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States, Primary Care and Health Centers: Fostering Delivery System Changes

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Introduction

In the wake of the passage of the Patient Protection and Affordable Care Act (ACA), states are grappling with challenges in implementing the law's major provisions. In addition to developing state strategies related to Medicaid expansion and health insurance benefit exchanges, a critical area of focus is on health care delivery system reform and efforts to foster integrated delivery system models centered on primary care and comprehensive coordinated care.

Across states, health centers are engaged as a part of these evolving health care delivery system reforms. (For purposes of this paper, unless otherwise specified, "health center" will be used as a general term to refer to Section 330 grantees, Look-Alikes (LAL) and Federally Qualified Health Center's (FQHC) collectively).[1] Since 2006, the federal Health Resources and Services Administration (HRSA) provided support for effective engagement of health centers in state health reform implementation through its National Cooperative Agreement (NCA) between the National Academy for State Health Policy (NASHP) and the HRSA Bureau of Primary Health Care (BPHC).

In 2010, shortly after passage of the ACA, NASHP convened state teams of primary care associations and offices, state officials serving in its Academy, key national and federal partners, and other experts to discuss the role of FQHCs in health care delivery reform efforts. NASHP published a summary report in early 2011 titled *Re-Forming Health Care Delivery Systems: A Summary of a forum for States and Health Centers* (available at http://www.nashp.org). The report profiled state and community models and approaches to achieving a common vision for delivery system reform and highlighted key policymaker and health center challenges and promising strategies for change. Recommendations from the 2010 forum called for ongoing dialogue among policymakers and health centers to explore issues in more depth as ACA implementation unfolds.

On June 8 and 9, 2011, NASHP convened another primary care forum, *Constructing a Mile High Integrated Delivery System for Vulnerable Populations: A Forum for State Policymakers and Health Center Partners,* in Denver, Colorado. The event again brought together state officials, state health policy and primary care teams and key partners to learn from Colorado's efforts and to further examine key issues and considerations in system reform for state policymakers and program administrators, primary care associations and health centers, and vulnerable populations. Using Colorado as a targeted case study, the agenda (see appendix) fostered shared learning and in-depth discussion. Dialogue focused on key issues and infrastructure challenges for states and health centers to support effective health care for vulnerable populations as part of a new health policy environment.

Participants in the 2011 forum included primary care teams from five states participating in the HRSA NCA (Missouri, New Mexico, Oregon, Rhode Island, Tennessee), representatives from two alumni teams (Hawaii, Massachusetts) and NASHP Academy Advisors from four states. National partners included the National Association of Community Health Centers (NACHC) and the Association of State and Territorial Health Officials (ASTHO), as well as HRSA and the Centers for Medicare and Medicaid Services (CMS). Leaders from Colorado's public agencies, safety net provider systems, health information technology organizations and health reform initiatives also participated, offering presentations to spur shared learning about Colorado and other state approaches on key issues. The appendix provides a full participant list.

NASHP provided background materials that helped frame discussions during the 2011 forum. These resources provide a backdrop for the findings that are summarized in this brief:

- The 2010 forum report *Re-Forming Health Care Delivery Systems: A Summary of a Forum for States and Health Centers* framed emerging delivery system and state and health center workforce policy issues following the passage of the ACA.
- *On the Road to Better Value: State Roles in Promoting Accountable Care Organizations*, a February 2011 NASHP report highlighting state efforts in supporting development of the accountable care model, pointing to areas for continued innovation.
- An unpublished NASHP synthesis of interviews with states, safety net systems and national organizations about challenges for the safety net with integrated delivery systems. This synthesis will be published in 2011 as a blog of The Commonwealth Fund.

This report from the 2011 forum frames a set of key issues and provides findings and recommendations that emerged from discussion among the participants. These are organized to include:

- An overview of how delivery system reforms are evolving across forum participants' states, profiling Colorado and highlighting key variables about health center participation in state delivery system reform efforts.
- An examination of two key implementation issues and infrastructure challenges—payment reforms and building data and information technology supports—considered crucial for ongoing development of robust integrated delivery system models with health center and other safety net provider involvement.
- Key themes and supports needed to foster continued evolution in delivery system models effectively involving integrated care and safety net systems.

State Strategies to Foster Integrated Health Care Systems

Interested in promoting better value in health care spending, many states are exploring new approaches for organizing and paying for health care services. Ongoing state economic constraints have increased the urgency for accomplishing delivery system changes to ensure access to affordable and necessary health care services, especially in the context of the ACA and impending Medicaid expansions. There are concerns about ensuring current and newly eligible populations, as well as the uninsured, have access to needed health care services that typically have been provided by safety net providers i.e., FQHCs and others.

Passage of the ACA created new opportunities, including federal resources and leadership through the Center for Medicare and Medicaid Innovation (Innovation Center), for states and providers to develop and test pilot programs for delivery system changes. Recognizing that there are different levels and incremental approaches being taken, delivery system changes termed "integrated care" or "accountable care," have common features that include:

- A focus on primary care and promoting integrated, organized processes for delivering coordinated services that meet the highest quality and efficiency standards;
- Payment reform; and
- Performance measurements that rely on timely and accurate data to promote organizational accountability for quality and costs of care for a defined population.[2]

Some states have been leaders in developing health care delivery system reforms, and many are in the early stages of their efforts. State strategies to foster the movement to integrated health care delivery systems are taking various forms, spanning Medicaid and multi-payer medical home pilot programs to broader, value-based purchasing initiatives.[3] As early case studies reveal, there are several core issues that must be addressed as part of a state's strategy to foster more integrated delivery systems of care. These issues, with implications for both states and their safety net providers serving vulnerable populations, include:

- Defining new care delivery models that will serve state populations, such as health or medical home models, or accountable or coordinated care organizations;
- Structuring contract terms e.g. for provider participation and populations that must be served, defining the service areas and what providers and services will be part of networks;
- Setting timeframes for organizing, implementing and demonstrating results;
- Defining system and program performance assessment metrics and required data reporting; and
- Establishing payment methodology, potentially including levels of shared savings and risks.

Lessons Learned from One State's Strategy and Early Implementation Efforts

Before the passage of the ACA, Colorado's Medicaid program took action to implement a health care delivery system reform strategy. Unlike other states with robust Medicaid managed care contracting programs, Colorado's Medicaid managed care initiatives had a troubled history. A risk-based capitation program was launched in the late 1990's with several participating health maintenance organization (HMO) plans, but largely abandoned by the state 10 years later. Colorado Access, still serving Medicaid clients under different terms, was one of the participating Medicaid managed care plans, offering FQHCs as part of its network through its corporate partner, the Colorado Community Managed Care Network (CCMCN);

CCMCN was formed in 1997 to organize FQHCs to participate in Medicaid risk-based capitation contracts.

By 2007, Colorado faced unprecedented economic constraints, the highest expenditures and caseload in the state's Medicaid history, with 85 percent of Medicaid beneficiaries served under unmanaged fee-for-service (FFS) arrangements. Under a new administration, Colorado's Medicaid agency, the Department of Health Care Policy and Financing (HCPF), formulated the Accountable Care Collaborative Program (ACC Program). The ACC Program built upon then-Governor Bill Ritter's agenda for delivery system reform, collected extensive stakeholder input by various means, and leveraged a newly established budgetary initiative, the Medicaid Value-Based Care Coordination Initiative. The ACC program is a strategy to transform Colorado's health care delivery system from a traditional fee-for-service model to a regional, outcomes-focused, patient centered, coordinated system of care for Medicaid clients. The ACC Program relies on three major components that include Regional Collaborative Care Organizations (RCCOs), networks of primary care medical providers (PCMPs) and data analysis support from a contracted Statewide Data and Analytics Contractor (SDAC).

Table 1 – Components of the Colorado Accountable Care Collaborative Program

	Regional Care Collaboratives (RCCOs)	**Primary Care Medical Providers (PCMPs)**	**Statewide Data and Analytics Contractor (SDAC)**
Accountability	Demonstrate cost and quality outcomes	Provide comprehensive care coordination that is client and family centered	Information supports to foster RCCO accountability and continuous improvement
Core Functions	Ensure comprehensive care coordination and a medical home level of care for every member	Medical management	Maintain data repository
	Network management • Formal contracts with PCMPs • Virtual network of specialists/ancillaries	Utilization management	Data analytics and reporting
	Provider support • Administration • Practice supports • Data/web access	Member empowerment	Web portal and access

To structure and launch the ACC Program, HCPF faced several significant challenges. A primary concern was establishing a financing strategy and obtaining authorization from the state legislature to start and sustain the program, given severe state budget constraints. The legislature approved a budget request that called for starting the ACC Program with state funds on a pilot basis to demonstrate proof of con-

cept and budget neutrality. The plan called for expanding the Program by July 2012 based on successfully achieving program savings to meet budget neutrality goals. However, as part of budget cuts, expectations for enrollment during the pilot phase were doubled to help meet savings targets. To gain stakeholder support and minimize association of the ACC Program with past attempts at capitation in Medicaid managed care, a payment methodology was structured to use a combination of fee-for-service, case management per member per month payments (PMPM) and incentive payments.

Given the urgency for moving forward, HCPF chose a strategy that did not involve obtaining a federal waiver but relied on voluntary enrollment. The agency analyzed its Medicaid client populations and providers and considered various ways to structure service delivery areas and contracting options; it then launched the ACC Program, relying on contracting with RCCOs to serve Medicaid clients throughout the state.

Through a Request for Proposal (RFP) process, the state selected a RCCO for each of the regions identified. In the requirements outlined in the RFP, HCPF chose not to be prescriptive about the RCCO models and how they would ensure care coordination. The agency worked closely with the CMS regional office to seek approval for the information that would be provided to clients about the ACC Program and their option to voluntarily enroll in a RCCO.

The requests for proposals for RCCO and SDAC participation were released in August and September of 2010, and contracts were awarded by the end of January 2011 for a program launch in May 2011. In summary form, the various features of the Colorado ACC Program are outlined below.

Table 2 – Colorado Accountable Care Collaborative Program – Key Features

Feature	Description
Authority	• Colorado legislative budget request to fund PMPM payments • CMS Regional approval for information to be provided to Medicaid clients • No waiver requested based on client enrollment being voluntary • State Medicaid Plan updated
Structured Participation	• State divided into 7 Regions • 7 RCCOs, one per region under contract to the Medicaid agency • Voluntary enrollment of Medicaid clients into ACC Program and patients can opt-out • RCCO Provider networks variable by RCCO • RCCOs required to engage diverse providers (but no prescribed hospital-physician relationship)
Financing	• Federal funding via Federal Medical Assistance Percentage (FMAP): Medicaid Management Information System (MMIS) and PMPM payments • State fund investment for initial provider and RCCO PMPM payments • Expectations for budget savings in first 12 months (RCCOs expand enrollment, achieve savings)

Feature	Description
Payment/ Incentives	• Medicaid pays PCMPs FFS for medical services • Medicaid pays PCMPs a PMPM payment for medical home services • Medicaid pays PMPM payment to RCCOs for PCMP support and accountability for client health and program costs • Incentive pool created with $2 ($1 from RCCO, $1 from PCMP) withhold from PMPM payments beginning after pilot phase
Stakeholder Engagement	• ACC Program to have Improvement Advisory Committee, and Medical Management Oversight Advisory Committee • Each RCCO to have Performance Advisory Committee • SDAC to have Operations Advisory Committee
Phases/ Timeframe	• Initial phase to test program concept: Each RCCO identifies and launches in one focus community and doubles enrollment in six months to meet program budget savings targets • Second phase after budget neutrality goals attained: RCCO expands to entire regional RCCO service area (July 2012)
Performance	• With SDAC-provided data, RCCOs identify unique members (attribution) • First year performance measures include monthly SDAC calculation of emergency room (ER)visits, hospital readmissions, high cost imaging (3 utilization measures in first year, easy to calculate) • Subsequent years reporting includes expanded utilization, quality and outcome measures

Colorado RCCO Implementation and Health Centers

Like many states, Colorado's broad network of health centers consists of FQHCs and other types of health centers that vary in size, scale and levels of sophistication. Colorado health centers have a longstanding record of progress in building new care models that are the foundation for integrated care systems, having benefitted from federal initiatives, philanthropic support for capacity development, and internal investment strategies. Notably, Colorado FQHCs participated in HRSA BPHC quality improvement initiatives for primary care redesign. Many health centers have moved forward to implement medical home models, including integration of physical and behavioral care; they also are advanced in their efforts to adopt electronic health records (EHRs) and meet federal "meaningful use" requirements. In certain rural and frontier areas of the state, there are centers that defy stereotypes about rural clinic capacity; for example, certain clinics serve very small client populations, yet have advanced electronic health information and telemedicine systems.

Overall, these circumstances have positioned Colorado health centers to be more ready than perhaps other private providers to respond positively to the Colorado ACC Program. Led by their member organization, the Colorado Community Health Center Network (CCHN), health centers have taken an active role in analyzing

the implications of the ACC Program, providing input on program design and implementation, and helping health centers transition to the shared risks and savings accountable care model.

During the forum, CCHN reported that upon launch of the ACC program, its members initially feared the negative impact of the RCCOs on health center operations and sustainability. A particular concern focused on the risk of undermining the managed care services and business model of Colorado Access. Colorado Access is a Medicaid managed care plan currently contracting with HCPF; Colorado Access includes a group of FQHCs, the Colorado Community Managed Care Network, as a corporate partner. Other health center concerns included whether RCCO service regions would make sense for health centers and enable them to participate and whether the provisions of the RCCO program would result in a loss of local control—a fear that new ACC entities would be controlled by large companies that would siphon off patients or savings.

According to CCHN and health center participants in the forum, these early concerns have not materialized. Pointing to a strong level of commitment among Colorado health centers to the principles of the ACC Program for fostering integrated delivery systems, CCHN observed that Colorado health centers see themselves as key partners in the potential success of the Colorado Medicaid RCCO strategy. They have leveraged various opportunities for ACC Program participation, including serving as providers in several RCCOs, participating on the HCPF advisory committee and creating and owning a new RCCO entity.

Colorado health centers are eager to participate in a shared risk and savings arrangement, and appreciate being accountable for demonstrating performance results to serve Medicaid goals. However, they also recognize there are great risks for health centers as well as the state if the RCCO program does not achieve its implementation targets. Key issues and interdependencies that were identified during forum discussion include:

- The timing for demonstrating performance to meet legislative budget requirements and RCCO and ACC Program savings expectations remains a serious business challenge. Health centers worry that not meeting a target for savings within 12 months could trigger a legislative demand for mandatory enrollment and contracting strategies based on awards to the lowest bidder; this would disadvantage them, favor large systems, and represent a loss of flexibility and opportunity for health centers.
- Health centers must be able to carefully count patients as their own to assure attribution and demonstrate performance. The policy of voluntary RCCO enrollment presents challenges to meeting enrollment attribution targets within prescribed timeframes. Also, there are significant data issues and challenges to accurately match Medicaid enrollees with a particular health center providing primary care as part of a RCCO in a timely manner.
- Certain health centers have sites in multiple RCCO regions. While health centers have internal data from their electronic health record systems, they need additional data about what happens when their patients access care from other systems, such as hospital emergency rooms, to calculate performance measures. This requires building new data sharing business relationships.
- There are challenges for rural health centers to build RCCO network relationships. Some rural providers, while very sophisticated, have smaller patient panels that make PMPM payment strategies more difficult to work financially.

- An inherent challenge for health centers is working out the on-the-ground relationships with other providers in all of their participating communities to be able to manage up versus downside risk. It takes time to negotiate this alignment of performance and payment incentives as part of RCCO participation; however, accomplishing it is a key dimension of program sustainability.

Comparisons and Contrasts Across States – State Policy Considerations

In comparing other states' experiences to Colorado's, it becomes clear that market characteristics, experience with managed care, and health policy approaches influence the scope and specifics of current delivery system reform efforts. In certain states like Tennessee, Medicaid managed care and Medicaid managed care organizations (MCOs) are predominant. In Tennessee, discussions about fostering accountable care organizations (ACOs) are not active at this point, although promoting a medical home model integrating behavioral and primary health care as part of managed care plans has been a priority. In the Northwest, Oregon and Washington have both reorganized state government to support effective health care purchasing functions. They each have well-established managed care environments, yet are revamping their health care purchasing strategies to advance the movement to integrated delivery systems.

Health centers are incorporated into states' health care delivery system reform strategies to varying degrees. Oregon has longstanding adoption of medical homes, and is now moving toward a statewide ACO legislative strategy that will address governance requirements for ACOs to ensure that they serve Medicaid and vulnerable populations, involving health centers as providers. In Washington state, policymakers are looking to implement broad integration strategies across public and commercial markets, including community-based strategies to serve Medicaid and other vulnerable populations, drawing upon health centers. Massachusetts built upon health centers serving vulnerable and uninsured populations as part of health care reforms to provide prevention, education, and other population specific supports as part of health coverage offered through the health insurance exchange. Many states are looking to health centers to foster the integration of physical services with behavioral and other social services.[4]

Discussion among forum participants identified the following variables and considerations for achieving effective reforms that will benefit vulnerable populations and support the health center providers that serve them.

Table 3 – Key Policy Design Decisions and Considerations

Policy Design Decisions	Considerations
Being strategic to align policy goals for system changes with the characteristics and readiness of the statewide health care environment	• Differences in strategy need to be considered for highly managed versus unmanaged health care environments and public programs. • There are benefits from structuring state policy levers to foster integration across both public and commercial payers. Key factors to consider include: 1) the history and maturity of integrated care strategies to date; 2) approaches such as defining different levels and types of health homes i.e., "secondary health home" for social services; and 3) opportunities to set state policy goals and system performance targets that will accelerate delivery system changes (i.e., Washington state's policy goal to limit its health care cost growth trend to four percent annually).

Policy Design Decisions	Considerations
Distinguishing integrated delivery system models from managed care	• Purposeful principles and strategies need to be articulated to ensure that key principles of integrated delivery systems are served. • Communication strategies are important to articulate the purposes and advantages of integrated care systems, and to make clear differences between integrated care strategies and certain managed care practices. This is especially important if past negative experiences with managed care approaches exist.
Structuring accountability requirements to ensure that vulnerable populations are adequately served by integrated delivery systems	• An option to ensure that integrated delivery systems are accountable to serving the needs of vulnerable populations is to structure requirements for involving consumers and other key stakeholders as part of integrated delivery system governance bodies and advisory groups. • Requirements—more or less prescriptive—can be established to foster the inclusion of certain types of providers and services as part of integrated care system provider networks.
Defining a data strategy for consistent and effective performance measures and data analysis	• It is important not to create additional levels of variation or complexity for providers and health plans. States need to strive for consistency in the development of measurement systems and align performance measures with those for commercial payers. • Establishing an insurance exchange and the process of determining criteria for Qualified Health Plans (QHP), as provided for in the ACA, provides opportunities for states to foster integrated care strategies, including networks that serve vulnerable populations and include the safety net. • A data strategy – defining performance measures, data reporting requirements, and provisions for timely data analysis – needs to include ongoing processes to work with program participants to foster data capacity.
Developing risk adjustment methods that reflect the complex psychosocial and health characteristics of vulnerable populations.	• For performance-based payment strategies to be optimally effective, mechanisms are needed to account for and adjust payments based on care required by populations with complex psychosocial characteristics, beyond medical conditions. • Without effective risk adjustment, performance-based payment strategies run the risk of exacerbating health disparities, and compromising the positive impact of exchanges on the insurance marketplace.

Policy Design Decisions	Considerations
Structuring policy requirements to ensure the levels of participation required to achieve scale and system economics (Voluntary versus mandatory enrollment)	• Trade-offs between mandates and voluntary strategies to grow accountable care program participation need to be considered. • Voluntary enrollment may slow down enrollment, but can reduce resistance to a new strategy. Without taking into account the start-up time required under a voluntary strategy, challenges to adequately track attribution and achieve enrollment numbers may disadvantage health centers in meeting ACO performance and payment targets. • Applying for a waiver to allow mandatory enrollment is an alternative that can enable a more robust enrollment strategy but is more complex and time consuming.
Managing expectations for savings and returns on investment (ROI)	• It is critical that states have the conversation about where there is and is not value in the current health care system in order to consider where and how to set savings and performance targets that will result in significant system changes. • Providers need to be involved in developing value-based strategies versus being in a reactive position and being asked to absorb flat rate cuts. • There are understandable pressures for short-term savings versus longer-term results from delivery system reforms. Strategically, short-term "wins" from new integrated care programs need to be promoted. However, it is most productive to advocate for measuring return on investment (ROI), and channeling program savings into further investments to advance delivery system reforms.
Supporting delivery system redesign by prioritizing change management supports.	• Many levels of system redesign are at play. Health centers have to develop and manage relationships, expectations and process changes at the ground level in order to achieve effective operational alignment of incentives and practices. • As the pace and progress of provider EHR adoption efforts demonstrate, achieving changes in health care processes, roles, and use of resources requires dedicated time and attention. • Redesigning information systems and IT supports under the Health Information Technology for Economic and Clinical Health provisions (HITECH) and under the ACA (to support the role of exchanges and Medicaid programs) requires explicit attention to change management: the time, training and culture change required by Medicaid clients, providers and organizations.

Both states and health centers see important opportunities for health centers to participate as part of integrated care networks serving key populations, including those newly eligible for Medicaid under the ACA. The ACA establishes a new context for the continued development of integrated delivery systems. It creates new roles within each state's health insurance system for either a state or federally-run health insurance exchange and raises questions about how providers serving Medicaid-CHIP populations will be involved in exchange contracting strategies. For example, the ACA provisions for qualifying health plans and definition of benefit plans provide options for states to consider how health centers and coordinated medical and social supports will be part of coverage obtained through an exchange.

However, certain factors are key for integrated delivery systems to realize their potential as part of state reform strategies, and for health centers to successfully navigate these new practice environments. The 2011 forum participants focused their discussion on two critical priorities:

- Implementing new payment methodologies to create incentives for the delivery of high-value health care services, and
- Building IT supports to ensure the timely availability of data and information sharing that is critical to achieve the benefits of integrated care through methods including actively engaging clients and fostering and rewarding high-value providers and systems.

Payment Reform, Integrated Care Strategies and Safety Net Providers

As forum participants observed, the health care environment is responding to the ACA and the movement to integrated delivery systems. Providers themselves are pursuing a variety of new network relationships, such as hospitals acquiring primary care practices. Broadly, changes are being called for across the health care marketplace to move from FFS to other payment structures that reward quality and outcomes over volume of services.

The ACA calls for simultaneous and multifaceted changes to insurance coverage, financing, and the health care delivery system designed to achieve the triple aims of health reform: improving the experience of care, influencing the health of populations and containing the per-capita cost of health care services. Framing the discussion about accountable care strategies, health centers and payment reform, Colorado managed care leader Marshall Thomas reflected upon the results of payment methodologies that have allocated resources across providers without an alignment of shared accountabilities for common goals and outcomes. He emphasized that achieving the triple aim ideal requires establishing effective partnerships, redesigning primary care delivery, targeting prevention and health promotion and controlling costs. Here especially, the relationships between providers are a key factor.

Dr. Thomas remarked that FQHCs have historically been more integrated and progressive than many private provider systems and cushioned from certain negative aspects of traditional fee-for-service by their Prospective Payment System reimbursement (PPS) and other funding. However, while FQHCs have been able to demonstrate more system-based processes of care and deliver better outcomes for lower costs, they have not necessarily been focused on tracking costs for patient populations in the way that will be required to demonstrate the success of the Colorado ACC Program. Dr. Thomas sees important benefits for FQHCs participating in integrated care systems. These include broader access to specialist services from participation in larger medical networks, access to patient panel cost and outcomes data and addi-

tional incentives for demonstrating savings. However, the challenges mirror these advantages. Integrating with larger systems can bring competition for patients. Payment systems and financial management must adjust to accommodate the interaction of PPS and forms of bundled or capitated payments. Information systems must be adequate to capture data, generate reports of quality and utilization metrics, and support performance measurement beyond the usual boundaries of services provided directly by a health center.

Colorado's ACC Program Payment Structure and Health Center Implications

The Colorado ACC program has been established with an initial investment of general fund dollars (to be matched with federal funds), with the expectation that this will be offset by savings to result in overall budget neutrality.

Table 4 – ACC Program Milestones

	Phase One Pilot Launch (May 2011)	Monthly	Quarterly	6 Months	2012 Program Expansion
Reporting	Passive enrollment begins in targeted focus communities (7 regions statewide)	SDAC calculates simple utilization measures for each region	SDAC calculates overall cost savings	Enrollment doubled (from 60,000 to 123,000)	123,000 clients enrolled; Savings targets met

Table 5 – ACC Payment Milestones

	Accountability	Monthly Payment	Year 1 Expansion Phase	Year 2
RCCOs	• Total costs of care per member • Support to PCMPs • Improved health outcomes	• PMPM payments per enrollee	• SDAC calculates RCCO performance on key utilization/ cost and outcome measures	• Incentive payment withholds begin ($1 from PMPM payment) • RCCO incentive payments based on meeting cost and outcome targets established collaboratively between the RCCOs and HCPF

	Accountability	Monthly Payment	Year 1 Expansion Phase	Year 2
PCMPs	• Focal point of care for clients • Provide comprehensive and coordinated primary care	• PMPM payments • Medical home incentive payments begin • FFS/medical services		• Incentive payment withholds begin ($2 from PMPM payment) • Incentives distributed to PCMPs based on regional performance toward cost and outcome measures

The time table for demonstrating the success of the ACC Program in terms of achieving savings is quite aggressive, therefore both HCPF and health centers face pressures to rapidly implement and demonstrate success with the RCCO program to meet legislative expectations.

As a current case study, Clinica Campesina (Clinica) highlights the challenges for an FQHC to now participate as part of the state's Medicaid integrated delivery system strategy. Clinica is a Colorado FQHC that is nationally recognized for its care model. Beginning with participation in the BPHC quality improvement initiative, the Clinica enterprise made a major commitment to redesigning its processes of care and operating a health home model for the delivery of services, having achieved recognition by the National Committee on Quality Assurance (NCQA) as a level 3 Primary Care Medical Home (PCMH). Clinica reports that despite the fact that Medicaid reimbursement did not support its system investments, Clinica has had success in managing its financial position, leveraging revenue streams to support its investments in capacity and service expansions that are part of Clinica's medical home care system. However, because of current state budget cuts and major payment reductions to providers, Clinica's FQHC payment rate is below its costs; the additional incentive of up to $4 PMPM becomes a critical component for sustaining Clinica's current delivery system and financing model. Clinica's Board has agreed to draw on its reserves to support the basic operating costs of its medical home care model as the ACC program is implemented, anticipating that it can continue this subsidization for up to two years. This is based on confidence that Clinica saves the state in avoided hospitalizations, specialty care, drugs and emergency room use, However, from a financial perspective, it is imperative for Clinica to receive timely payment for having achieved performance objectives under the parameters of the ACC Program to break even and support this care system. If the Colorado ACC Program experiences delays in making performance-based payments as projected, Clinica reports that it would have to dismantle its medical home model that currently includes behavioral health, care management, IT supports and other features and revert to a more limited model of primary care.

Integrated System Financing, Payment Structures and Health Center Financial Viability

Despite differences in approaches and timing for delivery system reforms playing out across states, forum participants – state agencies, primary care offices and associations and health centers – identified a common set of issues and concerns about achieving effective payment reforms to support the development of integrated care systems serving vulnerable populations. Forum discussions pointed to several key implementation challenges that must be addressed to structure types of payment that will help health centers survive and thrive in a new policy context. These emerging challenges include:

- Understanding the appropriate rates to adequately support medical homes.
- Setting the right standards and incentives to encourage care teams to make a true shift to a new care model. An example highlighted was the potential for new contracting approaches to encourage the movement to integrated networks among very small provider practices. Network standards for serving Medicaid clients as part of an integrated care strategy could be set to require levels of care management services that would motivate one and two person small practices to explore new integrated care delivery relationships and processes of care in order to participate.
- Having timely data and feedback to understand performance and manage risk. For example, performance measures about ER visits and hospitalizations require more timely data than claims data. Making this data available is a goal of health information technology (HIT) and investments in health information networks for more robust health information exchange (HIE) among providers. These are capacity building efforts that may need to be prioritized and accelerated.
- Accounting for the time to build capacity to scale, including mobilizing infrastructure investments and allowing for marketplace flexibility, such as through subcontracting arrangements.

An important issue is what will happen with savings achieved through delivery system reforms, as well as what challenges exist in ensuring that the savings are distributed in a fair manner among various provider subtypes in health delivery systems. For instance, reform savings could come out of the health care system, revert to the state general fund for other purposes, or remain with the Medicaid agency to reinvest in program support and enhancement. Forum participants stressed the importance of allowing a successful value-based purchasing program, such as the Colorado ACC Program, to keep its savings for reinvestment in program enhancements and sustainability. Especially with current state budget constraints, publicly-funded providers serving vulnerable populations critically need to reinvest savings in services and system enhancements that support coordinated care for their clients. A related example is long term care. A policy priority to move people out of nursing homes has to be coupled with additional investments in home and community-based services and information supports in order for these providers to maintain timely records and monitor patient status. The overall savings from such a program of aging services are not immediate but accrue over a longer term, based on reinvesting in alternate ways to purchase services.

Because state health budgets rely on blended state and federal financing streams, the extent to which states have leveraged their state resources to draw matching funds is a factor in where and how states look to make budget cuts. Past efforts to use mechanisms like hospital taxes have allowed states to leverage federal funds and channel resources back to providers. However, because of the depth of budget cuts now being required, more difficult conversations are in store about reducing costs where value is not being generated.

In this context, health centers face challenges to understand and demonstrate their value in new ways, including how the current PPS plays an ongoing role in the evolving new health care environment. FQHCs operate under PPS as a distinct prospective payment structure supporting care of vulnerable populations. Rob Kidney, with the National Association of Community Health Centers (NACHC), emphasized that the PPS was established by Congress with the intent of ensuring appropriate payment for Medicaid-covered individuals so that health centers would not be cross-subsidizing Medicaid-related costs with federal grant funds. PPS is a bundled payment that covers the cost of care, care management and enabling services and is paid on an encounter basis. Kidney pointed to PPS as a reform model noting several factors. PPS improves upon open-ended fee-for-service payments with rates that are set prospectively factoring in growth limits, and uniquely set based on each Center's costs and scope. PPS is effectively risk-based (if patients need more care it is furnished but at no additional cost) and in essence, PPS serves as performance and accountability-based reimbursement due to the role HRSA plays in holding health centers to standards of performance.

Primary Care Association (PCA) leaders and other forum participants emphasized the critical role of PPS payments for covering "enabling services" beyond care management—services like child care, eligibility assistance, health education, interpretation and translation, outreach, transportation and supportive counseling services. These enabling services address non-clinical, psychosocial issues that are critical barriers to health among health center populations. The elements of care that health centers provide as part of enabling services are not well captured in typical data systems; this makes it difficult to clearly demonstrate their value. However, Craig Hostetler, with Oregon's PCA, emphasized that even as long ago as 2000, a national Relative Value Unit (RVU) study validated by the Medical Group Management Association (MGMA) comparing enabling and medical services in average FQHC visits found that more than 50 percent of the RVU in Oregon FQHCs was attributed to enabling services.

Key stakeholders have conflicting views about PPS moving forward—some perceive that PPS has a lack of flexibility and does not allow a level playing field for providers, or even for safety net providers. However, PPS also is seen by many as essential for FQHCs, which have patient populations that are on average sicker than those seen by other outpatient providers, and who are required by statute to provide a broader range of services than traditional providers to both Medicaid patients and the large number of uninsured these health centers serve. As part of her comments, Polly Anderson, with the Colorado Community Health Network, summarized the challenges related to PPS as threefold: first, the continued importance of protecting funding for the uninsured from Medicaid underpayment; second the ROI for paying PPS which is there, but needs to be demonstrated; and third, how to balance the requirement to pay PPS in the move toward transparency and quality payments.

Under state reforms such as those in Colorado, health centers may now participate as part of integrated networks with non-health center providers, requiring health centers to navigate new business relationships as part of preserving and enhancing financial viability. As they become part of innovative integrated delivery system networks, FQHCs are called upon to build on their experiences in managing high risk populations, and apply these lessons learned to more competitive and complex financial scenarios. Adding to the urgency of the challenges is the evolving relationship of health centers with commercial health plans as part of insurance marketplaces that will be mediated by insurance exchanges created under the ACA.

Pending final rules, the interpretation of the ACA requirements regarding health center participation and payment as part of qualified health plans (QHPs) offered through an exchange is unsettled. The stated intent in proposed rules is to afford states discretion in how exchanges operate, and to give deference to QHPs regarding the nature of their provider networks. Under proposed rules, HHS requires QHPs participating in an exchange to include in the QHP provider network a sufficient number of essential community providers, where available, that serve predominately low-income, medically-underserved individuals.[5]

Regarding payment, HHS indicates that the ACA has conflicting provisions related to requirements to pay FQHCs PPS versus generally applicable payment rates of a plan. Different approaches are being considered to resolve this conflict. Meanwhile, forum participants emphasized the importance for states and health centers to explore ways to encourage health plans that may participate in the exchanges to include health centers in their networks to provide cost-effective health home care management for vulnerable populations. Risk adjustment becomes key, including data reporting to support risk adjustment as part of a performance measurement strategy. In discussing the move toward value-based payment, risk adjustment and developing appropriate methods to account for the psychosocial characteristics of vulnerable populations were highlighted as pivotal policy and payment issues. Here again, Craig Hostetler from Oregon argued that performance-based payment alone, without well-constructed risk adjustment, could weaken care for vulnerable populations and worsen—rather than mediate—health disparities. Forum participants agreed that it

takes time and sophistication to get to the level of data reporting needed to adequately measure factors such as hospitalization and ER utilization upon which performance incentives will be based. Colorado's structure of sub-regions or sub-RCCOs is seen as an advantage for building and monitoring approaches that will be successful.

Information Needs and Health IT Capacity

The interoperability of health information—the ability to share clinical and other health records across providers and settings—is widely acknowledged as critical to achieving necessary improvements in the nation's health care system. Enhancing care coordination requires that patient-centered information be available to providers to profile their patient populations, proactively plan for health care needs, and provide for patient needs that span health care settings. At the state policy level, information is required to establish and monitor delivery system performance targets, apply incentives for providers and set state budget targets for health care expenditures. Patients and Medicaid clients need their health records to be available to their providers whenever and wherever they seek care, and to be available for their own use to enhance their personal health management.

Over the past decade, a nationwide movement to achieve the interoperability of clinical health information (referred to as "health information exchange" or "HIE") has been spurred by the policy framework laid out in the American Recovery and Reinvestment Act and its provisions related to health information technology (known as HITECH - Health Information Technology for Economic and Clinical Health). The HITECH goals are for widespread meaningful use of HIT to improve health care. CMS oversees the HITECH EHR Incentive Program to provide financial incentives to providers who adopt and use certified EHR systems. The Office of the National Coordinator for HIT (ONC) also directs programs implementing HITECH investments that target provider adoption of medical records (Regional Extension Center Program, and Beacon Community Program) and grants for state-led HIE planning and implementation (State HIE Program).

Goals for achieving the ACA insurance and delivery system reforms rely on advances in information technology and state-led IT capacity building efforts to achieve both clinical and administrative interoperability. This includes the ability to meet new policy standards for "best of class" customer experiences in seeking eligibility determinations and enrolling in insurance coverage. Evolving federal guidance and funding for IT system development and operations now provide a framework for states' exchange and Medicaid IT capacity building efforts, in addition to the capacity building for the meaningful use of HIT across public and private health care clinical delivery systems.[6] States are in the process of evaluating their assets, identifying an IT system architecture that fits their health care environment, and charting a course to build additional capacity required to meet federal funding guidelines. For all states, this involves being able to leverage scant state budget resources and meet timelines for implementation of the ACA. As part of this pressured capacity building environment, states must consider the types of data and IT supports needed and how to build to scale.

Colorado and Health IT Capacity to Support the ACC Program and Health Centers

In many respects, Colorado has been at the leading edge of statewide efforts to build statewide HIT capacity. Health centers have been active participants, having had the advantage of early leadership for innovative efforts targeting different aspects of the HIT landscape. A brief profile of key organizational entities and their roles in relation to HIT and HIE follows.

- Colorado has a relatively well established non-profit HIE organization, the **Colorado Regional Health Information Organization (CORHIO)**. CORHIO serves as a state designated entity

under HITECH and also serves as the state's Regional Extension Center (REC) to advance the provider implementation and use of EHRs as part of care management. Health centers, through Clinica, are represented on the Board of Directors.[7] CORHIO is helping communities and providers across the state to be part of a statewide, shared HIE network that leverages shared investments and builds HIT solutions that meet prevailing federal technical and privacy and security standards. For more information, see: www.corhio.org.

- Clinica participates as part of the **Integrated Physician Network (iPN),** sharing an electronic health record with Avista Hospital and 50-100 private physicians in the community. This shared health record system is a key component for community based clinical quality improvement efforts.
- The **Colorado Community Health Center Managed Care Network (CCMCN)** was originally organized to help health centers organize and collaborate as part of Medicaid managed care. As HIT efforts took hold in Colorado, CCMCN launched an HIT initiative in 2006 called the Colorado Associated Community Health Information Enterprise (**CACHIE**). CACHIE has been working with health centers to develop population-based data strategies, including vendor solutions to support a common data set and data warehouse from which to extract and standardize data from multiple health center EHR platforms to generate business intelligence reports. Dan Tuteur, CCMCN and CACHIE leader, emphasized during the forum that the key to building IT capacity is understanding the data needed to answer key questions, then collecting and analyzing the data in a credible and timely way. He describes challenges in the CACHIE effort that include building new data sources, such as receiving data from hospitals in real-time to make decisions about interventions, and normalizing care coordination activity measures to assess the effectiveness of care management teams. For more information, see: www.cachie.org.
- The **Northern Colorado Health Alliance** is a non-profit, community based HIE partnership in northeast Colorado focused on the safety net; it began 10 years ago to organize and integrate IT supports for patient-centered physical and behavioral health care. The Alliance first created a coordinated electronic patient care record and organized patient-centered health home and community management services. Alliance leader Dr. Mark Wallace reported that over time, the Alliance has learned and been humbled by the scope of shared IT investment requirements and challenges in mobilizing sufficient resources. Resourcefulness and partnerships have proven key; as part of Colorado Access, the Alliance has worked to create synergy between standardized care management practices and IT supports, and to prioritize the availability and use of information i.e., surfacing information about high utilizers. The Alliance is now faced with investment challenges based on the costs to link with CACHIE and CORHIO, and the need to be able to expand its data sharing and ability to demonstrate performance as a RCCO provider. For more information, see: www.nocoha.org.

Issues and Challenges Across States—Building Supports for Integrated Systems, Populations and the Safety Net

There are several points of comparison and contrast in the approaches states are taking to build statewide HIT and data sharing capacities. These highlight how historic, cultural and political preferences, the nature of the health care marketplace and current economics influence the pathways taken to develop interoperability. Oregon, for example, is a robust Medicaid managed care environment, with a mature information network—the Oregon Community Health Information Network (OCHIN)—that supports data sharing among safety net providers. However, unlike Colorado, in Oregon there is less agreement on how public and private care delivery systems can be linked for broad interoperability. Carol Robinson, the state's HIT coordinator, observed that a more statewide HIE strategy is necessary for Oregon to link public and private health care systems and make the data available that is necessary for integrated delivery system strategies to be successful.

In addition to Oregon, other forum participants related various levels of activity to meet meaningful use requirements and develop HIE statewide and among health centers. Similar challenges include engaging all providers in HIT adoption and broadly linking providers' systems. States also are making efforts to target health centers: Tennessee is targeting efforts to make sure that health centers receive meaningful use incentives; and in New Mexico, 11 of 15 FQHCs have joined a health-center controlled network.

As with other forum topics of discussion, participants again identified the overriding importance of "system-ness" in considering capacity needs and infrastructure approaches to support the timely information and IT needs of safety net providers. Health centers anticipate the need to build new collaborative partnerships, and the need for increased involvement in statewide IT initiatives. As summarized below, while discussing their respective HIT environments, forum participants identified the issues and challenges related to building effective IT capacity that will support an integrated care system involving safety net providers.

Table 6 – Issues and Challenges to Build HIT Capacity for Delivery Systems and the Safety Net

Prioritizing HIE capacity development to support integrated care strategies	• States are struggling to balance short-term priorities versus longer range HIT investments to support more robust data sharing capability. • Iterative strategies that begin with more simple and direct data sharing options have promise, assuming they then develop into more advanced HIE capacity building. Provider support for this enhanced level of interconnectivity (and the investments it requires) can be linked to participation in delivery system reforms.
Timing	• Integrated delivery system strategies are contingent upon data being available on a real-time basis to effectively coordinate care. • Medicaid priorities for containing per-capita costs while also expanding eligibility under the ACA create opportunities for targeted HIT development to support integrated delivery systems serving vulnerable populations.
Building Trust Relationships	• It is challenging but necessary to build trust relationships among data sharing partners. Top-down strategies have a role in establishing mandates and defining incentives, but local efforts among health care "business partners" are critical to achieving meaningful buy-in for data sharing. Health centers are brokers for these kinds of relationships. • IT governance mechanisms are important to ensure that safety net providers organize their IT needs and capacity building efforts, and that they interconnect as appropriate as part of regional and statewide HIE development.

Leveraging shared investments	• Under HITECH and the ACA, additional resources have been made available to Medicaid agencies for HIT and HIE development to support meaningful use, and for financing of exchange-Medicaid eligibility and enrollment systems. States are being encouraged to explore shared solutions and cost allocation within and outside the state. • In the face of resource constraints, states need to explore options for shared investments with other states or regions to take advantage of links to Medicaid and the 90 percent federal matching rate for Medicaid systems. • States and health centers face great short-term pressures to build information supports to meet federal requirements. However, states and stakeholders cannot afford to have vendors build solutions multiple times in each state. • Short versus longer-term investments are contingent upon being able to demonstrate a business case for investing in HIT.
Leadership for community based/shared solutions	• Leadership at both state and provider/health center levels is needed to facilitate relationship building, identify shared value propositions for IT investments, and sponsor marketplace procurements that demand value-added and shared solutions. • Efforts need to be made to align local and statewide HIT-HIE efforts and to build "enterprise" IT strategies that link clinical and administrative information system development under HITECH and the ACA. • Building leadership and support—bench strength—at all levels is important to foster consistent commitment to reforms, despite potential shifts in politics, resources, and other changes in the landscape.
Redesigning Roles and Functions	• Federal policy guidance and advances in IT will enable new options for how data and IT operations can be managed. • Public health needs to be engaged as part of delivery system reform efforts to examine how traditional public health population based data functions, such as registries, can be advanced.

Key Themes for Moving Forward – Evolving Needs and Supports

Rich discussion among the various local, state, national and federal primary care leaders present at the forum brought forward several key themes and recommendations. These reinforce the findings from the June 2010 forum discussion, and reflect the evolving status of state delivery system reform efforts. This synthesis points to key factors that will be critical for realizing reform goals as federal and state integrated delivery system strategies unfold.

Key Themes

- **Leadership is critical at multiple levels.** Achieving delivery system reforms requires that states balance the time required to develop creative solutions and build supports for key changes with short-term pressures to identify cost reductions. Lessons learned from the recent phase of health care reform show how critical it is to build "bench strength"—both human capital and social capital for reforms—that can transcend changes in administration.
- **Vision is key**. Successfully implementing new care delivery models and levels of system reorganization requires a clear vision for how and why the system needs to change. This vision is crucial for setting the right goals and expectations, then for working to achieve shared understanding and buy-in for the benefits to be expected from system changes.
- **Managing expectations in a difficult political environment is critical.** In reality, achieving the system changes envisioned by integrated delivery system strategies are long term, requiring system re-engineering at multiple levels. However, political and economic circumstances are generating pressure for cost savings and continued legislative support depends on the ability to demonstrate progress and results in the short term. It is difficult but critically important for states and providers to find ways to structure short-term "wins." It is critical to work with new administrations and legislatures to foster learning and support for key priorities that lead to positive ROI as an alternative to short-term savings as a goal.
- **A multifaceted communication strategy is key.** One priority is to manage policymaker expectations for short-term versus long-term impacts from delivery system reforms. Communication strategies also need to be able to articulate clear principles for how accountable care models and integrated care system strategies compare and differ from managed care efforts, both past and current. A third strategic communication priority is to foster community engagement and support for delivery system reforms, especially as they involve the development of electronic health information systems. Engaging populations at the community level can help develop social capital and ultimately strengthen and expand political support for the longer-term investments required to develop new integrated care systems.
- **Strategic alignment across federal, state and local levels is critical** for effective delivery system reforms. In their role as a bridge between federal and local levels, states have a critical role to play in providing feedback and real-time issue identification and fostering federal agency responsiveness to specific state concerns. Informing federal strategies is a critical priority. States have an important opportunity to provide feedback to the CMS Innovation Center about local and state perspectives on health centers, integrated delivery systems and ACO development.
- **Local innovation needs to be prioritized and supported.** In Colorado, health center involvement in the RCCO strategy has generated local engagement, creativity and resources. States have an important role to play in fostering local innovation and providing critical supports for health center providers, such as

providing data required for development of local care models. States should consider how state level goals can provide critical impetus for local system development. Washington state's goal to contain the health care cost trend at four percent annually is one example.

- **Policy development needs to prioritize populations over existing provider and system structures.** This is part of distinguishing integrated care systems from managed care. As a matter of principle, the current delivery system redesign trends emphasize care systems for populations and reflect the need to serve distinct social characteristics and needs, rather than assuming that integrated systems need to be structured to rely on existing characteristics of provider panels and structured services.
- **Balancing structure versus flexibility is a key challenge for states in setting policy.** States must be attentive to marketplace movements and carefully weigh how to apply key system redesign principles. For example, hospital-created and controlled integrated systems may have inherent disincentives to shift emphasis to primary care services. States can use state policy levers to balance population and provider priorities, factoring in community and safety net provider input and ongoing strategy assessment and refinement strategies.
- **IT capacity development has to target multiple levels and prioritize integrated system supports.** Building information capacity is a critical priority, and illustrates how states are an important bridge between federal and local levels, providing a platform for common policies, rules and standards and building non-redundant technical capacities. Integrated care systems inherently require interoperability and the real-time sharing of health information across settings and systems. Currently, various IT capacity building initiatives are proceeding on parallel tracks across states, such as provider adoption via the Regional Extension Center and EHR Incentive programs, meaningful use and HIE development via the State HIT Cooperative Agreement Program, and HIT and quality improvement via the Beacon Communities program. States and safety net providers face an invaluable and vitally important opportunity to prioritize population based IT capacity development.
- **Payment reform has to be considered for its purpose and applied in different contexts** including managed care and FFS and rural and urban health care environments. Nonetheless, it is crucial that states demand levels of performance from health care systems that will truly "bend the curve" and achieve systemic impacts like the triple aim. States need to be extremely careful with strategies for shared savings without investments in new approaches.

Evolving Needs and Supports for States and Health Center Partners

The needs and supports that states and health centers identify as most timely and strategically important provide a blueprint for follow-up action. They point to the need for productive and ongoing federal-state-local dialogue and partnerships as delivery system reforms continue to evolve. Forum participants identified the following important issues warranting further attention.

- **Risk adjustment methods** must be developed to reflect the complexity of social and health risks of vulnerable populations, beyond medical factors, in payment strategies.
- **Measurement methodologies, tools and provisions for timely data analysis** must continue to be advanced, including data and tools to support patient stratification.
- Continued work is needed on **payment methodologies** that support the ability of health centers to serve vulnerable and complex patients but that fit within the state-federal shift to

integrated care systems and value-based contracting and payment. An important next step is federal-state-local leadership for productive dialogue about the role of PPS in a new payment and delivery system environment.

- Strategies need to be developed for the **effective engagement of businesses and consumers** to understand and support population-based needs and care systems, especially as implementation of the exchanges occur.
- **Effective workforce models** need to be identified as they emerge from innovative local and state system development efforts. Approaches for involving community health workers, care coordinators, and other clinical and non-clinical providers are needed as part of new network configurations and care models for population-based services as part of state delivery system reforms. Lessons learned from effective networks can inform targeted health care workforce training strategies.
- **A focus on the safety net in policymaking is needed.** Effective communication in state and national policy discussions is important to focus attention on preserving and enhancing the strength of the safety net. Priorities include articulating the critical role of the safety net as a source of care for underserved areas and for remaining uninsured populations, including the undocumented; providing a timely voice and leadership to foster strategies addressing health center issues, resources and system investments; and disseminating promising innovations in population-based care as they evolve.
- **Priorities for IT infrastructure development** must address the needs of integrated care systems and the safety net, including how resources and strategies can be leveraged to accelerate capacity building and position health centers to function as part of new health care delivery and insurance coverage reform scenarios.

Conclusion

Forum participants agreed that venues are needed for urgent and ongoing dialogue, shared learning, and coordinated development of policy and implementation solutions across federal-state-local, policy and delivery system levels. Health center and state participants emphasized throughout the forum that a "perfect storm" of converging opportunities and challenges is brewing. Locally, health centers face serious challenges to building and sustaining innovative approaches to care while riding out deep budget cuts. States are challenged by difficult timing—they must manage drastic budget cuts, just when resources are needed in the system to drive innovations that will pay off in the longer term. There are great risks in making budget projections incorporating delivery system reforms that are contingent upon meeting performance targets for savings without having sufficient data or risk management methodologies in place, and without factoring in the time required for re-tooled health care systems to take shape and begin to deliver cost-savings results that are reliable.

Given these issues, the local, state and national primary care partners participating in the 2011 forum agree and remain committed to taking advantage of the unprecedented opportunity that exists to improve care systems for vulnerable populations. They encouraged NASHP and others to continue to facilitate communication across states, between states and safety net providers, and between states and federal partners, striving to share perspectives on issues and challenges related to delivery system reforms and safety net providers. They urge ongoing dialogue with key agencies—CMS, HRSA, and others—to foster the alignment of federal, state and local efforts relative to the safety net as federal policy and resources are deployed. Last, forum primary care providers and policymakers were eager to benefit from ongoing dissemination of timely analyses of promising practices; these will be key as state strategies evolve and implementation efforts progress. In the absence of good data, even framing the implications of "worst case scenarios" will be helpful to keep the focus of attention on necessary system investments.

Appendices

Appendix 1: June Forum Agenda

Constructing a Mile High Integrated Delivery System For Vulnerable Populations: A Forum for State Policymakers and Health Center Partners

June 8 – 9, 2011

The Oxford Hotel • Sage Room • 1600 17th Street • Denver, Colorado

AGENDA

Meeting Objectives: (1) Learn from Colorado as well as other states about their delivery system reform efforts and how they are working with Federally Qualified Health Centers in those efforts; and (2) Identify challenges and potential strategies for achieving these reforms including the use of models and tools such as Accountable Care Organizations, Health Information Technology/Information Exchange and payment reform. We hope that the strategies discussed in this forum as well as the previous 2010 Primary Care forum may help frame and focus our next proposed National Cooperative Agreement to provide technical assistance to state teams. In addition, ideas and discussion from this forum and from the 2010 forum will help support and develop recommendations from the *National Workgroup on Integrating a Safety Net Into Health Care Reform Implementation*.[1]

June 8	
8:30-9:00am	**Welcome & Introductions** Catherine Hess, MSW, Managing Director for Coverage and Access, National Academy for State Health Policy Joan Henneberry, MS, Director of the Colorado Health Insurance Exchange
9:00-10:30 am	**I. Mile High Aspirations: Forming an Integrated Delivery System with Safety Net Providers** This session will describe Colorado's Regional Care Coordination Organizations (RCCOs)—the state's accountable care organization for Medicaid beneficiaries. The speaker will describe how, why and where the RCCOs were formed and the principles that guide their operations including governance, composition, payment, partnerships, and accountability. The speaker will also describe the lessons learned to date. **Moderator:** Catherine Hess, Managing Director for Coverage and Access, NASHP **Speakers:** Laurel Karabatsos, MA, Deputy Medicaid Director, Colorado Department of Health Care Policy and Financing **State Reactors:** Craig Hostetler, MHA, Executive Director, Oregon Primary Care Association; MaryAnne Lindeblad, RN, MPH, Assistant Secretary, Aging and Disabilities Services and Administration, Washington State Department of Social and Health Services

9:00-10:30 am (continued)	**Questions for discussion:** • What is your state's experience in working toward an integrated delivery system and how have FQHCs fit in to this vision • Do FQHCs need to participate in ACOs or integrated delivery systems to survive or thrive in a reformed health care system? • Why or why not would this kind of model work in your state?
10:30-10:45am	**Break**
10:45am-12:15pm	**II. At the Helm: What Does it Take to Support an ACO?** States fostering the development of ACOs for safety net providers need well-organized, high functioning providers or plans to lead their operation. What type of organization is fit enough to serve as an ACO? What necessary skills and infrastructure are needed for all those under the safety net umbrella (patients, providers, FQHCs, health plans, community supports) to thrive in this model? The speaker will address these questions including the role of the PCA in this development, as well as how and why a rural-based FQHC made the transformation to lead one of Colorado's seven RCCOs and the ripple effect created through its organization from patients to CEO. **Moderator**: Representative Tishaura Jones, State Representative, Missouri House of Representatives **Speaker:** Polly Anderson, Policy Director, Colorado Community Health Network **State Reactors:** Christi Granstaff, MSW, Deputy Director, Tennessee Primary Care Association ; Julia Dyck, MPA/H, MA, Director, Massachusetts Primary Care Office **Questions for discussion:** • What does it take to organize as an ACO? Specifically, what are the roles of the federal and state governments, Primary Care Association, Regional Extension Centers, and FQHCs to develop integrated delivery systems?
12:15-1:30pm	**Lunch** Opportunities and Challenges for Health Centers in Health Insurance Exchanges **Moderator:** Kathy Vincent, Staff Assistant to the State Health Officer, Alabama Department of Public Health **Speaker:** Joan Henneberry, MS, Director of Colorado Health Insurance Exchange

1:30-3:00pm	**III. Reaching the Triple Aim Through Innovative Payment Models** Integrated delivery systems provide the infrastructure to reach Triple Aim goals: population health, lowered costs and enhanced patient experience. New payment models are needed to support and motivate providers within these systems to reach these goals. How can payers move FQHCs and other providers toward new payment models including performance-based and risk-based payments that support Triple Aim goals? The speaker will discuss the evolution of the new payment model for Colorado RCCOs and the implications for safety net plans and its network of providers. **Moderator:** Mary Takach, Program Director, NASHP **Speaker:** Marshall Thomas, MD, President and CEO, Colorado Access **State Reactors:** Cheryl Roberts, Deputy Director for Programs, Virginia Department of Medical Assistance Services ; Rob Kidney, Assistant Director, State Affairs, National Association of Community Health Centers **Questions for discussion:** • How sacred is the PPS funding stream? • What kind of payment do FQHCs need to thrive in a competitive, integrated environment?
3:00-3:15pm	**Break**
3:15-5:00pm	**IV. Critical Supports for Success: Health IT for ACOs and Safety Net Providers** Fostering the adoption of electronic health records and building the capacity for real time information sharing through health information exchange networks is critical for integrated delivery systems and ACOs to achieve their goals. Under the proposed federal rule for Medicare, ACOs are required to use Health IT for care management and patient-centeredness, align with meaningful use, and be able to share relevant patient information with entities in and out of the ACO. Building capacity across providers and different initiatives is a significant barrier to reaching system goals. Colorado is the process of overcoming these barriers through its regional extension centers and other networks being developed throughout the state. **Moderator:** Lynn Dierker, RN, Senior Program Director, NASHP **Speakers:** Dan Tuteur, MHSA, Executive Director, Colorado Community Managed Care Network (CCMCN) ; Mark Wallace, MD, President, Northern Colorado Health Alliance; Director, Weld County Department of Public Health **State Reactor:** Carol Robinson, State HIT Coordinator, HIT Oversight Council Director, Oregon Health Authority

3:15-5:00pm (continued)	**Questions for discussion:** • How are providers and multiple initiatives being connected using information technology? What is being done in the meantime to share information across providers until health information exchange is established? • Are meaningful use standards enough to motivate providers to adopt electronic medical records? • How are statewide initiatives e.g. Regional Extension Centers and Statewide HIE networks involving and prioritizing safety net providers? • What are the implications of HIT capacity for safety net providers being able to participate in integrated delivery systems that might emerge as ACOs?
5:00-5:15pm	**Wrap-up**
June 9 **Putting it All Together – Field Trip to ACO**	
8:00-11:30am	Leave at 8:00 am for ACO field trip Pecos Medical Clinic, Clinica Family Health Services 1701 W. 72 Ave, 3rd Floor Denver, CO 80221 **Host: Peter Leibig, President and CEO, Clinica Family Health Services** Introduction to Clinica. Speakers will describe the transformation and new roles required of patients, providers, staff, and CEO. Tour of Pecos
12:00-1:00pm	**Wrap-up at the Hotel** **Facilitator:** Catherine Hess, MSW, Managing Director for Coverage and Access, NASHP **Questions for Discussion** What were each of your major take homes, "aha" moments? What major conclusions and recommendations would you want to see in the report from this meeting and follow-up presentations and discussions with federal policymakers or other key stakeholders or facilitators?

Appendix 2: Forum Participants

State Teams

Missouri
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Senior Health Policy Consultant

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New Mexico
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Rhode Island
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Alumni State Teams

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Massachusetts
Julia Dyck
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State Academy Advisors

Tishaura Jones
State Representative
State of Missouri

MaryAnne Lindeblad
Assistant Secretary
Washington State DSHS
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Cheryl Roberts
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Kathy Vincent
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Alabama Department of Public Health

Federal Partners

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Centers for Medicare and Medicaid Services

Lisa Wald
Public Health Analyst
Office of Training and Technical Assistance Coordination
Bureau of Primary Health Care, HRSA

Speakers, NCA and Other Partners

Polly Anderson
Policy Director
Colorado Community Health Network

Jeff Bontrager
Program Manager
Colorado Health Institute

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Notes

1 As described by HRSA under its National Cooperative Agreement to promote consistency in the use of terms, a "Health Center grantee" is an organization that receives grants under Section 330 of the Public Health Service Act. A "Look-Alike" (LAL) is a health center that has been certified by CMS, as recommended by HRSA, to meet all the qualifications of a Section 330 grant, but has not actually received a grant. A "Community Health Center" (CHC) is commonly used to refer to a subset of grantees that receive funding to target a general community (as opposed to targeted funding to serve a statutorily defined special population). A "federally qualified health center" (FQHC) is a term defined in statute to indicate that a health center site is approved to be reimbursed under Medicaid and Medicare using specific methodologies laid out in statute for FQHCs.

2 Kitty Purington, Anne Gauthier, Shivani Patel, Christina Miller, On *the Road to Better Value: State Roles in Promoting Accountable Care Organizations* (Washington, DC: National Academy for State Health Policy, February 2011).

3 Mary Takach, "Reinventing Medicaid: State Innovations to Qualify and Pay for Patient-Centered Medical Homes Show Promising Results," *Health Affairs*, 30, no. 7 (2011): 1325-1334.

4 Kitty Purington, Anne Gauthier, Shivani Patel, Christina Miller, On *the Road to Better Value: State Roles in Promoting Accountable Care Organizations*.

5 National Association of Community Health Centers, "Spotlight on the States, Issue Brief #4: Summary of Key Provisions of a Proposed Rule Relating to the Establishment of Exchanges and Qualified Health Plans," September 2011. Includes reference to 45 CFR Parts 155 and 156. Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, Department of Health and Human Services.

6 Centers for Medicare and Medicaid Services (CMS), *Guidance for Exchange and Medicaid Information Technology (IT) Systems, Version 2.0* (Washington, DC: U.S. Department of Healthy and Human Services, May, 2011).

7 Colorado Regional Health Information Organization (CORHIO). "CORHIO." Retrieved 22 August 2011. www.corhio.org.