

# Safety Net Workforce in the Context of Health Care Reform

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Many states are in the process of crafting programs to expand health coverage to reach more, if not all, of their uninsured population. Programs to cover almost every citizen are under way in Maine, Vermont, and Massachusetts. States as diverse as Illinois, California, Kansas, and New Mexico are in various stages of planning reforms. The literature on state experience so far has focused on the cornerstone implementation issues of mandates and affordability. Less attention has been paid to the question of whether there is adequate provider capacity to deliver care, especially to those who could gain coverage under state health reform.

The National Academy for State Health Policy (NASHP), under a National Cooperative Agreement with

the Health Resources and Services Administration (HRSA), Bureau of Primary Health Care (BPHC) is working to better inform state policy makers on how actions to expand coverage may affect the health care safety net, and in particular federally funded community health centers. This *State Health Policy Briefing* and other NASHP activities also are intended to stimulate dialogue and promote collaboration between state government and safety net providers in addressing shared missions and goals for assuring access to care for vulnerable populations.

As part of this National Cooperative Agreement, NASHP convened in May 2007 a day-long meeting of representatives from the primary care office (PCO) and primary care association (PCA) in six states, along with state policy makers who are members of NASHP steering committees. The discussion showed that there was concern about workforce shortages facing safety net providers, and how the safety net would be affected by health care reform efforts that seek to expand health coverage. Will the newly insured create a wave of new demand that will overwhelm the health care infrastructure? Is that infrastructure already overwhelmed? How will state policy makers and health centers meet this challenge?

To further examine these questions, NASHP staff conducted site visits to two states that are in two very different places along the continuum of health care infrastructure and health care reform efforts – Massachusetts and New Mexico.

Massachusetts has one of the lowest levels of uninsurance among states, and the health care industry is a major employer and factor in the state's economy. New Mexico, by contrast, has one of the highest levels of uninsurance, and has acute provider shortages in most areas of the state. Massachusetts, which is now implementing its combination of an individual health insurance mandate and subsidized

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products for people with lower incomes, is being closely watched by policy makers across the nation for early signs of success or failure. New Mexico is in the very early stages of health reform. After the recent completion of a study council that outlined three possible approaches for expanding coverage, Governor Bill Richardson has outlined a plan that will be introduced in the 2008 New Mexico legislative session.<sup>1</sup>

While there are significant differences between these two states, three lessons emerged from our discussions in each state, and these lessons are broadly applicable to how policy makers in any state might think about the role that health centers should play in the context of workforce planning and health care reform.

- Lesson 1: State policy makers and health center representatives need to have consistent, well-developed lines of communication, so that they can respond quickly and effectively to new issues and opportunities as they arise.
- Lesson 2: Health centers are now facing challenges in workforce planning at all levels, from clinicians to front-office staff to executives. States and health centers must work together with other stakeholders to coordinate and integrate planning for workforce issues affecting the health system.
- Lesson 3: Even in the context of efforts aimed at providing “universal” health care coverage, health centers will continue to have a role in caring for underserved communities, responding to the needs of new populations, and providing enabling services beyond medical care.

Health care reform of the scale under way in Massachusetts, and envisioned in New Mexico, is a bold new experiment. Prospects for success are uncertain. As states embark on their reform efforts, they ought to pause to think about the condition of their safety net.

## Snapshots of Massachusetts and New Mexico

### MASSACHUSETTS

Massachusetts pioneered the nation’s first community health center when two Tufts Medical School faculty opened a community-based primary care clinic in a public housing project in Boston in 1965. The state’s health care workforce is robust; Massachusetts enjoys one of the highest levels

of employment of health professionals per capita among states. According to a study by HRSA’s National Center for Health Workforce Analysis, in 2000, Massachusetts ranked well above the national average in its numbers of physicians, nurses, and dentists.<sup>2</sup> However, even with this robust health care infrastructure, there are areas of the state and populations that are not reached by the private health care delivery system. Today, 52 community health centers with 184 sites provide services to 760,000 patients annually. Since the mid-1990s, health centers have expanded into new parts of northern and western Massachusetts, and into the Cape Cod and Island region of the state. In 2006, 30 percent of Massachusetts health center patients were uninsured, and 39 percent were enrolled in Medicaid.<sup>3</sup>

The state’s health centers are represented by the state’s primary care association, the Massachusetts League of Community Health Centers. The League has a strong history of working with the Massachusetts Department of Public Health (DPH), and the primary care office housed in DPH. The Department of Public Health provides funding to health centers for a variety of projects, including health center capacity-building and funding for specific programs, such as women’s health and AIDS services. In state fiscal year 2007, DPH disbursed combined federal and state funding of more than \$31 million to freestanding health centers, and another \$12.6 million to hospital-licensed health centers.<sup>4</sup>

Collaboration between the DPH and the League has continued in the context of Massachusetts health reform. In May 2007, the primary care office and the primary care association met with a team from HRSA to discuss the state’s strategic partnership, and the role that this partnership is playing in health care reform. The discussion outlined the collaboration of the partners in supporting expansion of health centers, integrating behavioral health into health centers’ delivery of primary care, working together on Health Professional Shortage Area (HPSA) designations, loan repayment, and implementation of electronic medical record systems and other health information technology.

### About the National Academy for State Health Policy

The National Academy for State Health Policy (NASHP) is an independent academy of state health policy makers working together to identify emerging issues, develop policy solutions, and improve state health policy and practice. As a non-profit, non-partisan organization dedicated to helping states achieve excellence in health policy and practice, NASHP provides a forum on critical health issues across branches and agencies of state government.

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The state's current reform, authorized under Chapter 58 of the 2006 state statutes, builds on decades of access and coverage initiatives in the state. Through these initiatives, Massachusetts has made gradual progress in reducing the percentage of uninsured persons in the state to very low levels. Health centers are cited in many sections of Chapter 58, and the League has been an active participant in health care reform development and implementation. This is a natural outgrowth of the role that health centers played in the Uncompensated Care Pool, a program to reimburse acute care hospitals and community health centers for a portion of the cost of services provided to income-eligible uninsured and underinsured people.

As part of the state's negotiations with the federal government, this pool has been replaced with the Health Safety Net Trust Fund, and the state has developed the new Commonwealth Care program to provide subsidized insurance on a sliding scale of premiums to people between 100 and 300 percent of poverty, with no premium required for those below 100 percent of poverty.<sup>5</sup> Many of the people newly enrolled in Commonwealth Care are those who previously utilized the Uncompensated Care Pool. They still appear to be receiving services at their community's health center; at this point, the primary change has been the funding source.

The League noted that many Massachusetts stakeholders recognize the important role played by health centers. Since many health centers, especially in Boston, participate in large integrated delivery systems, Massachusetts health centers have greater visibility than may be the case in other states. This may be especially true among hospital leadership, who know the centers' executive staff, and who view the health centers' mission as part of their own. Likewise, the leaders of the four managed care organizations that hold Commonwealth Care contracts realize that there would be a danger to the state's health care infrastructure from destabilizing the health centers.

## NEW MEXICO

New Mexico is starting from a very different place than Massachusetts. Uninsurance is much more prevalent in New Mexico, with approximately 21 percent (roughly 419,000) of the state's two million people uninsured.<sup>6</sup> New Mexico representatives noted that many more people – potentially up to 40 percent of the state's citizens – experienced some difficulty in accessing medical care at some point in the previous year.

New Mexico operates in an environment of severe health care workforce shortages. According to the HRSA Bureau of Health Professions, New Mexico has fewer physi-

cians, registered nurses, and licensed practical nurses per 100,000 population than the national average, and ranks 49<sup>th</sup> among states in the number of dentists per capita.<sup>7</sup> The state has no dental school and only one medical school. In 2005, the state had 67 medical school graduates.<sup>8</sup> Nearly every New Mexico county has at least one type of Health Professional Shortage Area (HPSA), with 39 primary care HPSAs, 35 dental HPSAs, and 29 counties designated as mental health HPSAs.<sup>9</sup>

New Mexico's health center safety net includes 99 medical center sites, 40 dental sites, 17 school-based sites, and 18 state-operated school-based sites. The New Mexico Primary Care Association (NMPCA) represents 15 Federally Qualified Health Centers (FQHCs), which often operate multiple sites, 3 non-FQHCs, and a specialized behavioral health intervention project.

The primary care office in New Mexico plays a slightly different role than comparable offices in other states. Rather than independent county health departments, New Mexico has local public health offices that are staffed by state employees. There are almost 50 of these local offices, overseen by 5 regional offices, which in turn receive direction from the state Department of Health (DOH). Because the work of these local offices is more integrated with the state-level office than in states where the local public health departments are directed by counties, PCO officials see part of their role as helping the PCA and health centers form bridges to other state entities, rather than county governments.

This role is reinforced through the legislation that enables the primary care office, the Rural Primary Health Care Act (RPHCA). This act, largely unchanged since its passage in 1978, stands separately from the act that enables the Department of Health. The RPHCA describes the state's responsibilities in regard to the safety net: to recruit and retain health care professionals; and to assist in the provision of primary care through technical assistance, funding of community efforts, and the development of a primary care infrastructure. RPHCA gives the PCO substantially the same mission as the PCA – to expand and strengthen the state's primary care safety net – and provides a continuity of direction to the PCO's efforts, even amidst changes in administration and direction at DOH. The funding available to the PCO under RPHCA has risen from \$200,000 nearly 30 years ago to approximately \$12 million today. Our New Mexico representatives noted that this clear mandate from the state is something that other states might want to consider in seeking ways to strengthen state support for the safety net.

Community health centers in New Mexico see approximately 290,000 patients per year, roughly 15 percent of the

state's population. Forty-six percent of health center patients are uninsured, and 84 percent have incomes below 200 percent of the federal poverty level. RPHCA funds, administered by the PCO, subsidize the otherwise unfunded services and encounters for core primary care services, and these funds account for 10 to 12 percent of health center revenue.

The PCO and PCA engage in joint efforts to assist in the growth and development of health centers. The PCO gave out planning funds and seed funds for FQHC “look-alikes,” which it then helped to convert into federally grant-funded clinics when more federal grant funding became available. New Mexico has also “grown” such clinics out of National Health Service Corps sites, rural health clinic sites, and tribal sites.

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## Lesson 1: Maintaining Consistent Lines of Communication

Site visit participants in both Massachusetts and New Mexico said that clear, consistent communication between the primary care office and primary care association was integral to the functioning of the safety net. Moreover, it is useful for these partners to work together to communicate with the broader policy-making community in the state about issues affecting the safety net. This is particularly important in the context of a changing policy environment.

In Massachusetts, the legislature set the broad parameters for health care reform, but left most of the implementation details of the reform – defining benefit packages and “affordability” of health insurance premiums, for example – to the Connector Board and to various councils authorized under Chapter 58. The development of the rules and processes governing the reform effort has required significant public participation, along with a willingness among stakeholders to withhold judgment until the new framework has had some time to work. Our meeting participants felt a general sense that the state was undertaking an experiment that key stakeholders had agreed to, and that their duty was to not short-circuit that experiment. Communication has been essential in maintaining what one participant called this air of “quiet acceptance.”

Representatives of the Massachusetts League of Community Health Centers sit on several advisory councils (the Quality and Cost Council, the Disparities Council, the Community Health Worker Advisory Council, and the

MassHealth Payment Policy Advisory Board). Thus, the League feels it has the ability to raise concerns effectively about the interface of community health centers and the new framework. For example, the League was a leading advocate for the elimination of “duplicate” premiums faced by some Commonwealth Care-enrolled parents, who would have had to pay a family premium to the Connector as well as a premium if their child was separately enrolled in SCHIP. Also, the League has been supportive of funding for dental services for people with incomes under the federal poverty level. The trust that has been built among stakeholders has led them to accept compromises that give every group something that they want, but no group everything that they might desire from the coverage initiative. In addition, a Community Health Centers Steering Committee, which meets monthly with representation from the League, the PCO, other offices of the Department of Public Health, the Office of Medicaid, the Division of Healthcare Finance and Policy, and the University of Massachusetts Medical School, offers another effective vehicle for communication on workforce, health care reform implementation, and similar issues.

New Mexico meeting participants stressed that a strong PCO-PCA relationship, built over time by a small group of leaders, can help strengthen the safety net by coordinating scarce resources and identifying opportunities to work together to develop new resources. This is due, in part, to the very substantial workforce pressures and restrictive fiscal environment that the state faces.

The New Mexico PCO and PCA partners are actively working together to emphasize the importance of the safety net by seeking out opportunities to collaborate. In so doing, they lay the groundwork for safety net issues to be taken into account in large-scale health reform initiatives. One of the New Mexico representatives said that the trick to sustaining a vibrant PCO-PCA relationship is to build trust and understanding over years, and to work together on opportunities as they arise. This helps to show that each partner, and the partners together, can be trusted by other policy makers and stakeholders, like the legislature and other executive branch agencies, to work effectively on bigger issues. In the intervals between these opportunities, the partners ought to continue discussions and planning, to be able to respond rapidly and coherently to new situations and opportunities.

For example, the state recently embarked on a project to double the number (from 30 to 60) of schools providing school-based health services. At the time this initiative was announced, it was not recognized that many schools subcontracted these operations to FQHCs, and health centers were not included in the initial plan. Raising awareness of

the natural role for health centers has been hard. The PCO and PCA, working together, have negotiated a role for the PCA, which has developed a data management tool shared by six large health centers, and which will serve as the data backbone of this project.

In previous years, New Mexico's collaborative efforts included closer relationships with federal partners at HRSA. Officials from the PCO and the PCA served on a BPHC advisory committee of PCOs and PCAs to coordinate state and federal policy development. This advisory structure included National Cooperative Agreement holders and quarterly conference calls. At the time of the site visit, these calls had not been held in some time. Our meeting attendants felt that states could benefit from a reinstatement of a federal expectation of joint efforts and joint products from the PCO and PCA, since effective two-way communication with federal partners is also essential for the development and strengthening of the safety net. Since the site visits, HRSA announced a national meeting of PCOs and PCAs, which occurred in early 2008.

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## Lesson 2: Integrating Planning for Multiple Levels of Workforce Shortage

Health centers, primary care associations, and state government partners face multiple challenges in strengthening the safety net workforce. While state efforts are typically focused on training and recruitment strategies for clinicians, health centers face shortages involving all levels of operation, from front desk staffing to administration, from outreach work to clinical provider staff. Meeting participants noted that policy makers should be engaged in thinking broadly about whether their state's workforce can support their plans for coverage expansion, as well as focusing on the workforce support that health centers will need to sustain and expand their work in underserved areas.

Health centers must find ways to attract medical professionals to positions in underserved, often rural or poor, areas. They must compete in an environment that is producing fewer primary care practitioners. They also must identify and engage providers to deliver critical specialty services, such as dental and mental health care. They must have staff resources to meet the language and cultural needs

of populations who may have low English proficiency and differing understandings of what health care is. And, as states are considering and implementing major changes to health care financing and delivery, health centers must deal with an impending wave of retirements of executive directors and senior staff. Both our New Mexico and Massachusetts meeting participants suggested that there were many actions states could pursue to address these challenges, but that these efforts would be greatly aided by a coordinated national response.

### CLINICIANS

Health centers provide an avenue for uninsured and underinsured people to obtain access to primary care services. In order to provide those services, health centers need to have an adequate supply of primary care providers, including physicians specializing in family practice, internal medicine, and pediatrics. However, because of the more attractive salaries available to sub-specialists, fewer medical students are entering these fields. Even in a state like Massachusetts, where health care and higher education combined are the state's largest industry, constituting 14 percent of the state's employment, health centers face significant obstacles in provider recruitment and retention. The health care industry in Massachusetts also has one of the highest numbers of job openings in the state, with more than 16,000 vacant positions (3.8 percent of the total positions in the industry) in 2005.<sup>10</sup> In a recent internal document, the Massachusetts League indicated that it anticipates that it will have to fill 100 clinical openings for primary care physicians in each of the next three years.<sup>11</sup>

The scarcity of primary care providers presents severe problems to health centers in obtaining and maintaining an adequate workforce. Because of their relatively modest means, health centers are often unable to offer salaries to new physicians that are competitive with those offered by hospitals and physician groups. The health center environment also involves a set of stresses – tight budgets, large workloads, and a patient population with complex needs and unstable circumstances – that create challenges in retaining providers for more than a few years. In addition to these strains, participants in both of our site visit states also cited as a stressor the lack of outlets for providers to refer patients for specialty care, like oncology or ophthalmology. A recent report by the Center for Studying Health System Change notes that this is a common problem for health centers nationally.<sup>12</sup> Trying to locate non-health-center specialty providers who will accept Medicaid or uninsured patients is time-consuming and emotionally draining, and contributes

## THE NEW MEXICO HEALTH RESOURCES INTEGRATED RECRUITMENT STRATEGY

NMHR coordinates with many federal and state programs, including National Health Service Corps loan repayment programs, the New Mexico Loan Repayment Program, and the New Mexico Health Service Corps, a state-funded program that subsidizes medical residencies. All of these programs carry an obligation to serve in underserved areas, which often entails placement at health centers. New Mexico also participates in the Western Interstate Commission on Higher Education (WICHE) program, a joint partnership of several western states which tries to obtain tuition reciprocity for students entering medical, dental, or veterinary school, on the condition that they come back to their home state to practice. NMHR works with partners at the PCO, the PCA, and the University of New Mexico to weave together these programs into an offer that draws students to health centers, and ensures that they are retained there for several years. An essential part of the program's success is personal outreach to students to determine the best candidates for assistance, and the best placement for those candidates.

to professional turnover.

One of the major strategies that states and health centers pursue to enhance the pipeline of providers entering into service at health centers is to provide students in training with guarantees of financial assistance – grants and loan repayment programs – in exchange for service in underserved areas. This approach recognizes that these students are not likely to practice at the health center for much longer than the term of their “obligated” service, so it requires that there be a reliable pipeline of new providers to keep the available slots continuously filled.

Recruitment of graduating students to health centers is a major focus of New Mexico's efforts to strengthen the safety net. Its vehicle for this recruitment is New Mexico Health Resources (NMHR), a nonprofit organization that is authorized under the same RHPCA legislation that authorizes the PCO. It is a clearinghouse for workforce recruitment to underserved areas, and has operated for 27 years under a contract with the PCO. NMHR serves as a matchmaker between individual practices or clinics and approximately 45 new providers per year, mostly physicians and dentists.

One of the challenges facing rural states like New Mexico in implementing a vigorous provider recruitment strategy such as this is the limited control that the state has over the medical-education infrastructure, especially in the apportioning of medical and dental residencies for new graduates. Medical residencies are conducted through a national match, and rural states are at a competitive disadvantage, as graduating students are drawn to areas with more health resources. Legislatures have some theoretical control over the educational infrastructure, but the actions that they take may not directly result in improvements in the workforce situation. For example, states may invest new dollars into capital expansions for universities, but there is no

guarantee that students coming to a state university will not leave immediately after graduation.

Our meeting participants noted that the situation would benefit from a reexamination of this system of residencies by the federal government and by the national medical education system. More broadly, there needs to be a national reevaluation of the reimbursement methodologies of Medicaid, Medicare, and private insurers that value the services of subspecialists more than primary care physicians.

Additionally, all states are faced with a shortage of nurses. Rising demand for nursing services, coupled with an aging workforce and difficulties recruiting new people to the field mean that, over the next two decades, HRSA projects that the nation will face a shortage of more than one million registered nurses.<sup>13</sup>

Partially as a result of the scarcity of physicians and nurses, both of our site visit states, like many states across the nation, are working to further expand primary care teams to include other types of providers. This includes expanding the duties of physician assistants, loosening the supervision requirements of dental hygienists, and giving psychologists limited ability to prescribe medications. However, even here, health centers' efforts can be impeded by narrow workforce pipelines. In New Mexico, for example, nursing education regulations require a student-to-faculty ratio of 8:1.<sup>14</sup> The National League for Nursing's accreditation standards also require nursing preceptors to have (or be seeking) master's degrees.<sup>15</sup> Our New Mexico representatives reported that the lack of preceptors has resulted in an average wait time of 2 years for clinical nursing rotations, and limited the size of incoming nursing classes to 1/3 of qualified applicants. Some of our participants said that there is some emerging national awareness of the workforce issues posed by this training structure, but as of yet, no coherent national policy to address it.

## DRAWING ON THE COMMUNITY FOR FRONT-LINE WORKERS

Another way that health centers are seeking to extend their capacity is through expanding their use of Community Health Workers. Our Massachusetts participants indicated that they found Community Health Workers, particularly those who had been health care workers in their country of origin, to be good ambassadors for reaching out to newly-arrived communities of immigrants. Community Health Workers work in these communities to connect individuals with health and human services; they provide education, informal counseling, and social support, ensure people receive needed services, and advocate for individual and community needs.

The demographics of many Massachusetts communities served by health centers are highly dynamic – the ethnic mix of residents may change rapidly with new waves of immigration. This includes Hispanic populations moving into new areas of the state, and also influxes of African, Eastern European, and Russian populations, who bring distinct language and cultural needs. In response, health centers also seek to bring members of these communities into the health center as front-office employees. While it once was enough to have English/Spanish bilingual staff, health centers are now finding that they need staff proficient in three or four languages to meet the needs of their patients.

Source: Community Health Worker definition adapted from Gail Ballester, *Community Health Workers: Essential to Improving Health in Massachusetts – Findings from the Massachusetts Community Health Worker Survey*. Massachusetts Department of Public Health, (March 2005), 3.

## EXECUTIVES AND SENIOR OFFICIALS

An equally imposing problem for health centers is the impending retirement of a large cohort of health center leaders. Our meeting participants from New Mexico were keenly aware that this shift is likely to have a profound impact on how the safety net functions in their state. The current relationship between New Mexico's PCO and PCA has deep roots among a small number of people who have been involved in public health and primary care issues since the first introduction of community health centers in the late 1970s. The personal connections between individual actors, as well as a shared sense of history and mission, have been critical in steadily advancing the organizations' shared priorities. Our participants expressed concern that as those individual actors leave the stage, the integrity and visibility of the state safety net might suffer.

The participants in Massachusetts told a similar story, and also remarked that the wave of health center expansions that has occurred since the mid-1990s has mostly depended on members of this

same age cohort for leadership. Most executive directors for the new sites have come from other health centers, or from administration of hospitals that are aligned with health centers. The League has provided extensive assistance to individual health centers on leadership transition, and is now engaged in more comprehensive statewide succession planning for health center executives. Our New Mexico site visit participants remarked that such planning might be an area where PCOs and PCAs would benefit from increased

## THE MASSACHUSETTS C.H.I.L.D. MODEL FOR LEADERSHIP DEVELOPMENT

The leadership cliff facing state officials, health center directors, and even legislators involved in safety net issues is daunting, and while our two site visit states have recognized the importance of succession planning, work remains to be done on a coherent strategy to address it. The Massachusetts League has developed a promising model in the Community Health Institute for Leadership Development (CHILD), the umbrella for a variety of workforce-related projects, including a certificate program with Suffolk University for front-line health center managers, a training curriculum in strategic financial management, and pre-employment training for people seeking entry-level jobs in health centers in their local communities. CHILD is intended to be a pathway for health centers to develop leadership and expertise internally, and to help build the economic infrastructure of the neighborhoods where health centers are located.

Source: Massachusetts League of Community Health Centers, "Workforce Development: A New Frontier," *Massachusetts League of Community Health Centers Monograph Series*, 2006.

collaboration with federal partners, who could help develop model strategies for states.

## Lesson 3: The Continuing Need for Health Centers in the Context of Health Reform

Our meeting participants noted that it is vital for health centers to think actively about their future in an environment of “universal” coverage, as they see a continuing role for health centers. In fact, our Massachusetts participants were careful to emphasize that the state’s reform will not fully guarantee “universal coverage.” Although the state has expanded eligibility for children under MassHealth, Massachusetts’ individual mandate is only for adults. People can obtain exemptions from the mandate if they cannot find affordable coverage, or due to religious beliefs. People can also simply refuse to enroll and incur a tax penalty. People who do not keep up their premium contributions may end up losing coverage. Moreover, there will continue to be some people in the state who will never be eligible for coverage due to immigration status. This point resonated with meeting participants in New Mexico, who recognize that this set of uninsured people pose a particular challenge in their state.

Even beyond meeting the needs of the remaining uninsured, our meeting participants believed that there will continue to be an important role for health centers in delivering access to care for people, particularly in places that are not well-served by the private health care system. The workforce shortages that both states face will not go away if more people carry health insurance, so the health care safety net will continue to be crucial to rural areas, as well as urban neighborhoods where it is difficult to find a private provider who accepts Medicaid-enrolled or uninsured patients. Health centers can provide access to medical homes in rural or migrant communities where it is not feasible for the private sector to fill that role. The clientele of health centers is comfortable and familiar with seeking care there, and relies on the enabling services that are provided, such as outreach, translation, transportation, and coordination with housing and social services. These services are not ordinarily covered by private health insurance products or provided elsewhere as part of primary care, but the League believes that the continuing need for these services is a key part of why health

centers will continue to play a vital role in the “post-reform” world. In Massachusetts, this is being borne out by evidence that many health centers are experiencing growth in their caseload since the introduction of Commonwealth Care.<sup>16</sup>

Site visit participants in both states emphasized that policy makers contemplating health care reform must think not only of the goal of reform being insurance coverage for all, but also must consider whether the insured will have access to the health care services that they need to achieve improved health outcomes. In that light, it is important for them to think about the existing capacity that health centers provide, and how they might leverage that capacity to serve more of the newly-insured, and those uninsured who will inevitably be left behind. At a minimum, our New Mexico participants noted that the cost-based reimbursement structure that exists under Medicaid must be preserved. Medicaid financing forms the backbone of the Massachusetts health care reform, and it plays a similar role in reform proposals being debated by other states. Our meeting participants stressed that it is important that health centers be reimbursed the cost of providing care to these patients, so that the centers can continue to provide care to the uninsured as well as the ancillary services that Federally Qualified Health Centers are required to provide.

## Conclusion

Although our Massachusetts site visit participants cautioned that many factors at play in its reforms are somewhat unique to the state, and that it is still too soon to draw conclusions about the ultimate fate of its experiment, policy makers across the country are looking for early lessons to guide their thinking about health care reforms. All of our site visit participants would advise them to begin thinking about safety net and workforce issues early in their process. Our conversations were by no means exhaustive, and further attention could be given to a variety of topics, from the appropriate role of the state educational infrastructure and post-graduate medical education in meeting safety net workforce needs, to the most effective ways to use federal programs, like the J-1 visa program for medical professionals, to strategies for retention of clinicians once they have been recruited to health centers. However, the very distinct experiences of New Mexico and Massachusetts in regard to state health care reform yielded a few similar findings.

- Open lines of communication between health centers and the state, as well as with the wider policy community in the state, are important to identify and

address issues of access for underserved populations within the context of health care reform. A legislative framework such as the New Mexico Rural Primary Health Care Act that aligns the priorities of the primary care office and primary care association may be helpful.

- States, and especially safety net providers, are facing intense workforce pressures because of structural issues related to clinician training, difficulty in recruiting and retaining providers to work in health centers, and the impending leadership cliff as the first wave of health center executives prepare to retire. There may be a benefit to an enhanced federal role in helping states and primary care associations plan for these challenges.
- Health centers will continue to play a vital role in a context of expanded insurance coverage for many reasons. They will still serve as a safety net, to catch those who will inevitably be left out of “universal” coverage plans. There will still be a need to support access to care for populations and geographic areas that are not well-reached by private providers. Health centers offer both high quality primary care and supportive services that are needed by underserved communities.

So far, state health care reform efforts have tended to focus on “coverage” as the main goal of expansion efforts, rather than ensuring that the insured will have access to needed health care services. This may be changing in states like Pennsylvania, which is designing its health reform plans with workforce issues in mind.<sup>17</sup> Our Massachusetts and New Mexico participants recognize the need for thoughtful and careful analysis of systems capacity issues and careful consideration of the role that the safety net will play in their reform plans.

## NATIONAL ACADEMY for STATE HEALTH POLICY

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## Notes

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