

REPORT

FINAL REPORT

Strategies by Federally-Funded Health Centers to Facilitate Patient Access to Specialty Care

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INTRODUCTION

Many patients of federally-funded health centers face problems finding specialty physicians to treat their health problems in a timely manner. By definition, health centers are located in medically underserved areas or where there are medically underserved populations. Low payment rates and significant administrative burdens often limit the number of providers willing to participate in Medicaid. Uninsured patients often find out-of-pocket expenses for specialty care unaffordable, even when they qualify for discounted fees based on income. These problems are compounded by the non-medical needs and challenges that make it difficult for many health center patients to keep specialty appointments and comply with treatment plans.

In the face of these challenges, federally-funded health centers are pursuing a range of strategies to facilitate access to specialty care for their patients. In recent years, many health centers also have begun to participate in a variety of initiatives whose payment and care delivery models may influence many health center patients' access to care, including specialty care. These initiatives are often called delivery system reforms; in this report, we refer to them as patient-centered care (PCC) models.

This report summarizes findings from a small qualitative study of six health centers that are pursuing a diverse range of approaches to facilitating specialty care for patients. Most of these health centers also are engaging in PCC models. Key questions addressed by the study include:

- What appear to be the most promising strategies for improving specialty care for health center patients? Are some approaches better-suited to certain specialties or patient populations? What are the key challenges and limitations of each approach?
- To what extent can these strategies be replicated by other health centers? Under what circumstances?
- How is participation in various patient-centered care models changing payment and care delivery models for health centers? What impact, if any, are these reforms having on patients' access to specialty care?

DATA AND METHODS

The study was conducted by Mathematica between May and September 2017. Most of the information used in the report is drawn from telephone discussions with leaders from the six health centers selected for the study. Data from these phone discussions were supplemented by secondary research on selected topics, particularly patient-centered care models.

Selection of health centers

To identify health centers to include in this study, the research team conducted discussions, mostly by telephone, with five national experts and 12 state primary care associations to obtain their recommendations about health centers that are (1) pursuing a variety of active and innovative specialty access strategies, and (2) participating in different patient-centered care models. Based on these experts' recommendations, the research team produced a memorandum proposing nine health centers from six states for consideration by ASPE. From this list, ASPE

selected five health centers for inclusion in the study; in addition, ASPE suggested that the study include one health center from a state with no PCC model (Wisconsin). Table 1 identifies the six health centers that were included in this study, and presents basic descriptive characteristics for each of these health centers.

Table 1. Key Characteristics of Health Centers in the Study

Health center	Location	Number of patients	Percent of patients covered by Medicaid	Percent of patients without health insurance	Number of primary care sites	Patient-centered care model
Northeast Valley Health Corporation	San Fernando, California	90,742	68.2	26.9	14	Capitation
Peak Vista Community Health Centers	Colorado Springs, Colorado	90,329	68.4	11.8	26	Medicaid ACO
Lynn Community Health Center	Lynn, Massachusetts	40,009	60.5	13.7	5	Medicaid ACO
Family Health Centers at NYU Langone	Brooklyn, New York	130,652	49.6	20.8	9	DSRIP
Mosaic Medical	Prineville, Oregon	19,174	57.5	12.3	14	Medicaid ACO; APM pilot
Progressive Community Health Centers	Milwaukee, Wisconsin	11,408	71.9	5.6	3	None

Source: Phone discussions with health center respondents and HRSA Health Center Program 2016 Health Center Profiles, available at <https://bphc.hrsa.gov/uds/datacenter.aspx?q=d>.

Note: ACO = Accountable Care Organization; APM = Alternative Payment Methodology; DSRIP = Delivery System Reform Incentive Payment

Phone discussions with health centers

The research team conducted an average of two phone discussions per selected health center. Each phone discussion lasted 60 to 90 minutes. For most health centers, the key respondents were the health center director and the Chief Medical Officer.

Semi-structured discussion guides were used to organize and facilitate phone discussions. Main topics covered in the discussions included:

- The level of access to specialists for health center patients in the local community, and the major factors affecting access;
- Key specialty access strategies employed by the health center, reasons for pursuing these strategies vs. others, challenges and facilitators for each strategy, and impact of each strategy on patients' access to care;
- Behavioral health services offered by the health center, degree of integration with primary care, and reasons for pursuing certain behavioral health models vs. others; and

- PCC models the health center is participating in, how payment methods under the model differ from conventional visit-based payment, and the impact that the PCC model has made on access to care overall and access to specialty care in particular.

All phone discussions were recorded, with permission from respondents. The recordings were used to produce detailed discussion summaries for each health center. These discussion summaries formed the nucleus of findings highlighted in this report. We obtained permission from health center leaders to present their organizations as case studies in a public report. Health center leaders reviewed and provided feedback on earlier drafts of the case studies; their feedback was incorporated into the case studies presented in this report.

Limitations

The findings in this study are drawn largely from the observations and perspectives shared by the leaders of six particular health centers. The extent to which their experiences can be generalized to other health centers—even those operating in similar settings and/or in the same states—may be limited. The study did not include complementary perspectives from knowledgeable respondents external to the health centers—perspectives that might have differed from those offered by health center leaders.¹

Because the scope of topics covered in the phone discussions was broad, and the time allotted to the phone discussions was limited, we prioritized in-depth data collection about specialty access strategies over other topics. For behavioral health and patient-centered care models, in particular, the focus was on gathering basic descriptive information rather than delving in detail into every aspect of the topic.

¹ Examples of such respondents include hospitals engaged in affiliations with health centers; organizations providing telehealth services; and organizations playing a central role in state PCC models.

HIGHLIGHTS OF KEY FINDINGS

Specialty access strategies

- Rather than adopting a single model for improving access to specialty care, health centers pursue multiple approaches simultaneously.
- The six health centers in the study pursue a diverse range of specialty access strategies—a reflection of factors such as:
 - Differing needs and opportunities in particular specialties;
 - Patient insurance status and coverage; and
 - Constraints and opportunities facing each health center in its local community, such as:
 - Health care market structure and organization, including degree of hospital and physician consolidation, and existence of hospitals focused on serving the safety net;
 - Overall availability of specialists in the community, and willingness of those specialists to serve low-income patients; and
 - Specific approaches dictated by payers.

Behavioral health

- The scope and scale of services offered by health centers vary widely.
- For mental health:
 - Two of the six health centers offer nearly all outpatient services in-house, while the other four focus on those aspects of mental health that are related to primary care;
 - All six health centers have been working on integrating mental health with primary care, but some are close to achieving full integration, while others are still in the early stages;
 - Most health centers observed that patients are far more willing to accept mental health treatment provided within primary care clinics than to accept external referrals, in part because of the greater perceived stigma of the latter;
 - In some states, separate regulatory structures for physical and mental health have created key barriers to behavioral health integration.
- For substance abuse:
 - Only two of the six health centers provide outpatient services in-house, and only one provides comprehensive outpatient services.

Patient-centered care models

- PCC models vary widely across states.
 - Even the three Medicaid ACO models in the study differ markedly from one another, with Massachusetts' program differing most dramatically.

- Two health centers—those in California and Oregon—are participating in capitated payment models, which provide the most flexibility.
- New York is the only state in the study whose PCC model is based on a Delivery System Reform Incentive Payment (DSRIP) program.
- Few, if any, direct links can be drawn between PCC model participation and access to specialty care.
 - In part, this stems from the design of many PCC models, which focus on primary care.
 - Some PCC models are still at very early stages of implementation, and evidence of impact can't be expected yet.
- One aspect of PCC models that has improved specialty access has been per-member, per-month (PMPM) payments for care coordination or care management.
 - These payments have enabled health centers to expand their primary care teams; especially helpful has been the hiring of team members whose responsibilities include helping patients navigate the referral and appointment-making processes and helping the health center close the referral loop on specialty visits.

CASE STUDIES

Northeast Valley Health Corporation (California)

Background

A large health center serving the San Fernando and Santa Clarita Valleys in northeastern Los Angeles (LA) County, Northeast Valley Health Corporation (NEVHC) provides care to about 72,000 patients in its 14 primary care clinics, plus an additional 18,000 patients in its homeless network.² Excluding patients in the homeless network, about 77 percent of NEVHC's patients have Medi-Cal (California Medicaid) coverage.³ Most of NEVHC's uninsured patients are enrolled in My Health LA, the county program that manages and pays for medical care for low-income county residents, including undocumented immigrants, who are ineligible for any other coverage.

Access to specialists in the community

Access to specialty care varies between the two geographically distinct areas served by NEVHC. In the Santa Clarita Valley, the local hospital and a significant proportion of specialists choose not to contract with Medicaid managed care plans. As a result, many of the health center's Santa Clarita patients have to travel to the San Fernando Valley for specialty care. Transportation is a particular issue in this sprawling region. Patients in the San Fernando Valley have substantially better access to specialty care within their own communities. However, patients who need certain types of care, such as subspecialty and tertiary care, may need to travel

² The number of patients reported in Table 1 includes patients in the homeless network.

³ Most Medi-Cal patients are enrolled in managed care plans, but a small number of Medi-Cal patients are covered by fee-for-service arrangements, which have different referral processes for specialty care. This report focuses on specialty access processes and strategies under Medi-Cal managed care.

to LA County's large academic medical centers at the University of California, Los Angeles (UCLA), the University of Southern California (USC), and Children's Hospital Los Angeles.

The particular specialty providers that health center patients can be referred to depend on the patients' insurance status and coverage. Uninsured patients enrolled in the My Health LA program can only use specialty providers within the public health system owned and operated by LA County. Referral patterns for Medi-Cal patients vary depending on intricate managed care arrangements. All Medi-Cal managed care patients are referred to specialists who belong to the provider network of Health Care LA, the large independent practice association (IPA) that manages the provider network and Medi-Cal managed care contracts on behalf of NEVHC and many other health centers in LA County. The IPA holds full-risk arrangements with several Medi-Cal health plans for a portion of their patients. Under these arrangements, several safety-net hospitals have separate risk pools for selected health plan members, each with a single health center, or several, in its service area. For example, 15,000 NEVHC patients are in Valley Presbyterian Hospital's risk pool. If these patients need specialty care, NEVHC staff would refer them to Valley Presbyterian-affiliated specialists contracted with the IPA. However, a Medi-Cal patient can request another provider who is not in the provider network for the patient's assigned risk pool, as long as that provider belongs to the IPA network. In such cases, NEVHC staff would help patients to transfer to another health plan that is a better match for their provider utilization patterns or preferences. Finally, any Medi-Cal referral to an out-of-network specialist requires prior approval from the IPA. For example, for most specialties, the county health system is not an in-network provider for the IPA, so if a Medi-Cal patient wants to use a specialist at a county-owned hospital for a non-contracted specialty, that request must be pre-approved by the IPA.

Specialty care access strategies

Since 2012, NEVHC and other health centers in LA County have used electronic consultation and referral (eConsult/eReferral) systems extensively. Two separate eConsult programs are in effect: one administered by LA County for uninsured enrollees in the My Health LA program, and the other administered by Health Care LA IPA for Medi-Cal managed care enrollees. In addition, NEVHC uses a telehealth service specifically for diabetic retinopathy screenings, and it also directly employs specialists on a very limited basis.

County eConsult/eReferral program for uninsured patients. In 2012, LA County implemented an electronic system through which all specialty referrals and radiology requests for My Health LA patients must be submitted. Once a request has been submitted, a specialist in the county health system reviews the record and either makes recommendations for treatment that the health center's primary care staff can provide, or approves a referral for the patient to be seen by a county-employed specialist. In the latter case, the system automatically generates an eReferral.

Overall, this county eConsult program has reduced the number of in-person specialty visits for uninsured patients significantly, and reduced appointment wait times for the remaining visits. The reduction in visits can be ascribed, at least in part, to the fact that the staff reviewing eConsult requests are salaried county employees. Unlike specialists compensated on a fee-for-service basis, county employees have no financial incentive to generate more billable visits.

The county eConsult system experienced early difficulties with logistics and workflow. The platform was developed with the idea that the health center provider would submit the question and the county specialist would respond, but that plan did not account for all the administrative information, such as demographic and insurance data, that needed to be fed into the system by health center staff. Because the county had conceived of its eConsult system purely as a means for doctor-to-doctor communication, the platform initially did not allow other health center staff to submit any information. The system has since been tweaked to address these shortcomings, but some logistical challenges remain.

The eConsult/eReferral system has added an extra layer of work for health center primary care providers (PCPs), requiring them to co-manage the referral process with other health center staff more than they did under the traditional referral process. In recognition of this extra work, NEVHC revised its provider incentive plan in 2016 to add prompt completion of items in the eConsult queue as one of the performance metrics for which providers could earn incentives.

The health center has found that response times from specialists vary widely. Sometimes responses arrive within minutes, but in other instances, responses can take as long as 10 weeks. Some delays can be traced to the health center provider not submitting all the needed documents, such as lab or imaging results, in the eConsult record. At times, these gaps have resulted in further delays, with patients needing to be brought back to the clinic for tests or lab work, and some patients not complying. Over time, the number of “aging eConsults” (requests not resolved within a month) has declined steadily, thanks in large part to mechanisms the health center has implemented, including the provider incentive program noted above.

Another positive impact of this program is that some of the health center’s primary care providers have been able to apply the lessons learned from particular eConsult cases to similar cases that later presented in the clinic.

IPA eConsult/eReferral Program for Medi-Cal patients. Launched in 2012, the same year as the county eConsult program for the uninsured, this eConsult program for Medi-Cal managed care patients is more limited in the number of specialties it covers. Some specialties are excluded because they require no IPA preauthorization; a few of these specialties can be accessed through self-referrals by the patient, and others through direct referrals by the primary care provider. Other specialty services have been excluded from eConsult because they may require urgent or time-sensitive access; in these cases, IPA preauthorization is obtained through a utilization management portal.

The IPA contracted with specialists in the IPA network to serve as eConsult reviewers, and pays these specialists for each eConsult review they conduct. Unlike the salaried county-employed specialists in the county eConsult program, these IPA specialists are typically private-practice physicians who bill on a fee-for-service basis. Perhaps as a result of these differing financial incentives, this IPA eConsult program has not significantly reduced the number of in-person specialty visits. In most cases, specialists reviewing the IPA eConsults still recommend an office visit. However, the health center reported that the IPA has continued the program because it believes the quality of referrals improves when the PCP and specialist have communicated, and all the necessary tests have been completed ahead of the specialty visit.

Like the county eConsult program, the IPA eConsult program has had some problems with logistics and workflow. However, specialty reviewer response times have been faster and less variable in the IPA program, perhaps reflecting that reviewers are not salaried, but compensated according to how many eConsults they complete.

Other eConsult/telehealth services. Along with many other California health centers, NEVHC collaborates with specialists at the University of California, Berkeley to test diabetic health center patients for vision loss through remote retinopathy screenings. Retinal images are captured during patients' primary care visits and forwarded to Berkeley, where a team of optometrists reviews the images and makes recommendations about whether the patient needs to be referred for an in-person ophthalmology visit. In the case of uninsured patients enrolled in My Health LA, this retinal screening program is integrated into LA County's eConsult/eReferral system. The Berkeley specialists upload the retinal images to the county eConsult platform and rate each case on risk. High-risk patients are fast-tracked into the county eReferral system.

This retinopathy screening program began as a demonstration project in the 1990s, in a collaboration between the Health Resources and Services Administration (HRSA) and the Community Clinic Association of Los Angeles County, a county-wide clinic consortium. At the time, the county's uninsured patients with diabetes often had to wait more than a year for an eye exam. NEVHC received grant funding to acquire its first retinal cameras. It has since purchased enough cameras to provide the service in each of its primary care clinics.

In recent years, NEVHC has expanded its use of the Berkeley program to include Medi-Cal managed care patients as well as uninsured patients. Participation in the program has allowed the health center to boost its retinal screening rate to nearly seven in 10 diabetic patients annually. Diabetic retinopathy screening is a key metric widely used in performance ratings of providers and health plans. NEVHC is not reimbursed by payers for capturing retinal images, because the health center receives capitated payment rates for most of its patients (see final section on patient-centered care models for details), but providing this service helps NEVHC earn incentives in the pay-for-performance programs it participates in with Medi-Cal managed care plans.

The other telehealth program NEVHC engaged in was a pediatric developmental and psychiatric program. Funded under a grant that recently ended, the program allowed face-to-face intake interviews to be conducted remotely while pediatric patients were at one of NEVHC's primary care clinics. The health center contracted with community mental health agencies whose specialists conducted the interviews. Designed to ease bottlenecks in the referral process, the program also helped patients feel comfortable because they could remain in a familiar place while taking the first steps in the referral process. The program was discontinued when the grant funding ended, but results were promising enough that the health center may use operating revenues to restart the program.

Direct employment. NEVHC currently employs only two specialists—both focusing on particular subpopulations. One is a psychiatrist working exclusively with HIV patients under a grant. The other is an infectious disease (ID) specialist who has been instrumental in pushing for hepatitis C treatment—a service that NEVHC began offering over the past year. This ID specialist is also a core provider in the health center's HIV/AIDS division.

Behavioral health services

California has an intricate network of regulations governing behavioral health services. Counties are tasked with providing some services (such as treatment of severe mental health issues) directly for Medi-Cal patients. State oversight and reimbursement of physical and behavioral health are kept separate, so behavioral health is carved out of Medi-Cal managed care. Instead, it is managed by specialized behavioral health plans that pay providers on a fee-for-service rather than the prevailing capitated methods used to pay for primary care services in the LA market.

Most of NEVHC's health centers use a coordinated rather than an integrated model of care delivery to provide behavioral health services. The health center's behavioral health specialists—mostly licensed clinical social workers (LCSWs) and marriage and family therapists (MFTs)—are available at certain primary care sites at certain hours, and providers conduct warm handoffs of patients to these therapists when possible.⁴ Most referrals to behavioral health are made by PCPs, but other members of the primary care team can also make referrals; patients can self-refer as well. The care team administers annual PHQ-9 screenings to all patients 12 years and older; all high scores (10 or above) receive automatic referrals to behavioral health, even without action from PCPs.

NEVHC plans to move to a fully integrated model of behavioral health, but progress has been slowed by resource constraints. One key factor is California law, which currently does not permit health centers to bill for services provided by MFTs. A new state law has been passed that allows MFT billing, and is expected to take effect in mid-2018. Behavioral health expansion also has been slowed by space constraints within NEVHC's primary care clinics, which have limited the number of counseling rooms available for behavioral health visits.

Patient-centered care model

Although California has not yet implemented any Medicaid Alternative Payment Methodology (APM) models for Federally Qualified Health Centers (FQHCs), the state has a strong, unique history of managed care and a long-prevalent practice of paying primary care providers on a capitated basis. NEVHC receives capitation for a large majority of its patients—from Health Care LA IPA for Medi-Cal patients, and from LA County for uninsured enrollees in My Health LA. The county program operates much more like a true capitated arrangement than Medi-Cal capitation does, because Medi-Cal includes a year-end reconciliation process and wraparound payments from the state to ensure that FQHC payments do not fall below the prospective payment system (PPS) equivalent. In that sense, the Medi-Cal model is still visit-based.

California is working to implement an upcoming Medi-Cal APM pilot for health centers, which is scheduled to roll out in mid-2018 and run for three years. Unlike current Medi-Cal capitated arrangements, the new payment model will not include a year-end reconciliation process and subsequent wraparound payments from the state to health centers. Instead, the state will review total historic payments (both prospective and retrospective) made to each clinic site,

⁴ A warm handoff is a transfer of care between two members of the health care team that (1) takes place in the presence of a patient, and (2) engages the patient in communication with the team members.

and roll these different payment streams into a single “mega-capitation” rate that will be paid prospectively.⁵

APM rates will be both risk-adjusted and risk-stratified. The stratification will take the form of separate mega-cap rates developed for each of four Medi-Cal populations: children; Seniors and Persons with Disabilities;⁶ adults who began receiving Medi-Cal as part of the Affordable Care Act expansion; and all other adult Medi-Cal managed care enrollees. Separate mega-cap rates will be calculated for each individual health center site.

The payment pilot will expose health centers to more risk than the current capitation-with-reconciliation model does, but also offers them more flexibility in delivering care. With all payment to be made prospectively on a capitated basis, health centers will have more flexibility and incentive to invest in innovations such as adding capabilities to primary care teams (for example, by hiring clinical pharmacists to improve medication management) and delivering care electronically or in group settings. With one of its primary care sites slated to participate in the APM pilot, NEVHC has formed work groups to explore such practice transformation efforts. The health center is also working with a consultant on data analysis in preparation for rate setting with the state and the launch of the payment pilot.

Peak Vista Community Health Centers (Colorado)

Background

A large health center located in the Pikes Peak and east central regions of Colorado, Peak Vista has 20 locations that serve more than 90,000 patients a year in 26 clinics. About 68 percent of Peak Vista’s patients have Medicaid coverage, and 12 percent lack health insurance. Colorado Springs—with a population of about 465,000—is the largest urban center in Peak Vista’s service area. The health center also runs several rural clinics in the eastern portion of its service area; these clinics became part of the Peak Vista network as a result of a merger with Plains Medical Center in 2014.

Access to specialists in the community

Availability of specialty care varies across the geographic areas served by Peak Vista. In the rural, eastern parts of its service area, few if any specialists are available in the community. Some types of specialty care are offered at Lincoln Community Hospital (near Limon), but if patients need specialists who are not available there, they have to travel to Colorado Springs or Denver.

More specialists are available in the Pikes Peak region centered in Colorado Springs, but some specialties—such as adult ENT (ear, nose, and throat), neurology, and orthopedics—are in short supply. Patients needing care in these specialties often have to travel to Denver or other large urban markets. A growing number of the specialists in the Colorado Springs area now

⁵ California also has proposed to implement risk corridors for both increases and decreases in visits per member per year. As of September 2017, the state was waiting for the Centers for Medicare & Medicaid Services to approve the pilot program.

⁶ Known as the aged, blind, and disabled population in other states.

work for one of three hospital systems. Children’s Hospital, based in Denver, is building an inpatient facility in Colorado Springs and has already launched a specialty clinic there. This clinic has brought pediatric sub-specialties that previously could be accessed only in Denver to the Colorado Springs community. Over the past few years, Colorado Springs’ two inpatient facilities for adults, Memorial and Penrose Hospitals, became members of larger systems—UCHealth (the University of Colorado system) and Centura Health, respectively. Throughout its history, Memorial Hospital reportedly has been more focused on serving patients with low incomes. The trends of hospitals (1) consolidating into systems and (2) buying up specialty practices are both still relatively new, and the impact these developments may have on low-income patients’ access to specialty care remains uncertain.

Health center respondents described the Pikes Peak region as having a strong sense of community, including a willingness on the part of many physicians to serve low-income patients. Most specialty practices accept at least some Medicaid patients, and among those that do not, some specialists choose to serve low-income patients by volunteering in Peak Vista’s program providing on-site specialty care (see section on Volunteer Specialist Program below). Indeed, Peak Vista’s leaders credited the size and success of the volunteer specialist program primarily to the commitment the region’s physicians have to serving the community’s low-income patients.

As in many other communities, access to specialty care tends to be less of a challenge for children than for adults. Not only do pediatricians advocate strongly for their patients, but Children’s Hospital also has a culture of serving all children, regardless of ability to pay. For adults, it is the routine referrals that often mean long waits and other serious challenges. In serious or urgent cases, direct doctor-to-doctor interactions (for example, a health center primary care physician calling a specialist directly to advocate for a patient) typically are very effective in securing specialty appointments.

Specialty care access strategies

Peak Vista uses referral teams to match patients with specialists, taking into account the patient’s insurance coverage, financial resources, and other factors. As a first step, care teams consult lists of specialists in the community who accept Medicaid. If there are no available local specialists that a Medicaid patient can be referred to, the care team works to get approval for an out-of-region referral. For uninsured patients, the care team forwards the case to the health center’s centralized care management department, which has grant funding and other resources to help patients with payment. For certain specialties, the health center’s volunteer specialist program is also an option.

In addition to embedded nurse care managers, each care team includes resource navigators, who facilitate referrals by helping schedule appointments and arrange transportation. They also follow up with patients who don’t show up for appointments, and they are responsible for closing the loop after the referral.

Referrals to local specialists. As noted, most specialists in Peak Vista’s service area accept at least some Medicaid patients. Peak Vista has referral agreements in place with many specialty practices in the community, including sliding-scale fee arrangements for low-income uninsured patients. Each memorandum of understanding covers all of the health center’s patients instead of leaving specialty providers the option of selectively accepting certain categories of patients.

However, many specialty practices in the community are not large enough to see every health center patient who seeks care. In addition, low reimbursement levels cause some specialty practices to limit the number of Medicaid and other low-income patients they will serve at any given time.

Closing the referral loop historically has been a challenge for referrals to external specialists. Often, health center staff marked the referral as closed in the patient record as soon as the patient was referred; there was often no tracking of whether the specialist visit took place, and sometimes no report on visits that did take place. After resource navigators were made responsible for these tasks over the past few years, the ability to close the referral loop has improved. Two broader market developments—the growth of the state health information exchange, CORHIO, and the increasing hospital acquisition of physician practices—also have helped make notes of specialist visits more accessible by making it easier to share information electronically.

Referrals outside the region. When patients need specialty care that is not available in the community, they have to travel to larger urban centers—primarily Denver—for care. For Medicaid patients who are part of Colorado’s Medicaid accountable care organization (ACO) model, the Accountable Care Collaborative, Peak Vista’s care team works to obtain approval for the referral from the regional coordinated care organization (RCCO) (see the final section here on patient-centered care models for details) and help patients with travel arrangements and appointments. Because uninsured patients on low incomes often cannot afford to travel, they get fewer referrals outside the community than Medicaid patients do.

Volunteer specialist program. Peak Vista has a long-standing program in which volunteer specialists provide care to patients who are unable to get access to needed specialty care in the community. Currently, the health center has volunteers in about a dozen specialties, including cardiology, dermatology, general surgery, hematology/oncology, rheumatology, urology, podiatry, and chiropractic medicine. Some of the major specialty gaps in the volunteer program—including adult ENT and orthopedics—reflect broader shortages in the community.

Most of the volunteer physicians work out of one Colorado Springs clinic that has been set up to support specialty visits; however, a few volunteers choose to see patients at other sites. The specialists are supported by Peak Vista staff consisting of medical assistants, a team nurse, and an administrative director. Because the same clinical staff are regularly assigned to the same specialists, they are familiar with specialty procedures and equipment. For example, the medical assistants assigned to support the general surgeon are adept at assisting on the minor skin procedures regularly performed by this surgeon. Peak Vista staff also are responsible for entering the report of the visit into the health center’s electronic health record (EHR), making documentation more seamless than it is for external referrals.

Many volunteers in the program are retired from active practice, but they maintain relationships with former partners and colleagues. In many cases, this allows the volunteer specialists to intervene on behalf of health center patients who need services beyond what can be provided in Peak Vista’s clinic. For example, when an undocumented immigrant suffered a major knee injury, the volunteer orthopedist arranged for one of his former partners to perform surgery on the patient.

Some volunteers in the program are still actively operating their own practices, but prefer to see low-income patients on a volunteer basis at Peak Vista's clinic. To limit the financial and administrative burden on their practices, some of these specialists may not accept Medicaid at all, while others may limit the number of Medicaid patients they take. Seeing patients at Peak Vista allows specialists to volunteer their own time without also having to pay for their staff's time or other overhead costs.

Some specialists join the volunteer program as a result of Peak Vista's outreach and recruitment, but many also reach out to Peak Vista about volunteer opportunities. Word of mouth among physicians has been a highly effective recruiting tool; many specialists reach out to the health center and begin working in the program after hearing about it from colleagues.

Behavioral health services

Peak Vista first began providing behavioral health on site at one of its clinics in 2003, and now has embedded behavioral health providers in most of its clinics. The health center would like to expand services to embed behavioral health providers at all of its clinics, but has been constrained to date by both staffing and funding challenges. In addition to three psychologists, the health center's behavioral health staff consists of licensed clinical social workers (LCSWs) and licensed professional counselors (LPCs).

Currently, the health center has a staffing ratio of one behavioral health provider for every nine medical providers, which spreads behavioral health resources quite thin. The state's current Medicaid payment reform model has provided little support for behavioral health integration, but the next phase of payment reform will encompass behavioral health as well as physical health (detailed in final section on patient-centered care models). In preparation for that next phase of payment reform, the state—through its RCCOs—has made grant opportunities available. One such grant enabled Peak Vista to fund several of its current behavioral health positions, and the health center has applied for another grant to fund several more positions.

Peak Vista uses a consultative model of behavioral health in most of its clinics: A PCP who deems it helpful can call a behavioral health provider into a medical visit, and the two providers can then conduct a co-visit. The behavioral health provider can conduct up to six follow-up sessions with that patient (the maximum number allowed by state Medicaid regulations in a primary care setting). Peak Vista's eastern, more rural clinics use a hybrid model that combines the consultative model with a more traditional co-location model.⁷ The differing models reflect the fact that the eastern clinics belonged to another independent health center that merged with Peak Vista in 2014. It was only after the merger that the eastern clinics began pursuing a more integrated approach to primary care and behavioral health.

Two types of behavioral health screenings take place in certain subsets of primary care visits. Medical assistants administer the PHQ-2 assessment tool for depression to all new patients, and in all physicals and well-child visits. The health center is working to create a more standardized workflow in which a high score would automatically trigger a follow-up contact

⁷ In the co-location model, primary care and behavioral health providers share the same facility but practice independently using a traditional referral model.

from the behavioral health provider. The other type of screening is the SBIRT (Screening, Brief Intervention, and Referral for Treatment) for drug and alcohol abuse. This screening is not automatically given, but is administered to a patient if a provider deems it appropriate.

PCPs can refer patients to specialty mental health and substance abuse providers, but there are severe shortages of both psychiatric and substance abuse treatment resources in the community. In addition, the many barriers to keeping behavioral health appointments when patients are referred out—the stigma, long waits, transportation and financial challenges—mean that patient no-show rates for external referrals can reach 80 percent.

Recently, Peak Vista began exploring innovations with Colorado Access—which is designated as both a Behavioral Health Organization and a RCCO—with the goal of expanding the behavioral health resources available to providers and patients at two of Peak Vista’s clinics. These include virtual consults and telehealth visits provided by Colorado Access providers.

Patient-centered care model

In 2011, Colorado launched its Medicaid ACO model, the Accountable Care Collaborative (ACC), in which the state Medicaid agency contracts with seven regional networks (RCCOs) to provide coordinated care for Medicaid patients within their regions. Over time, the state plans to phase in payment reforms that increasingly reward outcomes instead of volume.

ACC Phase I: Regional Coordinated Care Organizations. In each region, RCCOs contract with Primary Care Medical Providers (PCMPs) to serve as medical homes for Medicaid patients. Because Peak Vista has a large service area spanning multiple RCCO regions, it contracts as a PCMP with three RCCOs. Its main RCCO is Community Care of Central Colorado, Region 7’s RCCO. Region 7 covers Colorado Springs and El Paso County, where most of the health center’s patients are concentrated.

All Medicaid beneficiaries are attributed to the RCCO for the region they live in, and to a PCMP in that region, unless they opt out of the ACC model. Under the current payment model (ACC Phase I), health centers are still paid visit-based PPS rates. In addition, they receive per-member, per-month care coordination fees from two funding streams. From the state Medicaid agency, Peak Vista receives about a few hundred thousand dollars a month, or about \$3 per attributed patient. From the RCCO, it receives \$4 per attributed patient. The health center has used these funds to add care coordination staff, including nurse care managers and resource navigators, and to integrate its care teams. As noted, these resources have helped improve specialty access for patients.

In addition, health centers and other organizations are eligible to receive grants from the state, awarded through RCCOs, to fund pilot programs designed to improve care delivery. Peak Vista has been awarded several of these grants, including one for an emergency department (ED) diversion program that links ED patients with medical homes. Another grant funded a pilot to change care delivery at one Peak Vista clinic to be value-based rather than volume-based.

A third ACC funding stream that the state also will implement is a pay-for-performance program, in which 4 percent of encounter revenues will be withheld to form a quality bonus pool. PCMPs can earn all or part of the revenues back by meeting certain performance benchmarks.

One of the ACC's mandates for RCCOs was to expand provider networks. Peak Vista's main RCCO, Community Care, initially was able to expand its specialist network by contracting with some large medical groups in Colorado Springs. However, these providers were later acquired by DaVita Healthcare, a large national company not known for having Medicaid-friendly policies. These DaVita-owned providers have since left the RCCO provider network, so access to specialists in the region did not improve as initially expected.

ACC Phase II: Regional Accountable Entities (RAEs). In July 2018, the ACC model will move into Phase II, which will expand the program to include behavioral as well as physical health. RAEs will be the new iteration of regional networks, replacing the current system of RCCOs and separately carved-out Behavioral Health Organizations. Although the state has not released details about how care coordination fees or other payments will change under Phase II, the move to RAEs is expected to boost support for health centers' efforts to expand behavioral health services and integrate them with medical care.

No timetable has been set for the introduction of ACC Phase III, but that iteration of the model will begin phasing in provider risk.

Lynn Community Health Center (Massachusetts)

Background

Located about 14 miles north of central Boston, Lynn Community Health Center (LCHC) serves about 40,000 patients a year across five primary care sites, numerous school-based clinics, and its Program of All-Inclusive Care for the Elderly (PACE) locations. Sixty-one percent of its patients have Medicaid coverage, and 14 percent have no health insurance. Before the launch of Massachusetts health reform in 2006, the uninsured rate for LCHC patients had exceeded 40 percent.

LCHC was first established in the early 1970s as a storefront mental health clinic in response to the community's dearth of mental health resources. The health center later added comprehensive primary care services, but its origins in mental health care are still evident today, with its staff of behavioral health providers outnumbering its workforce of medical providers.

Access to specialists in the community

An urban area with a population of more than 90,000 residents—many of them low-income—the city of Lynn is surrounded by more affluent suburbs in the North Shore region of the Boston metropolitan area. Most of the area's specialists are either employed by the local hospital, North Shore Medical Center, or they are in private practice in the more affluent North Shore communities. Because the North Shore's only inpatient facilities are community hospitals, there are some gaps in the specialties available in the community. To access most sub-specialties, patients have to travel to Boston, which is home to several academic medical centers and has one of the highest concentrations of specialists in the country.

Although many North Shore specialists—including the North Shore Medical Group affiliated with the hospital—accept Medicaid patients, health center patients who are referred to local specialists often face a number of significant barriers to receiving care. Some specialist offices make it difficult for low-income patients to schedule prompt, convenient appointments,

and private practices typically lack the language services that some patients need. Patients can often miss appointments, in part because they may not feel comfortable going to a private doctor's office, and in part due to other challenges such as literacy and transportation barriers. Patient no-shows tend to feed into a vicious cycle, with specialty practices becoming more reluctant to serve health center patients, who in turn become more uncomfortable with the referrals available locally.

Specialty care access strategies

LCHC refers a fair number of patients to local specialists, including physicians in the North Shore Medical Group affiliated with the local hospital. However, because of the aforementioned limitations, the health center also pursues other avenues for obtaining specialty care for its patients. Whenever possible, health center staff try to offer patients a choice of providers and locations, with each choice entailing its own set of constraints and tradeoffs.

Referrals to Boston Medical Center (BMC). Historically, BMC served as Boston's public hospital. Although it no longer has that status, BMC has maintained its safety-net mission and orientation. As a large academic medical center and tertiary care provider, it offers a comprehensive range of specialty services. It also provides language services and other support services for patients with low incomes.

Massachusetts has a program, the Health Safety Net, to reimburse community health centers and acute care hospitals for the essential medical care they give to uninsured patients. Because the program does not cover services provided in private doctors' offices, uninsured patients who need specialty care are often steered to BMC. Some are referred to other Boston AMCs, such as Massachusetts General or Massachusetts Eye and Ear, but because of BMC's safety-net orientation, it serves the most health center patients.

Many of LCHC's Medicaid patients also receive specialty care at BMC. For example, many ophthalmology cases are sent to BMC, in part because Medicaid only reimburses for cataract surgeries performed at hospitals, and not those performed in ambulatory surgery centers. More broadly, the health center's Medicaid patients might be referred to BMC if they need specialty services that are only available at a large AMC, or if they express reservations about being sent to a private practice.

It can be a major hassle for patients to get to and from BMC appointments. The trip can take an hour each way by car because of heavy traffic. Many health center patients have no access to a private car and rely on public transportation, which can take much longer.

Specialty telehealth services: the MAVEN project. In 2016, LCHC became one of the pilot sites in the Medical Alumni Volunteer Expert Network (MAVEN), a national nonprofit that organizes volunteer physicians to provide visits and consults through telemedicine. Most MAVEN volunteers are either retired or working in academic medicine. The program supports both synchronous (real-time) and asynchronous consults.

Dermatology has been the most commonly used and successful specialty handled by MAVEN specialists. Through a grant, LCHC was able to purchase imaging technology from a

company called 3Derm.⁸ This technology allows primary care providers to capture high-resolution, two- and three-dimensional images. The consulting dermatologist then reviews a complete set of images, along with other information about the patient, to make a diagnosis.

MAVEN matched LCHC with a dermatologic surgeon at MassGeneral, who was able to review more than 75 cases in his first three months as a MAVEN volunteer. About 30 percent of the reviews resulted in recommendations for high- or medium-priority in-person visits to specialists; most were potential cases of skin cancer. LCHC found that a large number of dermatology referrals were for acne and eczema—conditions that could be managed by PCPs. The health center has since provided training to help PCPs manage most such cases.

Dermatology is particularly well-suited to telehealth because many consults involve straightforward questions (for example, “Is the skin lesion concerning enough to warrant an in-person dermatology visit?”) and there is no need for the specialist’s review to take place in real time. High patient volumes for dermatology have led LCHC to augment the services available from MAVEN volunteers with services provided by 3Derm, the private company that supplied the imaging technology. For the health center, there is no difference between the specialist services provided by 3Derm vs. those from MAVEN. From the payer’s point of view, the difference is that 3Derm pays specialists for their time, and in turn bills health plans for the specialist visit.

Other specialties LCHC is accessing through MAVEN include cardiology, hematology/oncology, and rheumatology. These are more challenging than dermatology, in part because they require real-time visits, which makes it necessary to coordinate appointments around the volunteers’ schedules. In addition, some specialties and conditions, by their nature, lend themselves less readily to telehealth. In rheumatology, for example, PCPs sometimes make referrals more to get respite from patients with progressively worsening, non-curable conditions than to seek an answer to a specific, straightforward question. Telehealth also tends to be less suited to patients with chronic conditions that need ongoing management, such as many hematology conditions. Because MAVEN cannot ensure the same specialist will continue handling a given patient’s case over time, these consults are not ideal for the patient and the primary care provider.

The health center has not measured patient or provider satisfaction with telehealth, but no-show rates for telehealth visits have been much lower than for external specialty referrals, which sometimes have no-show rates as high as 75 percent.

LCHC is beginning to explore other options for expanding telehealth, including arrangements in which the health center pays a subscription fee for access. Paying for telehealth would enable the health center to set logistical and technical requirements (for example, EHR documentation) that it cannot demand from a volunteer organization. One key constraint on

⁸ “Meeting a Need: Tele dermatology in Lynn, Massachusetts,” MAVEN Project Quarterly Newsletter, June 17, 2017. Available at <http://www.mavenproject.org/wp-content/uploads/2017/07/Outreach-Summer-Newsletter-2017.pdf>. Accessed September 11, 2017.

telehealth services available to Massachusetts health centers stems from current state regulations, which require telehealth providers to be licensed and credentialed in Massachusetts.

Behavioral Health Services

Reflecting its origins as a mental health clinic, LCHC has a large behavioral health staff offering a comprehensive set of outpatient services in behavioral health. All outpatient needs in this area—including substance abuse treatment—are handled in house through an internal referral system. (One exception is intensive detoxification services, which LCHC does not offer.) The staff includes three full-time psychiatrists, seven or eight Ph.D. psychologists, five or six psychiatric nurse practitioners (NPs), and 30 to 40 licensed clinical social workers (LCSWs).

Each primary care team has its own behavioral health specialist—typically an LCSW—who works as a therapist. This person consults with the behavioral health team lead—typically a psychologist—and they each play the role of team lead for multiple primary care teams. Each team also has access to a part-time psychiatrist or psychiatric NP.

In cases where primary care providers refer patients to therapists, they conduct warm handoffs about one-third of the time. LCHC’s goal is to increase the warm handoff rate to 50 percent. With warm handoffs, the health center has found that the no-show rate for behavioral health appointments drops to half the rate of the regular no-show rate (for internal referrals without a warm handoff). Even the regular no-show rates—in the mid-20s—are quite low compared to the rates for external referrals.

The health center has just begun to measure patient satisfaction with behavioral health services. Early results show that satisfaction levels for LCHC’s behavioral health patients are about 20 percentage points higher than they are for its medical patients. LCHC has some of the highest rates in the country in engaging patients in treatment for addiction, alcoholism, and depression, but these rates are still low, ranging from the high 20s to low 30s.

Historically, recruiting and retaining behavioral health staff was not a serious problem for the health center. However, as Massachusetts providers move toward accountable care organization (ACO) models, many are expanding their behavioral health capacity. As a result, competition for behavioral health staff has increased, making it more difficult to recruit and retain staff.

Behavioral health reimbursement rates from both Medicaid and private insurance are low. Currently, LCHC does not break even on behavioral health and uses revenues from better-paying services to subsidize behavioral health care. The health center is hoping that quality bonus payments under the new ACO (see below) will improve financing for behavioral health services.

Patient-centered care model

In late 2016, CMS approved a Medicaid Section 1115 waiver for Massachusetts, which established three mutually exclusive Medicaid ACO models that health centers can participate in.⁹ Participation is voluntary, but nearly all Massachusetts health centers have opted in, because

⁹ Lloyd, Jim, and Katherine Heflin. “Massachusetts’ Medicaid ACO Makes a Unique Commitment to Addressing the Social Determinants of Health.” Center for Health Care Strategies, blog post, December 19, 2016. Available at

taking part in an ACO is the only way to gain access to the substantial federal funding available under the waiver.

LCHC elected to participate in Model B, the Primary Care ACO model, along with 12 other health centers throughout the state. Beginning in 2018, the ACO will begin receiving a global PMPM budget. Each participant will continue billing for services on a fee-for-service basis; in the year-end reconciliation process, participants will receive a share of savings if they come in under budget, and will owe money if they have run over budget. PMPM payment rates will be risk-adjusted and will also be adjusted for quality performance. Each ACO member forms its own risk unit, and each chooses whether it wants to accept low, medium, or high risk. LCHC chose the medium-risk category.

In another of the state's ACO models, Model A, each ACO consists of a health plan, a hospital, and multiple health centers. Many health centers, including LCHC, were wary of partnering with hospitals in an ACO relationship, given hospitals' conflicting financial incentives. The concern was that if the ACO realized savings, the hospital would have strong incentive to keep most of the savings in order to help compensate for revenues lost through reduced inpatient use.

Family Health Centers at NYU Langone (New York)

Background

One of the largest health centers in the country, Family Health Centers at NYU Langone, is based in the borough of Brooklyn in New York City and provides care for nearly 100,000 patients a year across its nine primary care sites and an extensive network of clinics based in schools and homeless shelters.¹⁰ About half of the health center's patients have Medicaid coverage, and roughly one in five lack health insurance.

Established in 1967 as the Sunset Park Family Health Center, the health center has had a unique relationship from the beginning with its local hospital, Lutheran Medical Center. In fact, it was the hospital that was the original grantee for the establishment of the health center. Over time, Sunset Park grew into an extensive network of clinics that came to be known as Lutheran Family Health Centers. Recognized as a Level 3 patient-centered medical home, the health center offers extensive specialty care and dental services, as well as comprehensive primary care.

In 2016, the entire Lutheran Healthcare system—including the hospital and the health center—became part of the larger New York University (NYU) Langone Health system. After the merger, the health center initially became known as NYU Lutheran Family Health Centers. In mid-2017, NYU rebranded the former Lutheran entities, with the hospital becoming NYU

<https://www.chcs.org/massachusetts-medicaid-aco-makes-unique-commitment-addressing-social-determinants-health>. Accessed September 11, 2017.

¹⁰ The health center's sub-grantees serve an additional 31,000 patients a year, bringing the total number of patients the health center reported to HRSA to 132,000.

Langone Hospital—Brooklyn (NYU-Brooklyn) and the health center becoming Family Health Centers at NYU Langone (FHC-NYU).¹¹

Access to specialists in the community

Many health centers in Brooklyn and New York City have trouble finding specialty services for their patients, but the uniquely close affiliation between FHC-NYU and NYU-Brooklyn has given FHC-NYU patients much better access to specialty care. Because NYU-Brooklyn is an academic medical center, it offers a greater breadth of specialty services than community hospitals typically do. Historically, the hospital has also maintained a focus on serving its local community—including the many residents with low incomes—to an extent not matched by all teaching hospitals. In this symbiotic hospital-health center relationship, the hospital has not had to operate its own outpatient clinics. Instead, it has been able to use the health center’s primary care sites as its outpatient clinics and residency training sites. In return, the health center has been able to gain much more direct access to a wider variety of specialty services than most other health centers enjoy. In addition, the health center’s patient base has long been large enough to warrant providing either full- or part-time access to an extensive number of specialties on site at its primary care clinics (details in the following section).

Because NYU has historically focused on competing for well-insured commercial patients, the recent merger raised some concerns about whether NYU-Brooklyn (formerly Lutheran Hospital) would become less focused on serving low-income residents and the local community. However, during the merger negotiations, the health center reached agreement with NYU that all of its patients—regardless of ability to pay—would have access to any NYU specialist. Despite some logistical challenges in implementing this agreement early on, NYU has honored its terms. As a result, FHC-NYU patients’ access to specialty care has been broadened. In addition, NYU has added to the specialty services directly available at NYU-Brooklyn. For example, Lutheran gained its first surgical robots as well as additional services in cardiac surgery and cancer treatment, allowing patients to receive these services without leaving the community. NYU also has provided some financial support to the health center, including paying for its conversion to NYU’s EHR system. Before the merger, Lutheran Family Health Centers and Lutheran Medical Center had been on separate EHRs; the post-merger conversion of all NYU entities to a common EHR has made it more seamless for the health center to obtain reports of the visits its patients make to external specialists.

Specialty care access strategies

FHC-NYU patients who need specialty care are often referred to NYU-Brooklyn specialists (and, since the NYU merger, can also be referred to specialists in the broader NYU network when necessary). In addition, the health center’s patient volumes have long been large enough to allow some of the more common types of specialty care to be provided by its own primary care clinics, either by specialists whom they directly employ or specialists obtained by leasing their time from NYU-Brooklyn. Key benefits of providing specialty care on site instead of through external referrals include greater convenience and access for patients, better compliance by

¹¹ In this report, the health center and hospital are referred to by their new names, even though many of the strategies and processes described here pre-date the NYU affiliation.

patients in keeping appointments, and enhanced coordination of patient care between primary care and specialty staff.

Direct employment of full-time specialists. Four specialties—cardiology, pulmonology, gastroenterology, and infectious disease—have patient volumes high enough to warrant FHC-NYU hiring full-time specialists directly onto its own staff. These physicians, who typically have board certifications in both internal medicine and in one of those four specialties, are responsible for running programs in their specialties. For example, the internist-gastroenterologist leads the health center’s colon cancer screening program and regularly performs colonoscopies on health center patients at the hospital; the internist-pulmonologist runs the health center’s programs in asthma and chronic obstructive pulmonary disease; and the internist-cardiologist runs the program in congestive heart failure and other heart disease. (Interventional and advanced cardiology cases continue to be referred to hospital-based cardiologists.)

Leasing specialists on a part-time basis. FHC-NYU tracks the number of referrals in each specialty. For specialties that do not have high enough patient volumes to need a full-time physician, but do have enough demand to justify providing some service on site, the health center leases specialists on a part-time basis from NYU-Brooklyn. The health center contracts either with the hospital or directly with the specialist for a certain number of hours per week depending on patient need. The leased specialists are then credentialed to work in the health center, and they see patients at one of the primary care clinics. The health center pays the specialists on an hourly basis and bills payers for the services they provide.

The health center currently provides about 26 specialties in house through part-time leasing arrangements with hospital-affiliated physicians. Examples include endocrinology, general surgery, and oncology. Because of the high prevalence of diabetes, hiring a full-time endocrinologist would be the health center’s preferred approach, but the low supply of endocrinologists combined with their high compensation levels makes part-time leasing a more feasible option.

When leased specialists work at the health center, they are usually teamed with a nurse practitioner (NP) in the same specialty. The NPs typically handle routine cases on their own, work with the specialists on more complex cases, and help ensure continuity of care for patients. In endocrinology, for example, the health center manages a risk pool, or registry, of diabetic patients, who are classified as low, medium, or high risk. The NP independently manages low-risk and most of the medium-risk patients (those whose diabetes is under control), but consults with the part-time endocrinologist on all high-risk and some medium-risk patients (those whose diabetes is not controlled).

Because the health center’s size and its unique hospital affiliation make a wide range of specialty care accessible on site, it is not uncommon for other health centers in the area to refer their patients to FHC-NYU for specialty care.

Behavioral health services

New York’s state regulatory structure historically has drawn clear divisions between physical and behavioral health, with the former overseen by the Department of Health and the latter by the entirely separate Department of Mental Health. Only clinics licensed as Article 31

mental health clinics could provide and bill for mental health services; medical clinics could only diagnose patients and refer them to Article 31 clinics for treatment. Moreover, state regulations prohibited co-location of the two types of clinics; medical and mental health clinics had to be in entirely separate buildings. As a result of this state-mandated division, FHC-NYU has long maintained a separate behavioral health clinic. More broadly, the provision of medical care and mental health care has tended to take place in separate silos.

Over the last few years, New York policymakers and regulators began recognizing that many medically complex and expensive cases had key behavioral health dimensions and that it was ineffective to treat medical and behavioral issues separately. As a result, the state has begun to relax some of its guidelines to allow for more behavioral health integration and to pay for some of these services.

Now in its first year of transitioning to behavioral health integration, FHC-NYU has been adding behavioral health providers to each of its clinics and embedding these providers into its primary care teams. The health center currently has a staff of 12 psychiatrists (8 adult, 4 pediatric), 28 psychologists, and 30 social workers. Because there is less stigma associated with receiving behavioral health services in familiar surroundings where they already receive primary care, patients are more willing to accept treatment when offered and more likely to keep appointments once they are scheduled; their engagement and appointment show rates were lower when they were referred to a separate behavioral health clinic.

The health center has begun experimenting with some innovations in delivering behavioral health services, including:

Telepsychiatry. FHC-NYU is exploring the feasibility of conducting eConsults that would generate referrals from all of its clinics to its main behavioral health clinic site. Because of New York's current regulatory constraints, which lag behind the available technology, the health center currently is able to provide telepsychiatry only to the sites (for example, school-based clinics) that are licensed as satellites of the main behavioral health program.

Group sessions. The health center is experimenting with providing behavioral health services in group settings—such as group counseling sessions and support groups—in its clinics. Providers have found many patients to be more willing to engage in group sessions than to follow through on a referral for an individual behavioral health session, in part because of the stigma associated with the latter. In school-based clinics, support groups have been particularly effective in attracting participants, and sessions organized around social issues like the impact of social media can engage participants in important behavioral health issues, such as the effects of bullying.

Patient-centered care model

New York is participating in the Delivery System Reform Incentive Payment (DSRIP) program, authorized under Section 1115 of the Social Security Act. The state's DSRIP, which has the stated goal of “reducing avoidable hospital use by 25 percent through transforming the

New York State health care system into a financially viable, high-performing system,”¹² began in April 2014 and runs through March 2020. Key components of New York’s DSRIP waiver include the development of integrated delivery networks and the transition of most Medicaid payment in the state to value-based arrangements.

Performing Provider Systems. New York required Medicaid providers and community-based organizations to form integrated delivery networks, referred to as Performing Provider Systems to receive DSRIP funding. Of the more than 20 such systems that have formed statewide, nearly all have been led by hospitals. FHC-NYU is part of NYU Langone’s network.

Each performing provider system could choose from a menu of projects intended to build infrastructure in care management and population health management, enhance disease management for targeted chronic conditions, and improve population health. In practice, however, most hospitals serving as PPS leads reportedly have kept the lion’s share of DSRIP funds for their own organizations, using much of the money to build IT systems or other infrastructure that some observers view as having little, if any, direct impact on access to care.

Many health centers participating in the PPS typically have received only a scant proportion of their PPS DSRIP funds passed down from the hospital lead grantee. FHC-NYU, for example, has received less than 1 percent of its PPS network’s DSRIP funds, even though it accounted for more than 40 percent of its network’s attributed patients. With similar issues occurring in many of New York’s other DSRIP provider networks, some stakeholders and observers have come to regard these networks as a disappointment, believing they have not lived up to their promise of transforming care delivery for Medicaid patients, moving from volume to value, and emphasizing the importance of primary care.

Value-based contracting. New York’s DSRIP includes a value-based payment roadmap, which outlined a five-year plan for achieving comprehensive payment reform, including a shift to 90 percent value-based payments through Medicaid managed care organizations (MCOs) by the end of DSRIP (early 2020). Unlike some states that have imposed specific contracting requirements on value-based arrangements, New York largely left the details to MCOs and providers to negotiate.

In the past year, FHC-NYU has signed contracts for shared savings models with three Medicaid MCOs, covering a total of about two-thirds of the health center’s Medicaid patients. Two of the contracts—covering a total of about half of FHC-NYU’s Medicaid patients—involve both upside and downside risk. The third is a full-risk contract, which the health center was able to take on because the MCO involved is a hospital-owned health plan, Health First. As one of Health First’s owners, NYU—which is large enough to have its own risk pool within the health plan—was willing to take on full risk because any loss would be an accounting loss only, and any savings would be fully retained within the NYU system. Because FHC-NYU is still in its first year of value-based contracting, it is too early to tell how the health center will fare

¹² New York State Department of Health. “New York State Delivery System Reform Incentive Payment Program Project Toolkit.” October 2014.

financially under these arrangements, or what impact the arrangements may have on access to care.

Movement toward Alternative Payment Methodology (APM). In the past, many New York health centers have been reluctant to consider moving away from encounter-based PPS payment toward a capitation-based APM model. However, issues with lack of funding for health centers under the DSRIP PPS model reportedly made many health centers realize the challenges of remaining financially viable under the current financing model. As a result, health centers are increasingly willing to consider an APM, and the state primary care association has begun working with the state Medicaid authority to develop an APM model over the next two years. FHC-NYU will be involved in exploratory efforts to design the model.

Mosaic Medical (Oregon)

Background

Located in central Oregon, Mosaic Medical serves nearly 20,000 patients a year in a total of 14 clinics, including five full primary care sites, one mobile van, several school-based clinics, and a few clinics embedded into communities of vulnerable populations. Two of Mosaic's clinics are in rural areas, and the majority of its patients are in the Bend region—a community with a population of 85,000. Mosaic's patient mix includes about 58 percent Medicaid and 12 percent uninsured patients. The health center's Medicare population has increased in recent years, in part due to an aging local population, and now accounts for 14 percent of all Mosaic patients.

Access to specialists in the community

Health center respondents described access to specialty care for Medicaid patients in the central Oregon region as decent overall. Specialists who are in private practice belong to the Central Oregon Independent Practice Association (IPA) for contracting purposes, and this IPA requires all members to accept Medicaid patients. Specialists who are employed by the local hospital, St. Charles Health System, also see Medicaid patients. St. Charles is a nonprofit hospital with a long-standing orientation toward serving the local community.

The region has a short overall supply of some types of specialty providers—such as gastroenterologists—and even commercially insured patients can have trouble getting access to them. Also, some practices limit the number of Medicaid patients they accept, which means health center patients can face long waits for an appointment. If specialty care is not available for a Medicaid patient within central Oregon, the Coordinated Care Organization (see final section on patient-centered care models for details) directs the patient to a specialty provider in another region—most often Portland. These out-of-region referrals can pose transportation and other logistical challenges for patients.

Providing access to specialty care for uninsured patients is more challenging than it is for Medicaid patients. Health centers like Mosaic rely to some extent on volunteer specialists, who are typically retired, or they work to persuade specialists to see uninsured patients. In the latter case, however, health centers cannot necessarily protect patients from the financial burden of high out-of-pocket expenses.

Specialty care access strategies

Because most specialists in the central Oregon community accept Medicaid patients, local referrals are the most common way for Mosaic patients to receive needed specialty care. These referrals are supplemented by other strategies, including remote consults, for specialties not readily available locally.

Local referrals (with PCP-specialist consultations). As a first step before making a referral, Mosaic primary care providers often consult with specialists to discuss whether the patient needs to be seen by a specialist, what tests should be completed, or what other actions should be taken. Mosaic's leaders regarded these initial consults as common practice in primary care, and not a practice specific to their own health center. At the same time, Mosaic providers' ability to access specialists to consult on a regular basis likely reflects, in part, the relatively greater willingness of central Oregon specialists to serve Medicaid patients in comparison with providers in many other communities nationwide. Mosaic's leaders also noted that they have long encouraged their primary care providers to forge strong relationships with specialists in the community. These relationships have helped expand the network of local specialists that Mosaic providers can reach out to when patients need specialty care.

Although most specialist consults take place by phone, many community providers supplement this with the use of a secure, HIPAA-compliant texting application. Mosaic's primary care providers can text any provider who uses the app, and share images and other test results.

Consultations with specialists outside the region. In cases where needed specialty expertise is not available in central Oregon, Mosaic PCPs use a variety of consult services beyond the community. For example, Oregon Health & Science University (OHSU) offers free consult lines that primary care providers in Oregon can use to speak with the specialists on call. These OHSU resources are particularly useful in plugging gaps for specialties that are difficult to access locally. One of the consult services OHSU provides is focused on pediatric psychiatry. The service, called Oregon Psychiatric Access Line for Kids (OPAL-K), offers free, same-day consults to all Oregon providers, and is widely used by Mosaic's pediatric providers.

Mosaic clinicians also have access to Project ECHO (Extension for Community Healthcare Outcomes), an initiative designed to expand PCPs' knowledge of specialty care and their ability to treat certain conditions that would otherwise be referred to specialists.¹³ Only a few Mosaic providers have used the service; the only current participant in the program is a behavioral health provider. Taking part in Project ECHO requires time to present cases, which can keep some busy clinicians from participating.

Using volunteer specialists. Volunteers in Medicine (VIM), a nonprofit providing free medical care to low-income, underserved patients, has a clinic in Bend staffed mainly by retired physicians. Mosaic refers some uninsured patients to the VIM clinic, but this resource—

¹³ Project ECHO was developed at the University of New Mexico Health Sciences Center and is now in health centers across the United States and in other countries.

constrained by the specialties of the available volunteers—does not represent a major source of specialty care for the health center’s patients.

Pilot programs to address specific access gaps. Over the past year, Mosaic has partnered with the local hospital, St. Charles Health System, to give low-income uninsured patients free lab tests. Patients who qualify for the health center’s sliding fee discounts can obtain a card allowing them to access hospital lab services without filling out additional paperwork for the hospital’s charity care program. By removing financial barriers to obtaining the tests required before many specialist visits can take place, this program has the potential to improve uninsured patients’ access to specialty care. However, the program has been underutilized to date.¹⁴

The health center has also engaged in a few pilot programs to test new ways of delivering care. In the first pilot, Mosaic partnered with a local cardiology group that provided care on site at one of the health center’s Bend clinics, while also offering visits by telehealth to one of Mosaic’s rural clinics. The program used a computer system with a stethoscope, which made it easier to treat patients remotely. The program was discontinued as a result of turnover in the cardiology practice. In addition, Mosaic found that on-site care did not affect access much, because the cardiology practice and the Mosaic clinic where cardiologists saw patients were located near each other; and the telehealth service to the rural clinic also was underutilized. The health center continues to explore opportunities to deliver specialty care on site at its urban clinics and electronically to its rural clinics.

Mosaic also is engaging in a pilot to give patients group support for pain management. Under the program, the health center’s behavioral pain specialist (see the next section for details) developed a group class on managing chronic/persistent pain for patients at all sites. The specialist then teaches the class curriculum to Mosaic’s behavioral health consultants, who in turn lead patient groups in learning approaches to managing pain. The pain specialist continues to work directly with a subset of patients who need more intensive support.

Behavioral health services

In 2010, Mosaic took its first steps toward integrating physical and behavioral health care when it used grant funding to begin embedding a behavioral health consultant (BHC) into a primary care team. This practice has expanded over time, and a BHC is now embedded in each of the health center’s care teams. The staffing model also has evolved, moving from contracting with external providers to employing providers directly. Mosaic’s staff has grown to include not only eight BHCs (mostly licensed clinical social workers or licensed family counselors), but also a behavioral pain specialist, a psychiatric nurse practitioner, and two substance abuse counselors. Mosaic also has a number of providers of medication-assisted treatment, who work with patients with opioid use disorders. The health center recently created and staffed the new position of behavioral health director to help manage these services better.

During a primary care visit, if a PCP identifies any condition that might have a behavioral health component (including physical conditions such as uncontrolled diabetes), the PCP can

¹⁴ This may be because some of the health center’s PCPs don’t know about the program, or health center staff may be too busy to create the cards that grant patients access to the program.

seek input from the BHC and conduct a warm handoff to the BHC during that primary care visit. Patients can then arrange appointments with the BHC, usually for a later date, but if needed, BHCs can lead immediate interventions. Mosaic's behavioral health model calls for quick visits, with substantial behavior modification and a focus on the aspects of behavioral health that are related to primary care.

The health center has observed that patients are significantly more willing to accept and engage in behavioral health treatment when services are offered within the walls of the primary care clinic. Patients are less willing to follow through with external referrals, and this seems to stem in part from the stigma attached to receiving off-site treatment. For example, patients who would not go to an addiction treatment center just across the parking lot from one of Mosaic's clinics were willing to take part in addiction counseling provided in the clinic itself.

If patient needs exceed what Mosaic's own BHCs can provide, they are referred to specialty providers in the community. However, access to mental health and behavioral health services in the three-county area served by Mosaic is limited overall, and especially scarce in Crook County. Throughout the region, there is limited availability of psychiatric services, particularly for uninsured patients.

Patient-centered care model

In 2012, Oregon began implementing a statewide Medicaid ACO model in which regional Coordinated Care Organizations (CCOs) accept upside and downside risk for both cost and quality performance. In addition to Oregon health centers' universal participation in CCOs, some health centers, including Mosaic, are voluntarily participating in the state's Alternative Payment Methodology (APM) pilot, called the Alternative Payment and Advanced Care Model (APCM).

Coordinated Care Organizations. Within each region, a CCO is intended to be a partnership of payers, providers, and community organizations that work together to provide coordinated, efficient care for Medicaid patients. Each CCO receives a fixed global budget, capped at a 2 percent annual growth rate. From this global budget, the CCO makes capitated payments to Medicaid providers within its region. The state withholds 3 percent of its total payments to CCOs to form a common "quality pool." To earn their full incentives, CCOs have to meet benchmarks or improvement targets on several quality metrics, called Quality Improvement Measures (QIMs). Providers like Mosaic can earn quality bonus payments if both the provider and the CCO perform well on those metrics. In addition, a portion of each CCO's quality bonus pool goes to the governing body of the CCO; in Mosaic's region, this governing body is the Central Oregon Health Council. This entity allocates these dollars by awarding grants. Providers like Mosaic, as well as other organizations, can apply for grants to fund projects designed to improve care delivery related to the QIMs. Providers can also participate in shared savings arrangements with their CCOs; this provides another funding stream for provider organizations that manage their patients well. Mosaic has received payments from each of these funding streams.

Alternative Payment and Advanced Care Model. The APCM pilot, launched in 2013, is designed to move health centers from visit-based to value-based reimbursement. Under APCM, participating health centers like Mosaic are paid on a capitated basis, but are protected from

downside risk by a year-end reconciliation process that ensures their total payments do not fall below what they would have received under conventional PPS payment.

For health centers, one advantage of APCM is the elimination of the long lag time between the provision of services and the reimbursement received from payers—a lag that often spans six to nine months under PPS. Another key advantage of the model, which moves payment away from visit-based incentives, is that it facilitates health centers' efforts to develop their team-based care models and pursue other innovations not billable under traditional payment. The combination of capitated payments under APCM and CCO, as well as the opportunity to earn quality bonus payments and shared savings under the CCO, rewards health centers like Mosaic that manage their patients well on both cost and quality dimensions.

Currently, the APCM pilot only covers physical health services. Dental care, prenatal care, and behavioral health are carved out of the arrangement. Oregon intends to expand the model to include behavioral health in the capitated payment.

Progressive Community Health Centers (Wisconsin)

Background

An urban health center located in Milwaukee, Progressive Community Health Center serves over 11,000 patients a year in three primary care clinics and an urgent care center. Almost three-quarters of Progressive's patients have Medicaid coverage, and 6 percent lack health insurance. The health center's proportion of uninsured patients declined dramatically after Wisconsin used a Section 1115 waiver to expand Medicaid eligibility and subsidized marketplace insurance products were introduced as a result of the Affordable Care Act (ACA).¹⁵ Before these developments, uninsured patients accounted for more than 30 percent of Progressive's patient population.

Access to specialists in the community

Progressive patients' access to specialty care improved markedly after 2014, when many of the health center's adult patients gained coverage through the Medicaid expansion and the subsidized marketplace coverage. Before these insurance expansions, the health center faced daunting challenges connecting its many uninsured patients to specialty care. Typically, uninsured patients lacked choice of provider and location; they were limited to charity care provided by Froedtert Hospital and the Medical College of Wisconsin (MCW)—the teaching hospital that had a long-standing partnership with Progressive. Because Froedtert-MCW facilities (and the specialty practices affiliated with them) are not located near Progressive clinics, many patients had difficulty getting to appointments. The cost of care was another barrier, because even those with low enough incomes to be eligible for charity care had to pay out-of-pocket expenses depending on the sliding-scale fee schedule. In addition, patients could often afford to fill medication prescriptions only when health center staff could direct them to

¹⁵ Wisconsin declined to participate in the ACA Medicaid expansion, which granted eligibility to all adults with incomes up to 138 percent of the federal poverty level (FPL). Instead, the state enacted a series of coverage expansions through a Section 1115 waiver. In 2009, childless adults with incomes up to 200 percent of FPL became eligible, but there was an enrollment cap. In 2014, the cap was lifted, but the eligible income level was lowered to 100 percent of FPL.

steep discounts offered by pharmaceutical manufacturers or to the \$4.00 generic drug programs available at retail chains.

As noted, nearly three-quarters of Progressive patients now have Medicaid coverage. Health center leaders described access to specialty care as being very good overall for Medicaid patients. The Milwaukee community is served by four nonprofit hospital systems—Froedtert-MCW, Aurora Health System, Columbia St. Mary’s Hospital, and Wheaton Franciscan Healthcare—that all accept Medicaid. As a result, health center staff can offer many Medicaid patients a choice among providers and locations for their specialty referrals.

With a large and growing number of specialists joining one of the four hospital systems, most referrals made by Progressive providers are to hospital-employed specialists. (However, independent practices still dominate in a number of specialties, including mental health, pain management, and occupational/physical therapy.) The specialties for which access remains the most challenging tend to be those with overall shortages in the Milwaukee region. These include neurology, rheumatology, behavioral health, and dental care.

Specialty care access strategies

To facilitate external referrals for its patients, Progressive employs referral specialists, whose responsibilities include working with Medicaid managed care organizations (MCOs) to find specialists who accept the patient’s insurance; coordinating with the patient about his or her preferences for providers and locations; and contacting the specialist’s office to confirm insurance arrangements and help make appointments. After the visit, referral specialists are tasked with documenting the report of the visit in the patient’s electronic health record. The fact that most Milwaukee providers, including Progressive, are on an Epic platform makes it easier to track and document specialty visits.

Hospital affiliations. For more than a decade, Progressive has had a strong relationship with Froedtert, which has supported the health center in numerous ways through its community benefits program. Progressive continues to receive strong support from Froedtert, but in recent years, other hospital affiliations have formed in the community as well. These include:

Specialty Access Program for the Uninsured (SAUP). An initiative of the Milwaukee Health Care Partnership—a consortium of hospitals, health centers, and other community stakeholders—SAUP was launched in 2012 to improve access to specialty care for uninsured patients. The program was created in recognition of the fact that most of the community’s specialty capacity was based in the hospital systems, and therefore, any meaningful approach to improving specialty access had to involve buy-in and collaboration among all four hospital systems. These systems all agreed to share the burden of specialty care for uninsured patients, viewing this as a way to contain overall costs by reducing uncompensated hospital use. SAUP paired up each health center in a referral dyad with a hospital partner. Progressive was one of the three health centers paired with Froedtert-MCW—a reflection of their strong, long-standing relationship.

Under SAUP, Progressive could refer uninsured patients to Froedtert for specialty appointments. A few specialties and services were excluded (for example, elective plastic surgery, occupational and physical therapy), but most were available. Patients had to meet

certain eligibility requirements, including income limits of 200 percent of the federal poverty level.

With many of Progressive's uninsured patients gaining insurance coverage over the past few years, the health center's reliance on the program declined. The same was true for the other two health centers assigned to Froedtert. At the same time, Milwaukee health centers that served large populations of undocumented immigrants continued to rely heavily on SAUP, and these health centers' hospital partners received a disproportionate share of referrals. In response to these changes, the program was adapted to allow cross-dyad referrals, so the burden would be distributed more evenly across hospitals, and access would be eased for the remaining uninsured patients.

Progressive-Aurora collaboration. In 2016, Progressive began a partnership with Aurora Health System by opening two clinics on the campus of Aurora Sinai Hospital: an urgent care clinic next to the hospital emergency department (ED) and a primary care clinic in the same medical office building used by the hospital-employed medical group. The collaboration aims to reduce inappropriate use of the ED, especially by patients newly covered by Medicaid, who had no usual source of ambulatory care. A longer-term objective is to prevent the worsening of chronic conditions over time by matching these patients with a medical home, thereby reducing avoidable inpatient admissions. With the health center's presence on campus, hospital staff can refer patients to Progressive as their new source of care. In this symbiotic partnership, Aurora has the potential to reduce its costs and the strain on its resources, and Progressive can gain new insured patients and, at the same time, fulfill its mission of providing a medical home for underserved patients.

It was Aurora that first approached Progressive about collaborating in such an arrangement, and the hospital system provided some financial support for building and staffing the clinics. Progressive also received a New Access Point grant from HRSA and funding from the Milwaukee Healthcare Partnership to help launch the clinics.

Early indicators from the new clinics suggest they have had a positive impact in establishing medical homes for patients who did not have a regular source of care in the community. Although improving patients' access to specialty care was not a primary motivation for opening the clinics on Aurora's campus, the partnership has been beneficial for health center patients needing specialty care. Patients at the new primary care clinic can sometimes be referred to specialists co-located in the same medical office building. In addition, uninsured patients seen at this clinic can be referred to Aurora specialists.

Providing specialty services on site. Currently, Progressive offers very limited specialty services on site. Besides dental care, the following services are available at one of its primary care clinics:

Pulmonology on a part-time basis. A Froedtert-MCW pulmonologist sees patients twice a month at a Progressive primary care clinic. This specialist leases space from the health center and bills payers directly. In this symbiotic relationship, the specialist is able to bring residents, fellows, and students on site and use the clinic as a teaching site, and the health center is able to ease access for its patients by providing them with specialty care in the primary care setting.

Progressive is exploring opportunities with both Froedtert-MCW and Aurora to expand such arrangements to other specialties. The health center analyzed referral patterns to determine the most high-volume specialties. These include gastroenterology, orthopedics, cardiology, nephrology, dermatology, podiatry, and ophthalmology. Not all arrangements would require specialists to be on site; for example, if the health center can obtain retinal cameras for its clinics, consulting ophthalmologists at another location can later review the images to screen for diabetic retinopathy.

Radiology services. In early 2017, Progressive launched a radiology center at one of its primary care clinics, providing diagnostic x-ray, ultrasound, and mammography services in house for the first time. Previously, patients had to be sent outside the health center for these tests. The radiology center is part of Progressive's partnership with Froedtert, which donated all the equipment and is providing staffing free of charge for the first two years.

Behavioral health services

Progressive began offering behavioral health services on site in 2015, after recognizing that many opportunities were being missed during primary care visits to diagnose depression and some basic mental health disorders. The situation was compounded by large access gaps for behavioral health in the community. The health center received a HRSA grant to help launch behavioral health services, and began hiring behavioral health consultants (BHCs). Currently, it has a staff of three licensed clinical social workers (LCSWs) working as BHCs and integrated into primary care teams. The behavioral health staff also has a psychiatrist working half-time. Shortages in the community make recruiting for psychiatrists and psychologists particularly challenging. To date, the health center has been unable to recruit a psychologist or a full-time psychiatrist.

During primary care visits, PCPs administer standardized screenings for behavioral health issues; when appropriate, they can offer to treat behavioral health conditions or offer counseling sessions with BHCs. If PCPs are uncertain what treatment is needed, they can refer the patient to the in-house staff psychiatrist. Some patients are still referred externally if their cases are complicated, but as noted above, accessing care in the community tends to be very difficult.

Patient-centered care model

Wisconsin currently has no state-level payment reforms or patient-centered care models, and there does not appear to be momentum for any such reforms in the near future. There reportedly is much disagreement among health systems and Medicaid MCOs about how a system of care coordination should be organized. The state has a Medicaid waiver application pending with the Centers for Medicare & Medicaid Services, but it is focused on changing eligibility and cost-sharing requirements, not on care delivery or payment innovations that would be used to manage and coordinate care.

The only feature of Medicaid payment to Wisconsin health centers that approaches payment reform is the recent movement toward value-based incentives in MCO contracts. These incentives are paid in addition to visit-based reimbursement. Each health center negotiates a different set of metrics with each MCO. For example, one MCO's contract with Progressive bases its incentives on the number of wellness visits conducted with Medicare patients, whereas

another MCO's incentives focus on an obstetric medical home program, setting targets for the number of prenatal visits that must be met to be eligible for bonus payments. In southeast Wisconsin, health centers like Progressive must deal with 10 Medicaid MCOs, which contributes to a fragmented set of contract requirements and incentive programs. Health centers have asked the state to limit the number of MCOs participating in Medicaid, but the state has not been responsive to these requests.

CROSS-CUTTING FINDINGS AND THEMES

Specialty access strategies

The literature on health centers' specialty access strategies includes a study by Katherine Neuhausen and colleagues that presents a useful typology of models for accessing specialty care.¹⁶ The authors identified six unique models of how health centers access specialty care, which they classified into the following categories: Tin Cup, Hospital Partnership, Buy Your Own Subspecialists, Telehealth, Teaching Community, and Integrated System. This typology provides a helpful framework for organizing and analyzing health center strategies, but does not fully account for the real-world constraints and opportunities facing each individual health center that may lead that health center to pursue multiple models simultaneously.

Indeed, we found that each of the six health centers profiled in this study uses multiple approaches to expanding specialty access for their patients. To a large extent, the strategies they employ vary by specialty, with certain approaches (e.g., providing care on site at the health center's primary care clinics) pursued for common, high-volume specialties; other approaches (e.g., local referrals) used for a large number of specialties; and still other approaches (e.g., telehealth) used to plug specific gaps in care that are challenging to address locally or through traditional means. To some extent, the strategies pursued also depend on a patient's insurance status and coverage, so that health center staff might guide a Medicaid patient through certain referral processes based on the requirements of that patient's particular managed care or Medicaid ACO network, but have to rely on a volunteer program to provide specialty care for an uninsured patient with the same specialty need.

The key approaches employed by each health center reflect not only the overall supply of specialists in each community, but also the willingness of those specialists to serve low-income patients. Those market-level characteristics, which vary widely across communities, in turn are determined by a complex interaction among factors such as the structural characteristics of each local health care market (e.g., provider consolidation, hospital employment of specialists) and the culture of the physician community. Some communities that do not have a large overall supply of specialists, such as central Oregon, nevertheless appear to have a structure and culture that interact to provide relatively good access to specialty care for low-income patients.

In some cases, key specialty access approaches used by a health center may be mandated by payers rather than actively chosen by the health center itself. A notable example is Los Angeles, where health centers' use of separate eReferral/eConsult systems was initiated by Los Angeles County (for patients in the county program for low-income uninsured residents) and a large IPA (for Medicaid managed care patients).

Below, we briefly review key specialty access strategies used by the health centers profiled in the case studies, and discuss what conditions appear best suited to the successful deployment

¹⁶ Neuhausen, Katherine, Kevin Grumbach, Andrew Bazemore, and Robert L. Phillips. "Integrating Community Health Centers Into Organized Delivery Systems Can Improve Access To Subspecialty Care." *Health Affairs*, August 2012, Vol. 31, No. 8. Available at <http://content.healthaffairs.org/content/31/8/1708>. Accessed September 25, 2017.

of each strategy. That section is followed by brief discussions of the behavioral health services provided by these health centers, and the patient-centered care models each health center is participating in.

Hospital affiliations

While all health centers use referrals to local hospital-based specialists as a source of specialty care, affiliations with local hospitals—particularly academic medical centers that offer a wide range of specialties—can significantly increase access to hospital-based specialists. Among the many different types of hospital-health center affiliations, the tightest alignment is the type formed between the entities originally known as Lutheran Medical Center and Sunset Park Family Health Center (now both members of the NYU Langone system) in Brooklyn. Under this unique arrangement, the health center has been an integral member of the hospital system since its inception: The health center’s primary care clinics serve as the hospital’s outpatient clinics and residency training sites, and the hospital meets a large majority of the health center’s specialty care needs. The relationship not only facilitates referrals to the hospital’s specialists, but also provides the health center with a supply of specialists who can see patients on site at the health center’s primary care clinics. (While this relationship typifies the Integrated System model in the typology presented by Neuhausen *et al.*, this health center also uses the Buy Your Own Subspecialists model to facilitate access for more common specialties.)

While opportunities for such an exclusive and symbiotic affiliation may be scarce, other health centers have been able to forge more limited, but still beneficial, partnerships with hospitals. In Milwaukee, for example, Progressive Community Health Centers has long received multiple kinds of financial and in-kind support—including specialty care—from one hospital system (Froedtert), and recently developed another hospital partnership (with Aurora). The opportunities to form such affiliations depend, in large part, on whether a health center is located in the same geographic area as a not-for-profit hospital that is oriented toward serving the local community—including low-income residents within that community, and whether that hospital perceives the potential for a mutually beneficial partnership with a nearby health center.

Providing specialty care at primary care clinics

Some health centers—particularly those with high patient volumes—make certain specialty services available on site at the clinics where patients already receive primary care. Key advantages of this approach include increased convenience, access, and familiar surroundings for patients, which combine to substantially improve show rates for specialty appointments, compared to external referrals. On-site specialty care also facilitates better communication between primary care and specialty providers, and enhances overall coordination and continuity of care for patients.

Health centers use a range of approaches for providing specialty care on site, including:

Direct employment of specialists. Among the six case studies, Brooklyn’s Family Health Centers at NYU Langone employs full-time specialists to a greater extent than other health centers. For a number of common specialties—such as cardiology, gastroenterology, and pulmonology—FHC-NYU has sufficient patient demand to employ full-time specialists. Among

other responsibilities, these physicians oversee key health center programs in their respective specialties, such as the colon cancer screening and heart disease programs.

Only one other health center profiled in this study employs any medical specialists. Los Angeles County's Northeast Valley Health Corporation has an infectious disease specialist on staff who focuses on certain subpopulations, including HIV and hepatitis C patients.

Employing full-time specialists tends to be a feasible option only for very large health centers with sufficiently concentrated patient demand in certain specialties. And, even when there is enough patient volume to warrant hiring specialists, health centers often face serious challenges competing against other, better-financed provider organizations for a limited pool of available specialists. Several health center directors noted that these challenges have become more acute as hospitals in many communities continue to consolidate into larger systems and to buy up specialty practices.

Leasing specialists' time on a part-time basis. Brooklyn's FHC-NYU stands out for the large number of specialties (26) for which hospital-based specialists see patients at the health center's primary care clinics on a regular part-time basis. The close affiliation with its local AMC, NYU-Brooklyn, gives the health center direct access to a large pool of specialists. Under these leasing arrangements, specialists are paid on an hourly basis for their work at the health center, and the health center bills payers for the specialists' services.

Another health center in the study—Milwaukee's Progressive—has developed a much more limited part-time, on-site arrangement for specialty care. Currently, Progressive only has one pulmonologist from Froedtert-Medical College of Wisconsin seeing patients twice a month at one primary care clinic. Unlike FHC-NYU's arrangement, this specialist leases space from Progressive but bills payers directly. Progressive is exploring with its hospital partners, Froedtert and Aurora, opportunities to bring more specialists on site to provide high-volume services. Another study participant—Lynn Community Health Centers, north of Boston—arranged in past years for several specialists to come to one of its clinics once a month to see patients—primarily uninsured patients. However, because Lynn does not have a relationship with any hospital, these arrangements were made with individual providers and lacked the stability of arrangements backed by large pools of hospital-based specialists. As the specialists gradually terminated their arrangements with Lynn—because of retirement or other reasons—the health center had difficulty finding replacements for them.

Bringing volunteer specialists on site. One health center in this study, Colorado's Peak Vista, relies on its volunteer specialist program to provide care for patients who have trouble obtaining needed specialty care in the community. Most volunteers provide care at one Peak Vista clinic that has been set up to support specialty visits. Taking part in the program allows specialists to volunteer their time, while being supported by the health center's infrastructure and staff resources. Other health centers use volunteer specialists, but the substantial scale of Peak Vista's program and its location within a primary care clinic set the program apart. This approach likely would be most replicable for health centers that have a similarly large, well-established presence in their communities, and also are located in communities with a strong physician culture of serving low-income patients.

Remote visits and consults

In recent years, a plethora of different approaches has developed for providing specialty visits and consults remotely. Among the six health centers in this study, three are using some form of telehealth or eConsults to access specialty care to a significant degree. The models used by these three health centers differ markedly from one another—reflecting the different sets of constraints and opportunities existing in each of their communities and the particular specialty access gaps confronting each health center.

As noted above, NEVHC in Los Angeles uses two separate eConsult/eReferral platforms—one mandated by the county, the other by a large IPA—to address the specialty needs of most of its patients. Another key telehealth initiative NEVHC participates in—along with other California health centers—is a diabetic retinopathy screening program with UC Berkeley. This initiative addresses a specific access gap in the community that affects many patients. Retinal screening is one of the specialty services particularly well-suited to telehealth, in large part because the transmission of high-resolution images allow remote specialists to answer a straightforward question (“Is the retinal image concerning enough to warrant an in-person ophthalmology visit?”) very reliably. In addition, the remote consult does not need to take place in real time; the images captured by health center providers during a patient’s primary care visit can be saved and forwarded to the specialist for later review. This store-and-forward process eases the logistical and workflow requirements for health center staff and allows the remote specialists to complete large numbers of consults efficiently.

Another health center that uses telehealth extensively is Massachusetts’ Lynn Community Health Centers. Lynn receives most of its remote visit and consult services through the MAVEN Project, a nonprofit network of volunteer physicians. MAVEN provides a range of specialty services, with tele-dermatology being the most successful and widely used by Lynn providers. Similar to the retinal screenings noted above, the remote review of skin lesions to screen for possible skin cancer is a straightforward task that need not be completed in real-time visits with patients or consults with primary care providers. Those characteristics make ophthalmology and dermatology particularly well-suited to telehealth, according to several respondents. In contrast, other specialties that Lynn accesses through MAVEN, such as hematology and rheumatology, pose more challenges because diagnosis tends to be more complex and visits have to take place in real time. The latter requirement makes it necessary to coordinate appointments around the remote specialists’ schedules, thus increasing the administrative burden for health center staff and limiting the number of cases the volunteer specialists can handle.

Central Oregon’s Mosaic Medical uses remote consults in two different ways. First, a secure, HIPAA-compliant texting app is used to support some of the traditional telephone consults that Mosaic’s primary care providers engage in with local specialists. The app allows providers to share patients’ test results quickly and securely, thus boosting the productivity of the consult itself and any subsequent referrals. In addition, Mosaic providers use a range of statewide remote consult services provided by Oregon Health & Science University—Oregon’s only academic medical center. The OHSU service that Mosaic providers use most often is a same-day pediatric psychiatry consult line. These resources, available at no charge to Oregon primary care providers, are particularly useful in filling gaps for specialties not readily available in central Oregon.

Exploring which telehealth options work best for a given set of specialty access needs and implementing those approaches can be challenging. As one clinic director noted, “It takes a considerable amount of time and resources to look into all the different [telehealth] programs...in a thorough and systematic way.” Some remote consult programs—such as the OHSU consult lines—may be available only to providers in a given state or other geographic area. Other remote consult programs have significant start-up costs, such as the purchase of special cameras or video equipment for primary care clinics—expenses that many health centers might be able to afford only with the help of grant funding.

State telehealth laws are a key constraint that all health centers have to navigate when considering remote visit and consult options. Although state laws vary, most states require the consulting practitioner to have a license to practice in the state where the referring provider or the patient are located.¹⁷ Telehealth consultations across state lines require licensing paperwork—which some states have policies and processes aimed at streamlining, but many do not. Medicaid reimbursement policies for telehealth also vary considerably across states. Some states reimburse only for remote visits conducted in real time, while others reimburse for store-and-forward consults, but only for a limited set of services.¹⁸

Behavioral Health Services

Wide variations in the scope and scale of behavioral health services offered by health centers reflects, in part, major differences in the historic mission and orientation of each health center. All six health centers in the study offer on-site mental health services. Among study participants, Massachusetts’ Lynn Community Health Centers stands out for providing a comprehensive range of outpatient behavioral health care—a natural extension of Lynn’s origins as a mental health clinic that later added medical services. In contrast, other health centers originated as medical clinics and only later began adding behavioral health services—some of them only recently. Milwaukee’s Progressive Community Health Centers, for example, did not begin building in-house behavioral health capacity until 2015, and its staff of behavioral health providers is still quite small.

Differences across the six health centers in the study are also the result of wide variations in state regulatory structures and Medicaid reimbursement policies. New York and California are among the states that long ago established entirely separate regulatory structures for physical and behavioral health, which helped keep care delivery for these two types of health care largely in separate silos. Indeed, New York stipulated that only separate mental health clinics could provide and bill for mental health services. Only over the last few years has the state relaxed those restrictions to allow for more behavioral health integration and to pay for some of the integrated services. As a result, Brooklyn’s Family Health Centers at NYU Langone has long provided mental health services in a standalone clinic, and has only moved to an integrated behavioral health model over the past year. In California, Northeast Valley Health Corporation’s progress toward a fully integrated model of behavioral health has been slowed by California

¹⁷ HealthIT.gov. “Are there state licensing issues related to telehealth?” Accessed at <https://www.healthit.gov/providers-professionals/faqs/are-there-state-licensing-issues-related-telehealth>.

¹⁸ In California, for example, Medicaid reimburses store-and-forward services in three specialties: tele-ophthalmology, tele-dermatology, and tele-dentistry.

policies prohibiting health centers from billing Medicaid for the services of certain providers, such as marriage and family therapists (MFTs). A new state law eliminating the prohibition against MFT billing will not take effect until mid-2018.

Workforce capacity constraints also play an important role in determining each health center's ability to integrate behavioral health with primary care—a model that includes embedding behavioral health providers into each primary care team, conducting warm handoffs of patients from the primary care provider to the behavioral health provider, and providing as much basic outpatient behavioral health care as possible within the walls of the primary care clinic. Health centers in settings ranging from urban Milwaukee to rural east-central Colorado noted the challenges they face in recruiting and retaining behavioral health providers, given the short supply of these providers overall in their communities.

Funding gaps also pose major challenges for health centers trying to ramp up behavioral health services. Several health centers noted that the low reimbursement rates from both Medicaid and private insurance make it necessary for them to subsidize behavioral health services with revenues from better-paying services. In addition, while the model of embedding a behavioral health provider into each primary care team may be optimal from a patient care perspective, making this model work financially can be difficult, because some embedded behavioral health providers may not have sufficient demand from their primary care team's patient base to cover their salaries fully.

While all six health centers in the study offer on-site mental health services, only two offer substance abuse treatment. Lynn, in Massachusetts, provides the full range of outpatient substance abuse services, except for intensive detoxification. Mosaic, in central Oregon, offers more limited substance abuse counseling and opioid abuse treatment services.

The leaders of most health centers in the study pointed out that patients are much more willing to engage in behavioral health treatment that is provided within the walls of the primary care clinic, compared to treatment offered at external facilities dedicated to mental health or substance abuse treatment. These standalone facilities carry a much greater stigma in many patients' minds, and may also be less convenient and accessible for patients than their own primary care clinics. Within the primary care setting, several respondents also emphasized the important role played by warm handoffs from primary care providers in making patients more comfortable with behavioral health providers and more willing to accept treatment from these providers.

Patient-centered care models

Types of reform initiatives

Of the six health centers in the study, four are participating in PCC initiatives sponsored by their states.¹⁹ These are the health centers located in Colorado, Massachusetts, New York, and Oregon. A fifth health center—Northeast Valley in California—will not begin participating in a

¹⁹ Progressive Community Health Centers is the only health center in the study not yet participating in either a state-sponsored PCC model or an alternative major payment reform program sponsored by other payers. Wisconsin has no current or pending state-sponsored payment or care delivery reforms.

state-sponsored PCC model until mid-2018, but has long been paid on a capitated basis for most of its patients. These capitated arrangements, common in large California health care markets, represent a more advanced payment reform than most state-sponsored PCC models. Only one other health center in this study—Oregon’s Mosaic Medical—is paid on a capitated basis for its Medicaid patients. Mosaic’s capitated payment results from the health center’s participation in Oregon’s Alternative Payment Methodology pilot as well as the state’s Medicaid ACO program.

PCC models vary widely across states, making it difficult to generalize about them. Even when states share the same basic approach—such as the Medicaid ACOs implemented in Colorado, Massachusetts, and Oregon—the models may be designed and implemented in dramatically different ways. In particular, Massachusetts’ nascent Medicaid ACO model—actually a collection of three different, mutually exclusive ACO models—diverges sharply from the regional ACO models implemented by Colorado and Oregon.

New York is the only state in the study with a reform initiative based on a DSRIP program. The main components of the program include the development of regional, provider-led integrated delivery networks and a required shift from volume-based to value-based contracting in Medicaid managed care. Nearly all the regional integrated delivery networks in the state are led by hospital systems.

Impact of reform initiatives

Several health center respondents noted that few, if any, direct links can be drawn between their participation in PCC models and their patients’ access to specialty care, in large part because most PCC models, by design, focus more on transforming various aspects of primary care than on improving access to specialty care. In addition, some PCC initiatives are still at a nascent stage of implementation, so any impact likely will not be felt for some time. In Massachusetts, for example, the Medicaid ACO that Lynn is participating in will not begin implementing risk sharing for providers until 2018. And in New York, many health centers have only begun to negotiate and sign new value-based contracts with Medicaid managed care plans. Nevertheless, several observations can be drawn from the more mature PCC models that have been in effect for at least a few years. These include:

- A common critique of New York DSRIP’s integrated delivery networks (Performing Provider Systems) is that hospitals serving as lead entities of these networks have kept a large majority of the funding for their own organizations, and what funding these hospital leads have spent on network partners has been focused on health IT and other infrastructure investments that many believe have little impact on access to care overall and specialty access specifically.
- Some aspects of PCC models that were intended to improve specialty access and initially showed promise of doing so have been counteracted or negated by broader changes taking place in health care markets, such as provider consolidation. In Colorado, for instance, one of the state’s mandates to regional ACO entities was to broaden provider networks. The main regional ACO entity in Peak Vista’s region did manage to broaden its network initially, by contracting with a couple of large provider organizations that included specialty providers. However, those providers were later acquired by a large national company that

chose not to pursue Medicaid business, and subsequently withdrew from network participation with the regional ACO. As a result, access to specialty care did not increase.

- Receiving per-member, per-month payments for care management or care coordination—as primary care providers receive from the Medicaid ACOs in Colorado and Oregon—has helped health centers build their primary care team capacity. Among other benefits, this enhanced capacity has facilitated patients’ access to specialty care. In Colorado, for instance, Peak Vista used its care coordination payments to fill several positions for nurse care managers and resource navigators. These staff—particularly resource navigators—play key roles in identifying specialists to whom patients can be referred, guiding patients through the referral and appointment-making processes, and closing the referral loop by documenting the specialty visit.
- Of the states in the study, Oregon takes the most comprehensive approach to incentivizing and rewarding providers to manage patients well on both cost and quality. Oregon does so by pairing capitated payment, under its Alternative Payment Methodology pilot, with opportunities to earn quality bonuses and shared savings, under its Medicaid ACO model. In addition, providers have the opportunity to win grants awarded by their regional Medicaid ACO entities to test new ways of delivering care that might improve quality and access for patients. Early evidence suggests that this comprehensive approach has made a positive impact on overall quality, access, and costs for Medicaid patients in central Oregon. With respect to specialty care, there is less evidence of direct impact, but—as noted above—the capitated payments in this model have helped build primary care team capacity, which in turn facilitates access to specialty care for patients.

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