

February 17–19, 2004 / South Carolina

**NATIONAL
HEALTH
POLICY
FORUM**

Site Visit Report

The Health Care Safety Net in South Carolina: A Test of Tenacity

THE GEORGE
WASHINGTON
UNIVERSITY
WASHINGTON DC

CONTENTS

Acknowledgments	ii
Background	1
Program	3
Impressions	5
Concerns for the Future	10
Agenda	11
Federal Participants	17
Biographical Sketches —	
Speakers	19
Federal Participants	25

Site Visit Managers

Jennifer Ryan / Randy Desonia

Administrative Coordinator

Marcia Howard

National Health Policy Forum2131 K Street, NW, Suite 500
Washington, DC 20037

202/872-1390

202/862-9837 [fax]

nhpf@gwu.org [e-mail]

www.nhpf.org [web site]

Judith Miller Jones – *Director***Sally Coberly** – *Deputy Director***Michele Black** – *Publications Director*

NHPF is a nonpartisan education and information exchange for federal health policymakers.

ACKNOWLEDGMENTS

This site visit, “The Health Care Safety Net in South Carolina: A Test of Tenacity,” represented a long-awaited return to the South for the National Health Policy Forum. The value of the lesson “when you’ve seen one state, you’ve seen one state” was illustrated throughout our time in the Charleston area. Made possible through generous support from the Forum’s core funders, the W. K. Kellogg Foundation and the Robert Wood Johnson Foundation, with additional funding from the David and Lucile Packard Foundation and the John D. and Catherine T. MacArthur Foundation, the two-day tour and study of South Carolina’s health care system provided a number of valuable lessons for 20 site visitors and five NHPF staff.

We experienced the famous “southern hospitality” throughout the site visit, but special recognition and thanks go to several individuals who hosted us in their facilities on Johns Island and in North Charleston. Thanks to Nancy Bracken and Genevieve Jones, MD, and their staff for providing an excellent tour of the Sea Island Medical Center. We would also like to thank Sister Mary Joseph Ritter and her staff for so graciously hosting us at the Our Lady of Mercy Outreach. Jakki Jefferson and Annette Maranville were particularly helpful to us in our planning for the visit. The wonderful luncheon that was provided by the Rural Mission will stay in all of our memories as well. Finally, we are grateful for the commentary provided by Alicia Carvajal and Deborah Harnish during our tour of a local migrant farm worker camp.

Our visit to North Charleston was also rewarding. We are grateful to Maggie Michael and Patty Fournier for hosting us at the Medical University of South Carolina (MUSC) Children’s Care site and for their assistance in planning for the visit. We also appreciated the time Matt Davis, MD, gave to us in demonstrating the electronic medical record system.

We also want to thank the many distinguished speakers who so generously traveled to Charleston from around South Carolina and beyond to participate in our program: Pete Bailey, Dave Murday, Robby Kerr, Kathy Schwarting, David Hayden, Pete Bowman, Lathran Woodard, Ann Lewis, Nela Gibbons, Ken Trogdon, and Hugh Greeley. Several people from the South Carolina Department of Health and Human Services were helpful to us in our preparation for the site visit, including Robby Kerr, Gwen Power, Susan Bowling, Nela Gibbons, Pete Bailey, Dennis Dickerson, Diane Tester, and Helen Thomas.

As always, the thoughtful insights, questions, and discussion points raised by our federal participants were integral to the success of the site visit and help us to continuously improve the timeliness and value of our programming.

February 17–19, 2004 / South Carolina

The Health Care Safety Net in South Carolina: A Test of Tenacity

BACKGROUND

The state of South Carolina has a rich and complex history that has made the creation of a site visit there fascinating. The make-up and significance of the health care safety net is a result of the economic, cultural, and political environment that has been exacerbated by the recent budget crisis. South Carolina's economy has evolved over time—shifting focus from agriculture to industry to tourism—leaving in its wake an unemployment rate of 7 percent and an average per capita income of less than \$25,000. Although the state ranks low in annual income, it ranks high in geographic and cultural diversity: rural areas make up 40 percent of the state, one-third of the population is African American, and the Latino population is growing exponentially. While, in many ways representative of its sister states of the South, South Carolina's approach to its health care system is often unique.

Medicaid and SCHIP

Reflecting its relative poverty and smaller tax base, South Carolina's Medicaid and State Children's Health Insurance Program (SCHIP) eligibility levels have not increased at the same pace as those of states in other regions of the country. Its SCHIP Medicaid expansion provides coverage for children with incomes up to 150 percent of the federal poverty level (FPL) (\$22,890 for a family of three in 2003), but Medicaid coverage for adults is limited to 50 percent of the FPL (\$4,490 for an individual).

As in most other states, the state's budget crisis has begun to take its toll on public health programs. South Carolina has curtailed outreach efforts in hopes of curbing the enrollment increases that resulted from the implementation of SCHIP; and last year the state stopped its practice of providing "passive renewals" of eligibility, meaning that individuals are no longer assumed to be eligible until they report a change of income. This change resulted in a net caseload decline of 30,000 individuals. Further eligibility and benefits cuts are not anticipated, nor are reductions in provider payments, but all options remain on the table in the state legislature.

South Carolina used the federal matching percentage increases allocated last year to fully fund the Medicaid program, but that money is expected to run out this summer, with no additional funds available to begin the next state fiscal year.

It is notable that the state has not yet used managed care to contain costs in Medicaid, although the state legislature has repeatedly considered proposals to do so in the face of strong resistance from the provider community. The state's private insurance market remains almost entirely fee-for-service, with only 7 percent managed care penetration. While several managed care organizations have plans to enter the South Carolina market, only one has done so thus far.

Safety Net Dynamics

Because of limited availability of public and private health insurance coverage, the "safety net" in South Carolina plays a vital role in providing access to health care for a large portion of the population. A broad network of community health centers (CHCs), hospital systems, and community and faith-based organizations make up an intricate patchwork of service delivery for the uninsured, the undocumented, and other low-income populations.

South Carolina boasts at least one hospital in all but three counties across the state. Particularly in many of the rural areas, these hospitals are struggling to compete with larger, more technologically advanced and better-funded facilities that see opportunities to expand their catchment areas to communities with high incidences of diabetes, heart disease, obesity, and asthma. As a result, these larger hospitals attract the higher-income patients, leaving those with fewer means and who often lack transportation to be cared for in the smaller facilities. South Carolina is one of only a handful of states that receive disproportionate share hospital (DSH) funding that exceeds 12 percent of total Medicaid payments, and the state has made a commitment to ensure that DSH funds go to hospitals with high rates of uncompensated care.

CHCs play a vital role in serving low-income populations, providing primary care services and community-based programs at low or no cost. A mix of urban and rural, the 20 CHCs in South Carolina provide health care services to more than 200,000 patients each year. Because of the small proportion of physicians who accept Medicaid patients in their private practices, in some communities, CHCs are the only available source of health care providers. In many cases, the viability of a health center is dependent on the availability of federal funding—earning federally qualified health center (FQHC) status—which ensures that the center will receive Medicaid cost-based reimbursement that often enables them to stay in business.

Necessity, the Mother of Invention

As has become apparent across the country, the safety net has many holes and is often frayed along the edges. In response, several provider-driven and other privately funded initiatives have emerged to take matters into their own hands. For example, in the late 1990s, Jack McConnell, MD, a physician and entrepreneur who retired to Hilton Head Island, decided to start a health clinic called Volunteers in Medicine (VIM). The clinic, staffed by a broad network of retired physicians and other volunteers, provides free health care to the low-income community on the island. The concept has taken off and has been replicated in several other states as part of an overall physician volunteerism movement.

A slightly different approach was designed by a physician who was frustrated with the inadequacies of the health care system. Casey Fitts, MD, a surgeon by training, spent a one-year hiatus working to secure foundation and community funding for a program named Tri-County Project Care (TCPC). He designed the program with the goal of moving away from a health care system in which delayed preventive care too often results in recurring acute care episodes that require expensive and time-consuming trips to the emergency room. Targeted at low-income, working adults with no other access to health insurance, TCPC connects enrollees to a provider network and ensures that they receive needed medical care. The program initially relied on providers' volunteering their services but has incrementally increased payment rates so that providers are currently reimbursed at 60 percent of their costs.

South Carolina, like most other states, faces ongoing challenges in ensuring access to health care for its most vulnerable citizens. This safety net, a fragile weaving of state and local, community and private resources, will continue to strive toward ensuring access to health care in a difficult fiscal environment—it is a true test of tenacity.

PROGRAM

From February 17 through 19, 2004, a group of 20 site visit participants and five National Health Policy Forum staff took an in-depth look at the health care safety net in the state of South Carolina, with particular focus on the Charleston area. The program opened on Tuesday afternoon at the headquarters hotel in the historic district. The first session provided an informative overview of South Carolina's history and political context, presented by Pete Bailey and David Murday, two of the state's foremost experts in health policy and research. In the second session, the state Medicaid director, Robert Kerr, provided a description of the state's Medicaid program and highlighted some of the key policy and political issues that have been defined by the current economic environment. An informal dinner followed, and the two opening speakers joined the group for continued conversation.

Day two opened with a session at the hotel that brought to life the issues around serving vulnerable populations in rural areas. Representing hospital systems and community health centers, the speakers discussed the economic challenges of operating their facilities and the importance of federal funding in keeping their doors open.

Next, the group departed for a visit to Johns Island, which provided a significant contrast to Charleston, despite being only 15 miles away. The first stop was a tour of the Sea Island Medical Center, the island's only community health center. After a short tour of the facility, the Sea Island staff accompanied the site visitors to a nearby location where they were able to continue the conversation about policy issues. There, the discussion further explored the role of the Sea Island Medical Center on the island as well as some of the center's problems with service delivery and management.

The second area the group looked at on Johns Island was the health and social services provided by a local faith-based organization, Our Lady of Mercy Community Outreach Services (the OLM Outreach). The director gave site visitors an overview of the mission and its wide range of services, including those offered through a Wellness Center that provides primary and preventive dental care as well as prenatal care for pregnant women (who are predominantly undocumented immigrants and therefore not eligible for Medicaid). The group toured both the OLM Outreach facility and the Wellness Center and continued a discussion with the leadership and staff that increased understanding of the ways the organization is structured and financed and some of the successes and challenges that arise when serving low-income, uninsured families.

The visit to Johns Island included a special focus on the health conditions of the local migrant farm worker community, conditions that are only exacerbated by language barriers, immigration status issues, and substandard living quarters. The group briefly toured a local migrant camp (where workers will live next summer) that is near the OLM facility.

The final day of the site visit opened with a discussion of the overall role of community health centers in sustaining the safety net and focused on a promising strategy for reducing health disparities illustrated by CareSouth Carolina, a health center network in the Pee Dee region of the state. The group then moved to an on-site visit to highlight another promising effort in South Carolina, a movement to enroll children in "medical homes" designed to help ensure access to primary and preventive care. Sponsored by the Medical University of South Carolina (MUSC), the Children's Care center also utilizes an electronic medical record system that is bolstering the efficiency and continuity of care. The group next heard from two representatives of the South Carolina Department of Health and Human Services who provided an overview of the Medicaid eligibility and enrollment process and highlighted some

of the proposed program restrictions, such as eliminating the State Children’s Health Insurance Program (SCHIP) and implementing an active redetermination process, that have been subject to debate in light of the state budget crisis.

The final session of the site visit focused on several provider-driven initiatives that attempt to round out the safety net in South Carolina. The group heard about physician-sponsored efforts at the Volunteers in Medicine clinic in Hilton Head, pharmaceutical assistance provided to low-income individuals through Communicare, and Tri-County Project Care, a fledgling insurance program for low-income working adults. The discussion provided an excellent closing to the two-day experience of studying the innovation and difficulties of weaving together many sources of care in hopes of improving the overall health of the population.

IMPRESSIONS

Overall

Access to health care in South Carolina is hindered by socioeconomic factors such as low educational attainment and multigenerational poverty.

South Carolina has struggled with its education system, often having problems with funding and administration. In 2000, with a high school graduation rate of only 56 percent, South Carolina ranked 46th out of all 50 states. More than 70 percent of 18-year-olds in the state are considered “not available for college application.” These educational deficits lead to lower earning potential and increased likelihood of living at or near the poverty line. While South Carolina is not an extremely poor state (ranking as the 21st poorest state in 2000), it continues to suffer from the loss of manufacturing jobs, a trend that began 20 years ago. The state also has a low rate of unionization and corresponding employer-sponsored health coverage, combined with a limited Medicaid program. A recently released state survey indicated that 19 percent of the residents of South Carolina were uninsured at some point during the year, one of the highest rates in the nation.

Despite committed efforts by providers and program administrators, the safety net seems to be a loosely connected patchwork.

A combination of hospitals, community health centers, public health coverage programs, and faith-based and other community-supported efforts makes up a fragile, although not entirely ineffective, safety net. The disconnects seem to be exacerbated by tensions between the executive and legislative branches of the state government.

South Carolina relies heavily on the ability to leverage federal funding to support public programs.

The state’s financial structure has grown increasingly dependent on federal funding sources—Medicare reimbursement, Medicaid matching funds, disproportionate share hospital (DSH) payments, and special earmarks secured by the state’s

IMPRESSIONS

long-serving, high-ranking members of Congress—to sustain health access and treatment programs. On one hand, federal funding sources enable states to finance programs and services that could not be provided with state dollars alone. However, dependence on these funds, which are accompanied by federal requirements for how they can be used, can also be a barrier to tailoring programs to meet the needs of an individual state.

Chronic diseases and conditions (diabetes, hypertension, and obesity) are pervasive, and health care providers are struggling to treat them as well as to shift the paradigm toward prevention.

These issues were evident throughout the site visit and seemed to be driven by a combination of culturally influenced eating habits and lifestyles and the lack of usual sources of preventive care.

The rich yet troubled history of the region continues to play a role in how different racial and ethnic communities interact.

While race is not blatantly an issue in policy debates, the historical divisions between people have made communication and, in some cases, collaboration more difficult. In addition, the recent influx of immigrants and corresponding growth of a Latino community has also influenced the dynamics of the health care and social service sectors.

Hospitals and Health Centers: Sustaining the Rural Safety Net?

Some rural health care providers are looking for ways to work together by pooling resources and sharing best practices that will enable them to compete with larger, more advanced health systems.

A question remains whether keeping small hospitals open in nearly every county is the best thing for the community or whether resources could be better utilized by supporting primary care expansions and quality improvement efforts. Because federal funding streams generally support only acute care, these rural hospitals have little incentive or ability to focus on prevention efforts. Instead, any additional money is spent primarily on developing diagnostic capabilities and administration. Finally, the hospitals are in dire need of capital investment to update and renovate facilities, most of which were built in the 1950s. Federal funding limitations that require all monies be used exclusively for providing direct services seem to disregard the ongoing need for building maintenance.

Disproportionate share hospital (DSH) funding and Medicare reimbursement are essential to the survival of many hospitals, particularly those serving this very rural state.

More than 40 percent of South Carolina is made up of rural communities, and all but ten hospitals in the state qualify for a portion of the \$400 million disproportionate share hospital (DSH) allotment, a key lifeline for many. South Carolina is one of nine

“high DSH” states, meaning that DSH funds exceed 12 percent of total Medicaid spending each year. Rural hospitals and health care providers are increasingly dependent on Medicare reimbursement and special financing sources that are intended to assist facilities serving a large number of frail and elderly individuals.

Transportation is a persistent barrier to accessing health care services.

Many low-income families do not own a car or only have one vehicle, which the primary wage earner needs for getting to and from work. In most areas of the state, there is no public transportation system at all; in the areas that do have bus systems, services have often been reduced. Consequently, individuals must rely on friends and family members or on the limited services provided by some hospitals and health centers. Medicaid-funded transportation is available but complicated and difficult to use. Drivers can be unreliable, and the rules require that only the individual who has the appointment can ride in the vehicle, which can lead to child care difficulties.

Medicaid and the Bottom Line

As in most other states, the state budget crisis is taking its toll on the Medicaid program, with prescription drug costs topping the list of major fiscal pressure points.

While South Carolina’s legislature voted to use the entire sum of federal assistance provided last year to fund the Medicaid program, shortfalls are projected again for the next fiscal year. A key problem has been the rising cost of prescription drugs. The state saw a 42 percent growth rate in Medicaid drug spending in 2002 and has begun to take steps to contain costs. The state will limit the number of prescriptions and plans to utilize prior authorization and preferred drug lists in hopes of finding savings.

The tension between the state and federal governments has increased in recent months.

The federal government’s increased scrutiny of Medicaid accounting practices has caused alarm in many states, including South Carolina. The state’s efforts at maximizing federal matching funds over the past decade have resulted in increased scrutiny. Consequently, South Carolina will likely become a testing ground for the Centers for Medicare and Medicaid Services’ new focus on requiring tighter financial accountability and changing federal policies regarding permissible methods of drawing down federal funds.

South Carolina has been hesitant to utilize managed care—either as a potential cost-saving mechanism or as a method of improving quality of care—despite some incremental steps in that direction.

Resistance in the provider community has prevented the state legislature from mandating various levels of managed care in Medicaid. However, providers are

IMPRESSIONS

IMPRESSIONS

increasingly recognizing the value of the concept of “care management,” and a few strategies, like the MUSC medical home model, are being tested.

Administrative changes to a Medicaid program—such as moving from a “passive” to an “active” eligibility redetermination process—can effectively limit enrollment and contain costs.

While the state has not officially cut Medicaid or SCHIP eligibility to date, administrative changes to the renewal process resulted in the loss of eligibility for 30,000 individuals in 2002. In addition, the state has considered moving to a three-month eligibility redetermination process as an additional cost containment mechanism.

Mental health services receive a growing proportion of South Carolina’s Medicaid budget and are subject to increased scrutiny from state officials.

The disabled population accounts for 46 percent of overall Medicaid spending, with expenditures for mentally ill persons constituting a significant share of this total. Due in part to the scarcity of private-sector mental health providers, most services to mentally disabled Medicaid recipients are delivered by the state’s mental health agency. In turn, nearly all of the agency’s budget is funded through the Medicaid program. State Medicaid officials are beginning to consider ways of improving the management of mental health services as a cost-containment strategy. Childrens’ mental health has increasingly emerged as a focus of these activities. However, the current structure of the state government and fragmented interaction between state agencies have complicated these efforts. At this point it is unclear whether these proposed cost-containment strategies would improve or undermine the quality and accessibility of care available to the mentally ill.

Migrant/Immigration Issues

The Latino population in the low-country region of the state has grown substantially in recent years.

South Carolina’s place near the beginning of the Atlantic coast migrant stream has made the state a favorite settling place for many families wanting to stay in the United States permanently.

The migrant farm worker community faces a myriad of barriers to healthy living and access to care.

In the absence of significant state funding of a safety net beyond Medicaid, few resources are available to support these workers and their families. Because of their undocumented immigration status, most migrants are not eligible for Medicaid and therefore must rely on free services provided through organizations such as the OLM Outreach and Wellness House or pay according to the sliding-fee schedule at community health centers. Typically, migrants are not provided

sick or vacation leave by their employers, so they must use unscheduled work leave (such as rainy days) to visit health facilities. Finally, problems with trust and with language skills only exacerbate the lack of access to care. Language barriers can be particularly troublesome in smaller settings such as individual physician or dentist offices.

Ongoing demographic changes in the Charleston area are influencing the range of health care needs as well as the service delivery structure that has been established to meet those needs.

South Carolina has become a favorite choice for permanent residence of many migrants who have given up the migrant life for year-round work in landscaping, construction, and other lower-wage jobs that support much of the new development taking place in the island communities outside of Charleston. Many of these former migrant workers have sent for their families to join them, increasing the need for prenatal and well-child care services.

Silver Linings

South Carolina provides an example of community resourcefulness in identifying need and supplying care.

Despite the systemic barriers that exist, a wide array of health centers, hospitals, provider-sponsored volunteer groups, and faith-based organizations have stepped forward in their communities to work toward providing access to primary and preventive care as well as other social services for low-income individuals and families. In some cases, community organizations have begun to collaborate, as evidenced during the group's visit to the Sea Island Medical Center and to Our Lady of Mercy Outreach Services and Wellness House. In addition, some of the provider-sponsored efforts have begun to supplement the existing system. For example, Tri-County Project Care has placed brochures in many of the state's community health centers, hospitals, and physician's offices in hopes of reaching uninsured working individuals and enrolling them in the program.

The need to use resources effectively has prompted innovative projects, such as the Health Resources and Services Administration–sponsored Health Disparities Collaboratives, which have given some health centers a new lens through which to view the treatment and prevention of chronic conditions.

CareSouth Carolina is an example of the success of one of these collaboratives. The organization's dramatic shift in management style and approach to delivering care has brought about an entirely new practice model to focus on outcomes of care for patients. The new model has resulted in significant decreases in blood glucose levels of diabetic patients, a more than 80 percent screening and follow-up rate for depression, and near-elimination of trips to the emergency room for asthma symptoms.

IMPRESSIONS

IMPRESSIONS

The Medical University of South Carolina's medical home initiative is connecting children with a primary care physician and regular source of medical care, giving families—perhaps for the first time—a real alternative to emergency rooms.

MUSC's medical home concept offers both a financially sound approach to primary care and a method of reducing pressure on overburdened emergency departments. The capitated payment structure has served as an incentive for avoiding the emergency room and for helping manage care. Technological advances such as the use of the electronic medical record enable physicians to see more patients and provide better-coordinated care management.

Recognizing the need for better care management and access to primary and preventive services, provider-driven and other private initiatives in the Charleston area are providing an additional, nongovernmental layer to the safety net.

Providers who are frustrated with treating uninsured patients with preventable conditions have begun to work outside "the system" and are developing innovative models for delivering care in the early stages of a disease. Some of the models are acknowledged as stopgap measures until broader financial access is achieved, and others are viewed as new and improved methods of providing health care that is community-supported, rather than government-financed.

CONCERNS FOR THE FUTURE

While the site visit revealed several promising initiatives taking place in South Carolina's health care system, even more apparent were the many barriers that low-income families face in trying to access care and the constant challenges the state and the rest of the safety net must overcome in striving to provide that care. Some key concerns for the future include the following:

- The lack of additional federal assistance in the coming fiscal year, combined with the more targeted emphasis on financial accountability in Medicaid, will likely perpetuate the state budget crisis and require additional Medicaid cost-containment strategies.
- The impending retirement of Sen. Fritz Hollings (D-SC) will result in a further loss of seniority in the U.S. Senate, which may hinder South Carolina's ability to rely on special federal financing and earmarked appropriations to fund health care initiatives.
- Historical and ongoing disparities in education, income, and health status, particularly among racial and ethnic minorities, suggest continued challenges for the future.
- Competition rather than collaboration among health care providers and communities may hinder their ability to advocate on behalf of patients and themselves and to maximize resources, develop and share best practices, and connect to hospitals and specialty services to provide comprehensive care.

Tuesday, February 17, 2004

AGENDA

3:00 pm Check-in at headquarters hotel [*Charleston Place, 205 Meeting Street*]

3:15 pm Welcome and introductions [*Jenkins-King Room, Charleston Place*]

3:30 pm THE PALMETTO STATE:
HISTORY AND POLITICAL CONTEXT

David Murday, *Assistant Director, Health Policy, Center for Health Services and Policy Research, Arnold School of Public Health, University of South Carolina*

Pete Bailey, *Director, Health and Demographics Division, South Carolina Office of Research and Statistics*

- What are the key demographic characteristics of the state?
How does South Carolina rank in terms of per capita income, employment, education, and health status?
- What is the historical context of these demographics? How has the make-up of the state's population changed over the past 20 years?
- What are the most prevalent health conditions in the state?
What factors contribute to the high incidence of certain conditions?
- What are the critical programs and state policies that address the needs of vulnerable populations in South Carolina?
- What role do rural hospitals play in making up South Carolina's safety net?
- How has the state budget crisis affected the health care delivery system? What are the priorities of the current administration and the state legislature? Where do the tensions lie?
- What are the key political dynamics affecting South Carolina's health care system today as compared to 20 years ago?

5:00 pm SOUTH CAROLINA MEDICAID:
TOBACCO TAX OR TOUGH DECISIONS?

Robert Kerr, *Director, South Carolina Department of Health and Human Services*

- What are the defining characteristics of South Carolina's Medicaid program and State Children's Health Insurance Program (SCHIP)?
- What have been the key successes and challenges of Medicaid and SCHIP in recent years?
- What has been the impact of the state budget crisis on the Medicaid program? How has program enrollment changed over time?

AGENDA**Tuesday, February 17, 2004** (cont.)

- What options are being proposed to bridge the projected shortfall in Medicaid funding in the next fiscal year?
- What is the likelihood of passage of the much-debated increase in the tobacco tax? If the increase is passed, will the revenue be used to fund Medicaid?
- What are the elements of the state's "medical home" initiative? Have the efforts proven effective?
- What are the governor's key priorities with respect to health care in the coming year?

6:00 pm Adjourn and break before dinner.

6:30 pm Walk to dinner in downtown Charleston [*Hank's Seafood, Church and Hayne Street*]

Wednesday, February 18, 2004

8:00 am Breakfast available [*Jenkins-King Room, Charleston Place*]

8:30 am THE RURAL SAFETY NET

Kathy Schwarting, *Executive Director*, Low Country Health Care Network—Bamberg

David Hayden, *Executive Director*, Low Country Health Care System, Inc.—Annandale

Pete Bowman, *Administrator*, Carolinas Hospital System—Lake City

- What are the demographics of South Carolina's rural areas? How do they differ from those of Columbia and Charleston?
- What health conditions pose the greatest challenges for providing high-quality care in a relatively isolated area?
- What are the key financial challenges in operating a rural hospital or health center? How do Medicare special payments and other funding sources assist with financial viability?
- What role does disproportionate share hospital (DSH) funding play in serving low-income populations?
- What are the socioeconomic barriers, such as lack of transportation, that inhibit individuals from seeking and receiving needed health care?

9:45am Break

AGENDA

Wednesday, February 18, 2004 (cont.)

10:00 am Bus departure for Johns Island

10:30 am Tour of Sea Island Medical Center [3627 Maybank Highway, Johns Island]
Genevieve Jones, MD, *Medical Director*, Sea Island Medical Centers, Inc.
Nancy Bracken, *Interim Executive Director*, Sea Island Medical Center, Inc.

11:00 am Bus departure to Our Lady of Mercy (OLM) Community Outreach Services [1684 Brownswood Road, Johns Island]

11:15 am THE SAFETY NET IN ACTION:
 HEALTH CENTERS AND HEADACHES

Nancy Bracken, (see title above)

Genevieve Jones, MD, (see title above)

- What are the demographics of the Sea Island community and how are they changing?
- What is the history of the Sea Island Medical Center? How have the ownership and management challenges affected the center's capacity to deliver services?
- What are the most common events and situations that make up a typical day?
- What are the cultural barriers that affect access to care?
- What is the payer mix for patients who come to the health center? How are prescription drugs financed?
- How have the state budget crisis and resulting changes in the Medicaid program affected Sea Island's ability to meet the needs of low-income families?

Noon Lunch (provided by Rural Mission, Inc.) and informal discussion with members of the Sea Island Medical Center Board of Directors.

1:00 pm Tour of OLM facility

1:30 pm SERVING "THE WHOLE PERSON":
 LESSONS IN SOCIAL SERVICE DELIVERY

Sister Mary Joseph Ritter, *Executive Director*, OLM Community Outreach Services

Jakki Jefferson, *Outreach Staff*, OLM Community Outreach Services

Annette Maranville, *Wellness Health Coordinator*, OLM Wellness House

John Howard, DMD, *Dental Director*, OLM Wellness House

Deborah Harnish, *Social Worker*, OLM Community Outreach Services

AGENDA

Wednesday, February 18, 2004 (cont.)

- How did “the Outreach” come to be? How is it financed? What range of services does it provide?
- What are the population dynamics of the Sea Island community? How do the changing needs of the population affect OLM’s mission?
- What are the primary health needs that are being met at the Wellness House? What challenges remain?
- Why has OLM chosen not to become a Medicaid provider or to seek other federal funding?
- How do the needs of the local migrant population differ from those of the rest of the community? What are the key challenges in serving migrants? What have been some of the successes?

3:00 pm Bus departure for headquarters hotel (with view of migrant camp en route)

3:45 pm Free time in Charleston

6:15 pm Walk to dinner in downtown Charleston [*Blossom Café, 171 East Bay Street*]

Thursday, February 19, 2004

8:00 am Breakfast available [*Jenkins-King Room, Charleston Place*]

8:15 am SHIFTING THE PARADIGM: COMMUNITY HEALTH CENTERS (CHCs) AND DISPARITIES COLLABORATIVES

Lathran Woodard, *Executive Director*, South Carolina Primary Health Care Association

Ann Lewis, *Chief Executive Officer*, CareSouth Carolina, Inc.

- What role do community health centers play in the make-up of the safety net in South Carolina?
- What are the key policy and financing issues facing health centers in the current environment? How has the state fiscal crisis affected CHC policy?
- How has the Bush administration’s CHC initiative helped or hindered the success of the health center movement?
- What are the goals of the Health Disparities Collaboratives? How must health centers restructure their policies and procedures to reduce disparities?
- What have been the key lessons learned through participation in the collaboratives? Why are more health centers not involved in this effort? What are the barriers to success?

AGENDA

Thursday, February 19, 2004 (cont.)

9:15 am Bus departure for Medical University of South Carolina (MUSC)
Children's Care clinic [2070-A Northbrook Boulevard, North Charleston]

9:45 am MEDICAL HOMES: PATH TO PREVENTION? [MUSC Children's Care]

Maggie Michael, Director, Center for Advocacy and Development,
MUSC Children's Hospital

Patty Fournier, Practice Manager, MUSC Children's Care

Matt Davis, MD, Attending Physician, MUSC Children's Care

- What is the medical home initiative and what was its genesis?
What are the measures of success?
- What are the advantages and disadvantages of the "one-stop shopping"
model?
- Are medical homes intended to be part of an overall strategy or are
they simply a targeted effort to connect children with primary care
providers?
- What challenges have emerged as the target population has become
increasingly diverse?
- What is the role of electronic medical records at this site and how do
they help improve the accuracy and efficiency of health care?

11:00 am MEDICAID ON THE FRONT LINES:
A TEST OF TENACITY

Helen Thomas, Medicaid Eligibility Administrator, South Carolina
Department of Health and Human Services (DHHS)

Jadin Miller, Human Service Specialist, South Carolina DHHS

Nela Gibbons, Deputy Director, Medicaid Eligibility and Beneficiary Services,
South Carolina DHHS

- What are the key steps in the eligibility intake process? What are
the most common reasons for denial of a Medicaid application?
- What is the average caseload for a Medicaid eligibility worker?
- How has the state budget crisis affected the Medicaid eligibility
process?
- What effect have the recent program changes had on enrollment and
caseloads?
- What are the administration's priorities for Medicaid and SCHIP
in the coming year?

11:45 am Bus departure for Charleston Place

AGENDA

Thursday, February 19, 2004 (cont.)

12:15 pm Checkout and working lunch [*Jenkins-King Room, Charleston Place*]

12:30 pm WORKING OUTSIDE THE SYSTEM:
PROVIDER-DRIVEN INITIATIVES

Hugh Greeley, *Chairman*, Volunteers in Medicine Institute

Ken Trogdon, *Director*, Communicare

Casey Fitts, MD, *Chairman of the Board and Medical Director*, Tri-County Project Care

- What was the genesis of Volunteers in Medicine, Communicare, and Tri-County Project Care? How was financing secured? Is the financing sustainable?
- What have been the key successes of the initiatives?
- What is the main motivation for working outside of the system to effectively create another, nongovernmental, layer to the safety net?
- What role have physicians and other health care providers played in creating and operating these programs? How has provider participation changed over time?
- What strategies (such as provider credentialing) are in place to ensure quality of care?
- How do these initiatives fit within the traditional sources of health care delivery and financing? Has the availability of these initiatives changed the insurance market (for example, employers' commitment to offering health coverage)?
- What are the largest barriers (such as malpractice coverage for volunteers and access to pharmaceuticals) to expanding these efforts?

1:45 pm Wrap-up discussion

2:00 pm Adjournment and bus departure for Charleston Airport

Federal Participants

Jennifer Babcock

Health Insurance Specialist
Division of State Children's Health
Insurance
Family and Children's Health
Programs Group
Center for Medicaid and State Operations
Centers for Medicare and Medicaid Services
Department of Health and Human Services

Evelyne P. Baumrucker

Analyst in Social Legislation
Congressional Research Service
Library of Congress

David Black

Legislative Assistant
Office of Rep. J. Gresham Barrett (R-SC)
U.S. House of Representatives

Ed Bonapfel

Legislative Assistant
Office of Sen. Lindsey Graham (R-SC)
U.S. Senate

Andrea Cohen

Health and Oversight Counsel (D)
Committee on Finance
U.S. Senate

Jeffrey Dunlap

Senior Advisor
Bureau of Primary Health Care
Health Resources and Services
Administration
Department of Health and Human Services

Ruth Ernst

Assistant Counsel
Office of the Legislative Counsel
U.S. Senate

Jennifer Friedman

Budget Analyst (D)
Committee on the Budget
U.S. House of Representatives

April Grady

Analyst in Social Legislation
Domestic Social Policy Division
Congressional Research Service
Library of Congress

Suzanne Hassett

Policy Coordinator
Office of the Secretary
Department of Health and Human Services

Jean Hearne

Specialist in Social Legislation
Domestic Social Policy Division
Congressional Research Service
Library of Congress

Janet Heinrich

Director
Health Care, Public Health Issues
U.S. General Accounting Office

Lisa Herz

Specialist in Social Legislation
Domestic Social Policy Division
Congressional Research Service
Library of Congress

Lindy Hinman

Senior Medicare Analyst
Health Division
Office of Management and Budget

Kate Massey

Senior Medicaid Analyst
Health Division
Office of Management and Budget

Susan McNally

Director
Medicaid Analysis Group
Office of Legislation
Centers for Medicare and Medicaid Services
Department of Health and Human Services

Dawn Myers

Legislative Director
Office of Rep. John Spratt (D-SC)
U.S. House of Representatives

Lori Neal

Legislative Assistant
Office of Sen. Blanche Lincoln (D-AR)
U.S. Senate

Federal Participants (cont.)

Rhonda Rhodes*Director*Division of Benefits, Coverage, and Payment
Family and Children's Health Programs

Group

Center for Medicaid and State Operations

Centers for Medicare and Medicaid Services

Department of Health and Human Services

Vince Ventimiglia*Health Policy Director (R)*Committee on Health, Education, Labor,
and Pensions

U.S. Senate

NHPF Staff

Judith D. Moore*Senior Fellow***Randy Desonia***Senior Research Associate***Marcia Howard***Program Associate***Eileen Salinsky***Principal Research Associate***Jennifer Ryan***Senior Research Associate*

Biographical Sketches — Speakers

Walter Phillip (Pete) Bailey is chief of the Health and Demographics Section of the Office of Research and Statistics of the South Carolina Budget and Control Board. In addition to serving as the State Data Center for Census products and analysis, the office also maintains data systems that track inpatient hospital discharges, outpatient surgeries, emergency department visits, home health encounters, health manpower, health education and facilities information, and the South Carolina State Employee Health Insurance Program. Bailey received his BA degree in mathematics at Huntingdon College in Montgomery, Alabama, and holds an MPH in biostatistics from the University of North Carolina in Chapel Hill.

Pete Bowman is the administrator of the Carolinas Hospital System in Lake City, South Carolina. Previously, he was health services administrator for the South Carolina Department of Disabilities and Special Needs in the Pee Dee Region. From 1998 to 1999, Bowman was the area manager for Tri-Atlantic Healthcare, Inc., where he was responsible for the Tricare managed care contract with the Department of Defense. He spent 16 years as a medical service corps officer for the U.S. Navy and spent several years working with Anderson Memorial Hospital, including acting as vice president of the hospital. He received a BS in business administration from The Citadel and an MBA in healthcare administration from the University of South Carolina.

Nancy Bracken is the interim chief executive officer of Sea Island Medical Centers, Inc. Since 1988, she has worked as an independent contractor providing leadership at a variety of community health centers across the country. Bracken served as interim administrator of the South East Missouri Health Network and consulted at the Little River Medical Center in Little River, South Carolina. She spent most of her career in upstate New York as the executive director of Oak Orchard Community Health Center in Brockport and as administrator of the Community Medical Center in Castille. Bracken holds a master's degree in public administration from the State University of New York at Brockport.

Matt Davis, MD, is an attending physician at the Medical University of South Carolina (MUSC) Children's Care.

Casey Fitts, MD, is chairman of the board and medical director of the Tri-County Project Care (TCPC) program, which he runs in conjunction with the Charleston County Medical Society. Having dedicated more than a year away from his private medical practice to develop the program, Fitts plans to return to his general surgery practice of ten years but will continue in his position with TCPC. Fitts has been a fellow of the American College of Surgeons since 1992 and is a member of the American College of Surgeons, the American Medical Association, the South Carolina Medical Association, the Charleston County Medical Association, and the Medical Society of South Carolina. He completed his medical degree at the Medical University of South Carolina and his general surgery residency at the University of Mississippi Medical Center. Fitts received his undergraduate degree from Harvard University.

Patty Fournier, RN, is the practice manager for MUSC Children's Care clinics.

Biographical Sketches — Speakers (cont.)

Cornelia (Nela) D. Gibbons is the deputy director for Medicaid Eligibility and Beneficiary Services and the director of Aging Services at the South Carolina Department of Health and Human Services (DHHS). Gibbons served as former Gov. David Beasley's Chief advisor for health and as director of the Division of Health and Human Services in the Office of the Governor. Her career includes teaching social work at Columbia College, serving as the executive director of the South Carolina Chapter of the Arthritis Foundation, director of development for the Center for Cancer Treatment and Research at Richland Memorial Hospital, director of the Continuum of Care for Emotionally Disturbed Children, executive director of the South Carolina Children's Foster Care Review Board System, and director of planning and privacy officer for the South Carolina Department of Health and Environmental Control. She is also active in volunteer and civic activities. Gibbons received both her BA in secondary education and her master of social work degree from the University of South Carolina.

Hugh Greeley is chairman of the Volunteers In Medicine Institute (VIMI), a not-for-profit organization dedicated to assisting medical staffs, hospitals, and communities in the development of clinics serving the uninsured. He is also founder of the Greeley Company, a division of HCPro, Inc. Before founding the Greeley Company, he held a number of positions with the Joint Commission on Accreditation of Healthcare Organizations; InterQual, Inc.; and Kenosha Hospital Medical Center. Greeley was a member of the board and professional affairs committee of Deaconess-Incarnate Word Health System in St. Louis, Missouri. He was also one of the founding partners of the Credentialing Institute and a contributing editor to many health care journals. Greeley has served on the faculties of the Estes Park Institute and the American College of Physician Executives.

Deborah Harnish has been the social worker on staff at Our Lady of Mercy Community Outreach Services, Inc., since July 2002. After graduating with a BA in sociology from Furman University in Greenville, South Carolina, she spent two years working with the Wilkinson Center, providing emergency and long-term services for impoverished people in Dallas, Texas. Following her time in Dallas, Harnish moved to Columbia, South Carolina, where she became the administrative and program associate with the South Carolina Christian Action Council, a group of 16 Christian denominations working on various social justice and public policy issues. Harnish holds a master of social work degree from the University of South Carolina.

David Hayden is the executive director of the Low Country Health Care System, Inc., which has its main office in Fairfax, South Carolina, and a satellite site in Blackville, South Carolina. The Low Country Health Care System is a federally qualified health center serving Allendale and Barnwell counties and portions of Hampton and Bamberg counties. The health system is the main source of basic primary health care for residents of this rural and low-income area. The Low Country Health Care System is also the only provider of obstetrical services within this service area. In addition to primary health care services, Hayden administers a six-county Ryan White Title III program. Previously, Hayden served six years as the director of the South Carolina Office of Rural Health, following a 13-year tenure with the Low Country Area Health Education Consortium.

Biographical Sketches — Speakers (cont.)

John Howard, DMD, is the dental director (and a provider) at the Wellness House Dental Program at Our Lady of Mercy Community Outreach. In this capacity, Howard provides guidance and supervision to the Wellness House dental staff, which includes a number of dental students and other volunteer dentists. He also provides dental education to patients and other groups, conducts examinations and screenings, and provides more urgent treatment. Since 1988, Howard has also been dental director at the Coastal Center, where he provides dental care for people with developmental disabilities. He also serves as a colonel in the U.S. Army Reserve as a member of the 7224th Medical Support Unit. Howard was in private practice in Mt. Pleasant, South Carolina, from 1984 to 1988. He has a BA from Clemson University and received his doctor of dental medicine degree from the Medical University of South Carolina.

Jakki Jefferson has been a team member of Our Lady of Mercy Outreach Services, Inc., since 1989. As a team member at the Outreach, Jefferson facilitates sessions (interagency agency meetings, parenting classes, quilting classes), teaches jazzercise to the elderly participants in the Nutrition Program, offers a program at the local middle school teaching discipline through African drumming and dancing, teaches English as a Second Language for the local Latino population, assists with homework help for students at the Outreach, and visits clients in their homes. She also serves on committees and boards at the following: Sea Island Medical Center, School Governance Council, Habitat for Humanity, and Wadmalaw Island Improvement Committee. Jefferson worked at St. Francis Xavier hospital in downtown Charleston from 1973 until 1989 in nursing administration and planning and marketing. Jefferson has maternal lineage on Johns Island as well as paternal lineage on Wadmalaw Island, enabling her to make a unique contribution to the Outreach.

Genevieve Jones, MD, is the medical director of Sea Island Medical Centers, Inc., where she is responsible for direct patient care as well as day-to-day administration and clinical operations. Her work in South Carolina also includes two years as medical director of the Franklin C. Fetter Family Health Center in Charleston and service as an urgent care physician at Greenville Memorial Hospital and at the Urgent Care Center in Spartanburg. She has also spent several years as a private practice physician in family medicine in South and North Carolina. Jones has been a board-certified family physician since 1978, is a member of the Charleston County Medical Society, and has staff privileges at Roper Hospital and St. Francis Bon Secour Care Alliance Hospital. She received her medical degree from Temple University Medical School in Philadelphia and served in residency at Howard University in Washington, DC.

Robert Kerr has been the director of South Carolina's DHHS since March 2003. Kerr has been with DHHS since 1985 and served as chief financial officer from 1999 until 2003. Kerr has also served as director of internal audits and compliance for the agency, handling a wide range of fraud and abuse issues. A 1981 graduate of the University of South Carolina, Kerr is a certified public accountant and certified management accountant.

Ann Lewis has served as the chief executive officer of CareSouth Carolina, Inc., for 23 years. Under her leadership, the organization has grown from a small community health

Biographical Sketches — Speakers (cont.)

center with four employees in Society Hill, South Carolina, to a regional health care system with nine primary care sites, 194 employees and a national model of success in the delivery of health services to those in need in rural communities. CareSouth Carolina is the recipient of the South Carolina Primary Health Care Association Community Health Center Achievement Award and has been recognized in a number of national television reports as well as in *Time* magazine. Lewis has served as president of the South Carolina Primary Health Care Association, chair of the Great Pee Dee Champion Community, and a board member and founding president of the South Carolina Rural Health Association. Currently serving as a faculty member for the Institute for Healthcare Improvement and co-chair of the BPHC Finance-Redesign Collaborative, Lewis has extensive experience in developing and implementing care management services in a community health center setting. Lewis is a native of South Carolina. She holds a graduate degree in health care administration and gerontology from the University of Southern California at Los Angeles.

Annette Maranville has been the Wellness Coordinator for Our Lady of Mercy (OLM) Wellness House since its establishment in 2001. She coordinates all programming for the Wellness House and provides outreach education in the Sea Island community. Maranville began working with OLM as an employee of Bon Secours St. Francis Hospital in 1995. Based on Sea Island, she provided health education and home visits throughout James, Johns, and Wadmalaw Islands. She now operates two programs at Wellness House—prenatal care to low-income migrant/immigrant pregnant women and dental care for low-income individuals in the Sea Island area. Services are provided free of charge. Maranville holds a BSN from Niagra University and a master's degree in nursing from George Mason University.

Maggie Michael is the director of the Center for Advocacy and Development at MUSC Children's Hospital. She is also an officer on the South Carolina Children's Hospital Collaborative and co-founder of the MUSC Pediatrics Medical Home Project, which began in 1999 and is operating in sites in North Charleston and Monk's Corner, South Carolina.

David Murday, PhD, is assistant director for health policy at the Center for Health Services and Policy Research, where he oversees all policy research and evaluation projects that the center conducts in collaboration with state agencies and professional organizations. He also holds an adjunct faculty appointment at the University of South Carolina School of Public Health. Before joining the center in 1995, Murday worked for the South Carolina legislature for 17 years, most recently as director of research for the Joint Legislative Health Care Planning and Oversight Committee. He holds an undergraduate degree from Rutgers University and a doctorate in clinical/community psychology from the University of South Carolina.

Sister Mary Joseph Ritter has been the executive director of Our Lady of Mercy Community Outreach Services, Inc., for the past 12 years. She was born in Charleston, South Carolina, and became a member of the Sisters of Charity of Our Lady of Mercy in 1960. Ritter taught elementary and secondary school for ten years and served as vice president of mission effectiveness at St. Francis Hospital. She received a BS in English and

Biographical Sketches — Speakers (cont.)

education and acquired her master's in administration of elementary and secondary schools at Seton Hall University in New Jersey.

Kathy G. Schwarting is the executive director of the Low Country Health Care Network, a collaboration of four rural counties in the low country region of South Carolina. The goal of the network is to promote shared services, recruit and retain primary and specialty providers, and foster partnerships between health care providers and organizations in the low country region. After completing an administrative residency in Marion, South Carolina, with the Marion County Hospital District, Schwarting joined the Bamberg County Hospital and Nursing Center serving as a grant writer, physician recruiter, and liaison between the medical community and the administration. She is a member of the South Carolina Rural Health Association and the South Carolina Advisory Council on Aging. Schwarting holds a BS degree in Business administration from the University of South Carolina and a master's in health administration from the Medical University of South Carolina.

Helen Thomas is the regional administrator for Medicaid eligibility for Region 8, overseeing Charleston, Berkeley, and Dorchester Counties in South Carolina. She supervises 86 employees across several eligibility intake and processing offices. Thomas has held supervisory positions in the Medicaid program since 1988 and has served in a variety of positions, including intake, eligibility processing, and outreach; she also served as a program manager over both the Temporary Assistance for Needy Families and Supplemental Security Income programs. She holds an undergraduate degree from Winthrop College and a master's degree from New Orleans Baptist Theological Seminary.

Ken Trogdon is the executive director and one of the founders of Communicare, a nonprofit health care program that coordinates volunteer doctors, dentists, nurse practitioners, hospitals, and pharmaceutical companies to provide free medical care for South Carolina's working poor. Communicare has become a national leader in providing prescription medications to the uninsured. Trogdon has also worked in advertising and has managed marketing for a health care network. In 1998, he launched *Smiles for a Lifetime*, which operates pediatric dental clinics for families with no insurance. In 2000, the U.S. Department of Health and Human Services chose Communicare as one of five national "Models That Work" ("innovative, culturally competent models of service delivery that are effective in increasing access to primary health care and positively impacting on disparities in health within their communities"). Since then, Trogdon has been traveling across the country, helping other states establish similar programs.

Lathran Woodard has been the executive director of the South Carolina Primary Health Care Association since 1991. Woodard also serves as the vice president of the Southeast (eight-state) Health Care Consortium. Previously, Woodard served as the deputy director of maternal health at the South Carolina Department of Health and Environmental Control (DHEC). She was employed by DHEC in different health administrative positions for 14 years. Woodard was also a 2000 fellow of the Health Resources and Services Administration's Primary Care Policy Fellowship. She, along with her team, presented a policy to U.S. Department of Health and Human Services Secretary Donna

Biographical Sketches — Speakers (cont.)

Shalala on screening for depression in women in a primary care setting. Woodard's concentration was the screening of women of color and the screening occurring at all levels within the primary care system. She has an extensive background in health administration and a degree in business administration from Southern Wesleyan University.

Biographical Sketches — Federal Participants

Jennifer McGuigan Babcock has been a project officer with the State Children’s Health Insurance Program (SCHIP) at the Centers for Medicare and Medicaid Services (CMS) since October 2002. Before joining CMS, Babcock was a special assistant to the deputy secretary of health care financing at the Maryland Department of Health and Mental Hygiene. She has worked as an associate health policy analyst for the Lewin Group, as an MPH Fellow at the Consumer Health Foundation in Washington, DC, and as a research assistant at the University of Michigan. Babcock has also served as executive director of the Lovelight Foundation, an antipoverty organization in Detroit, Michigan. She holds a master of public health degree from the University of Michigan, Department of Health Management and Policy, and a bachelor of arts in English from Kalamazoo College, in Michigan.

Evelyne P. Baumrucker is an analyst in social legislation in the Domestic Social Policy Division of the Congressional Research Service (CRS). In her five-year tenure at CRS, she has worked on Medicaid and SCHIP. Before joining CRS, Baumrucker earned an MA degree from the George Washington University.

David Black is the health legislative assistant to Rep. J. Gresham Barrett (R-SC) in the U.S. House of Representatives. Previously, Black served for three and a half years on the staff of Sen. Strom Thurmond (R-SC). He is a graduate of the Citadel in Charleston and a native of Columbia, South Carolina.

Ed Bonapfel has been the health legislative assistant to Sen. Lindsey Graham (R-SC) since March 2003. He began his career on Capitol Hill in September 2002 in the office of Rep. John Linder (R-GA). Bonapfel is a 2002 graduate of Davidson College in North Carolina and a native of Atlanta.

Andrea Cohen, JD, is the Democratic health and oversight counsel for the Senate Finance Committee and has worked for the committee since 2001. She works primarily on Medicaid and CMS oversight issues, and she played an active role in negotiating the Medicaid and low-income subsidy provisions in the recently passed Medicare prescription drug bill. From 1996 to 2001, Cohen worked as a trial attorney in the Civil Division of the U.S. Department of Justice, representing various federal agencies—including the Department of Health and Human Services (DHHS), the Department of State, the Central Intelligence Agency, and the Department of the Treasury—in civil litigation in U.S. District courts. From July 2000 to January 2001, she served as counsel to Attorney General Janet Reno. Cohen clerked for Chief Judge Myron Thompson in the U.S. District Court, Middle District of Alabama, after graduating from Columbia Law School in 1995. She worked as a staff assistant for the Health Subcommittee of the Committee on Ways and Means in the House from 1990 to 1992. Cohen is a 1990 graduate of Harvard College.

Jeffrey Dunlap was asked by the administrator of the Health Resources and Services Administration (HRSA) to serve as part of a new management team for the Bureau of Primary Health Care (BPHC) and became a senior advisor for the associate administrator in August 2002. He currently leads the newly established Office of Policy, Evaluation, and

Biographical Sketches — Federal Participants (cont.)

Data. Previously, Dunlap was the director of BPHC's Division of State, Community, and Public Health, where he supervised 41 staff and more than a dozen discrete health professions training-related programs with an overall budget of over \$100 million. He also served as the acting director of the Center for Public Health. Dunlap served as senior advisor in HRSA's Center for Public Health Practice and as senior advisor to the associate administrator for field operations; in that position, he spearheaded restructuring efforts and served as focal point for the agency's border health activities. Dunlap began his federal service as a presidential management intern. Before joining the government, Dunlap served as program director for MAP International and served in the highlands of Ecuador as a Peace Corps volunteer. Dunlap has a BA in international relations from Syracuse University and an MSPH from the University of North Carolina at Chapel Hill.

Ruth Ernst, JD, is an assistant counsel in the Senate Office of Legislative Counsel. She has been with the office for over ten years. Ernst concentrates on health and welfare programs, including Medicaid and SCHIP. She has a JD degree from the University of Chicago.

Jennifer Friedman is a budget analyst with the Democratic staff of the Committee on the Budget in the U.S. House of Representatives. Friedman's portfolio includes Medicare, Medicaid, and public health programs. Prior to joining the Budget Committee, she worked for five years as a program examiner at the U.S. Office of Management and Budget. In that capacity, Friedman developed policy proposals, reviewed regulations and waiver proposals, and prepared materials for submission of the president's budget for a range of programs, including Head Start, child care, food stamps, and Medicare. Friedman has a master's degree in public policy from the University of California at Berkeley and a bachelor of arts from Georgetown University.

April Grady is an analyst in social legislation with CRS. Her work focuses on Medicaid and SCHIP program issues, including enrollment and spending. Before joining CRS, Grady held positions at the Center for Health and Social Policy at the LBJ School of Public Affairs and at Mathematica Policy Research. She received a BA from Syracuse University and an MPA from the University of Texas at Austin.

Suzanne Hassett is a policy coordinator in the Office of the Secretary, DHHS, where she is responsible for coordinating policy information regarding the Medicaid and SCHIP programs. Before coming to the secretary's office two years ago, Hassett worked in the Office of the Administrator of the Health Care Financing Administration (now CMS), primarily on Medicaid and SCHIP issues. She also spent five years working in the office of Sen. Jack Reed (D-RI).

Jean Hearne has been a specialist in social legislation with CRS for six years. Her areas of expertise include private health insurance and Medicaid. In 1997, as a contractor to CRS, she worked on the development of the SCHIP legislation. Previously, Hearne was a program director at the Institute for Health Policy Solutions, where she worked with states to implement health reforms providing public subsidies for employer-based insurance. From 1989 to 1997, she served as principal health analyst at the Congressional

Biographical Sketches — Federal Participants (cont.)

Budget Office (CBO). While at the CBO, she developed spending models to estimate Medicaid expenditures and worked on the team of analysts estimating the budgetary impacts of President Clinton's Health Security Act.

Janet Heinrich, DrPH, RN, is a director in the Health Care Group in the U.S. General Accounting Office. She oversees all issues dealing with public health. Heinrich previously served as director of the American Academy of Nursing and as the director of Extramural Programs for the National Institute of Nursing Research at the National Institutes of Health. She has experience as a public health nurse in both urban and rural areas and has worked in public policy at the local, state, and federal levels.

Lisa Herz, PhD, is a specialist in social legislation in the Domestic Social Policy Division of CRS. She has been with CRS for six years, providing policy analysis to Congress on Medicaid issues (eligibility and benefits for children, families, and pregnant women; financing; upper payment limits; and managed care) and SCHIP (all issues). Before joining CRS, Herz was an analyst for the Medstat Group, a private health care research consulting firm. She has had over 25 years of experience in the health care field and holds a PhD degree from Loyola University of Chicago.

Lindy Hinman is a senior Medicare analyst at the Office of Management and Budget in the Executive Office of the President. Her responsibilities include providing economic, legislative, and regulatory analyses of issues related to Medicare Part A hospitals, post-acute care facilities, and quality of care. She briefs officials at OMB, the White House, and DHHS on policy recommendations. Hinman holds a bachelor of arts degree from Washington University in St. Louis and a master's degree in health services administration from the University of Michigan School of Public Health.

Kate Massey is a senior Medicaid analyst at the Office of Management and Budget in the Executive Office of the President. Her responsibilities include assisting in the formulation of the president's legislative and regulatory agenda and briefing OMB and White House policy officials on current Medicaid issues. Massey has worked on a number of health policy issues while at OMB, including 1115 waiver policy, Medicaid spending trends and issues related to the uninsured. She holds a bachelor of arts degree from Bard College and a master of public affairs from the Lyndon B. Johnson School of Public Affairs, University of Texas.

Susan McNally, JD, is director of the Medicaid Analysis Group in CMS's Office of Legislation, where she is responsible for legislation and policy affecting the Medicaid and SCHIP programs as well as initiatives to increase coverage for the uninsured. With respect to the recently enacted Medicare Prescription Drug Modernization and Improvement Act of 2003, McNally has responsibility for issues affecting dual eligibles, low-income subsidies, and the interaction of the new Part D benefit with state Medicaid programs and state pharmaceutical assistance programs. Before joining CMS, McNally worked as director of federal affairs at the National Association of Community Health Centers. She also served as assistant counsel in the Senate Office of Legislative Counsel, attorney advisor in the DHHS Office of the Assistant Secretary for Legislation, associate staff director and general counsel of the 1991 Advisory Council on Social Security

Biographical Sketches — Federal Participants (cont.)

(Steelman Commission), and senior health policy advisor to Representative Fred Grandy (R-IA). McNally is a graduate of Barnard College and the Columbia University School of Law.

Dawn Myers, JD, is the legislative director for Rep. John M. Spratt Jr (D-SC). She served as legislative counsel for Spratt from 1997 until 2003. Myers holds an undergraduate degree from Vanderbilt University and a JD from Tulane University.

Lori Neal has been a legislative assistant for Sen. Blanche Lincoln (D-AR) since July 2003. She is responsible for Medicaid, Temporary Assistance for Needy Families, education, labor, and other social issues. Neal began her career on Capitol Hill in 2002 as a legislative correspondent for Lincoln. A Lawton, Oklahoma, native, Neal holds a bachelor's degree from the University of Oklahoma and a master of public administration from Columbia University.

Rhonda Rhodes is the director of the Division of Benefits, Coverage, and Payment in the Family and Children's Health Programs Group in CMS's Center for Medicaid and State Operations (CMSO). Rhodes provides leadership and management for policy development on benefits and coverage issues such as Medicaid's EPSDT program, maternal and child health, and the recently enacted breast and cervical cancer prevention and treatment option. She is also director of the Noninstitutional Payment Team in CMSO, a national team responsible for oversight of noninstitutional payment policy, including outpatient hospital and clinic upper payment limits, school based clinics, federally qualified health centers and rural health clinics, and physicians. Previously, Rhodes served as deputy director of the Division of Integrated Health Systems, where she provided guidance and expertise on Medicaid managed care issues and Section 1115 and Section 1915(b) waiver initiatives. She has also served as a legislative aide on Capitol Hill. Rhodes worked in the private sector consultant with a Washington, DC-based firm specializing in Medicaid and Medicare managed care. She holds a master of science degree in consumer economics from the University of Maryland at College Park.

Vincent Ventimiglia, JD, is the Republican health policy director of the Senate Health, Education, Labor, and Pensions Committee. Previously, he was director of government affairs for Medtronic, Inc., a leading medical technology company. Ventimiglia served as counsel to the Senate Committee on Labor and Human Resources from 1995 to 1998 and staff attorney to the U.S. Sentencing Commission from 1990 to 1994. He has also served as program director at the Capitol Hill Housing Improvement Partnership and as a student attorney at the Harrison Institute for Public Law. Ventimiglia began his career on Capitol Hill in 1985 as a legislative assistant to Sen. Gordon Humphrey (R-NH). He received his BA degree from Yale University and holds a JD from the Georgetown University Law Center.



**National Health
Policy Forum**

2131 K Street, NW
Suite 500
Washington, DC 20037
202/872-1390
202/862-9837 [fax]
nhpf@gwu.edu [e-mail]
www.nhpf.org [web site]
