

## The Experience and Performance of Community Health Centers Under Managed Care

Nathan L. Stacy, BA

### **Abstract**

**Objectives:** To (1) analyze the performance of 7 community health centers (CHCs) under managed care contracts and (2) identify key planning and operational components that all CHCs must address to remain viable as populations shift to managed care.

**Design and Methods:** In-depth studies of 7 geographically diverse CHCs were conducted. Centers with multiple years of managed care contracting experience were selected. A detailed questionnaire about CHC operations under managed care was administered on-site to management staff from the 7 participating CHCs. Cost and utilization performance data were collected from managed care organizations, and their staff were interviewed to gauge the performance of the 7 CHCs within managed care networks.

**Results and Conclusions:** The shift of state Medicaid and other insured populations to managed care and changes in federal protection for CHCs suggest that CHCs must participate in managed care delivery systems to remain economically viable. In-depth studies of 7 CHCs with extended contracting

histories with managed care organizations demonstrated that the CHCs offered comparable performance to other network providers, with lower cost and utilization for specialty care. Centers also experienced lower per-member monthly pharmacy costs. In addition, CHCs served as important sources of enrollment for managed care organizations. To succeed under managed care, CHCs must undertake substantial changes in their planning and operations, including developing appropriate risk relationships, diversifying their revenue base, mainstreaming operations, and improving performance monitoring.

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Community health centers (CHCs) are an important source of primary and preventive healthcare services to uninsured, underinsured, and Medicaid populations across the country. These providers recognize the particular barriers to good health faced by low-income and poverty-level individuals and families and have sought to address these barriers through community outreach programs, a multilingual staff, transportation services, and patient education efforts. Because of their location in low-income, health professional shortage, and other underserved areas, CHCs have traditionally served the Medicaid population under states' fee-for-service programs and received cost-based reimbursement for the services provided. Many of these CHCs also receive direct grant funding from the federal government under Section 330 of the Public Health Service Act.<sup>1</sup>

The author is a graduate student at the University of Washington School of Public Health, Seattle, WA. At the time of writing, the author was with The Lewin Group, Falls Church, VA.

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Address correspondence to: Nathan Stacy, 225 NE 65th Street, #305, Seattle, WA 98115. E-mail: nathanstacy@hotmail.com.

With the expansion of at-risk managed care in state Medicaid programs, more Medicaid recipients are receiving services through closed-network managed care organizations (MCOs). In many cases, CHCs participate in these programs as contracted MCO providers; in a few instances, CHCs contract individually or collectively with a state to act as independent capitated MCOs. Managed care continues to increase its penetration in the privately insured and Medicare markets as well, absorbing some of the working insured and Medicare beneficiaries who rely on CHCs.

Although federal Medicaid legislation requires states to ensure access to federally qualified CHCs under managed care, these managed care programs can nonetheless reduce Medicaid utilization and revenue for CHCs through a variety of means. Program design features and special waivers can serve to limit health centers' participation in managed care programs. In addition, given the continuing pressure to increase states' flexibility in designing managed care programs, it is possible that the existing financial and guaranteed access protections extended to these providers may be diminished. Federal legislative action in 1997 required nonexempt states to provide supplemental payments to ensure that federally qualified CHCs receive reasonable cost reimbursement for Medicaid. At the time of passage, this guarantee extended until 2003 and reduced the required payment level from 100% of reasonable cost to 70% of reasonable cost during that period.<sup>2</sup>

As the health service delivery models adopted for Medicaid and other insured populations shift to managed care, CHCs will have to adapt to this environment from a financial perspective and an operational perspective. Current trends indicate that CHCs must become participants in managed care delivery systems or they may well find their non-grant sources of funding quickly dwindling, leaving them to a tenuous existence dependent largely on the federal grant process and the budgetary uncertainties surrounding this funding.<sup>3</sup> Without the revenues and financial protection offered through Medicaid, CHCs may not be able to provide the same level of care to the uninsured population. Moreover, with growth in managed care and increases in the uninsured population, CHCs will have an increasing need for additional external support to fulfill their mission.<sup>4</sup>

This article provides a qualitative and quantitative assessment of the performance of selected CHCs under managed care from the perspective of MCOs.

Simultaneously, this article explores certain key aspects of CHC planning and operations and identifies characteristics necessary for CHCs to succeed in a managed care environment. These analyses are based on interviews with staff from MCOs and CHCs and on the collection of cost and utilization data from MCOs.

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... METHODS ...

### Case Study Approach

A case study approach was used to examine the performance of CHCs in a managed care environment at 7 sites across the country. A series of full-day interviews were conducted on-site with staff from 7 participating CHCs, and 2-hour interviews were conducted with staff from 8 MCOs with which the CHCs contract. Through these interviews, researchers obtained a qualitative assessment of CHC performance and identified key attributes of CHCs that are successfully operating with managed care contracts.

In addition, a specific set of cost and utilization data was collected from MCOs for the participating CHC, a comparable provider group in the network, and all primary care providers within the network to assess CHC performance. Whenever possible, MCOs provided specific cost and utilization indicators for primary care, referral services, emergency services, and inpatient hospital services, along with any available data on quality and satisfaction. The data reflected Medicaid, commercial, Medicare, or a combination of enrollees based on the nature of the contracting relationship between the MCO and the CHC and the ability of the MCO to separate data by payer.

### Site Selection and Site Descriptions

To select the 7 participating CHC sites from among the hundreds of federally qualified CHCs nationwide with managed care activity, sites were limited to those with multiple years of managed care experience and enrollment of 1000 or more individuals under contracts with MCOs. Community health centers whose contracting activity was limited to a primary care case management contract directly with a state were excluded. Of the approximately 65 remaining sites, CHCs were ranked to favor those with relatively higher levels of managed care enrollment and to ensure geographic diversity.

Telephone screening of CHC and MCO staff provided a more detailed understanding of each potential site's managed care contracts, enrollment, and

performance reporting. Seven sites were selected to participate based on the following criteria: at least 1 contracting MCO was willing to participate and able to provide performance data, the CHC was not at comprehensive risk for inpatient hospital services, and the CHC did not fully own or operate a health plan. The 7 selected sites, by location, are rural Arizona (AZ); urban Colorado (CO); metropolitan Chicago, Illinois (IL); metropolitan Boston, Massachusetts (MA); rural Ohio (OH); metropolitan Philadelphia, Pennsylvania (PA); and urban Tennessee (TN).

Each CHC selected has considerable experience under managed care (5 of 7 sites have more than 10 years of managed care experience). In 1992, these 7 sites were among fewer than 100 federally qualified CHCs with some form of managed care relationship.<sup>5</sup> The number of CHCs with some form of managed care contracting activity expanded to more than 650 in 1996 (including primary care case management programs) and has grown even more since that time.<sup>6</sup>

For the majority of the 7 sites selected for participation, the metropolitan statistical areas in which they operate are characterized by above-average managed care penetration. Examination of 1997 Medicare managed care data from the Health Care Financing Administration showed that Medicare managed care penetration was higher than the total US average for 5 of the 7 metropolitan statistical areas. Likewise, Medicaid managed care penetration was

higher than the national average for 5 of the 7 metropolitan statistical areas.<sup>7,8</sup> The AZ, PA, and TN CHCs have among the highest levels of Medicaid managed care penetration nationwide because of state managed care programs that have mandatory enrollment for most Medicaid beneficiaries.

Each participating CHC had managed care contracts with multiple MCOs, and the managed care populations treated varied by CHC, ranging from Medicaid and state-insured enrollees to Medicare and commercial enrollees. The contracted level of risk for CHCs also varied considerably. Table 1 provides an overview of the CHCs' capitated contracts with MCOs.

**Table 1.** Summary of CHC Capitated Managed Care Contracts

CHC	No. of Capitated MCO Contracts	Types of Enrollees	Full-Risk Services*	Partial-Risk Services*
Arizona	4	Medicaid, Medicare, commercial	Primary care, limited hospital physician, limited laboratory	None
Colorado	2, plus 1 forthcoming	Medicaid, Medicare, commercial, Veterans Administration	Primary care, obstetrics/gynecology (except deliveries)	None
Illinois	7, plus 2 forthcoming	Medicaid, Medicare, commercial	Primary care, specialty care, radiography, laboratory, pharmacy, outpatient diagnostic, transportation	Inpatient hospital
Massachusetts	4	Medicaid, Medicare, commercial	Primary care	Specialty care, inpatient hospital
Ohio	4 (under 2 contracts), plus 1 forthcoming	Medicare, commercial	Primary care, laboratory, radiography	Specialty care, inpatient hospital
Pennsylvania	4	Medicaid	Primary care	None
Tennessee	4	Medicaid, state insured	Primary care	None

CHC = community health center; MCO = managed care organization.

\*For each CHC, risk for services varies by MCO contract.

... RESULTS AND DISCUSSION ...

**Community Health Center Performance From the Managed Care Organization's Perspective**

Information from interviews with MCO staff and cost and utilization data collected from MCOs provide a picture of the performance of each of the 7 participating CHCs within their respective MCO networks. Data on per-member per-month cost and utilization per 1000 member-months offered some insight into where these CHCs were stronger or weaker in the delivery of cost-effective care. Statements from MCO management staff complemented the data by describing the strategic importance of the CHCs within the managed care networks and providing an assessment of the qualitative strengths and weaknesses of the CHCs.

Because the participating CHCs are, by design of the site selection process, among the most experienced in managed care contracting, coupled with the fact that data are limited to 7 CHCs, the perfor-

mance of these CHCs cannot be treated as generally representative of all federally qualified community and migrant health centers. Indeed, as a group, these participating CHCs conceivably reflect the top tier of CHCs with respect to managed care contracting. In actuality, each CHC's performance was affected by a variety of factors inherent to the particular CHC, such as the managed care environment, the nature of the community served, the competing provider community, the availability of funding, and the strength of management and clinical staff.

*Cost and Utilization Performance of Community Health Centers.* The participating MCOs provided indicators that reflect per-member per-month costs and utilization per 1000 member-months. These data were requested for the participating CHC, a non-CHC comparison provider group that treats a similar mix of enrollees and is at risk for a similar set of services, and the MCO's regional primary care network of providers. The data were provided for

**Table 2.** Deviation of CHC Cost and Utilization Performance From the Network Average\*

CHC	Population	Cost per Member per Month					
		Total	Inpatient Institutional	Emergency Services	Referral Services	Pharmacy	Primary Care
Arizona	MD	--	--	--	--	--	-
Colorado <sup>†</sup>	MD/CM	NA	NA	NA	-	-	0
Illinois <sup>‡</sup>	MD	++	++	+	+	+	+
Massachusetts	CM	0	0	-	0	NA	-
Ohio	MC/CM	0	+	++	0	NA	+
Pennsylvania	MD	0	-	+	-	--	NA
Tennessee <sup>§</sup>	MD	+	++	NA	--	NA	0

CHC = community health center; MD = Medicaid only; MD/CM = Medicaid and commercial; CM = commercial only; MC/CM = Medicare  
NA = valid comparison data not available; MCO = managed care organization.

\*For each CHC, the corresponding MCO stated that the CHC met or was better than the plan's expected range of performance. Network  
†Only limited comparative cost and utilization data were available for the Colorado CHC.

‡The MCO stated that the Illinois CHC is prepaid through capitation for most nonhospital services and that cost and utilization are within to increase.

§Cost and utilization data provided for the Tennessee CHC contained several anomalies that were not resolved by the MCO.

Medicaid, Medicare, commercial, or a combination of populations based on each MCO's ability to separate data for different payers. Although a range of indicators was requested, each MCO's data-reporting capabilities varied substantially, with no MCO able to provide all of the indicators. The quality of data provided by MCOs also varied greatly, and certain data contained anomalies that made comparisons of provider groups difficult. All significant data limitations are noted throughout this discussion.

To compare CHC cost and utilization performance to network averages, CHC data were indexed to the networkwide data and organized into quintiles based on their percentage variance from the network average. Table 2 presents the deviation of CHC performance from the MCO network average for each of the cost and utilization data elements collected. Each CHC's cost and utilization performance is characterized based on the following ranges: >30% lower, 10% to 30% lower, 10% lower to 10% higher, 10% to 30% higher, and >30% higher. Table 2 also

denotes indicators for which valid comparison data for a particular CHC were not provided by the MCO.

Per-member per-month costs across the CHCs varied in most areas but were generally lower in 2 areas. Community health centers' total, inpatient institutional, emergency services, and primary care costs varied compared with the network experience overall—with an approximately equivalent number of CHCs demonstrating higher costs as those demonstrating lower costs and several CHCs demonstrating equivalent costs. For example, total costs were nearly equivalent to the network average for 3 CHCs, higher than the network average for 2 CHCs, and lower than the network average for 1 CHC (1 MCO did not report total cost data). Conversely, CHCs' costs were consistently lower than the network average for referral services and pharmacy. Four CHCs incurred lower costs for referral services vs the network average and 2 incurred nearly equivalent costs, whereas only 1 CHC had higher referral costs vs the network average.

Utilization per 1000 Member-Months

Total Admissions	Maternity Admissions	Nonmaternity Admissions	Total Days	Maternity Days	Nonmaternity Days	Referrals	Emergency Department Visits
-	NA	NA	--	NA	NA	--	--
NA	NA	NA	NA	NA	NA	-	NA
++	++	++	++	++	++	NA	NA
-	++	-	0	++	-	NA	0
NA	NA	0	NA	NA	+	--	0
--	0	--	--	+	--	-	0
--	+	--	NA	NA	NA	NA	NA

and commercial; - = >30% lower; - = 10%-30% lower; 0 = 10% lower to 10% higher; + = 10%-30% higher; ++ = >30% higher;

averages for MCOs excluded CHCs from calculations in some cases and included CHCs in calculations in other cases.

plan expectations. Other providers are new to the network and experienced disproportionately low utilization, which the MCO expects



Community health centers experienced lower or comparable utilization per 1000 member-months for total hospital admissions and inpatient days, nonmaternity hospital admissions, and referrals. The only measures in which CHCs reported consistently higher utilization were maternity admissions and maternity days, which were higher in all reported cases. Emergency department utilization was essentially the same for CHCs and other network providers. A notable caveat is that for most of the utilization indicators, nearly half of the MCOs were unable to provide valid comparison data.

The lower referral costs and referral utilization demonstrated by the CHCs are consistent with the typical CHC's family practice model of care, which emphasizes providing more medical services in-house relative to other providers. Community health centers and several MCOs indicated that the CHCs' higher maternity hospital admissions and maternity inpatient days reflect the large maternity caseload typically handled by most CHCs. Although it is sometimes believed that CHCs serve a disproportionately sicker population because of their location in historically underserved communities, overall inpatient institutional costs and nonmaternity inpatient hospital admissions and days were not consistently higher across the 7 CHCs for the managed care populations they treat.

Three CHCs—IL, MA, and AZ—were identified by MCOs as among the top tier of provider groups within the network. The cost and utilization statistics for the AZ CHC were indeed considerably lower than the network average (note that according to the MCO, the network average included certain high-cost hospitalized patients, which may have resulted in a slight upward bias). The MA CHC also demonstrated strong utilization and cost performance, with equivalent or lower cost and utilization in all areas except maternity admissions and maternity hospital days.

Although the IL CHC's reported cost and utilization were considerably higher than those of other network providers, the MCO stated that the CHC's cost and utilization were within plan expectations and that the CHC was the network's premier provider group. Staff from the MCO believed that other network providers were new to the network and experienced disproportionately low utilization because they had fewer enrollees with ongoing treatment relationships (at the time, the MCO had been in operation for <2 years). Because the IL CHC is capitated for most services and has a patient base

composed primarily of past clinic users, they have higher costs and utilization compared with other provider groups that are new to the network.

According to other participating MCOs, the remaining 4 CHCs also met or exceeded their overall expectations for cost and utilization performance; however, for 1 of these 4 CHCs—the TN CHC—the data provided by the MCO contained several anomalies that were not resolved on further inquiry.

Likewise, a second comparison was made to contrast performance for each CHC and a comparable non-CHC provider within the MCO's network. This analysis showed trends in cost and utilization that were similar to those presented in Table 2. Costs for CHCs varied about evenly between higher and lower for total cost, emergency services, and primary care services. Cost for referral services were generally lower, and inpatient institutional costs and pharmacy costs were lower more often than not. In most cases, utilization per 1000 member-month indicators also mirrored the trend observed for CHCs vs all network primary care providers combined. Significant data limitations existed, however, when comparing the CHC with a single provider group within the network. Differences in the health status and other patient characteristics between the 2 groups, along with occasional differences in the way data were reported for the comparison provider and the CHC, could not be controlled for in the analysis.

*Strengths and Weaknesses of Community Health Centers.* During interviews conducted at the 8 participating MCOs, executives and management staff conveyed their impression of the CHCs' qualitative performance during the years they contracted with the CHCs. Each MCO discussed the strategic importance of the particular CHC within their network and outlined specific strengths and weaknesses of the CHC. Staff also commented generally on their overall impression of the quality and cost effectiveness of care provided by CHCs and the strength of CHC financial management and operations.

Managed care organization staff emphasized the strategic importance of several CHCs to the individual MCO network in which they participate or to a particular geographic area within the network. Four of 5 CHCs located in urban or suburban areas were identified as key provider groups by the MCOs. For example, the PA and IL CHCs had the most enrollees of any provider group within the network, and staff from an MCO that contracts with the IL CHC believed that the CHC served as a focal point

for the MCO's Chicago-area network. Staff from another MCO stated that the MA CHC is one of the older provider groups within their regional network and is in the top 10% of all providers in terms of size of its enrollment base. Similarly, staff from a Colorado MCO believed that the CO CHC has a strong historical relationship with local community residents and stated that the MCO originally contracted with the CHC many years ago because of the CHC's status as one of the community's larger provider groups.

The 2 sites in rural areas, the OH and AZ CHCs, facilitated the entry of MCOs into the markets the CHCs serve. Staff from the MCO contracting with the OH CHC stated that the CHC is integral to the MCO's network in the nearby rural areas and has enabled the MCO to expand its presence in these areas. Likewise, staff from an Arizona MCO stated that the AZ CHC accounts for half of the plan's total enrollment in a large rural Arizona county.

Staff from the MCOs strongly praised 3 sites—MA CHC, IL CHC, and AZ CHC—and ranked them among the best provider groups within the MCO network. The CO and PA CHCs also received strong reviews from MCOs, and the remaining CHCs were ranked on a par with other provider groups.

For example, the MCO contracting with the MA CHC indicated that the CHC and other CHCs within the network are adept at operating under managed care, partially because of their significant experience under the highly evolved Massachusetts managed care market. The MCO provided comprehensive quality data for the MA CHC that showed the CHC ranked above the network average. Similarly, the MCO contracting with the AZ CHC ranked the CHC in the top 10% of all of the plan's providers in terms of overall performance and quality. The MCO stated that the AZ CHC's greatest strengths are above-average performance for cost and utilization and the high immunization rates of the CHC's patients.

The MCO that contracts with the IL CHC also considered the CHC to be among the premier provider groups within the network. The MCO elected to contract with the IL CHC because of its extensive experience and expertise in managed care and in serving the Medicaid community. Staff from the MCO cited the CHC's excellent integrated social and physical health programs and its strong immunization program; the MCO and CHC also partnered to develop an asthma management program.

Strong points of other CHCs participating in the study include the family practice model of care,

the offering of centralized services, and staff who are attuned to and supportive of the needs of the Medicaid population. Community health centers often perform services that other providers do not, resulting in better utilization of primary vs specialty care services. Staff from the MCOs also cited innovative disease management, utilization management, and other programs as strengths of the participating CHCs.

Overall, MCO staff were hesitant to identify specific weaknesses of the CHCs participating and, in general, believed that most of the participating CHCs were among the stronger performing provider groups within their networks. Consequently, although some MCOs pointed out the weaker aspects of the participating CHCs, most spoke about the areas in which other CHCs needed to improve.

Concerns cited by a Pennsylvania MCO include greater turnover in the physicians employed by CHCs, a lack of sufficient extended hours compared with private physician groups, and 24-hour coverage that is sometimes inadequate because of overextended on-call physicians. Staff from a Massachusetts MCO shared detailed member satisfaction data that showed, for several measures, the percentage of respondents who rated the CHC as fair or poor was slightly higher than the health maintenance organization (HMO) average but was still within HMO guidelines; the weakest satisfaction areas were for length of time to get an appointment and waiting time measures.

Additional concerns cited by a Colorado MCO included some difficulties in the CHC's provision of hospital coverage, where CHC physicians prefer not to provide 24-hour coverage at 1 of the area's 2 main hospitals. These MCO staff also believed that, in general, CHCs are somewhat less effective than other provider groups at establishing patient eligibility at the time of the visit and also at following preauthorization procedures.

Additional comments came from staff from a Tennessee MCO, who would like to see CHCs improve documentation of health maintenance services for well-patient visits and treatment plans for individuals with chronic diseases; staff from this MCO also believed that CHCs sometimes have trouble maintaining adequate 24-hour coverage and do not always provide proper primary care physician backup before referral. Managed care organization staff would also like CHCs to become better marketers for health plans. Finally, staff from an Arizona MCO believed that several CHCs within its network

have operational inefficiencies, including long appointment waiting times and billing problems.

### Key Planning and Operational Components

During visits at the 7 study sites, researchers administered a detailed questionnaire to CHC managers to collect information on CHCs' organizational response to managed care. Based on this information and the results of separate interviews with MCO staff, the author identified 6 key planning and operational components that affect CHCs' ability to succeed in a managed care environment. These factors, ranging from risk evaluation and management to mainstreaming infrastructure and operations, are important focal points for CHCs that must meet the expectations of MCOs while continuing to enhance their ability to serve populations that have historically lacked access to care. By identifying and discussing these components, the author hopes to provide beneficial information to CHCs as they critically assess their operations within the early stages of contracting under managed care. It is also the author's intention to highlight the technical assistance needs of CHCs, thereby better informing federal and state policy makers as they develop programs and policies that affect CHCs.

Overall, the challenge faced by CHCs is not unlike that faced by other private practice provider groups under managed care, namely, they must become effective clinical practice managers. Specific findings from the site visits are cited in each of the functional areas described below.

*Developing Appropriate Risk Relationships and Managing Risk.* Managers of CHCs across the 7 sites recognized the need to become effective negotiators, risk evaluators, and risk managers. Executive directors at the PA, IL, and TN CHCs emphasized how their multiple years of experience under managed care have helped them better understand contracted risk relationships. Clearly, CHCs with no managed care contracts need to evaluate the MCO options and begin negotiating contracts, and those with existing contracts should critically evaluate their performance and renegotiate as necessary. This experience better prepares CHCs for states' quick transition to mandatory Medicaid managed care programs and prepares them for overall increases in managed care penetration.

As CHCs transition more fully to managed care, they need to develop financial models to assess their internal costs and determine the services for which they should take risk. Most CHCs have adopted a family practice model of care in which they provide

a wide range of services in-house, partially because of historically poor access to specialty care for their patient population. Community health centers that elect to take risk only for primary care services often continue to provide an extensive range of services in-house and sometimes have difficulty obtaining reimbursement for services provided outside of basic primary care. This point was emphasized by the TN CHC, which has struggled financially because of what it characterized as low reimbursement rates under managed care for its "primary care only" contracts. The CHC also had disagreements with MCOs about the scope of services covered under the primary care capitation, resulting in the CHC losing a substantial amount of revenue for services provided.

The CHC model of care suggests that some CHCs would benefit from taking risk beyond basic primary care services. The experience of some of the CHCs supports the notion of taking additional risk for services. The IL CHC undertook the most comprehensive risk for specialty care services and demonstrated the best internal financial performance of the sites visited. The PA, AZ, and CO CHCs were all exploring options to partner with other CHCs to collectively contract for specialty services. Moreover, in the performance data collected across the sites, the areas with demonstrated cost savings were specialty care and pharmacy. To reap the rewards for their effective use of primary care and use of lower-cost drugs, CHCs should seek opportunities to contract some level of risk for these services.

To evaluate potential risk-sharing opportunities, however, CHCs must develop or procure the skills to analyze contracts in the context of the local market and to evaluate the adequacy of capitation rates and the accompanying scope of services. Many centers believed that they did not possess the internal expertise to critically evaluate contracts, and some CHCs believed that they could not afford to hire external expertise to evaluate risk-contracting opportunities. In addition to having trouble identifying the right contracting opportunities, CHCs find it difficult to establish adequate leverage in negotiations with MCOs. The TN CHC stated that they possessed a weak negotiating position with MCOs and have been unable to negotiate desired changes to their contracts. The OH CHC also cited mixed results in negotiating changes to contracts. Options for CHCs to increase their negotiating strength include joining together with other centers to collectively contract with MCOs, partnering with hospitals or other organizations, or perhaps deciding to



form their own MCO instead. Community health centers must identify and evaluate the benefits of partnering with other groups and understand the potential risks involved—such as the risk of alienating other organizations or the risk that their strategic partner may fail. In conjunction with these efforts, CHCs need to improve the marketing of their services to MCOs, such as demonstrating potential enrollment growth and CHCs' ability to help MCOs meet Medicaid contracting requirements.

*Establishing Revenue Replacement Strategies.*

Community health centers face the approaching elimination of required payment rate protection for federally qualified CHCs, combined with the possible loss of a portion of their traditional Medicaid base. Compounding the problem for some CHCs, their uninsured, sliding-fee population has been increasing faster than other populations. The CO CHC presented data that showed that their uninsured, sliding-fee scale patient population has grown considerably over time. Data collected under the Bureau of Primary Health Care's Uniform Data System show that, across all federally qualified CHCs, the share of CHCs' patient base that is uninsured increased from 35% to 40% between 1995 and 1997 and was estimated to be even higher in 1998.<sup>9</sup> Welfare and Medicaid reform, coupled with increasing coverage gaps in the small group and individual insurance markets, could cause CHCs to continue to lose insured, full-paying patients while increasing their uninsured patient population. Consequently, CHCs must critically assess their internal capacity and evaluate their particular healthcare market for potential new revenues.

Opportunities may include leveraging existing Medicaid contracts to treat Medicare and commercial enrollees or serving beneficiaries under other programs, such as the Children's Health Insurance Program funded under Title XXI of the Social Security Act. All but 2 of the CHCs participating in the study contracted with MCOs for products beyond Medicaid, such as Medicare and commercial populations. To accomplish their diversification strategy, CHCs need to examine ways to better market themselves to insurers, hospitals, and individuals. As CHCs begin to serve a more diverse set of socioeconomic groups, they must focus on meeting the needs and demands of these groups.

*Mainstreaming Infrastructure and Operations.*

One of the most important steps CHCs must take is to develop the efficient administrative operations and modern facilities that healthcare consumers demand. Namely, CHCs must improve overall cus-

tomers service. Community health centers must make such improvements not only to attract new patients across the socioeconomic spectrum but also to retain their historical patient base in a market of more choice. Perhaps the most striking example of reengineering provided by the participating sites was that of the AZ CHC. The CHC changed its name, updated its facilities, and revamped its operations—including improving its appointment management system and establishing a centralized referral department.

Community health centers often pursue a variety of mechanisms to fund expansion and renovation, including federal grant funds; other grant opportunities; local community fundraising; and strategic partnerships with hospitals, MCOs, and other organizations. Yet, for some CHCs there remains a paucity of funding sources, making them unable to expand facilities to meet overall increased demand for services, open clinics in areas that are more convenient for patients, or renovate facilities to increase efficiency and better appeal to patients. Developing efficient operations is also challenging. Community health centers may have difficulty creating an adequate appointment scheduling system that ensures that patients do not wait too long to see a provider on arrival while also ensuring that there are enough walk-in and emergency slots to meet demand. To survive and compete, CHCs must continue to work to improve their infrastructure and administrative services and to convey an image as efficient, modern, and mainstream organizations.

Finally, CHCs need to assess the success of their efforts through regular monitoring of customers' opinions. Assessing clinic users' preferences for treatment and expectations of outcomes, conducting standardized satisfaction surveys, soliciting suggestions from clinic users, asking users open-ended questions, and creating a culture that welcomes and encourages complaints and comments are potential methods for the continuous assessment of satisfaction.<sup>10</sup>

*Building Staff Expertise in Operations Under Managed Care.* Community health centers need to develop staff with expertise in operations under managed care. Community health center executive staff and board members must improve their skills in the areas of contract negotiation, risk management, and overall financial management. Attracting skilled senior management is challenging, as exemplified by the experience of the CHCs in this study. Two CHCs had experienced recent turnover in the

position of chief financial officer (CFO), and a third was attempting to fill a newly created CFO position. Community health center senior management must also be effective overall operations managers for CHCs to offer efficient service. Staff from one of the MCOs interviewed suggested that the tight labor market for healthcare managers, combined with the relatively lower salaries offered by CHCs, make it difficult for CHCs to attract and retain management staff.

Other staffing issues that CHCs should consider include centralizing administrative staff to handle the referral process and to serve as the primary contacts between MCOs and the CHC. This approach can reduce time spent by clinicians interacting with payers and free them to provide more patient care. At the same time, communication and relationships between CHCs and MCOs would be improved. Six of the 7 participating CHCs had created a centralized managed care department and made other staffing changes in response to managed care.

Community health centers must improve training of front-office staff in eligibility verification, copayment collection, and other administrative requirements imposed by managed care. Accurate eligibility verification ensures that the CHC is adequately reimbursed for the services it provides. And, in a tight fiscal environment, copayment collection is an importance source of revenue. Perhaps of most importance, well-trained, polite, and efficient front-office staff is a component affecting overall customer satisfaction.

*Improving Clinical Case Management and Utilization Management.* Under a managed care system, CHC clinicians must be cost-effective clinical care managers. Consequently, CHCs need to undertake the training of clinical staff in appropriate case management and utilization management under managed care, particularly in the area of inpatient hospital care. The IL CHC, which contracted for the most risk for services outside of primary care, identified tracking and controlling hospital utilization as one of its greatest challenges. In addition, some CHCs may want to consider incentive systems to improve physician productivity and encourage effective care management. Managed care organization staff also stated that CHCs need to develop the extended clinic hours, after-hours on-call care systems, and hospital care coverage systems that many MCOs demand and require in their contracts.

*Monitoring Financial and Clinical Performance.* Community health centers must assess their internal performance by identifying key finan-

cial and clinical performance indicators for individual physicians and the entire CHC. These indicators must then be compared with appropriate managed care market and CHC benchmarks. Currently, as demonstrated by the financial reports provided by CHCs participating in this study, much of the performance tracking by CHCs is limited to revenues, procedure codes, and visits. Community health centers that are at risk for primary care need to be able to track revenues and internal costs (not just federally qualified CHC average costs) separately by MCO to evaluate the cost of care and revenues for each MCO's particular mix of enrollees. In addition, CHCs need to move toward tracking other data, such as referrals, as they prepare to take risk for specialty services. Likewise, CHCs need to define and track more advanced clinical benchmarks for managed care.

Most of the 7 participating CHCs recognized the need to improve their performance tracking, including developing more advanced clinical and financial benchmarks. Three of the CHCs studied had begun or were considering tracking specialty care utilization. At least 1 site, the MA CHC, performed detailed physician profiling using Current Procedural Terminology code data. Benchmarking using Current Procedural Terminology code data is a credible method often favored by physicians.<sup>11</sup> Nearly all of the participating CHCs stated that they do not use MCO reports for routine performance tracking, and a few of the CHCs questioned the validity of the data in reports sent to them by MCOs.

To improve their overall monitoring, CHCs must have a management information system that allows them to adequately track and manage clinical and financial data. One challenge highlighted by CHCs is that such a system needs to offer the additional ability to meet federally qualified CHC and other federal reporting requirements unique to CHCs while also performing necessary billing functions. Three CHCs participating in the study stated that obtaining a new management information system is one of the greatest administrative challenges they face. Procuring such a system is difficult for CHCs in terms of cost and in choosing the right system for their needs. Community health centers need to solicit input from internal staff, other CHCs, private practice groups, and/or outside contractors to identify their system needs. Such input would be useful to help CHCs outline system requirements and, if necessary, to develop a strategy to expand the capabilities of their current system or procure a new system. Participating CHCs stated that critical com-

parative systems information and information on what systems other provider groups use is not readily available to them.

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... CONCLUSIONS ...

The dramatic shift of state Medicaid populations and other insured populations to managed care, coupled with uncertainties in federal funding and reimbursement protection for CHCs, suggests that CHCs must participate in managed care delivery systems to remain economically viable. The experience of the 7 CHCs examined, each with an extended contracting history with MCOs, illustrates that CHCs can offer care that is comparable to that of other network providers in terms of cost and utilization. In several cases, the CHC family practice model of care contributed to lower cost and utilization of referral services relative to other providers. Community health centers also have prescribing practices that result in a lower-cost mix of drugs. In addition, the participating CHCs demonstrated an expertise in developing preventive care programs and community outreach efforts that effectively meet the needs of Medicaid beneficiaries and others. The positive reputation of CHCs in the community and their large existing patient base also made them attractive to MCOs.

For CHCs to be successful under managed care, they must undertake substantive changes in their planning and operations. Although some of these needs reflect the unique role that CHCs play in the nation's healthcare system, many are similar to those presented to any provider group facing increased competition. The most prominent challenges to CHCs in the current and future managed care environment include developing appropriate risk relationships, diversifying their revenue base, mainstreaming infrastructure and operations, building staff managed care expertise, improving clinical case management, and establishing effective performance monitoring systems.

If CHCs are able to contract successfully with MCOs and operate effectively under managed care, they may be able to diversify their existing patient bases (and thereby expand revenues) while continuing to achieve their mission of providing care to the underserved population. Demographic and market realities and financial constraints, however, are like-

ly to prevent some CHCs from attracting new revenue streams. Each CHC must devise strategies that fit their individual situations to adapt to the changing healthcare environment. Meanwhile, policy makers must consider how and to what degree public policy should continue to play a part in determining the future of these providers.

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