

Community Health Centers and Medicaid Delivery and Payment Reform: A Closer Look at Massachusetts and New York

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Vikki Wachino established Viaduct Consulting in 2017. Between 2015 and 2017, Ms. Wachino headed the Center for Medicaid and CHIP Services for the Obama Administration, where, among other responsibilities, she oversaw the Massachusetts and New York DSRIP demonstrations.

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About the Geiger Gibson / RCHN Community Health Foundation Research Collaborative

The Geiger Gibson Program in Community Health Policy, established in 2003 and named after human rights and health center pioneers Drs. H. Jack Geiger and Count Gibson, is part of the Milken Institute School of Public Health at the George Washington University. It focuses on the history and contributions of health centers and the major policy issues that affect health centers, their communities, and the patients that they serve.

The RCHN Community Health Foundation is a not-for-profit foundation established to support community health centers through strategic investment, outreach, education, and cutting-edge health policy research. The only foundation in the U.S. dedicated solely to community health centers, RCHN CHF builds on a long-standing commitment to providing accessible, high-quality, community-based healthcare services for underserved and medically vulnerable populations. The Foundation's gift to the Geiger Gibson program supports health center research and scholarship.

Additional information about the Research Collaborative can be found online at <https://publichealth.gwu.edu/projects/geiger-gibson-program-community-health-policy>

or at www.rchnfoundation.org.

Executive Summary

The relationship between Medicaid and community health centers is especially strong. Health centers care for 1 in 6 Medicaid beneficiaries nationally, and Medicaid accounts for nearly half of all health center financing. As a result, health centers in many states have been extensively involved in the effort to achieve delivery and payment reform. This analysis focuses on health center participation in delivery transformation in New York and Massachusetts as part of both states' § 1115 Medicaid delivery transformation demonstrations known as DSRIP. It illustrates how long-standing relationships between health centers and Medicaid agencies, as well as statewide and community-level approaches to achieving deeper health system change, both shape health center involvement.

Background

State Medicaid programs are engaged in wide-ranging efforts to improve health care and more effectively align care with broader strategies to promote population health. The Affordable Care Act has helped spur these initiatives by significantly expanding Medicaid's reach and by encouraging delivery reform. This encouragement has taken the form of expanded use of managed care, patient-centered medical homes and health homes, and the introduction of accountable care organizations.¹

Delivery transformation, like high-performing health systems generally, rests on a foundation of comprehensive primary care.² Because of their location, whom they serve, and what they do, community health centers thus assume a potentially important role in Medicaid agency delivery transformation efforts. In 2017, over 1,300 health centers operating in more than 11,000 locations served more than 27 million children and adults. Nationally, health centers

served 1 in 6 Medicaid and CHIP beneficiaries that year; in some states this figure reached 1 in 4.³ Health centers play a major role in integrated care delivery networks, and over 60 percent of all Medicaid-covered health center patients are enrolled in managed care.⁴ Furthermore, in many communities, health centers are not only a source of comprehensive care but also provide an entry point into nutrition, housing, educational programs, and social services aimed at addressing the underlying social determinants of health.⁵ Strengthening the ability of health care providers to address population health needs has emerged as a major theme for Medicaid agencies.

Likewise, Medicaid is essential to health centers. In 2017, Medicaid insured 49 percent of all health center patients and accounted for 44 percent of health center operating revenue,⁶ a figure more than double the proportion of health center revenue derived from federal grant funding. Medicaid's central role in insuring their patients means that health centers have an especially great interest in delivery

¹ Gifford, K. et al (2017). Medicaid Moving Ahead in Uncertain Times: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2017 and 2018. Kaiser Family Foundation. Available at <https://www.kff.org/report-section/medicaid-moving-ahead-in-uncertain-times-emerging-delivery-system-and-payment-reforms/>

² Shih, A., Davis, K., Schoenbaum, S. C., Gauthier, A., Nuzum, R., & McCarthy, D. (2008). Organizing the US Health Care Delivery System for High Performance. The Commonwealth Fund. Available at <https://www.commonwealthfund.org/publications/fund-reports/2008/aug/organizing-us-health-care-delivery-system-high-performance>

³ Sharac, J., Shin, P., Gunsalus, R., & Rosenbaum, S. (2018). Community health centers continued to expand patient and service capacity in 2017. Geiger Gibson/RCHN Community Health Foundation Research Collaborative, George Washington University. Policy Research Brief No. 54. Available at <https://www.rchnfoundation.org/?p=7172>

⁴ Bureau of Primary Health Care. (2018). 2017 Health Center Data: National Data. Health Resources and Services Administration. Available at <https://bphc.hrsa.gov/uds/datacenter.aspx?q=tall&year=2017&state=>

⁵ National Association of Community Health Centers. (2012). Powering Healthier Communities: Community Health Centers Address the Social Determinants of Health. Available at http://www.nachc.org/wp-content/uploads/2016/07/SDH_Brief_2012.pdf

⁶ Sharac, J., Shin, P., Gunsalus, R., & Rosenbaum, S. (2018). Community Health Centers Continued to Expand Patient and Service Capacity in 2017. Geiger Gibson/RCHN Community Health Foundation Research Collaborative, George Washington University. Policy Research Brief No. 54. Available at <https://www.rchnfoundation.org/?p=7172>

and payment reform, and across the country, health centers are active participants in delivery reform initiatives. This active engagement extends to initiatives in several states in which Medicaid agencies and health centers are jointly testing alternative payment approaches designed to move from Medicaid's federally qualified health center (FQHC) encounter-based prospective payment system to payment structures using value-based capitation and global payment approaches.⁷

Given the importance of the Medicaid - health center relationship, the Geiger Gibson/RCHN Community Health Foundation Research Collaborative undertook a study whose purpose was to more deeply explore this relationship in a delivery and payment reform context. Because delivery reform strategies vary significantly and are complex, we focused on two states – Massachusetts and New York – both of which are engaged in comprehensive delivery system and payment reform efforts and as such, participate in Delivery System Reform Incentive Payment (DSRIP) program demonstrations under § 1115 of the Social Security Act. DSRIP enables states to introduce new care models (such as Massachusetts' move to greater use of accountable care organizations, a core element of its comprehensive effort). DSRIP also supports state efforts to test new payment structures tied to performance and value and to make investments in delivery transformation. Examples of the types of investments made possible through DSRIP are new delivery sites, development of team-based care, addition of key personnel, investments aimed at integrating physical and behavioral health care, broadening the use of telehealth care and consultation, expanded use of health information technology, and developing provider networks that have the capacity to bridge clinical and social services.⁸

In 2017, ten states maintained active DSRIP demonstrations.⁹ Because DSRIP models operate under

§ 1115 authority, they are experiments, and their impact will be measured through a formal evaluation process that can inform future policy.

We chose New York and Massachusetts because both have fully implemented the ACA insurance reforms, both are recognized Medicaid policy leaders, and both have made better primary care a key DSRIP element. At the same time, the two states are quite distinct in how their Medicaid programs are financed and in their approach to Medicaid policy-making. Additionally, both have different histories where health center collaboration is concerned. For these reasons, we concluded that a focus on these two states would offer an important policy learning opportunity.

We conducted our study over the spring and summer of 2018. Our approach combined detailed inspection of relevant documents with focused interviews with key state officials leading delivery reform efforts, and in-person, round-table discussions with health centers in both states, which were organized by the Community Health Care Association of New York State (CHCANYS) and the Massachusetts League of Community Health Centers (Mass League).

Delivery System Reform in Massachusetts and New York

New York and Massachusetts share similar DSRIP goals: to increase provider collaboration and integration in order to reduce health care system “silos”; to increase the use of value-based payment strategies that incentivize quality; to strengthen primary care; and to improve access to behavioral health and social services. In implementing their strategies, both states have sought to promote the concept of shared savings, using methods similar to those that Medicare is deploying. Importantly, both states have sought to have more direct involvement in matters of health care

⁷ Rosenbaum, S., Shin, P., & Sharac, J. (2016). Community Health Centers and the Evolution of Medicaid Payment Reform. The Commonwealth Fund. Available at <https://www.commonwealthfund.org/blog/2016/community-health-centers-and-evolution-medicaid-payment-reform>

⁸ Center for Health Care Strategies. (2016). Delivery System Reform Incentive Payment (DSRIP): State Program Tracking. Available at <http://www.chcs.org/media/DSRIP-State-Program-Tracking-120516-FINAL.pdf>; National Academy for State Health Policy. (2018). Exploration of the Evolving Federal and State Promise of Delivery System Reform Incentive Payment (DSRIP) and Similar Program. Available at <https://www.macpac.gov/wp-content/uploads/2018/03/Exploration-of-the-Evolving-Promise-of-DSRIP-and-Similar-Programs.pdf>

⁹ National Academy for State Health Policy. (2018). Exploration of the Evolving Federal and State Promise of Delivery System Reform Incentive Payment (DSRIP) and Similar Program. Available at <https://www.macpac.gov/wp-content/uploads/2018/03/Exploration-of-the-Evolving-Promise-of-DSRIP-and-Similar-Programs.pdf>

organization and delivery rather than relying solely on high-level contracts with managed care organizations with broad discretion over network, performance, and payment matters.

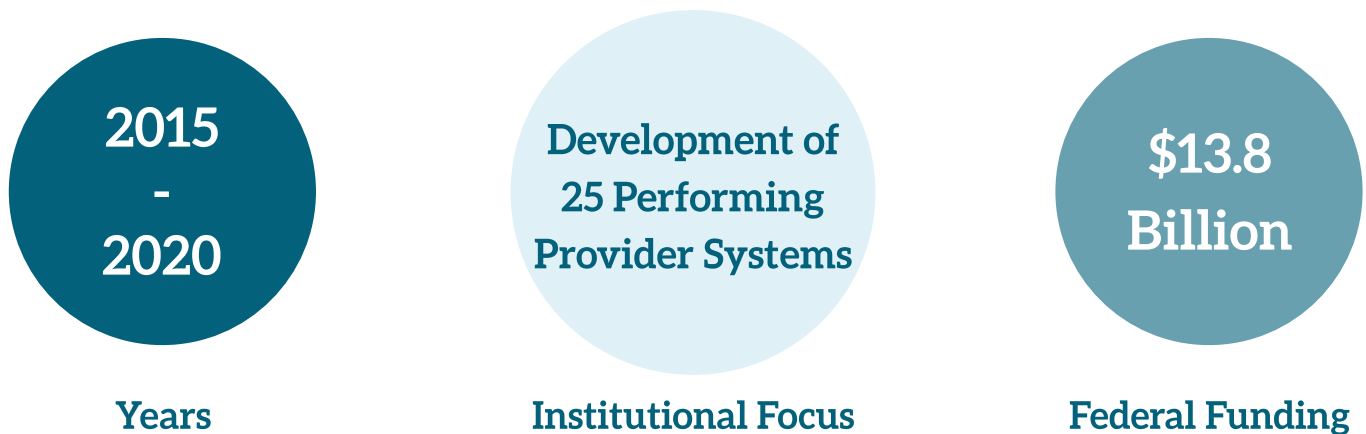
Both the New York and Massachusetts DSRIP demonstrations are the result of lengthy and complex negotiations with CMS, and both approved demonstrations are subject to detailed federal conditions regarding the activities to be undertaken, as well as the delivery, payment, and performance matters to be tested. In other words, both state DSRIPs are carefully designed federal demonstrations.

New York DSRIP

With a monthly Medicaid and CHIP enrollment of 6.5 million in 2018, New York faces a massive challenge in its effort to transform care.¹⁰ Developed following an extensive stakeholder involvement process using Medicaid Redesign Teams to discuss and develop delivery system reform priorities, DSRIP in New York was rooted in a determination by the state and key stakeholders that prioritizing population health was central both to managing costs and to improving the performance of the state's health care

¹⁰ Kaiser Family Foundation. (2019). Total Monthly Medicaid and CHIP Enrollment. Available at <https://www.kff.org/health-reform/state-indicator/total-monthly-medicaid-and-chip-enrollment/>

Figure 1. New York DSRIP Model



Health Center-Relevant Aims

- Incentivize providers to create and sustain an integrated, high performing delivery system
- Over time, move to value-based payment models for 80-90% of all payments subject to managed care
- Transform safety net providers at both the local system and statewide levels
- Ensure sustainability of model improvements through long-term managed care payment reform

Attribution

A basic element of the PPS system, with attribution focused a complex formula that considers health care utilization across a range of primary and specialty care*

How are Health Centers Involved?

- Health center involvement ranges from leading a PPS to co-sponsorship of a PPS network without a governance role.
- Health center receipt of DSRIP investment funds flows through local PPS systems.

* See more at <https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/1115-ib12-508-dsrp-attribution.pdf>

system. DSRIP reflects the state's effort to meet this complex challenge, through two specific goals: (1) a 25 percent reduction in avoidable hospitalizations; and (2) by 2020, move to value-based payments for between 80 percent and 90 percent of all provider payments. These specific goals, and the broader population health objectives underlying them, led to the development of large provider networks that provide integrated care and manage financing and quality improvement.

To achieve these results, New York has used DSRIP to help stimulate the development of integrated provider networks entailing formal, broadly-structured collaborations among providers in their service areas. These local networks – twenty-five in all as of summer 2018 – are termed Performing Provider Systems (PPS). These systems consist of regional networks of hospitals, primary care and other outpatient providers, clinics, behavioral health providers, and community and social service organizations that meet specific requirements. PPS systems work alongside, but are organizationally separate from, the state's managed care system; the efforts of managed care organizations (MCOs) and PPS' alike are guided by a value-based payment roadmap that is updated regularly.¹¹ The twenty-five PPS integration models cover nearly the entire state, with some overlap. Under DSRIP they are expected to implement quality improvement projects, earning DSRIP financing that in turn enables them to make performance-based payments to providers.¹²

Most of the twenty-five PPS systems are hospital-led. One of the hospital-led systems is the only hospital-linked health center in the state – Lutheran/Sunset Park, now known as NYU Langone Brooklyn. Another is Adirondack Health Institute (AHI), an established health care collaborative whose governing members include Hudson Headwaters Health Network, a health center network. In addition, one

local community health center-led PPS, Refuah Community Health Collaborative, serves primarily members of the Orthodox Jewish community, and reaches over 45,000 patients in Rockland and Orange Counties. It competed successfully in the state's PPS leadership application process, and the state considers Refuah to be a leader in delivery and payment reform.¹³ New York also has one independent physician association (IPA)-led PPS.

Although the PPS governance models are intended to serve as local care collaboratives that engage multiple system stakeholders, hospitals are generally key actors, reflecting their historic and central role in New York's Medicaid program, and their growing emphasis on providing more integrated care. This emphasis on hospital-led PPS is illustrated by the state's attribution system, which uses a complex provider utilization algorithm that considers both primary care and specialty care and seeks to align patients with the providers they visit most often. This means that, for attribution purposes, use of specialty care, such as behavioral health, could outweigh where patients receive primary care. New York historically also has relied on local public hospital financing to meet its state Medicaid spending obligations, using federal intergovernmental transfer (IGT) authority. Thus, hospitals are critical not only to delivery reform but to DSRIP financing.

All health centers in the state are part of at least one PPS, while many are members of more than one. In most cases, health centers serve on PPS governing boards. According to CHCANYS, one-third of the state's health centers have achieved what the association terms meaningful involvement in designing at least one PPS payment structure used to reward network providers for meeting performance goals, while nearly one-quarter have achieved meaningful involvement with the networks in which they participate.¹⁴

¹¹ New York State Department of Health. (2017). A Path toward Value Based Payment: Annual Update, New York State Roadmap for Medicaid Payment Reform. Available at https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_library/docs/2017-11_final_vbp_roadmap.pdf

¹² PPS member hospitals must demonstrate high Medicaid involvement. They must have at least 35 percent of outpatient volume and at least 30 percent of inpatient volume as Medicaid, uninsured and dual eligibles, or serve at least 30 percent of all Medicaid, uninsured, and duals in the PPS service area. Nonhospital based providers must have a total volume with at least 35 percent as Medicaid, uninsured, and duals. Non-qualifying organizations for participation in a PPS are also eligible subject to state and CMS approval if DSRIP payments to these organizations are less than 5 percent of the total project valuation.

¹³ Refuah Health Center. Available at <http://refuahhealthcenter.com/>

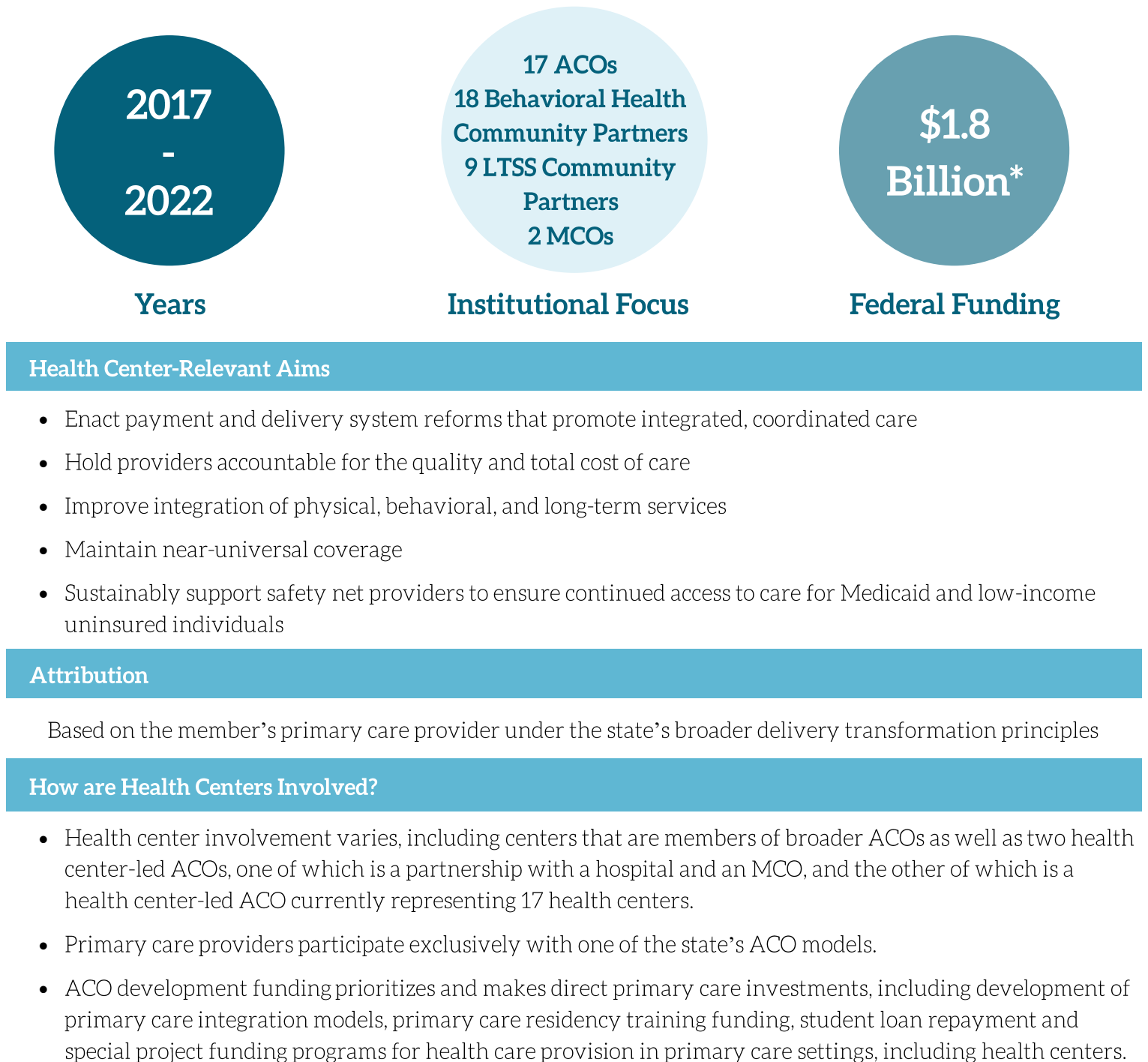
¹⁴ Interview with CHCANYS and New York health centers, June 26, 2018

Massachusetts DSRIP

Like New York, Massachusetts has used § 1115 to achieve broader changes in health care organization, delivery, and payment. As part of this effort, the state has promoted the growth of Accountable Care Organizations (ACOs), which, like the New York model, are charged with collaborating with the state to drive delivery and payment reform within an overall budgeting context.

Implementation of the Massachusetts DSRIP model began in 2017, two years after New York launched its demonstration. As a result, Massachusetts is at an earlier stage; indeed, New York's approach informed the development of the Massachusetts demonstration.

Figure 2. Massachusetts DSRIP Model



* for the DSRIP component of Massachusetts' broader delivery transformation effort

Health Centers' Roles in New York and Massachusetts DSRIP Development and Implementation

A smaller state, Massachusetts enrolled approximately 1.8 million Medicaid beneficiaries as of November 2018.¹⁵ As in New York, some Massachusetts hospitals have historically played a role in Medicaid financing through use of IGTs. However, in developing its DSRIP model, Massachusetts decided to move forward without hospital financing of the reform plan, thereby creating a different set of operational and political relationships between the state Medicaid agency and local health care delivery systems. IGTs thus play a diminished role in Massachusetts' overall delivery transformation effort. The Massachusetts model also bases its patient attribution on primary care utilization patterns.

Massachusetts is testing three distinct ACO models, each of which is accountable for quality and cost but varies in its approach to risk and payment. Health centers participate in all 3 models, and in the case of two models – MCO partnerships and primary care-led systems – health centers play leadership roles. In the case of the health center/MCO/hospital-led model, classical vertical integration principles apply within a risk-bearing system. By contrast, within the state's primary care model is a health center-led ACO, known as Community Care Cooperative (C3). This model, which also includes two other non-health center-led participants, tracks Medicaid's long-standing primary care case management (PCCM) principles while also introducing efficiency innovations. With 17 health centers, C3 accounts for between 115,000 and 120,000 members and uses its state investment to test the use of vertical integration management techniques within a more open network environment. At the same time, C3 is able to limit downstream risk to individual health centers by means of a stress test that assesses member capabilities to manage financial risk.

In both New York and Massachusetts, community health centers represent a significant part of the state's primary health care system for low-income and medically underserved communities and populations. But the history of health centers as a policy and political presence within each state is quite distinct. These distinctions came through in our discussions with the states, the state associations and health centers themselves, as we sought to understand each state's delivery system transformation effort.

New York

In 2017, 65 health centers, operating in more than 681 sites, served over 2.1 million state residents in New York State¹⁶ – one in nine residents¹⁷ and 22 percent of Medicaid/CHIP beneficiaries in the state.¹⁸ New York's health centers carry out their work in a state characterized by size, diversity, regional variation, and a long tradition of local control on many social matters, including health care. New York chose a delivery reform structure that would reflect these basic social, political and economic contours. Furthermore, the state's emphasis on driving system change through local collaboratives inevitably shapes health centers' thinking about how best to address many issues, including delivery system transformation.

These themes carried through in our discussions with health center leaders and CHCANYS staff. In New York, the state association tends to play a coordinating and technical support role. Although the organization engages in considerable state-level advocacy, its members historically have placed less emphasis on this particular aspect of CHCANYS' work.

¹⁵ Kaiser Family Foundation. (2019). Total Monthly Medicaid and CHIP Enrollment. Available at <https://www.kff.org/health-reform/state-indicator/total-monthly-medicaid-and-chip-enrollment/>. Interviewees reported that the number, updated since the Kaiser report, stands at 1.8 million.

¹⁶ Bureau of Primary Health Care. (2018). 2017 Health Center Data: New York Data. Health Resources and Services Administration. Available at <https://bphc.hrsa.gov/uds/datacenter.aspx?q=tall&year=2017&state=NY>

¹⁷ US Census Bureau. (2018). Current Population Survey, Annual Social and Economic Supplement. Available at <https://www.census.gov/cps/data/cpstablecreator.html>

¹⁸ GW analysis of 2017 UDS data (numerator) and CMS Medicaid/CHIP enrollment numbers for December 2017 (denominator); Kaiser Family Foundation. (2019). Total Monthly Medicaid and CHIP Enrollment. Available at <https://www.kff.org/health-reform/state-indicator/total-monthly-medicaid-and-chip-enrollment/>

Health center participation in DSRIP is consistent with the state's approach to reform. To be sure, New York's development process was global and statewide, with heavy local consultation in developing the overall state approach toward system transformation. State officials described a process that attempted to meld statewide priorities and policies in a manner driven by improved collaboration and performance at the local level, particularly with respect to elevating the role of primary health care in order to reduce potentially preventable hospital admissions. Officials also noted the important role played by health centers in achieving the state's goal of integrating physical and behavioral health care.

However, while New York officials recognized the importance of health centers, they did not appear to identify them as a distinct, statewide asset to be deployed in achieving statewide goals. Instead, they were viewed as an important local care resource. Indeed, state officials viewed local PPS arrangements as the entities in charge of value-based payment decisions. Consistent with that objective, PPS leadership requirements include the ability to manage money across the entire delivery system, distribute DSRIP funding in alignment with performance goals, pay participating providers, and manage a network. State officials indicated that although the PPS application process was an open one and not limited to hospitals, the basic requirements for PPS sponsorship tended to favor entities that could run large performance networks, were vetted fiduciaries, and could attract a sufficient number and range of community service providers to create a comprehensive network.

Not surprisingly, the state's approach has, in turn, led health centers to focus predominantly on achieving leadership roles in local transformation efforts. Although CHCANYS has maintained active involvement in statewide implementation, it did not play a major role in the earlier state/CMS negotiation process that set the terms for the demonstration.

Several themes emerged from our discussions. The first was the importance placed by health centers on local inclusiveness and leadership. New York health centers are

eager to advance local transformation efforts in order to improve care, better manage care shortages, improve provider relationships, and test new value-based payment models. Prior to DSRIP, health centers had participated in local or regional efforts to strengthen primary care and coordination. Still, health centers viewed health care in New York as locally focused. As the state developed DSRIP, health centers described tracking the effort closely and ultimately engaging the state, but at a later stage of the process. They ramped up their advocacy substantially after the DSRIP was approved and as state officials were making key decisions about PPS composition.

The second was the need to accommodate to political realities. Health centers understood that in the New York DSRIP model, control would focus on local hospitals and hospital systems, as reducing Medicaid hospital spending would fund the state share of transformation. Thus, while health centers had a longstanding relationship with the state over issues involving Medicaid's FQHC payment methodology, they viewed DSRIP as (and the state designed DSRIP to be) a more localized undertaking. Within this local focus, however, a key theme for health centers remains retaining the types of protections inherent in the health center payment methodology, which by its very encounter-based structure, offers protection, in their view, against high patient volume unaccompanied by sufficient global financing.

Consistent with New York State political realities, health centers assumed a "die has been cast" position, seeing the core DSRIP model as hospital-based and immutable. They saw little likelihood of alternative models such as the health center-led models that have emerged in Massachusetts (an important exception is the health center-led PPS, Refuah). Although the association proposed a health center-led statewide model, they also found that the very basic provisions of PPS as envisioned by the state did not easily lend the model to health center control. Health centers did not view themselves as possessing the capabilities that the state established for PPS leaders. In their view, the model favored larger lead entities. Additionally, the structure of patient attribution and payments favored the creation of large PPS entities.

Reflecting on DSRIP implementation thus far, state officials credited health centers with being strong performers on both primary care and behavioral health, meeting or exceeding their initial expectations. Health centers are “the model for behavioral health integration,” one official told us. Though not necessarily reflective of health center experience but relevant to primary care access, state officials also noted that DSRIP implementation has increased attention to meeting the needs of small primary care practices, particularly in rural areas, to help advance integration, coordinated care, and value-based payment. Both the health centers and the state described significant progress in care integration since the establishment of the DSRIP. “We keep hearing, ‘We worked in the same community, but we had never talked before,’” one New York official told us.

Health centers have experienced local implementation challenges. Some have raised issues with the flow of funds through PPS entities to providers and the limited access to investment funds. According to state officials, hospitals have received 29 percent of all DSRIP funds, while 16 percent of funds have flowed to clinical providers, which include health centers.¹⁹ The remaining funds have been distributed to other activities.²⁰ In addition, state officials noted that the terms of the § 1115 demonstration require 95 percent of funding to flow to safety net providers; however, the provider participation standards established under the § 1115 waiver have foreclosed involvement by a number of community-based social service organizations, a problem that had not been resolved by the time of our interview, although state officials noted that this result was inadvertent and occurred because these organizations did not fit within the definition of safety net providers used to allocate financing.

Massachusetts

In 2017, 39 health centers operated in 279 sites throughout Massachusetts and served 773,139 patients,²¹ representing 1 in 9 state residents²² and 18 percent of Medicaid/CHIP beneficiaries.²³ The state has a fabled history with health centers, having served as home to the nation’s first community health center. Massachusetts’ health centers not only provide care to a significant portion of the state’s population but also have a long history of leadership in state health policy transformation, one that has focused on both expanding coverage and improving care.²⁴ As in New York, Massachusetts health centers have been active in managed care formation and their respective state’s medical homes initiative. The Massachusetts League of Community Health Centers (Mass League) was extensively involved in shaping the state’s large-scale shift to Medicaid managed care in the mid-1990s and played a major role in the enactment of the landmark Massachusetts health reform law that in turn served as the prototype for the Affordable Care Act.

Consistent with their long history of state-level advocacy on coverage and delivery reform, and distinct from the experience of New York’s health centers, Massachusetts health centers played a significant, direct role in helping the state shape DSRIP, from the time of its early proposal, and throughout its implementation. In this respect, it is this state-level involvement from the earliest point of development that most clearly sets Massachusetts apart from New York.

What also became clear was that rather than seeing health centers solely as important local assets, state officials came to view the Mass League as an important source of statewide policy development and as affirmatively important, from a state policymaking perspective, to its

¹⁹ New York State Department of Health. (2018). DSRIP Updates. Available at https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/paop/meetings/2018/docs/2018-11-29_updates.pdf

²⁰ New York State Department of Health. (2018). Midpoint Assessment Action Plan Final Summary. Available at https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/mid-pt_assessment/2018-03_mid-pt_action_final.htm

²¹ Bureau of Primary Health Care. (2018). 2017 Health Center Data: Massachusetts Data. Health Resources and Services Administration. Available at <https://bphc.hrsa.gov/uds/datacenter.aspx?q=tall&year=2017&state=MA>

²² US Census Bureau. (2018). Current Population Survey, Annual Social and Economic Supplement. Available at <https://www.census.gov/cps/data/cpstablecreator.html>

²³ GW analysis of 2017 UDS data (numerator) and CMS Medicaid/CHIP enrollment numbers for December 2017 (denominator); Kaiser Family Foundation. (2019). Total Monthly Medicaid and CHIP Enrollment. Available at <https://www.kff.org/health-reform/state-indicator/total-monthly-medicare-and-chip-enrollment/>

²⁴ Mass League. (2018). Massachusetts Community Health Centers — Get the Facts. Available at <http://www.massleague.org/About/FactsIssuesBrief.pdf>

overall success in transforming primary care. While state officials varied in the level of support they had for options put forth by the associations, in their view health centers were “well-positioned to be the focal point of care,” in the words of one — part of the cost and quality solution to primary care.

Although the Massachusetts DSRIP demonstration is in an early stage and has not yet yielded significant impact information, both the state and health centers viewed the ACO rollout favorably. “We are much better positioned to do what we want to do with ACOs because we have such a strong relationship with health centers,” the Massachusetts official observed. Having made primary care a focus of the ACO model, the state effectuated this vision designing an ACO attribution system that turns on primary care, with the patient’s primary care provider as the focal point.

In keeping with their history of statewide health policy involvement, Massachusetts health centers began their DSRIP engagement with state officials when the initiative was in its formative stages in order to ensure that under a DSRIP award, creation of a health center-led ACO would remain a policy implementation pathway choice. The state’s aim was to test multiple models rather than a single delivery mechanism, and the state remained free to adjust specific elements of transformation design (such as the phase-in of risk sharing or modification of payment rules) in order to be able to test transformation in multiple structural contexts. This assurance of flexibility as a feature of the state’s DSRIP award meant that health centers could, as implementation proceeded, start down distinctly different pathways: as active participants in local ACO models; or as the creators of health center-led models, whether as primary care-led ACOs or through partnerships with MCOs and hospitals.

While Massachusetts health centers, like those in New York, have had continuous dialogue with Medicaid on a variety of payment issues, it is also the case that Massachusetts health centers have a long history of close collaboration with the Commonwealth. This longstanding, robust working relationship on matters of both delivery and payment, coupled with health centers’ commanding position as primary care providers, paved the way to DSRIP collaboration. The long working relationship also meant that

health centers could be involved formally from the point of conceptualization and informally with state leaders as CMS negotiations progressed. For their part, Mass League staff, along with health center leaders, viewed state officials as fundamentally supportive of and committed to health centers’ ability to weather large-scale transformation without sacrificing their fundamental stability as primary health care anchors in their communities. Although state officials initially raised questions in the early stages of DSRIP development about the best role and structure of health centers in the ACO model, the state and health centers worked through these concerns collaboratively.

This mutual respect and understanding about the need for engagement meant that although state officials expressed initial concerns about the viability and stability of a health center-led ACO, they also agreed to certain modifications of the model, especially the level of risk that ACOs otherwise are expected to carry. These adaptations include a modified approach to risk sharing, a greater level of flexibility in how referral systems work in practice (with more leeway to preserve local variation in provider referral arrangements), and adjustments in performance time frames. In addition, within the DSRIP transformation funding, specific funding mechanisms support full participation of primary care providers, including workforce development and behavioral health provider recruitment.

What Are the Lessons for Health Centers and Medicaid from the Massachusetts and New York Health DSRIP Experiences?

What lessons can be drawn for community health centers and for state Medicaid programs from the implementation experiences of health centers under two states’ ambitious DSRIP models?

A shared mission and a mutual dependence. The first point, one seen in each state’s DSRIP’s design and the desire on the part of health centers to be part of DSRIP implementation, is how much each depends on the other where payment and delivery reform are concerned. This is not surprising. Medicaid and health centers share a mission

and focus; Medicaid, the vastly larger of the two, focuses on coverage while the job of health centers is complementary – to create a pathway to health care itself for vulnerable populations. Health centers’ existence depends on Medicaid’s fortunes. Grant funding is essential for uninsured populations and services, but Medicaid represents one out of every four dollars used to operate a health center today.²⁵ This figure is even higher in expansion states such as New York and Massachusetts, where Medicaid covers virtually all low-income patients.

Likewise, Medicaid agencies depend on health centers as the single most important source of primary health care. One in every six Medicaid beneficiaries is a health center patient, a figure even more pronounced in New York and Massachusetts, where health center penetration is exceptionally high, and where health center patients account for approximately one in four Medicaid beneficiaries, respectively.²⁶ To succeed, delivery and payment reform depends on more than reducing waste; their success is tied to agencies’ ability to better connect beneficiaries with high-value primary care more strongly integrated with social services. From its origins as a Great Society experiment, the health center model was designed to be exactly this type of bridge. Achieving high performance among health centers thus becomes a major element of transformation success.

Health centers want to be leaders in delivery and payment reform; local conditions and circumstances will largely shape their pathway. In both New York and Massachusetts, health centers are eager to think differently and innovatively about payment models as an extension of health care quality and efficiency. Health centers in a number of states are engaged in developing alternative payment models, which can be negotiated under federal Medicaid law without the need for special waivers. This interest has led to

payment reform experiments underway or under discussion in twelve states and a willingness on health centers’ part to test global and bundled payment models, models tied to annualized patient costs over an enrollment period (capitation), and models that trade volume for greater efficiencies.²⁷

Health centers in both states have assumed leadership roles, although in distinctly different ways that reflect tradition and each state’s own customs and priorities. In New York, health centers as leaders have tended to focus on their own localities, through participation in local models specific to health centers’ individual service areas. One health center leads a PPS, having competed successfully for inclusion.

By contrast, in Massachusetts, health center engagement as a matter of statewide policy is an embedded feature of that state’s DSRIP design. The historically strong relationship between Massachusetts Medicaid and the state’s health centers – shaped by the public’s dependence on the health center model and the features of the model itself – in turn led to a delivery reform experiment that literally has placed some of the state’s health centers at the payment reform helm; others remain just active participants in payment reform. The state’s interest here is not altruistic; instead, it reflects the state’s desire to strengthen the health center primary care model, as well as to put health centers in a position from which they lead the effort to move from volume to value.

Where payment reform is concerned, there is much to gain from a strong working partnership between Medicaid and community health centers. Along with rural health clinics, community health centers represent the only remaining health care providers that enjoy certain protections against Medicaid’s traditionally discounted payment arrangements. Congress established the FQHC payment system, as it is

²⁵ Sharac, J., Shin, P., Gunsalus, R., & Rosenbaum, S. (2018). Community Health Centers Continued to Expand Patient and Service Capacity in 2017. Geiger Gibson/RCHN Community Health Foundation Research Collaborative, George Washington University. Policy Research Brief No. 54. Available at <https://www.rchnfoundation.org/?p=7172>

²⁶ Sharac, J., Shin, P., Gunsalus, R., & Rosenbaum, S. (2018). Community Health Centers Continued to Expand Patient and Service Capacity in 2017. Geiger Gibson/RCHN Community Health Foundation Research Collaborative, George Washington University. Policy Research Brief No. 54. Available at <https://www.rchnfoundation.org/?p=7172>; GW analysis of 2017 UDS data (numerator) and CMS Medicaid/CHIP enrollment numbers for December 2017 (denominator); Kaiser Family Foundation. (2019). Total Monthly Medicaid and CHIP Enrollment. Available at <https://www.kff.org/health-reform/state-indicator/total-monthly-medicaid-and-chip-enrollment>

²⁷ National Academy for State Health Policy. (2018). Exploration of the Evolving Federal and State Promise of Delivery System Reform Incentive Payment (DSRIP) and Similar Program. Available at <https://www.macpac.gov/wp-content/uploads/2018/03/Exploration-of-the-Evolving-Promise-of-DSRIP-and-Similar-Programs.pdf>

known, in order to ensure that federal grant funding – the only other major source of federal funding – would not be used to offset any losses associated with Medicaid payments.

The essence of that model is avoiding financial stress in a provider system that lacks basic cost-shifting capability because of the poverty of its patients and the high number of uninsured patients served. The larger question raised by the application of delivery system reforms to health centers is whether avoiding unmanageable financial exposure requires a volume-driven, fee-for-service payment approach. Or is it instead possible to develop a financial mechanism that can set efficiency and quality targets, and support transformation by helping health centers adapt their practices to be able to achieve those targets, while simultaneously ensuring the necessary guardrails (such as stop-loss and risk corridors) against inappropriate financial risk, given health centers' importance to both Medicaid and uninsured patients? Such an approach might test bundled payments and global budgeting, thereby letting health centers move away from volume and toward a care delivery model that produces high-quality results while avoiding the kind of unmanageable encounter frequency that can cause high clinical staff turnover and challenge recruitment.

It is too early to assess how either state's model will affect health centers specifically or the broader, underlying currents of health care for low-income and vulnerable populations. In both models, health centers are playing an essential role, however. In New York, their influence can be seen in local delivery systems and their leadership in integrating behavioral health and primary care. In Massachusetts, this local impact is joined by health centers' leadership at the state level, offering a model of broader delivery reform in which primary care drives the allocation of resources and the evolving relationships among community providers.

As the New York and Massachusetts models continue to evolve, evaluating payment and delivery reform in the context of health centers emerges as an important issue. How do health centers perform as ACO participants and how does their performance compare to that of other providers?

Can health centers develop improved relationships with specialty and institutional providers, and what mechanisms among them foster collaboration and break down silos? What challenges do health centers face in adapting to a higher financial risk climate? How does financial risk shape the decisions health centers make about populations served, services offered, patient management strategies, prioritization of practice improvements, and resource and quality measurement? What is the effect, if any, on health centers' capacity to serve uninsured patients, to offer services that insurance does not cover, and to offer related health and social support services? Finally, how can the payment and practice transformation experience of New York and Massachusetts health centers inform efforts in other states, particularly as health centers and states pursue alternative payment models?

These questions, and others, will help shape not only the future of health centers in a transforming health system but also the feasibility of system transformation itself, given their central role in health care delivery, not only for Medicaid patients, but for their communities as a whole.