HEALTHY SAFETY NET 2012: A BLUES SYMPOSIUM
HEALTH REFORM AND MICHIGAN’S SAFETY NET: MANAGING UNCERTAINTY

The FQHC perspective
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FQHCS- INFRASTRUCTURE VS. SAFETY NET

What is a Safety Net?


safety net, n.
1. a net used in a circus to catch high-wire and trapeze artistes if they fall
2. any means of protection from hardship or loss, such as insurance

Institutes of Medicine Safety Net Provider Definition

Although no commonly accepted definition of the safety net exists, in mid-1990's the Institute of Medicine (IOM) appointed a committee with the purpose to: "examine the impact of Medicaid managed care and other changes in health care coverage on the future integrity and viability of safety net providers operating primarily in ambulatory and primary care settings."

This IOM committee defined the "health care safety net" as follows: "Those providers that organize and deliver a significant level of health care and other related services to uninsured, Medicaid, and other vulnerable patients."

"In most communities there is a subset of the safety net that the committee described as 'core safety net providers:'

These providers have two distinguishing characteristics: (1) either by legal mandate or explicitly adopted mission they maintain an 'open door,' offering access to services for patients regardless of their ability to pay; (2) a substantial share of their case mix is uninsured, Medicaid, and other vulnerable patients."

"Core safety net providers typically include public hospital systems; federal, state and locally supported community health centers (CHCs) or clinics (of which federally qualified health centers [FQHCs] are an important subset); and local health departments. In most communities several smaller special service providers (e.g., family planning clinics, school-based health programs, and Ryan White AIDS programs also are considered a part of the core safety net. In some communities teaching and community hospitals, private physicians, and ambulatory care sites with demonstrated commitment to serving the poor and uninsured fulfill the role of core safety net providers."

MICHIGAN’S FQHC PROFILE

Numbers

32 - Michigan CHCs (30 FQHCs or LA)
190 - Delivery Sites (more in growing season)
1,208 - Medical Providers (FTEs)
351 - Dental Services (FTEs)
66 - Mental Health (FTEs)

600,000 - Patients seen annually
42% - Covered by Medicaid/SCHIP
34% - Uninsured
59,000+ - Patients best served in a language other than English
Capabilities

- 80% have EHR (compared to 50% private)
- Many eligible for Meaningful Use attestation (42% private)
- PCMH
- 8 sites MiPCT (Primary Care Transformation Project)
- 18 sites/11 agencies CMS Medicare PCMH Demo
- 18 organizations in MPCA PCMH Learning Community
- Quality Measures
- Team based care
- Integrated Care (Primary, Oral Health, Behavioral Health)
MICHIGAN’S FQHC PROFILE

So, while by historical definition, FQHCs can be categorized as “Core Safety Net Providers”, in the current ACA environment, they are as much a part of the health care infrastructure as any health provider, regardless of target community or openness of access.
PROJECTED IMPACT OF ACA
PRE JUNE, 2012

Source:
The Commonwealth Fund Blog: How the Affordable Care Act Supports a High-Performance Safety Net

January 16, 2012

By Pamela Riley, Julia Bere, and Cara Dermody


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1. OPPORTUNITIES TO PROMOTE COORDINATION AND INTEGRATION OF CARE FOR THE SAFETY NET

- Accountable Care Organizations (ACOs)
  - § 3022 (Medicare)
  - § 2706 (Pediatric)
- The Center for Medicare and Medicaid Innovation (CMMI)
  - § 3021
- Medicaid Health Homes
  - § 2703
- Medicaid Bundled Payments
  - § 2704
- Medicaid Demonstration of Global Payments for Safety-Net Providers
  - § 2705
- Community-Based Collaborative Care Networks
  - § 10333
- Co-Location of Community Mental Health and Community Health Clinics
  - § 5604
- Permitting Health Centers to Engage in Contractual Collaboration with Rural Primary Care Providers
  - § 5601(b)
2. CHANGES TO SAFETY-NET FINANCING AND PAYMENT

- Reduction of Disproportionate Share Hospital (DSH) Funding
  - § 2551

- Health coverage expansions
  - § 2001 (Medicaid expansion)
  - § 1311, § 1312 (Exchanges)

- Requirement that plans offered through the Exchanges contract with essential community providers
  - § 1311(c)(1)(C)

- Requirement that qualified health plans reimburse FQHCs no less than the Medicaid Prospective Payment System (PPS) rate
  - § 10104(b)(2)

- Addition of preventive services to FQHCs' Medicare payment rate
  - § 5502(a)

- Elimination of the Medicare payment cap on FQHC payments
  - § 10501(i)
3. BUILDING THE CAPACITY OF THE SAFETY NET

- Health center program expansion
  - § 10503(c)
- Program to develop and finance residency programs at health centers
  - § 5508
- Expansion of school-based health centers
  - § 4101
- Program to support the development and operation of Nurse-Managed Health Clinics (NMHCs)
  - § 5208
- Funding for National Health Service Corps
  - § 5207
- Health care workforce loan repayment for specialists in underserved areas
  - § 5203
The goal of this integration proposal is to offer high quality, seamless and cost effective care through coordinated, person-centered services that meet the unique needs of all MMEs. When fully implemented, Michigan’s program will integrate services and funding for more than 200,000 people who are eligible for and enrolled in both Medicare and Medicaid which, on an annual basis, currently costs the state and the federal government in excess of $8 billion.

Source: Integrated Care for People who are Medicare—Medicaid Eligible, Michigan Department of Community Health
March 5, 2012
EXAMPLES OF COORDINATION AND INTEGRATION OF CARE CHALLENGES

Response:
Under current law, there is $1.58 billion in discretionary funding for the Health Centers program this year, with another $1.5 billion available through the mandatory Health Center Fund in FY2013. By maintaining this $3.1 billion in total program funding, health centers can extend care to 2.5 million new patients. Health Centers also ask Congress to consider that the mandatory funding is scheduled to end, and to allocate the highest possible portion of total funding to the discretionary base of the Section 330 Health Centers program. This will help to ensure the future viability of health centers after 2015 while still allowing for needed health center expansion to reach communities and individuals currently waiting for desperately needed access to primary care.
Response:

The Health Center Request:
America’s Health Centers ask that Congress preserve and expand the vital work of the Health Centers Program while acting to preserve the long-term stability and viability of the program by:

- Providing a total of $3.1 billion in total funding for FY 2013 – with $1.2 billion from the Health Center Fund transferred to establish a base discretionary Health Centers funding level of $2.8 billion; and,
- Directing the remaining $300 million increase to expand care to 2.5 million new patients who lack access to a health center today.

“The U.S. has 352,908 primary-care doctors now, and the college association estimates that 45,000 more will be needed by 2020. But the number of medical-school students entering family medicine fell more than a quarter between 2002 and 2007.”

— “As a specialist physician I will suggest that until primary care physicians can earn 70-80% of what most specialists make without killing themselves, there will be no incentive for the best and the brightest to go into primary care.”

—Michael Brennan

The Wall Street Journal – On Line; Monday, April 12, 2010; http://online.wsj.com/article/SB10001424052702304506904575180331528424238.html

Figure 1 Source -medscape.com/compensation2012
Response:

- Recruit as aggressively and diversely as possible (physician and mid-level),
- Partner with primary care residencies where possible, improve productivity.