Protecting the Health Safety Net:
Models to Help Non-FQHCs Prepare for Health Care Reform Implementation
August 13, 2012

Model	Description	Examples
1. Electronic health records and billing systems that provide for full and efficient billing to multiple partners	Electronic health records systems that include or are linked to electronic billing systems. Full implementation of such a system facilitates billing to Medicaid (fee for service and managed care), Medicare, other public programs, and private insurance companies.	Arlington Pediatric Center, with assistance obtained through Northern Virginia Health Foundation. As part of its capacity building role, the Foundation provides consultants to assist clinics that accept Medicaid and/or third-party reimbursements to improve billing and coding processes. Billing and coding enhancements led to a 45% increase in patient revenue for APC, which provides comprehensive, affordable, quality health care to children through 18 years of age, who live in Arlington County and have family incomes at or below 200% of the federal poverty level.
2. Favorable agreements with Medicaid MCOs, exchange providers, and other health insurers	Safety net providers obtain contracts that make them part of a service delivery network. Since the safety net provider is not receiving direct Medicaid reimbursements, it can negotiate a favorable rate with a Medicaid Managed Care Organization (MCO) or insurance company based on its ability to bring in new clients and improve retention of groups that are hard to serve. The provider usually takes on specific roles in service delivery or support to patients. The safety net provider may be responsible for providing specific services, or for serving specific populations such as the homeless or people living with HIV disease. Some medical insurance providers and	• In Los Angeles, arrangements were made so that all Ryan White HIV/AIDS program providers are becoming certified providers under Healthy Way LA, the county's Low Income Health Program (LIHP) Medicaid demonstration. • In the DC metro area, Kaiser Permanente of the Mid-Atlantic States operates a Community Ambassadors Program that pays the salaries and benefits for nurse practitioners or physician assistants who work in selected safety net clinics.

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	managed care organizations offer other support to safety-net clinics in the form of grants or in-kind assistance.	
3. Joint EHR and billing systems	Several safety net clinics or a network of such clinics develop arrangements for joint billing, using the same electronic health records and billing systems and shared staff or contractors. Safety net clinics often provide a wide range of services and have a complex mix of public and private funding sources with different billing and reporting requirements. This means that systems often need a lot of customization. This can complicate efforts to share systems, but also makes cost sharing especially attractive.	OCHIN, an Oregon nonprofit, is one of the nation's largest health information networks. It provides "a package of Health IT systems that support the activities" of its members, many of them safety net clinics. These include: "the practice management systems that support billing and enrollment functions, electronic health records (EHRs) that support the management of patient information at the point of care, and the various custom interfaces (*e.g.*, labs, radiology, etc.) that OCHIN has created to bring additional information into the EHR in order to create a more comprehensive picture of patient health." Practice management and EHR systems supported include EPIC, AllScripts, and eClinicalWorks. A majority of OCHIN's Board members are the Executive Directors of its member clinics.
4. Affiliation with an FQHC or look-alike	A non-FQHC merges with or establishes an affiliation with an FQHC or look-alike. The affiliation may involve hiring the non-FQHC to provide outreach, navigation, and/or retention services or other specific wrap-around services to a particular population, defined by race/ethnicity or other client factors (for example, homeless, HIV-positive, Latino immigrants).	• Jeanie Schmidt Free Clinic in Herndon is merging with Loudoun Community Health Center (LCHC), which received an Access Point grant from the HRSA Bureau of Primary Health Care in June 2012 that calls for a site in Fairfax County, where Jeanie Schmidt is located; the clinic will be moving to a larger facility in Herndon. • Whitman Walker Health has indicated an interest in contracting with HIV/AIDS

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		providers to provide services such as outreach to particular populations, and is engaged in discussions with several providers.
5. Obtaining of patient-centered medical home (PCMH) status	A safety net clinic obtains certification as a patient-centered medical home (PCMH). A PCMH is a model of health care practice in which a team of health professionals, led by a primary care provider, delivers continuous, comprehensive, culturally and linguistically appropriate, and coordinated care to individual patients and families. The PCMH either provides directly for all of a patient's health care needs or collaborates with other professionals or entities to ensure that these needs are met. Four accrediting bodies using similar standards can certify a provider as a medical home; the National Committee for Quality Assurance (NCQA) is the best known for this role. There are three levels of PCMH recognition; Level 3 is the highest level. Until a few years ago, most PCMHs were private medical practices or practices associated with hospitals. Today, state laws encourage providers to obtain medical home status, a national demonstration led by the Commonwealth Fund is helping six networks of safety net clinics (mostly FQHCs) to become PCMHs, and funders are helping safety net clinics to prepare for and obtain medical home status.	• Of the 24 safety net clinics surveyed for this project, 4 said they are already patient-centered medical homes and 6 are in process; 9 others plan to seek medical home status. • Inova Juniper, a major hospital-linked HIV/AIDS provider in Northern Virginia, has received level 3 PCMH status from NCQA. • Arlington Pediatric Center is in the process of becoming a Level 3 patient-centered medical home, with consultant assistance provided through the Northern Virginia Healthcare Foundation. • Family Medical and Counseling Service and Whitman Walker Health are among clinics pursuing PCMH status through funding from Kaiser Permanente of the Mid-Atlantic States. • Grants for becoming a PCMH: CareFirst made grants in the spring of 2012 to help the following Washington area non-FQHCs become medical homes: - Arlington Free Clinic - Primary Care Coalition of Montgomery County Collaborative, including Holy Cross and Mobile Medical Care - Spanish Catholic Center

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	A growing number of public and private insurers offer enhanced reimbursement rates to PCMHs, with the largest enhancements to Level 3 PCMHs; supplements of $3-$6 per client per month seem typical. Some states do not plan to provide this enhancement to CHCs/FQHCs with PCMH status, arguing that they already receive an enhanced rate due to their status.	
6. Specialization and excellence – particular hard-to-reach or serve population, particular services	A safety net clinic demonstrates very high service quality and the ability to successfully serve particular populations, and this reputation for specialization and/or excellence leads to one or more of the following sustainability-enhancing results: • Insurance companies want them as part of their networks (see #2 above) • FQHCs, hospital-based clinics, or other clinical providers contract with them as part of their medical home networks • Individuals with insurance use their services and generate funds that help them maintain services for the uninsured • PCMH status may be available to some entities; the proposed new medical homes program for specialty practices may offer additional opportunities; NCQA is currently seeking comments on draft standards for the new program	• Planned Parenthood clinics – reproductive health services. Possibility exists for becoming medical homes, since OB/GYNs meet federal requirements as primary care physicians, but PCMHs must provide primary care services to 75% of their clients. One Virginia affiliate has expanded its services and is becoming a PCMH. ACA guarantees women access to an OB/GYN provider without having to wait for a doctor's referral or approval from the insurance company. • The Rose, Houston – a provider of breast health care to women, regardless of ability to pay. The Rose has contracts with hundreds of health insurance plans, and is a provider for Medicaid, Medicare, and Veterans Affairs. “Key to The Rose’s sustainability and uniqueness is that patients who have the ability to pay for

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		services help offset the costs for those who cannot pay."[1]
7. Participation in a "health home" or patient-centered medical home network or related model	Rather than becoming a PCMH, the safety net clinic becomes part of a network that functions as a medical home, or becomes part of a "health home." The Center for Medicare and Medicaid Services (CMS) is providing funding for several types of health homes. Section 2703 of ACA gives states the option of enrolling Medicaid beneficiaries with chronic conditions into a health home that provides comprehensive medical and supportive services. These health homes include a team of health professionals and provide a comprehensive set of medical services as well as care coordination. Another type of health home involves integration of health and behavioral health services. A variety of other innovative models are being funded and tested, largely to provide services to Medicare and/or Medicaid clients. Many provide opportunities for the participation of safety net clinics, behavioral health organizations, and in some cases support service providers.	• Chronic care health home networks being established in New York, including medical, mental health, and social services safety net providers; state has demonstration funds from CMS. • In North Carolina, the Office of Rural Health and Community Care (ORHCC) has established Medicaid managed care enhanced primary care coordination model called Community Care of North Carolina (CCNC). Safety net providers receive monthly capitation payments in addition to fees for service to coordinate care. Such payments are available to cover disease management, care coordination, costs of clinical directors, pharmacists, psychiatrists/behavioral health, quality improvement, and informatics/data/ software. Entities such as free clinics and school-based clinics are included. The related HealthNet program provides funding for CCNC networks to help them cover uninsured individuals based largely on donated care. • The 2012-2014 comprehensive HIV/AIDS care plan for the DC metropolitan area under the Ryan White Part A program

[1] See The Rose's 2010-2011 Fact Sheet, http://www.the-rose.org/TheRoseFacts2010-2011Official.pdf

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		calls for exploration of a medical homes model to provide coordinated care for people living with HIV disease once health care reform is implemented.
8. Obtaining of FQHC or FQHC look-alike status	Safety net clinics obtain designation from the DHHS Bureau of Primary Health Care (BPHC) as an FQHC or FQHC look-alike. The Bureau of Primary Health Care (BPHC) within the Health Resources and Services Administration (HRSA) has provided several rounds of competitive grants to help establish new FQHCs and add access points for services, in order to increase primary care capacity under health care reform. A major benefit of FQHC status is an enhanced Medicaid or Medicare reimbursement rate. Companies that participate in a health insurance exchange must provide the same enhanced rate to FQHCs. Other benefits include access to lower cost drugs and federal grant funds. FQHC look-alikes get the enhanced reimbursement rate but are not eligible for grants or some of the other FQHC benefits.	• **FQHC:** Family Medical and Counseling Service has been designated an FQHC through an Access Point grant from BPHC, announced June 2012. • **Planning:** Bread for the City, Carl Vogel Center, and Mobile Medical Care received FQHC planning grants on September 15, 2011.
9. Transition to acceptance of third-party reimbursements	Safety net clinics that have operated as free clinics, or as other nonprofit or public clinics that have not previously accepted third party reimbursements (or for DC clinics, accepted only DC Healthcare Alliance payments), decide to accept third-party reimbursements (e.g., Medicaid, Medicare, and/or private health insurance) for the first time. There is no	• Several safety net clinics that have not previously accepted Medicaid, Medicare, or private insurance, including the Spanish Catholic Center (SCC), are considering obtaining Medicaid certification. SCC has indicated that if it decides to become Medicaid-certified, it will limit the proportion of Medicaid patients to ensure

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	single accepted definition of a free clinic, but it is usually described as a volunteer-based, safety net health care organization that provides a range of medical and related health services to economically disadvantaged individuals who are usually uninsured. Free clinics are generally nonprofit, tax-exempt organizations or are affiliated with such an organization (sometimes a religious entity). Some free clinics charge a nominal fee or ask for donations, but they deliver services regardless of the patient's ability to pay. Some free clinic associations (including the Virginia Association of Free Clinics) do not accept as members clinics that accept third-party reimbursements. Once a free clinic accepts third-party reimbursements, it loses access to medical malpractice liability protection under the Federal Tort Claims Act. Such coverage was extended under ACA to include not only volunteers but also paid staff, volunteers, Board members, and contractors. This is an important consideration for some free clinics. There is reportedly discussion in Virginia about maintaining partial eligibility for malpractice protection to volunteers within some free clinics that begin to accept third party payments, under certain specified conditions.	that continued services are available to low-income clients not eligible for Medicaid. • Health department clinics in Maryland, including the Dennis Avenue Clinic in Montgomery County and the Cheverly Clinic in Prince George's County, are in transition to accept third-party reimbursements.