Charity Care Subgroup Meeting
June 20, 2013
Olmsted Room
Utah State Capitol

Next Meeting: Thursday, July 18; 10:30am-12:30pm; Room 20, House Building (map)

Note: *The following is a partial transcript of the June 20th Charity Care Subgroup meeting at the Utah State Capitol. It is meant to be illustrative of the statements made by some of the participants, but it is not comprehensive of the entire meeting.*

Pamela Atkinson, co-chair (PA): Described goals of the subgroup based on the matrix provided by the DoH. Goal: Which program features to include in charity care plan.

Rep. Mike Kennedy (MK): From legislative session, the original goal was to involve LDS church. We all donate a lot in this state, mentions scouts, , Jake Anderegg is working on LDS church partnership.

PA: It has been hard to come up with the bottom-line cost for each clinic—Malieh, Fourth Street, CHCs, etc. Each clinic uses different systems and numbers
PA: We want to provide consistent, quality care across the entire state.

Jennifer Dailey (JD): Utah Academy of Family Physicians
Up until this point, charity care has been the antithesis of comprehensive medical care, patient-centered medical home; every clinic must have an EMR. Short of ideal of medical home, the concept of consistent care is still important: one doctor, one team, and all communicating together; charity car=e doesn't do that.

PA: Describes the concept of having community health workers based in each community to help people learn how to take better care of themselves. Goal is similar to Sen. Luz Robles SB85 "Community Health Workers" legislation in 2013 general session.

MK: Describes the current medical billing system. He claims that he does work for $30, bills Medicaid $200, and $130 goes to administration. MK claims the government takeover of healthcare happened in 50 years ago, and led to the rise in costs.

MK: "All I need is my eyes, ears, nose, and a stethoscope to practice medicine." Plus, my patient's bad habits cause most of their problems. Let's not do brain surgery with charity care.

Sen. Stuart Adams (SA): Let's set up a network where doctors can know where to go to volunteer their time. Does that exist?

MK: We should set up a charity care screening process for patients. If you are willing to meet our expectations, we can give you care. If not, it's not for you. Create a contract. Doctors know that success for patients is mostly dependent on what the patients give.

Victoria Brimhall (DOH staff): Describes large-scale efforts by private Central Utah Clinic group; has over 77 clinics, did $10m in charity cancer care; affiliated with Rep. Stewart Barlow.

Central Utah Clinic - http://www.centralutahclinic.com/locations

Ray Ward, MD (RW): Note that the Central Utah clinic is a private entity. It makes money off some patients, and gives charity away on others. Those costs are shifted around the organization. It either charges some patients more, pays doctors less, or absorbs the losses. This is not real charity care, he says. This is a business absorbing a loss.

RW: Respond to Rep. Kennedy, Ward says that 10% cost is not just time, but also money and administration. He says it would be far easier to tax a doctor $15,000 than to ask them to donate 10% off their time.

Sen. Allen Christensen (AC): We are kicking around the same issues. It's all going to end up with zeroes (ie. that charity care doesn't make financial sense, and it doesn't offer effective care).
Christensen's solution: Let's pick a county, a location, and create a model to see if it works.
AC: "This is charity care. It isn't Cadillac care. It isn't everything care."
Liability: If a doctor or the clinic is paid $1, the Good Samaritan law doesn't apply to them.
AC: I wrote the Good Samaritan law. I can change it, and I will.

Kim Bateman, MD (KB): Mentioned specialists making huge impact in international settings like Africa.
His solution: We can do primary care in clinics, and do specialty care in limited spaces and times, like international medical missions

MK: How do you incentivize charity care in primary care settings? He suggested offering a rebate on state licensing, CME credits, use medical students, PAs. "BYU students where I live are dying to get in there and work on patients."

PA: Showed interest in Sen. Christensen's idea: Do a pilot study in one clinic in one county

Jennifer Hyvonen (JH): At the Fourth Street Clinic, we have specialists come in once a week.

RW: The average patient does not know how to access what we have already, I have story after story of patients asking me where they can get charity care.

PA: More people finding out about 2-1-1 (United Way Call Center) as an information resource to connect to benefits

PA: We need to narrow down the program features, what should be included in a statewide charity care program

PA: There is even the proposal to drop the term "charity care," and create the term like "financial assistance." Some people react negatively to charity care. And we need to change the Good Samaritan law.

Rep. Rebecca Chavez-Houck (RCH): if we do a pilot program, we could do it in conjunction with Medicaid expansion.

Malieh Free Clinic: Our clinic has all of our labs and imaging donated by IMC.

Malieh: Funding structure: 1/3 comes from wealthy donor, 1/3 comes from annual gala, 1/3 comes from private donors. Malieh has one paid doctor, and all others are volunteers.

PA: By January 2014, we won't have all the clinics we need to cover the people getting mandatory coverage

Sen. Adams: Physicians are passionate to help people. Do they have a way to go and donate time? Is there an education to assign doctors to this system?

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