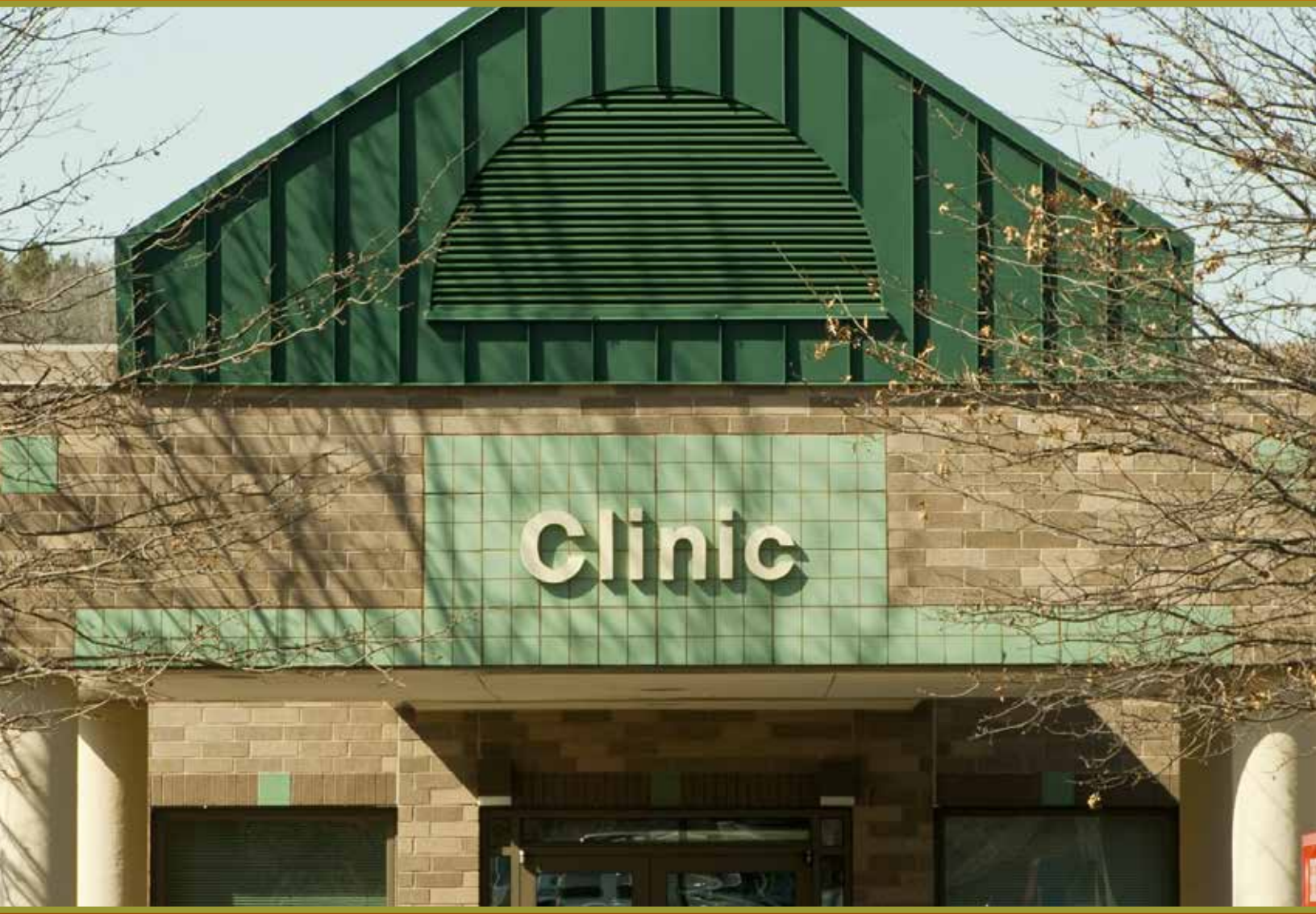

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Maintaining Clinic Financial Stability:
Navigating Change, Leveraging Opportunities

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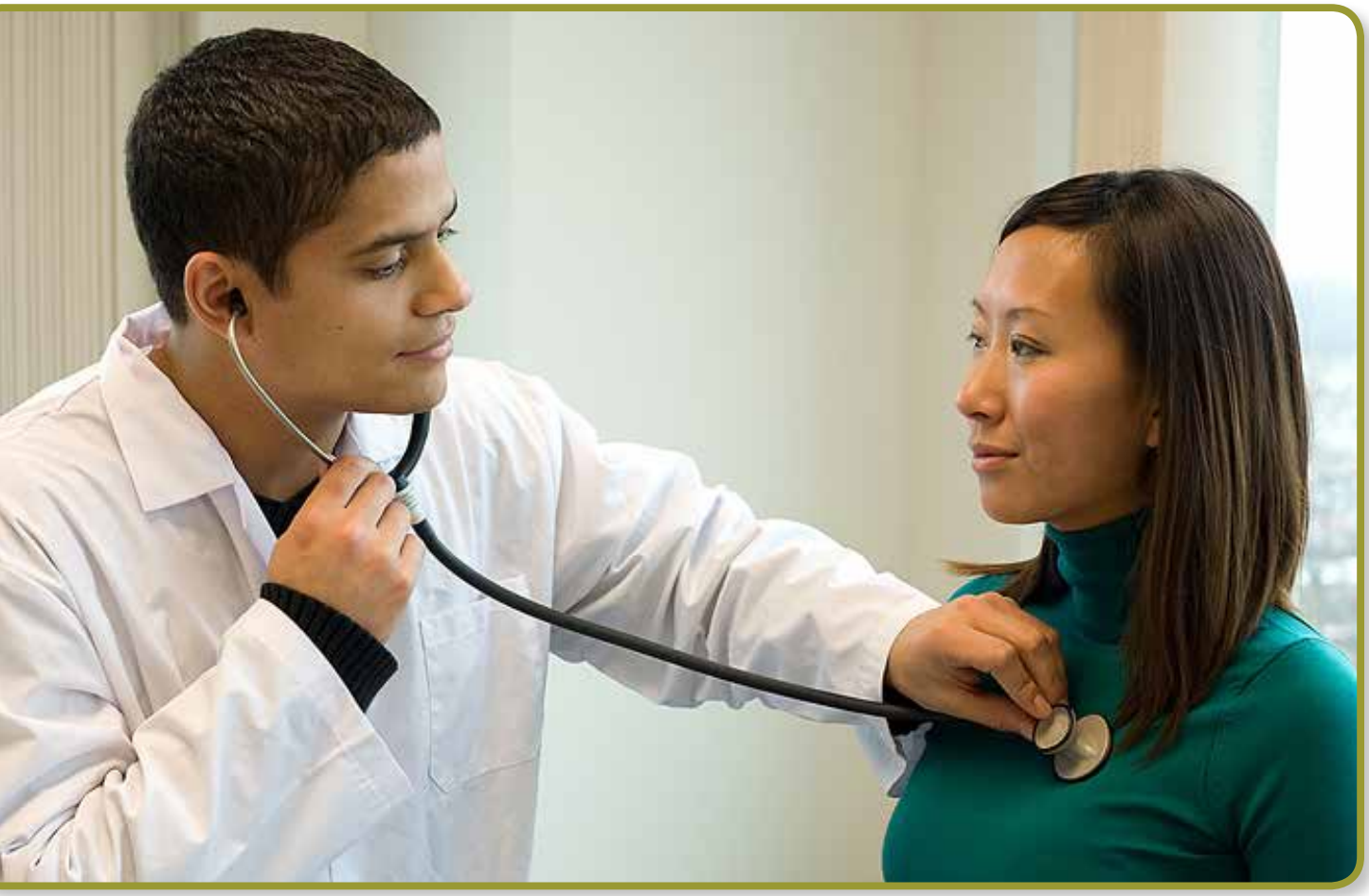
INTRODUCTION



California's community clinics and health centers (CCHCs)[1] are grappling with unprecedented change and huge financial pressures. Many CCHCs have matured during the last 40 years to become multi-site corporations that are the economic hubs of their communities and providers of high quality, coordinated care. However, the weak economy, coupled with the need to transform CCHC operations under state and federal health care reform (Patient Protection and Affordable Care Act of 2010 or ACA), is forcing clinics to reexamine their strategies and their role as safety net providers.

This primer describes the current funding environment and factors that are shaping the future of CCHCs, including federal and state health care reform, the state budget, local funding, and private funding. Building on the sizeable body of work about clinics and their role, revenue streams, and patient base, we discuss the current and future opportunities and challenges for CCHCs. Strategies for leveraging these opportunities and mitigating the challenges are emphasized. In addition, with input from clinic representatives and experts from diverse arenas, we examine the key strategies that hold great potential for positioning clinics to thrive during this period of great uncertainty. These times call for new visions and nimble business models. The intention of this primer is to help CCHCs and their partners "surf the tsunamis of change" and successfully meet the challenges of the decade ahead.

BACKGROUND

CCHCs serve as the safety net for the medically underserved, providing primary care services by and large to people at or below 200 percent of the Federal Poverty Level (FPL). This group represents 82 percent of the clinic patient base. Of these, two-thirds are under 100 percent of the FPL.[7] During the Bush and Obama Administrations, clinics expanded their capacity to serve more medically underserved low-income Californians. The number of licensed primary care clinics increased from 973 clinics to 1,081 clinics from 2007 to 2011 (an 11.1 percent increase). During the same period, the number of patients being seen at California CCHCs increased from 4.1 million to 5.2 million (a 27.3 percent increase). As a result, clinic total operating revenues increased from $2.07 billion in 2007 to $2.86 billion in 2011 (a 37 percent increase) with the revenue mix remaining relatively stable.[8]

The populations served by CCHCs determine, in large part, how clinics are reimbursed. The major sources of patient revenue by payer are Medi-Cal (California's Medicaid program) (34.9 percent), Medicare (4.7 percent), private insurance (4.5 percent), and self-pay/sliding fee/free (4.0 percent). Medi-Cal has grown in CCHC patient service revenue, from $714.8 million in 2007 to $999.5 million in 2011[12] (see **Figure 1**). However, there is significant diversity in individual clinic Medi-Cal revenues. Federally Qualified Health Centers (FQHCs) and Federally Qualified Health Center Look Alikes (FQHCLAs) are paid through a prospective payment system (PPS) under Medi-Cal managed care, a modified cost-based payment system that is tied to the average of each FQHC's allowable costs and adjusted for inflation by the Medicare economic index for primary care. More than half of all Medi-Cal enrollees are in managed care. For physicians that are paid on a Fee-For-Services (FFS) basis, the fees are state-determined and can be significantly less than other insurers or Medicare fees. Medi-Cal FFS rates are capped as set out in state Medi-Cal regulations. They are the fourth lowest in the country.[13]

Clinic Designations

California's community clinics and health centers (CCHCs) operate in a complicated regulatory and funding environment that shapes health center operations and financing. CCHCs can be operated by public agencies (such as public hospitals and health systems), health care districts, and by private and nonprofit organizations. Saviano identifies five types of clinics:[2]

- Federally Qualified Health Centers (FQHCs): A FQHC is defined by the Medicare and Medicaid statutes and includes all organizations receiving grants under Section 330. They can be county and non-county based, and are eligible for grant funding up to $650,000 under the New Access Point (NAP) program. In 2011, there were 121 FQHCs grantees in California that operated 1,124 delivery sites;[3]
- Federally Qualified Health Center Look-alikes (FQHCLAs): A FQHCLA is a clinic that is governed, operates, and provides services in the same way as Section 330 grantees. However, it does not receive Section 330 grant funding but it does receive enhanced reimbursement under Medicaid and Medicare. In 2011, there were 75 FQHCLAs in California;[4]
- Rural Health Clinics (RHCs): Most RHCs are for-profit, freestanding clinics that receive enhanced reimbursement under Medicaid and Medicare. In 2010, there were 295 RHCs in California;[5]
- Free Clinics: Free clinics do not charge patients and rely on volunteer providers and receive their funding through private donations. In 2011, there were 52 free clinics in California;[6]
- County-run Clinics: Some counties operate clinics that may or may not be FQHCs. In 2008, 11 counties were Section 330 grantees; and
- Private and Other Types: Other types of clinics include Indian Health Service clinics, family planning clinics, as well as school-based clinics.

With the exception of county-run clinics, all primary care clinics are required to be licensed. FQHCs and FQHCLAs are required by federal law to provide certain services. While cumbersome, this is also the route to obtaining enhanced government reimbursement and access to dedicated funding sources. In addition, the FQHC/FQHCLA designation is a strong base upon which to build.

In California, there are more FQHCs than other clinic types. They accounted for 81 percent of the total clinic revenue in the state and were the only type of clinic that grew in number of sites and revenue from 2005 to 2008. They serve a greater proportion of patients under 100 percent of the FPL but have strong revenue growth due to higher reimbursements per encounter from government payers. FQHCs earned more per Medicare ($133 per visit) and Medi-Cal ($121 per visit) than the other clinic types. Finally, FQHCs received more Medi-Cal managed care revenue (23 percent) than other types of clinics that received managed care revenue in 2008.[9]

There are differences in financial stability by CCHC size, with smaller clinics more likely to experience variability in bottom line performance in both the positive and negative direction. Large clinics (over $15 million) are likely to experience greater revenue stability. They rely more on Net Patient Service Revenue (70 percent of operating revenues). They have a high Medi-Cal portion and a higher cost basis, which may drive higher PPS cost-based reimbursement rates, and/or better negotiating power in terms of rates. Large clinics accounted for 14 percent of total clinics but earn over half of total revenues. Median clinics ($5–$15 million) earned the largest share of income from contracts and grant sources (36 percent). Small clinics rely more on contributions and fundraising income (16 percent) than the other clinic types. The smallest clinics represented 36 percent of all clinics in 2008, but only accounted for four percent of the overall revenue. The trend is towards more clinics above $5 million in revenue and a decrease in clinics below $5 million. Clinic size makes a difference to financial health, but large clinics are still vulnerable, with most having an operating margin of 2.9 percent. A healthy operating margin is three percent or higher. Similarly, most CCHCs have 50 days of cash on hand and the goal is 60 days.[14]

While the 2000s provided many opportunities for CCHCs at the federal level, clinics had to contend with a variety of challenges, particularly annual state budget shortfalls and proposed 10 percent cuts in Medi-Cal provider reimbursement rates. Medi-Cal's reimbursement rates are so low that many non-CCHC providers refuse to take Medi-Cal patients, creating a capacity issue and inadequate supply of providers. Additionally, an increasing number of health center patients are uninsured and lack an adequate payer source. The number of uninsured patients (self-pay/sliding fee/free) being seen by clinics grew 29.1 percent, from 1,224,407 people in 2007 to 1,580,447 in 2011.[15] This coupled with the credit crisis and difficulty in getting loans for capital improvements has placed some clinics at risk. Twelve California clinics have closed since 2009.[16]

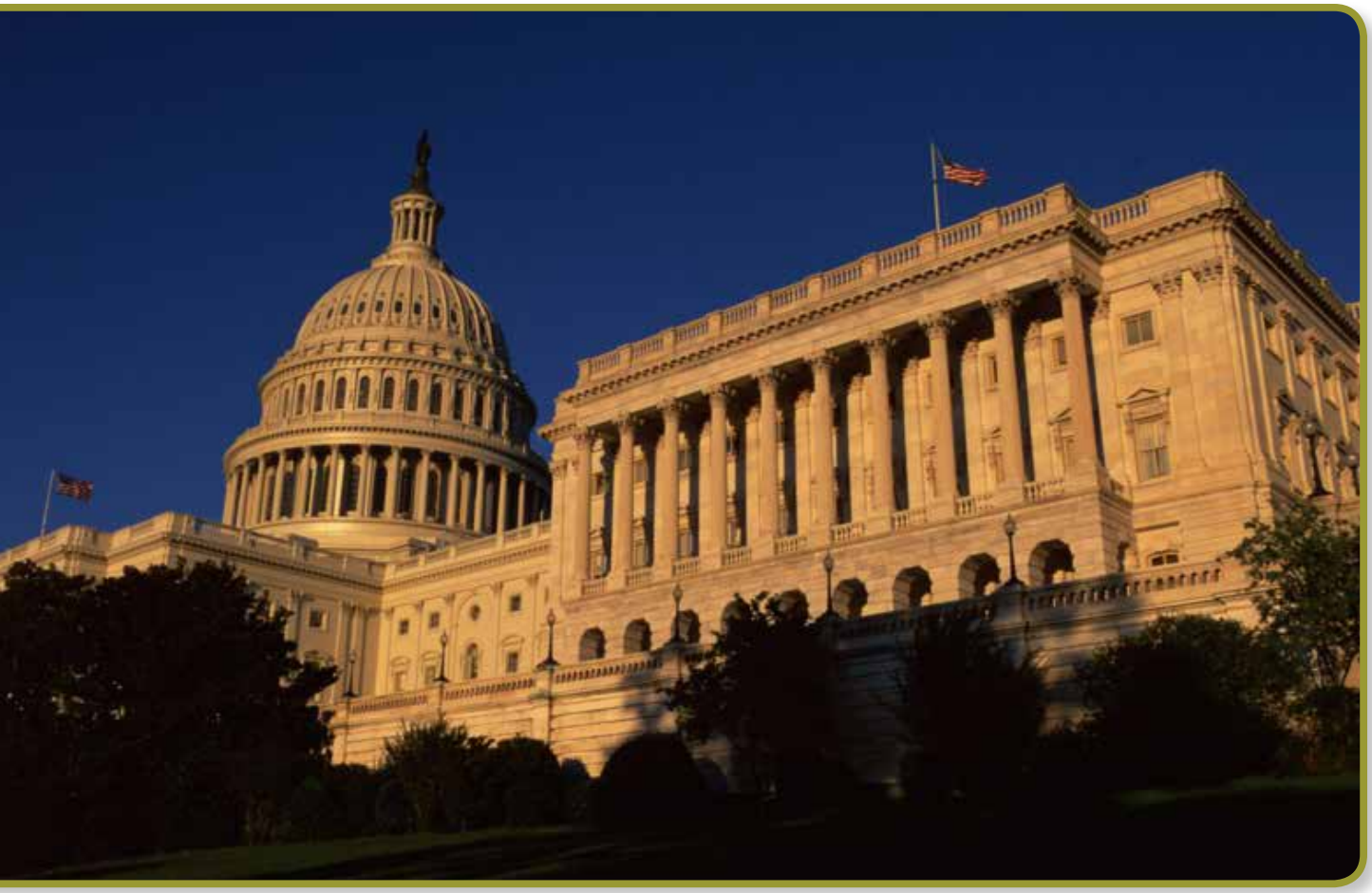
To better understand the financial opportunities and challenges currently confronting California's CCHCs, the primary sources of current and future CCHC funding are described—Federal, State, Local/County and Private support. The following section discusses the opportunities of each for clinics, including available funding and areas of growth under the Affordable Care Act, as well as challenges in securing funding.

Figure 1: Clinic Patient and Non-Patient Revenues

CCHCs earn approximately two-thirds (69.42 percent) of their operating revenues through direct charges for patient services, which grew from $1.3 billion in 2007 to $1.98 billion in 2011. Medi-Cal is the largest source of patient revenue or 34.9 percent. Medicare and private health insurance is a relatively modest source of patient revenue and account for 4.75 percent and 4.5 percent of clinic total operating revenues respectively. Last, self-pay/sliding fee/free accounts for 4.05 percent of clinic revenue. [10]

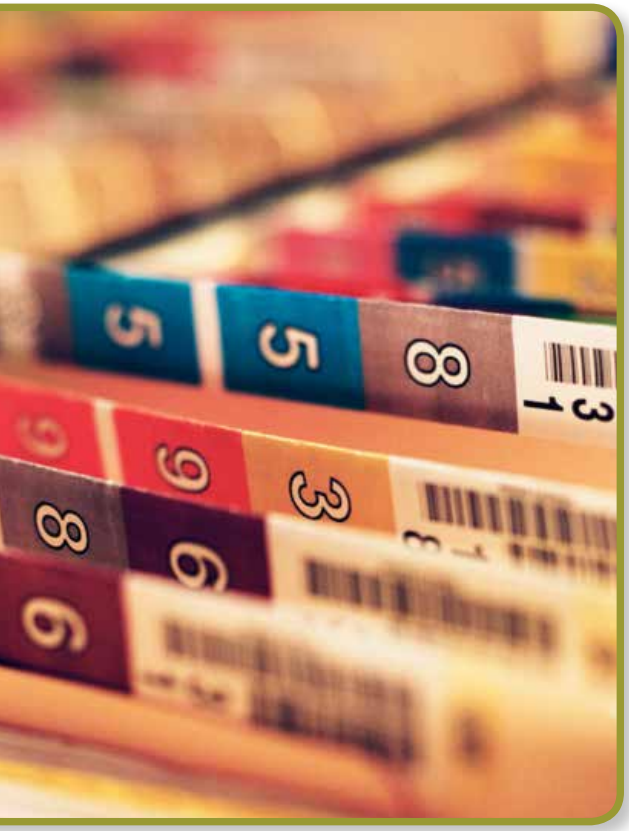
Non-patient revenue accounted for 30.58 percent of total clinic operating revenue in 2011. Federal Revenue (not including Medicare and Medicaid) represented 46.8 percent of clinic non-patient revenue in 2011, County and local grants and contracts, such as the Los Angeles Public Private Partnership (PPP) Program, are an important source of funding, representing 19.2 percent of clinic revenues, while State Grant and Contract Revenue was 2.6 percent of total clinic non-patient revenues.[11]

FEDERAL FUNDING



Initially administered by the Office of Economic Opportunity, federal support for clinics goes back to 1965, when neighborhood health centers were created to provide health and social services to medically underserved communities as part of the "War on Poverty." The federal government has made a significant investment in CCHCs during the last 10 years, with appropriations for FQHCs increasing from $1.6 billion in 2000 to $2.2 billion in 2010. While federal revenue (primarily Section 330 grants and cost-related Medicaid payment rates) represented 16 percent of CCHC revenue in 2008, it has been of vital importance in supporting capital expansions and helping to defray the costs associated with treating the uninsured. Moreover, federal funding does not just translate into expanded access, but generates an estimated 8:1 return for medically underserved communities, while also creating much needed jobs. The $11.5 billion in new clinic funding under the Patient Protection and Affordable Care Act (ACA) of 2010 is estimated to result in $33 billion in new economic benefits.[17]

But the days of stable federal funding for CCHCs may be over, as illustrated by the diversion of $600 million in ACA funding to cover base-level clinic funding cuts scheduled for FY 2011. This loss was estimated to translate into a $1 billion loss in economic stimulus for medically underserved communities and 10,000 fewer job opportunities.[18] For California clinics, this translated into fewer grants being awarded.



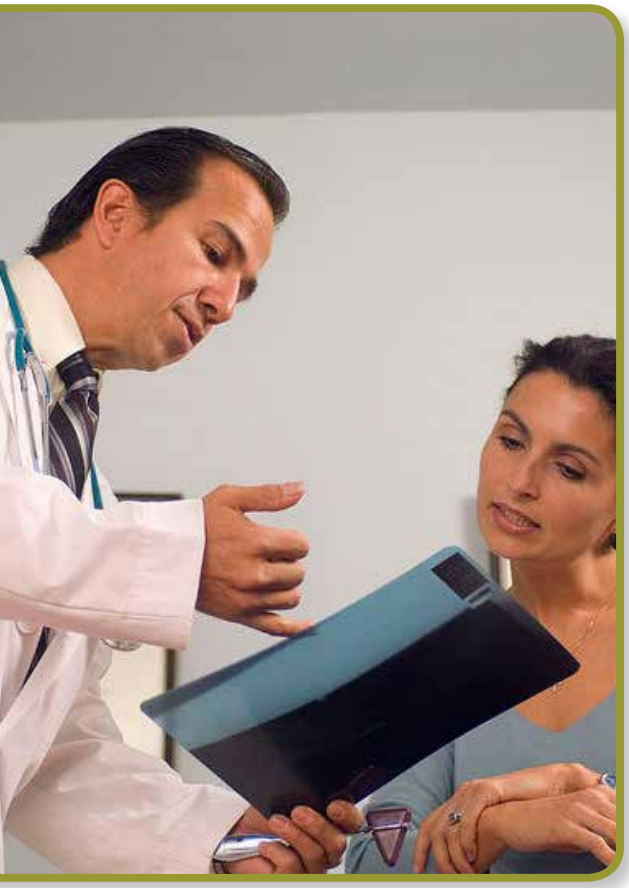
Additionally, combining new ACA provider funds with Section 330 grants raises questions about the desired program size and how to maximize federal investment to reduce safety net fragmentation. For example, should other safety net providers receive federal support, such as new types of clinics (Nurse Managed Health Clinics, for example)?

Last, efforts to reduce the federal deficit and address the nation's rising debt include spending reductions to Medicaid and Medicare, which are key sources of clinic revenue. As of April 1, Medicare provider and insurer payments have been cut by two percent under the federal budget sequester called for under the Budget Control Act of 2011. While the Medicaid program is exempt from across-the-board cuts of $85 billion, it is still vulnerable to cuts. For example, the Obama administration has proposed a blended match rate, which combines the varying payment rates for traditional Medicaid, the Children's Health Insurance Program (CHIP) and the ACA Medicaid expansion into one rate. Additionally, the House and Senate are proposing radically different FY 2014 budget proposals to reduce the deficit. The House approved Congressman Paul Ryan's (R-Wis.) plan, which repeals the Affordable Care Act, turns Medicaid into a block grant program, and transitions Medicare to a premium-support program. The Senate approved a FY 2014 budget proposal that includes $10 billion in cuts to Medicaid, a $265 billion reduction in Medicare, and restores the $1.2 million in automatic spending cuts.

The four sources of federal funding important to CCHCs are discussed below: the Health Center Program, the American Recovery and Reinvestment Act (ARRA), the Children's Health Insurance Program (CHIP), and the Patient Protection and Affordable Care Act (ACA).

Health Center Program

Most clinics (FQHCs) currently function under Section 330 of the Public Health Service (PHS) Act, which is commonly referred to as the Health Center Program. The Health Resources and Services Administration (HRSA) Bureau of Primary Health Care (BPHC) within the Department of Health and Human Services (HHS) administers the program. This federal framework has been an important vehicle for clinic expansions and supporting care for the uninsured and underinsured, particularly during the Bush Administration when health center funding was increased by $2 billion from 2002 to 2008. The goal of the Presidential Initiative was to create and expand health center access points to impact 1,200 communities and six million new patients served by clinics, doubling both over five years. California FQHCs fared well under the Bush Initiative. Funding increased from $200 million in 2008 to $272 million in 2011.[19] Prior to the Bush Initiative, California clinics received substantially less Section 330 funding than any other state when analyzed in terms of the number of uninsured residing in the state.



The Health Care Safety Net Act of 2008 reauthorized the Health Center Program and funding was increased through 2012 to grow the program by 50 percent, resulting in an annual funding level of $3.3 billion in FY 2012. It also reauthorized and increased funding for the National Health Service Corps.[20] The Patient Protection and Affordable Care Act (ACA) permanently reauthorizes the Health Center Program, and the ACA health center provisions and Health Center Program are consolidated under the Community Health Clinics Trust Fund.

Maintaining federal support at this historic level is increasingly uncertain as evidenced by the retrenchment of federal support in 2011. Under the final FY 2011 Appropriations Bill (H.R. 1473), the Health Center Program was cut by $600 million, reducing the $1 billion in ACA funding to clinics to $396 million in new health center funding through FY 2011. Instead of being used to expand clinic services in anticipation of increased utilization by the newly insured in 2014 and to expand behavioral health and dental services, ACA funding was used to support existing clinic capacity. One health center grant, The Expanded Services Opportunity, was suspended.

The FY 2012 Health Center Program funding was a victory for clinics, which came out entirely unscathed, but below the $2.2 billion level of funding pre-ARRA (American Recovery and Reinvestment Act) in 2010. Discretionary funding was $1.6 billion, which keeps funding levels stable as compared to FY 2011.[21] There was no rescission to any mandatory ACA funding, so with the Community Health Center Trust Fund, clinics are expected to see a $197 million increase in funding.[22]

Congress maintained this funding when it passed the Consolidated and Further Continuing Appropriations Act of 2013, bringing total clinic funding to $3.1 billion for FY 2013. Of the $300 million funding increase, $48 million will be allocated to FQHC base grant adjustments for existing health centers that have not received a base grant adjustment. Funding will assist with covering the costs of services provided to the uninsured since 2009, This funding can be used immediately, and will provide for the expansion of care to 1.5 million new patients.[23]

However, FQHCs are expected to lose $120 million in discretionary grant funding under the federal budget sequestration unless Congress restores funding. This is estimated to result in approximately 900,000 fewer patients receiving services in 2013, particularly at centers that are more dependent on grants than on Medicaid, such as centers that serve the uninsured (migrant farmworkers, homeless and public housing residents). Clinics are still waiting to see if Health Center Program funds will be used to backfill lost funding through the appropriations process.[24]

The President's proposed FY 2014 budget reaffirmed the Administration's commitment to expanding primary care capacity, increasing funding to the Health Center Program by $700 million for a total of $3.8 billion. This $700 million increase translates into increased access to care for an estimated five million new patients.[25]

The continued uncertainty of federal funding for the Health Center Program raises serious questions about clinic readiness to address the health care needs of new patients when the state Health Exchanges and Medicaid expansion are implemented in 2014. Even if federal spending remains stable or $1.6 billion per year through 2015, CCHCs will experience a loss of $3 billion (see **Table 1**). Moreover, when clinic funding under the Affordable Care Act Health Center Fund expires in 2016, CCHC funding will be reduced by 70 percent at a time when they are predicted to serve upwards of 30 million people nationally.[26]

American Recovery and Reinvestment Act of 2009 (ARRA)

The American Recovery and Reinvestment Act of 2009 (ARRA) provided $2 billion for health center expansions. The funding was intended for new sites and services, new and improved infrastructure, adoption of Electronic Health Records (EHRs) and other health information technology, telehealth, training of primary care professionals, and Medicaid coverage assistance. The timing of this funding was critical and coincided with the decrease in state funding and increase in people seeking services from clinics. California clinics received 107 New Access Point grants.[27]

Table 1: Federal Health Center Funding, 2010-2015

Funding Source	2010	2011	2012	2013	2014	2015
Regular Appropriation	$2.2B	$1.6B	$1.6B*	$1.6B*	$1.6B*	$1.6B*
ACA ($9.5B)		$1.0B	$1.2B	$1.5B	$2.2B	$3.6B
TOTAL	**$2.2B**	**$2.6B**	**$2.8B**	**$3.1B**	**$3.8B**	**$5.2B**

* Federal discretionary funding stays at FY 2011 level.
Source: Shin, P. and Rosenbaum, S. "Community Health Centers: the Challenge of Growing to Meet the Need for Primary Care in Medically Underserved Communities." Kaiser Commission on Medicaid and the Uninsured. March 2012.

Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs

Under the HI-TECH portion of ARRA, there are incentive payments for Medicare and Medicaid providers to adopt, implement, upgrade or demonstrate "meaningful use" of certified EHR technology. Upwards of $34 billion will be provided by Center for Medicare and Medicaid Services (CMS). Providers could start applying in November 2011 and the program is set to run through 2021.[28] Eligible providers can access $21,250 for the first year to cover purchasing an EHR, and an additional $8,500 per year for a total of five years to cover operations and maintenance, totaling $63,750 over a six-year period. Providers at FQHCs are eligible if they serve at least 30 percent Medi-Cal patients or if they practice predominantly at the FQHC and serve 30 percent needy individuals (which includes uninsured patients) and show they are engaged in adopting, implementing, or upgrading certified EHR technology.

California's CCHCs are working with over 2,500 eligible professionals to participate in the Medicaid meaningful use program. It is estimated that 80 percent of California clinic corporations are participating. This is an opportunity for clinics to achieve a 100 percent clinic EHR implementation rate (it is estimated to be 50 percent currently), as well as recoup their IT costs. However, there are some limitations for CCHC participation. First, it is the provider's choice to reassign the payment to the CCHC. Second, not all provider types are eligible, such as Behavioral Medicine Specialists without the requisite credentials. Last, funding does not cover the full implementation costs, including the losses in productivity, which can occur as systems are replaced and staff are retrained.

Children's Health Insurance Program (CHIP)

The ACA makes numerous changes to the CHIP program through 2013, including the addition of incentives to states to expand outreach as well as tools to simplify the enrollment process. Under the ACA, states must maintain their current eligibility for CHIP until 2019 and funding is extended through 2015. Also, beginning in 2015, states will receive a 23 percent increase in their federal Medicaid matching rate for CHIP expenses up to a cap of 100 percent. Nationally, an estimated 6.5 million children will gain coverage.[29]

California's CCHCs are slated to receive a Prospective Payment System (PPS) rate with retroactive payments. Although children covered under CHIP (referred to as Healthy Families in California) represented a small percentage of total clinic revenues (1.8 percent) in 2011, shifting to paying CCHCs at their PPS will have a significant financial impact.[30] California adopted the October 2009 timeframe and began making payments to CCHCs in September 2011 equal to $20.1 million for the period of October 2009 through June 2011; they will continue to receive $14 million available annually in new funding.[31] However, the Governor's 2012-13 budget proposes to reduce the Healthy Families managed care rates by 25.7 percent effective October 1, 2012. The state is also in the process of moving 860,000 Healthy Families enrollees into Medi-Cal beginning on January 1, 2013. While clinics will retain their PPS rate, there could be a potential interruption of coverage for over 120,000 children that are served by California CCHCs. [32]

Patient Protection and Affordable Care Act (ACA) of 2010

The Patient Protection and Affordable Care Act (ACA) makes a significant investment in the expansion of FQHCs using multiple strategies. The health center provisions are intended to create the primary care workforce and infrastructure to meet the health care needs of the newly insured. Additionally, the launch of the CMS Innovation Center under the ACA is an opportunity for CCHCs to take advantage of "building blocks" that will help to lay the ground work for payment and delivery system reforms that are intended to increase efficiencies and stabilize costs, while providing higher quality of care. The ACA also emphasizes access to affordable health insurance and greater clinical integration and health care innovation.

Nationally, clinics will play a pivotal role in caring for the newly insured and are anticipated to serve 44 million patients in 2015 and 50 million in 2019. The proportion of Medicaid patients being served by clinics will rise from 36 percent in 2009 to 44 percent by 2019.[33] However, their role of "provider of last resort" is unlikely to change dramatically. The remaining uninsured served by health clinics is estimated to decrease from 38 percent in 2009 to 22 percent in 2019.

Investments in Clinic Capacity

Nationally, FQHCs will receive $11 billion over five years under the ACA: $9.5 billion for operational capacity to serve nearly 20 million new patients, including new service sites and services, and $1.5 billion for capital improvements, such as IT systems. They will receive an additional $1.5 billion in capital funding, which the Department of Health and Human Services (HHS) is issuing in two blocks.[34] It issued $732 million in the first block, with a little more than $80 million of that going to clinics in 13 California counties. Another $728 million was granted in the spring of 2012 with $105 million going to 26 clinics in California. However, the amount meets less than half the demand. HHS received more than 700 applications with requests for more than $1.6 billion.[35] Key areas receiving funding are described in **Figure 2**.

Figure 2: ACA Clinic Funding

- National Health Service Corps (NHSC): To help clinics meet the increased demand for services once the Exchange and Medicaid expansion are implemented, the NHSC will receive $1.5 billion over five years (through FY 2015), which will help place an estimated 15,000 primary care providers in communities. Loan repayment awards to NHSC members are currently limited to $30,000 per year, although awards of up to $50,000 per year are authorized under the ACA.[36] However, this comes after a period of increased funding for the NHSC under the ARRA. It is anticipated that there will be fewer new grants awarded in the future and some clinics that have been funded by the NHSC may experience a loss in funding, especially those with low HPSA scores.[37] As of September 2012, there were 948 NHSC clinicians providing primary care services in California compared to 362 in 2008;[38]
- Teaching Health Clinics: The ACA authorizes a new Title VII grant program for the development of residency programs at health clinics and establishes a new Title III program that would provide payments to community-based entities that operate teaching programs (an approved graduate medical residency program in a FQHC, community mental health center, rural health center, or IHS health center). The program will receive $25 million for FY 2010, $50 million for FY 2011, and such sums as may be necessary for each fiscal year thereafter. Also, the ACA directly appropriates $230 million over five years under the Public Health Service Act for Title III payments. The application for grants was released in September 2011 for $16.5 million to support 30 entities;
- Nurse Managed Health Clinics (NMHCs): A $50 million grant program was established for each of FY 2011 through FY 2014 to provide funding for community-based primary care sites administered by advanced practice nurses. NMHCs will provide comprehensive primary health care and wellness services to vulnerable or underserved populations. In FY 2012, California received $2.9 million in grant funding to support nurse managed clinics; and
- School-Based Health Centers (SBHCs): A $50 million grant program was established for each of FY 2010 through FY 2013 to pay for the operating costs of SBHCs that provide age-appropriate services. In California, 39 grantees were awarded a total of $15.7 million in FY 2012.

The opportunities for CCHCs are significant. The Insure the Uninsured Project (ITUP) estimates that California clinics will receive $1 billion in new funding over five years.[39] But this funding is not guaranteed and funding cuts in other areas can have an impact on ACA clinic funding as evidenced by the elimination of $600 million in Health Center Program funding and the reduction of the original $1 billion in ACA funding to clinics through FY 2011 (see **Table 1**). Another issue is that upwards of 200 non-profit California clinics do not have Section 330 health status and will not directly benefit from federal grant funding, including the ACA.[40]

There are many other ACA provisions that are not directly targeted to CCHCs that hold promise of having a significant impact on clinics, including:

- *Insurance expansions* (Medicaid expansion, Health Benefit Exchange, Patient Navigators, Basic Health Plan, and Medicaid Primary Care Reimbursement Floor);
- *Medicare payment reform* (PPS for clinics and elimination of Medicare payment cap);
- *Delivery system reform* (Patient-Centered Medical Home and Accountable Care Organizations); and
- *Prevention expansions* (Community Transformation Grants, Community Health Teams, Preventive Care Incentives, and expansion of prevention services covered by private health plans).

These provisions are described in more detail below.

Insurance Expansions

Medicaid Expansion

The Supreme Court ruling in July 2012 gave states the option to expand Medicaid eligibility to low-income adults under age 65 with incomes less than 138 percent of the FPL without any categorical restrictions. However, states are required to implement the other ACA-related Medicaid provisions, including streamlining eligibility and enrollment. In California, AB 50 (Pan) would simplify the Medi-Cal eligibility process and allow hospitals to determine presumptive eligibility for Medi-Cal, allow for electronic verification, and protect consumers from being steered to a health plan and/or provider without his/her consent. States are also required to maintain their current Medicaid and CHIP eligibility for children until 2019 and to maintain their current Medicaid eligibility for adults until new insurance Exchanges are operational in 2014. An estimated 2.5 million people under the age of 65 are currently eligible but not enrolled in state-only Medi-Cal (California's Medicaid program) or Healthy Families and more than 1.4 million Californians will be newly eligible for Medi-Cal under the optional expansion.[41]

The financing is intended to be cost neutral to state government. States will receive 100 percent federal funding for 2014-2016 for all the newly eligible populations; 95 percent in 2017; 94 percent in 2018; 93 percent in 2019 and 90 percent thereafter. The financial gains to the state will be significant. It is estimated that the increase in Medi-Cal enrollment based on the expansion and the increase in enrollment among the already eligible but not enrolled Californians will generate between $2.1 billion and $3.5 billion in new federal funding in 2014 and between $3.4 and $4.5 billion by 2019.

California has made a commitment to undertaking the optional Medicaid expansion although there is not a consensus about how to proceed. State lawmakers passed Medi-Cal expansion bills (ABX1-1 and SBX1-1) to expand program eligibility to more than one million people and simplify eligibility and enrollment. However, Governor Jerry Brown (D) is seeking a limited expansion. In addition to proposing to eliminate the expansion program if federal funding drops below the 90 percent match, the Brown administration is proposing to limit optional benefits, limit former foster youth enrollment in Medi-Cal, and roll back existing income deductions that allow some low-income parents to qualify.

California's CCHCs (FQHCs) provide services to 16 percent of the Medi-Cal population and they will benefit financially from expanded Medicaid eligibility. The expansion will provide the means to invest in capacity-building initiatives to meet the needs of the newly insured under public and private insurance programs, as well as those who remain uninsured.[42] Under the ACA, FQHCs are guaranteed their PPS rate for previously eligible and newly eligible beneficiaries. The state Medicaid agency is required to reimburse CCHCs the "wrap-around" payment. Resources provided under the ACAto expand clinic services and the primary care workforce are intended to prepare clinics for this expansion.

CCHCs will be key players in addressing the health care needs of many already and newly eligible Medicaid beneficiaries. If the Medicaid expansion is fully implemented, FQHCs will see approximately 20 million new patients nationally.[43] In California, it is estimated that between 750,000 and 910,000 newly eligible Californians under age 65 and between 240,000 and 510,000 already eligible people are expected to enroll in Medi-Cal by 2019.[44] The state and private foundations are engaging in multiple strategies to boost Medi-Cal enrollment, which will have a positive impact on health outcomes and stabilize funding to clinics. The California Endowment recently announced that it is committing $20 million to Medi-Cal Assister payments. Combined with the 50/50 federal match, this translates into 450,000 to 500,000 retention payments.

While the shifting of uninsured health center patients into Medi-Cal will have a positive economic impact on CCHCs, these gains will be challenged on a couple of fronts. There is also a push to transition 28 counties into Medi-Cal managed care, which is not widely supported by consumers. Enrollment in managed care has steadily grown from 3.2 million people in 2006 to 4.0 million people in 2010, eclipsing the 3.4 million enrolled in Fee-For-Service Medi-Cal.[45] Second, the state's overall provider capacity will shape the Medicaid expansion since the newly insured will demand more primary care services. Roughly half of all practicing physicians have closed their practices to Medi-Cal patients and Medi-Cal patients are clustered into a small share of practices and clinics with 25 percent of physicians providing care to 80 percent of Medi-Cal patients.[46] However, California may not fare that poorly. In their analysis, Ku et al. rated California 30th and gave it an Access – Challenge Index score of 88.8, where scores above 100 are predicted to have higher-than-average Medicaid expansions relative to their primary care capacity.[47] Similarly, Cunningham reports that California has between 11.5–15 Primary Care Physicians (PCPs) per 10,000 persons, the median.[48] Several strategies are being considered to expand primary care capacity, including legislation that would expand the scope of practice for mid-level health care providers in California and loan forgiveness programs for providers that practice in underserved areas. The California Endowment is providing $90 million to increase the number of health care professionals in medically underserved areas.

CCHCs will need to attract the newly insured under Medicaid as well as maintain their current patient base and position themselves as "providers of choice." They have a strong base upon which to build and patient satisfaction with CCHCs is high. A recent Blue Shield of California Foundation (BSCF) study found that 44 percent of CCHC patients reported their satisfaction with CCHCs as "excellent" as compared to 56 percent of patients served by Kaiser or private doctors. However, less than half (46 percent) of CCHC users said that the reputation of CCHCs was "excellent" or "very good."[49]

CCHCs are part of the movement to develop a "culture of coverage" and they will need to address the health needs of a population that does not have a history of coverage under Medi-Cal and has had limited access to health providers in the past. The health status of the newly insured Medi-Cal population may also pose some challenges for clinics. Most of the uninsured are a relatively young population (60 percent are under the age of 40) and no less healthy than current, non-disabled Medi-Cal enrollees. But a segment of the population (15 to 25 percent) could have significant health care needs and require coordinated care across primary, mental health, and specialty care services.[50]

The Medicaid expansion is an important vehicle for achieving broader policy objectives to expand access, quality, primary care capacity, and develop new models of primary care. However, pressures to reduce the federal budget deficit through cuts in Medicare, Medicaid and Medicaid block grants are serious threats. At the state level, the expansion comes at a time when California is struggling to fund its share of the program and is seeking cost-savings. While the state proposes to participate in the Medicaid expansion, the administration is considering tapping into the anticipated savings to counties when many indigent patients go into Medi-Cal to help off-set the costs of the mandatory expansion.

Counties are at risk of losing some of their realignment funding (between $300,000 and $1.4 billion), which is used to provide care to the medically indigent. CCHCs that contract with counties to provide services to the indigent population could be at risk of losing this funding.[51]

Health Benefit Exchange (Covered California)

Under the ACA, states must have fully functioning Exchanges for lower and middle-income individuals between 133 and 400 percent of the FPL and small businesses (Small Business Health Options or SHOP Exchange) by January 2014. The goal is to create a competitive, transparent marketplace that brings Medicaid, subsidies, and CHIP seamlessly together. The Exchange is an important vehicle for delivery reform and participating health plans are expected to act as vehicles for transforming health care delivery, including care coordination, prevention of hospital readmissions, adoption of a medical home model, and adoption of wellness and health promotion activities. It is also a tool for states to advance other health care priorities, such as payment reform, Patient-Centered Medical Home (PCMH) development, and consumer-directed health insurance. Most of the responsibility for the design and implementation is left to the states. In California, AB 1602 and SB 900 created California's Health Benefit Exchange in 2011. The state received a Health and Human Services (HHS) Level 1 Exchange establishment grant in August 2011 for $39 million and in August 2012 it received another $196 million HHS establishment grant to cover operating expenses through June 2013. The state was awarded a $674 million Level 2 establishment grant in January 2013 to fund the set-up of the Exchange through 2014.

The California Health Benefit Exchange, which was renamed "Covered California," has made considerable progress in laying the groundwork for achieving its mission to "increase the number of insured Californians, improve health care quality, lower costs, and reduce health disparities though an innovative, competitive marketplace that empowers consumers to choose the health plan and providers that give them the best value." It has had to move quickly to fulfill this mission, including:

- Approval and launch of the Statewide Marketing, Outreach and Education Program and the Assisters Program strategies (June 2012);
- Approval of policies that will govern the participation of Qualified Health Plans (QHPs) in the Exchange (August 2012);
- Passage of AB 1453 (Monning) and SB 951 (Hernandez), establishing Essential Health Benefits;
- Conditional approval of an online marketplace (January 2013); and
- Development of a "bridge" between Medi-Cal/CHIP coverage and private insurance in the Exchange (February 2013).

Recently, the Exchange received conditional approval from the U.S. Department of Health and Human Services (HHS) to establish a health care marketplace on January 3, 2013 and it anticipates enrolling individuals beginning on October 1, 2013.

There are many components of the Exchange that will have direct and indirect impact on California's CCHCs. There are provisions in the final Exchange regulations issued by HHS in March 2012 that encourage, but do not require, full participation by safety net providers in the Exchange. Qualified Health Plans (QHPs) are not required to contract with "essential community providers," which includes providers participating in the 340b program, such as FQHCs and safety net hospitals. Instead there are network adequacy standards that require QHPs to maintain a network of providers that is sufficient in number and types of providers and include essential community providers. States may develop more rigorous standards, providing an opportunity for clinics to make the case that QHPs should be required to contract with clinics. In California, CCHCs have prevailed and QHPs must contract with a "sufficient" and "reasonable" distribution of essential community providers, including 15 percent of all eligible providers in every service area with a balance of hospital and non-hospital 340b providers.[52]

A key goal of the Affordable Care Act is to make sure that everybody is able to get and keep insurance while driving down costs. In California, low-income individuals up to 400 percent of the FPL will have access to affordable plan options through Covered California that will be substantially less expensive than they pay today (for example, households earning 250 to 400 percent of the FPL will pay on average 45 percent less), reducing the barriers to coverage.[53] CCHCs are anticipated to experience an increase in the number of insured patients and a decrease in uncompensated care for high-income uninsured and underinsured. Nationally, privately insured patients, including those covered by Exchange plans, are projected to increase from 14 percent in 2010 to 23 percent in 2019. The number of clinic uninsured patients is projected to decrease from 38 percent in 2010 to 22 percent in 2019.[54] In California, between 790,000 to 1.2 million uninsured adults and children are expected to receive subsidized coverage under Covered California. The number of remaining uninsured is projected to be between 3.1 million and 4 million (including 1.2 million undocumented) in 2019.[55]

The Exchange is also a means for ensuring that CCHC patients have access to comprehensive services. Beginning in 2014, individual and small group health plans must offer an Essential Health Benefits (EHBs) package, which includes services in 10 broad categories, including mental health and substance abuse treatment services. While it is a robust set of benefits that align with benefits covered under the Kaiser Small Group 30 health plan, they do not include dental and vision benefits, services that are part of the comprehensive bundle of services offered to CCHC patients, as well as CCHC enabling services, such as case management and health education. California passed AB 1453 (Monning) and SB 951 (Hernandez) to establish the state's Essential Health Benefits in October 2012. Individual and small group markets inside and outside the Exchange and the Medi-Cal plans are required to cover the EHBs. The state still needs to select its Essential Health Benefits benchmark plan for Medi-Cal. It recently opted to have the same comprehensive benefits for the optional Medicaid expansion, including long-term care, mental health and substance abuse.

A major concern is whether or not clinics will be adequately paid by Qualified Health Plans (QHPs) for providing their full range of comprehensive services to increasing numbers of privately insured patients. In California, commercial plans represented 4.5 percent of clinic patient revenues in 2011.[56]

Private insurance paid substantially less per encounter or $115 in 2011 (versus $136 under Medi-Cal managed care). In FY 2011, CCHC net revenues from commercial plans were $115.8 million.[57]

The final regulations uphold the earlier requirement that QHPs must pay FQHCs no less than their Medicaid PPS rate unless the QHP and a FQHC negotiate a mutually agreed upon payment rate that is at least equal to the generally applicable rates of the QHP. However, a QHP must pay a FQHC its PPS rate if the clinic provides services to an out-of-network QHP enrollee. While QHPs could potentially force FQHCs to accept a lower payment rate or forgo a contract if they do not, there are some protections in the ACA and final Exchange rules that clinics can draw on to preserve their Medicaid payment rate. States can require QHPs to contract with any willing clinics. In California, the Exchange has opted to encourage QHPs to include FQHCs in their networks by assigning greater weight to QHP bids that include FQHCs.[58]

There are many hurdles to expanding enrollment and maximizing clinic participation in Covered California. The ACA does not provide any safeguards regarding the assignment of lives and there is the possibility that clinic target populations will not be enrolled due to a complicated enrollment application. To streamline enrollment, the state and Covered California are establishing CalHEERS, an electronic hub where individuals can enroll in the Exchange and be referred to Medi-Cal. It will become operational in the summer of 2013 and CCHCs can start enrolling people on September 28, 2013. It is also possible that too few patients or a high number of adversely selected patients will be assigned to clinics. Therefore, it is critical that there be adequate opportunity and information for enrollees to select a clinic, in addition to default enrollment provisions that benefit clinics. Last, it is also possible that some clinic patients will be at risk of losing coverage under the Affordable Care Act. California is considering providing premium assistance to purchase coverage in the Exchange to lawful immigrants who have lived in the United States for less than five years instead of enrolling them into Medi-Cal under the optional Medicaid expansion. There are concerns that this population will be unable to afford coverage through the Exchange and remain uninsured. The Governor's revised budget proposal for FY 2013-2014 (May Revision) proposes to cover all cost sharing not covered by the federal premium tax credits.

The ACA recognizes that success of the Exchange hinges on reaching as many people as possible and generating sufficient enrollment in the participating plans. In California, this translates into 5.3 million people who will be targeted through marketing and outreach activities of the Exchange. Because many Californians have never purchased health insurance on their own, a multi-pronged outreach approach is required. Covered California plans on spending $290 million on public outreach.

It recently launched the Outreach and Education Grant Program in January 2013 and is allocating $43 million to community groups of all types to raise awareness and educate people about Covered California over a two-year period. It is targeting upwards of: 2.6 million people who qualify for subsidies and 2.7 million who do not qualify for subsidies.[59] The Governor's proposed budget (May Revision) includes an increase of $71.9 million in 2013-14 for increased county administration costs related to implementing the Affordable Care Act, such as training eligibility workers and processing insurance applications. Additionally, HHS recently announced a new $150 million initiative to help FQHCs enroll uninsured patients in health insurance exchanges. All California grantees will receive approximately $50,000 to hire and train staff, conduct community outreach activities, and provide in-person enrollment assistance, for a total of $22 million in new funding.

Patient Navigators

Additionally, the ACA requires that Exchanges establish a Navigator program and it details eligibility requirements for entities to receive a Navigator Grant, entities that can and cannot have Navigator programs, and activities that a Patient Navigator must perform. Patient Navigators provide assistance with coordinating health services and provider referrals, and disseminate information about clinical trials. There is a priority on improving outreach to populations with disparate health status or access. California state law (AB 1602) repeats the ACA duties. The California Health Benefit Exchange approved the Assisters Program in June 2012, which builds on existing application assister capacity and provides in-person assistance to help eligible individuals apply for coverage through Covered California. The Program taps into 44,000 Certified Application Assisters and Eligibility Workers, as well as health insurance agents, consumer assistance groups and advocacy groups. While all Assisters will be trained, certified and registered with the Exchange, only designated Navigators will be compensated by the Exchange. Additionally, in 2013, the Center for Medicare and Medicaid Services (CMS) is distributing $54 million in grants to fund Navigators for one year.

Community clinics were identified as the only health care providers eligible to receive Navigator Program grants. They will receive $58 for each successful enrollment application into a Qualified Health Plan (QHP) in the Exchange. Clinic consortia, local health plans, Promotoras, community clinics, and consumer organizations would be possible Navigators. Only health insurance issuers, hospitals and providers cannot serve as Navigators. California clinics already perform this function and have existing partnerships with CAAs. However, they will have to do more than just assist individuals in applying for coverage. The BSCF study on low-income consumer perceptions suggests that six out of 10 would switch to a new facility. Cost of care, location of the facility and short wait times were key reasons for choosing a new health care provider.[60] To participate as "providers of choice" in the Exchange and expand their privately insured patient base, California's CCHCs will have to transform themselves, such as upgrading the front office and changing their billing practices.

Last, it is important that newly covered individuals have continuous coverage under the Exchange and avoid disruption in care as their income changes. During the Special Session, the state is considering a Bridge Plan (SBX1-3), which will offer low cost Bridge plan options to be provided as soon as possible in 2014. Individuals between 138-200 percent of the FPL will have the option of staying with their Medi-Cal Managed Care plan and provider network or transitioning into private insurance coverage under Covered California as their income increases. They would only have the low-cost plan option if they remained in their Medi-Cal Managed Care plan. Family members could also be covered by a single plan with the same provider network. Between 670,000 and 840,000 people are estimated to enroll in the first year.[61]

The Bridge Plan is an opportunity for CCHCs to participate in Covered California as well as ensure continuity of care for this population. However, CCHCs would not be guaranteed their PPS rate since the Medi-Cal coverage would be under the auspices of Covered California. The Bridge program was adopted by the Covered California Board in February 2013 and is anticipated to go live in April 2014.

Basic Health Plan (BHP)

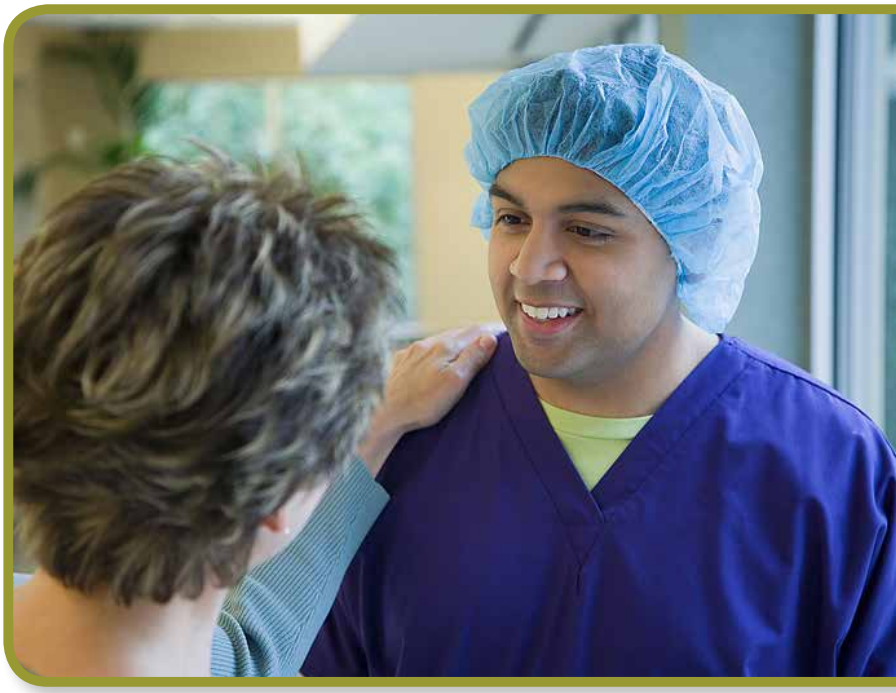
The ACA gives states the option to create a low-cost plan for individuals with incomes between 134 percent and 200 percent of the FPL, including legal permanent residents with incomes below 133 percent of the FPL who are ineligible for Medicaid. The BHP has some advantages in that it would lower costs for low-income consumers compared to the Exchange, ensure continuity of care between coverage programs as income fluctuates, and leverage safety net providers that already provide care to these populations. The BHP population would be the first income group to receive a subsidy through the Exchange and are likely to fit into the hardship exemptions and remain uninsured if the Exchange is their only option.

The federal government will support 95 percent of the premium credits and cost-sharing reductions that individuals would have otherwise received if enrolled in the Exchange. Premium rates and provider compensation would need to be below the 95 percent Exchange threshold to prevent state costs. In addition, the federal government will pay states a cost-sharing subsidy, based on the cost-sharing subsidy available under the Exchange. States have significant discretion in the design of their programs in ways that may depart from ACA rules.

In California, it is estimated that between 720,000 and 950,000 eligible individuals would enroll if the BHP were enacted, increasing coverage by 60,000 to 120,000 people by 2019.[62] This would mean clinic patients between 133 percent and 200 percent of the FPL would be covered, possibly by a Medi-Cal managed care plan. (California's clinics saw 778,859 people between 100-200 percent of the FPL in 2010.[63])

California legislation to implement a BHP or SB 703 (Hernandez) was proposed in 2011 but failed to make it out of the Assembly Committee on Appropriations in 2012. SB 703 included several provisions that benefit safety net providers. It required both safety net participation and creation of a community provider plan that has the highest percentage of traditional and public and private safety-net providers in its network and it provided care to legal permanent residents that do not qualify for Medi-Cal. However, it did not provide PPS rates to clinics.

The federal rollout of the BHP has been postponed until 2015. In the meantime, states can work with the Department of Health and Human Services (HHS) to develop similar strategies to ensure continuity of coverage and affordability of individual income changes, such as California's Bridge Program. Additionally, Covered California is working to ensure that affordable coverage is available through the Exchange. It recently established standard benefit designs, ensuring that Californians will be able to compare plan options and make informed choices. Consumers can use the new consumer website—CoveredCA.com—to get information about their exact benefits, premium costs and out-of-pocket costs. Moreover, households earning less than 250 percent of the FPL will receive significant financial assistance, increasing the likelihood that they will seek preventive care and address health issues before they become medical emergencies.



Medicaid Primary Care Reimbursement Floor

Under the ACA, Medicaid payment rates for primary care physicians will be raised to the level of Medicare payment rates for equivalent primary care services starting January 1, 2013 through December 31, 2014. The goal is to encourage physicians to continue accepting Medicaid patients, as well as encourage those who do not accept Medicaid. However, the Medicaid reimbursement floor will have varying impacts on physicians in different states. In California, the Medicaid-to-Medicare Fee Ratio for all primary care services was 0.47 in 2008 (compared to the national average of 0.66).[64] California physicians should see a much greater increase in Medicaid rates, which should help with capacity issues. Additionally, physicians could gain from more continuously covered adults. On the other hand, physicians may not expand their practice if the fee increase only lasts two years. Managed care organizations, which also pay physicians, are under pressure to reduce rates and may not be able to comply without federal and state assistance. They will have to adjust their capitation rates. In California, the rate increase is expected to go into effect by summer 2013. It applies to both Fee-For-Service and managed care systems. The savings to California are estimated to be approximately $82 million.[65]

The direct impact on CCHCs may be negligible and a large percentage of patients are not expected to shift to private physicians. However, expanding primary care capacity overall will help relieve some of the provider capacity issues anticipated by expanding the number of insured Californians. While FQHCs and Rural Health Clinics (RHCs) are not eligible for the rate increase, the state is seeking guidance from CMS about whether or not non-FQHC licensed community clinics are eligible.

Medicare Payment Reform

The Medicare program is seen as a vehicle to achieve transformation in health care delivery, a common theme in U.S. policy. While a smaller percent of California's CCHC patients are on Medicare (in 2010, Medicare patients comprised five percent of health center patients), the proportion of CCHC Medicare patients is likely to increase with an aging population.[66] In California, there are approximately 1.6 million Medicare beneficiaries.

There are some opportunities for CCHCs under the ACA Medicare provisions. The Medicare payment cap on FQHC payments, which was established in 1992 and is estimated to adversely affect nearly 75 percent of FQHCs, will be eliminated.[67] Other opportunities include:

- *Medicare Primary Care Bonus*: From 2011 to 2016, the ACA provides a 10 percent bonus payment to Medicare primary care providers and to general surgeons in Medicare. Bonus payments may range from $2,000 per year to $16,000 per year. It will be payable to physicians, nurse practitioners, clinical nurse specialists, and physician assistants who furnish at least 60 percent of their services in these primary care codes. In addition, the bonus will be available to practitioners who provide major surgical procedures in areas of the country where there are shortages of health care professionals. Upwards of $3.5 billion will be made available; and
- *Develop PPS Rate for Health Center Services:* A new prospective payment system for Medicare covered services furnished by FQHCs, including preventive services, will be developed and implemented on or after October 1, 2013. Upwards of $400 million in additional revenue for clinics is expected.[68]

Delivery System Reform

Woven through the ACA are several strategies to generate bottom-up transformation in the way health care is delivered. One strategy that directly affects health center operations is supporting health center adoption of the Patient-Centered Medical Home (PCMH). It is estimated the U.S. health system could save upwards of $175 billion over 10 years if primary care providers shifted to a medical home model.[69] Another potentially important vehicle for the integration of clinics with other providers, while containing costs, is participation in Accountable Care Organizations (ACOs). These provisions are described below.

Patient-Centered Medical Home (PCMH)

The PCMH is a huge opportunity for CCHCs and is considered "the right thing to do for patients." The ACA provides grants to help clinics develop expertise in PCMHs, such as developing training programs, providing financial assistance to trainees and faculty, enhancing faculty development in primary care and Physician Assistant programs, and establishing/improving faculty units in primary care, where patients can receive regular care and have a health care team comprehensively address their needs. The ACA also gives states the option to enroll Medicaid beneficiaries with chronic conditions into a "health home" composed of a team of health professionals that would provide a comprehensive set of medical services, including care coordination. Specific health center opportunities are described in **Figure 3**.

California's CCHCs are natural medical homes. They already provide a wide spectrum of care and are familiar with the medical home models. Their experience in quality improvement and team-based disease collaboratives creates a foundation for the PCMH. CCHCs have made significant progress in the integration of primary care with mental health and other social services, positioning them ahead of other providers.

Figure 3: Health Center PCMH Opportunities

- *FQHC Advanced Primary Care Demonstration:* The FQHC Advanced Primary Care Demonstration is a three-year demonstration initiative that began November 1, 2011 to evaluate the effect of the PCMH in improving care, promoting health, and reducing the cost of care provided to Medicare beneficiaries served by FQHCs that serve at least 200 Medicare beneficiaries. The goal is to help patients get the care they need in a primary care setting rather than in an emergency department. FQHCs receive a monthly primary care management fee of $6 for each eligible Medicare beneficiary to help defray the cost of transformation. The health center must agree to pursue Level 3 PCMH recognition by National Committee for Quality Assurance (NCQA) by the end of the demonstration.[70] Centers for Medicare and Medicaid Services (CMS) will provide $42 million each to as many as 500 FQHCs in 44 states over three years to coordinate care for Medicare patients; $1 billion is expected to be invested over the course of the program. To date, 70 California FQHCs have been funded under the Advanced Primary Care Demonstration;
- *Medicaid Health Home State Plan Option:* Under Section 2703 of the Affordable Care Act, for states that opt to participate in the "health home" program, the federal government will provide an enhanced contribution (90 percent) exceeding the usual federal-state Medicaid matching rate for the first two years. This rate for primary care practices will vary by state, but could result in tens of thousands of additional payments to a health home practice each year.[71] As of July 2012, CMS had approved six health home State Health Plan Amendments submitted by four states and Washington, D.C. In addition, 14 states, including California, had applied and received a planning grant from CMS to explore the health home option;

Nationally, six percent of clinics have attained National Committee for Quality Assurance (NCQA) PCMH recognition and another twelve percent have a pending application.[73] Finally, clinics are the natural venue for improving population health and adopting the community-centered health home model.[74]

California is making steady progress in encouraging implementation of the PCMH. The state applied and received a planning grant from CMS to explore the health home option under Section 2703 of the Affordable Care Act. Additionally, the California Endowment has offered to provide the 10 percent state match to draw down the 90 percent federal match for a two-year pilot project, including enrollment of upwards of 400,000 persons with two or more chronic conditions receiving care through community clinics in an ACA Medi-Cal health home. Legislation has been proposed to this end or AB 361 (Mitchell), which would create a health home program for acutely ill individuals who frequently seek care in emergency rooms.

However, many of the barriers to health center adoption of the PCMH are financial. Level 3 PCMH accreditation requires significant clinic investment in infrastructure (EHR, evidence based guidelines, culturally competent care). In 2011, 47 percent of clinics reported having an EHR in place. Some clinics do not pursue NCQA recognition since there is no financial reward. Last, Medicare represents on average fewer than five percent of the clinic patient mix.[75] Some of these hurdles are being addressed at the federal level. The HRSA Bureau of Primary Health Care (BPHC) will cover the application fee. However, the cost of additional clinical staff or administrative staff is not captured under the current payment system.[76]

Figure 3: Health Center PCMH Opportunities (continued)

- HRSA is also providing funding under the FY 2012 Supplemental Funding for Quality Improvement in Health Centers to improve access to services, quality of care, and clinical outcomes through that patient-centered medical home model of care. The funding will also focus on improving outcomes related to cervical cancer screening for health center patients. In FY 2011, 101 California clinics received funding and 85 clinics received $55,000 each in FY 2012;
- The California Primary Care Association launched its Patient-Centered Health Home (PCHH) initiative in October 2012 to transform CCHCs into NCQA-recognized Patient Centered Medical Homes (PCMH). Upwards of 900 member clinics will have access to a web-based project management tool or PCMH Accelerator Portal, tailored coaching, online learning modules, and a data management and analytics tool to help them organize patient care, work in provider teams and track patient health over time;[72] and
- The Center for Care Innovations (formerly Community Clinics Initiative), with funding from The California Endowment, recently launched the Health Home Innovation grant program, which provides grantees up to $500,000 over two years to support the development of regional implementation of health homes for low-income populations and communities of color throughout California. Grantees include eight regional partnerships that include six clinic consortia, four local health plans and several CCHCs in San Joaquin, Inland Empire, San Diego, North Coast, Orange County, San Francisco, Redwood/Sonoma, and Santa Cruz County.

Accountable Care Organizations (ACOs

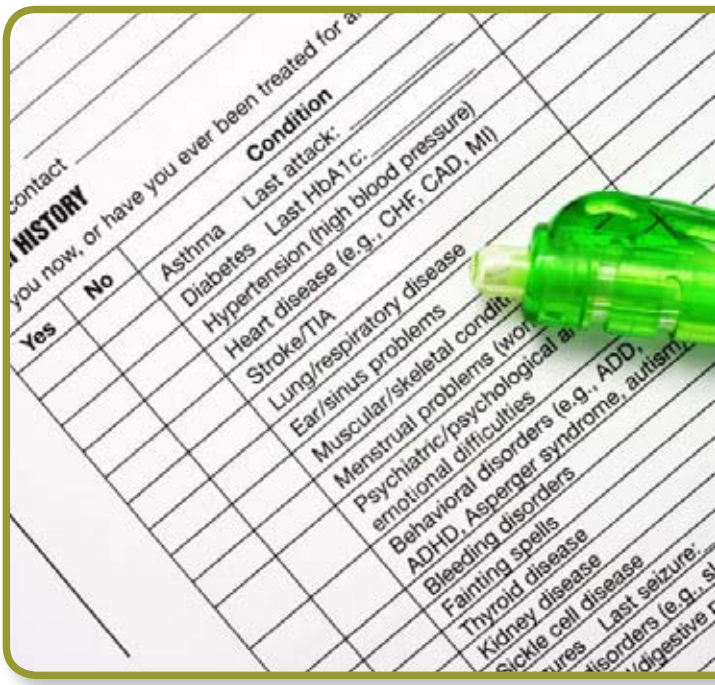
An ACO is a group of providers that has the legal structure to receive and distribute payment to participating providers. The goal of an ACO is to contain costs through better integration among health care providers, where delivering quality care is encouraged through financial rewards. The Congressional Budget Office (CBO) estimated Medicare ACOs would save $5 billion in its first eight years.[77]

Initially, FQHC-formed ACOs were barred from participating and FQHC Medicare patients were barred from being assigned to an ACO in which a FQHC participates. But with over 1,300 public comments submitted, the administration broadened participation to all communities and providers in different stages of integration in the final rules. It moved away from a prescriptive approach to facilitating collaboration among different providers throughout the country and across different payment systems. FQHCs and RHCs are eligible to form ACOs and Medicare patients served by FQHCs and RHCs can be assigned to an ACO.[78] A diversity of models now is allowed. The administration created a prospective assignment methodology tailored to FQHCs/RHCs. Last, it recognizes the greater use of practice teams and physicians as part of teams.[79] Several initiatives where clinics can participate as partner organizations are described in **Figure 4**.

Figure 4: Health Center ACO Opportunities

- Medicare Shared Savings Program (MSSP): The MSSP will provide incentives for health care providers who agree to work together and become accountable for coordinating care to at least 5,000 beneficiaries for a period of three years. Participants must meet certain standards and the higher the quality of care, the more shared savings the providers may keep. FQHCs and RHCs can work together in implementing this program. To date, 259 Medicare ACOs have been funded. Nine California ACOs were selected to participate in January 2013;
- Pioneer ACO Model: This initiative focuses on organizations with experience operating as an ACO. It is different from the MSSP in that it is designed to test the effectiveness of a particular model of payment. FQHCs can participate. Finalists were selected in December 2011 and six organizations out of 32 were from California;
- Advance Payment Model: With the final rule, CMS launched the Advance Payment Model in December 2011. It targets rural and physician-led ACOs, including FQHC-led ACOs that require capital to coordinate care. It tests the role of advance payments in increasing participation in the MSSP and improving care for beneficiaries. To qualify, an ACO must not include inpatient facilities that have less than $50 million in total annual revenue. They are eligible to receive three types of payments: 1) an upfront, fixed payment; 2) an upfront variable payment; and 3) a monthly variable payment depending on the number of Medicare beneficiaries. The CMS Innovation Center began accepting applications for the Advance Payment Models for ACOs beginning August 1, 2012. Only ACOs that enter the MSSP in April 2012 or July 2012 are eligible. Thirty-five ACOs participate in the program, including two organizations from California; and
- Comprehensive Primary Care Initiative: Medicare will work with commercial and state health insurance plans and offer bonus payments to primary care doctors who better coordinate care for their patients. CMS will pay primary care providers for improved and comprehensive care management and after two years offer them the chance to share in any savings they generate. Providers will receive a per-beneficiary, per month fee of about $20 for two years and then it will be reduced to an average of $15 for years three and four. After two years, all practices participating in this initiative will have the opportunity to share in the portion of the total Medicare savings in their market. The initiative will also be applied to practices serving Medicaid patients. The CMS Innovation Center announced the 500 participating primary care practices in August 2012. California was not one of the seven selected states.

The ACO provisions provide many opportunities for clinics to advance population health goals and participate in the development of new payment models. As leaders in patient-centered care, clinics are well positioned to participate in and/or lead ACOs, making primary care the core of any ACO. ACOs are also mechanisms to provide access to capital and investments in medical homes.



The clinic share of savings may be reinvested in clinic activities. California entities have received funding to study different payment methodologies. For example, the Integrated Healthcare Association received $2.9 million from Agency of Healthcare Research and Quality (AHRQ) in February 2011. Commercial ACO pilots are emerging in California, including a pediatric ACO in Orange County, and ACO principles may be incorporated into Section 1115 Medi-Cal Delivery System Reform Incentive Payments (DSRIP) initiatives.

Overarching issues that may impede CCHC participation in ACOs include the lack of a standardized definition, lack of financial reserves (capital and infrastructure), and lack of collaboration with other safety net providers.[80] Bundled payment requires clinics to understand their business in a different way to evaluate performance. There is also the question of whether FQHCs and other safety net providers will participate in California where there is high penetration of managed care and the perception that safety net providers already operate in an ACO-like model.

Prevention Expansions

Prevention figures prominently in the ACA and there are many grant programs that name clinics as mandatory partners. Specific provisions that have high applicability to CCHCs include:

Community Transformation Grants

CCHCs are eligible to apply for funding to implement community-based preventive health activities. All grantees will address key priority areas: 1) tobacco-free living; 2) active living and eating; and 3) evidence-based quality clinical and preventive services, specifically the prevention and control of high blood pressure and high cholesterol. Twenty-six states and communities will build capacity to implement change by laying a solid foundation for community prevention efforts. Funding for these initiatives ranges from $147,000 to $500,000. Second, thirty-five states and communities will implement evidence- and practice-based programs designed to improve health and wellness.

Funding for these initiatives ranges from $500,000 to $10 million. A total of $103 million was awarded in 2011. Four California grantees were Implementation grantees and six were awarded Capacity-Building grants. In 2012, $70 million was awarded, including continued funding for the four California Implementation grantees, five Capacity-Building grantees, and four communities funded under the CTG Small Communities grant.

Community Health Teams, Community-Based Collaborative Care Networks, and Primary Care Extension Centers

In 2011, the U.S. Department of Health and Human Services (HHS) began awarding grants to states, state-designated organizations, as well as American Indian tribes to establish "community health teams" to support patient-centered medical homes. These teams are comprised of a range of health professionals who will contract with local primary care services to provide support for an array of services, including preventive care and health promotion activities. A second grant program will support "community-based collaborative networks", which will help low-income individuals obtain access to and use of medical homes, conduct outreach, expand telemedicine, and provide direct patient care services. The program is authorized to run from 2011 to 2014. Finally, the Agency for Health Research and Quality (AHRQ) is responsible for establishing the Primary Care Extension Program, which will provide educational support and assistance to primary care providers. The legislation allocates $120 million for FY 2011 and 2012 for the Program, and such sums as may be necessary in 2013 and 2014.[81]

Incentives for Patients to Receive Preventive Care

Preventive services were added to the FQHC Medicare payment rate on January 1, 2011. This represents a federal investment of $3.6 billion to cover free annual wellness visits during which each beneficiary will receive a personalized prevention plan.

Preventive Services Covered by Private Health Plans

The ACA requires private insurers to cover certain preventive services without any patient cost sharing. This will also apply to individual and group plans in the Exchange. Many screenings, immunizations, and other preventive services are now available to consumers with no co-payments, co-insurance or deductibles. Governor Schwarzenegger signed AB 2345 (De La Torre) and incorporated the federal protections into law in 2010.

CCHCs have a long history of prevention and successful outreach to target populations in the communities they serve and they make ideal partners. However, many provisions are targeted to state and local governments. Another issue is that ACA funding for prevention is vulnerable to cuts as evidenced by the recent elimination of $5 billion (out of $15 billion) from the Prevention and Public Health Fund.

In sum, the ACA provides an infusion of new funding in many areas that will transform clinic missions and operations, including: increasing federal health center grants; increasing Medicaid revenues; expanding coverage through the insurance Exchange; and raising the Medicare payment rates (see **Figure 5**).

Despite new funding under the ACA, federal funding is increasingly constrained by larger political and economic forces, as well as programmatic restrictions (such as lack of funding for core support), and is not the solution to filling the gaps left by state and local budget deficits. While the ACA includes many opportunities for CCHCs to transform themselves and become "providers of choice," threats to federal funding jeopardize the primary care capacity expansions required for implementation of the Exchange and Medicaid expansion in 2014. Clinics will have to weigh these opportunities carefully and consider the challenges they pose.

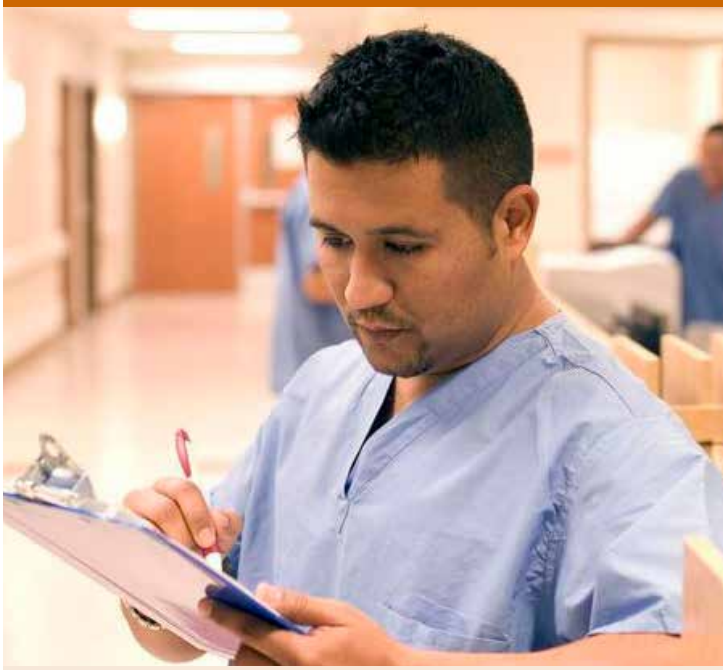
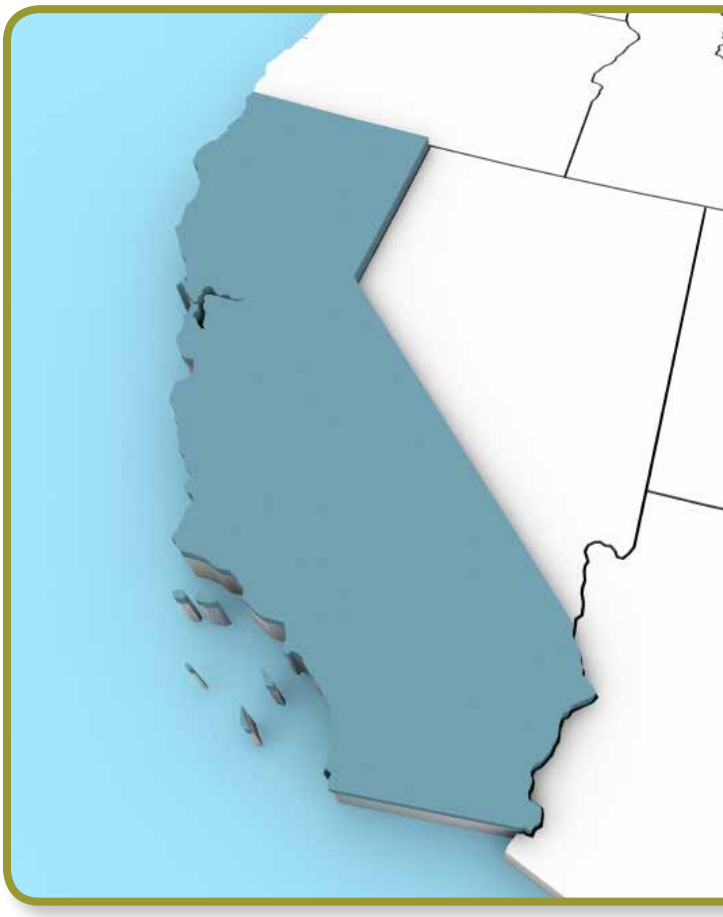


Figure 5: ACA Funding and Provisions Benefiting California Clinics

As of June 2012, the following reforms and allocations had taken affect, benefiting California CCHCs and their communities:[82]

- $727 million in capital grants to upgrade and expand clinics;
- $290 million in new funding for the National Health Service Corps (NHSC);
- $1.9 million to support 11 new Teaching Health Center residency programs;
- $28 million to support New Access Point grants (California received 45 awards);
- $31.6 million to support 904 Quality Improvement grants at clinics (California received 20 awards);
- $10 million to support 125 health center planning grants;
- $8.5 million to health clinics located in Beacon Communities (13 San Diego area clinics were awarded grants);
- $320 million from the Prevention Public Health Trust Fund to expand the primary care workforce;
- $250 million from the Prevention and Public Health Trust to strengthen clinical and community prevention efforts and public health infrastructure; and
- Coverage and no cost sharing for certain preventive services under Medicare and most health insurance policies.

STATE FUNDING

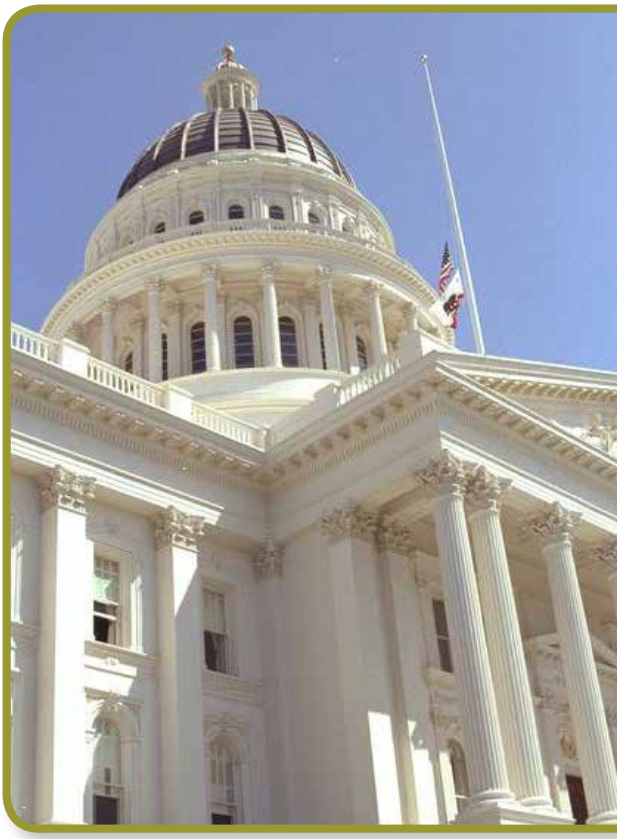


California's CCHCs have weathered some significant challenges at the state level in recent years, particularly the elimination of the Traditional Clinic Programs and Medi-Cal Optional Benefits in 2009, reducing state support for clinics by 40.5 percent from 2006 to 2009.[83] The California Primary Care Association (CPCA) determined that the reduced state support has resulted in a loss of $35 million annually in funding to clinics for Traditional Clinic Programs, a loss of $75 million annually in the elimination of adult dental services, as well as the closure of twelve clinics since 2009.[84]

Notwithstanding the state's improved financial picture with passage of Proposition 30 (a temporary sales tax increase and tax rate on higher incomes), the outlook in the near-term suggests continued pressure on other clinic funding streams. It is unlikely that previous cuts will be restored; state policy is a mixture of achieving cost-savings through perennial cuts to Medi-Cal and related programs serving low-income populations, while also quickly moving forward with implementation of ACA provisions. In 2012, the state passed legislation laying the groundwork for the Health Benefit Exchange, including the identification of Essential Health Benefits, restrictions on deceptive marketing in the Exchange, streamlining eligibility and enrollment in the Medi-Cal expansion, and notice of coverage options during life changes. The state has convened a special legislative session to focus on individual and small group market reforms, Medi-Cal eligibility, and establishing a "bridge program" in the Exchange. While the individual market reform bills and bridge legislation are anticipated to be passed by lawmakers by the end of the 90-day session, the Medi-Cal expansion bills may require further deliberation during the regular session.

The key state-level funding streams important to CCHC financial stability are discussed below, namely the Medi-Cal Program and the state's Section 1115 Medicaid Waiver or Low Income Health Program (LIHP).

Medi-Cal



California's Medicaid program (Medi-Cal) has posed serious challenges for CCHCs in recent years but this might be lessening as the state's overall financial outlook improves. General Fund expenditures for Medi-Cal are projected to increase from $14.6 billion in FY 2012-13 to $15.7 billion in FY 2013-14.[85] There are several aspects of the Medi-Cal program that are important to CCHC financial stability, including:

FQHC Payment Reform

In 2012, the Administration proposed to waive the Prospective Payment System (PPS) payment methodology for FQHCs and RHCs in managed care counties in favor of a Per Member, Per Month rate (PMPM). While FQHC payment reform is estimated to achieve a savings of $30 million for the state, it was anticipated to have a huge negative impact on clinics, including: clinic closures (particularly in rural areas), restricted access to services (such as hours), and decreased capacity to care for the uninsured. CPCA estimated that this translates into a 10 percent cut or $100 million annually.[86]

So far, the state has not been successful in reforming PPS. The state Assembly and Senate budget subcommittees rejected the proposal in April 2012. Currently, the state and CCHCs are exploring the option of developing and piloting an Alternative Payment Methodology (APM), which is viewed as a vehicle for payment reform. While states must still pay clinics an amount that is at least equivalent to what a clinic would have received under PPS, there is significant latitude in the type of payment methodology that can be used. With the goal of bending the total cost of the health care cost curve, improving health outcomes, and allowing CCHCs to transform delivery of care, the state and pilot clinics statewide are exploring a PPS-equivalent capitation model that builds on existing payment reform mechanisms (such as Pay-For-Performance (P4P) and capitation).[87] The state will still need to submit a State Plan Amendment (SPA) and get CMS approval before proceeding with the pilot, which will last two to three years.

Medi-Cal Managed Care Expansion

The Administration is shifting 28 rural Medi-Cal Fee-For-Service (FFS) counties to managed care, which would mean the PPS waiver would apply to all California clinics. There are concerns about provider network adequacy and access to specialty care in remote, rural areas. Many clinics do not have experience contracting with managed care organizations.[88] Additionally, Fee-For-Service patients tend to be more expensive, so in this sense, FFS ensures adequate payment to providers. In 2011, Medi-Cal FFS net revenue per encounter was $167 compared to $136 for Medi-Cal managed care.[89]

Ten Percent Medi-Cal Provider Rate Cut

In 2011, the state legislature approved AB 97, a 10 percent Medi-Cal provider rate reimbursement cut retroactive to June 2011, saving the state an estimated $431 million. CMS approved the state's request, however, the cut was blocked in January 2012 by U.S. District Court Judge Christina Snyder. This decision was overturned by the 9th Circuit Court of Appeals in December 2012, giving HHS Secretary Kathleen Sebelius the authority to decide whether or not states can reduce Medicaid rates. California health care providers appealed the court decision and filed a re-hearing request in January 2013. While the Governor has included the payment reduction in his 2013-14 budget proposal, there is a possibility that the cut will continue to face legal challenges well into the future. The cut does not apply to FQHCs, FQHC Look-Alikes and Rural Health Centers (RHCs), but they do apply to non-FQHC community clinics and free clinics and may be retroactive to June 2011, potentially compromising access to care during the Medi-Cal expansion.[90] Recently, state lawmakers have moved to repeal the Medi-Cal cut, passing AB 900 (Alejo) and SB 640 (Lara) in the House and Senate Committees on Health. The Governor remains opposed to rescinding the cut.

Section 1115 Medicaid Waiver: Low-Income Health Program (LIHP)

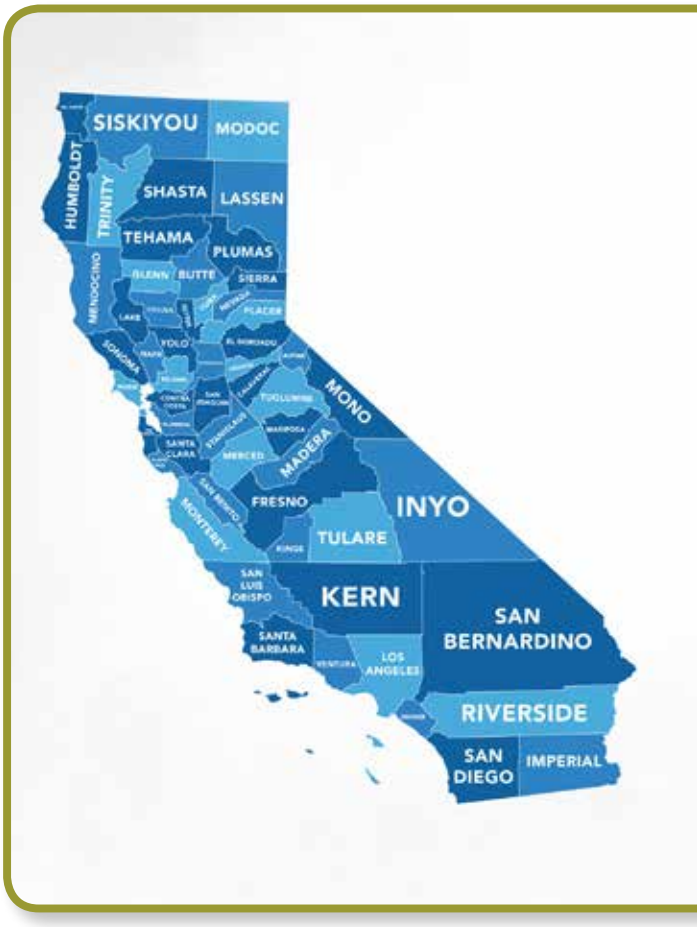
California's Section 1115 Medicaid Demonstration ("Bridge to Reform") under the authority of Section 1115(a) of the Social Security Act is intended to prepare California's health care safety net for implementation of the ACA coverage expansions in 2014. The five-year Waiver is an $8 billion investment by the federal government, which is estimated to prevent $500 million in additional Medi-Cal cuts.[91] Existing county health dollars are combined with new federal matching funds to provide coverage earlier than 2014. The federal match for the Medicaid Coverage Expansion (MCE) (470,000 enrollees under 133 percent of the FPL) is unlimited and for the Health Coverage Initiative (HCI) (27,000 enrollees between 133 to 200 percent of the FPL) is capped at $630 million.[92] Fifty-three counties have launched their initiatives, covering 642,192 adults (cumulative unduplicated enrollment). Five counties will not be implementing programs (Fresno, San Luis Obispo, Merced, Santa Barbara, and Stanislaus).[93]

CCHCs are anticipated to fare better under the current waiver than the last waiver where counties were not required to include CCHCs in their provider networks and some of those that did get contracts were dissatisfied with the reimbursement rates.[94] CCHCs already see a high number of uninsured patients—1.3 million in 2010—and make for natural partners.[95] Of the 53 counties that have launched their initiatives, an estimated 50 counties are contracting with non-county FQHCs.[96] The waiver requires that the LIHPs contract with at least one FQHC and that FQHCs be paid at their PPS rates, but does not require all non-profit FQHCs in a county to be part of the LIHP network.

The state has taken the first steps to transitioning LIHP enrollees to a coverage option under the Exchange or Medicaid expansion on January 1, 2014. It submitted an initial plan to CMS in August 2012, including stakeholder recommendations to use the LIHP enrollee's medical home to determine the plan assignment.

LOCAL/COUNTY FUNDING

California counties are integral partners in enacting specific health care reform provisions, such as participation in the Low Income Health Program (LIHP) and expanding provider capacity to address the health care needs of the nearly insured and remaining uninsured. However, implementation of the Affordable Care Act has created opportunities and challenges for counties. While county expenditures for the medically indigent are anticipated to decrease as these individuals gain coverage through Medi-Cal, the state is proposing to redirect these savings to local human services. It estimates that $300 million will be shifted in FY 2013-14, $900 million in FY 2014-15, $1.3 billion in 2015-16 and $1.3 billion in FY 2016-17.



State lawmakers are considering proposals to ensure that counties have adequate resources to care for the remaining uninsured— one million undocumented immigrants and two million legal residents who cannot afford health insurance but do not qualify for Medi-Cal. While the Governor wants to use savings from the optional Medicaid expansion to expand the counties' role in human services programs, specifically CalWORKs, CalWORKS-related childcare programs and CalFresh (formerly Food Stamps), some advocates have proposed shifting $700 million to the LIHP to serve the remaining uninsured.[97]

While CCHCs receive most of their funding from state and federal sources, county or local funding plays an important role and accounted for six percent of total clinic revenues or $168.4 million in FY 2011.[98] These include county contracts with CCHCs to provide services to medically indigent populations, allocation of local Mental Health Services Act (MHSA) funding to integrate primary care and mental health, and passage of local measures in some counties (such as Alameda County) to fund safety net health care services. For example, The Public-Private Partnership (PPP) Program is an organized system of primary health care clinics in Los Angeles County, which began in 1997 as an initiative of a Medicaid 1115 waiver. When the waiver terminated on June 30, 2005, the Los Angeles County Board of Supervisors voted to fund the PPP Program with county dollars. In 2008, the Board of Supervisors approved the allocation of $44.8 million in Tobacco Settlement funds to PPP clinics to support capital projects and renovations, a health information exchange to improve coordination of care, and expansion of primary and specialty care visits.[99]

As described above, CCHC participation in the LIHP is determined at the county-level and it appears that a majority of counties have developed contracts with CCHCs, even counties that have county-run clinics. These contracts are an opportunity to explore new payment models, such as an alternative payment methodology that is being discussed by Los Angeles County and non-county clinics that are providing services under the County's LIHP program. Additionally, CCHC relations with Medi-Cal managed care plans are key and could greatly benefit CCHCs when LIHP enrollees are transferred to these plans.

Last, CCHCs are being encouraged to negotiate new partnerships with other safety net providers as part of the movement to create integrated, seamless systems of care. However, there is great diversity in local health care safety nets, including many counties that do not have county-run health care services, such as Humboldt County and San Diego County, and many counties that have a mix of county-run and private safety net providers, such as Contra Costa and San Francisco. On the one hand, these different configurations may contribute to marketplace competition that is a disadvantage to CCHCs. On the other hand, there is evidence from other states that entering collaborative relationships with other private safety net providers has a positive effect on health center financial position, quality of care, staffing mix, scope of services, and center mission.[100]

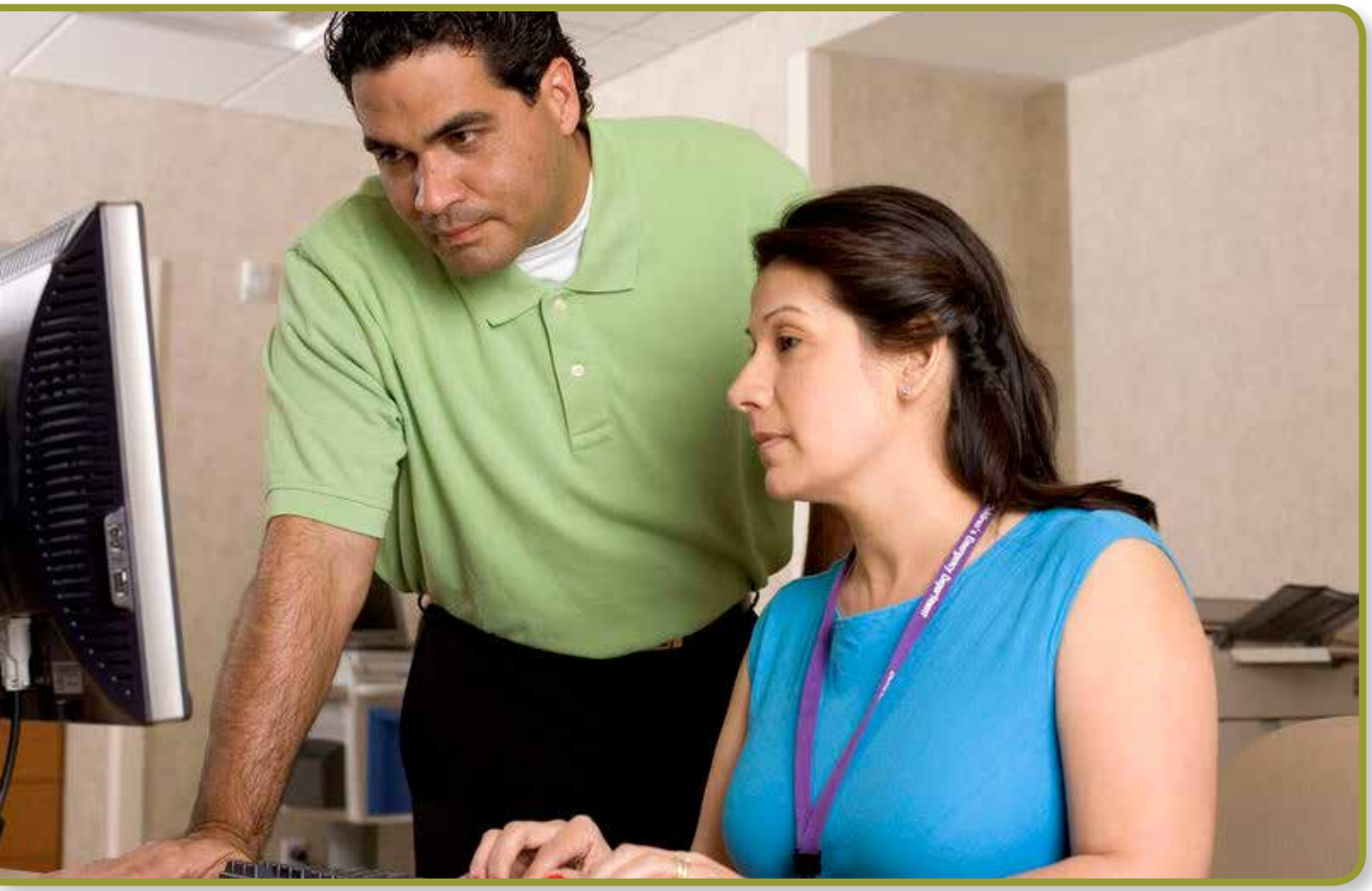
PRIVATE FUNDING SOURCES

CCHCs enjoy strong support from private foundations and other private funding sources, which have proved invaluable in expanding health center horizons. They have provided a mix of core support funding and targeted grant support to strengthen clinics operations, as well as expand clinic advocacy capacity. California's private philanthropies have also served as a safety net for CCHCs during the state's economic downturn, including the creation of a "rainy day" fund in 2009 to assist clinics during the budget impasse. They have provided support to CCHCs to prepare for health care reform, expand coverage, as well as facilitate adoption of Health Information Technology (HIT), chronic disease management models, and specialty care/primary care integration. Specific initiatives and support include:

- The Blue Shield of California Foundation provides grants for core operating support and provides support for clinic transformation under health reform;
- The California Endowment provides grants to most of California's regional and local clinic consortia and CPCA to engage in ACA education, policy, education and technical assistance about health home implementation and "no wrong door" enrollment activities;
- The California HealthCare Foundation launched the California Catalyst Fund in 2012, which provides technical assistance to CCHCs exploring or implementing strategic collaborations and restructuring projects. The Foundation also provides funding to eight CCHCs to measure, understand and improve the patient experience. Last, it matches experience leadership with clinics seeking to improve their performance under the Encore Fellows in Community Health Centers program; and
- The California Wellness Foundation provides core support assistance to clinics working to improve the health of underserved communities in California.

Last, Kaiser Permanente's Building Clinic Capacity for Quality (BCCQ) program provides support to CCHCs in Southern California to enhance their capacity to engage and sustain quality improvement initiatives that are supported by health information technology.

STRATEGIES TO ACHIEVE CLINIC FINANCIAL STABILITY



The ACA affords CCHCs many opportunities to leverage their strengths and achieve the three goals of the Triple Aim: improve the health of the population; enhance the patient experience of care; and reduce, or at least control, the per capita cost of care. New funding to expand services and facilitate adoption of new models of care will undoubtedly position health centers to provide care to the newly insured and remaining uninsured. However, federal, state and county budget deficits mean that health centers are under pressure to do more with less. Additionally, the remaining uninsured will still require a robust health care safety net. In California, the uninsured population is expected to decrease to 3.1 million people by 2016 with the launch of the Health Benefit Exchange.[101] How CCHCs accomplish the twin missions of addressing the health care needs of the newly insured, while also serving as the health care safety net for the remaining uninsured, depends on the ability of individual health clinics to maximize the opportunities under the ACA, as well as their ability to engage in collective action to preserve CCHC funding.

Individual Clinic Strategies

There is no one-size-fits-all approach to ensuring that individual CCHCs succeed in this quickly changing and uncertain environment. Local circumstances play a significant role in determining clinic opportunities, including competition among providers, unique target populations, geographic barriers, and organizational culture.[102]

For example, a health center that serves a large population of young families with children is likely to receive more Medi-Cal funding compared to a health center that primarily serves a large uninsured population. Nevertheless, there are some general strategies that individual CCHCs can undertake to enhance their operations while remaining financially viable. Drawing on the literature and interviews with experts, these strategies are listed by type in **Table 2** (see **Page 35**).[103]

First and foremost, *clinics need to aggressively manage their payer mix* so that it reflects changes in anticipated coverage expansions, such as pursuing outreach and enrollment. Despite the financial shortcomings of private insurance, CCHCs need to diversify their payer mix to include commercial plans and tailor services to a new population if it exists in their geographic area.

The emphasis on efficiency and high quality care will fuel the transition from payment for individual encounters to payment for episodes of care. *CCHCs will have to transition to payment models that emphasize value over volume*, including negotiating Per Member, Per Month (PMPM) rates that include clinic services and activities that are not usually reimbursed, such as enabling services. Concomitantly, clinics need to demonstrate that they provide added value and are able to "bend the cost-curve" of health care costs. *CCHCs will need to leverage their ability to provide high quality care*, while also ensuring that they still have the resources to support services for the uninsured. For many clinics this will mean expanding clinic facilities and considering new designs that support the Patient-Centered Medical Home (PCMH), such as co-location of mental health and primary care services. *Different care models need to be considered as well as care coordination approaches with other safety net stakeholders*. There is evidence that California's FQHCs are achieving some of the Triple Aim goals and demonstrating value. In the recent study by John Snow, Inc., adult patients being seen by FQHCs had lower unadjusted hospital utilization rates and lower hospital readmission rates.[104]

Strategic partnerships will be instrumental in expanding clinic capacity while shoring up a clinic's position in a competitive marketplace. Partnerships will also be essential in improving access to care as well as providing seamless, coordinated care to the newly insured and remaining uninsured. California has demonstrated progress in the integration of primary care and mental health under the Mental Health Services Act (MHSA) and the Specialty Care Access Initiative.

The Low-Income Health Program (LIHP) and Delivery System Reform Incentive Payments (DSRIP) under the Section 1115 Medi-Cal Waiver will be instrumental in ensuring access to a full range of primary care and specialty care for health center patients, as well as expanding clinic capacity to care for patients with chronic conditions. The California HealthCare Foundation launched the Strategic Restructuring Assistance to California Primary Care Clinics initiative in 2010 to provide technical assistance to five CCHCs interested in pursuing strategic restructuring and new partnerships to improve their competitive position, such as partnering with hospitals.[105]

Clinics will increasingly be seen as stewards of the health of their communities, including managing populations and generations. They will have to look beyond their usual populations and look at the community as a whole. While this has been a long-time goal of many CCHCs, they will have to transition to payment structures that emphasize population outcomes. *Clinics will need to modify operations in order to accommodate a broader patient-base,* such as redesign of the front office to address the needs of newly insured and/or installation of a kiosk to reduce wait time.

CCHCs will also have to marshal their expertise in addressing social disparities and expanding access to health insurance, as well as leveraging strategies to respond to the social determinants of health, such as providing culturally-appropriate nutrition education and working with community groups to change the environment surrounding a clinic.

CCHCs will need to be creative in how they expand provider capacity, including recruitment and retention of providers and coordinating with the National Health Service Corps (NHSC) ACA expansions. Alternative staffing models, such as the "Teamlet" model, expanding scope of practice for nurse practitioners and physician assistants, as well as use of Health Information Technology (HIT), such as Telemedicine, will greatly extend clinic capacity, especially in under-represented areas.

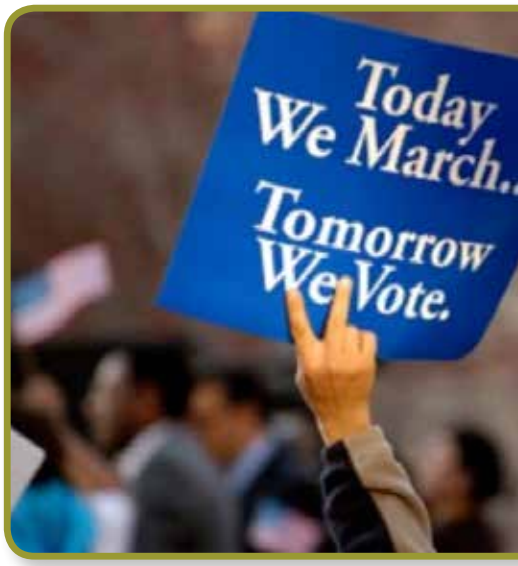
Last, to make these changes, *CCHCs will need to think strategically and invest in training and support at all levels of the organization to manage change and the stress that comes with it.* This entails considering new management structures, such as the creation of a centralized manager who is responsible for all clinic sites. These changes will require leadership that is able to broker partnerships with other providers who will also be competing for the insured population under the Exchange, while being mindful of the clinic's mission.

Table 2: Clinic Strategies

Building on Their Base	Expansion and Growth	Operational Stability	Physical Space, Practice Model and Staffing	Culturally Effective Services	Partnerships
• Leverage CCHC track record in communities and nationally; • Use data from quality metrics to enhance service and improve outcomes; • Provide comprehensive, coordinated services that include behavioral health, oral health, specialty care, and social services; • Address social disparities through increased access, chronic disease management, and prevention; and • Recognize CCHCs as economic engines in their communities.	• Perform aggressive outreach, eligibility identification and enrollment assistance so that every patient that qualifies for coverage expansion gets coverage as quickly as possible; • Expand primary care provider capacity, including workforce initiatives to attract and retain mid-level staff and physicians; • Get certified as PCMHs to ensure patients receive coordinated, high quality care; • Pursue safety net integration initiatives with other providers, including specialty care access, and mental health/primary care integration; • Continue/accelerate HIT Adoption, particularly EHR, data sharing, telemedicine, and Health Information Exchange (HIE); • Develop approaches for Exchange enrollees, such as co-location of services; and • Embrace payment changes that prioritize value over volume, such as participate in ACOs.	• Maintain a positive operating margin: manage and diversify payer mix, maximize productivity, manage patient flow, and align reimbursement mechanisms with clinic services; • Build financial reserves technologies, new populations, and new models of care with revenues;[106] • Maximize payment per patient visit, including outreach and enrollment in public and private insurance, expanding percent of patients enrolled in Medi-Cal, Medicare; and • Brand or grow CCHC market share by positioning health clinics as "providers of choice," such as target population identification, communications campaign.[107]	• Consider new sites and renovation of existing sites; • Consider new models in clinic facility redesign to better coordinate and provide services, such as co-location of services, use of new technology, and mobile clinics;[108] • Expand provider capacity, including recruitment and scope of service; • Consider alternative staffing models, such as provider staffing ratios, and Teamlet model; and • Distribute staff among health center sites, such as centralized CFO versus one CFO per site.	• Address access barriers using economically sustainable models, such as adopting targeted enabling services that are reimbursed through sustainable funding mechanisms; and • Adopt multiple health care models to address the different health care needs of the newly insured through the Health Benefit Exchange and the uninsured population and/or chronically ill that may require more face-to-face care.	• Consider strategic restructuring or different types of partnerships with clinics and other providers to maximize resources and sustain health center operations, such as collaboration (program coordination), administrative consolidation, and corporate integration;[109] • Consider strategic partnership with regional clinic associations and the California Primary Care Association to maximize their roles in local integrated health care delivery systems, such as technical assistance, advocacy, and communications;[110] and • Partner with Medi-Cal managed care plans to implement one-time initiatives, including coordinated services and service expansions.

Collective Action – Statewide Clinic Strategies

Many California CCHCs are powerful forces in their own right and have individually and collectively shaped the growth and success of clinics statewide. As described above, CCHCs operate in diverse communities and have different designations. However, the opportunities afforded by health care reform and the challenges of a recession have forced them to "up their game" and undertake coordinated approaches to preserve the gains of the last 10 years. This includes mobilizing their base—clinic staff, patients, safety net providers—and working with advocacy allies on several fronts to educate decision makers about the value of clinics.



At the federal level, CCHCs enjoy national bipartisan support and they are continuing to work with decision makers to assure that ACA funding is not eliminated. They are also proactive to assure that California clinics receive their share relative to other states. Congress voted to repeal the Affordable Care Act 33 times during the 112th session and Congressman Paul Ryan's (R-Wis.) FY 2014 budget proposal calls for the repeal of the Affordable Care Act. The Medicaid program will continue to be vulnerable to cuts and CCHCs will have to remain vigilant. Additionally, California CCHCs have a vested interest in supporting immigration reform and expanding coverage for upwards of 11 million undocumented and recent immigrants, of which 2.6 million reside in California. In California, 26 percent (765,180 people) of potential Medi-Cal recipients under the expansion are immigrants who will not qualify.[111]

At the state level, Medi-Cal policies that influence patient volume and reimbursement of CCHCs are paramount, particularly the optional Medicaid expansion and the LIHP transition. Additionally, providing incentives for health plans that assign beneficiaries to CCHCs and inclusion of health clinics in provider networks are important to clinics. For example, the Healthy Families Program encourages health plans to contract with safety net providers. The plan in each county that has the most traditional safety net providers is designated as the county's community provider plan (CPP). Families pay a lower premium if they choose the CPP.[112]

Other state-level policy options that expand CCHC capacity to meet the needs of the newly insured and remaining uninsured include: providing incentives for partnerships between public and private safety net providers, maximizing the role of clinics in implementing a "no wrong door" eligibility and enrollment system for public health insurance programs, and supporting HIT (including interoperability and data analysis TA).[113] It is critical that county realignment funding is maintained for the remaining 3.1 to 4 million Californians who are referred to as the "residually uninsured" and are predicted to remain uninsured in 2019.

At the county level, clinic consortia can represent clinics and work with counties to successfully transition LIHP enrollees to Medi-Cal or the Exchange. Additionally, CCHCs and clinic consortia can continue to educate decision makers and the public about the benefits of coverage expansion. CPCA has launched a "Health Care Ambassador Program" to educate health center staff and clinicians about the ACA. CPCA has trained over 400 individuals who in turn educate more staff and patients on the benefits of the ACA for health clinics and their communities.

Last, *collective action is also necessary to transform every health center into a health care reform success story*. CCHCs, local and regional clinic consortia, CPCA, and private foundations have mobilized to provide training and technical assistance to facilitate health center adoption of the PCMH, achieve meaningful use of electronic health records, grant development support to maximize federal funding, and engage technical assistance (TA) providers to develop and implement strategic restructuring projects. Local and regional consortia play an important role in strengthening health center data systems and conducting the analyses to show that CCHCs control costs and improve health status. They can also lower the barriers to adoption of the PCMH, such as the "Pathways to PCMH" group convened by the Council of Community Clinics in San Diego County.

CONCLUSION: THRIVING IN AN UNCERTAIN FUTURE

California is poised to make good on its long-time commitment to achieve universal health coverage. It is already putting many ACA provisions into motion: it is the first state to pass state legislation authorizing a Health Benefit Exchange and it has moved aggressively forward with insurance marketplace reforms. The question is whether the state and its stakeholders will be ready when the Exchange becomes a reality in 2014, particularly the development of an integrated, seamless health care delivery system. Anything less will undermine the creation of a culture of coverage that promises to provide high quality health care to millions of Californians.

As described above, there are real opportunities under health care reform for California's CCHCs to build on their strong foundation and transform themselves into "community-centered health homes," whereby they can marshal their expertise in prevention and address the factors outside the health care delivery system that affect health outcomes (including food security, arts and culture).[114] At the same time, uncertain economic conditions threaten to undermine their financial position, as well as their mission to care for all patients regardless of their ability to pay. While health clinics have had to contend with similar challenges in the past, such as the shift to Medicaid managed care in the early 1990s, the pressure to do more with less forces them to consider radical operational and delivery system options.

At the federal level, clinics have to balance decreased federal 330 funding for existing clinic operations with increased ACA funding for clinic facilities and primary care workforce expansions. Continued efforts to reduce the federal deficit and address the nation's rising debt could result in further spending reductions to Medicaid and/or Medicare, key sources of clinic revenue. At the state level, CCHCs can anticipate incremental increases in state funding until the economy rebounds. There are opportunities at the county level but it varies from county to county and community to community. Partnerships with local stakeholders, such as Medi-Cal managed care organizations, public hospitals and county health agencies, will be instrumental in positioning clinics to thrive under the Exchange and the Medicaid expansion. Private funding in the form of foundation support, reimbursement from commercial insurers, and partnerships with other providers will help clinics shore up their competitive position, while creating opportunities for delivery system changes.

In sum, California's community clinics and health centers have greatly benefited from 10 years of federal investment in clinics. They need to work together to prevent further use of ACA appropriations to maintain existing clinic services as well as work with state decision makers to shape implementation of health care reform. Future success of individual clinics requires accelerated transformation of clinic operations, namely adoption of the PCMH and EHRs, while addressing the different health care needs of their communities. These strategies, coupled with solid financial planning that anticipates Medi-Cal payment reform and aggressive management of clinic payer mix under the Exchange, will position CCHCs to fulfill the goals of health care reform, as well as stay true to their mission.

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