Health Policy Brief

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Ready for ACA? How Community Health Centers Are Preparing for Health Care Reform

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SUMMARY: Community health centers (CHCs) are a cornerstone of the health care safety net. They are the primary source of care for many low-income populations, including both those newly insured under the Affordable Care Act (ACA) and those who were left out and will remain uninsured. The ACA provides challenges and opportunities for CHCs, which will require significant changes in infrastructure and care delivery approaches to meet those challenges. This policy brief assesses the progress made by CHCs in Los Angeles County in meeting a number of key indicators of ACA readiness in early 2014. The authors find that 39 percent of CHCs are well prepared, 23 percent have made some progress, and the rest are at the initial phases of preparation and/or lack adequate resources to meet the requirements. CHCs in the latter group will require help to embark on strategic improvements in infrastructure and care delivery.

> *Two in five CHCs have made significant progress toward ACA readiness.*

Community Health Centers (CHCs) have long been perceived as "providers of last resort." Now, as a result of the Affordable Care Act, their role is changing. As key providers of care to uninsured and low-income populations, CHCs are directly impacted by the size of the remaining uninsured population, fluctuations in the flow of funds to safety net providers, and the uncertainty of whether their newly insured patients will continue to seek care at CHCs, given their ability to choose from an expanded pool of providers. The readiness of CHCs to cope with these changes is of immediate importance in Los Angeles County, as the County Department of Health Services plans a fundamental change to the care of remaining uninsured patients by assigning them to CHCs starting in fall 2014.

Health Centers Surveyed in This Study

Twenty-eight Federally Qualified Health Centers (FQHCs) receive federal grants and must meet the requirements for care provision and administration under Section 330 of the Public Health Service Act, which provides funding for these health centers.

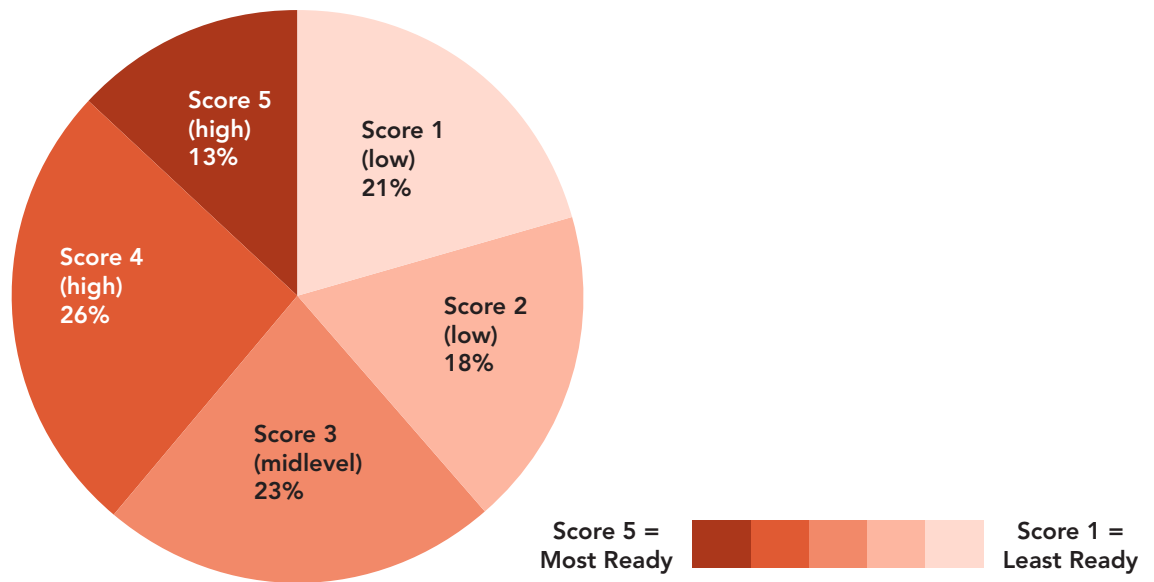**Three FQHC "look-alikes"** meet the same requirements as FQHCs but do not receive Section 330 funding.

Eight community or "free" clinics are independent, freestanding, nonprofit health centers with varied funding arrangements.[1]

Exhibit 1   ACA Readiness of Community Health Centers, Los Angeles County, 2014

Note: ACA readiness ranges from low (Scores 1 and 2) to high (Scores 4 and 5).

Source: UCLA analysis of 2012 primary care clinic utilization data from the Office of Statewide Health Planning and Development (OSHPD), data from the Community Clinic Association of Los Angeles County's Health Center Controlled Network, and a UCLA survey of Los Angeles County clinics.

In response, many CHCs have pursued interrelated and innovative strategies to become providers of choice. These strategies include:

1) Gaining recognition as a "patient-centered medical home" (PCMH, or simply medical home): CHCs recognized as medical homes deliver comprehensive primary care; coordinate all the care needed by the patient, including specialty and behavioral health care; use a diverse team of providers with different skills; and focus on both improving the health of the patient and reducing costs of care.[2]

2) Implementing and effectively using health information technology (HIT/MU): HIT, particularly electronic health records, allows CHCs to effectively monitor, evaluate, and coordinate care. However, CHCs must develop the infrastructure and provider 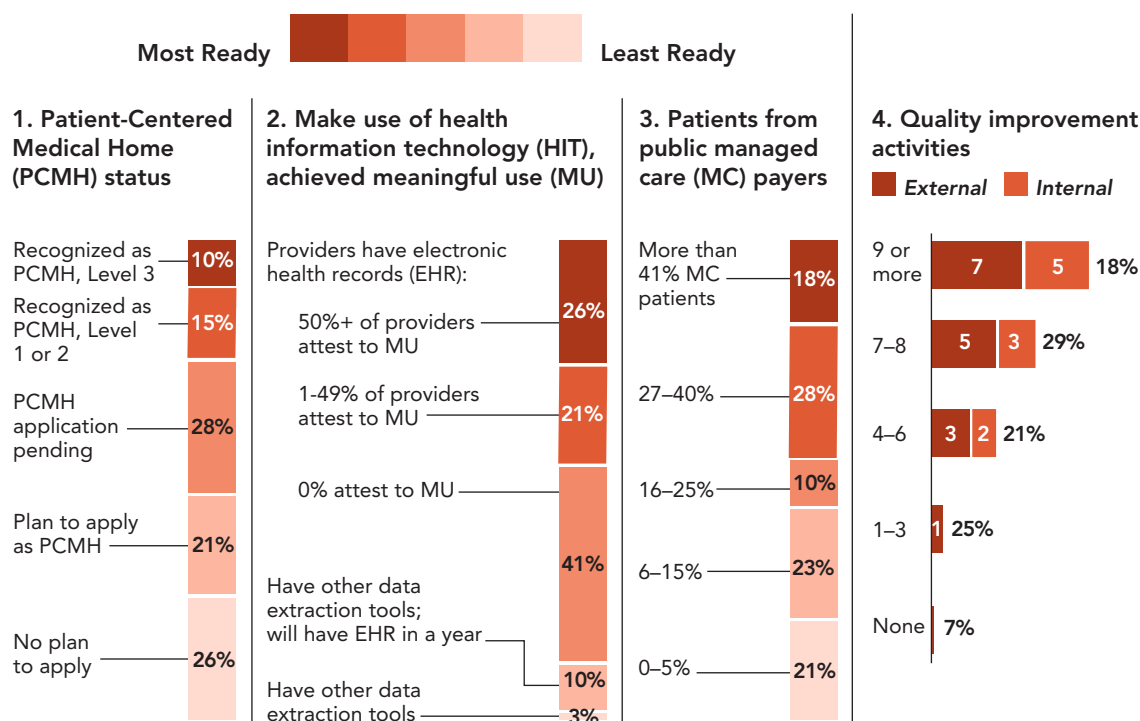skills for effective use of HIT and can demonstrate achievement of these advances through a process called meaningful use (MU).[3]

3) Increasing quality improvement (QI) efforts: Quality improvement (QI) activities are used to target inefficiencies or ineffective care delivery processes and to correct them, with the aim of both improving patient outcomes and reducing costs. Systematic and long-lasting improvements are generally more likely to result from participation in external QI collaboratives than from internal, limited-scope QI activities.

4) Contracting with managed care organizations: Managed care contracts provide a stable source of patients and revenue for CHCs and free up resources to provide more care to uninsured patients. These contracts also indicate skill in negotiating with payers and managing a variety of contracts.

Components of ACA Readiness of Community Health Centers, Los Angeles County, 2014   **Exhibit 2**

Most Ready — Least Ready

1. Patient-Centered Medical Home (PCMH) status

Recognized as PCMH, Level 3	10%
Recognized as PCMH, Level 1 or 2	15%
PCMH application pending	28%
Plan to apply as PCMH	21%
No plan to apply	26%

2. Make use of health information technology (HIT), achieved meaningful use (MU)

Providers have electronic health records (EHR):

50%+ of providers attest to MU	26%
1-49% of providers attest to MU	21%
0% attest to MU	41%
Have other data extraction tools; will have EHR in a year	10%
Have other data extraction tools	3%

3. Patients from public managed care (MC) payers

More than 41% MC patients	18%
27–40%	28%
16–25%	10%
6–15%	23%
0–5%	21%

4. Quality improvement activities

■ External   ■ Internal

	External	Internal	
9 or more	7	5	18%
7–8	5	3	29%
4–6	3	2	21%
1–3	1		25%
None			7%

Source: UCLA analysis of 2012 primary care clinic utilization data from the Office of Statewide Health Planning and Development (OSHPD), data from the Community Clinic Association of Los Angeles County's Health Center Controlled Network, and a UCLA survey of Los Angeles County clinics.

In this study, ACA readiness is measured on a scale ranging from 1 (low) to 5 (high), based on advances made in the four strategies described above.

Many CHCs Have Made Significant Progress Toward ACA Readiness

Two in five CHCs in Los Angeles County (39 percent) had made significant progress, scoring a 4 or 5 on the ACA readiness scale (Exhibit 1).

Another 23 percent had made some progress (scoring a 3), and the remaining CHCs were at earlier stages (scoring 1 or 2) of activities that would prepare them for the anticipated changes of the ACA.

Thirteen percent of CHCs are "very ready" to serve as a medical home

One-quarter of CHCs have obtained medical home recognition from the National

Committee for Quality Assurance (NCQA) or the Joint Commission, the two dominant organizations that recognize CHCs as medical homes (Exhibit 2).

An additional 28 percent of CHCs have applied for medical home recognition, and another 21 percent are in the application process. More than one-quarter of CHCs (26 percent) have not applied and do not currently plan to do so. These organizations may satisfy many of the requirements needed for medical home recognition, but they either lack the resources to commit to the substantial effort required to obtain medical home recognition or have competing priorities.

The great majority of CHCs have electronic health records

Eighty-eight percent of CHCs have electronic health records. Of those, 26 percent say that at least half of providers use this technology

"Many CHCs do not have the resources to gain Medical Home recognition."

regularly and effectively, but the rest do not report meaningful use (Exhibit 2). A small group (10 percent) plans to have electronic health records in the next year, and 3 percent have no electronic health records at all or any plans to implement them. However, the CHCs without electronic records have at least one type of electronic data tool, including practice management systems for enrollment and/or billing (5 percent), referral systems (8 percent), and data reporting systems (3 percent; data not shown).

Patients under managed care comprise a small percentage of CHC clients

Few CHCs currently serve a large managed care population. Eighty-two percent of CHCs have 40 percent or fewer managed care patients. Twenty-one percent have only a small proportion (0-5 percent) of patients covered by any public managed care organizations, including Healthy Families,[4] Medi-Cal, or Medicare.[5]

Varied participation rates in quality improvement activities

Seven percent of CHCs had not conducted any QI activities, and 25 percent had conducted one to three. In contrast, 18 percent had conducted nine or more QI activities (Exhibit 2). The latter group had participated in seven external collaboratives and five internal initiatives, on average, in the past two years. The most common topic-specific QI collaboratives targeted diabetes (64 percent), immunizations (39 percent), and asthma (36 percent). CHCs also participated widely in funder-specific QI collaboratives, such as Building Clinic Capacity for Quality (39 percent), Tools for Quality (29 percent), and Accelerating Quality Improvement Through Collaboration (25 percent; data not shown).[6]

Characteristics of CHCs and their patients vary among the most/least ready CHCs

CHCs with higher ACA readiness scores were more likely to be larger organizations with more providers and patients. For example, CHCs with a readiness score of 5 were frequently multisite organizations, had

more primary care providers and patients, and provided more services and patient encounters than those with a score of 1. In addition, the "most ready" CHCs had a higher share of Medi-Cal patient encounters, as well as more net revenues from patients (rather than from government grants or other sources) than the "least ready" CHCs (see Appendix for detailed data on these characteristics).

CHC patient characteristics depend partly on the CHC's location and on the size of the underserved population in that area. Nevertheless, the "most ready" CHCs had more young patients (under 20 years of age) and more patients with respiratory system diseases than the lowest readiness CHCs (see Appendix for detailed data on these characteristics).

Conclusions and Recommendations

About two in five CHCs in Los Angeles County have made significant progress in preparing for the anticipated changes associated with the ACA. These clinics may be better prepared to manage and coordinate care for both the newly insured and those who remain uninsured in Los Angeles County. However, an equal proportion of CHCs have not yet implemented many of the changes that would improve their readiness for the ACA. Many of these organizations do not have plans to apply for medical home recognition, do not have electronic health records, have not participated in many quality improvement collaboratives or conducted internal initiatives, and/or have not succeeded in contracting with managed care organizations. These CHCs have a smaller workforce, fewer patient encounters, and a lower percentage of patient-generated revenue.

ACA readiness is of immediate importance in Los Angeles County, as the County Department of Health Services will assign patients who are still uninsured and possibly ineligible for public insurance to CHCs starting in fall 2014.[7] CHCs may require further assistance and resources to accelerate

CHCs with higher ACA readiness scores were more likely to be larger organizations with more providers and patients.

their readiness for the ACA and to allow them to better serve patients who would like to or need to seek care in CHCs. Potential strategies for CHCs include:

- Continuing efforts to improve aspects of care delivery that are aligned with medical home principles, such as coordinating primary care with other care, taking a team-based approach to care delivery, and improving quality of care.

- Accelerating implementation of health information technology and increasing the number of physicians who have attested to meaningful use to enhance the ability of CHCs to improve care delivery processes and quality of care.

- Seeking contracts with public and private managed care organizations to retain newly insured Medi-Cal patients and attract patients enrolled through the Covered California Exchange marketplace.

- Increasing participation in quality collaboratives and implementing internal quality improvement initiatives targeting inefficiencies or ineffective care delivery processes.

- Increasing funding and revenues to implement the aforementioned and other innovative initiatives.

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Acknowledgments

Data and Methods

The 2012 California Office of Statewide Health Planning and Development primary care clinic utilization data were analyzed to determine CHCs' workforce, services provided, patient characteristics, and sources of revenues. Data on medical home recognition and HIT/MU were obtained from the Community Clinic Association of Los Angeles County's Health Center Controlled Networks. Clinics were surveyed for quality improvement history, as well as for data on medical home and health IT that were not otherwise available.

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Endnotes

1   Of the 134 primary care facilities licensed in Los Angeles County (304 sites), 118 were operating at the time of reporting to OSHPD. Of the latter group, 74 (202 sites) offered comprehensive primary care services rather than focusing exclusively on specific services (e.g., substance abuse, family planning, or counseling) or populations (e.g., HIV/AIDS, geriatric, or American Indian/Native American patients). Of these 74 CHCs, 39 (145) participated in the survey. FQHCs represented a larger share of respondents (72% vs. 41% of the overall CHC population). However, survey responses were considered to be representative of the 74 CHCs because nonrespondents did not differ significantly in the average number of patients seen or number of encounters, patient characteristics, staffing size and type, or services offered.

2   National Committee for Quality Assurance. Patient-Centered Medical Home Recognition. *http://www.ncqa.org/Programs/Recognition/PatientCenteredMedicalHomePCMH.aspx*

3   The Centers for Medicare & Medicaid Services (CMS) provides financial incentives to selected providers who can demonstrate "meaningful use" of the patient health management information included in electronic health records. Individual providers must formally "attest" to CMS that they have achieved meaningful use.

4   Healthy Families enrollees were transitioned to Medi-Cal in 2013, but the program still existed in 2012, the most recent year for which OSHPD data are available.

5   Data on private managed care patients were not available.

6   Descriptions of some of these quality improvement initiatives are available at *http://bccqprogram.org/* and *http://www.chcf.org/projects/2008/accelerating-quality-improvement-through-collaboration-aqic*.

7   *Los Angeles Times*. Healthcare Advocates Push for Medical Services for Uninsured. April 1, 2014. *http://www.latimes.com/science/la-me-obamacare-immigrants-20140402,0,3912725.story#ixzz2yDXgha3P*

> *"Community Health Centers must prepare for the new health care landscape."*

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