



OCTOBER 2011

Issue Brief

Promoting the Integration and Coordination of Safety-Net Health Care Providers Under Health Reform: Key Issues

LEIGHTON KU, PETER SHIN, MARSHA REGENSTEIN, AND HOLLY MEAD

The mission of The Commonwealth Fund is to promote a high performance health care system. The Fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy. Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and not necessarily those of The Commonwealth Fund or its directors, officers, or staff.

For more information about this study, please contact:

Leighton Ku, Ph.D., M.P.H.
Professor and Director
Center for Health Policy Research
School of Public Health and
Health Services
George Washington University
Leighton.Ku@gwumc.edu

To learn more about new publications when they become available, visit the Fund's Web site and register to receive email alerts.

Commonwealth Fund pub. 1552
Vol. 22

ABSTRACT: The Affordable Care Act includes several provisions designed to encourage greater coordination and integration among health care providers, including the promotion of accountable care organizations and health homes. While much discussion has focused on how these strategies might be adopted by Medicare and private insurers, little attention has focused on their application among safety-net health care providers. Such providers face particular challenges in coordinating care for their low-income and uninsured patients, and no single approach is likely to meet their diverse needs. Successful efforts will require federal, state, and local financial resources to sustain the safety net and make the investments needed to upgrade capabilities. In addition, they will require flexible strategies that can accommodate variations in community and state needs.

★ ★ ★ ★ ★

OVERVIEW

Recent health policy has sought to improve health care delivery by strengthening the coordination and integration of care—to create mechanisms to work across providers and settings to ensure that patients receive timely, appropriate care and avoid complications.¹ The Affordable Care Act includes a number of strategies to achieve this, including the promotion of accountable care organizations (ACOs) and primary care medical homes. Most of the discussion of these strategies has focused on their implementation in Medicare or private insurance markets. This brief examines how care coordination and integration might improve health care delivery among safety-net health care providers, such as community health centers and public hospitals that provide care to low-income and other vulnerable populations, including Medicaid beneficiaries and the uninsured.

Previous research and experience indicate that greater care coordination and integration can lead to higher-quality care as well as more efficient care. For example, evaluations of the Medicare Physician Group Practice demonstration—the precursor to the Medicare ACO model—found that a system of shared savings

could encourage medical practices to provide recommended care, often while reducing medical expenditures.² One of the most successful practices in that demonstration, the Marshfield Clinic, in Marshfield, Wisconsin, includes a large community health center within its system. Colorado's Denver Health is another widely cited example of a successfully integrated safety-net system, including a major public hospital, community health centers, school-based clinics, and public health clinics. Community Care of North Carolina, a partnership between the state and local provider networks, including community health centers, has achieved savings and improved quality of care by coordinating care for patients.³

The Commonwealth Fund's 2009 National Survey of Federally Qualified Health Centers provides broad-based evidence about the effects of specific methods to coordinate and integrate services.⁴ For example, the findings suggest that community health centers that have hospital affiliations are more successful at obtaining specialty care for their patients. Thirty-one percent of the centers with hospital affiliations reported it was easy to obtain specialty care procedures for Medicaid patients, compared with 21 percent of the centers without such affiliations. Twenty percent of the centers with hospital affiliations said it was easy to obtain specialty care for their uninsured patients, while just 9 percent of those without affiliations reported this. The survey also assessed whether health centers functioned as medical homes: were they able to, for example, track referrals and laboratory results, use patient registries, and report on and improve their performance. In general, health centers that had greater medical home capabilities were more successful at coordinating care; they had fewer problems obtaining specialty care for their patients and were more likely to receive notifications about care their patients received in hospitals. Still, securing access to specialty care and care coordination remained significant challenges for most community health centers.

OPPORTUNITIES TO PROMOTE COORDINATION AND INTEGRATION UNDER THE AFFORDABLE CARE ACT

The Affordable Care Act includes a number of provisions designed to promote coordination and integration of services:

- **Medicare ACOs.** Under Section 3022 of the legislation, ACOs are defined as fee-for-service networks of physicians and other providers who are responsible for the cost and quality of care for their assigned Medicare patients. ACOs whose collective Medicare expenditures are less than risk-adjusted benchmarks would qualify for a share of the savings. The expectation is that the combination of quality standards and financial incentives will prompt better-coordinated care, leading to quality improvements as well as cost savings.

The proposed ACO regulations issued in April 2011 by the Centers for Medicare and Medicaid Services (CMS) have elicited considerable debate and suggestions for changes from many parts of the health sector, including safety-net organizations.⁵ The National Association of Public Hospitals and Health Systems, for example, expressed concern that safety-net hospitals may be unable to form ACOs because the initial investments required to meet implementation standards may be too high, encouraging CMS to develop an ACO demonstration project for safety-net providers.⁶ The National Association of Community Health Centers took issue with the fact that federally qualified health centers (FQHCs) are barred from forming ACOs or being counted as primary care providers under the proposed regulations.⁷ According to CMS, FQHCs lack robust or detailed claims and payment systems that would attribute specific FQHC physicians or a set of services to a patient, making it nearly impossible to assign an FQHC patient to an ACO or back to the FQHC provider for purposes of receiving a share of the cost

savings. Although the proposed regulations include incentives for ACOs to include FQHCs, centers might not receive shared savings if they are not counted as primary care providers.⁸ Others have expressed concerns that ACO policies may discourage participation by safety-net providers and strengthen more affluent providers, thus having the unintended effect of exacerbating disparities in health care.⁹

CMS is in fact developing alternative ACO demonstration projects. The Pioneer ACO demonstration project would permit greater flexibility for organizations that are willing to advance to ACO status on an accelerated basis; this would permit FQHCs to be counted as primary care providers.¹⁰ The Center for Medicare and Medicaid Innovation has indicated that it is considering a safety-net ACO demonstration project.

- **Medicaid health homes.** Section 2703 of the Affordable Care Act includes a state option to establish “health homes” for those with chronic health problems under Medicaid. States that do so may receive up to 90 percent federal matching funds for the coordination services for up to two years. CMS guidance specifies that these projects should include the following services:¹¹
 - comprehensive care management;
 - care coordination and health promotion;
 - comprehensive transitional care from inpatient to other settings, including appropriate follow-up;
 - individual and family support;
 - referral to community and social support services, when needed;
 - use of health information technology to link services, as feasible and appropriate; and
 - consultation with the Substance Abuse and Mental Health Services Administration regarding behavioral and substance use services.

While medical home initiatives are generally focused on primary care providers, they require

active coordination of care with specialists and hospital providers, as well as with behavioral and substance abuse services. The statute explicitly permits community health centers, rural health clinics, and other primary care providers to be considered as health home providers, along with physicians and physician practices, and the CMS guidance notes that hospital clinics may also qualify.

As of mid-2011, 39 states had already initiated Medicaid medical home projects, and the health home projects will likely build on these earlier efforts.¹² CMS has also initiated two medical home demonstration projects: one is for FQHCs participating in Medicare and the other is a Multi-Payer Advanced Primary Care Practice demonstration, including Medicare, Medicaid, and private insurance plans in eight states.¹³

- **Bundled payments.** Under Section 2704 of the Affordable Care Act, up to eight states may establish Medicaid demonstration projects related to bundled payments for integrated care surrounding a hospitalization. Such payments would include both hospital services and concurrent physician services for an episode of care.
- **Global payments.** Under Section 2705 of the health reform law, up to five states may set up Medicaid demonstration projects under which safety-net hospital systems or networks could be paid under a global capitated payment, which presumably would include both hospital and ambulatory care services.
- **Pediatric ACO project.** Under Section 2706, a state may establish a pediatric ACO demonstration project for Medicaid or the Children’s Health Insurance Program. The requirements for this kind of ACO are different from those for the broader Medicare ACOs.
- **Basic health option.** Section 1331 enables states to create basic health programs that could serve as alternatives to the health insurance exchanges for people whose income is too high for Medicaid

(133 percent of the federal poverty level, or \$29,726 for a family of four in 2011), but below 200 percent of poverty.¹⁴ These programs would provide benefits comparable to commercial insurance plans but with lower cost-sharing and would include features such as case management or incentives for appropriate use of care.

- **Community-based collaborative care network project.** Section 10333 authorizes grants to create network programs that include Medicaid Disproportionate Share Hospital (DSH) payment hospitals and FQHCs to integrate care for low-income patients. However, this project is subject to appropriations and may not be funded.
- **Innovation Center.** Section 3021 created the Center for Medicare and Medicaid Innovation in CMS. The Innovation Center is charged with testing, evaluating, and helping to disseminate innovative approaches to health care delivery and payment reform. The Affordable Care Act provides \$10 billion in mandatory funding for the Innovation Center to help study new payment and delivery systems from 2011 to 2020.

As noted above, some safety-net providers have expressed serious concerns about the Medicare ACO program, as proposed in April 2011. If the final rules are comparable to the proposed regulations, it is reasonable to speculate that relatively few safety-net providers will form ACOs in the near future. In contrast, medical/health home models can be readily applied to safety-net providers, including health centers, public clinics, and hospital-based primary care clinics. In fact, many safety-net providers are already working to create medical homes for their patients.

Health information technology initiatives authorized under the American Recovery and Reinvestment Act of 2009, including the Medicaid and Medicare electronic health record payment incentives, may also promote care

coordination and integration by encouraging information exchange across providers.

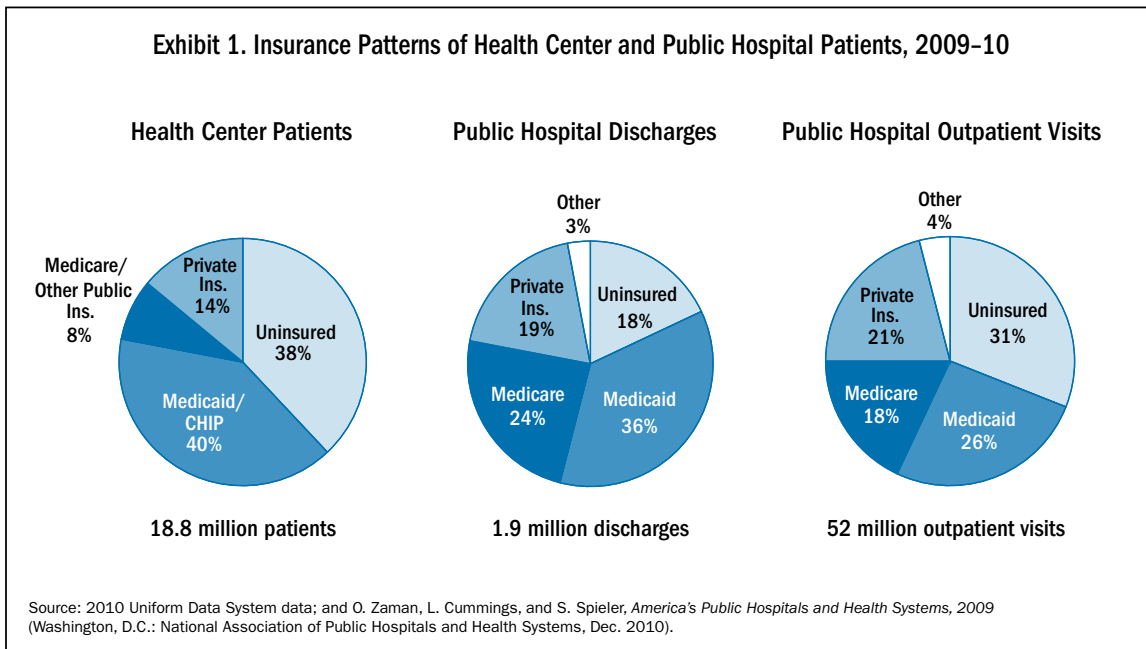
CARE COORDINATION AND INTEGRATION: ISSUES FOR SAFETY-NET PROVIDERS

Medicaid is the dominant source of coverage for community health center and public hospital patients, and large proportions of such patients are uninsured (Exhibit 1).¹⁵ This has a number of implications regarding care coordination and integration:

- **Fragmentation of care can be worsened by access barriers.** Analyses of care coordination in Medicare or private insurance generally assume that patients have access to primary, specialty, and inpatient care, but that such care may not be well coordinated across these levels. However, both Medicaid and uninsured patients may have severe problems accessing care.

Primary care clinicians often have difficulty securing referrals to specialists who will care for their Medicaid or uninsured patients. Similarly, it may be hard to arrange timely follow-up care after such patients are discharged from an emergency department visit or inpatient stay at a safety-net hospital. Even if providers are willing to serve Medicaid and uninsured patients, appointments may be delayed because of backlogs at safety-net facilities.

Access to care is the crucial foundation for care coordination. Patients who have difficulty accessing care are less likely to obtain timely services and more likely to receive poorly coordinated care. Delays in receiving Medicaid coverage, or churning on and off of such coverage, can impair continuity of care.¹⁶ Moreover, many safety-net patients face challenges such as homelessness, mental illness, language barriers, or transportation problems that can compound access barriers and make care coordination even more difficult.



Thus, to encourage care coordination among safety-net providers, it is first important to increase enrollment and retention of patients in Medicaid and the Children’s Health Insurance Program (and, in the future, the health insurance exchanges). In addition, safety-net providers must develop relationships with other providers who deliver care to their patients.

Starting in 2014, the health insurance expansions of the Affordable Care Act should greatly reduce the number of uninsured, but millions will remain so. Many of the newly insured may still encounter problems accessing care, either because of a shortage of Medicaid providers or the cost-sharing burdens in private insurance. Moreover, the remaining uninsured patients may become even more concentrated in safety-net facilities. Even though the number of uninsured people in Massachusetts fell after the state’s health reform, a larger share of the remaining uninsured received care at health centers after reform. Health centers served 22 percent of uninsured residents in 2006, but 38 percent of the remaining uninsured in 2009.¹⁷ Thus, access to care is likely to remain an issue for uninsured patients.

- Medicaid policies are largely determined by states.** Because of the economic downturn, most states have faced serious deficits and responded by trimming Medicaid spending, including reducing provider payments and the scope of benefits.¹⁸ In many cases, state and local governments have also reduced funding for safety-net facilities. While some states may be able to provide resources to help safety-net providers upgrade their capacity to coordinate services, others may not be able to do so. For example, states vary widely in the extent to which they have developed health information exchanges that can be used to share health records across providers.
- It is challenging to design financial incentives to coordinate care for the uninsured.** It is not possible to use increased provider payments or other financial incentives to promote care coordination for uninsured patients. Safety-net providers often receive grant funding to help support care for the uninsured, such as Section 330 community health center grants, other state and local grants, or Medicaid DSH payments. But these funds are typically allocated to specific providers and recipients may not be able to share these funds with other safety-net providers.

Nonetheless, in many communities, programs have been developed to support systems of care for the uninsured that extend beyond individual providers, whether by pooling some of these funds or tapping other resources (e.g., reallocating DSH funds or using Medicaid Section 1115 waiver funding).¹⁹ A prominent example is the Healthy San Francisco program, which gives uninsured adults access to a set of safety-net providers, including FQHCs, public clinics, and San Francisco General Hospital.²⁰ Denver Health has a similar system of care for the uninsured. These programs provide access to a limited network of safety-net providers for certain services; they do not offer benefits as comprehensive as Medicaid. Because there is some underlying funding that spans providers and helps guarantee access to care for their members, the programs can develop methods of care coordination. The limitations of funding for these safety-net systems force them to be efficient.

One-time grants (such as those developed under the federal Healthy Community Access Program from 2000 to 2006) can provide modest levels of funding for local programs to coordinate care across providers, but the lack of a sustainable funding base can make it difficult to sustain the activities.²¹

- **There is no federal statutory requirement to form ACOs in Medicaid.** Aside from the pediatric ACO demonstration project (Section 2706), the Affordable Care Act does not mandate the creation of ACOs among Medicaid providers, as it does for Medicare providers. CMS has not indicated what types of policies, if any, are planned for Medicaid ACOs. This may give flexibility to states in promoting ACOs among Medicaid providers, but it also creates risks and uncertainty in the absence of clear federal guidance.

One area in which CMS's policies regarding ACOs will clearly affect Medicaid enrollees pertains to dual eligibles, since these

beneficiaries are enrolled in both Medicare and Medicaid. Under the proposed rules, Medicare ACOs may serve dual eligibles, but the proposal does not clearly delineate how state Medicaid programs would interact with Medicare ACOs or what additional requirements might exist for providers serving dual eligibles.

- **Managed care is already dominant in Medicaid.** The concept of ACOs was first discussed as an alternative to fee-for-service care, but the implications in the safety net may play out differently, because managed care is common in Medicaid. This issue is discussed in more depth in the next section. The ACO concept was designed as an alternative to fee-for-service care in Medicare; it explicitly excludes managed care arrangements. But nearly three-quarters (71 percent in 2009) of Medicaid enrollees are enrolled in some form of managed care and almost half (47 percent) are in comprehensive capitated managed care plans, although the patterns vary from state to state.²² Under capitated payments, Medicaid pays the health plans are paid a fixed, prospective amount for each enrollee, regardless of their actual costs of care. The main alternative to capitated managed care in Medicaid is primary care case management, in which enrollees select or are assigned to primary care providers who serve as gatekeepers for other medical services. Managed care is common in Medicaid in large measure because beneficiaries may be required to join managed care on a mandatory basis, while participation is voluntary in Medicare, and because states view managed care as an effective way to limit expenditures.

Within Medicaid, capitated managed care is common for children (60 percent of all Medicaid children in 2008) and nonelderly adults (44 percent), but less common for the disabled (28 percent) or elderly (11 percent).²³ However, about 20 state Medicaid programs, including large states such as California, Florida, and New York, plan to expand capitated managed care for aged or disabled enrollees, so

the use of capitated managed care should grow in the future.²⁴

Health care providers may choose to form ACOs in order to assume greater leadership roles in financial and clinical decision-making, rather than being directed by insurance plans. But safety-net providers already have opportunities to take on leadership roles in managed care plans. Many Medicaid managed care plans were formed by safety-net providers, such as health centers or safety-net hospitals. For example, the Association for Community Affiliated Plans represents 58 safety-net health plans, which together serve about one-quarter of all Medicaid managed care enrollees.²⁵

THE RELATIONSHIP BETWEEN MANAGED CARE AND ACOS IN MEDICAID

Given the prominent role of managed care in Medicaid, what is the potential for the development of ACOs in Medicaid and how would such ACOs interact with existing managed care arrangements? Like ACOs, capitated managed care plans have a financial incentive to contain costs; if anything, such incentives are stronger for capitated managed care plans than for ACOs, since managed care plans keep 100 percent of all savings (relative to their premium income) and are at risk for all expenditures that exceed their premiums. In order to encourage efficient behavior, capitated plans typically undertake initiatives, such as disease management, care coordination, or enhanced medical home projects, to improve the quality of care or reduce costs.²⁶ Medicare ACOs are required to meet rigorous standards for qualification as ACOs and must meet quality benchmarks. Currently, Medicaid state agencies are required to establish quality assurance and improvement strategies for Medicaid managed care plans; they typically require that managed care organizations provide reports about quality of care, such as HEDIS data about clinical performance and surveys concerning enrollee satisfaction, and use External Quality Review Organizations to monitor quality. States may require that plans meet certain standards

and use their performance in determining whether plans may participate and may offer incentives to plans with better performance. Some states establish more rigorous benchmarks or performance incentives for Medicaid managed care plans and managed care plans often establish more rigorous standards or performance incentives for their participating providers. Given this, it is not clear what unique advantages ACOs would offer to Medicaid programs, compared with what capitated managed care programs already offer.

Apart from capitated plans, other forms of managed care play a role in coordinating care for Medicaid beneficiaries. Under primary care case management (PCCM), primary care providers bear responsibility for oversight of patients' total care and authorization of specialized care; providers are paid on a fee-for-service basis but also earn a fee (e.g., \$3 per member per month) for such services. The qualifications for provider participation in PCCM vary from state to state. Some programs, such as Community Care of North Carolina, are quite sophisticated and use regionally based networks to provide case management for high-cost, high-risk patients. They also work with local providers to reduce utilization, such as through initiatives aimed at mental health integration or care for chronic obstructive pulmonary disease.

Because of the extensive use of capitated managed care in Medicaid, the potential for development of Medicaid ACOs appears to be limited.²⁷ As illustrated in Exhibit 2, ACOs could function independently of managed care organizations—perhaps in areas dominated by Medicaid fee-for-service or PCCM models. Yet these areas, often rural, may not be well suited for ACOs because of the lack of concentration of health care providers.

More likely, ACOs organizations could function within capitated managed care plans as another type of provider. ACO integrated delivery networks could serve as subcontractors to Medicaid managed care organizations, paid through shared savings, performance-based payments, or subcapitation payments (i.e., the managed care plan makes a capitated payment to the delivery system for certain elements of

care). This differs from the vision for Medicare ACOs, which would replace fee-for-service care. In fact, integrated delivery systems have been used as subcontractors to Medicaid managed care plans for many years. These integrated delivery systems could have the same range of clinical and financial integration as ACOs, albeit under different organizational and regulatory structures.

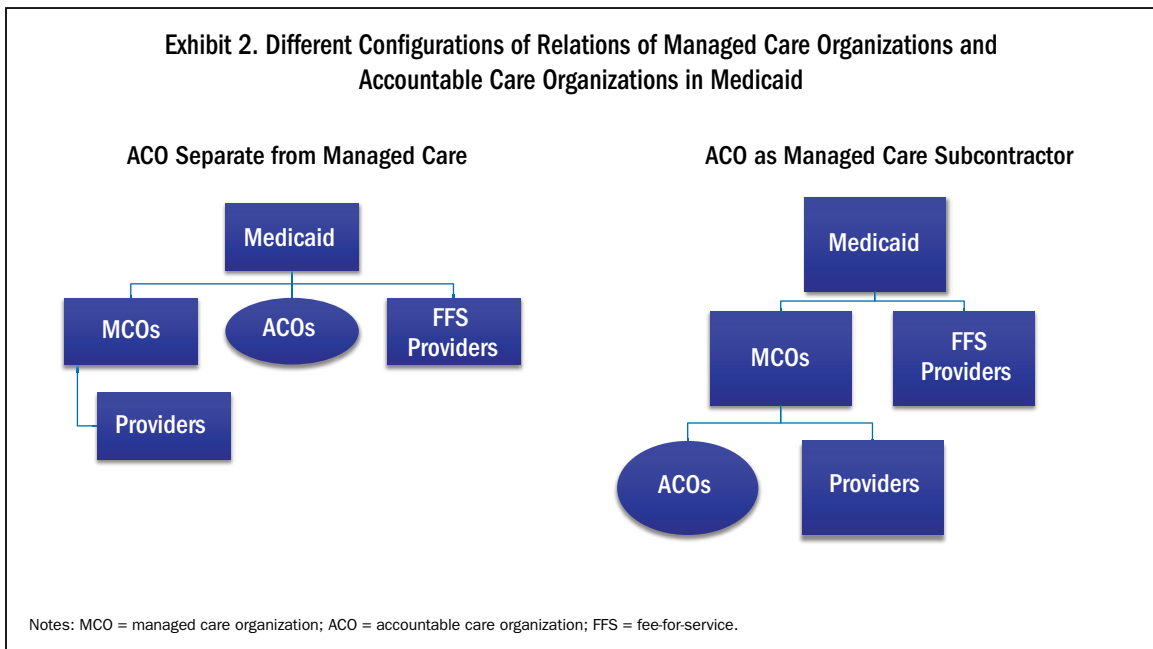
Since managed care can be mandatory in Medicaid, patients could be assigned on a prospective basis and “locked in” to a Medicaid ACO, as compared with the voluntary and retrospective assignment to Medicare ACOs proposed in the April 2011 regulations. It is common for Medicaid beneficiaries to select or be assigned to a managed care plan or primary care provider on a mandatory basis, although there is typically a period during which they may request to be reassigned to a different plan or provider, if they are not happy with the initial arrangement.

Because of the lack of clear federal guidelines, ACOs might be envisioned differently by different state Medicaid agencies. For example, New Jersey has been considering legislation to develop a Medicaid ACO demonstration project in which communities could form ACOs that include hospitals, primary care providers, and other organizations that would be paid through a shared-savings approach. The state would

permit Medicaid managed care organizations to participate in these ACOs as subcontractors, paid on a shared-savings basis.²⁸ This model would blend the two models shown in Exhibit 2.

In contrast, Colorado has developed an Accountable Care Collaborative model, which it describes as an ACO, but the approach resembles an enhanced medical home model in which regional collaboratives provide case management and coordination services and a statewide organization provides analytic support.²⁹ This bears many similarities to the Community Care of North Carolina medical home model.

Special issues may arise for ACOs or other networks of safety-net providers because of these providers’ status. For example, under federal rules, Section 330–funded health centers must be independent and governed by a community-based board of directors. Similarly, other safety-net providers may be governed by special rules if they are publicly owned or were established under legal covenants. These may prohibit a safety-net provider from simply being “acquired” by another provider or an ACO. Regardless, safety-net providers should be able to form collaborations that permit greater financial and clinical integration.³⁰ Many safety-net facilities, including health centers and safety-net hospitals, have been able to form Medicaid managed care plans and some—such as Colorado’s



Denver Health, Wisconsin's Marshfield Clinic/Family Health Center of Marshfield, and New York's Lutheran Medical Center/Lutheran Family Health Centers—have been able to develop integrated delivery systems. Many more are allied under other Medicaid managed care plans.

Finally, it is worth noting that the status of a particular provider or ACO may vary across insurers. For example, a hospital or clinic may be part of an ACO in Medicare, but be part of a managed care plan or a fee-for-service provider in Medicaid. This could be particularly relevant with regard to dual eligibles, who are enrolled in both Medicare and Medicaid. The financial arrangements for care of these beneficiaries could thus become more complex in the future.

OTHER FORMS OF INTEGRATION AND COORDINATION

While there may be some challenges in creating ACOs in Medicaid, medical/health home arrangements are clearly applicable. As noted before, most states already have some type of medical home project and the Affordable Care Act health home provisions are likely to encourage states to expand these programs. PCCM programs, a rudimentary form of medical home effort, are also already common in Medicaid, particularly in rural areas. In many cases, Medicaid medical/health home projects are undertaken within capitated Medicaid managed care plans. Medical/health home projects seek to upgrade the quality of primary care and enhance the coordination of care, although they are mainly directed at primary care providers who will coordinate care with specialists and hospitals.

CONCLUSION

The Affordable Care Act provides new approaches and heightened awareness of the need to coordinate care, including care provided to low-income and vulnerable patients by safety-net providers.

Regardless of the approach to coordinating and integrating care among safety-net providers—managed care, ACOs, or medical homes—it is important to consider the extent to which certain functions are attained:

- Is there a process to improve care management and coordination for patients, particularly those with chronic diseases, across primary, specialty, and inpatient care? Is there a primary care medical home that can serve as the main source of care for each patient? Are there care coordinators who can help patients with particularly complex, high-cost health conditions?
- Are there enhanced capabilities to monitor patients' care, both individually and on an aggregated basis, and to share information about patients across care levels? These capabilities often require the use of electronic health records, patient registries, and information exchanges.
- Are there financial incentives to encourage better coordinated and more efficient care, coupled with efforts to measure and improve the quality of care?
- Are there systems to help promote access to insurance coverage and care? Do the safety-net providers have capabilities to ensure their patients enroll in and retain coverage and to address other social and health needs that may create care barriers to accessing care?

No single approach can address the diverse needs for coordination of safety-net providers in communities and states across the nation. The mix of approaches used will likely vary in each community. Federal and state efforts to create incentives to use electronic health records and develop information exchanges are already helping to build a health information technology infrastructure that can support improved care coordination, although these efforts are still in the preliminary stages.

While there appears to be broad support for expanding enhanced primary care medical/health home approaches among safety-net providers, the prospects for safety-net ACOs are less clear. Some of the difficulties, based on reactions to the Medicare ACO proposed regulations, include: 1) the high initial costs of implementation; 2) the exclusion of FQHCs and rural health

clinics as assigned primary care providers; and 3) the lack of a mechanism to support improvements in the quality of care for the uninsured. A federal ACO demonstration project tailored to the needs of safety-net providers, or the funding of a coordinated care network as authorized by Section 10333 of the Affordable Care Act, could address some of these concerns.

Successful efforts to improve care coordination among safety-net providers will require federal, state, and local financial resources to sustain the safety net and make the investments needed to upgrade capabilities. In addition, they will require flexible strategies that can accommodate variations in community and state needs, as well as consensus among safety-net providers to encourage cooperation and coordination, rather than fragmentation and competition.

NOTES

- ¹ A. Shih, K. Davis, S. C. Schoenbaum, A. Gauthier, R. Nuzum, and D. McCarthy, *Organizing the U.S. Health Care Delivery System for High Performance* (New York: The Commonwealth Fund, Aug. 2008).
- ² Centers for Medicare and Medicaid Services, Factsheet: Medicare Physician Group Practice Demonstration (Washington, D.C.: CMS, Dec. 2010).
- ³ S. Artiga, *Community Care of North Carolina: Putting Health Reform into Practice in Medicaid* (Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, May 2009).
- ⁴ M. M. Doty, M. K. Abrams, S. E. Hernandez, K. Stremikis, and A. C. Beal, *Enhancing the Capacity of Community Health Centers to Achieve High Performance: Findings from the 2009 Commonwealth Fund National Survey of Federally Qualified Health Centers* (New York: The Commonwealth Fund, May 2010).
- ⁵ Centers for Medicare and Medicaid Services, Medicare Shared Savings Program: Accountable Care Organizations. *Federal Register* 19528-31, April 7, 2011.
- ⁶ Comment letter to CMS on the proposed regulations, submitted by Bruce Siegel of the National Association of Public Hospitals and Health Systems, June 6, 2011.
- ⁷ Comment letter to CMS on the proposed regulations, submitted by Roger Schwartz of the National Association of Community Health Centers, June 6, 2011.
- ⁸ S. Rosenbaum and P. Shin, *Medicare's Accountable Care Organization Regulations: How Will Medicare Beneficiaries Who Reside in Medically Underserved Communities Fare?* Policy Research Brief #23 (Washington, D.C.: Geiger Gibson/RCHN Community Health Foundation Research Collaborative, George Washington University, April 2011).
- ⁹ C. E. Pollack and K. Armstrong, "Accountable Care Organizations and Health Care Disparities," *Journal of the American Medical Association*, April 27, 2011 305(16):1706–07.
- ¹⁰ See <http://innovations.cms.gov/areas-of-focus/seamless-and-coordinated-care-models/pioneer-aco/>.
- ¹¹ C. Mann, State Medicaid Director Letter 10-24, Health Homes for Enrollees with Chronic Conditions, Nov. 16, 2010.
- ¹² M. Kaye and M. Takach, *Building Medical Homes in State Medicaid and CHIP Programs* (Portland, Maine: National Academy for State Health Policy, 2009). For an update, see <http://www.nashp.org/med-home-map>. L. Ku, P. Shin, E. Jones et al., *Transforming Community Health Centers into Patient-Centered Medical Homes: The Role of Payment Reform* (New York: The Commonwealth Fund, Sept. 2011).
- ¹³ Centers for Medicare and Medicaid Services, "Federally Qualified Health Center Advanced Primary Care Practice Demonstration: Demonstration Design" (CMS, June 6, 2011); Centers for Medicare and Medicaid Services, "Multi-Payer Advanced Primary Care Practice Demonstration Questions & Answers—Updated April 12, 2011" (CMS, 2011).
- ¹⁴ S. Dorn, *The Basic Health Program Option Under Federal Health Reform: Issues for Consumers and States* (Princeton, N.J.: Robert Wood Johnson Foundation, March 2011).
- ¹⁵ O. Zaman, L. Cummings, and S. Spieler, *America's Public Hospitals and Health Systems, 2009* (Washington, D.C.: National Association of Public Hospitals and Health Systems, Dec. 2010).
- ¹⁶ L. Ku, P. MacTaggart, F. Pervez et al., Improving Medicaid's Continuity and Quality of Care (Washington, D.C.: Association for Community Affiliated Plans, July 2009).
- ¹⁷ L. Ku, E. Jones, P. Shin et al., "The Safety Net After Health Care Reform: Lessons from Massachusetts," *Archives of Internal Medicine*, Aug. 8, 2011 171(15):1379–84.
- ¹⁸ V. Smith, K. Gifford, E. Ellis et al., *Hoping for Economic Recovery, Preparing for Health Reform: A Look at Medicaid Spending, Coverage and Policy Trends: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2010 and 2011* (Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, Sept. 2010).

- ¹⁹ M. A. Hall, “Approaching Universal Coverage with Better Safety-Net Programs for the Uninsured,” *Yale Journal of Health Policy, Law and Ethics*, Winter 2011 11(1):9–19.
- ²⁰ M. H. Katz and T. M. Brigham, “Transforming a Traditional Safety Net into a Coordinated Care System: Lessons from Healthy San Francisco,” *Health Affairs*, Feb. 2011 30(2):237–45.
- ²¹ See the Office of Management and Budget, www.whitehouse.gov/omb/expectmore/detail/10003515.2005.html.
- ²² Medicaid and CHIP Payment and Access Commission, *The Evolution of Managed Care in Medicaid* (Washington, D.C.: MACPAC, June 2011).
- ²³ *Ibid.*
- ²⁴ J. Carroll, “Stressed States Open Doors to Medicaid Managed Care,” *Managed Care*, March 2011 20(3):24–27.
- ²⁵ Association for Community Affiliated Plans, “Safety Net Health Plans Get High Performance Ratings,” press release (Washington, D.C.: ACAP, Oct. 22, 2010).
- ²⁶ America’s Health Insurance Plans, *Innovations in Medicaid Managed Care* (Washington, D.C.: AHIP Center for Policy and Research, March 2005).
- ²⁷ For discussion of this issue in New York, see D. Bachrach, R. Belfort, W. Bernstein et al., *Considerations for the Development of Accountable Care Organizations in New York* (New York: New York State Health Foundation, June 2011).
- ²⁸ J. Brenner and N. Highsmith, “An ACO Grows in Camden, But Can It Flourish in Medicaid?,” *Health Affairs Blog*, June 23, 2011, available at <http://healthaffairs.org/blog/2011/06/23/an-aco-is-born-in-camden-but-can-it-flourish-in-medicaid/>; E. Litten, “ACOs: Getting More for Less?,” *New Jersey Law Journal*, May 2011 204(8):1–2.
- ²⁹ Colorado Department of Health Care Policy and Financing, *Accountable Care Collaborative*, 2011, available at <http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1233759745246>.
- ³⁰ S. Rosenbaum, M. H. Zakheim, J. Leifer et al., *Assessing and Addressing Legal Barriers to the Clinical Integration of Community Health Centers and Other Community Providers* (New York: The Commonwealth Fund, July 2011).

ABOUT THE AUTHORS

Leighton Ku, Ph.D., M.P.H., is a professor and director of the Center for Health Policy Research in the School of Public Health and Health Services at George Washington University. For more than 20 years, he has conducted research and analysis regarding health care for disadvantaged populations, including studies of health care reform at national and state levels, Medicaid, safety-net health care, and immigrants. Prior to coming to George Washington, Dr. Ku was a senior fellow at the Center on Budget and Policy Priorities and a principal researcher at the Urban Institute. He has a Ph.D. in health policy from Boston University and an M.P.H. from the University of California, Berkeley.

Peter Shin, Ph.D., M.P.H., is an associate professor of health policy and research director for the Geiger Gibson/RCHN Community Health Policy Program at George Washington University. He focuses on the study of community health systems and integration of care for vulnerable populations and is the author of nearly 100 health policy reports on safety-net systems, community health centers, health disparities, health care financing, and economic factors related to care delivery and population health. Dr. Shin is an expert in survey design, the management and analysis of data, policy analysis, and program evaluation and has provided technical assistance to federal, state, and local agencies and organizations. He received his M.P.H. in epidemiology and Ph.D. in public policy from George Washington University.

Marsha Regenstein, Ph.D., is a professor in the department of health policy and director of doctoral programs for the School of Public Health and Health Services at George Washington University. She has led many projects that examine health care access and quality for low-income and vulnerable populations and has profiled dozens of safety-net communities around the country. Dr. Regenstein was previously vice president for research at the National Association of Public Hospitals and Health Systems and vice president of the Economic and Social Research Institute. She has a Ph.D. in health policy from George Washington University.

Holly Mead, Ph.D., is an assistant professor in the department of health policy at George Washington University. Her research focuses on disparities in health care, particularly around chronic illness care and patient self-management. She was the recipient of the Pfizer Fellowship in Health Disparities (2008–2011), which supported her work on disparities in the use of cardiac rehabilitation and other secondary preventive programs for patients with heart disease. Dr. Mead recently received an award from the National Collaborative on Aging to develop a peer-led patient activation program to promote the use of cardiac rehabilitation in minority and women patients. She holds a Ph.D. in public policy from George Washington University.

ACKNOWLEDGMENTS

We would like to acknowledge the contributions of a number of colleagues and experts who gave advice on this project, including many who participated in a roundtable discussion on September 20, 2010. These include (by alphabetical order of organization): Irene Fraser (Agency for Healthcare Research and Quality), Deborah Kilstein and Margaret Murray (Association of Community Affiliated Plans), Alex Ross and Seiji Hayashi (Bureau of Primary Health Care, Health Resources and Services Administration), Mary Kennedy and Jennifer Coleman (Centers for Medicare and Medicaid Services), Edward Schor (formerly of The Commonwealth Fund), Catherine Hess (National Academy for State Health Policy), Daniel Hawkins, Craig Kennedy, and Michelle Proser (National Association of Community Health Centers), Lynne Fagnani and Bruce Siegel (National Association of Public Hospitals and Health Systems), Aaron McKethan (Office of the National Coordinator for Health Information Technology), and Mark Hall (Wake Forest University). Colleagues from George Washington University who also participated include: Anne Markus, Brian Bruen, Emily Jones, Fraser Rothenberg Byrne, Kate Buchanan, Merle Cunningham, and Sara Rosenbaum. All opinions expressed in this report are those of the authors, however, and should not be ascribed to any of the above-named individuals.

Editorial support was provided by Martha Hostetter.

