

The Change Foundation
Funding Incentives for Integrating Patient Care in Ontario

A U.S. case study:
Federally-Qualified Health Centers (FQHCs)

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1. Executive Summary

Peter Orzag, President Obama's Director of the Office of Management and Budget testified at a 2008 Senate Finance Committee hearing:

"To alter providers' behavior, it is probably necessary to combine comparative effectiveness research with aggressive promulgation of standards and changes in financial and other incentives."¹

This comment was made in the context of policy methods being considered to promote the use of 'best practices' by physicians and other providers. Though we cannot know how "aggressive" this effort on the part of the United States government will in fact be as we enter an era of health care reform and we are only beginning to understand the specific behavioral objectives that the Obama Administration and Congress envision achieving via reform, the implication is clear that a national push is afoot to drill down on and refocus regulatory and financing policy in order to substantively alter the patient-physician relationship.

With this sea-change as our backdrop, The Change Foundation commissioned a study of Federally-qualified Health Centers (FQHCs) in the United States in order to assess this publicly-financed network of primary care providers in the U.S. as to their success in achieving integration (or continuity) of care on their patients' behalf.

An FQHC is a community health center or unit of another facility/entity that is constituted under a public or private/not-for-profit aegis, providing primary and preventive care and programs, including physical, behavioral/mental and dental care to all regardless of ability to pay and which has sought and received designation as and assumed the responsibilities attendant to being a FQHC. FQHCs bill for their care to both public and private payers, though they serve a largely publicly-insured/-financed patient population. As appropriate, patients are assessed as to their ability to pay for some part of their care on a sliding-scale.²

There are many benefits of being a FQHC, beyond grant funding from the Federal government to supplement reimbursements and offset the costs of uncompensated care or for care that neither the patient nor other payors can or will pay for. ³

Other benefits include:

- Enhanced Medicare and Medicaid reimbursement (including Medicare reimbursement for 'first-dollar' services because deductible is waived if FQHC is providing services to Medicare recipients)⁴
- Medical malpractice coverage through the Federal Tort Claims Act
- Eligibility to purchase prescription and non-prescription medications for outpatients at reduced cost
- Access to National Health Service Corps practitioners
- Access to the Vaccine for Children program

- Eligibility for various other federal grants and programs; for example:
 - Federal loan guarantees for capital improvements
 - Access to on-site eligibility workers to provide Medicaid and Child Health Insurance Program (“CHIP”)
- For new FQHC starts, funding up to \$650,000 can be requested⁵

FQHCs, in their role as the ‘medical home’ for many of their 20 million patients, work assiduously with or, in many instances, creatively around the obstacles that are inherent in the policies of (or between) respective financing sources.

Key findings emerging from this study include:

- Policies inherent in the primary funding sources for FQHCs create substantive ongoing confusion regarding how primary care practitioners can effectively refer patients for care, which is exacerbated by other Federal and State laws and regulations
- The Patient-centered Medical Home portends enhanced care management across the continuum, though better incentives may be achieved with other payment reform concepts such as Accountable Care Organizations or some combination therein
- Ease of access and referral to specialty care poses great hurdles for FQHCs, who are statutorily required to be situated in and serve Medically Underserved Areas (MUAs) and Medically Underserved Populations (MUPs), thereby inhibiting availability of critical features of the continuum of care. Private-public, Private-private initiatives are attempting to address selected though significant aspects of this inherent conflict of conditions and resources. Consortia (among FQHCs locally/regionally) and alliances (between FQHCs and other providers) can also offer support for improving continuity
- Federal policy initiatives and the funding therein (via the ‘stimulus’ act) is having multiple effects:
 - For expansion of/addition of FQHC facilities and services: improves overall access and, likely, volumes of patients seen for primary care, while State Medicaid budget cuts may further limit access to specialty care
 - For HIT/EHR development: could have a positive impact on integration efforts
 - Telemedicine holds great promise for continuity of care, especially in rural or isolated areas, but reimbursement policies must be realigned to accommodate technology breakthroughs and to reflect resulting changes in workflows and efficiencies
 - Funding vagaries are confounding the best intention of disease management programs, which are widely seen as the best ‘defense’ against the impetus to secure higher acuity services (including emergency care) to respond to unchecked changes in health status among the chronically ill
 - Improved referral practices can sometimes mitigate funding disparities between primary care and specialty providers

In conclusion, among the many incisive comments received from CEOs and other persons interviewed for this study, the following represents a small sample of those that helped to form the basis for our findings and conclusions:

- Visit-based reimbursement (with visits limited to 15 minutes each) does not permit FQHCs to address disease management generally, and the ability of FQHC practitioners to obtain

medically-necessary care for their patients who need diagnostic, specialty or hospital care in support of managing ongoing conditions and diseases.

- Categorical reimbursement (kids vs. seniors vs. mothers vs. Native Americans vs. the disabled vs. migrant workers, etc.) stands in the way of providing integrated care.
- Reimbursement policies established in each state can themselves confound integration of care; e.g. reimbursement permitted for LCSWs or licensed psychologists to provide mental/behavioral health care to FQHC patients, not Marriage & Family Therapists, who are more readily available in many parts of the state and less expensive.
 - A subset of the issue of state policy obstacles is when, as a result of the past year's economic crisis and recession, states greatly curtailed their Medicaid benefits or eligibility for coverage; for example, California excluded the podiatry benefit for its Medi-Cal patients which impacted FQHCs in their service to diabetics.
- FQHC reimbursement policy prohibits providing a mental health visit on the same day as a primary care visit, thereby (a) losing access to the patient until the patient can return for care and (b) forcing economically disadvantaged patients to find another date and time to return for medically-necessary care, which they often have access to only via public transportation (particularly problematic in exurban and rural areas).
- Capping of Medicare rates do not permit effective care of patients with multiple diagnoses who require both more and more complex treatment plans that include using services from a variety of sources along the continuum.
- In patient satisfaction surveys, vast majorities of patients identify their FQHC as their 'medical home' suggesting that FQHC patients rely heavily on FQHCs to assure that they receive all the care that they need.
- There is no real system in place to promote ease of referral of FQHC patients to specialty care except what they may be able to devise community-by-community.
- Supplemental funding from private grantors is essential to FQHCs to develop services not reimbursed or to establish alliances for such care to be available to their patients, but is too often limited to start-up funding, disappearing after the launch period.
- The use of telemedicine capabilities is limited by reimbursement policies
- Long wait times to translate referrals for specialty care into action often result in patients' conditions deteriorating and necessitating care from the hospital emergency department at far greater cost.
- Credentialing protocols (of practitioners) by managed care plans thwart access to specialists.

- Primary care physicians should be trained by specialists to do certain procedures in their stead
- Estimate is that 70+% of MDs in the U.S. are specialty-trained, so why is it so difficult to effect referrals to specialists for FQHC patients?
- Procedure-based referrals (i.e., surgeries, diagnostics, radiation, etc.) are some of the more difficult to secure.
- Growing depopulation of rural areas, including the presence of fewer medical resources, will further challenge rural FQHCs in securing needed care beyond their walls.
- FQHCs that organize as networks (and Technical Services Organizations) in their communities/regions will improve likelihood of negotiating for care on behalf of their patients (e.g., via specialty treatment pools for kids with asthma or for mammography or for HIV/AIDS patients who need medical or dental services, hospice or medication support), as well as promoting much needed improvements in technology and IT resources, which themselves will permit such integrative supports as e-prescribing, EMR, data exchange, disease registries, contracting technical assistance (with managed care plans), telemedicine collaboratives and regional hosting of more powerful IT systems and solutions.
- Working with hospital and other health care providers that have established a 'community benefit' program (cf. Kaiser Community Benefit) is a very effective way to create care pathways needed by FQHC patients that defuse traditional funding quandaries, while inuring other programming benefits to both parties.

2. Prologue

As Canadian opinion-maker, André Picard, conceived in his op-ed “We could learn a few things from the U.S.” (The Globe and Mail, August 6, 2009):

“Americans think Canada has an evil socialist system that ensures inefficiency, waiting and contempt for the patient; Canadians see the U.S. model as commodifying health for profit and catering to the rich at the expense of the poor.”

By selecting the U.S.’ Federally-qualified Health Centers as its subject for the U.S. case study, The Change Foundation and this author chose to focus on this Canadian image of U.S. health care’s orientation to health as a commodity and those at whose ‘expense’ it allegedly functions. In so doing, we landed on a sort of mother lode of confounding policies that, according to FQHC administrators, yield piecemeal reimbursement to their programs, impacting on health care delivery along the continuum, built, in part, on limitations inherent in the Federal enabling statutes and regulations and, in part, on the local and state authorities whose financing and influence serve both to support and confound efficient use of care resources along the continuum for FQHC patients. And this, for the most vulnerable among the American populace, representing Medicaid beneficiaries and uninsureds at a rate of over 150% of these cohorts that exists in the U.S. population as a whole. Most FQHCs have become or are adopting the responsibilities of being “patient-centered medical homes’ for their patients, nearly 20 million across the U.S., but are stymied in one of PCMH’s foundational tenets: coordinating care and getting health needs met.⁶

When Saskatchewan’s Patient First Review initiative issued its report last fall⁷ in response to 2 key questions—“Is the system putting the patient first?” And “Is the system achieving good value in care delivery and administration?”—Canadian medicare was cited for 6 substantive deficiencies:

- Convenience and timeliness: There is too much waiting and it's not easy to get in the right door for care, so people end up in ERs by default.
- **Lack of co-ordination: Patients do not move seamlessly through the system; there are often big cracks to fall through at transfer points.** (*Note: Emphasis added*)
- Lack of equitable care: Patients want reasonable access to care but feel they are discriminated against based on where they live, their age, their ethnicity and other factors.
- Lack of communication and information: When someone is sick or injured, they are frightened. They crave basic information but everyone is too busy.
- Lack of electronic health records: Patients hate repeating their medical histories over and over and tests are oft-repeated because of lack of modern records.
- Lack of respect: All too often, patients feel they are treated as a bother to health professionals. Patients are not cost centres, they are the *raison d'être* of the system.

As such, this study commissioned by The Change Foundation attempts to understand more clearly the well-identified and vexing problem surrounding integration and continuity of care to Canadian patients, in particular, those served by the Ontario Health Plan and the province’s extensive health care delivery network, by understanding funding policy-caused or –exacerbated conditions that American FQHCs face on a daily basis: in a world of ever-greater specialization among physicians, including escalating numbers of physicians who choose to become specialists over primary care or family medicine, FQHCs’ efforts to coordinate medically necessary care for their increasing cohort

of uninsured and under-insured patients in the U.S. are increasingly constrained, confounded or, at worst, vanquished.⁸

3. Introduction to FQHCs

Community Health Centers in a variety of forms have operated in the U.S. for over 40 years and include free clinics, community clinics, community health centers (both urban and rural) and Federally-qualified Health Centers and 'Look-Alike' FQHCs.

Emerging from the approximately 1,200 FQHCs designated by the United States Department of Health and Human Services, almost 7,500 FQHC sites now operate nationwide, serving urban and rural communities, migrant workers, the homeless, persons who live in public housing, those with insufficient insurance coverage (the "underinsured"), those with publically-financed coverage and those with no coverage at all. FQHCs constitute the single largest national network of primary care, offering an ever-expanding menu of primary care, ancillary and specialty services⁹ along with care coordination for men, women and children of all ages. Though established under statute and regulation, FQHCs are designed and operated to serve their respective communities with that complement of practitioners¹⁰ and services that is needed, either through direct provision of these services or through collaboration with other providers such as hospitals, physician specialists, etc., at no or low (sliding scale) cost to their patients.

Through their unique financing structures, which leverage Federal, state, county, city and other funding sources, FQHCs are empowered to offer, by dint of their Federal designation, a true 'case management' approach and have been doing so from before the managed care era when case management became a term of art elsewhere in the health care industry.

In light of the critical impact of the recession on employment, which in the U.S. is the primary source of private health care coverage, the Obama Administration is focusing great attention and additional substantial stimulus funding—more than US\$2 billion over 2009 and 2010—onto FQHCs, identifying them as a front-line in the economic reconstruction initiative embodied in the American Recovery and Reinvestment Act of 2009.

And the recently enacted 'health care reform' acts—the Patient Protection and Affordable Care Act passed on March 23, 2010, and the Health Care and Education Reconciliation Act of 2010 passed on March 30, 2010—further enshrines this position of leadership for FQHCs, which are now slated to double in both number (expanding to 15,000 sites) and volume of patients served (growing to 40 million) when the Acts are fully implemented.

Some of the Acts' provisions are:¹¹

- A cohort of currently uninsured patients will become Medicaid-eligible (estimated 16 million by 2014 when the program is initiated; 32 million and up by the time reform is in full swing)
- The need for primary care physicians will increase and, in so doing, produce severe PCP shortages, estimated at 160,000 by the year 2025
- Longer wait-times are expected in the interim, as supplies of physicians are taxed (some say, dwarfed) by patients seeking care with new-found coverage
- Over 5 years,
 - \$11 billion in **new** funding for FQHCs for expansion of capacity and services
 - \$1.5 billion for 15,000 new National Health Service Corps physicians

- Adds preventative services to Medicare rate and eliminates caps

What makes FQHCs “Federally-Qualified?”

Congress created the FQHC program to allow special Medicare and Medicaid payments for Community Health Centers and Migrant Health Centers (CHCs and MHCs) thereby ensuring that grant dollars intended for the uninsured were available for that purpose. In order to extend the CHC/MHC concept, which has evolved over the past 40 years,¹² Congress also authorized the special Medicare and Medicaid payments for clinics that operate in compliance with the requirements of the FQHC program, but that do not receive grant funding under the U.S. Public Health Services Act. These clinics are commonly known as “Look-Alikes” and are certified by the Center for Medicare and Medicaid Services (“CMS”) to receive Medicaid’s prospective payment system (or “PPS”) -based reimbursement for patient visits (see below). Look-Alikes choose not to pursue full designation and enriched funding via Bureau of Primary Health Care because they do not or cannot meet one or more of the basic requirements, which in their simplest form include:

- **Located in or serve a high need community** (designated Medically Underserved Area or Population). [Find MUAs and MUPs](#)
- **Governed by a community board** composed of a majority (51% or more) of health center patients who represent the population served. [More about health center governance](#)
- **Provide comprehensive primary health care** services as well as supportive services (education, translation and transportation, etc.) that promote access to health care.
- **Provide services available to all** with fees adjusted based on ability to pay.
- **Meet other performance and accountability requirements** regarding administrative, clinical, and financial operations.¹³

With the enactment of the Benefits Improvement and Protection Act of 2000 (BIPA), FQHCs were no longer funded using the original ‘retroactive/cost-based’ reimbursement formula under Medicaid, but rather using a prospective-payment system or “PPS” methodology based on the historical reasonable costs of the center. PPS methodologies vary by State both as to rules and fees (e.g., California’s fee schedule, which is based on an approved alternative payment methodology, is at the very bottom—48th—among the 50 states) and is capped, so it is not accommodating of changes in the demography and health status of the FQHC patient population, say our FQHC executives.

The payment rate is also negotiated so as to be clinic-specific as to the cost per visit; nonetheless, PPS requires each FQHC to establish a ‘scope of project’ that includes a “Required Scope of Services” as follows:

Comparison of Required Scope of Services ¹⁴		
Criteria	Rural Health Clinic	Federally Qualified Health Center
Primary Health Care Services	Required	Required
Primary Care for All Life-cycle Ages	Not Required	Required on-site or under

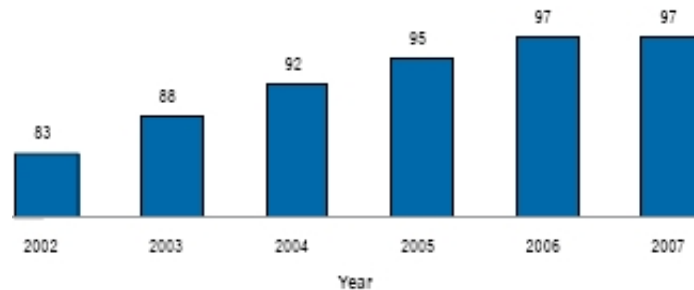
		arrangement
Basic Lab	Six specified tests required on-site, others required on-site or under arrangement	Required on-site or under arrangement
Emergency Care	First response capabilities required	Required on-site or under arrangement
Radiological Services	Required on-site or under arrangement	Required on-site or under arrangement
Pharmacy	Not Required	Required on-site or under arrangement
Preventive Health	Not Required	Required on-site or under arrangement
Preventive Dental	Not Required	Required on-site or under arrangement
Transportation	Not Required	Required by the site or under arrangement
Case Management	Not Required	Required on site or under arrangement
Dental Screening for Children	Not Required	Required on site or under arrangement
After Hours Care	Not Required	Required
Hospital/Specialty Care	Required by clinic staff or under arrangement	Required by clinic staff or under arrangement

FQHC Workforce

Though staffing is not per se mandated for FQHCs, in order to promote “...culturally-competent, accessible, and integrated care,”¹⁵ FQHC staffing include physicians, nurse practitioners, physician assistants, clinical psychologists, clinical social workers, health educators, and ancillary and administrative personnel. FQHCs employ:

- 8,000 physicians, a 40 percent increase from 2002.
- Over 4,700 nurse practitioners, physician assistants, and certified nurse midwives - a 49 percent increase from 2002.
- 50 percent of the National Health Service Corps field strength.

Average Number of Providers and Staff per Health Center: Growth, 2002-2007



Source: U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Primary Health Care. Uniform Data System. Rockville, Maryland: U.S. Department of Health and Human Services, 2002-2007.

Staffing is in part a function of what Medicaid and Medicare each independently require as services to be provided to their respective beneficiary populations and for which reimbursement, therefore, can be claimed and received.

Data from the 2008 Uniform Data Set regarding FQHC utilization:¹⁶

Over seventeen million patients were seen by FQHCs in 2008. Almost 36% are covered by Medicaid (aid to poor, assistance-connected persons; heavily weighted to women and children) with another 38% being uninsured, having no evidence of coverage or are otherwise deemed ineligible for public coverage. This latter cohort is growing noticeably, according to FQHC CEOs interviewed for this study, as between 333 and 625 persons every HOUR are estimated to lose their insurance coverage in the U.S. (Source: PolitiFact.com and ThinkProgress.com, respectively). Almost 16% of FQHC patients have private insurance coverage. Only 7.5% are Medicare-eligible (i.e. social insurance for Americans aged 65 and over), while the remaining 2% are covered by some form of State-sponsored coverage for children (e.g., S-CHIP, Healthy Families or equivalent).

Of the almost 67 million patient encounters seen in FQHCs in 2008, physicians saw almost 32 million, while nursing personnel performed another 18 million encounters. Dentists engaged in 7.3 million encounters and mental health professionals and paraprofessionals delivered care in 3 million patient encounters.

The top 3 adult diagnoses by number of patients include diabetes, hypertension and asthma, while the top 3 diagnoses by number of encounters per patient are symptomatic HIV, asymptomatic HIV and diabetes. ICD-9 –CM codes for otitis media and Eustachian tube disorders top the childhood diagnoses seen by FQHCs according to volume of patients seen.

4. Scope of study

The content for this case study was collected through interviews with key contacts, published evaluations and reports where available, along with grey literature. In addition, representatives from FQHC leadership, a state association of FQHCs, the National Association of Community Health Centers and the U.S. Bureau of Primary Health Care were interviewed in order to evoke information descriptive of how FQHC funding and the policies therein had an impact on the integration of care, together with initiatives to improve on continued gaps. The study's focus is on FQHC's in California, which is home to:

- ✓ ~7 million uninsured persons,
- ✓ ~120 FQHCs,
- ✓ operating nearly 1,000 sites,
- ✓ serving >2.3 million patients.¹⁷

Throughout this report, examples are presented of the myriad and creative ways in which FQHCs address funding disparities, inconsistencies, conflicts and gaps. These examples are meant to be illustrative of the ingenuity of these providers to promote or achieve integration and continuity of the care they provide in the face of funding policies that appear to have been devised without adequate consideration of the implications that lack of access to or ease of moving along the continuum of care has on maintaining health or resolving illness among FQHC patients.

5. Key Findings

- a. *Policies inherent in the primary funding sources for FQHCs create substantive ongoing confusion regarding how primary care practitioners can effectively refer patients for care, which is exacerbated by other Federal and State laws and regulations*

Sit tight:

Per the California HealthCare Foundation's scan of laws and regulations that govern adding specialty services to a California FQHC,¹⁸ prepared last July, it is clear that there is both obstacle and opportunity inherent in FQHCs seeking to expand the services along the continuum on behalf of their patients. A very brief and simplified summary follows.

U.S. Bureau of Primary Health Care:

Changing a FQHC's 'scope of project' to add services, including specialty care, demands approval by the Bureau of Primary Health Care under the Public Health Services Act's requirements for FQHC designation, not only to determine if one is adding these services (via an in-house program and/or via contract) to 'required primary health services' or 'additional health services' as they are prescribed but also whether or how the FQHC can accommodate and make available these new services to ALL patients 'equally' (usually via sliding scale arrangements).

Medicare and Medicaid:

These 2 payers covered 43% of all California FQHC patients, while another 45% are uninsured and/or able to pay little to nothing, according to the study. About half of all Medi-Cal eligible FQHC patients are enrolled in one of 4 models of Medi-Cal managed care plans, placing the onus for care coordination and fiscal risk-sharing squarely in the hands of the FQHC administrators. Medi-Cal managed care organizations offer FQHCs 'supplement' or 'wrap-around' payments to insure that FQHCs do not cost-shift in order to make up the deficit created by inadequate payment rates from private insurers, who represent 7% of FQHCs' revenue streams.¹⁹

And though there are 600% more Medicaid-covered patients (in California; generally true nationwide) served by FQHCs than Medicare patients, it is Medicare that defines coverage and what constitutes a "core" FQHC service, including who provides it and where service can be delivered for purposes of reimbursement. It requires the FQHC to be enrolled with 2 different intermediaries in order to bill for and be paid for care. As Irma Cota, CEO of North County Health Services of Vista, California, so aptly averred: FQHCs do and have always done an excellent job of case/care management for their patients, despite the fact that they are paid by the 'widget' which for them is a 15-minute visit and this does not itself foster a care-coordination mentality or environment. Physician specialists who provide FQHC patients with defined services need not enroll individually though if they follow the patient, admitting and attending to them in a hospital, then they must seek enrollment and must follow FQHC-specific billing requirements.

Medicaid also defines FQHC services to include not only Medicare "core providers" but also "any other ambulatory service that is offered by the FQHC and is covered by the state's Medicaid plan.'

Thus, in order to add a specialty service, a California FQHC must address the Medicaid (Medi-Cal) regulations and budget for the augmented service by building a new cost profile for its visits, understanding how reimbursement will impact the payment rate for a now enriched “FQHC visit,” inclusive of the added specialty service. But in order to apply for this ‘scope of project’ change, a threshold must be met showing that the service addition will result in at least a 1.75% change in the per visit reimbursement. In other words, an FQHC can go through the process of auditing itself and establishing a new specialty outreach program only to find that it does not

And though a Federal ruling has permitted FQHC dental contractors to care for FQHC patients in their own offices, other medical specialists must comply with the “Four Walls” rule²⁰, thereby severely limiting how patients can access specialty care.

Behavioral health consults present another challenge to FQHCs in California. Centers provided more visits for mental health and substance abuse conditions in 2007 than visits for hypertension or diabetes. Unfortunately, FQHCs cannot be reimbursed by Medi-Cal for a mental health visit if they handle the visit on the same day as seeing that patient for primary care: the patient must return on another day for their mental health care for the FQHC to be paid for their care. Pre-natal patient education consultations are similarly not permitted under these same-day prohibitions. Oddly though, dental care consults are not treated in this way and, as such, FQHCs are paid for a same-day primary care visit followed by a dental care visit for their Medi-Cal eligible patients. Our FQHC CEOs railed loudly about this inconsistency and its significant impact on health status, especially in light of the significant cohort of patients cared for at FQHCs who are homeless, acutely or chronically mentally ill or experiencing various forms and stages of dementia.

And there’s more...

Other laws that present challenges to FQHCs as they seek to establish specialty consultation opportunities/networks for their patients include:²¹

Anti-Kickback Statute and inherent ‘safe harbors’ regarding employment agreements, personal services agreements and, most recently, one for payments to FQHCs specifically (not applicable for ‘look-alikes’) to reimburse them for eligible specialist visits.

The Stark Law (named for U.S. Congressman F. Pete Stark of Berkeley, CA who has been a member of Congress since 1973) which limits referrals by physicians to physicians or other providers of ancillary, diagnostic, hospital, home care or other ‘designated health services’ as defined by Medicare in Part B (pays for physician services to Medicare-eligibles) in which they have a ‘financial interest’ which is broadly interpreted and as such must be carefully addressed by FQHCs entering into agreements with specialists.

And beyond this...

State licensing and certification laws in each state and the District of Columbia govern via discrete state statute and regulation how services can be delivered, staffing, facility parameters, health & safety precautions, etc. and are required to be applied for and adhered to by each FQHC. In other words, states regulate how primary care clinics like FQHCs can exist and function. And it is through licensing that a provider entity more often than not qualifies to be certified for

public and private reimbursement. As such, state licensing laws are a critical stepping stone to FQHCs being able to organize and provide care for which they are paid. In California, the “primary care clinic” license category under which FQHCs are licensed (cf. Health & Safety Code §1204) does **not** restrict licensees from providing specialty care services. The PCC license does require written notification of any changes to services or physical plant which describes changes in license-defined services and ‘special permits’ or additional licenses may be demanded for the addition of services and facilities for which separate statutes govern. Professional licensing (of practitioners) is statutorily separate from facility licensing in states.

And finally...

Counties, which, in California, are the jurisdiction through which health and human services are delivered (as opposed to cities on the east coast and in the Midwest), have an obligation to **support medically-indigent adults** (MIA) who are not otherwise covered and through these varied MIA programs may work directly with and through FQHCs or may establish county or public hospitals or collaborative to administer an often unique set of benefits and reimbursements for their beneficiaries served at FQHCs. Interviewed FQHC administrators cited long wait-times for referrals into public hospital clinics and recommended that organizing Medical specialty access networks were preferable even with their risk-sharing features.

And this represents the very simplest of synopses of the reimbursement maze through FQHCs must travel in order to serve the broadest cross section of their target populations with the most comprehensive array of practitioners, services and programs at the lowest cost to funders and patients alike with outcomes that meet or exceed that of their private-practice counterparts. *(Note: please see endnote #4 for further detail on Medicare and Medicaid reimbursement features)*

5. Key Findings (cont'd)

- b. *The Patient-centered Medical Home portends enhanced care management across the continuum, though better incentives may be achieved with other payment reform concepts such as Accountable Care Organizations or some combination therein*

According to the National Association of Community Health Centers (NACHC)²²,

“The patient centered medical home aims to redesign primary care practices to ensure accessible, timely, comprehensive, patient-centered primary care and effective coordination with other providers...Given that health centers are experts in and serve as models for community based comprehensive primary care, they should be engaged in medical home developments. It is important to know that thirty or more state Medicaid agencies have already [legislated](#) medical home initiatives with many fully engaged in demonstrations and the [Medicare-Medicaid Advanced Primary Care Demonstration Initiative](#) was announced in September 2009. The Safety Net Medical Home Initiative,²³ a five-year demonstration launched by the Commonwealth Fund, Qualis Health and the MacColl Institute for Healthcare Innovation, relies heavily on health center organizations; four primary care associations lead or co-lead the regional coordinating centers for this effort.”

“To function as high performing medical homes, providers of care, employee health programs and public health and social service agencies should be integrated to care for a defined population over time. Payment should be based on health outcomes, quality and reduced costs as opposed to volume and intensity of services. This concept is known as an Accountable Care Organization (ACO). Demonstrations or pilots of ACOs are included in the current major health reform bills before the Congress.”

NACHC sees its FQHC members as essential and well-positioned players in the ACO debate and would-be pilots, despite the fact that ACOs as they are being discussed in health care reform circles are focused on Medicare reform, which forms a small (i.e., <10%; for many FQHCs, <7%) though important revenue source for FQHCs.

The American Medical Association describes ACOs as²⁴:

“A typical Medicare ACO would include a hospital, primary care physicians, specialists and potentially other medical professionals. Services would still be billed under fee-for-service, but the organization's members would coordinate care for their shared Medicare patients with the goal of meeting and improving on quality benchmarks. Because ACO members are held jointly accountable for this care, they would share in any cost savings that stem from the quality gains.”

Elliott Fisher, MD, MPH, director of population health and policy, Dartmouth Institute for Health Policy and Clinical Practice, which has partnered with the Brookings Institution's Engelberg Center for Health Care Reform, proffers that "The benefits from collaboration may outweigh the 'fight over the pie mentality' with which some may approach this."²⁵

Among the guiding principles being promulgated by the Dartmouth Institute for Medicare for payment reform include:

“First, there is increasing agreement on the need for **local accountability** for quality and cost across the continuum of care. The consistent provision of high-quality care - particularly for those with serious and chronic conditions - will require the coordination and engagement of multiple health care professionals across different institutional settings and specialties. The health care system must not only facilitate, but also encourage such coordination.

Second, a successful approach to achieving greater accountability must be viable across the diverse practice types and organizational settings that characterize the U.S. health care system and should be sufficiently flexible to **allow for variation in the strategies that local health systems use to improve care.**

Third, successful reform will require a shift in the payment system from one that rewards volume and intensity to one that **promotes value** (improved care at lower cost), encourages collaboration and shared responsibility among providers, and ensures that payers - both public and private - offer a consistent set of incentives to providers.

Finally, with increased accountability on the part of providers must come **greater transparency for consumers.** Measures of overall quality, cost, and other aspects of performance relevant to consumers will facilitate informed choices of both providers and services and increase consumers' confidence in the care they are receiving as their providers face different incentives.

Many of the payment reforms that have been proposed or are already in use - for example, bundled payments, disease management, and pay for performance - represent meaningful steps toward greater accountability. The next step is accountability for care that leads to better outcomes and lower costs at the person level, with support for the infrastructure required to provide high-quality, coordinated care.”²⁶

Other payment reform concepts being considered as a feature of health care reform proposals being considered in Washington include:

Performance-based care coordination: Physicians earn a bonus for curtailing growth in the cost of health services by better managing treatment across care settings and by pursuing quality targets. A care-coordination model may be structured differently from an ACO and may also use different methods to calculate shared savings.

Payment bundling: Similar services are grouped together and are compensated using a single or global payment. Services could be grouped according to the care provided by a single doctor or multiple doctors.

Gainsharing: Hospitals share with physicians any savings resulting from system changes that lead to lower costs.²⁷

Pilot projects with both private insurers and state Medicaid programs are ongoing while Federal reform is being debated as it pertains to Medicare-sponsored payment reform models designed to promote new concepts of care coordination and risk-sharing (cf. Brookings-Dartmouth ACO pilot projects).

5. Key Findings (cont'd)

- c. *Ease of access and referral to specialty care poses great hurdles for FQHCs, who are statutorily required to be situated in and serve Medically Underserved Areas (MUAs) and Medically Underserved Populations (MUPs), thereby inhibiting availability of critical features of the continuum of care. Private-public, Private-private initiatives are attempting to address selected though significant aspects of this inherent conflict of conditions and resources. Consortia (among FQHCs locally/regionally) and alliances (between FQHCs and other providers) can also offer support for improving continuity*

CEOs we interviewed indicated that obstacles to effective specialty referrals they experience include:

- Availability of specialists committed to support FQHC patients
- Wait times for scheduling specialty consults
- Distance to travel for consults (in urban areas, often using public transportation, or from rural areas, requiring long driving distances)
- Need for family member to accompany referred patient
- Patients' work schedules interfering with scheduling
- No-shows once consult is scheduled
- Specialists citing lack of adequate preparation of patient prior to consult (e.g. tests not performed, test results/chart not available) thereby voiding visit
- Practitioner credentialing protocols (by either regulators, payers and provider organizations) putting up barriers to specialty consults, both as to cross-state/cross-organizational in-person or telemedicine consultations and as to restricting the types of licensed professionals who are authorized to perform consultations (cf. psychologists or social workers permitted to do behavioral health consultations but not licensed Marriage & Family Therapists who may be more readily available and more cost-efficient)
- Reimbursement limitations that define a 'visit' as an in-person/'within the four walls' consultation between practitioner and patient which restrict use of telemedicine technologies

Initiatives:

- ✚ Specialty 'pools' by Council of Community Clinics in San Diego: e.g., Ryan White Care Act HIV Specialty Pools (funded by the County of San Diego) to provide funding to HIV/AIDS infected individuals in need of medical services, dental services, home health/hospice services, and/or short-term medication assistance (cf. CCC website at <http://www.ccc-sd.org/about.aspx>) promoting access to the continuum of medically-necessary and – supportive care. Nationally, the Act, through its Transitional Grant Area (TGA) program, permits metropolitan areas from being designated to provide financial support to not

merely a single grantee, but rather “...a diverse set of organizations that together create a comprehensive system of care throughout...(the) region.”²⁸ The Act’s inclusion of home-based care services was one of the only times that this aspect of the continuum was referenced in this case study.

- ✚ Private foundation funding as well as community benefit programming via local hospitals and health system networks/associations form an essential alternative to the limitations placed on FQHCs by their Federal (Medicare, Sec. 330, etc.) and State reimbursement sources (e.g. Medicaid, Children’s Health Insurance Program, both of which are co-funded by Federal and State governments and administered by States).
 - Grants from private sources permit FQHCs to develop new programming or service lines to evaluate extending the reach and effectiveness of each center as it attempts to manage patient care along the continuum, either through new in-house methods or via collaborations with agencies and providers outside of the purview or control of the FQHC. This type of capitalization is important because new services cannot be added unless an FQHC can demonstrate the need for the service, ability to provide the service, and relevance/effectiveness of the service as part of their existing scope of service. Generally, though, foundation support is time-delimited and must be supplanted by other financing mechanisms when granting periods expire. Nonetheless, by permitting FQHCs the ability to launch and test out the effectiveness or efficiency of new strategies and tactics for securing care for their patients, FQHCs can then build the argument to their Federal and State payers to include them into a revised scope of service for which PPS and other public reimbursement can be billed.
- ✚ Collaborations that are on-going between FQHCs and local physicians and hospitals to keep the continuum intact for their primary care patients despite funding policy constraints are well demonstrated via two different peri-natal care models, one for FQHCs with a higher volume of OB patients and one for lower-volume centers, both located in San Diego County. In the high-volume model, the FQHC credentials OB/Gyns who are under contract with the hospital to be on the OB floor 24/7 to serve the FQHC’s patients. These physicians also serve the hospital’s emergency department’s gynecology referrals. Pediatrician residents and faculty do rounds on the newborns and make the connection for the mother and child to return back to the FQHC for their primary care needs. Pregnant women who present for care at the low-volume FQHC are seen by mid-level practitioners with MD supervision and a care plan devised for the term of their pregnancies that includes assignment to a private, community-based OB/Gyn who serves the patient and, with the woman’s FQHC practitioner, arranges for hospital care.

The funding conundrum: If the patient is deemed Medicaid-eligible, a determination that may take 30-60 days to confirm and is up to the woman to pursue with FQHC staff support,

the hospital can and will be paid by Medicaid for the patient's inpatient OB care (Note: new baby is automatically covered for 1st year of life if Mother is Medicaid-eligible). If the patient is not eligible for public financing and otherwise uninsured, the hospital, which has in place its 'community benefit plan,' is not paid and assigns the costs of care to their 'community benefit.' But, without Medicaid eligibility, the private physician participating in the low-volume model can be left without recourse for payment other than billing the patient and negotiating both the price and terms of payment, if the patient can be located. This reality discourages recruitment and extent of participation by specialty physicians.

The FQHC in both models is billing as they would normally but the physician and hospital in this latter model have greater exposure if the patient does not become Medicaid- or insurer-eligible and is therefore, uninsured. Though these efforts, and the many others like them around the FQHC national network, may be ultimately effective on the patients' behalf in assuring care along the OB continuum, they are each among very individualized, idiosyncratic strategies to create a much-needed patch over the gaps and vagaries built into reimbursement policies with which FQHCs must contend for the 30% of their patient population of child-bearing age.

- ✚ A diagnostic services company is working through the national FQHC association to establish relationships with local FQHCs, whereby the FQHC handles all reimbursement eligibility tasks for patients needing diagnostic services so that the company does not have to add these costs or risks to their bottom-line. Patient who needs it can be transported by the FQHC to the diagnostic center for tests. Program was so well received in the initial one-city pilot that it is now being expanded to 4 other cities and resident FQHCs. A very nominal co-pay is charged to patient for services.

- ✚ The goals of 2006 Specialty Care Access Initiative, a partnership between the California Association of Public Hospitals and Health Systems/California Health Care Safety Net Institute, California Primary Care Association (representing FQHCs) and Kaiser Permanente Community Benefit, were:
 - To identify, test, document and reduce barriers to specialty care access and demand management;
 - To identify, test, document and implement solutions to increase access to specialty care access;
 - To document, disseminate and facilitate the utilization of knowledge about barriers and solutions; and
 - To design, sequence and implement advocacy strategies for needed change.

- ✚ In a 2009 study by the California HealthCare Foundation ("CHCF")²⁹, specialty care by 'safety net' primary care providers was seen as a challenge that relies on public hospitals, community clinics and health centers (including FQHCs) and private specialists engaging on behalf of patients in need. A majority of community clinics and health centers (CCHCs) who

were surveyed indicated that their organizations provided at least one specialty service on-site, while more one-third offer 3 or more different specialties. Thirty-three percent of CCHC referrals were made to private specialists, with the lowest percentage of these emanating from CCHCs in neighborhoods with a public hospital (or university hospital), such as Los Angeles. Specialties most in need and most difficult to access (e.g. both longest wait times and according to the perception by CCHC providers) were orthopedics, gastroenterology, neurology and dermatology. In fact, one-third of the primary care provider respondents (including CCHCs and public hospital administrators/practitioners) 'frequently' limited their referrals to these difficult-to-access specialties (called "referral suppression" and which may be a behavior that skews data regarding the depth of specialty access challenges). CCHC respondents indicated that there were able to consult with a specialist "less than half the time that consultation was needed." Efforts to expand access in 2007 included:

- Provision of on-site specialty care (61% of CCHCs and all of the public hospitals surveyed)
- Expanding the scope of practice for PCPs (only 14% of CCHCs relayed their experience in this endeavor and only for dermatology, infectious diseases including HIV/AIDS and orthopedics.
- Building a specialty referral network (mostly accomplished through personal relationships with a limited array of practitioners)
- Building a telemedicine capacity (one-third had the equipment but did not indicate that it was being used to expand specialist access except in rural areas)

But coordination of specialty care referrals had not taken hold at the time of this survey, with 30% of all safety-net providers claiming they did not track specialty referrals "in any formal way" with only 4 percent of CHHCs indicating they used EMR and 68% citing use of a "manual log."

With the advent of the Kaiser Permanente Community Benefit/CHCF Specialty Care Initiative in late 2008, 23 coalitions of California providers were awarded grants³⁰ to implement access-enhancing strategies "to enable systemwide change and advance the larger goal of integrated community care in the safety net." The top 5 strategies being espoused by more than half the grantees are:

- Development and implementation of referral and/or clinical care guidelines
- Training for primary care providers, including fuller scope to incorporate specialty care activities
- Expanded specialist networks
- Web-based referral or consult systems
- Referral coordination improvements (addressing language and health literacy barriers, no-show rates, pre-consult patient education to enhance compliance)

Grantees are also implementing:

- Shared specialist or hub models to expand specialist networks
- Use of mid-level providers
- Internal specialty clinic re-design
- Chronic disease registries
- Clinical care screening programs
- Community collaborations and regional partnerships
- Public health campaigns
- Transportation services to specialty care appointments

Or, multi-faceted approaches of many combinations of these strategies. David O'Neill, senior program officer in CHCF's Innovations for the Underserved program, sees progress after the first year of the Initiative's implementation, in particular, via negotiated care guidelines and e-referral protocols with specialists and primary care physicians working collaboratively on guideline development, engaging in a dialogue on the strains, deficiencies and misalignment of their respective incentives to effect sound referrals, appropriate care and beneficial outcomes that each faces.

✚ In communities with a public/county hospital (or in some cases, a university hospital that has assumed its respective county's indigent care obligation as defined by state law or a sectarian hospital with a mission to care for the poor), opportunities emerge for securing specialty care and hospital admission/attending via contracting with hospital residency programs. Some FQHCs are actually in an alliance with, owned or organizationally linked with or part of a network that includes hospitals that support residency programs, which greatly enhances care along the continuum for FQHC patients. But many California public hospital systems are themselves underfunded to provide or expand their specialty care delivery, though the 2005 Medi-Cal Hospital/Uninsured Care Demonstration Project (often called 'the Waiver') has permitted 22 designated public and 5 designated university hospitals access to a new funding source for inpatient Medi-Cal fee-for-service or uninsured care which pays these hospitals about fifty cents on the dollar of costs they expend for inpatient care.³¹ This impedes FQHCs from entering into new or expanded specialty care arrangements with most public hospitals in this state.

✚ Though often organized around administrative and technical functions and the goal of creating economies of scale, FQHCs that organize or become active participants in consortia or alliances can reap benefits over time in improving their provider networks as well. For example, the Council of Community Clinics in San Diego has created a subsidiary, Community Clinics Health Network (CCHN), which offers its now 30 members an array of services including disease and quality management programs, managed care contracting support and information management/information technology technical assistance through a Technical Services Organization (TSO).

The TSO is currently offering members EHR adoption planning assistance, hosting of 'shared systems' that reduce or eliminate many of the upfront, recurring, and replacement

costs required to implement and maintain IT systems permitting resources to be redirected to patient care or other cost-saving investments and support for practice management applications across clinic sites, each of which permits members...to provide a foundation to continuously improve the health care provided to patient populations through enhanced deployment and utilization of information technology, providing an efficient foundation to continuously improve health care.³²

Through these collective administrative and technical supports, members are able to actively report, analyze and use accurate and readily accessible data to make the case for, seek practitioner support for and pursue appropriate payment for any and all care needed by patients, whether at the FQHC or elsewhere in the community. Consortia such as CCHN promote what Shortell postulated: that organized delivery systems do not require common ownership - what ties the organization together is the clinical and fiscal accountability to a defined population.³³

- ✚ Community Health Improvement Partners (“CHIP”) was established by San Diego private, not-for-profit hospitals in response to a state legislative directive which took effect in 1995 to provide evidence of a community benefit in order to warrant tax-exempt status. Of the 25 original organizations that came together to form CHIP, 23 remain and the current membership of CHIP has reached 30 entities, including the San Diego Council of Community Clinics which represents local FQHCs. Beyond producing a triennial community needs assessment, CHIP and its members have worked on a variety of initiatives to promote active collaboration in support for the underserved and to redress the most pressing local health, coverage and clinical imperatives along the entirety of the continuum through improved deployment of member resources and through alliances and advocacy with non-member organizations including governmental regulators and payers.

5. Key Findings (cont'd)

- d. *Federal policy initiatives and the funding therein (via the 'stimulus' act) is having multiple effects:*
- *For expansion of/addition of FQHC facilities and services: improves overall access and, likely, volumes of patients seen for primary care, while State Medicaid budget cuts may further limit access to specialty care*
 - *For HIT/EHR development: could have a positive impact on integration efforts*

The Obama Administration's promotion of FQHCs as the front line of his reform agenda via the billions of stimulus funding issued early in 2009³⁴ (through the enactment of the American Recovery and Reinvestment Act or "ARRA"), which had been preceded by the Bush Administration's increase in federal support for community health centers between 2002 and 2006, may aid but not solve current integration breakdowns and could, in fact, exacerbate the problem of coordinating care along the continuum. Though considered to be an essential investment in primary care infrastructure in order to accommodate the anticipated 10-50% increase in the uninsured cohort of patients to be served by FQHCs nationally, the concern remains that, by funding expansion of programs at current sites and increasing the number of sites of FQHC primary care delivery, locating new sites in previously unserved or underserved areas, the increase in this expanded cadre of primary care access points will merely stress the system further, as greater volumes of FQHC primary care patients need and are referred to specialty care and hospitalization, where funding has not necessarily been similarly augmented.

Nonetheless, with greater reach and more prominence in the health care delivery system of their respective communities and states, Federal stimulus funding may offer FQHCs the opportunity to use their growing collective critical mass of patients, primary care practitioners, facilities and IT infrastructure to energize care coordination/referral negotiations with current or prospective provider partners, especially those who, like FQHCs, are receiving stimulus funding through Medicaid and Medicare payment incentives.

Health IT Funding under the HITECH (Health Information Technology for Economic and Clinical Health) Act within ARRA appropriates US\$48 billion, US\$46 billion of which will be disbursed through Medicaid and Medicare payment incentives, while US\$2 billion of which will be disbursed through grants. These funds are directed toward a wide swath of providers for their use specifically to augment **EHR planning and implementation** including EHR adoption incentives directly to eligible FQHCs and indirectly to other health care providers with whom FQHCs are or can partner on behalf of their patients for such 'meaningful use' initiatives as e-prescribing, electronic health information exchange (which should directly impact positively coordination of care), clinical quality data reporting.³⁵

5. Key Findings (cont'd)

- e. *Telemedicine holds great promise for continuity of care, especially in rural or isolated areas, but reimbursement policies must be updated to accommodate technology breakthroughs and to reflect resulting changes in workflows and efficiencies*

Andie Martinez, Associate Director of Policy at the California Primary Care Association, cites three key organizations that advocate for and promote telemedicine in the state:

California Telemedicine & eHealth Center (CTEC) which describes itself as:

“...the leading source of expertise and comprehensive knowledge on the development and operation of telemedicine and telehealth programs. CTEC has received national recognition as one of six federally designated Telehealth Resource Centers around the country.”

California Telehealth Network (CTN) is a not-for-profit granting organization which is about to distribute US\$22.1 billion in an award from the Federal Communication Commission (plus \$100 million in State funds for capital improvements to expand and enhance medical education at the University of California, with an emphasis on telemedicine) for broadband connectivity installations at 300 health care providers including FQHCs statewide.

California Center for Connected Health Policy (CCHP) is a “non-profit planning and strategy organization working to remove policy barriers that prevent the integration of telehealth technologies into California’s health care system...with the larger goal of enhancing access and quality of care for all Californians, particularly uninsured and low-income Californians.”³⁶

One of the most consistently-made comments made during our interviews of FQHC executives was regarding their keen interest in, preliminary use of and hope for telemedicine among the plethora of e-health and HIT innovations to promote access to specialty care for their patients. But the enthusiasm is quickly dampened by the inelasticity of effort with which FQHC’s primary public payers are addressing the value of telemedicine through reform and simplification of existing payment policies.

CTEC has devised a guide (cf. [CTEC-FQHC Reimbursement Models Feb09.pdf](#)) to walk FQHC managers through the labyrinth that is telemedicine reimbursement for FQHCs via 6 scenarios that consider where the patient is physically located, the characteristics of the specialty provider site, the payment arrangement with the specialty provider and if there is a medical reason for a provider to be present.³⁷

After perusing this remarkably detailed guide, it is clear that FQHCs who activate a telemedicine strategy must do so with clarity and precision.

Some have even queried:

“Why would a payer organization choose to discriminate against a particular vehicle for delivery healthcare services—especially if that vehicle is faster, cheaper, or better? In an era of

rising healthcare costs and diminishing access to services, telemedicine advocates believe that payer organizations should leap at the chance to encourage (or at least enable) improved modes of healthcare delivery. So why haven't they?"³⁸

Telemedicine reimbursement is challenged by the breadth and fragmentation of the payer market, with each payer using its own protocols, guidelines, forms, data requirements, etc. with providers, with Federal Medicare regulations always lurking in the wings and with state legislators and payers being reticent to accept mandates that may require them to pay for services provided via telemedicine that they normally do not cover via in-person contact.³⁹

Reimbursement limitations though are not the only barriers. Physicians cite concerns about standards of care and malpractice liability, in addition to citing the lack of specific training in best practices for telemedicine consultation as being discouraging of their use of this tool. FQHC administrators cite the dearth of specialists with whom to make arrangements for telemedicine consults and the obstacle of the limited purview of credentialing protocols by both provider and payer organizations. And if an FQHC finds a specialist who does not live—and is therefore not licensed—in the state in which the patient lives, practicing via telemedicine across state lines is usually prohibited. Capitalization of telemedicine programming can be a hurdle, though grant funds and, now, stimulus funding in the U.S. can mitigate some of the initial investment. And privacy and liability issues pertaining to the over-the-air/web consultation, data transmission and storage will continue to be raised. Patients are often unaware of telemedicine as an option except when they hear about it in the media or via the referral of their primary care physician, which is the most powerful draw to patients' active embrace of telemedicine as a safe, effective and valuable strategy.

Nonetheless, rural FQHCs have been the most aggressive about using and, thereby, pushing the envelope on both advancing clinical and financial protocols regarding telemedicine for specialty care, especially for telepsych consults. Dean Germano, CEO of Shasta Community Health Center in Redding, California, cited that his FQHC performed approximately 50 to 60 telemedicine consults per month. The Humboldt County-based Open Door Community Health Centers have mobilized a Visiting Specialist Center at their Eureka site, where telehealth and specialty consultations are offered in pediatrics, diabetes education, behavioral health, HIV/Hepatitis C, Cardiology, Orthopedics, Pulmonology, Gynecology, Allergy/Immunology and Psychiatry.

Two telemedicine initiatives have been launched thus far in 2010. The California Center for Connected Health Policy has issued awards for its Specialty Care Safety Net Initiative – Linking UC (University of California) Specialists with Safety Net Clinic based on the hypothesis that:

“Policy, statutory and practice pattern barriers (beyond the barrier of low or no reimbursement rates for services provided to safety net patients) prevent UC Schools of Medicine from providing specialty care consults to safety net patients. Identifying and removing these barriers is essential to the long-term sustainability of UC based telehealth projects that provide service to safety net patients...to include development of new models of care delivery, changes in reimbursement mechanisms, statutory or regulatory changes, and/or modifications to practice patterns.”⁴⁰

And, in San Diego County, a Cisco Systems grant is piloting a telemedicine program with several health care providers including 2 FQHCs, one urban and one rural, to test the benefits of both

primary and secondary telemedicine service delivery for the underserved.⁴¹ According to Cisco:

“Cisco HealthPresence is a patient care delivery concept that combines Cisco [TelePresence](#)[™] and medical devices to enable caregivers and patients who may be miles apart to interact in a clinical setting.”⁴²

5. Key Findings (cont'd)

- f. Funding vagaries are at times confounding the best intention of disease management programs, which are widely seen as the best 'defense' against the impetus to secure higher acuity services (including emergency care) to respond to unchecked changes in health status among the chronically ill*

Medi-Cal, under its fee-for-service reimbursement plan, is piloting 2 disease management programs in 2 counties (Los Angeles and Alameda) which should conclude this year. The "DM1" demonstration is being managed under contract with McKesson Health Solutions for Medi-Cal eligibles with at least one of the following diagnoses: advanced atherosclerotic disease syndrome; 2) congestive heart failure; 3) diabetes; 4) asthma; 5) coronary artery disease; and, 6) chronic obstructive pulmonary disease. The "DM2" pilot is being managed for HIV/AIDS patients under contract with the AIDS Healthcare Foundation. UCLA's Center for Health Policy Research is charged with evaluating and reporting on the results of these demonstrations.⁴³

Initiatives:

- ✚ The "ALL" protocol for diabetes patient management ("ALL" refers to Aspirin, Lovastatin and Lisinopril) was developed and tested by Kaiser Permanente's Care Management Institute with tens of thousands of patients and has shown that by taking this 3-medication regimen daily the risk of stroke or heart attack is reduced by more than 50% and without the need for endocrinology visits. Via Kaiser's Community Benefit program grants, FQHC patients enrolled in various studies throughout San Diego's network are now benefiting from the ALL protocol, with 99% of patients staying on their regimen and getting and staying healthy. The clinics see their ALL patients every 60 days and fill all prescriptions at the time of the visit. An unintended consequence of the ALL protocol has been to catapult participants' overall health status over that of their non-diabetic patient counterparts at the FQHCs. A further 'private-private' initiative that has emanated from the success of ALL is through the Scripps Whittier Institute for Diabetes, which now funds retinal scanning for ALL patients at no cost. In addition, community surgeons have been identified and solicited to perform low-cost corrective laser surgery on patients with diabetic retinopathy, thereby saving sight and dollars by eliminating or mitigating further morbidity and/or disability and, therefore, utilization of other care resources along the continuum. (cf. "Welcome to Kaiser Community Benefit" at https://info.kp.org/communitybenefit/html/our_stories/global/our_stories_2.html)
- ✚ Project Dulce, a diabetes outreach, care and management program sponsored by the Scripps Whittier Institute for Diabetes that outstations highly-trained nursing and other staff who work in FQHCs providing clinical care and patient education for uninsured, underserved and/or ethnically-diverse patients. Established in 1997 by a collaboration of organizations⁴⁴, Project Dulce is now operating at 19 sites throughout the county, all but 2 of which are FQHCs.

The program's other features include:

- Training for peer educators to provide diabetes self-management education and support to their peers.
- Clinical standards and algorithms used to guide treatment
- An electronic diabetes registry, used to track patient care, monitor compliance with standards and report clinical outcomes
- Extensive socio-cultural research to adapt its group education curriculum and approach to address the needs of African-American, Filipino, and Vietnamese communities⁴⁵

Five thousand (5,000) patients are being actively case-managed, including for hypertension and lipid management. Now, Project Dulce is training FQHC nurses and peer educators in order to permit each center to establish and run their own diabetes care and management programs. According to Project Dulce's Director, Chris Walker, participants have regularly achieve the highest standards of care (per the American Diabetes Association) for HbA1C, lipid panel, foot examination, monofilament examination, and urinary croalbumin-to-creatinine ratio, thereby reducing the need for further emergency or specialty care. Project Dulce has also trained paraprofessionals to read retinal photos used for screenings for retinopathies for early detection.

Project Dulce will soon be serving additional patients at FQHCs via the County of San Diego's Health Care Coverage Initiative funding,⁴⁶ which is targeting diabetes and hypertension disease management. The Coverage Initiative was enacted by the California State legislature (SB1448 in 2006) to permit counties to use Federal funds through the MediCal program to cover a broader cohort of uninsured persons (aka Medically Indigent Adults).

- ✚ La Clínica de la Raza's Asthma Collaborative operates similarly, as La Clínica's CEO, Jane Garcia, discussed it and as it is described on her FQHC's website:

"La Clínica's Asthma Program started in 2002 and currently provides services to over 1,000 asthmatic patients. We document the severity of each patient's case, prescribe daily controller medication, monitor their health and work with our community partners to make necessary referrals to agencies, hospitals, and other health care organizations. Thanks to our Annual Benefit event in 2008, we have been to able expand comprehensive asthma care which includes: individualized asthma action plans, self management education, one on one education, home assessments, and spirometry tests (lung function tests) throughout the agency. Our goal is to improve the outcomes for all asthmatic patients by providing consistent, preventative and easily accessible health services to ensure proper management of asthma."⁴⁷

Ms. Garcia suggests that the data shows that assigning a multi-practitioner team to each patient results in optimum control, quality of life improvements and increased longevity.

- ✚ “Team Up for Health: Supporting Patients for Better Chronic Care” is being sponsored by the California HealthCare Foundation through a \$2.37-million, three-year initiative (launched in 2009) to help FQHCs and others to implement proven approaches to supporting self-care and develop new ways to engage with non-medical resources, including community, family, and peers. The focus is on diabetes, though some grantees plan to expand to additional conditions during the course of the implementation phase. The groups will focus on utilizing the entire care team to support self-management, developing a process to elicit, document, and utilize shared goals and plans between patients and providers, and taking steps to support patients and families outside the clinic setting. (cf. <http://www.chcf.org/topics/chronicdisease/index.cfm?itemID=133728>)

5. Key Findings (cont'd)

- g. Improved referral practices can sometimes mitigate funding disparities between primary care and specialty providers*

An 11-clinic study of 4 hard-to-access specialties (dermatology, gastroenterology, neurology and orthopedics) for California's safety-net clinics was conducted in 2009 by the California HealthCare Foundation.⁴⁸ The strategies noted here, though rephrased in paraphrased form from the study's report, were also frequently suggested by our interviewed FQHC CEOs. Though these recommendations cannot overcome funding policy disincentives, they can in fact promote more effective use of the continuum of care by FQHC patients. And, though primarily oriented to clinical and operational solutions, these 'access strategies' that form the conclusions to the study mirror those we are seeking from a funding policy perspective, including:

Ensure appropriate referrals, including 'clean' consults where patient case has been appropriately worked up, all data is available to the specialist in advance, patient shows up for appointment and specialists return information to the clinic and primary care provider in a timely fashion. Specialist triage of consult requests and PCP participation during consultation also aid in ensure referrals are necessary and well-organized.

Expand primary care site expertise, including only referring when specialist is required by strengthening PCP skillset and confidence, seeking teaching opportunities with specialists (and academic medical centers) on common referrals and increasing clinic capacity in specific specialty areas (e.g. hepatitis C, HIV, mental health, diabetes are most often addressed but other areas could include pediatric asthma, seizure management, rheumatology and a variety of women's health matters).

Increase non-visit tools to support consult needs, including handling ad-hoc questions with a consult ("curbside consult").

Bring specialty services on site, including investing in equipment needed for various procedures, bringing specialists on-site for brief rounds of consults

Expand use of telemedicine, by actively promoting value and adoption of telemedicine among providers (and payers, as this is a major roadblock to greater adoption in California, where Medicaid is not effectively organized to pay for these visits)

Build institutional relationships, including establishing/enriching relationships locally and beyond and forming alliances with local hospitals via their community benefit program and with academic medical centers via their residency programs.

6. Conclusions

“So much of the cost and harm in the current system can be mitigated by reliable execution of the clinical evidence and effectively managing the handoffs between levels and sites of care.”

(Source: “The Promise of Integrated Healthcare” by Rick Norling, CEO (retd.), Premier Healthcare Alliance; at www.healthcarefinancenews.com; Jan. 8, 2010)

- a. Transform payment structures to improve quality and patient satisfaction across the continuum with an emphasis on primary care, rather than using funding to promote efficiencies and control utilization at higher levels of care or funding that is categorical in nature, ‘slicing and dicing’ funding for what the provider views as an integrated care experience for the patient toward the end of optimal (or improved) health status for each patient.
- b. Mitigate funding policy obstacles by keeping patient at lowest level of care that maintains their health and functioning, thereby avoiding (or delaying) the need to wade into funding policy morasses
- c. Re-invigorate HIT, EHR and other eHealth planning and development efforts in order to mitigate competing funding by facilitating and rewarding communication of accurate, real-time patient data among providers
- d. Invest in telemedicine/telehealth programming, technology, staffing and facilities, and promulgate ‘friendly’ financing policies in order to promote its development and encourage its use as a means of shortening the continuum as the patient experiences it
- e. Promote adoption of a ‘medical home’ and/or accountable care organization policy (or significant broadening of existing medical home or ACO, testing continuity-promoting funding policies within these models of care)
 - i. Build in or enhance budget specifically for care coordination and case management
- f. Test combinations of strategies within different provider organizations such as those being evaluated by the latest Kaiser Permanente Community Benefit/CHCF Specialty Care Initiative, including:
 - o Development and implementation of referral and/or clinical care guidelines
 - o Training for primary care providers, including fuller scope to incorporate specialty care activities
 - o Expanded specialist networks
 - o Web-based referral or consult systems

- Referral coordination improvements (addressing language and health literacy barriers, no-show rates, pre-consult patient education to enhance compliance)
- Shared specialist or hub models to expand specialist networks
- Use of mid-level providers
- Internal specialty clinic re-design
- Chronic disease registries
- Clinical care screening programs
- Community collaborations and regional partnerships
- Public health campaigns
- Transportation services to specialty care appointments

Appendix A

Interviewees:

Vanesscia Bates, Deputy Director
Clinical Affairs
California Primary Care Association
Sacramento, CA

Irma Cota, CEO
North County Health Services
Vista, CA

Lucette DeCorde, Group Leader, Safety Net and Contributions*
Community Benefit Programs, Northern California Region
Kaiser Permanente
Oakland, CA

**Interview not yet completed due to a family emergency*

Margaret Flinter, Vice President and Clinical Director
CHC, Inc. (Community Health Center)
Director, Weitzman Center for Innovation in Community Health and Primary Care
Middletown, CT

Jane Garcia, CEO
La Clínica de la Raza
Oakland, CA

Dean Germano, CEO
Shasta Community Health Center
Redding, CA

Seiji Hayashi, Chief Medical Officer
Bureau of Primary Health Care
Health Resources and Services Administration
Department of Health and Human Services

Allison Homewood, Senior Healthcare Analyst
Health Center Operations
California Primary Care Association
Sacramento, CA

Marty Lynch, Executive Director
Lifelong Medical Care
Berkeley, CA

Andie Martinez, Associate Director of Policy
Government Affairs
California Primary Care Association
Sacramento, CA

Mark Masselli, President and CEO
CHC, Inc. (Community Health Center)
Middletown, CT

Karen McCabe, Director/Community Benefit Services
Scripps Mercy Hospital
San Diego, CA

David O'Neill, Senior Program Officer
California HealthCare Foundation
Oakland, CA

Robyn Prime, Director of Program Development
Mountain Health & Community Services, Inc.
Alpine, CA

Christy Rosenberg, Director
Community Clinic Health Network
San Diego, CA

Melissa Schoen, Senior Program Officer, Innovations for the Underserved
California HealthCare Foundation
Oakland, CA

Malvise Scott, Senior Vice President for Partnerships and Resource Development
National Association of Community Health Centers
Bethesda, MD

Judith Shaplin, CEO
Mountain Health & Community Services, Inc.
Alpine, CA

Scott Sporte, Managing Director, Community Investment Group
NCB – Capital Impact (a subsidiary of National Capital Bank)
San Francisco, CA

Chris Walker, Director,
Public Health Program (including Project Dulce)
Scripps Whittier Institute for Diabetes
La Jolla, CA

Appendix B

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“Who is the Puzzle maker? Patient/Caregiver Perspectives on Navigating Health Services in Ontario, The Change Foundation Health Integration Report, June 2008

¹ “Health Care: Who Knows ‘Best’?” by Jerome Groopman, The New York Review of Books, February 11, 2010

² “Profiles of Integrated Care: Working with an FQHC,” Ohio Coordinating Center for Integrating Care, Cincinnati, Ohio at www.ohioactcenter.org/occic.html

³ Ibid: Ohio Coordinating Center for Integrating Care, Cincinnati, Ohio

⁴ Per the National Rural Health Association in a presentation on cost reporting produced by Dixon Hughes PLLC in May 2008, a sample of FQHC reimbursement provisions under Medicaid and Medicare include:

- Primary care visits (cost-based)
 - All inclusive cost per visit
 - Subject to productivity standards (see Note 10 below) as well as per-visit cost limit
 - Vaccines (cost-based per formula)
- An ‘encounter’ is a face-to-face meeting between patient and physician or mid-level practitioner
 - Medical necessity determines whether a patient should see the provider
 - Inpatient hospital visits cannot be billed under the FQHC benefit
- Existing cost limits approximates \$100.96 per visit for rural areas and \$117.41 per visit for urban areas and are updated annually
- Not reimbursed (considered for grant funding in order to offset)
 - Physical Therapy
 - Radiology
 - Pharmacy
 - Laboratory (though for Medicaid patients, may be included in ‘cost per visit’ formulation)
- Medicaid PPS reimbursement is based on average of 2 base years (1999 and 2000) unless for a ‘new start’ in which case the area average is computed
 - Based on Medicare per-visit rate
 - Rate excludes productivity standards
 - Rate not subject to per-visit cost limits
 - Changes in scope of practice must be undertaken, data gathered, scope change sought and approved prior to payment rate being re-set

- Medicare (per testimony before the House Energy & Commerce Subcommittee on Oversight and Investigations on Community Health Centers of Director, Center for Medicaid and State Operations, Centers for Medicaid and Medicare Services, May 2005)
 - All-inclusive per-visit rate based on ‘reasonable costs’ as determined through Medicare cost report
 - Subject to one of 2 ‘upper payment limits’ depending on rural vs. urban setting.
 - Medicare spent \$265million in 2004 on FQHC provided care to its beneficiaries
 - Medicare also supplements reduced payments from patients seen by FQHC’s who are covered by Medicare’s HMO plans (known as “Medicare Advantage”) so that payments for these patients are equal to those covered under Medicare’s fee-for-service program

⁵ “The Health Center Program: Benefits” U. S. Department of Health and Human Services, Health Resources and Services Administration (and from a variety of state Primary Care Associations) at <http://bphc.hrsa.gov/about/benefits.htm>

⁶ “Medical Home Produces Better Care at No Added Cost,” Group Health Cooperative News at <http://www.ghc.org/news/news.jhtml;jsessionid=1L25WJT4I5QFTJCISQ3SHPQ?repositid=/common/news/news/20090901-medicalhome.html> A medical home provides expanded primary care that is personalized, focuses on prevention, actively involves patients in making decisions about their care, and helps coordinate all their care and get their health needs met.

⁷ “Here’s a radical health care idea: Put the patient first,” by André Picard, *The Globe and Mail*, October 22, 2009

⁸ Schoen, Cathy et al. Toward Higher-Performance Health Systems: Adults’ Health Care Experiences in Seven Countries, 2007. *Health Affairs*, 26, No. 6 (2007): w717-w734

⁹ Per Section 330 of the Public Health Service Act (42 USCS § 254b); cf. <http://bphc.hrsa.gov/about/legislation/section330.htm>

(1) Required primary health services.

- (A) In general. The term "required primary health services" means--
 - (i) basic health services which, for purposes of this section, shall consist of--
 - (I) health services related to family medicine, internal medicine, pediatrics, obstetrics, or gynecology that are furnished by physicians and where appropriate, physician assistants, nurse practitioners, and nurse midwives;
 - (II) diagnostic laboratory and radiologic services;
 - (III) preventive health services, including--
 - (aa) prenatal and perinatal services;
 - (bb) appropriate cancer screening;
 - (cc) well-child services;
 - (dd) immunizations against vaccine-preventable diseases;

- (ee) screenings for elevated blood lead levels, communicable diseases, and cholesterol;
- (ff) pediatric eye, ear, and dental screenings to determine the need for vision and hearing correction and dental care;
- (gg) voluntary family planning services; and
- (hh) preventive dental services;
- (IV) emergency medical services; and
- (V) pharmaceutical services as may be appropriate for particular centers;
- (ii) referrals to providers of medical services (including specialty referral when medically indicated) and other health-related services (including substance abuse and mental health services);
- (iii) patient case management services (including counseling, referral, and follow-up services) and other services designed to assist health center patients in establishing eligibility for and gaining access to Federal, State, and local programs that provide or financially support the provision of medical, social, housing, educational, or other related services;
- (iv) services that enable individuals to use the services of the health center (including outreach and transportation services and, if a substantial number of the individuals in the population served by a center are of limited English-speaking ability, the services of appropriate personnel fluent in the language spoken by a predominant number of such individuals); and
- (v) education of patients and the general population served by the health center regarding the availability and proper use of health services.
- (B) Exception. With respect to a health center that receives a grant only under subsection (g), the Secretary, upon a showing of good cause, shall--
 - (i) waive the requirement that the center provide all required primary health services under this paragraph; and
 - (ii) approve, as appropriate, the provision of certain required primary health services only during certain periods of the year.

(2) **Additional health services.** The term "additional health services" means services that are not included as required primary health services and that are appropriate to meet the health needs of the population served by the health center involved. Such term may include--

- (A) behavioral and mental health and substance abuse services;
- (B) recuperative care services;
- (C) environmental health services, including--
 - (i) the detection and alleviation of unhealthful conditions associated with--
 - (I) water supply;
 - (II) chemical and pesticide exposures;
 - (III) air quality; or
 - (IV) exposure to lead;
 - (ii) sewage treatment;
 - (iii) solid waste disposal;
 - (iv) rodent and parasitic infestation;
 - (v) field sanitation;
 - (vi) housing; and

- (vii) other environmental factors related to health; and
- (D) in the case of health centers receiving grants under subsection (g), special occupation-related health services for migratory and seasonal agricultural workers, including--
 - (i) screening for and control of infectious diseases, including parasitic diseases; and
 - (ii) injury prevention programs, including prevention of exposure to unsafe levels of agricultural chemicals including pesticides.

¹⁰ Ibid: “Though there are no specific requirements for staffing mix at FQHCs, these programs are required to have a core staff of full time provider...It is recommended that they maintain a staffing level that allows for between 4,200 - 6,000 visits per year for each full-time equivalent health care provider.”

¹¹ “Healthcare Reform and Rural Health Clinics,” prepared by Healthcare Business Specialists (specializing in Rural Health Clinic reimbursement), April 2010

¹² Excerpts from a Federal comparison of Rural Health Centers and Federally-Qualified Health Centers describe FQHCs as follows (**Source:** “*Comparison of the Rural Health Clinic and Federally Qualified Health Center Programs*”, Revised June 2006; Elizabeth Duke, Ph.D., Administrator, Health Resources & Services Administration, U.S. Department of Health and Human Services):

The term “Federally Qualified Health Center” or FQHC refers to 3 types of primary care clinics or “Health Centers” including those that have applied for, meet the requirements for and have received approval to receive augmented funding under Section 330 of the Public Health Service (PHS) Act as well as those that are FQHC “Look-Alikes” having met the definition of a Section 330 Health Center though they have not applied for Section 330 funding. Outpatient health care centers operated by tribal organizations or urban Indian organizations are also deemed FQHCs though they operate under 2 different legislative authorities.

The FQHC program [enacted under the Omnibus Budget Reconciliation Act of 1989 (OBRA 89) and expanded under the Omnibus Budget Reconciliation Act of 1990 (OBRA 90)] provides for cost-based reimbursement under Medicare and Medicaid for legislatively specified services and as such, is one of the few programs remaining to pay for publicly sponsored health care services in the U.S. under this formula.

The FQHC program was a logical extension of the Community/Migrant Health Center (CHC/MHC) programs enacted in the 1960s and 1970s. The original CHC/MHC programs provided Federal grants to Community Health Centers (CHCs) or Migrant Health Centers (MHCs) for the care of uninsured individuals. These facilities received no special Medicare or Medicaid payments.

¹³ “What is a Health Center?” at the Bureau of Primary Health Care, Health Resources & Services Administration website at <http://bphc.hrsa.gov/about/>

¹⁴ “Comparison of the Rural Health Clinic and Federally Qualified Health Center Programs”, Revised June 2006; Elizabeth Duke, Ph.D., Administrator, Health Resources & Services Administration, U.S. Department of Health and Human Services

¹⁵ From “Critical Connections: Health Centers, America's Health Care Home” on the Bureau of Primary Health Care website at <http://bphc.hrsa.gov/success/criticalconnections.htm>

¹⁶ Uniform Data Set: 2008 Summary Report of Health Center Data, Health Resources & Services Administration, U.S. Department of Health and Human Services; cf. http://www.hrsa.gov/data-statistics/health-center-data/NationalData/2008/2008_national_summary.pdf

¹⁷ From Federally Qualified Health Centers and State Health Policy: A Primer for California by California HealthCare Foundation, July 2009 (prepared by National Academy for State Health Policy)

¹⁸ From “Adding Specialty Services to a California FQHC: Legal and Regulatory Issues, a July 2009 publication of the California HealthCare Foundation (prepared by Regina M. Boyle, JD)

¹⁹ From Federally Qualified Health Centers and State Health Policy: A Primer for California by California HealthCare Foundation, July 2009 (prepared by National Academy for State Health Policy)

²⁰ Ibid

²¹ From “Adding Specialty Services to a California FQHC: Legal and Regulatory Issues, a July 2009 publication of the California HealthCare Foundation (prepared by Regina M. Boyle, JD)

²² From NACHC's website at <http://www.nachc.com/clinicalmedicalhomes.cfm>

²³ The Safety Net Medical Home Initiative at <http://www.qhmedicalhome.org/safety-net/about.cfm>

²⁴ “Accountable care organizations: A new idea for managing Medicare” by Jane Cys, published online at <http://www.ama-assn.org/amednews/2009/08/31/gvsa0831.htm>, August 31, 2009

²⁵ Ibid

²⁶ “Overview of the Accountable Care Organization” can be found on the joint Brookings-Dartmouth ACO Learning Network website at <https://xteam.brookings.edu/bdacoln/Pages/BackgroundInformationonACOs.aspx>

²⁷ “Accountable care organizations: A new idea for managing Medicare” by Jane Cys, published online at <http://www.ama-assn.org/amednews/2009/08/31/gvsa0831.htm>, August 31, 2009

²⁸ Health Resources & Services Administration website at
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²⁹ “Specialty Care in the Safety Net: Efforts to Expand Timely Access,” by the California HealthCare Foundation, May 2009 (prepared by Pacific Health Consulting Group)

³⁰ Kaiser Permanente-California HealthCare Foundation (“KP-CHCF”) Specialty Care Initiative: Summary of Grantee Strategies: [KP-CHCF Specialty Care Initiative Grantee Strategy Summary Sept 30 2009.pdf](#)

³¹ From “A Slippery Slope: Financing Specialty Services in California’s Safety Net,” by Pacific Health Consulting Group, January 2009

³² From the (San Diego) Community Clinics Health Network website at
<http://www.cchealthnetwork.com/services/technical-services-organization---tso.aspx>

³³ Shortell, Stephen et al. “The New World of Managed Care: Creating Organized Delivery Systems” *Health Affairs*, Winter 1994

³⁴ American Recovery and Reinvestment Act (“ARRA”) awarded to FQHCs as follows (Source: California HealthCare Foundation’s publication “The Impact of Federal Stimulus Funds on Community Health Centers in California” July 2009):

- in March 2009, 126 grants totaling US\$155 million for new FQHCs and new sites at existing FQHCs; 1,128 grants totaling US\$338 million to expand services at FQHCs and to serve more patients.
- in July 2009, US\$850 million in formula-based grants were issued for ‘capital improvements’ including construction, renovation, equipment and health IT purchases that can demonstrate access enhancement for the underserved and create jobs; US\$125 million for supplemental grants for health IT/EHR adoption competitive awards and support for individual FQHCs and FQHC-controlled networks; US\$515 million for major capital improvements for facility modernization or equipment installation (without increasing square footage) or square footage expansions via construction.
- Rules are being promulgated for HIT/EHR adoption incentive payments via Medicaid and Medicare using a ‘meaningful use’ set of criteria.

³⁵ From California HealthCare Foundation’s publication “The Impact of Federal Stimulus Funds on Community Health Centers in California,” July 2009

³⁶ From CCHP’s new and still being developed website at: <http://www.connectedhealthca.org>

³⁷ From FQHC Telemedicine Reimbursement Models, Discovery Series of the California Telemedicine and eHealth Center, February 2009

³⁸ From If You Bill It, They Will Come, a Literature Review on Clinical Outcomes, Cost-Effectiveness, and Reimbursement for Telemedicine, a collaborative policy development initiative of the California Telemedicine and eHealth Center, January 2009

³⁹ Ibid

⁴⁰ From Request for Proposal: Specialty Care Safety Net Initiative – Linking UC Specialists with Safety Net Clinics issued by the California Center for Connected Health (now California Center for Connected Health Policy)

⁴¹ “Telemedicine coming to the region,” by Earlexia Norwood, MD; at <http://www.signonsandiego.com/news/2010/feb/04/telemedicine-coming-to-the-region>

⁴² From the Cisco website at http://newsroom.cisco.com/dlls/2010/prod_011510b.html

⁴³ From “Chronic Disease management in the Medi-Cal Program” at <http://www.healthconsumer.org/cs058ChronicDiseaseManagement.pdf> by The Health Consumer Alliance, a partnership of consumer assistance programs operated by community-based legal services organizations to help low-income people obtain essential health care.

⁴⁴ Original Project Dulce partners included: Community Health Improvement Partners; The Whittier Institute for Diabetes; The California Endowment; Physician's Council of Community Clinics; University of California, San Diego School of Medicine Department of Endocrinology; Latino Health Access; San Diego State University Graduate School of Public Health; Johnson & Johnson; Merck; Scripps Health; LifeScan; Kaiser Permanente; Las Patronas; Bristol-Myers Squibb

⁴⁵ From Scripps Whittier Institute for Diabetes website at <http://www.scripps.org/services/diabetes/project-dulce>

⁴⁶ Brief by California HealthCare Foundation regarding California Senate Bill 1448 re: [County Health Care Coverage Initiative by CHCF.pdf](#)

⁴⁷ From <http://www.laclinica.org/modelprog-asthma.html>

⁴⁸ “Understanding Common Reasons for Patient Referrals in Difficult-to-Access Specialties” by California HealthCare Foundation, May 2009 (Prepared by NAS Consulting Services)