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Including Safety-Net Providers in Integrated Delivery Systems: Issues and Options for Policymakers

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ABSTRACT: Health care reform legislation has spurred efforts to develop integrated health care delivery systems that seek to coordinate the continuum of health services. These systems may be of particular benefit to patients who face barriers to accessing care or have multiple health conditions. But it remains to be seen how safety-net providers, including community health centers and public hospitals—which have long experience in caring for these vulnerable populations—will be included in integrated delivery systems. This issue brief explores key considerations for incorporating safety-net providers into integrated delivery systems and discusses the roles of state and federal agencies in supporting and testing models of integrated care delivery. The authors conclude that the most important principles in creating integrated delivery systems for vulnerable populations are: 1) an emphasis on primary care; 2) coordination of all care, including behavioral, social, and public health services; and 3) accountability for population health outcomes.

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OVERVIEW

While health care reform legislation has focused attention on insurance coverage, it also has spurred efforts to develop and spread models of integrated care delivery. Integrated health care delivery systems provide or arrange a coordinated continuum of health care services to a defined population, and they hold themselves accountable for the outcomes and health status of their patients.¹ By ensuring appropriate care, avoiding duplication of services, and reducing fragmentation, these systems seek to promote health care quality while also controlling costs. Populations that are vulnerable because of low income, poor health, or other factors may particularly benefit from integrated care.² Many of these vulnerable populations are expected to gain health coverage under the provisions of the Affordable Care Act (Exhibit 1). Since vulnerable populations are more likely than the general population to experience multiple health conditions as well as

financial barriers to care, those newly insured may find particular benefit from integrated delivery systems.³

State and federal policymakers are increasingly looking to integrated delivery systems, such as accountable care organizations (ACOs), to care for vulnerable populations. But it remains to be seen how safety-net providers such as community health centers, rural health clinics, public hospitals, and other non-profit and public providers that have long experience in caring for vulnerable populations will be included in such systems.⁴

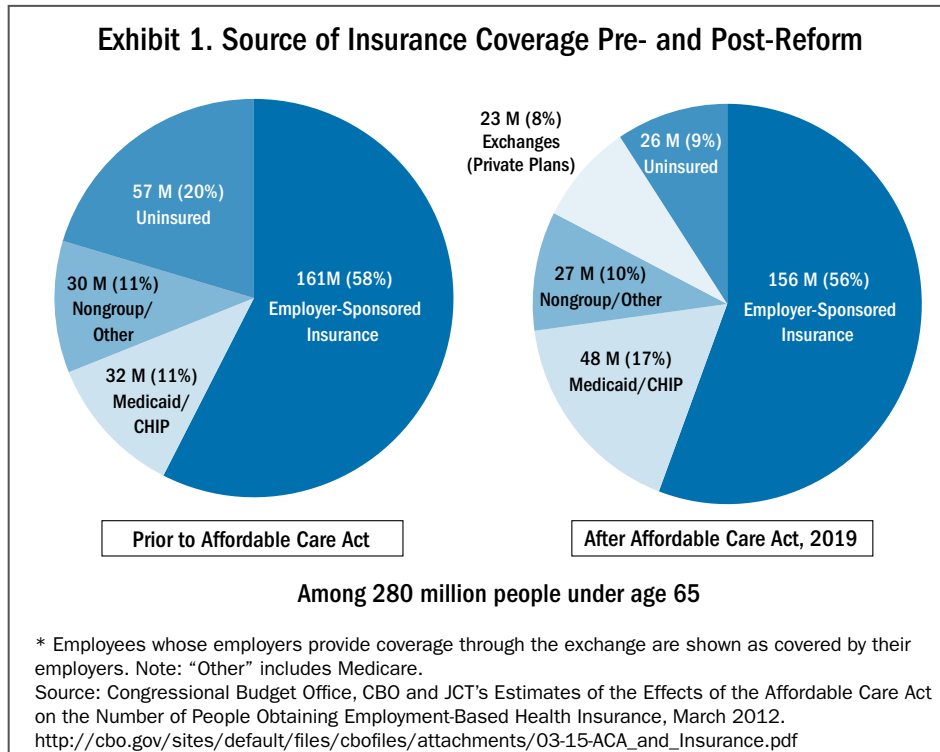
This issue brief, based primarily on discussions of the National Workgroup on Integrating a Safety Net into Health Care Reform Implementation (see box on page 10), explores key design considerations for including safety-net providers in integrated delivery systems and discusses the roles of state and federal agencies in supporting and testing models of integrated care delivery.

INTEGRATED DELIVERY SYSTEM INITIATIVES

Efforts to integrate care in the public, nonprofit, and for-profit sectors are driven by the conviction that only

fundamental change in how health care is delivered can improve quality while containing costs. Even before enactment of the Affordable Care Act, communities and states had begun work to develop integrated delivery systems.⁵ More recently, 16 states passed legislation to explore or implement accountable care organizations, and other states are already moving ahead with ACO implementation.⁶

A number of safety-net providers have developed integrated delivery models for vulnerable populations (Exhibit 2). The Cambridge Health Alliance in Massachusetts provides primary care, pharmacy services, and behavioral health care for Medicaid and uninsured populations. The Alliance has taken on financial risk for a group of its patients through a wholly owned managed care plan. In Los Angeles County, federally qualified health centers (FQHCs) have partnered with independent practice associations to take on risk for primary and specialty care for certain Medicaid managed care populations. In New Jersey, the Camden Coalition of Healthcare Providers uses hospital data to identify patients who have high utilization rates and coordinates their care, with demonstrated success in improving health and reducing



costs.⁷ In addition, integrated fee-for-service delivery models, such as Hidalgo Medical Services in New Mexico and Medical Home Network in Chicago, are serving the preventive, primary, and specialty care needs of vulnerable populations.⁸ Such initiatives offer lessons in how to design integrated delivery systems that include safety-net providers and meet the needs of vulnerable populations.

At the state level, North Carolina developed a successful integrated delivery system for Medicaid enrollees and, more recently, Medicare and commercially insured patients. Under the Community Care of North Carolina program, primary care providers and each of 14 community networks receive a per-member per-month fee to provide patient care and population management (e.g., disease and care management, population stratification, preventive services, and coordination across delivery settings) as well as support in implementing practice improvements.

In 2011, Colorado launched the Accountable Care Collaborative to provide coordinated care to Medicaid patients. The program is built on three

major components: 1) seven Regional Collaborative Care Organizations (RCCOs) that coordinate care; 2) primary care medical providers, including some community health centers, that deliver care; and 3) a statewide data and analytics contractor that collects data to ensure quality. Both the RCCOs and the primary care providers receive monthly payments for care coordination.⁹

The Affordable Care Act has a number of provisions to foster integrated delivery systems, including: the Medicare Shared Savings Program for accountable care organizations; Community Based Collaborative Care Networks that include safety-net providers (authorized but not funded); and Consumer Operated and Oriented Plans (CO-OP) modeled on nonprofit integrated delivery systems like Group Health in Seattle and HealthPartners in Minneapolis.¹⁰ The final rule governing the Medicare Shared Savings Program ACOs, issued November 2, 2011, allows FQHCs and rural health centers both to participate in and sponsor ACOs.¹¹ On April 10, 2012, the Centers for Medicare and Medicaid Services selected the first 27 ACOs to

Exhibit 2. Examples of Safety-Net Systems Pursuing Integrated Delivery System Models for Vulnerable Populations

System	Location	Description
Community Models		
Cambridge Health Alliance	Cambridge, Somerville, and Boston metro-north area, Massachusetts	CHA is a health care system operated almost entirely under one unified hospital license. The system currently runs three hospitals, an extensive primary care network, and the Public Health Department for the City of Cambridge.
Camden Coalition of Healthcare Providers	Camden, New Jersey	CCHP brings together health systems, hospitals, and private providers in the community in order to collaboratively care for the highest health care utilizers in Camden.
Medical Home Network	Chicago, Illinois	MHN is a collaborative of providers, hospitals, federally qualified health centers (FQHCs), state Medicaid, and others working to provide patient-centered, accountable care for South and Southwest Side Chicago residents.
Hidalgo Medical Services	Hidalgo County, New Mexico	HMS is a health system that provides primary, specialty, oral, and mental health care as well as family support services to the residents of the rural counties of Grant and Hidalgo.
Los Angeles County FQHCs	Los Angeles County, California	Los Angeles County FQHCs have partnered with independent practice associations to take on risk for primary and specialty care for certain Medicaid managed care populations.
State Models		
Accountable Care Collaborative	Colorado	The ACC program created seven Regional Care Collaborative Organizations to provide Medicaid enrollees with accountable care through affiliated primary care providers.
Community Care of North Carolina	North Carolina	CCNC is a statewide initiative that brings together regional networks of providers, health departments, social service agencies, and other community organizations to provide coordinated care to all North Carolina Medicaid enrollees through medical homes.

participate in the Shared Savings Program. Some of these ACOs include safety-net providers in their organizations. For example, Arizona Connected Care, LLC, includes three FQHCs in its ACO network, and North Country ACO, in New Hampshire, was formed by members of a rural health network.¹² On July 9, 2012, an additional 88 ACOs were announced.¹³

In addition, the health reform law established a Center for Medicare and Medicaid Innovation to test new health care delivery and payment models aimed at reducing costs and enhancing quality.¹⁴ The Innovation Center is already supporting various ACO models within Medicare, including 32 Pioneer ACOs funded effective December 19, 2011. Some of these Pioneer ACOs—Franciscan Alliance in Indiana, Seton Health Alliance in Texas, and TriHealth in Iowa—include FQHCs or other community health centers.¹⁵

The Innovation Center, in conjunction with the Health Resources and Services Administration, is also sponsoring the FQHC Advanced Primary Care Practice Demonstration.¹⁶ This project will test whether teams of physicians and other health professionals can effectively coordinate and improve care for their Medicare patients. Participating FQHCs will receive technical assistance to help them achieve national recognition as medical homes and a monthly care management fee for each beneficiary receiving primary care services.

In November 2011, the Innovation Center announced a Cooperative Agreement funding opportunity for the Health Care Innovation Challenge grants, a broad opportunity to test care delivery models that serve Medicare, Medicaid, and Children's Health Insurance Program populations.¹⁷ Funding is available to support creative workforce deployment as well as infrastructure costs. Innovation Challenge grant funds are flexibly structured and could be a vehicle for testing some of the recommended demonstration project strategies discussed below.

Selected provisions of the Affordable Care Act relevant to safety-net integrated delivery systems are included in [Appendix A](#).

DEVELOPING INTEGRATED DELIVERY SYSTEMS THAT INCLUDE SAFETY-NET PROVIDERS

Essential Principles

There are many options for building integrated delivery systems. Recently, there has been considerable discussion of accountable care organizations, generally defined as “a local health care organization and a related set of providers that can be held accountable for the cost and quality of care delivered to a defined population.”¹⁸ There are, however, other models of integrated care for policymakers to consider.

The most important principles for creating integrated delivery systems that serve vulnerable populations are: an emphasis on primary care; care coordination, including behavioral, social, and public health services; and accountability for population outcomes. These principles could be embodied in ACOs or similar approaches to organizing providers, or through revamped managed care arrangements that focus on achieving good health outcomes, rather than controlling costs.

Benefits and Risks for Safety-Net Providers

Integrated delivery systems, in a variety of forms, hold promise for expanding access to care as well as improving health care quality and outcomes while controlling costs. Such systems may be particularly beneficial for patients who face financial or other barriers to accessing care and/or have multiple health conditions.

Many safety-net providers are interested in joining or forming integrated delivery systems because they see the potential for furthering their missions and building on their care coordination expertise. Integrated delivery models such as ACOs would enable them to use funds to innovate and better manage care. Investments in infrastructure that are likely to accompany participation in integrated delivery systems also could help improve the effectiveness and efficiency of care delivery. Perhaps most important for their financial viability, participating in integrated delivery systems could put safety-net providers in a good position to serve newly insured populations, including those

who will receive coverage through the health insurance exchanges or Medicaid.

Despite their interest, safety-net providers recognize that there are many policy, structural, and operational questions to be addressed before they can be effective partners in integrated delivery systems.¹⁹ Further, many recognize the risks of such ventures, especially given the unknown factors. Safety-net providers that have already formed or joined broader health systems, or experimented with innovative delivery models, may be well positioned to participate and thrive in integrated delivery systems. Other safety-net providers may play different roles, for example by helping with patient outreach or as guides to help patients navigate the health care system.

Governance

Many questions remain with regard to the governance of integrated delivery systems, such as who will own and run the systems, and how system managers will interact with leaders of its member organizations. As the federal government begins to design ACOs, governance models are emerging. For example the Pioneer ACO program requires that the governing body “is reflective of the member groups of providers and suppliers that form the ACO, and includes meaningful representation from consumer advocates and patients.”²⁰ Governance models for integrated delivery systems that include safety-net providers will need to allow public hospitals or community health centers to participate without violating their own or funders’ governance requirements. For example, FQHCs must meet specific federal board requirements, including the provision mandating that a majority of board members are individuals served by the center.²¹

Infrastructure

It is also critical, particularly for safety-net providers, to have support in building and maintaining the infrastructure necessary to participate in an integrated delivery system. This includes physical facilities, equipment and technology, and human resource investments, including recruitment and training. Many also see care coordination services as part of

the infrastructure required for an integrated delivery system. A few states have successfully used Medicaid Section 1115 waivers to target financial support for capital projects and system restructuring at safety-net hospitals.²² Infrastructure development is a potential area for foundation investments to assist safety-net providers in building capacity and readiness to participate in integrated delivery systems, and thereby leveraging other financing for care. HRSA’s Rural Health Network Planning Grant and Rural Health Network Development Program are examples of funding opportunities that enable nonconstruction infrastructure development for safety-net providers.²³ Infrastructure enhancements are also permitted under the CMS Health Care Innovation Challenge grants.²⁴

To support the development and spread of integrated delivery models, states need funding to cover their administrative costs as well as the technology and data systems that enable monitoring and evaluation. These needs should be taken into account when federal agencies develop demonstration initiatives or review requests for state plan amendments or waivers.

Financial Risks and Rewards

Financial incentives for integrated delivery systems should reward achievement of the desired goals for such systems, including an emphasis on primary care, coordinated care, and improved outcomes. Different providers have differing levels of tolerance for risk—a reality that should be recognized in payment structures. Incentives could for example promote primary care and attach risk to specialty care.

Various funding streams, including but not limited to Medicaid payments, disproportionate share hospital payments, graduate medical education funds, Medicare, federal grants, and state, local, and private funds, reimburse or defray the costs of providing care at safety-net organizations. With the Affordable Care Act’s expansions to insurance coverage in 2014, the relative importance of these funding streams is likely to shift, though it is not clear how. While many uninsured patients who now rely on the safety net will gain coverage in the coming years, we do not know if they will stay with their safety-net providers. (When

Massachusetts expanded coverage, the newly insured largely chose to remain with their safety-net providers.²⁵) Even if all states choose to take up the Medicaid expansion, an estimated 22 million people will remain uninsured after the coverage expansions, so that financing will still be needed to support their care from safety-net providers.²⁶ The Commonwealth Fund Commission on a High Performance Health System recommends that states target their remaining Medicaid disproportionate share hospital funds to hospitals that serve uninsured patients.²⁷

When designing incentives and penalties for integrated delivery systems, the unique circumstances of safety-net financing must be taken into account. For example, it may be difficult for safety-net providers to demonstrate early savings through the provision of integrated care for two reasons. First, as more people gain access to primary care, some will need specialty care, which in turn will raise health care costs for those individuals in the short term. Second, the Medicaid reimbursements on which many safety-net providers rely have historically been lower than Medicare or private insurance payments, making it difficult to achieve savings.

While there is broad support for the concept of sharing risk among payers, health plans, providers, and patients, some experts and stakeholders feel that—given the financial disadvantages faced by safety-net providers—payment designs for them should favor financial incentives over penalties. Additionally, payment designs for low-volume providers need to be carefully considered so that success at reducing the number of hospital admissions does not reduce their income in ways that threaten their financial sustainability. This is of particular concern in rural communities. Supplemental payments to support rural infrastructure might be considered.

Payment Structures to Support Integrated Delivery Systems

In an integrated delivery system, primary, secondary, and tertiary care providers must work together to serve patients both effectively and efficiently. The payment structure that underlies an integrated delivery system,

be it shared savings, other incentives, or partial or full capitation, must therefore promote the use of appropriate services. Most health care reimbursement structures currently reward specialized services over primary care. The financing shift possible within an integrated delivery system would allow for greater investment in preventive and primary care as well as care coordination—areas of care in which safety-net providers tend to excel.

Payers could work together to align financing with the goals of integrated systems and to coordinate or pool different funding streams to support integrated care systems. For example, states must decide how to target federal disproportionate share hospital (DSH) payments, which will be reduced under provisions of the Affordable Care Act as greater numbers of hospital patients are expected to gain coverage. DSH payments could be awarded based on demonstrated progress on measures of integrated care.²⁸ DSH and graduate medical education (GME) payments could be allocated to support primary care delivery, for instance by tying the payments to the proportion of primary care delivered within an integrated system. Linking GME payments to primary care also could help ensure that primary care training slots remain funded. Another option would be for providers to manage medical education funds cooperatively and target funds to primary care needs.

Payment approaches should allow for flexibility and innovation in care delivery to support models such as team care, use of community health workers, group visits, and telehealth. This could be accomplished through up-front payment for a set of services, as is done through the Prospective Payment System for FQHCs.

Given that uninsured populations will still be turning to safety-net providers, funders could coordinate or pool funds for integrated delivery systems that serve a mix of uninsured and insured populations. Federal agencies and programs might coordinate or pool funds for public insurance programs such as Medicaid, the Children's Health Insurance Program, and Medicare with grant programs for health centers, maternal and child health, health professional training, substance abuse, and mental health services and potentially others such as housing and social services. Public

and private grant funds also could be used to help build infrastructure and promote the readiness of safety-net providers to participate in integrated delivery systems and support innovation in care delivery.

Team Care

New models for integrated delivery systems must support primary and specialty care physicians working alongside other clinicians in multidisciplinary care teams that provide physical health services, behavioral and mental health treatment, oral health care, and public health services. Such teams also benefit from inclusion of nonclinical providers to deliver services known to improve outcomes, such as care coordination and social services.

To facilitate team care, policy changes are needed that enable reimbursement for all members of care teams within the scope of their licenses. Current reimbursement approaches often lack ways to pay nonclinical providers. In some cases billing codes for particular services are lacking; in others, only a physician or other medical provider can be reimbursed for certain services. Financing methods need to support full integration of nonclinical services (e.g., social assessments) and nonmedical providers (e.g., care coordinators) into team care. Any integrated delivery system model must develop staffing and financing plans together to ensure that care can be delivered as envisioned.

Safety-net providers have experience in using care teams that include clinicians other than physicians, often because they have difficulty recruiting physicians. Many safety-net providers have adopted the medical home model, which emphasizes team care. Several states are partnering with safety-net providers to develop health homes demonstrations under Section 2703 of the Affordable Care Act to provide care for high-cost, complex populations.

Performance Measurement

Integrated delivery systems will ideally use meaningful and fair performance measures, and align the measures across payers and funders. Often, safety-net providers have to report different performance metrics to public

and private grant funders, in addition to third-party payers. To reduce such reporting burdens and ensure providers are working toward a common set of goals, consistent and meaningful measures related to access to care, health care quality, and cost at the system level are needed. For example, a measure that describes how quickly a patient can access needed specialty care would assess the efficiency of the integrated delivery system relative to that of an individual safety-net provider.

In November 2011, California won approval for its “Bridge to Reform” Section 1115 Medicaid waiver, which expands coverage and promotes delivery system transformation for the state’s public hospitals. Incentive funds are available for the development of infrastructure, implementation of innovative care delivery models such as medical homes, and other improvements in care delivery.²⁹ The waiver includes well-defined metrics for designated public hospital systems.³⁰ Similarly, a New York waiver awards funds to participating hospitals that achieve National Committee for Quality Assurance medical home recognition and implement system improvement projects.³¹ These waivers may serve as a useful starting point for others wishing to develop metrics for integrated delivery systems that include safety-net providers.

The integrated delivery systems in Colorado and North Carolina also include data analysis to support patient care and improve provider performance. Colorado has procured a statewide data and analytics contractor to support its Accountable Care Collaborative initiative through development of a data repository, Web portal, and analytics and feedback reports.³² In North Carolina, the Community Care of North Carolina Informatics Center gives providers access to reports for the purposes of population and panel management, performance monitoring, and quality improvement through a provider portal.³³

Roles for Managed Care Organizations

Evolving models for integrated delivery systems, including ACOs, are generally designed to organize providers that are working in fee-for-service environments. Yet many patients, especially Medicaid enrollees, currently receive health services through managed

care arrangements. Thus, questions arise as to how new integrated delivery systems will differ from managed care organizations, and whether there is, in fact, a role for managed care in the new systems.

Both managed care arrangements and new models of integrated care delivery emphasize care coordination. But managed care has historically been driven mainly by the goal of containing costs, rather than accountability for health outcomes. By contrast, new integrated delivery models explicitly emphasize the potential for coordinated care to improve health outcomes. Historically, some of the problems with managed care can be attributed to the lack of performance data necessary needed to manage care effectively, as well as failure to spread risk among providers and payers appropriately.

Today, it is possible to envision a role for managed care organizations in integrated delivery systems, given these organizations' experience in organizing and coordinating services. Managed care organizations could be transformed through incentives for improving care and outcomes. Indeed, requirements for such incentive structures may be important to promote a level playing field between managed care organizations and ACOs, which are required to meet quality benchmarks.

In addition, there are a number of ways managed care organizations could participate in ACOs or similar systems. A managed care organization could sponsor or serve as the administrative service organization for multiple community-based integrated delivery systems. It could join an ACO or other integrated delivery system, or it could contract with an integrated delivery system to serve its members. Regardless of the structure, the focus should be on transforming managed care to improve care coordination and health care quality.

Safety-net managed care plans such as those belonging to the Association for Community Affiliated Plans may be well positioned to develop integrated delivery systems focused on vulnerable populations. These plans have expertise in serving vulnerable populations and networks of providers already in place.

FEDERAL AND STATE ROLES IN PROMOTING INTEGRATED DELIVERY SYSTEMS THAT INCLUDE THE SAFETY NET

There are several ways for federal and state policymakers to foster integrated delivery systems that include safety-net providers. Policymakers could help to demonstrate, evaluate, and sustain new integrated delivery system models; review and revise current policies in areas such as managed care requirements, provider payment, and licensure; and provide technical assistance and other support. Both federal and state agencies could form partnerships with foundations or other private-sector partners to support demonstrations and help prepare potential system participants. States could play a particularly important role in serving as a neutral convener and broker for the various stakeholders—hospitals, health centers, managed care organizations, and other providers—that join together to develop integrated delivery systems. States are able to convene these stakeholders without violating antitrust regulations.³⁴

Developing, Evaluating, and Scaling Up Successful Elements of Demonstration Projects

The Affordable Care Act provides opportunities for federal demonstration projects that test various integrated delivery system models, and a number of federal agencies have authority and resources under prior legislation to develop demonstration projects. The federal Innovation Center not only has substantial resources to develop and test various kinds of models, but the mandate and authority to change policy to bring successful models to scale. States have the ability, resources permitting, to develop, test, and expand demonstration projects, although aspects of these often require federal approval, given the use of Medicaid and other federal funding streams in state delivery systems.

Diverse stakeholders support and encourage development of integrated delivery system models that are designed specifically to include safety-net providers and to improve the experience of care and the health of vulnerable populations, as well as to reduce

per capita costs of care. To be most useful in effecting such change, demonstrations should:

- include safety-net providers in all types of integrated delivery systems, as well as test models that exclusively comprise safety-net providers and institutions;
- allow for a range of models that meet systems where they are today, from unstructured fee-for-service environments to those that already have achieved some degree of integration;
- be limited to a small number of models, chosen for their potential influence on a limited number of outcomes that can be measured through population-based metrics;
- be scalable, with clear criteria, and replicable in similar situations;
- provide funds through grants or contracts, increased Medicaid and Children’s Health Insurance Program matching funds, or through waiver demonstration opportunities;
- foster partnerships between states and community health systems to benefit from innovation that can occur on the front lines of care as well as the support that states can leverage; and
- include rewards for safety-net providers that meet established outcome measures, rather than penalties for poor performance.

Integrated delivery system financing could be structured in a variety of ways, including fee-for-service, bundled, or capitated payments. Whatever the financing scheme, models should incorporate flexibility to test new methods of service delivery and use of ancillary providers. For example, models such as Community Care of North Carolina, which uses per-member per-month payments, have allowed community health centers, public health departments, and other kinds of providers to deliver a broad set of nonmedical services to improve care and health.

This flexibility enables integrated delivery systems to anticipate, plan for, and adequately reimburse for care coordination and other social services. As a result, two safety-net providers—a community health center and a public health department—have successfully run two of the 14 local networks.

Integrated delivery systems that include safety-net providers must recognize these providers’ continuing role in serving the uninsured. Funding models for integrated delivery systems that include the safety net optimally will take into account resources that will be needed to serve the uninsured. Public agencies and programs could work together so that funds available for uninsured and underserved populations could be used along with public insurance program payments to provide care for all vulnerable populations. This approach also provides the opportunity to influence continuity of care for individuals who cycle between Medicaid coverage and uninsured status.

CONCLUSION

Developing and implementing integrated delivery systems is complex, and the inclusion of safety-net providers in such systems raises specific design questions. The goals of integrated delivery systems—improving care coordination and enhancing connections to specialists and to nonclinical services to meet the needs of patients—align with the interests of safety-net providers. The flexible funding allowed by integrated delivery system models can enable safety-net providers to use funds in innovative ways to improve care delivery.

Integrated delivery systems have the potential to benefit all patients, but especially vulnerable populations with complex needs. As models are tested and brought to scale, more and more providers, including safety-net institutions, will be able to join integrated delivery systems, thus providing coordinated care to larger numbers of patients. Integrated delivery systems may be one lever for influencing quality of care while bending the cost curve, leading to healthier populations and savings for public and private payers, as well as patients themselves.

The National Workgroup on Integrating a Safety Net into Health Care Reform Implementation

The National Workgroup on Integrating a Safety Net into Health Care Reform Implementation (National Workgroup) selected integrated delivery systems as the top priority to focus on among 10 issues that confront policymakers in addressing the roles of safety-net providers in health care reform. All of these issues are summarized in *Toward Meeting the Needs of Vulnerable Populations: Issues for Policymakers' Consideration in Integrating a Safety Net into Health Care Reform Implementation*.³⁵

Established by the National Academy for State Health Policy with support from The Commonwealth Fund, the National Workgroup includes 22 state and federal officials, national experts and organizations, and safety-net providers. (See [Appendix B](#) for a complete list of National Workgroup participants.) As part of its year-long effort to identify and address the highest-priority issues related to integration of the safety net into health care reform, the National Workgroup convened a number of discussions from June to October 2011 about the policy issues and options related to including safety-net providers in integrated delivery system development efforts. This brief summarizes these issues and options in order to inform the decision-making of state and federal policymakers and health system stakeholders interested in promoting integrated delivery systems that can effectively serve vulnerable populations.

It is important to note that subsequent to these National Workgroup discussions, the federal Department of Health and Human Services issued several relevant new policies. The final regulation for Medicare ACOs and a new funding opportunity for health care system innovation both provide vehicles for safety-net providers to be included in new integrated delivery system models.^{36,37} This brief is intended to inform implementation of these new opportunities as well as shape future initiatives at community, state, and national levels.

Although this summary represents the sense of the entire group, it does not represent the specific views of any one or all participants or funders. The National Workgroup's discussions and conclusions related to workforce and to financing issues, the other two priorities selected from among the 10 issues that were identified, will be summarized in a final report later in 2012.

NOTES

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Appendix A. Select Provisions of the Affordable Care Act Relevant to Safety-Net Providers in Integrated Delivery Systems

Provision	Summary of Provision	Implementation Status
Accountable Care Organizations (ACOs) § 3022 (Medicare) § 2706 (Pediatric)	Authorizes funding for the development of Medicare (3022) and Pediatric (2706) ACO demonstration projects. ACOs are networks of providers that take responsibility for the costs and quality of care provided to their patients. These networks can share in savings earned by reducing the cost of health care delivered, contingent upon meeting performance standards.	Final regulations on the Medicare Shared Savings program were released on November 2, 2011, and permit community health centers, along with public hospitals, rural health clinics, and other safety-net providers, to sponsor ACOs. Some organizations that enter the Medicare Shared Savings program in April or July 2012 can also apply to be part of the Advanced Payment ACO Model, which provides funds for capital investments.
Center for Medicare and Medicaid Innovation (CMMI) § 3021	Authorizes creation of the Center for Medicare and Medicaid Innovation, a new agency under the Centers for Medicare and Medicaid Services that will test and disseminate innovative payment and delivery system models for Medicare, Medicaid, and the Children's Health Insurance Program.	<p>In 2011, the Innovation Center launched the Federally Qualified Health Centers (FQHCs) Advanced Primary Care Practice Demonstration, which will evaluate the impact of providing financial and technical resources to 500 FQHCs to make the transition into medical homes.</p> <p>The Innovation Center also created demonstrations around different ACO models, including the Pioneer ACO model. Thirty-two organizations participating in this demonstration were chosen on December 19, 2011. Some of the Pioneer ACO models include FQHCs or other community health centers in their ACOs.</p>
Medicaid Health Homes § 2703	Provides states with the option to receive an enhanced federal matching rate for expanding or implementing "health home" programs for Medicaid beneficiaries with chronic conditions. Health homes are designated primary care providers that work with teams of health professionals to coordinate medical, behavioral health, and social support services needed by those with chronic conditions. States that establish health homes may receive up to 90 percent federal matching funds for the coordination services for up to two years. States have flexibility in determining which providers are eligible to be health homes and receive payments for health home services.	<p>States must submit state plan amendments (SPAs) to the Centers for Medicare and Medicaid Services (CMS) in order to implement Sec. 2703 Medicaid health homes. Beginning in January 2011, states were able to receive planning grants from the federal Substance Abuse and Mental Health Services Administration and CMS.</p> <p>As of March 2012, 14 states and Washington, D.C., had received planning grants, four states had submitted SPAs to CMS for approval, and six SPAs from four states had already been approved.</p> <ul style="list-style-type: none"> • Approved—four states, 6 SPAs: MO (2); RI (2); NY; OR • Submitted—four states: NC; WA; IA; NY [second] <p>Note: Washington's is currently withdrawn</p> <ul style="list-style-type: none"> • States with Planning Grants—14 and DC: AL, AR, AZ, CA, ID, ME, MS, NC, NJ, NM, NV, WA, WI, WV, DC
Medicaid Bundled Payments § 2704	Authorizes a Medicaid demonstration project in up to eight states to test and evaluate "bundling" payments for episodes of care surrounding a hospitalization. A "bundled" payment is a single payment for multiple services from different providers during an episode of care.	Funds have not been appropriated.
Medicaid Demonstration of Global Payments for Safety-Net Providers § 2705	Establishes a program under which up to five states can set up Medicaid demonstration projects in which safety-net hospital systems or networks are paid under a global capitated payment. With participants limited to safety-net hospital systems or networks, this project will test an alternative payment approach that is based on quality—how well safety-net providers do in treating the patient—rather than payment based on the volume of services.	Funds have not been appropriated.
Community-Based Collaborative Care Networks § 10333	Authorizes grants to support community-based collaborative care networks, defined as a consortium of health care providers with a joint governance structure that would provide comprehensive, coordinated, and integrated health care services for low-income populations.	Funds have not been appropriated.

Colocation of Community Mental Health and Community Health Clinics § 5604	Authorized \$50 million in grants in FY2010 for eligible community-based, behavioral health settings to provide coordinated and integrated services through the colocation of primary and specialty care. As yet unfunded for FY2011–14.	Funds have not been appropriated.
Permitting Health Centers to Engage in Contractual Collaboration with Rural Primary Care Providers § 5601(b)	Permits community health centers to engage in contractual collaboration with rural primary care providers that agree to accept health center patients without discrimination and prospectively discount their charges in accordance with the health center's fee schedule. Eligible rural providers include: rural health centers, critical access hospitals, low-volume hospitals, and community hospitals.	Regulation became effective on March 23, 2010.

Source: Adapted from Table 1. P. Riley, J. Berenson, and C. Dermody, "How the Affordable Care Act Supports a High-Performance Safety Net," *The Commonwealth Fund Blog*, Jan. 2012.

Appendix B. Participants in a National Workgroup on Integrating a Safety Net into Health Care Reform Implementation

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[Catherine Hess, M.S.W.](#), is managing director for Coverage and Access at the National Academy for State Health Policy. She leads programs and conducts policy analysis on topics that include eligibility and enrollment, children's coverage, health care safety nets, and health care reform. She has over 30 years of senior and executive level state and national health policy experience, including with the Massachusetts Department of Public Health, as the first executive director of the national Association of Maternal and Child Health Programs, and as an independent consultant to state and federal health agencies and national organizations. Ms. Hess holds adjunct faculty appointments at both Johns Hopkins and George Washington Universities' schools of public health, and has a master's degree in social work from Boston University.

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