Protecting the Health Care Safety Net: Report-Back Session August 28, 2012

Summary of Key Findings

MOSAICA

The Center for Nonprofit Development and Pluralism

EGM Consulting, LLC

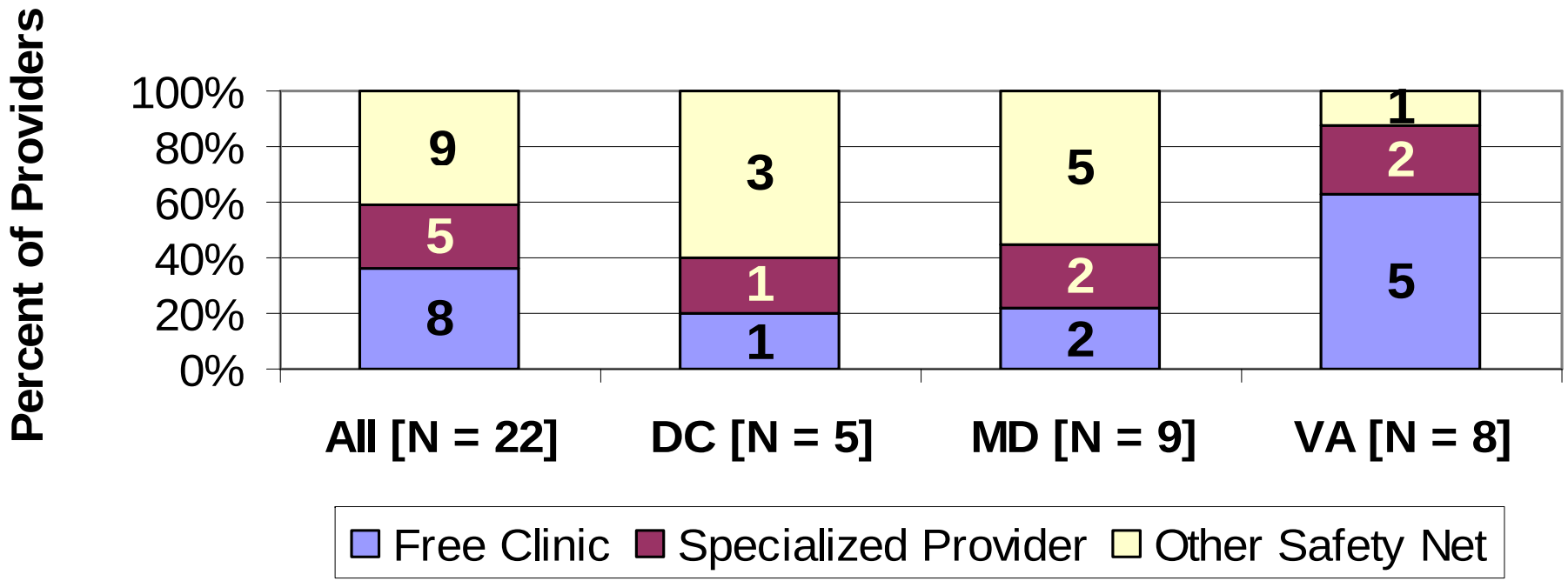
Integrated Summary of Findings from Research on:

- **Safety-net providers** (survey, interviews, and technical assistance)
- **Health grantmakers** (focus group, interviews, updates, secondary research)
- **Models** to enhance safety-net provider sustainability under health care reform (interviews, technical assistance, secondary research)

Safety Net Providers

- **Survey of 22 safety-net providers;** deliberately excluded community health centers/federally qualified health centers (CHCs/FQHCs) and FQHC look-alikes
- **Several types of providers:**
  - 8 free clinics
  - 5 specialized providers (e.g., pediatric, youth, women's/reproductive health, pharmacy)
  - 9 other clinics (nonprofit, public, freestanding but hospital-affiliated)
- **Located in all 3 jurisdictions**
  - 20 in the "inner suburbs"
  - 1 in Fredericksburg, VA
  - 1 in Carroll County, MD

Type of Safety Net Provider by Location



- The mix of clinics varies considerably by jurisdiction
- Northern Virginia has the highest proportion of free clinics (5)
- A majority of the DC clinics (3) are other nonprofit clinics
- A majority of Suburban Maryland clinics (5) are other nonprofit clinics
- At the time of the survey, DC had 5 FQHCs or look alikes, MD 2, and VA 3 – and 1 DC FQHC also had sites in MD

Scale and Importance

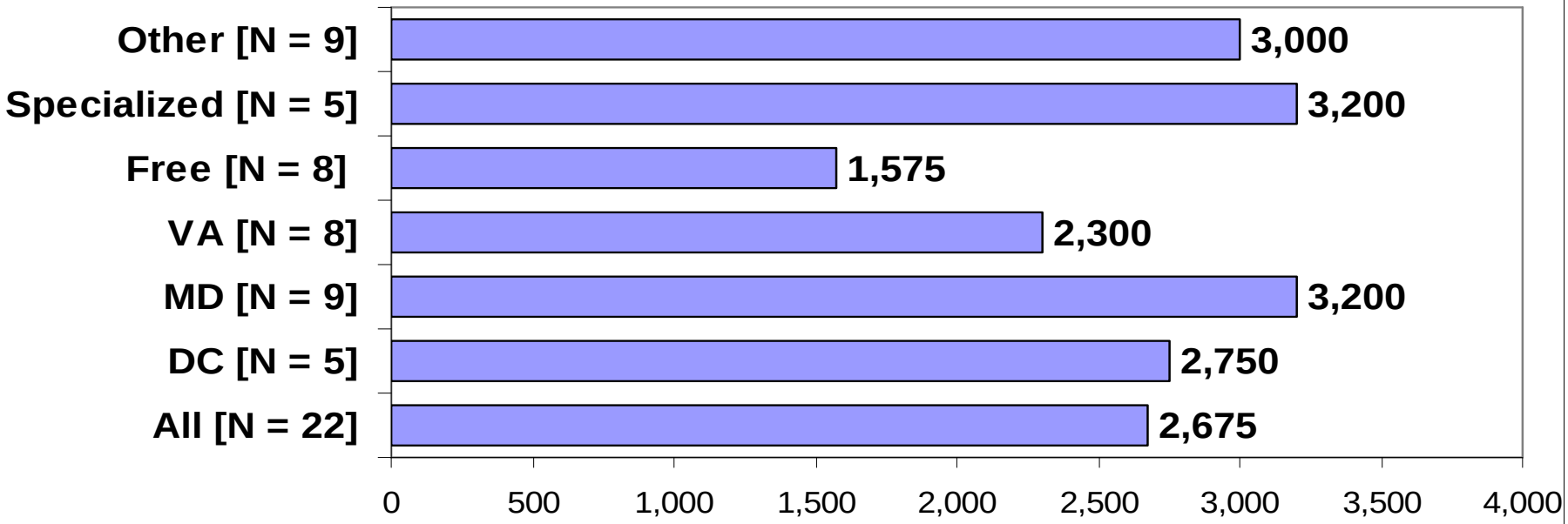
Number of patients served each year:

- These 22 providers serve nearly 75,000 patients annually; unduplicated total about 70,000
- Unduplicated number of patients per provider ranges from 600 to more than 19,000
- Totals by type of clinic:
  - 8 free clinics: 13,550
  - 5 specialized providers: 16,700
  - 9 other safety-net clinics: 44,165

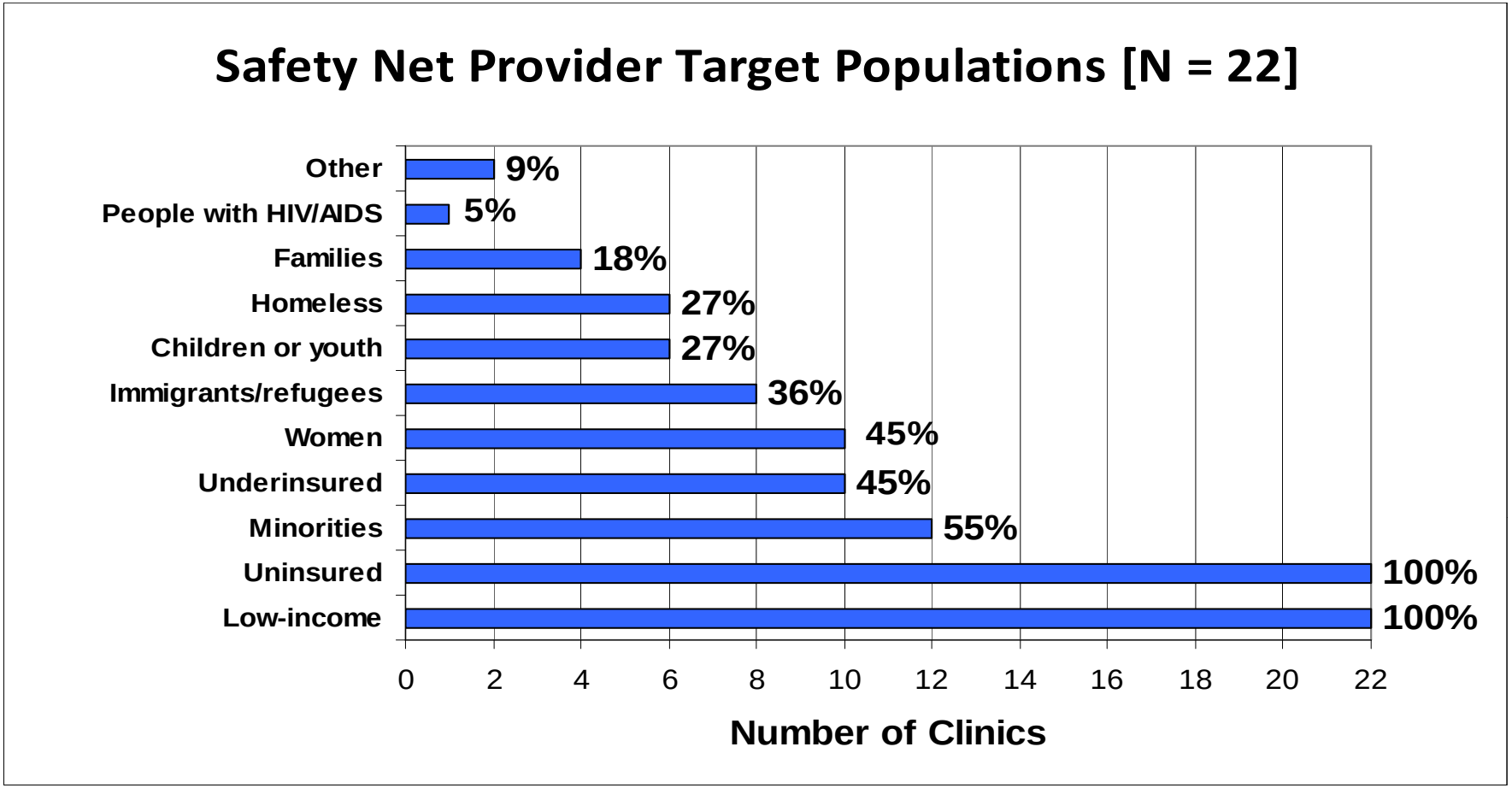
Populations served:

- All target low-income and uninsured
- Large majority of providers have patient populations that are more than 75% uninsured

Median Number of Unduplicated Patients Served Annually by Type of Provider and Jurisdiction

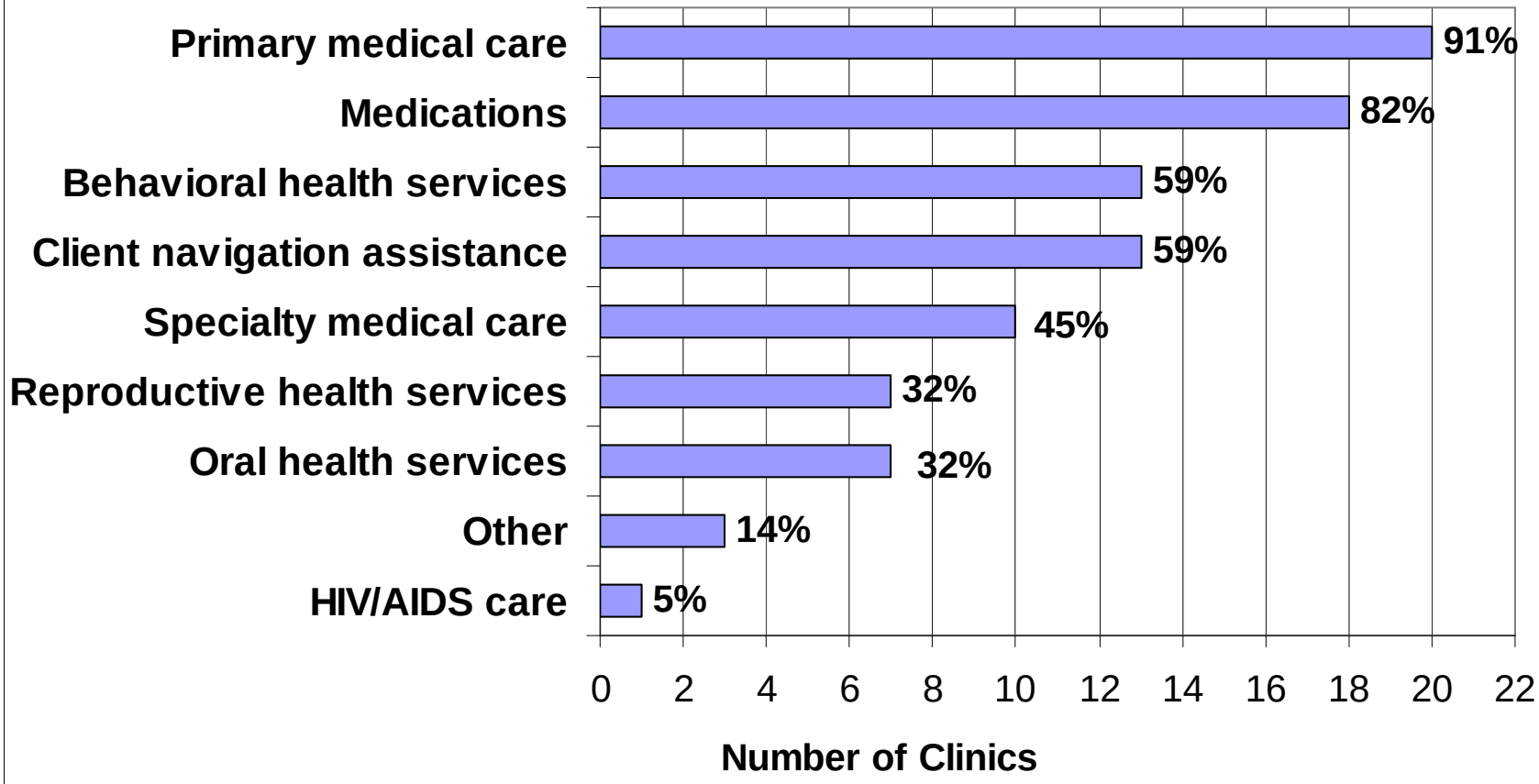


- **Type of Provider:** Median number of unduplicated patients ranges from 1,575 for free clinics to 3,200 for specialized clinics
- **Jurisdiction:** The median number of patients ranges from 2,300 for VA providers to 3,200 for MD providers



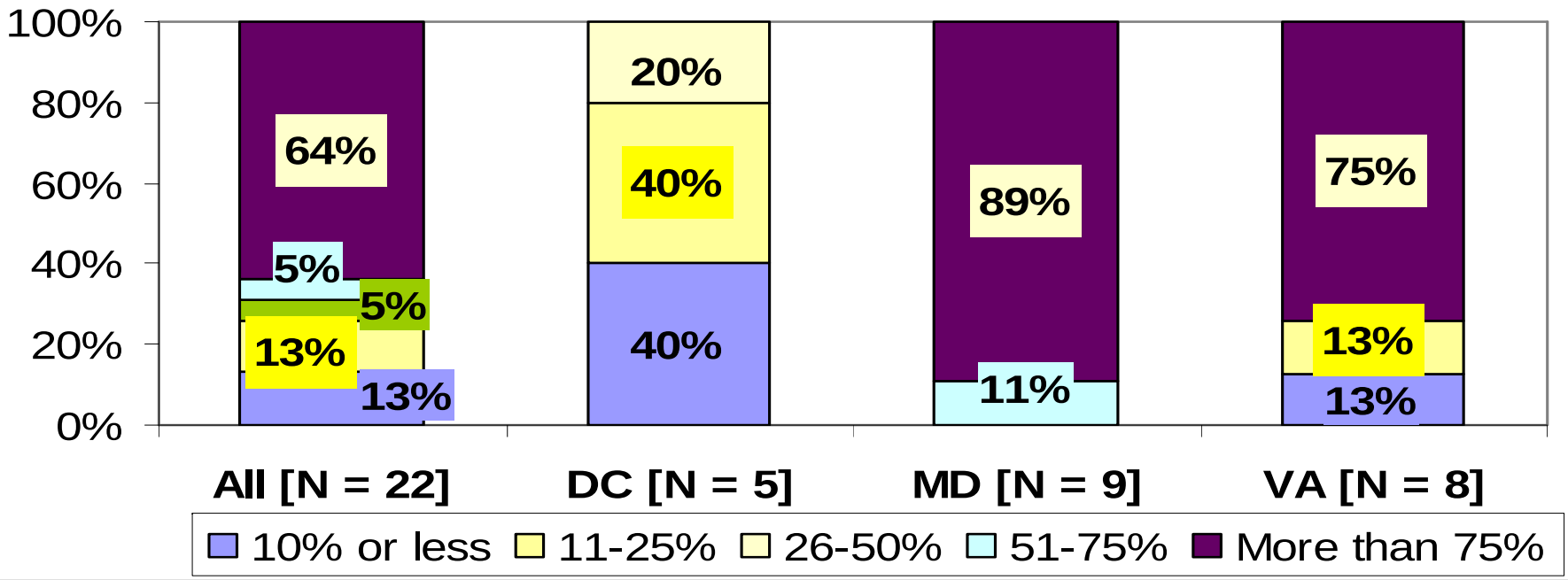
- All the providers target low-income and uninsured populations
- Free clinics often target only these 2 groups & they are key targets for VA clinics
- A majority of specialized providers also target minorities, the underinsured, children & youth, and immigrants & refugees
- Most other safety-net clinics also target minorities and women
- MD providers are especially likely to target women
- DC clinics all target minorities and the underinsured, and are also more likely than providers in other jurisdictions to target the homeless

Services Provided by Clinics [N = 22]

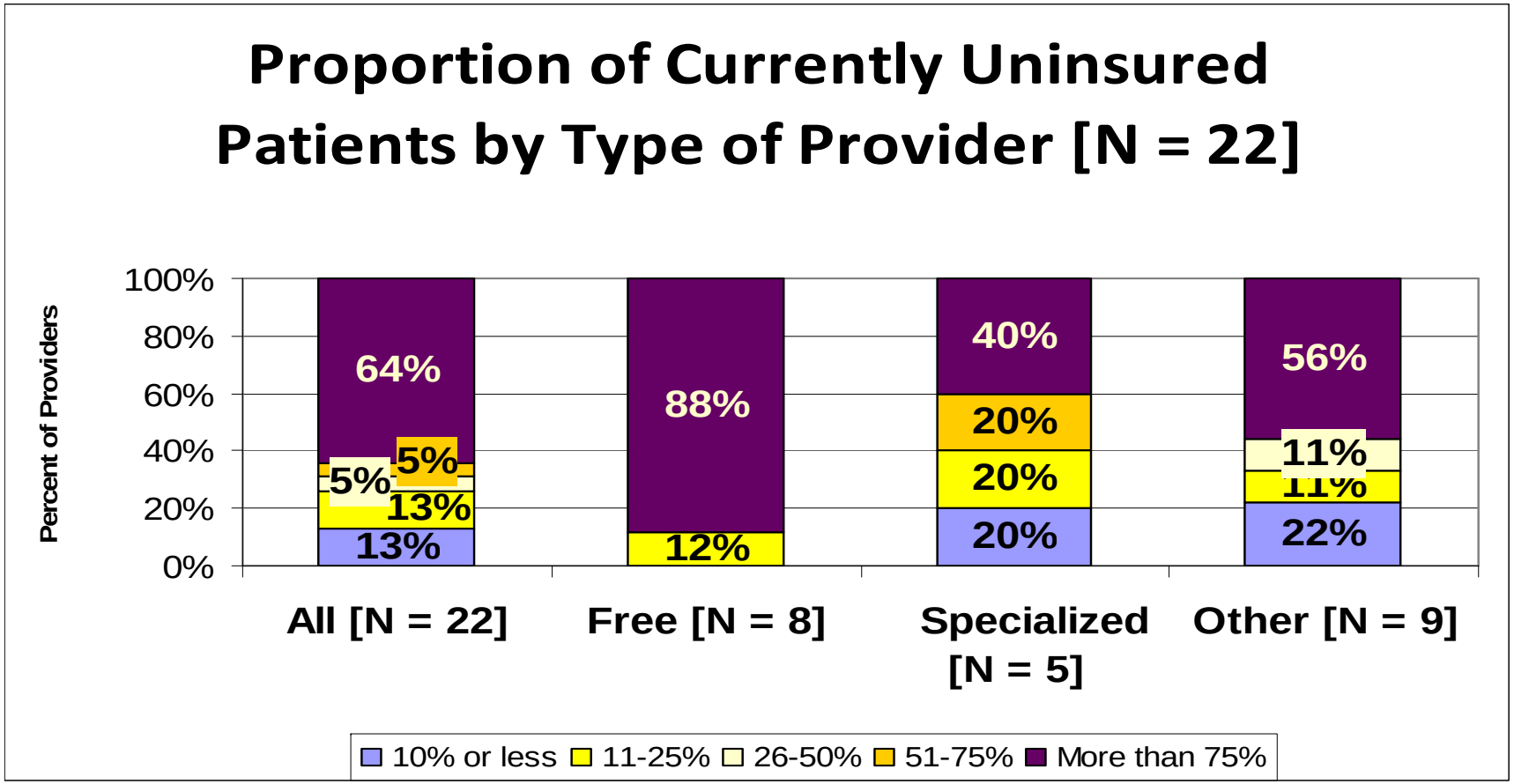


- Providers are most likely to provide primary medical care (20) and medications (18)
- A majority (13) offer behavioral health services and client navigation
- Nearly half (10) provide specialty medical care

Proportion of Uninsured Patients by Provider Jurisdiction

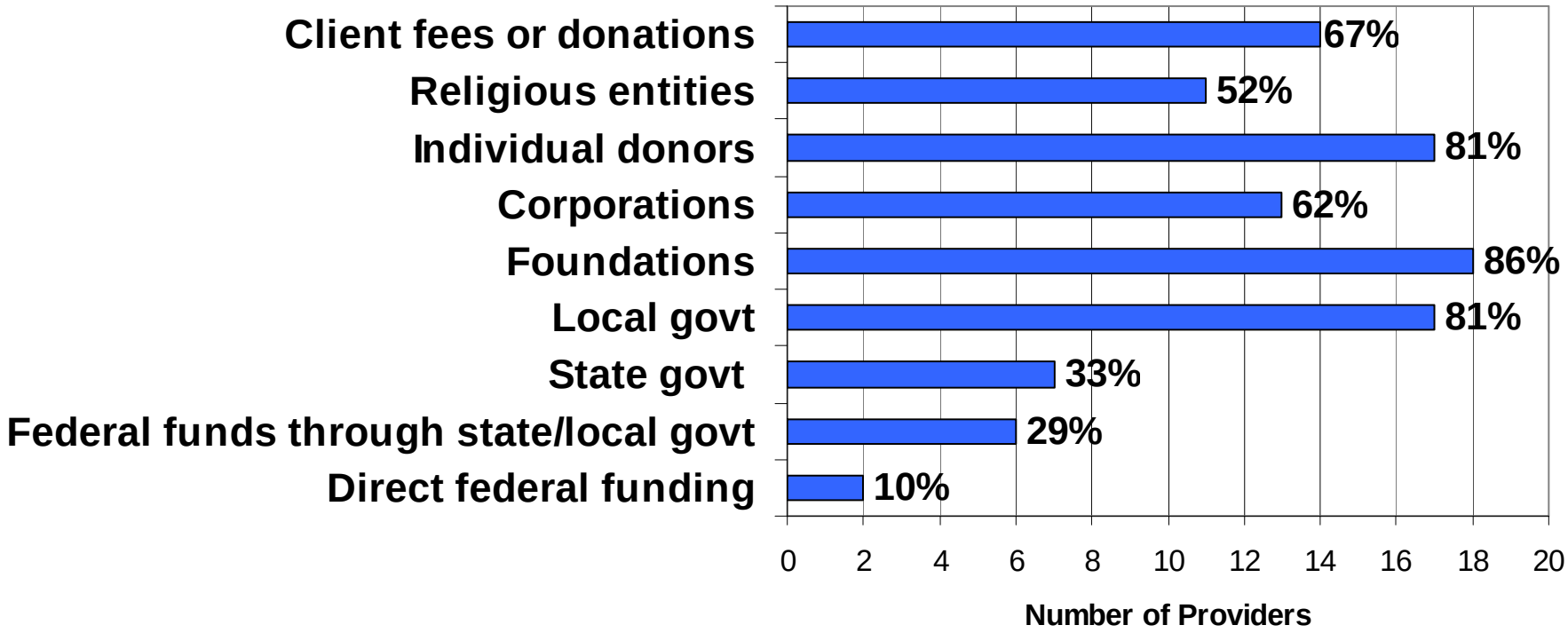


- **There are great differences by jurisdiction in the proportion of uninsured patients served**
- DC clinics have the fewest uninsured clients because DC has implemented Medicaid expansion and its DC Alliance serves individuals based on low income, without regard to immigration status
- MD and VA have a high proportion of uninsured patients; they all target this group and both states have significant uninsured populations



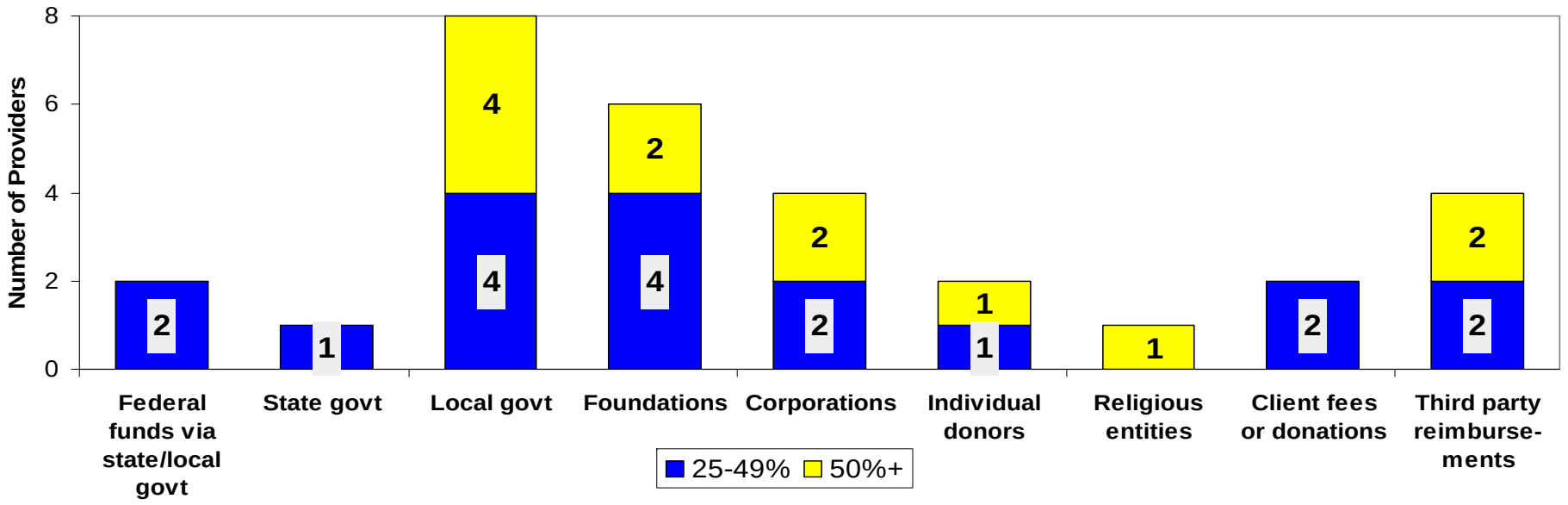
- Individuals with DC Alliance are counted as insured in this chart
- Free clinics have the highest proportion of uninsured clients – in 88% of these clinics, more than 75% of patients are uninsured
- Specialized clinics have the lowest proportion of uninsured – 40% reported that 25% of their patients or less are uninsured
- Other providers have more diversity in the proportion of uninsured clients, but over half (56%) have patient populations that are more than 75% uninsured

Sources of Funding [N = 21]

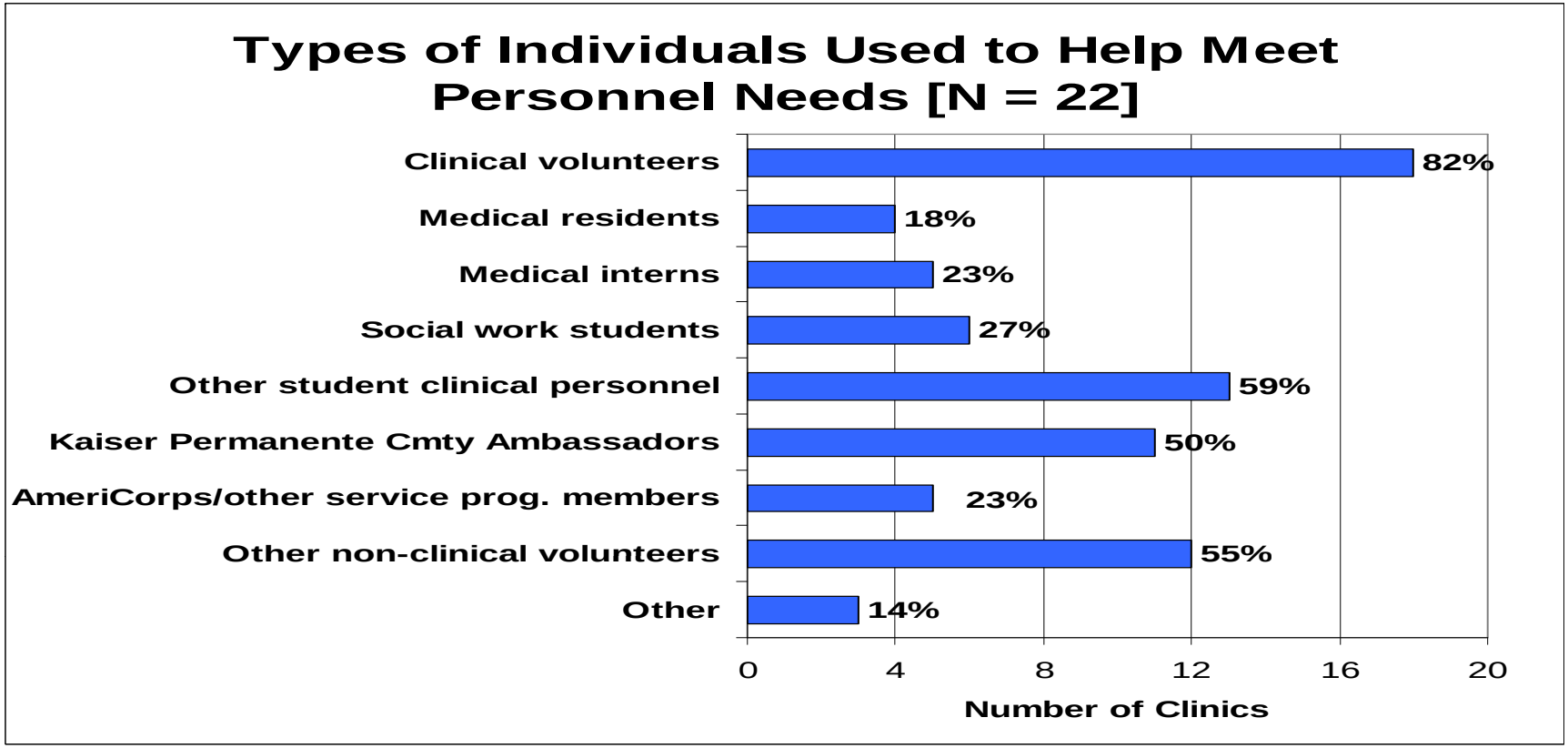


- **The most commonly reported funding sources are foundations (18 or 86%) and local government and individual donors (17 or 81% each)**
- Just 2 safety-net providers (10%) receive *direct* federal funding; 6 (29%) reported federal funding through state or local government
- 2/3 (14) receive client fees or donations
- About half (12) receive funds from religious entities

Major Sources of Funds (25%+) for Safety-Net Providers [N = 21]



- **Sources of at least 25% of total cash revenues to safety net clinics are most often local government (8 providers), foundations (6), and third party reimbursements (4)**
- Free clinics most often report at least 25% of their funding comes from foundations, local government, & corporations
- Specialized providers most often receive 25% or more of their funding from third party reimbursements, client fees & donations, & foundations
- Other safety net clinics most often receive 25% or more of their funding from local government



- At least half the clinics use each of the following: clinical volunteers, clinical students other than medical interns, other non-clinical volunteers, & Kaiser Permanente community ambassadors
- **Free Clinics** depend most heavily on volunteers; a majority use clinical volunteers (88%), other non-clinical volunteers (88%) & clinical students other than medical interns (75%); 3 said ½ their operating costs are covered by volunteer services & 3 said ¼ or more are covered by other in-kind (e.g., medications, equipment)
- **Specialized Clinics:** 60% use each of these: clinical volunteers, clinical students other than medical interns & Kaiser Permanente community ambassadors
- **Other Safety Net Clinics:** Only clinical volunteers are used by a majority (89%)

Funder Perspectives and Plans

Key Grantmaker Concerns

- **Availability of services to populations not eligible for or unlikely to benefit fully from health care reform** due to immigration status or conditions like homelessness, mental illness, and substance use
- **Financial sustainability of safety net clinics** that do not accept third party reimbursements and may lack fully implemented electronic health records (EHR) and/or needed technological and staff capacity, resources, & relationships
- **Access to and quality of care under health care reform,** given demands on the safety net, competition, and implementation uncertainties, including possibility that Virginia will opt out of Medicaid expansion

Current Grantmaker Activities

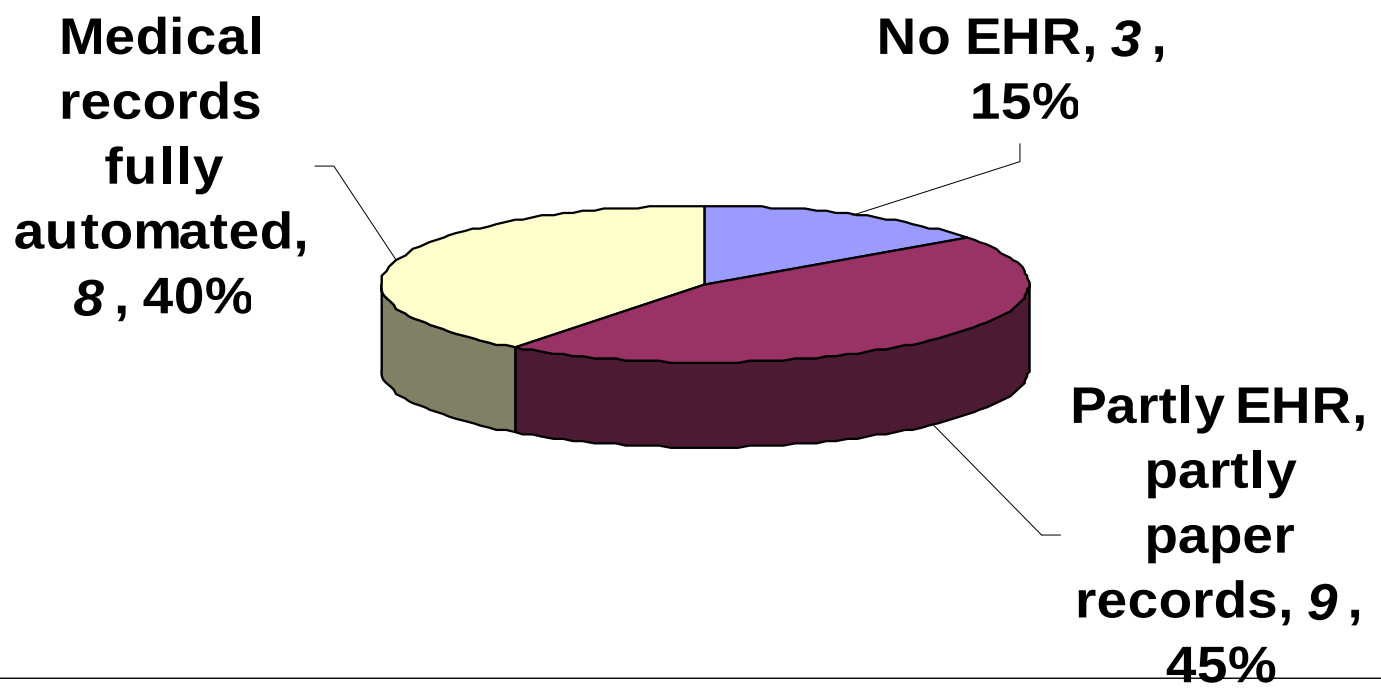
- Funding to FQHCs, free clinics, specialized providers, and other nonprofit clinics
- General support grants – most common type of funding
- Capacity building assistance (funds or hiring of consultants) a focus for many grantmakers
- Some project funding or support for capital campaigns
- Advice, consortium building, and convenings, including information and training related to health care reform

Capacity-Building Support Related to Health Care Reform

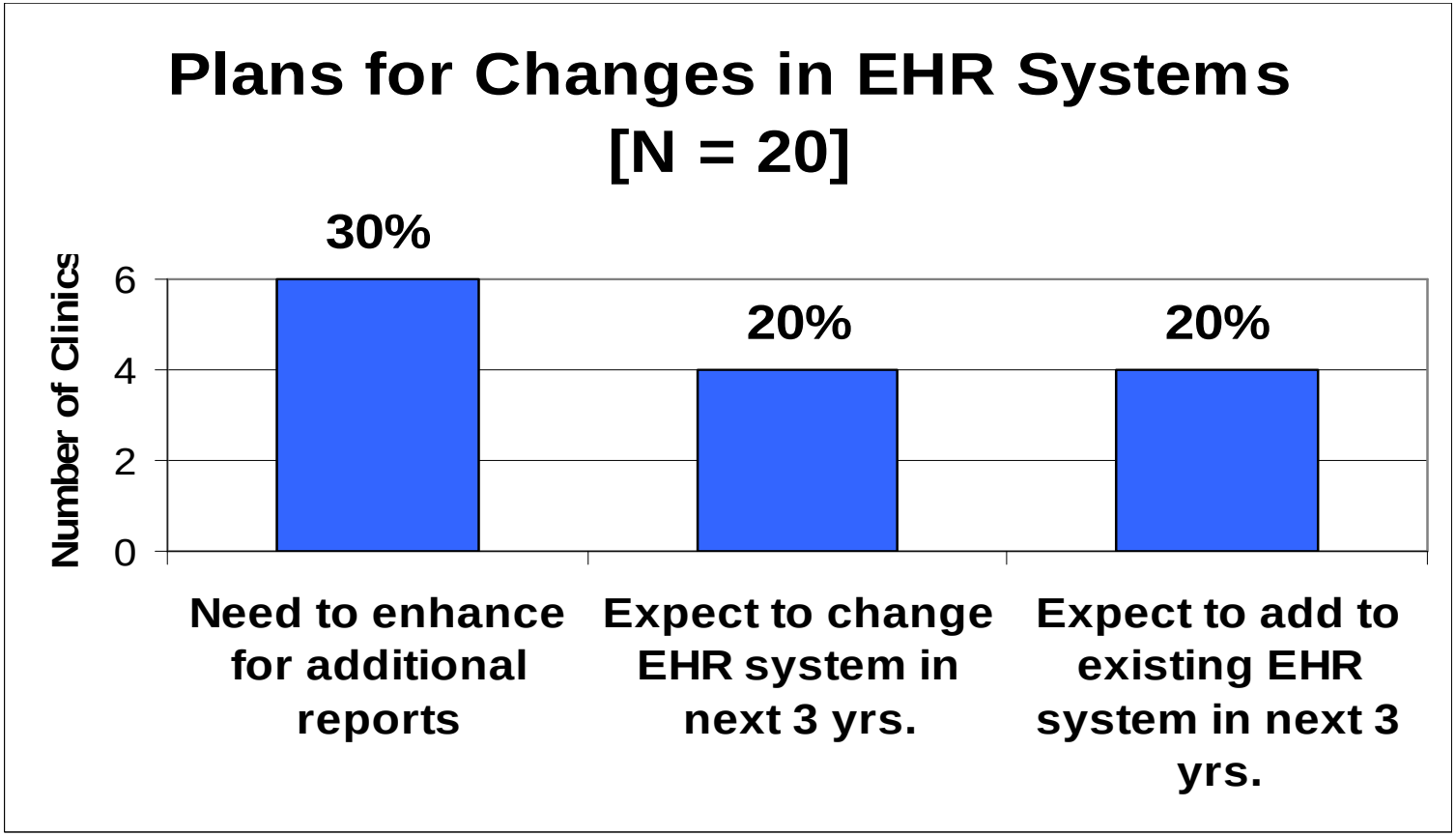
Funding, training, and consultants to help clinics:

- Fully implement and enhance EHR
- Establish and improve billing systems
- Maximize Medicaid reimbursements
- Improve other back-office functions
- Become patient-centered medical homes (PCMH)

Use of Electronic Health Records by Safety-Net Clinics [N = 20]



- 8 clinics reported their health records are fully automated, another 9 are partly automated, and 3 have no EHR system [the 1 non-clinic is excluded from this analysis]
- Among the EHR systems in use are eClinicalWorks (5), CHLCare through PCC (3), GE Centricity, MedServices, Medisoft Clinical, HEALTHeSTATES, eMds, and Care360



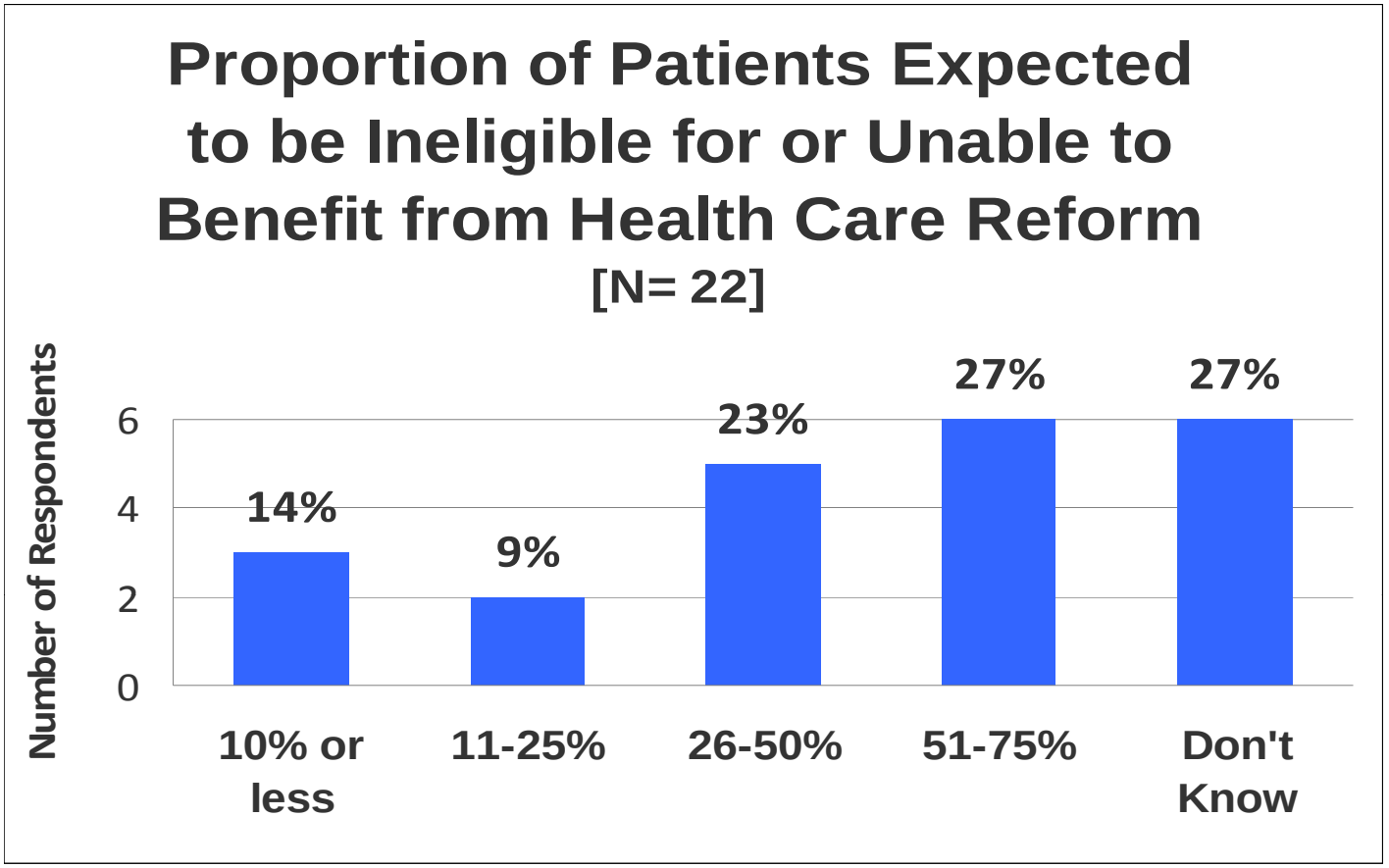
- 6 clinics indicated a need to enhance their current EHR system in order to generate additional reports
- 4 expect to change their EHR system within the next 3 years
- Another 4 expect to add to their existing EHR system to increase capacity for reporting and/or billing
- 3 clinics (15%) say costs of EHR are increasing rapidly
- **Some clinics fear they will be unable to maintain their EHR systems without ongoing grants and technical support – 1 estimated the annual cost at $60,000**

Future Funding of Non-FQHCs

- Extremely & increasingly competitive funding environment
- Some continuing support expected
- Careful consideration of which clinics deserve continuing support because of:
  - Populations served
  - Demonstrated ongoing need for their services
  - Types of services provided
  - Quality of care including coordination & continuity
- Some grantmakers: no support for clinics that do not take third party reimbursements for individuals eligible for insurance under health care reform
- Willingness to support clinics that collaborate with other providers and provide needed services to keep hard-to-reach patients in care

Funder Views on Immigration Status Issues

- Funders recognize that many safety-net clinics serve undocumented or recent immigrants who are not eligible for benefits under health care reform
- Many funders indicated commitment to supporting health care for these populations
- Pushback might come from a funder's Board of Directors
- Best approach: Discuss the issue in broader terms, such as:
  - Need to fill service gaps for special populations, including the homeless and people with chronic illness
  - Community benefits of universal access to care

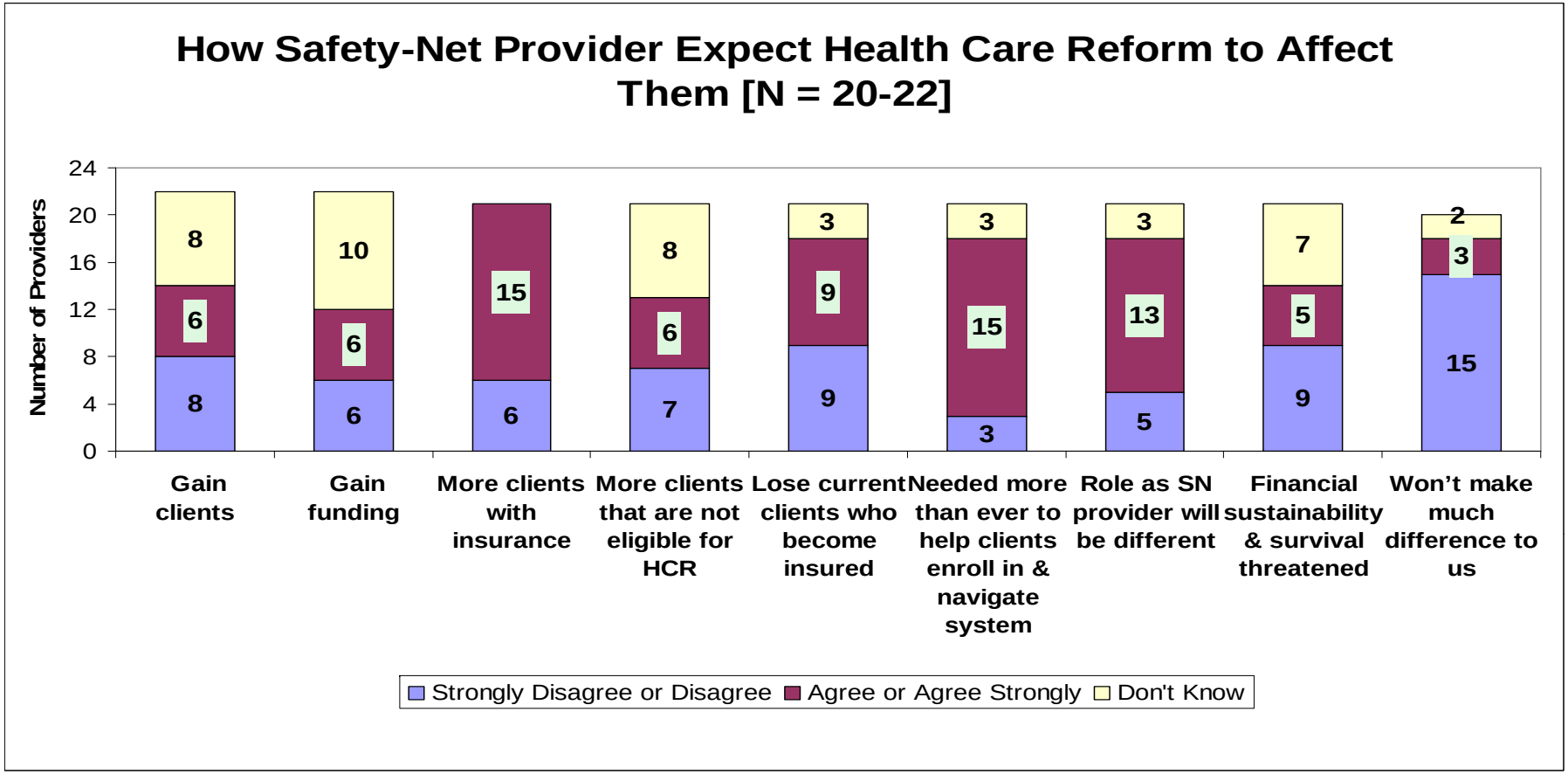


- **Many clinics expect a high proportion of patients who will not benefit from HCR: 50% (11) say 26-50% (5) or 51-75% (6)**
- About 1/4 of providers (23%) expect no more than 25% of their patients to be unable to benefit; another 1/4 (27%) don't know
- 40% of specialized clinics expect more than 50% of their patients to be either ineligible for health care reform or unable to benefit
- About 1/3 of free & other safety-net clinics are not sure how many of their patients will be unable to benefit
- No providers said more than 75% of their patients will be unable to benefit

Initial Criteria for Funding Free Clinics and Other Non-FQHCs

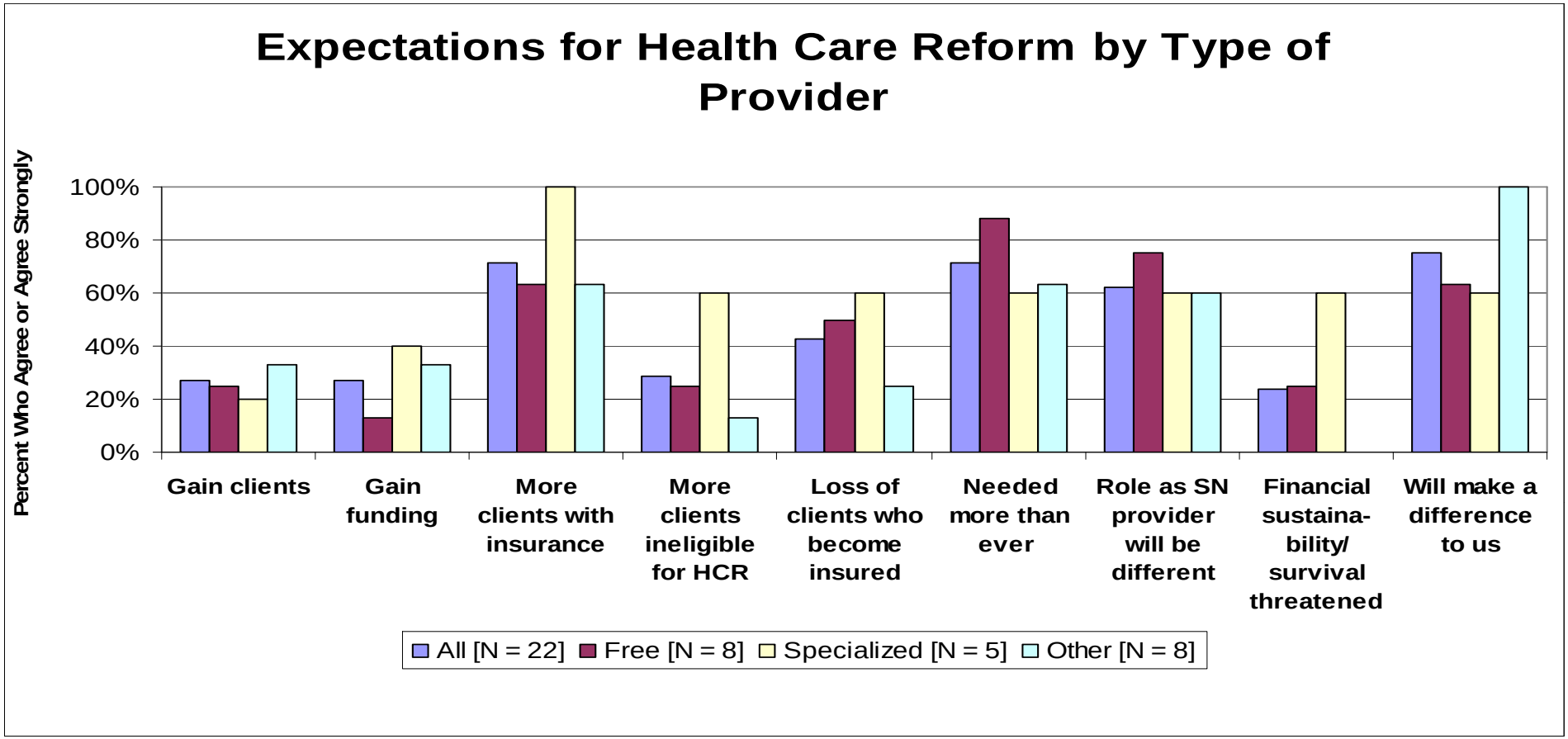
1. **Well documented need for clinic services**
2. **Level of services:** Significant number of hours and days per week; not “episodic” care
3. **Quality of care and use of best practices:**
   - Relationship building with patients & continuity of care
   - High quality care and use of quality and outcome measures
   - Fully implemented EHR systems
   - Ongoing monitoring of patient health status
   - Cultural competence
   - Capacity to make and follow up on referrals and navigate patients across systems and providers
4. **Capacity:** Skilled professional staff in key positions, to manage, oversee, and coordinate care – not just volunteers
5. **Plan for sustainability:** including diverse funding sources

Safety-Net Provider Plans and Actions regarding Health Care Reform

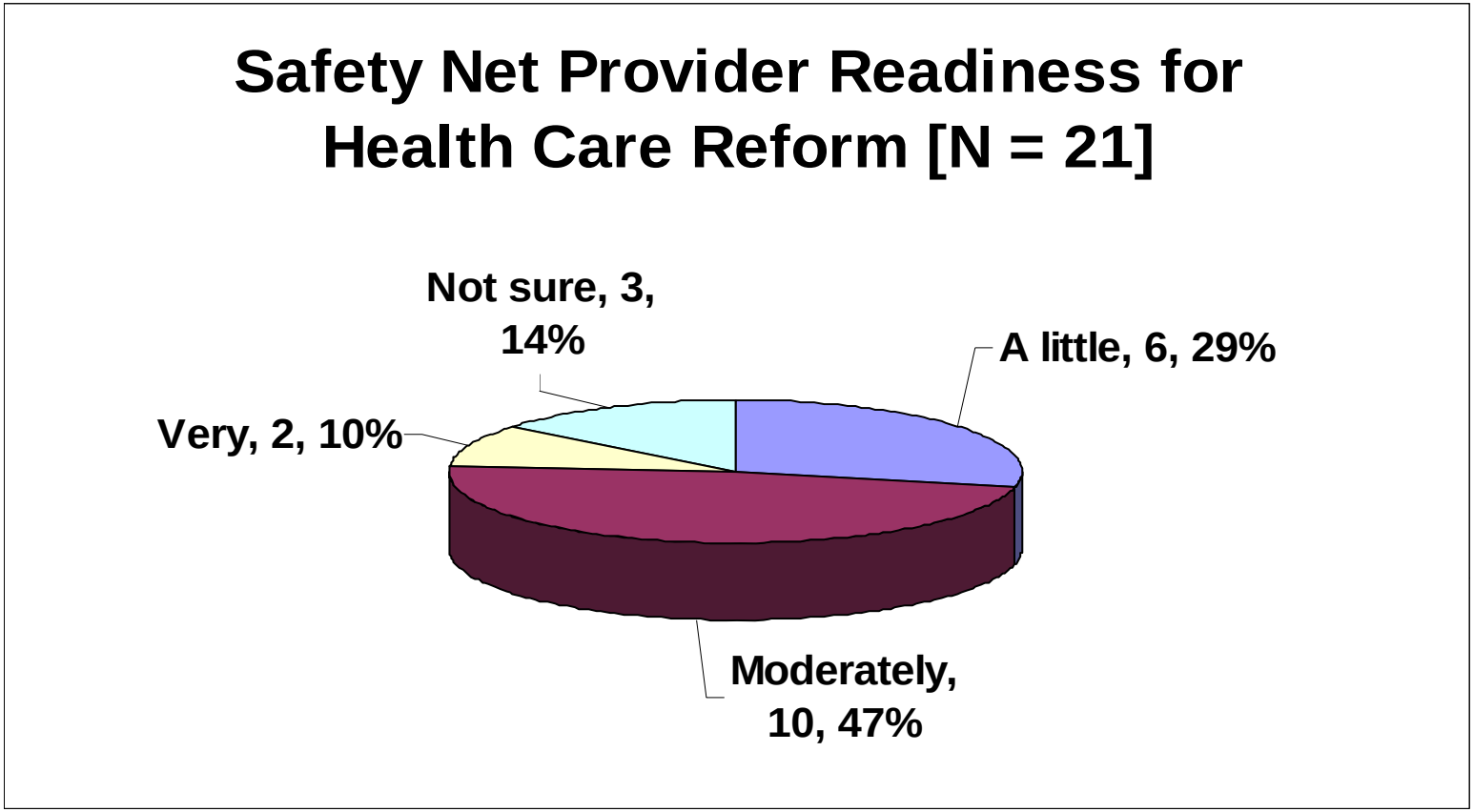


Safety net providers have varied expectations about health care reform:

- 3/4 believe it will make a difference to them
- Over 70% expect to have more clients with insurance; the same number believe they will be needed more than ever, to help clients enroll in and navigate the health care system
- Most fear they may lose clients & funding
- Over 60% believe that their role as a safety net provider will change
- 1/3 or more (7-10) don't know how health care reform will affect client numbers, funding & sustainability, or proportion of clients not eligible for HCR

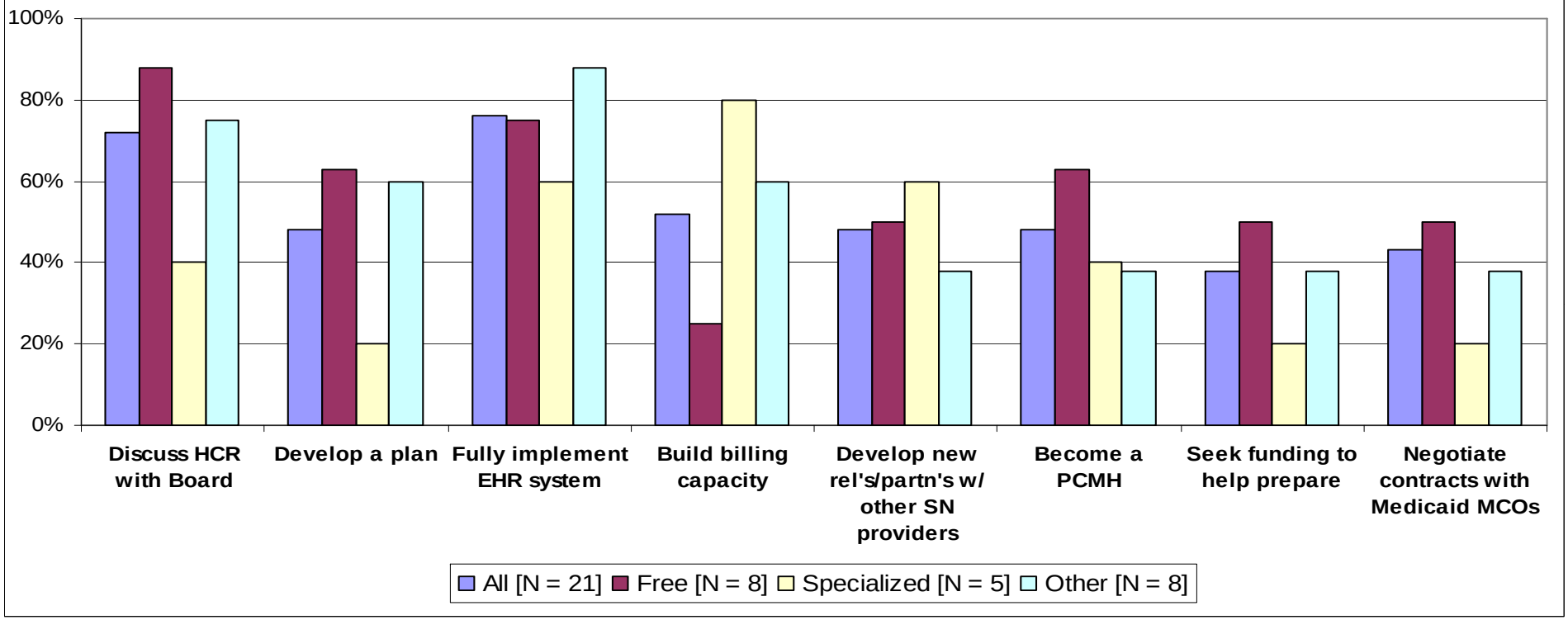


- Some expectations about health care reform vary by type of provider
- Most providers believe they will be needed more than ever but roles will be different – this is especially true for free clinics
- Specialty providers are especially likely to expect both more clients with insurance and more who are ineligible for health care reform benefits, loss of clients who become insured, and threatened financial sustainability
- Other safety net clinics are especially likely to see health care reform as making a difference to them and somewhat more likely than others to expect to gain clients



- Over half the providers (12 or 57%) reported being moderately or very prepared for health care reform; none said they were "not at all" prepared
- Half of free clinics (4) say they are either moderately or very prepared to adapt to or participate in health care reform, compared to 60% (3) of specialty providers and 63% of other safety net clinics (5)
- Free clinics are most likely to say they are only a little prepared (3 or 38%)

Health Care Reform Preparations Most Often Completed or in Process, by Type of Provider



- Despite describing themselves as less prepared than other clinics, free clinics also reported the greatest progress in most areas related to preparing for health care reform – such as discussions with their Boards, becoming a patient-centered medical home, and negotiating contracts with Medicaid MCOs
- Specialty providers have made the greatest progress in fully implementing an EHR system
- Other clinics are especially engaged in building billing capacity and developing new relationships with other safety-net providers

Models for Sustainability under Health Care Reform

Types of Models:

1. EHR & Billing Systems and Agreements
2. Collaboration, Linkages, and Mergers
3. Structures and Certifications
4. Demonstrating Excellence

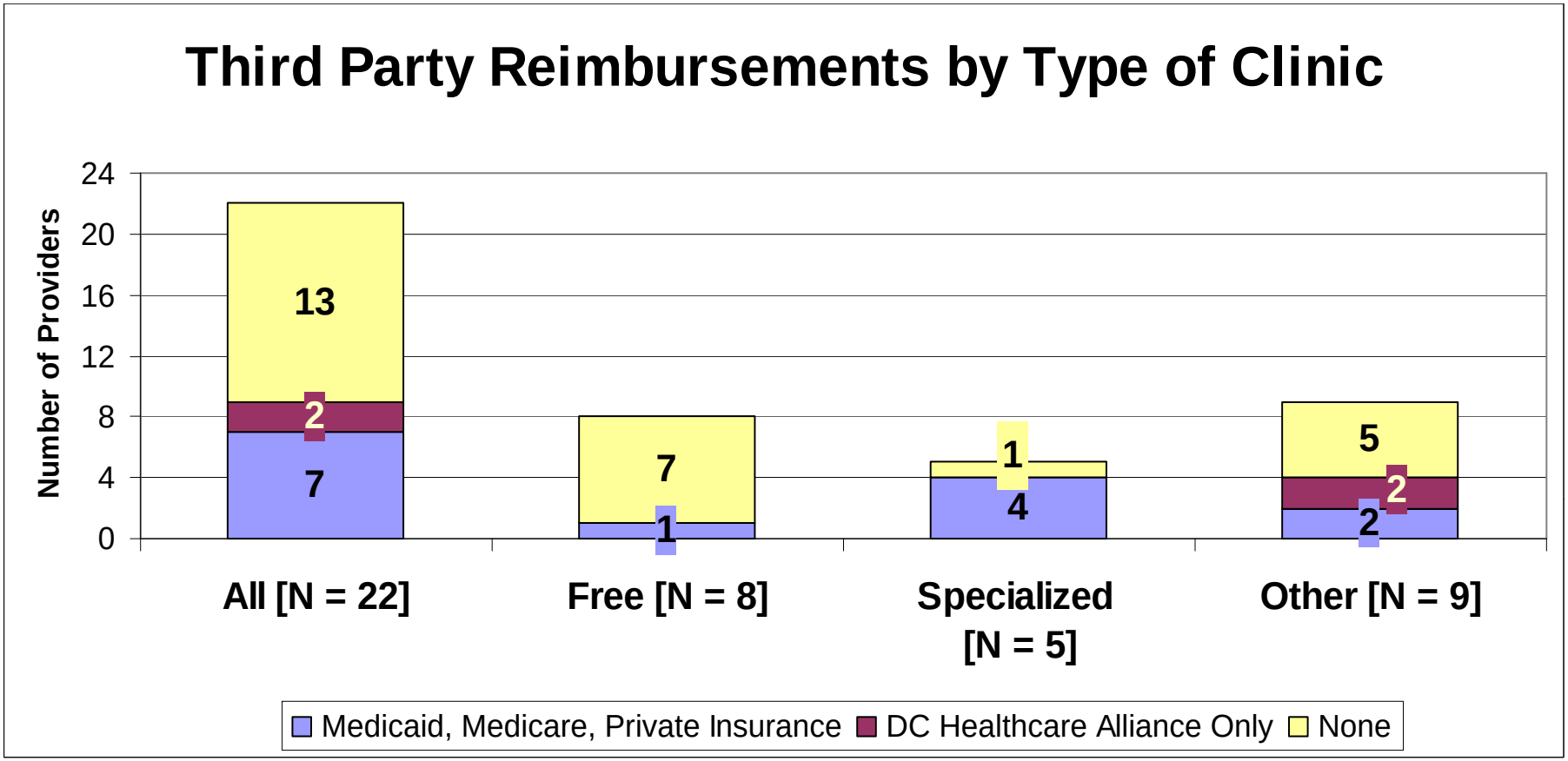
Sustainability Models/Strategies

1. EHR & Billing Systems and Agreements

- Transition to acceptance of third-party reimbursements
- Electronic health records and billing systems that provide for full & efficient billing to multiple partners
- Joint EHR and billing systems
- Favorable agreements with Medicaid MCOs, exchange providers, & other health insurers

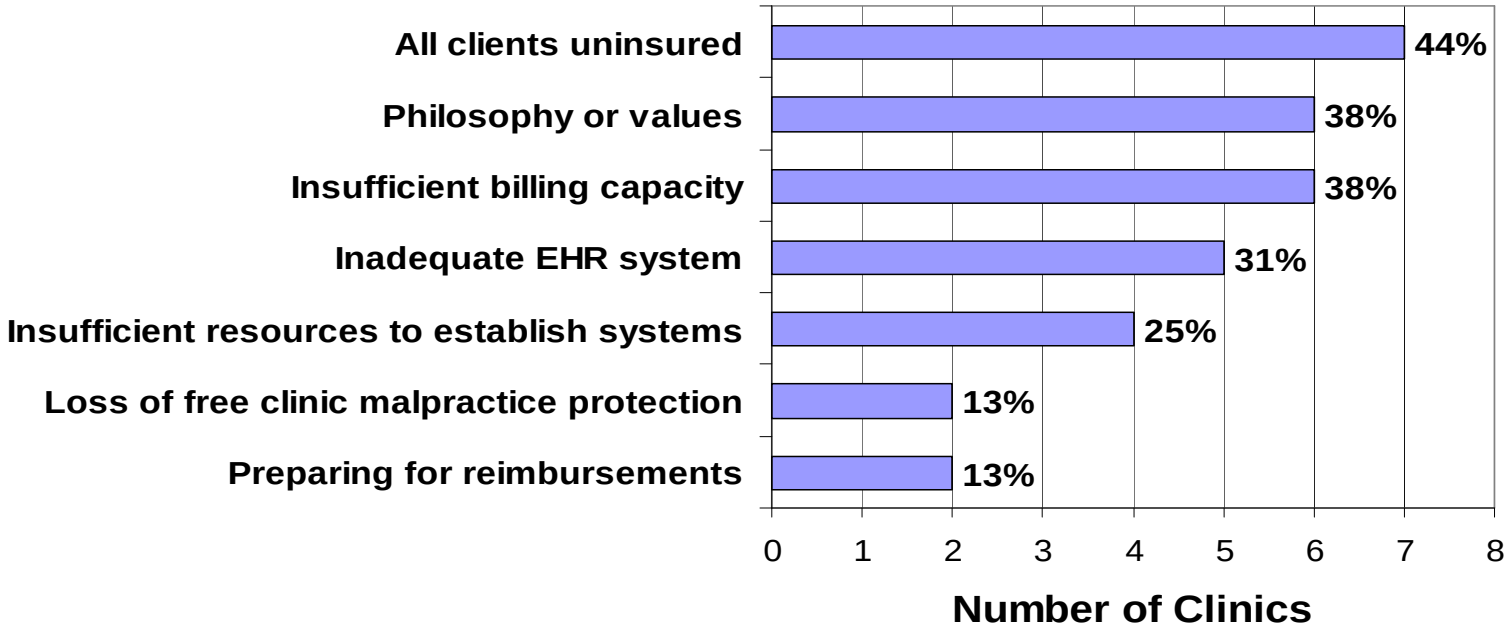
Examples of Actions Taken

- The Primary Care Coalition of Montgomery County (PCC) is working with 6 Community HealthLink clinics to develop a common EHR system; the County and the Healthcare Initiative Foundation have provided information technology funding
- DC Primary Care Association (DCPCA) has helped member clinics implement EHR systems
- Several clinics have received grants from funders such as CareFirst and Kaiser Permanente to implement or enhance EHR systems
- Arlington Pediatric Center increased Medicaid reimbursements by 40% with consultant help provided by the Northern Virginia Health Foundation



- 13 of the 22 clinics surveyed report no third party reimbursements; 2 receive only DC Healthcare Alliance
- 7 of 8 free clinics report no third party reimbursements
- 4 of 5 specialized providers do receive third party reimbursements
- 4 of 9 other safety-net clinics take either Medicaid or DC Alliance

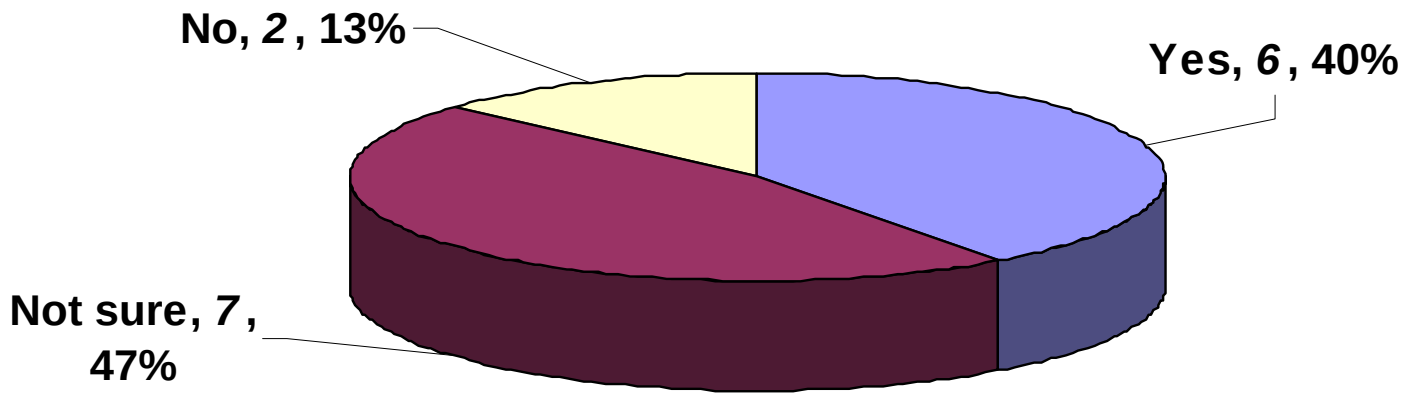
Reasons Clinics Do Not Receive Third Party Reimbursements
[N = 16]



Asked why they do not receive third party payments, providers most often mentioned the following:

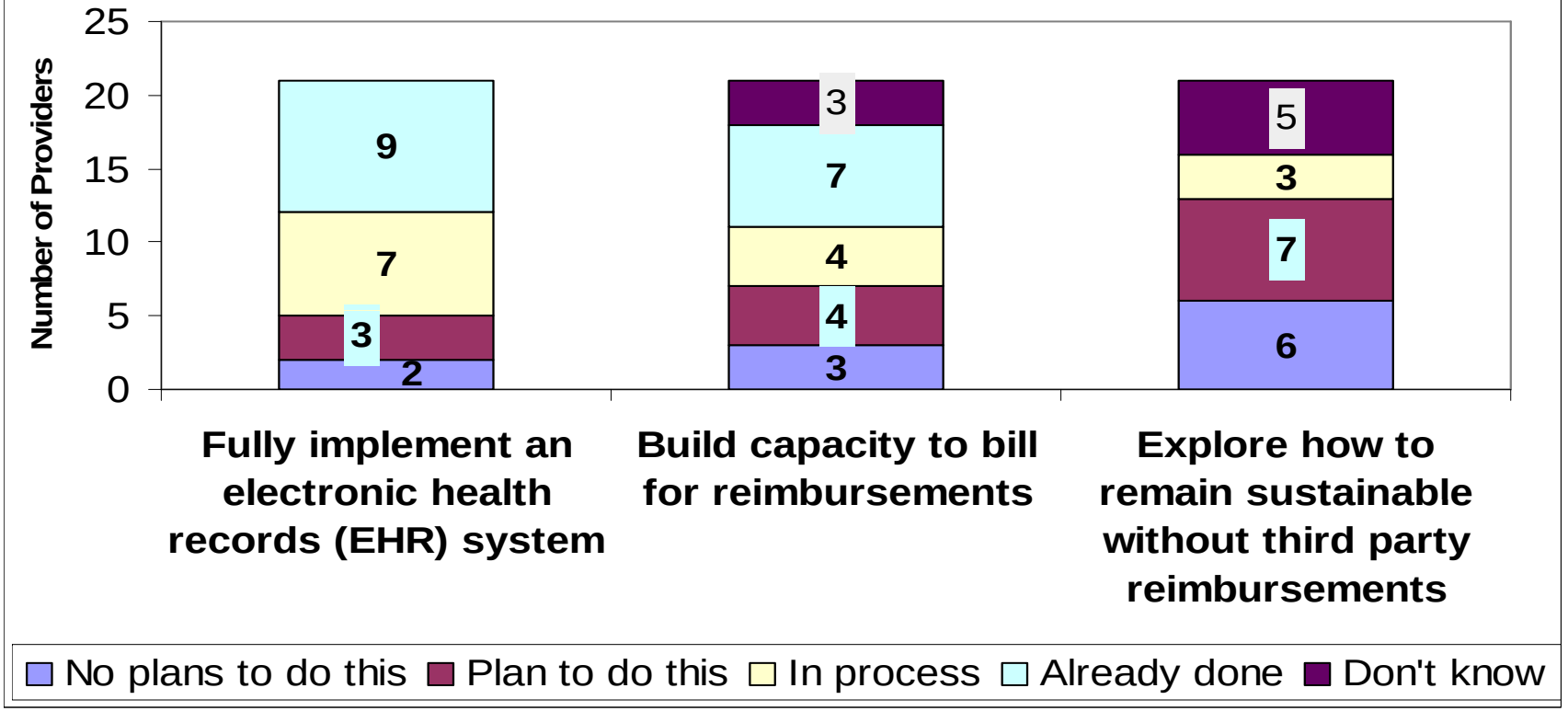
- Their clients are uninsured (7) – which may change as health care reform is implemented
- Receiving such payments is inconsistent with their values or philosophy (6)
- They lack billing capacity (6), an adequate EHR system (5), and/or the resources to establish needed systems (4)

Do Clinics Expect to Begin Receiving Third Party Reimbursements by 2014? [N = 15]



- Of the 15 clinics that currently take no third party reimbursements or only DC Healthcare Alliance, 6 expect to be accepting such reimbursements by 2014, 7 are not sure, and 2 do not expect to receive them
- Some are unsure because of philosophical concerns but believe that their sustainability may require acceptance of public or private insurance

Actions Related to Third Party Reimbursements [N = 21]



- 10 clinics expect to fully implement or enhance their EHR system
- 8 expect to develop capacity for billing
- 10 expect to explore how to remain sustainable without third party
- reimbursements
- 5 (all free clinics) are not sure what to do about sustainability and reimbursements

Sustainability Models/Strategies

2. Collaboration, Linkages, and Mergers

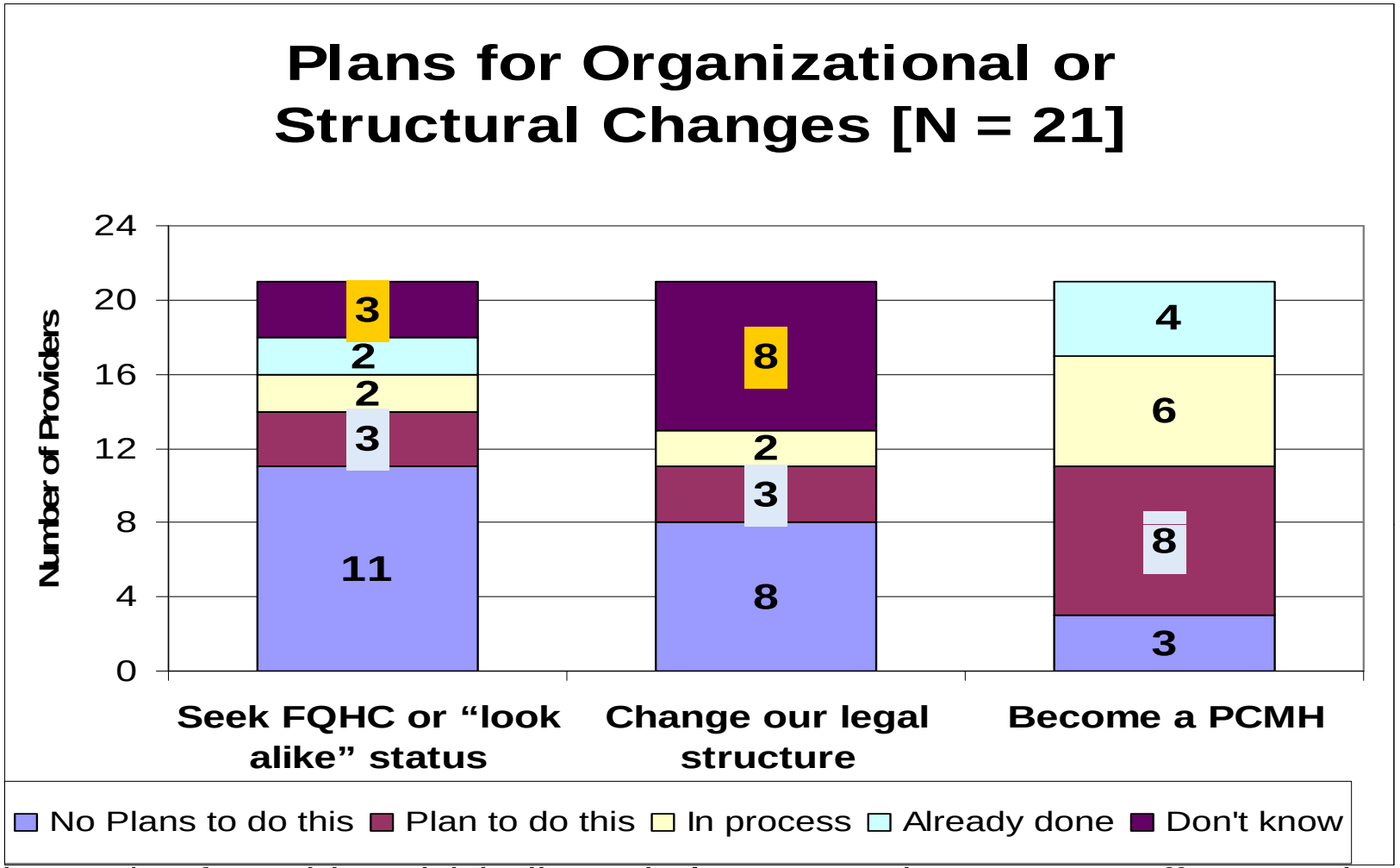
- Participation in a “health home” or patient-centered medical home network or related model
- Affiliation with an FQHC or look-alike

3. Structures and Certifications

- Obtaining of patient-centered medical home (PCMH) status
- Obtaining of FQHC or FQHC look-alike status

Examples of Actions Taken

- **Merger:** Jeanie Schmidt Free Clinic in VA is planning to merge with Loudoun Community Health Center; this will provide a CHC access point in Fairfax County
- **FQHC status:**
  - A clinic in DC (Family Medical and Counseling Service) was awarded FQHC status in June
  - 2 clinics in DC (Bread for the City and Carl Vogel Center) and 1 in MD (Mobile Medical Care) have received FQHC planning grants
- **Medical Home status:** Funders such as CareFirst, Consumer Health Foundation, Kaiser Permanente, and Northern Virginia Health Foundation have provided grants to help clinics become PCMHs or to support clinic association medical home efforts



- About 1/4 of providers (5) indicated plans to seek or current efforts to obtain FQHC status; 2 (9%) had received FQHC planning grants and 1 more had applied for FQHC status (and has now received it)
- Another 5 reported plans to change their legal structure; 8 (38%) don't know whether they will pursue this option; the same number have no plans to do so
- A large majority (18 or 86%) already are or expect to become patient-centered medical homes (PCMHs)

Sustainability Models/Strategies

4. Demonstrating Excellence

- Specialization and excellence – particular hard-to-reach or serve population, particular services

Examples of Action Taken

- Specialized clinics such as reproductive health providers and pediatric programs emphasize service need, quality, and uniqueness to public & private donors

Sum Up: Safety Net Providers

- Safety-net health care providers in the DC area that are not CHCs/FQHCs are preparing for health care reform but face many uncertainties
- **They are a major source of care:** together they serve nearly 75,000 patients a year (about 70,000 unduplicated)
- Most believe health care reform will mean changes in:
  - Client population
  - Funding
  - Role as a safety net clinic
- Most expect to be needed more than ever to help their clients enroll in Medicaid or an exchange and navigate the changed health care system

Sustainability = A Key Concern

- More than 1/3 are free clinics who depend heavily on volunteers, students, & non-governmental funding
- About 2/3 (15) either receive no third-party reimbursements from public insurance or receive only DC Healthcare Alliance (2 DC providers)
- Many expect to be obtaining third party payments by 2014, but nearly half aren't sure
- ¾ believe at least 25% of their patients will be ineligible or unable to benefit from HCR or don’t know
- Some are heavily dependent on local government or foundation funding
- They are not sure how health care reform will affect current funding sources and funding opportunities

Grantmaker "Take-Aways"

1. Foundation and corporate grantmaker priorities are changing & competition for funds will grow after 2014
2. Health funders expect clinics to develop plans & study sustainability options – and are helping clinics to prepare
3. Funders expect safety-net providers to implement and use EHR systems
4. Funders recognize an ongoing need for non-FQHCs that can demonstrate their value and quality of care
5. Clinics that do not choose to take third party reimbursements will need to make a strong case for continued support
6. Funders are developing criteria to guide future funding

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Project Advisory Committee

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- **Crystal Carr Townsend,** Healthcare Initiative Foundation
- **Athena Cross-Edge,** Planned Parenthood Federation of America
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- **JoAnn Pearson Knox,** NOVA ScriptsCentral
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- **Rachel Wick,** Consumer Health Foundation
- **Sharon Zalewski,** Primary Care Coalition of Montgomery County