrated is wrong, I can say its right, according to my son, because it's not only independent, but it builds on the medical home model, which is integrated. The wonderful thing about the IPA, it allows us to come together as health centers throughout the State of Missouri and contract for services with HMO's, health insurance programs and things of that nature, which are tremendously beneficial and right now we have 330,000 lives that are in that group of – within that system. And that is a for-profit company that has been established. You can see the challenges real quickly – workforce development, which we talked about today. The reimbursement models, which we have concerns about. Competition with the private sector, patient responsibility – we have talked about that. We can't sell that too short. Program accountability, if we are going to get the resources we do, we certainly need to be accountable for the increase that is expected. Most importantly, it is the uncertainty. As I said, Missouri has not expanded Medicaid at this time and our session, Congressional session concludes at 6:00 tonight, so we continue to make calls and to see if there is any changing of that and such. We don't anticipate it, but it's – it's really unfortunate that we are coming down to the last day to determine whether we are going to have expanded Medicaid or not. Why we do it all,

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just quite honestly, its right there. I have the benefit for my office to be able to walk down the hall and see why we put in the struggles that we do and such on a daily basis and everybody is a part of it. I think that that's important. Its not only work we do on the ground. None of that work would be possible without the work that you all do here. Our associations and such. We are very, very appreciative for that.

ED HOWARD: Thanks very much, Brooks. By the way, these last two folks have emphasized to me that they could probably have been part of the last two panels that we have put together at briefings and for one we have coming up. We did a session not long ago on the integration of behavioral health into primary care. Just on Monday with our colleagues at Commonwealth, we talked about the states that pursuing the third way of expanding coverage without that dreaded Medicaid word. And we have a session coming up on May 30th; I think it is looking at PCMH's, which seem to be very central to the way you folks think about what you are doing. So we must be doing something right and you may get another invitation. Now we are gonna turn to Michelle Proser who is the Director of Research for the National Association for Community Health Centers. Michelle has a decade's worth of experience doing research and analysis about CHCs and the people they serve. And in the process, offering up the results of that work to the communities directly affected so that they can improve their ability to serve. And the idea that you can actually use research is a wonderful advancement, it seems to me, and I want to thank you for that and thank you for being with us today.

MICHELLE PROSER: Thank you for having me, I'm pleased to be here. So I was asked to respond to a lot of the things you heard, especially from Brooks and Vernita and I think what you heard already is very consistent with what we are seeing at the national level. So hopefully I will be reinforcing a lot of those things. What I hope to show, some of the things you have already heard, but I would like to emphasize, that demand for health center care continues to increase, especially under the Affordable Care Act, but there are still a lot of unmet need out there that extends beyond insurance; people with new insurance cards who need a place to go. I want to echo how much the model actually works. It is designed to remove barriers and improve care outcomes and generate savings. And that health centers are a critical part of the healthcare safety net and will increasingly be so. But as you have heard from the other panelists, there are some capacity challenges. So I will also be talking about the support that is necessary to maintain, but also expand that capacity.

So starting with the challenges. As you have heard, there will be some increasing demand and that is going to shift the payer mix. We are going to be seeing more Medicaid patients, more patients in private insurance plans, especially through the exchanges. But also still a large number of uninsured and that actually does have an impact on revenue cycles too. So as you have heard from these folks and as I will talk about, maintaining funding streams is a critical challenge. Health centers have diverse revenue streams. And it's essential to maintain those streams for existing capacity, but also we need to think about, how do we bring in or increase those funding streams so that we are able to

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actually expand our capacity? Workforce is still in need, as you heard. I will talk a little more about that. Also complex patients. You have heard that health centers serve more patients with co-morbidities, but we are also serving patients that are really experiencing very entrenched social determinants of health and those have very significant impact on their healthcare outcomes and their utilization of services and their cost. Things like lower education or lack of access to healthy foods, lack of safe places to play and walk and move around, unemployment and so on. So patients are very, very complex. Health centers though are still very heavily invested in quality improvement activities as well as the infrastructure to help them do that. So we have talked a lot about HIT and hiring new staff and PCMH recognition. Patient Centered Medical Homes. As of last I have heard, data from the Bureau of Primary Healthcare, 44% of health centers already have been recognized, officially as a PCMH and the vast majority are undergoing other – or at various stages of reaching that recognition. But again, examples of delivery system and infrastructure challenges still to be met, there is still a need for better integrated care, particularly access to specialty care for our patients.

Regardless of the insurance expansion that is taking place right now, there is a continued need for health centers. There is a lot of unmet need out there. There is rising demand as we have talked about. There are still also a lot of communities out there without access to care, regardless of having an insurance card. In fact, as I am going to show you in a second, insurance coverage is not enough to guarantee you access to care and there will always be uninsured patients. I will probably say that six or seven times in the next five minutes, because it is still very critical. And these communities and these patients who need care, need not just a comprehensive model of care, but need a very accessible model of care that knows how to meet those specific needs, those complex needs we have talked about and how to break down barriers to care.

So this slide is actually – it's hard to see up here, I know, but it's actually in one of your handouts. The Access is the Answer briefs that we have just released. This actually shows at the county level, what percent of residents are experiencing shortages of primary care physicians. 62 million people across the country do not have access to primary care because of shortages. It has nothing to do with whether or not they have an insurance card. In fact, most of them do have insurance, only about 21% are uninsured. But of course, the uninsured are at higher risk of falling in this category, given where they tend to live. 28% of them are in rural areas, 43% are low income and 38% are minority. But of course this is just one measure of unmet needs that even when you live in a community that seems to have a lot of providers, those providers may not be there to serve all community residents, given their acceptance of certain insurances, the languages they speak, cultural barriers, lack of transportation and so on. Health centers actually have higher rates compared to other providers of accepting Medicaid patients, Medicare patients, uninsured patients and even new patients.

ED HOWARD: Michelle, before you change that slide, the 62 million figure, what does that represent?

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MICHELLE PROSER: So that represents the number of people who do not have access to primary care, specifically because there is no primary care provider to serve them. So it's a population to provider count. Thank you for asking that.

So I do want to just quickly touch base on the health center model. So I won't go through all of this, but the health center model is actually rooted in federal law and regulation, but what I want to emphasize is that health centers are designed to break down very complex barriers their patients experience and provide comprehensive services. Primary care, dental, behavioral health, vision, pharmacy and other services that actually facilitate access to care. Services that we call enabling services like home visitation, case management, transportation, translation and so on. But health centers also work by being customized to fit each individual community's unique needs and circumstances. For example, they must be run by a governing model that is made up of a majority of patients and that is very unique. And we think this model of care not only explains why they are so successful in improving access to care, but also generate significant savings to the healthcare system. 24 billion annually. Leighton showed you a slide of their cost differences and we have calculated that up to be at least 24 billion annually. And just briefly, health centers treat more uninsured patients, Medicaid and poor patients than other providers. It's probably obvious at this point. They also have more patients with chronic illness as well.

I know we have talked a lot about Massachusetts and Leighton had a lot of great slides here. Massachusetts is a really great example of what to expect in this post healthcare reform world. So I just want to emphasize two things. One is that there is still a large number of health center patients in Massachusetts that aren't insured and that rate has been fairly steady over the last couple of years too. It hasn't dropped below 20% - 21%. The other thing is they serve – while the number of uninsured and the percent of state residents without insurance dropped, health centers are actually serving more of the state's uninsured. So whereas before health reform occurred, they served 22% of all of the state's uninsured. Suddenly, now with insurance expansion, they now serve 38% of the state's uninsured.

And of course I want to talk about growing and sustaining health centers. So as you heard from Brooks, health centers tend to have very slim operating margins and nationally they hover around zero percent. I want to talk about federal health center funding because I think this is also another very critical piece. This funding is very, very critical as Leighton said, in helping to bring new community health centers and leverage other resources within existing communities, but also new communities. Health centers right now are facing a funding cliff and that funding cliff is because of the trust fund that was in the Affordable Care Act will sunset soon. And if that happens, that will be a 70% cut in funding, which means health centers are facing a significant cut in their current capacity, meaning they would have to close sites, they would have to lay off staff, they would have to have fewer hours and then of course it's going to reduce the number of

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patients they can serve. Every community would experience this differently and have to apply the cuts differently. This might be a great question for Brooks and Vernita. How is it that they would handle such a cut? And of course this is also while demand is increasing for their care and they are experiencing gaps in other revenue payment. So again, this federal funding is really critical for supporting the cost of the uninsured, but also caring for – or covering the full program that health centers provide, as Brooks called it, it's a community health model and these grant dollars really help health centers expand that model to provide a lot of services that other providers aren't able to do. And it also ensures that health centers serve all, regardless of that patient's risk. They are able to take on a lot more patients with these federal resources and it launches health centers into new communities as well. Health centers are also experiencing gaps in the Medicaid reimbursement. Eighty-one percent of their costs are actually what they get paid in Medicaid. So in other words, they are losing about 20% of their costs, it's not being reimbursed. So these costs have not kept up with the cost of care and we heard about some of the issues we are anticipating and are already experiencing with the exchange. Leighton talked about that. But I think the bottom line with these third party payers is that as the number and percent of patients who have these forms of insurance increases, it doesn't make up for per patient losses.

So I will move on to my last slide. So this is just a quick visual to show you the funding cliff that is anticipated or would be anticipated.

So moving onto future issues, obviously, I think the need is to continue to build and maintain capacity and meet those remaining needs. Also to help health centers continue to invest in quality improvement programs and infrastructure. The how, I know I have touched on quite a bit, but I think these are really critical issues. Federal funding is still very important. It's not just about maintaining or sustaining the current capacity we have now, but we also need to think about, how do we expand into new communities? Work force issues – programs like the National Health Service Corps is also facing a funding cliff starting at the same time health centers would and health centers are also – many health centers are also participating in the Teaching Health Center program that is federally funded and that funding also could expire unless its renewed. And what that program does, unlike the National Service Corps, which places providers in underserved communities that Teaching Health Center program is about training providers and then getting them to stay in these underserved communities.

But on a positive note, health centers are able to put these investments into use very, very rapidly and I think the model is really designed to actually continue to improve care and improve outcomes and generate some significant cost savings.

So with that, I want to thank you. I apologize for the brief presentation, but I look forward to questions and answers.

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ED HOWARD: Thank you, Michelle. We have now come to the point where if you would like to ask a question, there are microphones you can use. There are green question cards in your packets that you can fill out and hold up, if you will, and someone will bring them forward. I wonder if, pending the line up getting longer at the microphones, I might take just a moment to ask a clarifying question. Both Michelle and Leighton had talked about the potential underpayment in private insurance. Now, Medicaid is not known for its high rates and most private insurance, we keep hearing complaints about Medicaid shifting costs to private insurance. And you have a shortage of primary care providers in most parts of the country. How is it that community health centers don't have a little more negotiating clout with private insurance?

LEIGHTON KU: One issue is that it's not entirely clear that health centers have been able to negotiate. You may recall that when the health insurance exchange plans began, they began rather hurriedly last year. What many health centers expected was that insurers would come say, God, we desperately need you as a partner and we are willing to pay you a good rate. And Medicaid pays them [unintelligible] and the statute sort of suggested that that was the rate that they were supposed to be paid under the private health insurance exchanges too. What has happened is that in many cases, insurers said, we already have a contract with you for private health insurance in which we were paying you the same sort of rate that we would pay a regular primary care doctor and we are invoking that contract that we already had with you. So many health centers actually were never contacted at all. Never had the room to negotiate and then were locked into rates that they thought previously were only being used to regulate private insured patients. So this is where things are still a little messy and a little unclear exactly what happened. Is this evolving somewhat this year as plans are about to set up their new rate filing agreements? And that we would expect a little bit more change over time. But that is why in many cases they just never have the negotiations. We have heard this from other essential community providers that they expected that at some point the insurers would come contact them and in many cases they never did, but then they said, we already have contracts if you live to those contracts that pre-existed.

MICHELLE PROSER: I just want to add too. I agree with Leighton and I think that it's really important that this plays out well for health centers. Part of that negotiation is that health centers historically – 14% of their patients have had private insurance that is going to grow somewhat. We are not exactly sure how much. We were looking forward to watching and seeing how that happens. But in terms of negotiation, when you have several different private managed care contracts already for a small number of patients, suddenly that contract that you may be locked into is going to – and the payment that you are receiving for those few patients, is going to be that much harder to work with when say, ten patients moves to 50 patients, to 100 patients. So it's something that we are watching very, very carefully.

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ED HOWARD: Yes sir. I would ask the people who come to the microphones to identify themselves and the institutional affiliation if you have one and keep your questions as brief as you can so that we can get to as many questions as we can.

AUDIENCE MEMBER: Tony Housner, formally with CMS and now doing some work on the Affordable Care Act and the enrollment. I'm interested in hearing from some of the panel members what your key recommendations would be to the federal government and to state governments in terms of the Affordable Care Act. What are some of the key things that need to be done for this next go around in terms of enrollment and things like? Things within the current law that you think need to be addressed at both levels.

VERNITA TODD: That is a little bit of a loaded question for Indiana, because what we found that was that due to the significant division of interest of repealing or keeping the Affordable Care Act, we had a lot of folks who believed really erroneous information about what it was going to be. So we spent, I would imagine the lion share of our time explaining that there really were tracking devices going to be put in your arm if you got the Affordable Care Act. And whereas that sounds ridiculous, some of the information that was being shared was so over the top, that people were afraid of it. The folks who needed it were afraid of it. So for us, it's been an awareness building. I believe now that Indiana is expanding access to low income families, perhaps there will be more awareness in education for potential consumers so that they can learn the actual facts. The other thing is, what we realized is, if you have never had insurance, it's a difficult thing to understand with premiums and the difference between a deductible and "didn't I pay for that this month?" and "why am I pay an additional thing like that?" So there were those kind of components that just had to do with insurance, that folks really didn't get it. They had never been a part of it.

AUDIENCE MEMBER: Michael Kosta with Apt Associates. First of all, thank you all for a terrific and very informative presentation. This question is for the entire panel, whoever wants to pick it up. What has the experience been out there so far or what you anticipate it's going to be, preferably any information on what has occurred so far in regards to individuals who were previously traditional Ryan White clients, HIV/AIDS positive individuals, who are now moving into Medicaid or other insurance based care and I think likely finding their way to other care settings such as FQHC's or CHC's generally?

LEIGHTON KU: First of all, in many cases, FQHC's actually also operate Ryan White AIDS care and so they are already serving those patients in many, many sites. Obviously for not only HIV patients but for many other patients who have some serious chronic illnesses, some of them will be coming into insurance coverage for the first time. Then hopefully getting coverage at a health center is a blessing to the extent that it provides them a broad access of care. In many cases, they will still have the ability to access care at more specialized sites like Ryan White sites or other places that exist if they so have it. It might be confusing to people though. I mean, if you have been used to getting care at

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one facility and that facility now is not part of that say, private insurance network with the exchange, then it will take some orientation of how can they figure out how to get those care services? My understanding of the way Ryan White works is that even if someone is privately insured, they would still be able to get certain services from the Ryan White Centers. So they still have that access, but it could be confusing to some of the patients.

ED HOWARD: Brooks, did you want to comment on that as well?

BROOKS MILLER: The only thing I would comment and unfortunately this is where I believe Missouri is well behind probably a lot of places in the nation and we are just really getting active in the exchanges and such. As far as Ryan White and HIV patients, we see more – we have a very strong program in the Ozarks that is run by Lynn Meyerkord, who is the Services Director to that and also sits on my board of directors and they have the medical side of it fairly well down. Where we assist mostly with Ryan White is with regards to oral healthcare services, which are very limited in a lot of places. Now, that is kind of a two edged sword. In 2005, Missouri discontinued services to adult population as far as oral health coverage in Medicaid. So there is no Medicaid related to that and many of those patients participate in our sliding fee program. On a positive note, Missouri this year passed a reinstatement somewhat of those benefits of oral health, back to the adult population and so far has put 45 million dollars, I think, towards that effort. And should that hold, should the governor go ahead and release those funds, I think it will have a very positive impact not only for the HIV Ryan White population, but for those with mental disorders and things that have also been separated or taken out of that system.

AUDIENCE MEMBER: Florence Fee with No Health Without Mental Health. First of all, thank you all for the panel, for very informative and insightful discussion. I would like to get this issue on the table of integrated – behavioral health care into primary care, and get your views on this issue that no one talks about, but is the real deal killer, which is we live in a world of segregated behavioral health system delivery and provider payment. And this segregation effectively prevents real integration. What we really – I know we sort of move from a cross referral model of integrated care where primary care physicians refer patients to behavioral, but the reality is most patients will not go to a behavioral health referral. So then we move to a bidirectional integrated care model, which drops a behavioral health professional into the primary care setting. But still, the big issue on the table that we never seem to be able to address is that under managed behavioral health carve out system, behavioral health providers cannot work and get paid in primary care. So my question is, haven't we come to a time when we need to have behavioral health as just another standard medical benefit under health plans? So in other words, in segregated delivery and payment. I will leave that open, thank you.

BROOKS MILLER: The answer to your question is Yes. Quite honestly, for me, behavioral health has been one of the very difficult things for me to gain an

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understanding of. I think in comparison to oral health or primary care, which I believe has an end, behavioral healthcare often times does not. My frustration, exactly as you said, as you try to integrate that into the primary care setting, which I truly do believe that is where it should be, you don't get paid for it. If you have a patient that comes in, sees your primary care provider, who recommends that they have a counseling time with the behavioral health specialist, you get paid for one of those services and not two. So you sent the patient back home, you hope they come back and it really defeats the purpose of an integrated care system and I think that that's an issue that truly has to be addressed. I do believe also that behavioral health is the challenge of the future. I think as we look at work force development and things like that, that there is a real shortage of such. We know also that depression, antidepressants and things are probably the most prevalently prescribed drugs by primary care providers, who need the assistance of behavioral health, really to navigate those interactions. And so I don't know how we move forward from nationally, how we move that forward in a better way. It also has to be addressed at a local level, on a state level, to try to get Medicaid to recognize the importance of an integrated system and it's unfortunate as we push for a medical home where you have all these services available and not reimbursed for it. You are just defeating it. You know, if you go to the exchanges and they are going for the lowest possible price, issues like integration are certainly something that are pushed to the side and not incorporated within those plans.

LEIGHTON KU: Can I just have a quick moment of clarification for something Brooks mentioned that some of you might not get? It depends – varies from state to state, but many states, any services that a patient gets in an FQHC are paid once. So even if you get medical services and behavioral care services, you may only get one payment that is sort of an integrated payment. To some extent you think integrational care could be a good thing. On the other hand, what they say, it discourages them from providing behavioral care as that second service. So they would rather have, financially, someone come back another day for the mental health services, which is sort of an inefficient way to do things. States have the option to have separate billing for behavioral care and physical care, but the majority of states don't implement that system.

VERNITA TODD: I would just add, without getting into the weeds, Indiana, our primary care association several years ago was really concerned about this issue and really lobbied our legislature so that they do honor same day visits for behavioral health. For a limited number of what they call "brief interventional therapy" associated with the medical diagnosis and what we find is for families that are dealing with children with ADHD or anxiety or depression, things that the primary care provider can help manage until they can get to a more comprehensive mental health provider, that our state actually listen to that and so, instead of us saying, we are going to have to send you home because we don't make any money today, we went through our state legislature and we were able to get compensated for that. So I think it's a matter of what you do in your states in bringing that to their attention of how – remember I said, you've got to meet patients

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where they are. And it's not meeting them where they are if we are sending them home because we don't get paid.

ED HOWARD: And is that system in place in other states? Leighton, you were talking about the great variation, is that something that is on the way in a bunch of places or is Indiana blazing a path?

LEIGHTON KU: I must admit, at one point I knew, but I have forgotten how many states have same day billing. Is there anyone who remembers? I know Emily Jones was here just a moment ago, she would know. But I think Emily has left.

MELINDA ABRAMS: Yeah, it's increasing and also I think under the health home provision of the Affordable Care Act 2703, we are also seeing kind of new and other creative ways of trying to more rigorously and comprehensively integrate within primary care or also on the community mental health side, you know, sometimes some states have state plan amendments for their community mentally health programs to kind of flush out their primary care – particularly for kind of the persistent and severely mentally ill. So it's really on both sides. So I'm not saying it's not an issue, it is an issue, but I do think that there are – there is a lot of innovation going on across the country.

ED HOWARD: Yes, Bob?

AUDIENCE MEMBER: Bob Griss with the Institute of Social Medicine and Community Health. It sounds like there are lots of reasons to look at community health centers as a laboratory for experimentation in how to address the unique needs of patients with low income, with minority status, with disproportionate amount of social determinants of poor health. And yet, there is a lot of variation among the centers as we saw, based on the payer mix that their clientele represent. My question is really a research question and that is, have you – Michelle, focused enough on the differences among the centers, among the community health centers, so that you can make recommendations for healthcare policy at the state and federal level, so that the lessons that you have learned in how to deliver effective care to the population that is primarily the recipients of services in community health centers can be translated into standards of care for Medicaid, for quality standards in insurance in general. So concretely, for example, if you are not being reimbursed through the grant from the 330 grant for a lot of the subsidies needed to fill in the gaps between the medical care and other social services needed in the community, maybe there ought to be models, programs, at the state level that have that function for the people who are not lucky enough to be in the safety net that the community health centers represent.

MICHELLE PROSER: I think it's a very interesting question and I think we are just scratching the surface, honestly. Especially when it comes to measuring those social determinants of health. We know they are there and we are starting to actually collect more information on them. I think there is a lot of evidence out there in terms of health

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center programs and looking at specific under service across our patients in terms of insurance and low income and some education and how those interventions have led to improved care. But I would love to see more research about how do we actually include more of those social determinants of health, define those and test those innovations that worked in one health center and moved it to another health center and how do we customize those interventions to work across different communities that have maybe a different language, different cultural need, just a different social determinant. I think as health centers are asked to participate more in ACO's and integrated care models, that is also very critical. I think one of the things that health centers really bring to those things is not just a foundation in primary care, but an understanding and a plan for meeting social need and how that social need could really impact health outcomes and cost and I think some people – and I know Melinda has more to add on this, but I think you would also hear people say that these are factors that need to be considered and risk adjustment modeling as well. Risk adjustment is mostly based on medical acuity – gender and age and not enough on social factors and more and more organizations are paying attention to this. So I would like to see more work on risk adjusted modeling that includes just how at risk health center patients and safety net patients are.

MELINDA ABRAMS: I think your starting statement about kind of health centers as a laboratory from which the rest can learn, I think is actually – we have a good example of that. The Commonwealth Fund supported for five years a demonstration with 65 community health centers in five different states to kind of figure out what does it take to become a patient centered medical home? This was a demo that was led by Jonathan Sugarman and Ed Wagner, both of whom are in Seattle, Washington and not only did they create kind of a change package and a set of modules and implementation guides for what does it take and we kind of came up with a sequence that is now actually being used by academic health centers through residency training programs at Harvard or private practices. So I think there are examples where community health centers have actually been pioneers and led and that we are beginning to see some of that spread in private practices and in a bunch of integrated delivery systems. So we should probably move on to our next speaker or question.

AUDIENCE MEMBER: Thank you, I'm Seth Truger, I'm an emergency physician at Health Policy Fellow GW. We have heard a lot about the different issues and challenges you have raised as far as FQCH space, in terms of reimbursement and workforce. A lot of the critics of the ACA's coverage expansion have suggested that with the problems in the primary care safety net, we have that increase in coverage, is going to simply dump a lot more patients on already crowded emergency departments. Can you address those concerns?

MELINDA ABRAMS: Let me just make sure I understand the question. So the question isn't so much of a workforce question, or maybe it is, it's really about are we going to further bloat our emergency departments, which will only increase costs. In fact, a more

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expensive primary – that is a more expensive place to obtain primary care than in an FQHC.

BROOKS MILLER: I don't have an answer. But to kind of go a little bit further, I think from my experience when I went to Springfield. For instance, there was access to primary care. There is access to primary care in any community that has a hospital and unfortunately that is the areas that you work, the ER and we know while it's the most expensive level of care that you can get, that is where a lot of people go. What they didn't have access to was oral health and so we were able to build – I mean, we built on oral health and then came back and backfilled on primary care. One of the biggest frustrations I have is – and we talk about access and I think there was a graph that was brought up there that we can get patients in, in one or two days. And I think it goes back to somewhat the theme that we have talked about here today and one of the things, I feel like the Affordable Care Act may have missed somewhat and there may be disagreement on that, but it's not built around the patient and what the patient does. For instance, I tell my people all the time, if we don't get a patient in today, more than likely, that patient is going to do what? Go to the ER. And we live in a time when we have expectations, we want immediate service, if a lot of the population who has private insurance was given the option of waiting two days to go see your primary care provider, many of us probably would. But we are dealing with the third or fourth generation of population who has sought and gotten their primary care out of the Emergency Room and there is really no opportunity to shift that back to the primary care side or the medical home where it should be. Now, that is the emphasis of the medical home and one of the things we should work with, but you had to have buy-in from the patient. And oftentimes what we are seeing is – and we had a discussion last evening about this, is we are not seeing that buy-in from the patient and breaking that routine is a very difficult challenge.

LEIGHTON KU: I think one of the things that was a common misconception under the ACA was that as we expand insurance, emergency room costs will fall. I think now with more experience, we understand that when people have insurance cards, they are actually more likely to use ER's. In fact, the primary uses of ERs are privately insured; they use them at far more rates than the uninsured. Now, however, that being said, FQHC's are clearly something that help get people out of the Emergency Room to the extent that they can get the primary care. This is why the expansions of FQHC's is so important as a systemic effort to try to sort of meet those needs before things turn into emergencies.

MICHELLE PROSER: Just to emphasize, you need to expand insurance in sources of primary care at the same time. Leighton said it very well.

VERNITA TODD: I would just look backwards to look forward. The ACA also provided for the significant expansion of community health centers, but due to sequestration and other financial hits that the federal government took, some of that funding was diverted for appropriations to keep the annual grants. So the growth of health centers, while a lot is not at the same pace, I believe, as it would have been, but I

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agree our Emergency Room physicians feel just like you do and I imagine that is the case everywhere. And so I think we are all saying the same thing as expand community health centers and expand access.

MELINDA ABRAMS: I'm not going to say anything else, because I think enough has been said.

ED HOWARD: And I took somebody out of turn and I believe this gentleman was next in line.

AUDIENCE MEMBER: Yes, I'm Chancy Killions, I'm just a regular citizen, no degrees or nothing. And just like the panel that has a desire to meet the needs for the uninsured, I do too. I just have some concerns about the Affordable Care Act and the cost factor and how it's gonna help when we dismantle 75% or 80% of healthcare that is already working for a small percentage of people. Yes, they are important, but you would think that intelligent people, as yourself and those that run this country, would be able to create a system without dismantling something that is 80% effective. Not perfect, but effective to put together something that we are not even sure, without even trying, pilot programs in various cities to see if it will work and then instead of taking 20% or whatever the percentage is, of our government cost, to try to hope something will work to help 20% of a nation. Thank you.

ED HOWARD: Anybody want to take a crack at that first?

MELINDA ABRAMS: Ed, do you want to go?

ED HOWARD: Well, sure. But I don't want to preempt our expert witnesses here. I will take a crack at it. Its not clear that we are destroying 80% here and in fact I think what we have heard today in large part is evidence that there has been a lot of learning from the 20%, if you will, of your concern, about the ways in which we ought to be able to reach out to plug some of the gaps in the system. I mean, even after the ACA is fully implemented and if it goes according to plan, which some people might think is a long shot, we are still going to have 30 or 35 million people who don't have health insurance, who are going to need someplace to get care. And at least at this point, there has been a lot of agreement between Democrats and Republicans going back for the last generation or so, that FQHC's – that these community health centers are a good way to try to meet some of that need, not all of it. So, that is one of the reasons we thought it would be useful to shine a light on some of the things that are going on in the CHC world and to try to grapple with some of the challenges in trying to implement this law in a way that doesn't destroy what is already working.

MELINDA ABRAMS: Anybody else have a response?

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AUDIENCE MEMBER: Hi, my name is Brian Belicky with TFI. I have a two part question. One is research related and the other is more clinical/operations. It was nice to see -

ED HOWARD: I hate to interrupt the question; I don't want to preclude it. This will probably be our last question, given the time we have left, despite Melinda's 27 green cards and your nice filling them out. So what I would like you to do instead is to use these last few minutes, while you are listening to the two part question, to fill out the blue evaluation forms that are in your kits. Yes sir, I'm sorry to have interrupted.

AUDIENCE MEMBER: Sure, thank you. The first part of my question is, it was nice to see the differences between what you call CHC users and non-users, those have been replicated over decades. The question I have on that financial figure is, have you done any research to show what those differences look like when you look at some of the more complex cases that CHC's treat, versus other providers. Diabetes, hypertension, episodes of newborns and deliveries. Did those same kinds of differences hold up when you begin to look at sub-groups of sort of the bread and butter, I would think, of CHC's? And then the other part of my question is, whatever those differences are, what are some of the unique things or what might be distinguishing what CHC's do, versus all the other providers in the systems that CHC's might be able to sort of tout themselves on and say, hey, we are here to take on the toughest cases, the biggest challenges.

LEIGHTON KU: Sure. So you are mentioning – we did a study that sort of compared medical expenditures for CHC users versus non-users. That analysis actually tried to statistically control for a wide variety of differences. So tried to say, yes, we understand that someone who is diabetic or someone who has heart disease may be more expensive than someone who is in good health. So we try to statistically control for looking at that among the CHC users and the non-users. So that was an average, even after adjusting for insurance status, after adjusting for health status, so to the extent possible we tried to make it sort of simple. So here is the overall average impact. I can't say that we did it on a disease by disease basis, but none the less, we were trying to control for health status to the extent that we could. Now, why do they do this? I will say that these sorts of exercises don't necessarily fill in all the questions about why those differences exist. We tend to think, again, there is a lot of evidence that health centers provide good primary care services and that part of this, once again, is that many of the patients who are comparable to health centers, patients are uninsured and low income patients who frankly have difficulty getting access to primary care services. So part of the reason may be that they are just not able to get to a primary care service whether it's a regular private primary care physician or whoever. So eventually they end up in the ER. Eventually they end up admitted as a diabetic who hasn't controlled their diabetes status. So that is part of it. I will say we found the expenditure reductions both in ambulatory care, emergency care and inpatient care. So it suggests that once again, primary care for this needy set of patients really made a big difference in terms of improving health status and reducing medical expenses.

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ED HOWARD: Vernita and then Michelle? Can we get some quick comments from you?

VERNITA TODD: Yeah, I would just add operationally, you have heard the term “necessity is the mother of invention”? With our uninsured patients have very limited access to specialty care or other providers, meant the health center had to do as much as possible to help these patients manage chronic disease. So that is not to say we tried to become a nephrologist when we were not. But all the things that we needed to do to wrap around the patient so that we were addressing and meeting as much of the need as we could, which included addressing the social determinants of health and if it’s a diabetic, that’s great, can you get your medicine? That is the question every doctor will ask. But, are you eating? And if you are not, how do we get you access to healthy food or regular food? Those kind of wrap around services I think differentiate community health centers because we are looking at the whole patient and what are all the needs and things that are coming against them in their life. Those aren’t the things that get reimbursed, but that is the mission of every community health center.

MICHELLE PROSER: And I would simply add in my opinion, and you go back to that slide I had on the FQHC model that the whole is greater than the sum of its parts. That it really takes all those pieces in terms of being tailored to the community’s specific needs, to having the diverse services and those enabling services, regardless of whether or not they get paid and they often don’t get reimbursed by third party. Defining health broadly, doing regular community needs assessments, having an active quality improvement program and a quality improvement plan. And being required to serve all in the community in need and to target those patients specifically. I think that is really what does it. It’s that model together, but also makes health centers a good model for, I want to go there. A good model for anyone who is looking for a very broad high quality program with care.

ED HOWARD: Sounds like a pretty good way to bring this discussion to a close. Thank you, Michelle. Thank you to the rest of the panelists and let me just take this opportunity to say thank you also to our colleagues at the Commonwealth Fund for providing expert participation and co-sponsorship for this briefing. To you for bearing with us even though we couldn’t get to the questions that you wrote on the green cards. But you did ask some good ones at the microphones. And please join me in thanking our panel for a very enlightening discussion.

[applause]

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