



**DEVELOPING FEDERALLY QUALIFIED HEALTH CENTERS  
INTO COMMUNITY NETWORKS TO IMPROVE  
STATE PRIMARY CARE DELIVERY SYSTEMS**

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**ABSTRACT:** By fostering connections between federally qualified health centers (FQHCs) and other private primary care providers, states may be able to connect Medicaid beneficiaries with services needed to help them manage their health and reduce costly visits to hospitals. FQHCs' mandate to provide a comprehensive scope of primary and preventive health care and support services, coupled with their access to federal funds, gives them expertise and resources that might be leveraged in collaborative relationships with states and private practices. FQHCs may find that by entering into collaborative relationships with states and private practices, they strengthen their own financial position, advance their quality goals, improve their staffing mix, enhance the continuum of care and the kinds of services available to their patients, and further their mission.

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## EXECUTIVE SUMMARY

Across the nation, states are seeking to bolster the performance of Medicaid primary care providers in order to hold down costs while improving beneficiaries' health. In particular, more than 37 states are developing or implementing strategies that seek to improve primary care delivery through the creation of medical homes. A majority of U.S. physicians work in small to medium-sized practices, which often do not have the resources to provide complex care coordination, behavioral health care, extended hours, and other services needed to function as medical homes. As a result, such practices are frequently left out of medical home reform efforts. Connecting such practices to federally qualified health centers (FQHCs)—which provide comprehensive primary care services—could help improve the health of vulnerable populations and potentially reduce costs by achieving efficiencies and sharing scarce resources.

### What Is a Federally Qualified Health Center?

**Federally Qualified Health Center** is a designation from the Bureau of Primary Health Care and the Centers for Medicare and Medicaid Services given to a nonprofit public or private clinic that is located in a medically underserved area or provides care to a medically underserved population. FQHCs must provide a detailed scope of primary health care as well as supportive services to all patients, regardless of their ability to pay. They must be governed by a board, of which the majority members must come from the community served by the FQHC. Most, but not all, FQHCs receive federal grant funds under the Health Center Program, Section 330 of the Public Health Service Act.

By fostering connections between FQHCs and other Medicaid providers, states may be able to connect beneficiaries with services needed to help them manage their health and reduce costly visits to hospitals. FQHCs' mandate to provide a detailed scope of primary and preventive health care and support services, coupled with their access to federal funds, gives them expertise and resources that might be leveraged in collaborative relationships with states and private practices. In addition, FQHCs may find that by entering into collaborative relationships with states and private practices, they strengthen their own financial position, advance their quality goals, improve their staffing mix, enhance the continuum of care and the kinds of services available to their patients, and further their mission.

With support from The Commonwealth Fund, the National Academy for State Health Policy sought to identify states and FQHCs that are collaborating to build community networks to make medical home services available for vulnerable

populations. This report features three such collaborations, which offer important lessons for states to consider as they work to improve their primary care delivery systems.

### **Montana Health Improvement Program**

In 2009, Montana Medicaid shifted its management of complex patients from an out-of-state disease management vendor to 13 FQHCs and one tribal health center in the state. The agency collaborated with the Montana Primary Care Association to develop a Health Improvement Program (HIP) in which Medicaid pays these health centers \$3.75 per member per month to hire care managers to serve beneficiaries. Approximately 90 percent of the Medicaid patients served through this program receive their primary care from a private, non-health center provider.

Patients are identified for HIP care management through predictive modeling software and provider referrals, based on their risk for complications or inappropriate utilization of services. Trained HIP care managers, based at the health centers, coordinate care with patients and their providers either by meeting patients face-to-face or by telephone. They teach self-care skills, review medications, manage transitions between care settings, remind patients of upcoming appointments, and often arrange transportation.

Relationships between the FQHCs and private practices have been evolving over the past two years. Although data collection is limited, Montana Medicaid has been able to show cost savings from the program through better management of chronic conditions and avoidance of acute care utilization. In addition, the state has been able to extend care management services to a broader Medicaid population.

### **Community Care of North Carolina**

Over the past 13 years, North Carolina Medicaid has cultivated a robust system that has grown from an initial pilot of eight community networks to a statewide operation of 14 Community Care of North Carolina (CCNC) networks covering all 100 counties. The state Medicaid agency left the network design in the hands of large Medicaid practices but provides payments to the participating private practices and networks, which vary according to the size of the population served.

One large practice, Gaston Family Health Services, an FQHC, partnered with the public health department and a community hospital to form an affiliated nonprofit network, Community Health Partners. Gaston Family Health Services provides the management and staffing for 25 employees to operate the Community Health Partners network. Network staff members include a medical director, network manager, nurse

clinical manager, care managers, a pharmacist, and a psychiatrist. These individuals work directly with practices to improve patient care. Community Health Partners services span two counties and serve 47 practices and more than 33,000 Medicaid patients. Practices are each assigned a network-based care manager to provide services such as patient education, disease management, and medication review. The network also provides support for transitional care as well as data analysis and feedback to bolster practices' efforts to improve the quality of care. Although preference is given to patients of Gaston Family Health Services, patients involved in the network practices also have access to Gaston's dental clinic, HIV case managers, and diabetes nutrition and education center.

The effectiveness of the CCNC model has been documented in independent reports showing that it has controlled costs and improved health outcomes. The FQHC participating in this network has been able to strengthen its position as a community leader, improve care for its own patients, and better fulfill its mission of serving its community.

### **Indiana's Open Door Health Center**

The Open Door Health Center, an FQHC in east-central Indiana, operates an urgent care center that serves patients of FQHCs as well as patients of private primary care providers (including insured and uninsured patients). In 2006, Open Door Health Center took over operations of the Southway Urgent Care Center. Today, Southway offers expanded access to treatment for traumas and illnesses that are not life-threatening but demand quick attention.

Most Southway patients—about 44 percent—receive primary care from private providers. About 23 percent of Southway patients receive their primary care at Open Door, and about 33 percent lack a usual source of primary care. For the latter group, Southway works to establish a regular source of primary care by referring them to the FQHC or another primary care practice, if it is more convenient for the patient.

Indiana Medicaid's role in developing Open Door's urgent care center was indirect. A Medicaid managed care payment policy that paid providers on a capitated basis created an environment in which urgent care centers could flourish.

### **Developing FQHC-Based Networks**

Traditionally, the role of FQHCs has been to provide primary and preventive care services for the uninsured, underinsured, and underserved populations who walk through their doors. Fulfilling this mission requires a great deal of effort and resources, and there

are many federal, state, and institutional barriers that make it difficult for FQHCs to assume broader roles in their communities by forming collaborative networks with private practices. These include:

- large differences in capabilities from one FQHC to the next;
- lack of incentives for private practices to participate in an FQHC-based network;
- need for the involvement of multiple payers;
- lack of information-sharing between providers;
- limited capacity to collect quality data for an entire episode of care;
- Centers for Medicare and Medicaid Services (CMS) productivity requirements for FQHCs; and
- visit-based fee schedules that discourage innovation.

Federal health reform offers opportunities to overcome such barriers. The Affordable Care Act creates opportunities for states and FQHCs to pilot community networks, including:

- the Center for Medicare and Medicaid Innovation;
- enhanced funding for FQHCs;
- funding for community health teams;
- a new Medicaid state plan option for health homes for those with chronic conditions; and
- primary care extension programs.

## **Conclusion**

The creation of community-based networks to provide care management and greater access to health care services may enable states to hold down Medicaid costs while providing better care for beneficiaries. With the expansion of Medicaid through the Affordable Care Act, already-stretched primary care practices will need to take on additional Medicaid patients. Helping practices function more efficiently as medical homes—particularly for patients with chronic illnesses—can help improve access to high-quality care and control costs. In order for practices to function as medical homes, they will need resources to ensure the delivery of timely, coordinated, and comprehensive primary care. Many FQHCs have the infrastructure and expertise to help practices meet medical home requirements and may be ready partners for states to develop as community networks.

# **DEVELOPING FEDERALLY QUALIFIED HEALTH CENTERS INTO COMMUNITY NETWORKS TO IMPROVE STATE PRIMARY CARE DELIVERY SYSTEMS**

## **INTRODUCTION**

Across the nation, states are seeking to bolster the performance of Medicaid primary care providers in order to hold down costs while improving beneficiaries' health. In particular, more than 37 states are developing or implementing strategies to improve the performance of primary care providers through the creation of medical homes.<sup>1</sup> A majority of U.S. physicians work in small to medium-sized practices, which often do not have the resources to provide care coordination, behavioral health care, extended hours, and other services needed to function as comprehensive medical homes. As a result, they are frequently left out of medical home reform efforts.<sup>2</sup> Connecting such practices to federally qualified health centers (FQHCs)—which provide comprehensive primary care services—could be a way for states to help improve the health of vulnerable populations and potentially reduce costs by achieving efficiencies and maximizing scarce resources.

Although FQHCs are funded by and directly accountable to the federal government, states have the ability to foster connections between FQHCs and private practices serving Medicaid patients. FQHCs are well suited to provide medical home services. By federal law, they must:

- be located in a medically underserved area or serve a medically underserved population;
- provide a detailed scope of primary and preventive health care as well as supportive services (education, translation, transportation, etc.) as described in 42 U.S.C. 254b (b)(1);
- provide services to all residents in their service areas, regardless of their ability to pay; and
- be governed by a community-based board of directors, of which the majority are active patients of the health center and who collectively represent the population served.

Federally funded health centers have a variety of resources to help them meet their mission.<sup>3</sup> These include: federal grant funds; Medicaid and Medicare preferential reimbursement rates intended to cover the reasonable costs of providing the full

complement of health care and support services; providers through the National Health Services Corps; and eligibility to apply for government-sponsored malpractice coverage. FQHCs also have expertise in providing comprehensive medical homes to vulnerable populations, including linkages to health and social services. In addition to helping private practices, FQHCs may find that by entering into collaborative relationships with states and private practices, they strengthen their own financial position, advance their quality goals, improve their staffing mix, enhance the continuum of care and the kinds of services available to their patients, and further their mission.

The Affordable Care Act provides resources that may help states develop a better primary care infrastructure for Medicaid populations. These include significant federal funding for health center operational and infrastructure expansion, along with additional funding to improve primary care practice delivery.<sup>4</sup>

The inspiration for this report came from Montana Medicaid's Health Improvement Program. Conceived by the state Medicaid agency, the program has entailed shifting an existing budget for disease management from an out-of-state vendor to FQHCs across the state. FQHC-based staff members provide care management services for Medicaid beneficiaries, including those who do not receive their primary care from the FQHC. The state has developed "what's on hand" into a community resource or "shared utility" of services that may improve care delivery for all Medicaid beneficiaries, as well as reduce state costs. This model may have broad appeal for other states.

With support from The Commonwealth Fund, the National Academy for State Health Policy (NASHP) sought to identify other examples of state and FQHC collaborations that involve sharing services among practices to improve the delivery of comprehensive primary care. To do so, we interviewed a number of federal and national experts, scanned the literature, and surveyed state Primary Care Associations. Although there is increasing interest in developing resources to help small and medium-sized practices become medical homes, we did not find many models that involved state and FQHC collaboration.<sup>5</sup> According to those we interviewed, there may be several reasons for this: 1) state officials and FQHCs may not be aware of the potential for FQHCs to use their resources for activities and services provided outside of the four walls of their facilities; 2) the collaborative model may not be appropriate in certain types of communities or delivery systems; and 3) the inspiration and leadership needed to deploy such an innovative model may not be present.

Drawing on extensive interviews with state and local stakeholders conducted during a site visit to Montana, this report takes a close look at the state's Health Improvement Program. In addition, we used telephone interviews to explore two other models of care:

- A North Carolina FQHC that led the formation of a network involving FQHCs, hospitals, private practices, and other organizations that provides comprehensive services to help private Medicaid practices operate as medical homes.
- An Indiana FQHC that provides urgent care services to the surrounding community and has developed referral relationships with private practices, many of which are focused on avoiding emergency department visits.

In each of these three examples, the states played a direct or indirect role in the development of FQHCs as a community network. The Medicaid agencies in Montana and North Carolina took a leading role in establishing statewide networks to support all Medicaid practices. North Carolina took a bottom-up approach by letting local practices decide which infrastructure worked best for them. Montana took a top-down approach, with the state Medicaid agency designating the infrastructure and getting the network up and running in less than a year. In Indiana, an FQHC offered private practices and their patients an alternative to the emergency department for urgent care. A Medicaid managed care payment policy that paid providers on a capitated basis created an environment in which urgent care centers could flourish.

These three examples offer strong evidence of FQHCs' leadership, vision, creativity, and willingness to help states strengthen their primary care delivery systems. This report aims to promote conversation among states, FQHCs, and other stakeholders about new possibilities for collaborating to meet the increased demand for care under the expansion of Medicaid through federal health reform. It also highlights potential funding opportunities that federal health reform may bring to encourage and support such collaboration and innovation.

### **MONTANA'S HEALTH IMPROVEMENT PROGRAM**

Montana's Health Improvement Program (HIP) relies on the state's FQHCs to provide care management for high-risk beneficiaries of Passport to Health, Montana Medicaid's primary care case management (PCCM) program.<sup>6</sup> Montana Medicaid seized on an opportunity to rethink its Medicaid delivery system to develop this innovative program.

In 2008, Montana Medicaid’s disease management contract with an out-of-state vendor came up for renewal. The agency was not completely satisfied with the program; according to staff, “it was a lot of money for not a lot of concrete results.” In particular, Medicaid staff described the disease management program as having several shortcomings:

- The staff of 4.5 full-time equivalents (FTEs) could handle a caseload of only about 325 beneficiaries.
- The program was based mainly on telephone contacts.
- The staff had difficulty addressing beneficiaries’ social needs, such as access to housing, transportation, and healthy food, all of which have clear implications for health.
- The disease-based program was limited to four conditions: asthma, diabetes, heart failure, and chronic pain. Under this model, a patient with well-controlled asthma would receive services and a patient with uncontrolled hypertension would receive none.

Montana Medicaid used the contract renewal period to consider new ways to serve its high-risk, high-cost population in a way that would be focused on the “whole person,” rather than just their disease. They wanted a program that would better reflect the rural and frontier nature of the state, as well as the cultural needs of its large Native American population. According to the director of Montana’s Department of Public Health and Human Services, the state wanted to develop a program to help people navigate a complex system and to help “people who don’t have a voice get a voice.”

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North Carolina Medicaid’s Community Care program provided some of the inspiration for Montana’s care management program.<sup>7</sup> In addition, a presentation to Medicaid from the Montana Primary Care Association (PCA) describing their work helped build interest in using FQHCs as care management hubs.

## **LAYING THE GROUNDWORK**

In 2008, the state Medicaid agency reached out to the Montana PCA to discuss the creation of an FQHC-based care management program. This process was facilitated by the two organizations' strong collaborative relationship and what both parties described as "out-of-the box, forward thinkers." Still, the PCA faced challenges in gaining the support of its FQHC members. While many were eager to get involved, others were reluctant. The PCA facilitated an in-person forum that brought health centers together to discuss the concept, share ideas, and designate geographic catchment areas. Subsequent conference calls between the state, the FQHCs, and the PCA kept the process transparent, established trust, and maintained momentum.

Approval of the federal Health Resources and Services Administration (HRSA) was not needed to create the program, though HRSA did clarify that Federal Tort Claims Act (malpractice) coverage would not apply for care managers serving patients who do not receive primary or dental care from the FQHC.<sup>8</sup> This meant that FQHCs had to arrange separate malpractice coverage for their HIP staff.<sup>9</sup>

During this time, Montana Medicaid worked with the Centers for Medicare and Medicaid Services (CMS) to arrive at a mutually acceptable payment methodology. Having been told by CMS that a cost-based approach to reimbursement would not be acceptable, the state agreed to adopt an enhanced primary care case management approach under the authority of a 1915(b) waiver.<sup>10</sup> Under this arrangement, the state pays \$3.75 per member per month to a given FQHC for each Passport to Health (Medicaid) beneficiary in that health center's geographic catchment area—regardless of the patient's risk status.<sup>11</sup> This totals about \$2.8 million in Medicaid funding per year to the designated FQHCs—10 percent less than the previous disease management program's budget.

All Medicaid beneficiaries are eligible to receive HIP services, but only 5 percent are being actively care-managed. Montana Medicaid receives federal financial participation at the state's standard federal medical assistance percentage rate for per member per month fees.

Having arrived at an acceptable financial arrangement with the PCA and FQHCs, the state Medicaid agency used a request for proposals process to select 13 FQHCs and one tribal health center to serve as HIP sites.

## **KEY ASPECTS OF THE MODEL**

Participating health centers receive a capitated rate from Medicaid to hire care managers to serve beneficiaries receiving primary care from the health center, as well as those receiving primary care from private providers. In both cases, HIP care managers work closely with patients' regular primary care practices. The design of HIP addresses some of the shortcomings found under the state's former disease management model:

- In addition to offering phone-based care, HIP care managers regularly meet face to face with clients. The care managers are geographically dispersed throughout the large, 145,000-square-mile state. No patient is more than 200 miles away from a care manager—a significant improvement over the former program.
- HIP staff focus on the “whole patient,” rather than just their disease. Diagnosis is one of several factors taken into account when identifying which patients receive care. Additional considerations include demographics, procedure service history, and prescription drug records. The program also allows for provider referral. This supports whole-patient care, allowing patients who may otherwise appear low-risk to receive support services.
- HIP staff are familiar with local resources and are trained in using motivational interviewing to encourage healthy lifestyles.
- Through HIP, the health centers currently employ 32.5 care management FTEs, with plans to employ a total of 35 FTEs to manage care for 3,200 beneficiaries.

The state uses commercially available predictive modeling software (see box) to identify the 5 percent of the Passport to Health population most at risk for high costs and/or complications. In addition, primary care providers refer patients whom they believe could benefit from HIP services but were not identified through the software. To date, providers have referred only a small number of patients to HIP; as word of the program spreads, the Medicaid agency hopes to see the number of such referrals increase.

As of October 2010, about 80 percent of Passport patients receiving care management through HIP were adults, and 90 percent received their primary care from a private, non-FQHC provider.<sup>12</sup> In general, only one-third of patients identified for the program are being actively served at any given time. Another third are in “on-demand” status—they have been made aware of the program and completed a questionnaire, but have chosen not to receive care management services. The other third are individuals who are unreachable or unresponsive. Panels of “active” HIP patients range from 50 to 85 per care manager.

### **Predictive Modeling and HIP**

Montana Medicaid uses Impact Pro, predictive modeling software from Ingenix, to identify Passport to Health members who may benefit from care management services.

*What information is analyzed?*

- Patient demographics
- Medical claims, including diagnosis codes, procedure codes, Healthcare Common Procedure Coding System/Revenue Codes, and service dates
- Prescription claims, including National Drug Code codes and service dates

*What is this information used for?*

- To predict:
  - › Future costs for three and 12 months
  - › Relative risk for hospital admission for three and 12 months
  - › Inpatient stay probability
- To identify evidence-based opportunities for intervention

Source: Montana, memorandum from Wendy Sturn, Health Improvement Program, Managed Care Bureau, Montana Medicaid, *Impact Pro: Predictive Modeling Software by Ingenix*, 2010.

### ***The Role of Care Managers***

HIP care managers are registered nurses, licensed practical nurses, or social workers. They complete a 40-hour online Chronic Care Professional course through the HealthSciences Institute. This training program consists of six modules intended to “prepare clinicians to address the real-world challenges of evidence-based medical care, whole-person care, patient activation, adherence, cultural competence, self-care support, and lifestyle change.”<sup>13</sup> HealthSciences Institute also offers a regular series of online continuing education Web events on specific topics, such as weight-loss coaching.

Although there is no “normal day,” HIP care managers have common responsibilities. For a new patient, typical services include:

- Establishing first contact with a letter and then following up by phone to arrange a face-to-face meeting.
- Meeting the patient at the FQHC or another location, such as the client’s home, nearby community center, or the patient’s primary care provider’s practice. This meeting is used to administer a health assessment tool and jointly develop a treatment plan establishing concrete goals.
- Teaching self-care skills and reviewing medications.

- Promoting use of the NurseFirst advice line and other alternatives to the emergency department, when appropriate.

Other care manager responsibilities include:

- Reviewing risk-modeling software to identify opportunities for needed care (e.g., adult cancer screenings).
- Phoning patients to remind them of scheduled appointments and arranging transportation if needed (it is hoped that this strategy will decrease “no-show” rates and encourage more providers to accept patients with Medicaid).
- Monitoring patients’ compliance with their treatment plans.
- Following up with those who have visited the emergency department.
- Visiting patients who have been admitted to the hospital.
- Discussing patients’ needs and goals with their primary care providers.
- Connecting patients with safety-net resources in the community, such as food pantries and housing authorities.
- Calling Medicaid on patients’ behalf to inquire about covered benefits and otherwise advocating for their interests.

HIP care managers and staff described their advocacy role as particularly crucial: many patients find comfort in having a trusted partner who can help them navigate an often overwhelming, complicated, and unfamiliar health care system.

### ***Relationships with Private Providers***

One of the goals of Montana’s HIP is to support private primary care providers in caring for their patients with complex health care needs. Participating patients describe their care managers as pivotal in helping them improve their overall health and quality of life. But according to Montana Medicaid, the quality of the partnerships between care managers and primary care providers is highly variable.

There are many instances of effective collaborations between HIP care managers and private primary care providers. One private provider in the Missoula area described a HIP care manager’s assistance as “awesome.” According to this provider, after one patient began work with a HIP care manager, the patient was able to keep better track of his blood pressure. This provider also noted that her practice is too small to have its own care manager, and the HIP care manager has been valuable in filling this gap. Communication

between the HIP care manager and the provider is routine, effective, and strengthened through face-to-face meetings. The provider has since referred about 30 high-needs patients who were not identified through the risk-analysis software to HIP. She reported no apprehension about patients leaving her private practice for regular care at the FQHC, even though her practice is more conveniently located for her patient base than the FQHC and well established in its community.

Private primary care providers have been slow to embrace HIP because they are pressed for time, unfamiliar with the program, or, in a limited number of cases, resistant to the idea of sharing their responsibilities with someone (i.e., a care manager) who does not work for them. Montana Medicaid and HIP staff are pursuing several strategies to increase the engagement of private primary care providers. These include:

- Care managers now send a notification letter to a patient's primary care provider when one begins a treatment program. They learned early on to print notification letters on plain or HIP stationery, rather than FQHC stationery, so as not to confuse providers.
- Some HIP sites are now assigning care managers to patients on the basis of primary care providers. This way, it may be easier for care managers to form strong, productive relationships with particular primary care providers and their staffs.
- HIP staff believe that meetings among patients, their primary care providers, and their care managers can promote team care.<sup>14</sup> However, arranging these meetings has been logistically challenging, and most communication has been through regular mail.
- The Medicaid agency plans to offer private providers training about HIP and related changes to the Passport to Health agreement. They may also take steps to encourage providers to refer patients to the program and work with care managers.

#### **LESSONS LEARNED AND CHALLENGES**

Montana Medicaid launched HIP just over a year ago. In some areas of the state, FQHCs are still in the early phases of implementation. But the program is already showing some promising returns. Data provided by Montana Medicaid on a small sample of HIP beneficiaries (n=158) showed a net per member per month savings of \$304 five months after receiving HIP services, compared with patient costs five months prior to receiving such services. (The impact of the program on health outcomes is also being tracked, but it is too early to report findings in this area.) The Medicaid agency, Primary Care Association, and the health centers have already learned a number of lessons and are looking ahead at opportunities to improve the program.

### *Lessons for States*

*Develop a culture of collaboration.* Montana Medicaid’s innovative approach was valuable in developing the FQHC-based care coordination model, and its collaborative relationship with the PCA was important in refining it. Montana is a small state in terms of population. Stakeholders report that, among the community of providers serving Medicaid beneficiaries, “everyone knows everyone” and all share a strong sense of responsibility to serve them well. Developing collaborative relationships may prove more difficult in larger states.

By bringing in the PCA as a strategic ally, Montana Medicaid was able to draw on its resources to facilitate meetings with FQHCs and provide feedback on draft program plans. Montana Medicaid also values the ability of the PCA to identify gaps in care processes.

*Be flexible and persistent.* Montana Medicaid originally intended to pay FQHCs for serving as HIP sites through a cost-based reimbursement process. When CMS did not approve of this payment method, Montana shifted its approach to a per member per month fee. It took Montana Medicaid about one a year of negotiating with CMS to arrive at a mutually acceptable payment method.

*Serve the right clients.* Care management is more valuable for some Medicaid beneficiaries than for others, and there are some concerns whether HIP is reaching the population most likely to benefit from the services. Montana Medicaid staff note that some clients are hard to reach, and that HIP does not serve Medicaid beneficiaries who are also eligible for Medicare. Such “dual eligibles” often have a variety of medical and social needs that effective care management could address. Yet because these individuals are not included in the state’s Passport waiver, they are not eligible for HIP. Including them would require additional negotiations with CMS.

*Obtain maximum federal financial participation.* Under its previous disease management contract, Montana Medicaid was able to obtain the full federal matching rate for services. Under HIP, the state receives the full rate for the \$3.75 per member per month payments to health centers. But other expenses—including the costs of staff time, travel, printed materials, and predictive modeling software—receive federal funding at the lower administrative federal matching rate. To maximize federal funding, a state Medicaid program could conceivably increase the amount of the per member per month rate paid to sites and, in turn, require each site to pay a share of program’s administrative costs.

*Track data.* Currently, no central system exists to organize and track information for all HIP patients who are receiving care management. The Medicaid agency would like to track data using indicators already measured by the health centers, including:

- clinical indicators, such as blood pressure levels and HbA1c values
- patient contact information
- treatment plan progress, and
- other pertinent information, such as patient self-assessment scores.

Right now, HIP sites are tracking this information in spreadsheets that are unwieldy, labor-intensive, and make comparisons across sites difficult. A central, well-designed database could assist HIP care managers in tracking patient status, contacting hard-to-reach individuals, and communicating with primary care providers. A database could also help Medicaid analyze the performance of the HIP program.

*Keep it local.* State leaders, Medicaid officials, and HIP staff agreed that a key ingredient in successful care management is a shared sense of community. They believe that their patients respond better to those who understand their culture and are familiar with resources in their local areas.

#### *Lessons for PCAs and FQHCs*

Transitioning to an FQHC-based care management model is not easy for many FQHCs. Many are overwhelmed, underfunded, and lack the organizational capacity to hire new staff, serve new populations, and assume new responsibilities. PCA and FQHC staff in Montana consistently cited the FQHC mission of “improving the health of a community, not just our patient panels,” as the most salient reason for undertaking this role. One PCA executive stated:

It’s a win for the health center because the care managers become the community experts. They learn how to navigate the system and get what their patients need. They become the catalysts within the health centers. By really understanding the communities and the resources available, it improves the level of care for the entire community.

Health centers are also realizing other benefits from participating in HIP:

- One large FQHC that employs five HIP staff reports receiving about \$500,000 annually in Medicaid HIP care management fees.

- HIP provides a stream of insured patient referrals for other FQHC services, most notably dental care. While some FQHCs do not have spare capacity, others are eager to take advantage of these additional opportunities for revenue and have been able to hire more staff and significantly expand operations. An FQHC in Missoula reported that participation in HIP has brought in more covered visits to its behavioral health specialists.
- An FQHC looking to provide care management services for its patients may not have sufficient internal demand to justify hiring a care manager. For example, an FQHC in Butte described its previous care management services as being a “patchwork.” HIP has allowed this health center to hire a registered nurse care manager, which also gives it more credibility, and consequently better relations, with hospitals and providers.
- HIP provides training opportunities and ongoing funding for FQHCs to develop expertise in care management. Health centers are finding that this furthers their own efforts to develop into high-performing medical homes that can better serve their existing patient bases.

The PCA and FQHCs have identified opportunities for improvement:

*Avoiding care manager burnout.* The nature of HIP demands that care managers work almost exclusively with a sick, high-needs population. Although the turnover among care managers has been quite low, FQHC staff are acutely aware of the need to guard against staff burnout as the program matures. Suggestions to do so include enlisting other staff, such as receptionists and community health workers, to help care managers contact and follow up with patients.

*Focusing resources on new beneficiary outreach.* HIP care managers spend a great deal of time trying to establish and maintain relationships with hard-to-reach clients. (As mentioned previously, at any time about one-third of HIP beneficiaries are unresponsive or unreachable.) To address this challenge, care managers need the help of administrative support staff with strong “sleuthing” skills, as well as access to timely information from Medicaid. Such information from Medicaid, ideally delivered through a shared database, could provide a care manager with valuable tips, such as the location of a pharmacy where a patient picked up a recent prescription.

*Accessing clinical information.* HIP care managers are not always able to access up-to-date clinical information from private providers, hospitals, and other caregivers. For obvious reasons, this can complicate care management. Electronic health information

exchange could provide HIP care managers with easier access to information for all of their patients.

*Increasing opportunities for peer-to-peer learning and trainings.* HIP staff would like opportunities to meet with their peers and share best practices. Several care managers expressed a desire for in-person training sessions to complement the online Chronic Care Professional regimen. For example, they pointed to motivational interviewing—a technique through which a coach helps a patient overcome ambivalence and embrace change—as an example of a key care management skill that might be more effectively taught in person rather than through a distance-based method.

Care managers also want more comprehensive information on state Medicaid policy. A key function of care managers is to help patients navigate Medicaid and the broader safety-net system. HIP staff report that, while Medicaid officials are helpful in responding to their questions on an ad hoc basis, a systemic approach to familiarizing staff with important Medicaid policies such as eligibility requirements is needed.

There is a clear role for Montana Medicaid in bringing about these opportunities.

## **COMMUNITY CARE OF NORTH CAROLINA**

North Carolina Medicaid has cultivated a robust community network program that has grown from an initial pilot of eight networks to a statewide operation of 14 networks covering the state’s 100 counties.<sup>15</sup> Community Care of North Carolina (CCNC) now serves more than 1 million Medicaid beneficiaries and 4,200 Medicaid primary care providers. As in Montana, the North Carolina network model was built on an existing primary care case management platform. Both states aimed to improve quality by developing local care coordination services.

Over the past 13 years, North Carolina networks have grown substantially to better serve Medicaid providers and their patients. The networks now function as “virtual health centers,” providing care coordination and access to pharmacists, psychiatrists, informatics specialists, and more. In addition, the clinical, quality, utilization, and data administration for the local networks has moved from Medicaid to North Carolina Community Care Networks (NCCCN), a nonprofit umbrella organization.

## **LAYING THE GROUNDWORK**

Like Montana, North Carolina sought a local approach to helping practices care for complex patients. Unlike Montana, North Carolina left the network design in the hands of

the local providers. North Carolina Medicaid began by inviting its largest Medicaid practices (those with at least 2,000 assigned Medicaid patients) to build the networks from the ground up in exchange for additional per member per month payments. These practices could choose to be in the network themselves or develop one they thought would best serve local providers' needs, as long as it adhered to certain foundational principles. Given this flexibility, a variety of network structures emerged, including those based in an FQHC, a public health department, an academic teaching practice, a pediatric practice, and a community hospital. These organizational structures each developed community partnerships and formed nonprofit umbrella organizations in which affiliated Medicaid providers could operate.

Initially, the networks' target audiences were women and children who qualified under the former Aid to Families with Dependent Children program. But as the networks evolved and resources were added, the population expanded to include the aged, blind, and disabled (ABD) population and, more recently, those dually eligible for Medicare and Medicaid. Each network receives a \$3.72 per member per month payment (\$13.72 for ABD patients). The networks use this funding to work with Medicaid providers to better coordinate care, decrease fragmentation, and improve care delivery for enrolled Medicaid patients.

Gaston Family Health Services, an FQHC, was one of the first eight practices invited to form networks. Although most of the state's FQHCs responded to Medicaid's initial invitation and were involved in local network development, Gaston Family Health Services was the only one to assume a leadership role. Its reputation and strong ties to the local public health department and community hospital enabled it to build the necessary partnerships to form an affiliated nonprofit network, Community Health Partners. The former chief executive officer of Gaston Family Health Services shepherded the entire process, from responding to the initial Medicaid invitation to forming Community Health Partners. He currently serves as chief executive officer of Community Health Partners.

#### **KEY ASPECTS OF THE MODEL**

Gaston Family Health Services provides the management and staffing for 25 employees to operate the Community Health Partners network.<sup>16</sup> As of late 2010, the Community Health Partners network spans two counties, serving 47 Medicaid practices and over 33,000 Medicaid patients.

As an FQHC-based network, Community Health Partners has much in common with the other 13 CCNC networks. But because it is an FQHC-based network, it is able to draw on some of its own expertise and assets to enhance its services.

### ***Statewide Network Services***

Like the other networks of CCNC, Community Health Partners has a high Medicaid provider participation rate. Medicaid providers receive an incentive of \$2.50 per member per month for their Medicaid patients (\$5.00 for ABD patients) if they are enrolled in their local network. Enrollment comes with some additional requirements: providers are expected to operate after-hours coverage, work with the nurse care managers assigned to their practice, implement disease management protocols, use recommended screening tools, attend medical management meetings, and use data to improve their practice operations and patient management. The sources of the data include:

- Medicaid claims data
- pharmacy claims data
- case identification reports
- gaps in care analysis reports
- customized queries, and
- baseline measures, ongoing monitoring, and trend analysis.

Area Health Education Centers add to the feedback loop for practices by conducting external chart audits for all quality improvement initiatives.

Data feedback to practices is a core network service, but the key to the network's success is its ability to make this feedback a catalyst for change. Each network comprises a medical director, network manager, clinical care manager supervisor, care managers, pharmacist, and most recently, psychiatrist, all of whom work directly with the practices to use the data to improve patient care.

### ***Putting the FQHC Stamp on Network Services***

There are certain services that the six Gaston Family Health Services medical sites offer their local network to support area providers and their patients. Although preference is given to established FQHC patients, other patients also have access to Gaston's dental clinic, HIV case managers, and diabetes nutrition and education center.<sup>17</sup> Gaston Family Health Services and the local public health department are colocated in

three sites, which means that the organizations are well positioned to leverage each other's resources.

Community Health Partners has used either its own operational funds or secured grant support to implement other kinds of services needed in its community, including:

- a telemonitoring program for homebound patients that transmits a patient's blood pressure level, pulse oximetry, and weight to the care manager;
- a Health Check Coordination Program that supported two coordinators to identify children up to age 5 who are eligible for Medicaid and then educate their parents or guardians on the importance of regular preventive care; and
- the Assuring Better Child Health and Development Program that works with practices to introduce and integrate a standardized, validated screening tool that supports the healthy development of young children up to age 3.

### ***Role of Care Managers***

About 75 percent of each network's budget is dedicated to care managers. Practices are assigned a network-based care manager who provides patient education, medication compliance and reconciliation services, and, in the words of one private primary care provider, "all the legwork needed to ensure improved care continuity and patient management."

At Community Health Partners, care managers typically work with two to eight practices each, depending on the number of Medicaid patients. Together, they manage the care of about 4 percent of the Medicaid population assigned to their network. Care managers may move around between small practices or base themselves in a larger practice. They meet with patients at practices or hospitals, in their homes, or other locations as needed. Care managers have in-person consultations with providers and have become valued members of the care team. Community Health Partners also employs two care managers who concentrate solely on ensuring patients make smooth transitions from the hospital to their homes or other care settings. They communicate across the network when a patient is ready for discharge.

### ***Relationships with Private Providers***

A nurse practitioner in a small, private pediatric practice reports that practice staff develop strong working relationships with the care managers because each practice is assigned one. These relationships function through face-to-face meetings, regular phone calls, and e-mail. This particular pediatric practice has a high Medicaid population (90

percent), and finds that its work with Community Health Partners enables it to offer patients a variety of services that a small practice could not otherwise furnish.

In addition to care management services, practices take part in quarterly medical management sessions on educational topics chosen by the provider community.

**LESSONS LEARNED AND CHALLENGES**

The North Carolina CCNC model has evolved over the past 13 years into a mature care coordination and support system. The grassroots development approach has resulted in a variety of different network structures, including an FQHC-based network, that operate using common principles.

The success of the CCNC model has been documented in an independent report prepared by the Mercer Human Resources Consulting Group.<sup>18</sup> The report found that the CCNC program saved approximately \$60 million in state fiscal year 2003, \$124 million in state fiscal year 2004, and \$231 million in state fiscal years 2005 and 2006, compared with the costs of the previous primary care case management model. Subsequent cost-effectiveness analysis continues to show that CCNC is holding down costs for the North Carolina Medicaid program. In addition, health outcomes have improved, particularly for those with asthma and diabetes.<sup>19</sup> The Community Health Partners network has also observed promising changes in acute care utilization in recent years (Table 1).

**Table 1. Community Health Partners—Changes in Acute Care Utilization<sup>20</sup>**

|  | <b>Fiscal Year<br/>2010</b> | <b>Quarter 1 of<br/>Fiscal Year<br/>2011</b> | <b>Change</b>            |
|--|-----------------------------|--|--------------------------|
| Preventable readmissions as a portion of total admissions <sup>21</sup>                            | 13.7%                       | 13.2%  | Decrease of 0.5 points   |
| Inpatient Aged, Blind, and Disabled admissions (per 1,000 member months) <sup>22</sup>             | 32.1                        | 28.1   | Decrease of 4 admissions |
| Emergency department visit rate for Aged, Blind, and Disabled population (per 1,000 member months) | 107.8                       | 101.9  | Decrease of 5.9 visits   |

***Lessons for States***

Robust care management networks cannot be built overnight or, in the case of a state, in a single budget cycle. Returns will require long-term commitment and a willingness to reinvest some of the savings to grow the program and allow it to mature. This requires careful monitoring and, crucially, the steady support of legislative and executive branch leadership.

*Consider a public–private governance structure.* According to the current CCNC president and former North Carolina Medicaid director, moving the governance of CCNC outside state government three years ago was a smart decision. This has helped CCNC avoid some of the politics and cyclical nature of government and maintain stability. It ensures steady leadership that helps build program identity, achieve consistent performance, and advance long-term planning goals.

*Provide incentives for primary care providers to participate.* Before the launch of CCNC, North Carolina was paying Medicaid providers at 95 percent of Medicare rates—giving them a significant provider base. Currently, 94 percent of all North Carolina Medicaid providers are enrolled in CCNC. On top of the fee-for-service rates, provider incentives include an added per member per month care management payment for their patients. Earning these incentives requires providers to change the way they work and be accountable for the results.

*Build partnerships with public and private stakeholders.* North Carolina’s former Medicaid director emphasized that the agency could not have built a program such as CCNC on its own. CCNC began as an interagency partnership between Medicaid and the Office of Rural Health and Community Care, and partnerships with other state agencies and private organizations followed. These partnerships have enhanced the mix of services provided by the networks.

*Take a bottom-up approach.* Providers are more likely to embrace a shared network resource if they have input in its design and implementation. CCNC’s practice-based networks vary across the state because they reflect what local providers wanted. Identifying a medical leader that has community credibility to lead the effort is essential.

*Secure the higher federal rate for network services.* In order to receive the higher rate, CMS must be assured that any new services added to the networks will have clinical value. States have to demonstrate to CMS, as North Carolina has, that the network infrastructure meets federal criteria for the higher federal match, instead of the lower rate for administrative work.

*Provide timely feedback to participating practices.* Providing feedback to practices is essential for improving the quality of care and controlling costs. Getting real-time hospital claims data is vital to this effort and requires cultivating relationships with hospitals.

### *Lessons for PCAs and FQHCs*

Although many North Carolina FQHCs were invited to take the lead in local network development, only one—Gaston Family Health Services—agreed to do so. The CEO of Gaston Family Health Services and Community Health Partners listed five reasons why other FQHCs should consider leading community networks:

- In this kind of initiative, it is useful to be the leader. Everyone will be around the table, but you will be directing priorities.
- The FQHC will gain recognition as a leader and resource to private medical practices. In the past, this is a role that FQHCs have not been able to achieve.
- As network leaders, FQHCs are well positioned to take advantage of grant opportunities and join demonstration programs.
- Adopting a case management model based on the provision of evidence-based care will enable you to extend the benefits to all of your patients—both insured and uninsured.
- Participating health centers will benefit from economies of scale. For example, by adding well-paid employees from Community Health Partners to the health center payroll, Gaston Family Health Services was able to do more for all of its employees, such as offering them better rates for benefit plans.<sup>23</sup>

### **INDIANA’S OPEN DOOR HEALTH CENTER**

Many primary care practices are able to offer care only during traditional business hours. Offering care on nights on weekends, or even offering same-day appointments for conditions requiring speedy attention can be challenging—resulting in many patients turning to the emergency department for pressing but not life-threatening conditions. Use of the emergency department for nonemergent conditions is more common among individuals with Medicaid coverage than individuals covered by commercial plans.<sup>24</sup>

FQHCs are required to provide comprehensive services, which may position them to fill such community “gaps” in care by offering care outside traditional business hours. Open Door Health Center, an FQHC in east-central Indiana, operates an urgent care center that serves patients of FQHCs and private primary care providers, as well as insured and uninsured patients. Open Door’s Southway Urgent Care uses the resources of an FQHC—in this case, its affiliated urgent care center—as a “community utility.” Its formation was timely for its community of providers, as at that time some Medicaid managed care organization payment policies penalized providers for unauthorized emergency department visits.

## **KEY ASPECTS OF THE MODEL**

In 2007, Open Door Health Center took over operations of the Southway Urgent Care Center after receiving encouragement to do so from its former hospital holding company. Open Door requested and received approval from the Health Resources and Services Administration to include Southway as a site in their scope of project. Today, Southway offers treatment for traumas and illnesses that are not life-threatening but demand quick attention, such as bone fractures. Southway also offers influenza vaccinations. The center has four urgent care exam rooms and X-ray facilities.

Southway offers accessible care; walk-in patients are accepted from 8:00 A.M. to 8:00 P.M. on weekdays and from 9:00 A.M. to 5:00 P.M. on weekends, 363 days per year. No appointments are accepted. Patients are typically seen within 20 minutes of their arrival. In fiscal year 2010, Southway recorded more than 15,000 visits. Staff members include either a physician or nurse practitioner, two medical assistants, and one front-desk assistant. A registered nurse is on site during regular business hours and on call after hours. Southway shares an X-ray technician with another facility during regular business hours and employs an X-ray technician after hours.

Most Southway Urgent Care patients—about 44 percent—receive primary care from private providers. About 23 percent receive their primary care at Open Door Health Center, and about 33 percent lack a usual source of primary care. For the latter group, Southway works to establish a regular source of primary care by referring them to either the FQHC or another primary care practice, if more convenient. In many instances, primary care providers have referred patients to Southway because:

- care is not immediately available at the private practice (because of its operating hours or heavy patient volume);
- the practice does not have the capabilities required (e.g., X-ray machine) to treat the presenting condition;
- Southway—with its short wait times and ability to provide personal attention—offers better experiences than emergency departments;
- Medicaid managed care organization payment policy has discouraged unnecessary emergency department utilization; and
- follow-up care, when needed, takes place with patients' primary care providers.

For the 23 percent of Southway patients who receive their primary care at the Open Door Health Center, information-sharing is seamless. Urgent care staff are able to

access the FQHC's electronic medical records, and enter and receive health information as appropriate. For others, urgent care staff fax information about the urgent care visit to patients' primary care providers' offices. If a patient had only a minor treatment, such as a vaccination, patients are given a copy of their visit record to share with their primary care provider. Urgent care center staff generally do not "close the loop" for visits which are minor in nature.

## **LESSONS LEARNED AND CHALLENGES**

Southway Urgent Care has filled a niche for the community it serves. In developing the model, Open Door Health Center has learned a variety of lessons and identified possibilities for improvement.

### ***Lessons for States***

Federal health reform will provide millions of Americans with health care coverage. Ensuring these newly insured have access to care, particularly after-hours care, will be a challenge for states. Until electronic health information exchange systems are established, traditional forms of communication between providers through telephone and fax will need to be strengthened.

While community care networks in Montana and North Carolina were designed, planned, and implemented by the state Medicaid agencies in partnership with key stakeholders, Indiana Medicaid played only an indirect role in developing Open Door's urgent care center. An existing Medicaid managed care payment policy that paid providers on a capitated basis created an environment in which urgent care centers could flourish.

### ***Lessons for PCAs and FQHCs***

Leaders of Open Door Health Center report being very satisfied with their decision to take over Southway from its former hospital operator. Their strong relationship with the hospital enabled it to enter into a one-year lease, free of charge, and to lease the services of some of the hospital physicians as well. Today, the FQHC and hospital partnership continues with the sharing of radiology services.

Because Southway offers urgent care only, not primary care, Open Door's National Health Service Corps staff cannot work at the site. Still, all patients receiving services at the Southway site are enrolled as patients of Open Door (regardless of the patient's usual source of primary care). Being an FQHC site provides Southway with several advantages:

- Staff are covered by federal malpractice coverage.
- More than 80 percent of patient visits are paid for by commercial, Medicare, or Medicaid insurance—a much more favorable payer mix than Open Door’s other FQHC operations, which have a larger proportion of uninsured patients.
- Because urgent care providers do not spend time on lengthy chronic care consultations, a relatively small number of providers are able to see a relatively large number of patients. This improves Open Door’s overall productivity.
- Referrals for patients without a usual source of care from the Southway site to Open Door’s other sites for primary care has resulted in new patients for Open Door and a more diversified payer mix.

As a result of its positive experience thus far, Open Door is considering opening a second urgent care site. Looking ahead, Open Door leaders would like to improve communication between the Southway site and private primary care providers.

Through the Southway site, Open Door has developed strong relationships with some local private primary care providers. However, its outreach efforts have generally targeted new patients. It might benefit from further efforts to reach out to community providers to make them aware of the services provided at Southway.

## **OPPORTUNITIES AND CHALLENGES TO DEVELOPING FQHC-BASED NETWORKS TO SUPPORT PRIMARY CARE PRACTICES**

Among the stakeholders we interviewed, there was universal agreement that many primary care practices—particularly small and rural practices—could benefit from having access to shared support services. Community networks, what several described as “virtual health centers,” would enable community providers and FQHCs to share resources and better meet patient needs. States, too, stand to benefit from developing community networks that leverage the assets of FQHCs. The Affordable Care Act provides \$11 billion to create new federally funded health centers, providing new opportunities to partner to better meet delivery system goals.

FQHC-based community networks may be more appropriate in some communities than in others. In some communities, hospitals, managed care organizations, large practices, local public health departments, or other organizations—rather than FQHCs—may be best positioned to efficiently and effectively serve as hubs for sharing services. The level of leadership, commitment, and willingness to take on a broad mission are key variables to the success of an organization’s network, while infrastructure is also important.

Federal officials and national experts suggest that FQHCs' ability to leverage their expertise in offering whole-person, comprehensive care may make them an ideal foundation on which to build community networks. FQHCs have many resources that may help other primary care practices serve as medical homes, including:

- care coordination services;
- health education services, including nutritional counseling;
- technology expertise (e.g., remote patient monitoring, electronic medical records, and telemedicine capabilities);
- experience with quality performance improvement and team-based approaches, honed by participation in federal Health Disparities Collaboratives;
- pharmacy services;
- enabling services (e.g., outreach and enrollment to patients, transportation, and interpreters);
- behavioral health services; and
- dental care.

In addition, federally funded health centers have access to federal resources, some of which may be available to support collaborative activities, including:

- federal 330 grant funding;
- federal malpractice coverage;
- Medicaid cost-based reimbursement;
- National Health Services Corps providers; and
- American Recovery and Reinvestment Act funding for health information technology, serving new patients, purchasing equipment, and other needs.<sup>25</sup>

These resources have enabled FQHCs to develop the expertise, staff, infrastructure, and funding that many private primary care practices do not have. Most important, according to FQHC staff, their mission of serving all patients, regardless of their ability to pay, and their experience in developing community services aimed at addressing population health goals make them natural choices to lead networks. "Health centers need innovators and out-of-box thinkers," said the CEO of Gaston Family Health Services. "We were able to partner and pull this together without looking at a map.

Health centers need to stop acting like a federal program dropped in the middle of a state.”

As illustrated by the experiences in Montana, North Carolina, and Indiana, FQHCs can play innovative roles in the development of community networks. However, there are a number of barriers that they will need to overcome if they are to assume such roles in their state health care delivery systems.

### CHALLENGES

The mission of FQHCs is to provide primary and preventive services for the uninsured, underinsured, and underserved who walk through their doors. FQHC experts say that fulfilling this mission consumes a great deal of effort and resources. FQHCs may not want the burdens of new responsibilities—especially when the number of FQHC patients is expected to grow under health reform. The National Association of Community Health Centers forecasts that FQHCs will serve 40 million patients in 2015, up from 19.4 million patients in 2010.<sup>26</sup>

Collaboration with other providers is a necessary part of community network roles, and may represent a new role for many FQHCs. This may change going forward, however. In the application guidelines for new FQHC sites, the Health Resources and Services Administration is asking applicants to show evidence of community collaboration and demonstrate their capacity to engage with hospitals, schools, public health departments, and other providers.<sup>27</sup>

Stakeholders identified several other barriers that may limit the development and spread of FQHC-based community networks that enable other providers to serve as medical homes.

*Congressional mandates.* Federal law overseeing FQHCs limits a state’s ability to freely develop certain kinds of networks and may hinder collaboration.

*Different kinds of systems.* Private providers do not typically share FQHCs mission to serve all patients, regardless of their ability to pay. It thus may be difficult for such providers to relate to FQHCs’ priorities and build affiliations with them.

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## Health centers

need innovators and out-of-the-box thinkers. We were able to partner and pull this together without looking at a map. Health centers need to stop acting like a federal program dropped in the middle of a state.

*Gaston Family Health Services CEO*

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*Different levels of payments.* Some payers and providers feel that the federally mandated cost-based reimbursement system for FQHCs gives them an unfair advantage over other Medicaid providers.<sup>28</sup> (The Medicaid cost-based reimbursement is intended to help FQHCs cover the cost of caring for the uninsured and underinsured.) On the other hand, FQHC providers often find fault with providers who limit the number of Medicaid patients they see and do not care for patients who are unable to pay.

*Mistrust.* Some private primary care providers may fear that FQHCs will try to supplant their role as a patient's source of primary care, while FQHCs may fear that private providers will try to take away their Medicaid patients.

*Limited ability to share information.* In the absence of electronic health information exchange, it is challenging for FQHCs and private providers to communicate routinely, efficiently, and effectively if a patient's medical home lies beyond their walls. As one CMS official stated:

It is difficult to be a "full utility" without full information. You have to be in a position to be able to manage all aspects of care or be able to support private practices to be medical homes given all the services they need to provide.

*Limited payer participation.* An additional challenge in building FQHC-based community networks is obtaining the participation of multiple payers. Montana's Health Improvement Program, for instance, is limited to members of its Medicaid program who receive primary care case management. Until 2011, Medicaid and Medicare were the only payers participating in Community Care of North Carolina. Patients covered by nonparticipating payers generally do not receive services through the community network (though they may benefit from broader quality improvement efforts). This can be problematic for a variety of reasons:

- Providers and their staff members generally prefer to treat all of their patients the same. It can be confusing and inefficient to have different care management arrangements for patients with different types of health coverage.
- Private providers may not have enough Medicaid patients to make it worthwhile to participate in a network.
- Having only a limited number of participating payers may impede the establishment of a "critical mass" of patients to make care management efforts cost-effective.

*Wide variance in FQHC capabilities.* There may be tremendous differences in capabilities from one FQHC to the next. Initiatives may need to partner with FQHCs that are strong to begin with (e.g., offer a wide range of services such as behavioral health, oral health, and telehealth and/or have strong leaders).

*Visit-based fee schedule.* Current visit-based fee schedules make it difficult to innovate when many services fall outside of the face-to-face visit. Transitioning to new payment methods, such as bundled or performance-based payments, may make it easier for FQHCs to innovate.

*Managed care presence.* Networks, in general, may work best in states with low managed care presence. States may need to map the intensity of FQHC services to gauge the opportunities for this community network model to thrive in areas where managed care organizations do not reach.

#### **FEDERAL OPPORTUNITIES IN THE AFFORDABLE CARE ACT**

The Affordable Care Act provides federal funding to encourage states and providers to partner and develop innovative health care programs. It creates a number of new federal funding streams that may be used to build a better delivery system and pilot community network models.

##### ***Center for Medicare and Medicaid Innovation***

The Affordable Care Act created the Center for Medicare and Medicaid Innovation (CMMI) within CMS. The statute specifies that the:

Purpose of the Center for Medicare and Medicaid Innovation is to test innovative payment and service delivery models to reduce program expenditures under the applicable titles [Medicare and Medicaid] while preserving or enhancing the quality of care furnished to individuals under such titles. In selecting such models, the Secretary shall give preference to models that also improve the coordination, quality, and efficiency of health care services [for Medicare and Medicaid beneficiaries].<sup>29</sup>

The Affordable Care Act appropriated more than \$10 billion for CMMI activities, and specified that disbursements will not be required to show immediate budget neutrality. The statute further specifies types of innovative models that CMMI may test:

- Promoting broad payment and practice reform in primary care, including patient-centered medical home models for high-need applicable individuals, medical homes

that address women’s unique health care needs, and models that transition primary care practices away from fee-for-service–based reimbursement and toward comprehensive payment or salary-based payment.

- Supporting care coordination for chronically ill applicable individuals at high risk of hospitalization through a health information technology–enabled provider network that includes care coordinators, a chronic disease registry, and home telehealth technology.
- Establishing community-based health teams to support small-practice medical homes by assisting the primary care practitioner in chronic care management, including patient self-management, activities.
- Promoting greater efficiencies and timely access to outpatient services (such as outpatient physical therapy services) through models that do not require a physician or other health professional to refer the service or be involved in establishing the plan of care for the service, when such service is furnished by a health professional who has the authority to furnish the service under existing state law.

#### ***Enhanced Funding for FQHCs***

The Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, also includes funding “for expanded and sustained national investment in community health centers.”<sup>30</sup> The legislation appropriates \$11 billion for fiscal years 2011–15 to support expansion of the operations and infrastructure of community health centers, and another \$1.5 billion to support expansion of the National Health Service Corps. With these new resources, FQHCs may be better positioned to expand their roles.

#### ***Community Health Teams***

The Affordable Care Act establishes a community health team program that will offer key medical home services to primary care providers through interdisciplinary teams. States, state-designated entities, and tribes will be eligible to receive grants under this program. Conceivably, an FQHC, Primary Care Association, or FQHC network could serve as a base for a community health team. The teams envisioned in the statute appear to resemble networks similar to Community Health Partners of Community Care of North Carolina. The statute specifies that community health teams will offer primary care providers services such as:

- coordinat[ing] disease prevention, chronic disease management, transitioning between health care providers and settings and case management for patients;

- develop[ing] and implement[ing] interdisciplinary, interprofessional care plans that integrate clinical and community preventive and health promotion services for patients;
- assisting primary care providers in monitoring their performance; and
- broadly helping primary care providers offer coordinated, comprehensive, patient-centered primary care.<sup>31</sup>

***New Medicaid State Plan Option to Provide Health Homes for Chronically Ill Enrollees***

This new option will provide enhanced federal funding in the form of a 90 percent federal match for two years for states that expand or implement a health home initiative to serve Medicaid beneficiaries with chronic conditions, provided certain criteria are met.<sup>32</sup> States that want to enroll as many Medicaid practices as possible under this option may consider how to help those practices meet the health home criteria. Developing a community network to help practices provide comprehensive services is one potential approach to doing so.<sup>33</sup>

***Incentives for Prevention of Chronic Diseases Among Medicaid Beneficiaries***

The Affordable Care Act provides \$100 million for grants to states to help Medicaid beneficiaries adopt healthier lifestyles. Specifically, the legislation directs that the grant funds be used to test approaches to:

- stopping tobacco product use
- controlling or reducing weight
- reducing cholesterol levels
- reducing blood pressure
- avoiding diabetes, and/or
- improving diabetes management.

The legislation allows states to carry out the program through Medicaid providers or a wide range of other organizations. Although FQHCs are not explicitly mentioned, the statute appears to allow a state to use FQHC sites and resources as centers for administering the program.<sup>34</sup> CMS released additional guidance on the program in February 2011.<sup>35</sup>

### ***Community-Based Collaborative Care Network Program***

The Affordable Care Act establishes a Community-Based Collaborative Care Network Program that appears to have many similarities to the networks of Community Care of North Carolina. The legislation states that a community-based collaborative care network is a “a consortium of health care providers with a joint governance structure . . . that provides comprehensive coordinated and integrated health care services . . . for low-income populations.” Networks are to include FQHCs and hospitals, and priority for funding will go to networks that include “the broadest range of providers that currently serve a high volume of low-income individuals”—presumably including private providers—and local health departments. The federally funded networks will support private providers in a variety of ways, including by providing care management services and “expand[ing] capacity, including through telehealth, after-hours services, or urgent care.” It appears that an FQHC could lead such a network, provided governance is shared with a community of providers. The Affordable Care Act authorized such sums as may be necessary to administer the program for fiscal years 2011–15.<sup>36</sup>

### ***Primary Care Extension Program***

The federal Agency for Healthcare Research and Quality will award competitive grants to states for the establishment of state or multistate Primary Care Extension Program State Hubs. These hubs are intended to:

provide support and assistance to primary care providers to educate providers about preventive medicine, health promotion, chronic disease management, mental and behavioral health services (including substance abuse prevention and treatment services), and evidence-based and evidence-informed therapies and techniques, in order to enable providers to incorporate such matters into their practice and to improve community health by working with community-based health connectors (referred to in this section as “Health Extension Agents”).<sup>37</sup>

States will be awarded competitive grants to establish hubs. The hubs are to include the state health department, the state Medicaid agency, and a medical school. Other entities may collaborate with the core agencies in establishing the hubs. (Primary Care Associations are specifically identified in the statute as potential partnering entities.) The Affordable Care Act authorized \$120 million for the Primary Care Extension Program for fiscal year 2011.

## **ADDITIONAL POLICY OPTIONS TO PROMOTE COMMUNITY NETWORKS**

Our interviews with stakeholders identified a number of federal and state policies that could be improved or developed to provide further incentives to develop community networks led by FQHCs.

- Although Medicare productivity requirements are being discontinued under the Affordable Care Act, a 2005 Government Accountability Office report found that seven states limit reimbursement for reasonable costs by setting performance or productivity standards. These states stipulate the number of visits per year that a full-time-equivalent physician should provide and use similar guidelines for other practitioners. Most of the states using performance or productivity standards relied on the guidelines specified by Medicare.<sup>38</sup> FQHCs and Primary Care Associations complain that such requirements constrain an FQHC's ability to innovate. If providers are being asked see patients too quickly, there is little time for innovations that require Plan, Do, Study, Act approaches. *Less emphasis on visit-based productivity requirements is needed, particularly when FQHCs participate in innovative models of care.*
- A higher federal matching rate is needed for certain Medicaid services, now deemed administrative, that help states sustain a network infrastructure. For instance, the infrastructure that is needed to track clinical measures is currently paid for at the lower administrative rate. *CMS could consider providing a higher rate to help states develop the infrastructure needed to manage community networks.*
- Many private providers do not understand the federal requirements surrounding FQHCs. On the other hand, many FQHCs do not appreciate the extraordinary demands placed on high-volume Medicaid private providers. This lack of understanding may impede collaborative relationships. *Opportunities to help FQHCs and private providers build trust and improve collaboration might help bridge this divide.*
- Primary Care Associations or FQHC networks might serve as facilitators for developing collaborations and sharing best practices across sites within a state. Conceivably, a Primary Care Association or FQHC network might even serve as the community hub itself, perhaps offering data analysis and support to practices. *Opportunities are needed to convene FQHCs, Primary Care Associations, FQHC networks, and federal and state policymakers to collaborate on solutions to improve the primary care delivery system.*

- Both Medicare and private payers—in addition to Medicaid—are needed to help support the development of a sustainable infrastructure to truly transform the primary care delivery system. The president of Community Care of North Carolina and former North Carolina Medicaid director has said that, if the community network were founded today, he would seek to build a multipayer approach. However, the logistical challenges in doing so are formidable, including: building trust among private competitors, navigating antitrust law, standardizing quality improvement programs, and harmonizing disparate payment methods. Under the Medicare Advanced Primary Care Demonstration, additional payers (including Blue Cross Blue Shield) will soon join Community Care of North Carolina in select counties. Montana is exploring the potential of a medical home multipayer pilot. *Federal and state policy leadership is needed to help convene multipayer medical home initiatives that can better sustain the kind of primary care infrastructure needed.*
- Several FQHC-based networks that have had success at sharing information and coordinating care between providers have developed strong working relationships with area hospitals and other providers (such as embedding an FQHC care manager in a local hospital). *States may also consider forming networks in areas where regional extension centers or regional health information organizations are being formed to coordinate efforts to help support providers.*
- New payment models are needed to develop and sustain the infrastructure for improved primary care delivery. Often states interpret the FQHC payment methodology as a floor rather than a cap. *Instead of cost-based payment, states can pay FQHCs using an alternate payment methodology that may support innovative models.*

#### ***Lessons for PCAs and FQHCs***

FQHCs interested in establishing collaborations, whether by replicating the models described here or developing their own models, must consider the impact that the collaborations will have on their compliance with FQHC statutory, regulatory, and policy requirements, which ultimately govern their eligibility for funding and related benefits. In developing networks, both FQHCs and Primary Care Associations should consider how the model complies with or influences the following requirements:

- **Scope of Project**, which identifies the services, sites, providers, target population, and service area approved by HRSA for which FQHC funding may be used and related benefits may be available.

- **HRSA’s affiliation policies**, which limit third-party involvement in the governance, management, and operation of FQHCs.
- **Federal Tort Claims Act coverage**, which generally covers only FQHC services and sites within the approved scope of project and provided to the FQHC’s patients by its providers furnishing services within their scope of employment/contract (with certain limited exceptions).
- **Section 340B Discount Drug Pricing Program**, which is available solely for outpatient prescription drugs provided to FQHC patients (as defined by the 340B program).
- **Preferential Medicaid and Medicare reimbursement**, which generally is available only for services approved under the FQHC’s scope of project (although exceptions may exist based on a particular state’s Medicaid plan).
- **Federal anti-kickback safe harbor for FQHC grantees**, which protects certain low-cost and no-cost arrangements among grantees and other providers, suppliers, and vendors that could otherwise implicate the federal fraud and abuse laws.<sup>39</sup>

The Affordable Care Act presents numerous opportunities for FQHCs and Primary Care Associations to assume new roles in the health care delivery system. Community networks led by FQHCs or Primary Care Associations could be an important resource for accountable care organizations or other integrated delivery systems, particularly for managing the treatment of patients who are dually eligible for Medicare and Medicaid, have complex conditions, or have social/behavioral health needs. As CMS and states develop “risk-based payment models” as part of the Affordable Care Act or as part of state delivery system reform, FQHCs and Primary Care Associations may be uniquely situated to serve in an expanded capacity. To prepare for these new roles, FQHCs and Primary Care Associations will need to work together to demonstrate their ability to be financially competitive with other community providers, assume risk-based contracts, and demonstrate outcomes for an entire episode of care.

## CONCLUSION

The creation of community-based networks to provide care management and greater access to health care services may enable states to hold down Medicaid costs while providing better care for beneficiaries. With 20 million more Medicaid beneficiaries being added to the rolls in 2014, states will be challenged to help already-strained primary care practices take on additional patients. Helping practices function more efficiently as medical homes—particularly for patients with chronic illnesses—can help improve access to high-quality care and control costs. In order for practices to function as

medical homes, they will need resources to ensure the delivery of timely, coordinated, and comprehensive primary care. Many FQHCs have the infrastructure and expertise to help practices meet medical home requirements and may be ready partners for states to develop as community networks. There are many possible arrangements that states may choose to pursue. Table 2 highlights key arrangements and characteristics of the projects in Montana, North Carolina, and Indiana.

**Table 2. Featured Community Network Models**

|                        | <b>Montana<br/>HIP*</b>  | <b>CHP CCNC<br/>Network**</b>   | <b>Southway<br/>Urgent Care***</b>   |
|------------------------|--|---|--|
| <b>Patients served</b> | <ul style="list-style-type: none"> <li>• Active care management: about 2,050</li> <li>• On-demand care management: about 1,600</li> <li>• 5% of population served</li> </ul> | <ul style="list-style-type: none"> <li>• Active care management: about 670</li> <li>• Potentially eligible patients: about 33,500</li> <li>• 2% of population served</li> </ul> | Patients served: 7,848 in 2010   |
| <b>Staffing</b>        | 32.5 FTEs  | 12 FTEs   | 5.5 FTEs   |
| <b>Funding model</b>   | Medicaid pays \$3.75 PMPM to host FQHCs  | <ul style="list-style-type: none"> <li>• Medicaid pays \$3.72 PMPM for non-Aged Blind and Disabled (ABD) members</li> <li>• \$13.72 for ABD members</li> </ul>                  | Over 80% of patients are covered by public or private payers. The public payers reimburse for urgent care services using FQHC cost-based reimbursement system. |

Note: PMPM is per member per month.

\* Figures as of Jan. 2011.

\*\* Figures as of Feb. 2011.

\*\*\* Figures as of Dec. 2010.

An immediate concern for states to consider is finding ways to ensure patients have timely access to care to prevent them from visiting the emergency department for nonurgent care. Indiana’s FQHC-based urgent care center provides an example of one way to build after-hours systems of care. States also will need to consider how to foster relationships between urgent care centers and private practices so that information is communicated across sites.

States can play an important role in helping practices that do not have the resources and capacity to manage the care of complex patients. By sharing resources across practices through Medicaid-funded FQHC-based networks, states may be able to improve care while holding down costs. There is promising evidence that Medicaid-funded practice-based networks are able to share resources among multiple sites—

potentially improving patient care while holding down costs. States can use their authority and resources to create opportunities for network development in their states.

States that have a heavy managed care presence may prefer to work with plans to enhance their capacity to better coordinate care among providers. Other states may find that using practice-based infrastructure (such as FQHCs, local health departments, large practices, or others) to develop community networks makes sense. States that are looking to develop networks that mirror “virtual health centers” may find it logical to begin with FQHCs. In those cases, a great deal may depend on the FQHCs’ willingness and ability to coordinate and organize care, collaborate with providers (particularly hospitals), and connect with local resources. In other cases, PCAs or FQHC networks may be best positioned to assume the responsibilities of community networks.

For FQHCs and Primary Care Associations, leading community networks will enable them to strengthen their operations with new staff and services that will improve the care of existing patients while extending their mission of serving the community. Such efforts will be aided by new federal funding opportunities.

The Affordable Care Act includes many opportunities for states and FQHCs to develop shared resources to assist primary care practices to become medical homes. It will require states, PCAs, FQHCs, and private providers to work together, to think creatively, and to take advantage of community resources that hold great promise for improving state delivery systems.

## NOTES

<sup>1</sup> N. Kaye and M. Takach, *Building Medical Homes in State Medicaid and CHIP Programs* (Portland, Maine, and New York: National Academy for State Health Policy and The Commonwealth Fund, June 2009).

<sup>2</sup> D. R. Rittenhouse, L. P. Casalino, R. R. Gillies et al., “Measuring the Medical Home Infrastructure in Large Medical Groups,” *Health Affairs*, Sept./Oct. 2008 27(5):1246–58.

<sup>3</sup> Federally funded health centers receive competitive federal 330 grants to support their operations. Not all FQHCs receive federal funds. Some, referred to as FQHC look-alikes, meet the same requirements as FQHCs but do not receive federal 330 grants. When it is important to make this distinction, the authors use the term health center rather than FQHC.

<sup>4</sup> Health Care and Education Reconciliation Act of 2010, 2010, Public Law 111-152, 111th Cong., 2nd Sess. (30 March 2010), Sec. 2303, available at <http://www.gpo.gov/fdsys/pkg/PLAW-111publ152/pdf/PLAW-111publ152.pdf>; Patient Protection and Affordable Care Act, 2010, Public Law 111-148, 111th Cong., 2nd. Sess. (23 March 2010), Sec. 10503, available at <http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf>; Patient Protection and Affordable Care Act, 2010, Sec. 2703, 3021, 3502, 5405, 10333.

<sup>5</sup> M. K. Abrams, E. L. Schor, and S. C. Schoenbaum, “How Physician Practices Could Share Personnel and Resources to Support Medical Homes,” *Health Affairs*, June 2010 29(6):1194–99.

<sup>6</sup> Healthy Montana Kids Plus is Montana’s Medicaid Children’s Health Insurance Program expansion group. Its members are Medicaid Passport members and, as such, eligible for HIP.

<sup>7</sup> Community Care of North Carolina, “Program Overview,” 2010, available at <http://www.communitycarenc.com>.

<sup>8</sup> The Federal Tort Claims Act provides health centers with malpractice coverage for liabilities arising from services included in a health center’s scope of project that are furnished by its providers to its patients.

<sup>9</sup> According to an official with the Montana Primary Care Association:

The answer was “no” because some of the patients who receive HIP services have providers who are not health center employees, i.e., private practice docs, mid-levels, etc. Those patients were not considered by HRSA to be patients of the health center. Medicaid, however, pays the health centers to operate the program on a per person per month basis according to how many Medicaid eligibles there are in each health center’s area of coverage. To date, those payments have covered the cost of the services. The health centers do not bill Medicaid for any case/care management services for HIP patients. (Montana Primary Care Association, e-mail from MaryBeth Frideres, December 3, 2010.)

<sup>10</sup> CMS approved the waiver amendment in October 2009.

<sup>11</sup> Dual eligibles—those who receive both Medicare and Medicaid coverage—are not eligible for Passport, and therefore not eligible for HIP.

<sup>12</sup> Many HIP children also receive services through Montana’s Title V program. In these cases, Title V generally takes the lead in providing case management services.

<sup>13</sup> HealthSciences Institute, “Chronic Care Professional (CCP) Certification,” 2010, available at [http://www.healthsciences.org/information\\_about\\_ccp\\_certification.html](http://www.healthsciences.org/information_about_ccp_certification.html).

<sup>14</sup> The importance of having in-person meetings between primary care providers and remotely based support staff has been noted in the case of the Massachusetts Child Psychiatry Access Project (MCPAP). MCPAP staff based in hubs throughout the state assist primary care providers

in offering timely and appropriate psychiatric treatment. W. Holt, *The Massachusetts Child Psychiatry Access Project: Supporting Mental Health Treatment in Primary Care* (New York: The Commonwealth Fund, March 2010).

<sup>15</sup> D. McCarthy and K. Mueller, *Community Care of North Carolina: Building Community Systems of Care Through State and Local Partnerships* (New York: The Commonwealth Fund, June 2009).

<sup>16</sup> Community Health Partners is organized as a separate 501(c)(3) entity, and pays Gaston Family Health Services for management and staffing. Community Health Partners is considered an “other line of business,” and is operated outside Gaston Family Health Service’s HRSA-approved scope of project. As such, FTCA coverage does not apply to Community Health Partners activities, and Community Health Partners has had to secure malpractice insurance.

<sup>17</sup> The health center is able to provide these services by enrolling these patients as new FQHC patients.

<sup>18</sup> Community Care of North Carolina, “Program Impact,” 2010, available at <http://www.communitycarenc.com/ProgramImpact.htm>.

<sup>19</sup> Ibid.

<sup>20</sup> Community Health Partners.

<sup>21</sup> Limited to the enrolled, non–dual eligible population.

<sup>22</sup> Limited to the enrolled, non–dual eligible population.

<sup>23</sup> As discussed above, Community Health Partners reimburses Gaston Family Health Services for the costs associated with Community Health Partners employees. This funding comes from Medicaid management fees.

<sup>24</sup> Statistics apply to those under age 65. T. Carroll Garcia, A. B. Bernstein, and M. A. Bush, *Emergency Department Visitors and Visits: Who Used the Emergency Room in 2007?* (Hyattsville, Md.: National Center for Health Statistics, Centers for Disease Control and Prevention, 2010), available at <http://www.cdc.gov/nchs/data/databriefs/db38.pdf>. This may be attributable in part to federal limits on cost-sharing in Medicaid. An individual with commercial insurance may face the possibility of a hefty deductible, coinsurance, or copayment for using the emergency department. Those with Medicaid do not have this type of disincentive.

<sup>25</sup> The American Recovery and Reinvestment Act (ARRA), enacted in 2009, allocated \$25.8 billion to increase the use of health information technology and exchange. ARRA includes funding for state health information exchanges, provider electronic health record adoption, and a variety of other health information technology programs. U.S. Department of Health and Human Services, “Recovery Programs: Health Information Technology (IT),” 2010, available at <http://www.hhs.gov/recovery/programs/index.html#Health>.

<sup>26</sup> National Association of Community Health Centers, *Expanding Health Centers Under Health Care Reform: Doubling Patient Capacity and Bringing Down Costs* (Bethesda, Md.: NACHC, 2010), available at [http://www.nachc.com/client/HCR\\_New\\_Patients\\_Final.pdf](http://www.nachc.com/client/HCR_New_Patients_Final.pdf).

<sup>27</sup> Health Resources and Services Administration, *Service Area Competition (SAC) New and Competing Continuation Funding: Fiscal Year 2011* (Rockville, Md.: DHHS, 2010), available at <http://www.hrsa.gov/grants/apply/assistance/SAC/sac2011ppt.ppt>.

<sup>28</sup> For more information on the cost-based reimbursement process, see: Centers for Medicaid and State Operations, *Prospective Payment System for FQHCs and RHCs* (Baltimore, Md.: CMS, 2010), available at [http://www.insurekidsnow.gov/professionals/federal/chipra\\_fohc.pdf](http://www.insurekidsnow.gov/professionals/federal/chipra_fohc.pdf).

<sup>29</sup> Patient Protection and Affordable Care Act, 2010, Sec. 3021.

<sup>30</sup> Health Care and Education Reconciliation Act of 2010, Sec. 2303; Patient Protection and Affordable Care Act, 2010, Sec. 10503.

<sup>31</sup> Patient Protection and Affordable Care Act, 2010, Sec. 3502, 10321.

<sup>32</sup> National Academy for State Health Policy, “Health Homes for Medicaid Enrollees with Chronic Conditions: A Conversation with CMS and States Regarding the ACA State Plan Option,” webcast, Aug. 2010, available at <http://www.nashp.org/archives/2081>.

<sup>33</sup> Patient Protection and Affordable Care Act, 2010, Sec. 2703.

<sup>34</sup> Patient Protection and Affordable Care Act, 2010, Sec. 4108.

<sup>35</sup> Centers for Strategic Planning, Patient Protection and Affordable Care Act, Section 4108, Medicaid Incentives for Prevention of Chronic Diseases (MIPCD): Initial Announcement (Baltimore, Md.: CMS, 2011), available at [http://www.cms.gov/MIPCD/Downloads/HHS\\_ACA\\_S4108\\_Solicitation.pdf](http://www.cms.gov/MIPCD/Downloads/HHS_ACA_S4108_Solicitation.pdf).

<sup>36</sup> Patient Protection and Affordable Care Act, 2010, Sec. 10333.

<sup>37</sup> Patient Protection and Affordable Care Act, 2010, Sec. 5405.

<sup>38</sup> United States Government Accountability Office, *Health Centers and Rural Clinics: State and Federal Implementation Issues for Medicaid’s New Payment System* (Washington, D.C.: GAO, 2005), available at <http://www.gao.gov/products/GAO-05-452>.

<sup>39</sup> Feldesman Tucker Leifer Fidell LLP (counsel to National Association of Community Health Centers), e-mail from Marcie Zakheim, partner, Dec. 3, 2010.