HMA

HEALTH MANAGEMENT ASSOCIATES

Strategic Assessment of Primary Care Capacity in Harris County

COMMISSIONED BY THE
HARRIS COUNTY HEALTHCARE ALLIANCE

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Executive Summary

Health Management Associates (HMA) was engaged by the Harris County Healthcare Alliance (the Alliance) to conduct a strategic assessment of primary care capacity in the county. The assessment included individual "feedback reports" to each of the 13 health centers included in the "target group" identified by the Alliance, and a system-level analysis of the Harris County primary care safety net. The purpose of this report is to present our findings and recommendations with respect to the primary care safety net as a whole, including the identification of opportunities for expanding capacity.

Based on our findings, this report also describes a long-term vision for expanding primary care capacity in Harris County that is based on FQHC growth, consolidation and the development of several strategic partnerships to improve financial performance and better serve Houston's medically underserved populations. When fully phased in, the model reduces the estimated unmet need for low income uninsured primary care visits by approximately half. The proposed vision, comes with a significant price tag, however, roughly tripling the support required from third-party sources (including the philanthropic community and other non-federal funding sources) but providing nearly seven times the number of uninsured primary care visits as are currently being provided by the FQHCs.

With one of the highest uninsured rates in the nation, Harris County's primary care safety net faces tremendous challenges as it seeks to improve performance and expand capacity. These challenges include the following:

The Texas policy/payer environment makes the FQHC business model extremely difficult. While federally qualified health centers (FQHCs) receive cost-based reimbursement from Medicare and Medicaid, Texas' current Medicaid coverage levels, combined with large numbers of undocumented immigrants and other non-citizens, make the FQHC business model extremely difficult to sustain. Nationally, FQHCs see a payer mix that is approximately 36% Medicaid and 40% uninsured. On average, 16% of the patients seen in Harris County's FQHCs have Medicaid, while 72% are uninsured.

Small, developing FQHCs need help reaching national benchmarks and strong incentives to encourage performance and growth to scale. Relative to their peers around the nation, Harris County's FQHCs are extremely young and small and, as a result, most are struggling to reach national performance standards. As a group, the FQHCs fall below the 25th percentile for physician productivity, while the Harris County Hospital District (HCHD) clinics are close to the 50th percentile, though still well below the federal FQHC expectation of 4,200 visits per provider per

year. The other target group clinics are quite productive, exceeding the national 75th percentile (Table 1).

Table 1: Annual Harris County Provider Productivity (2007) versus National Benchmarks

							National Percentiles (2006)		
	FQHCs	Other Target Group	HCHD Clinics	Texas Mean	National Mean	HRSA Expectation	25th	Median	75th
Physician Productivity	3,009	4,289	3,528	4,114	3,846	4,200	3,080	3,676	4,261
Mid-level Productivity	3,358	3,786	4,251	3,045	2,879	2,100	2,262	2,810	3,358
Dentist Productivity	1,398	1,847	3,251	2,651	2,702	NA	1,996	2,525	3,089

Sources: 2007 UDS data for FQHCs and comparable 2007 data provided by non-FQHC health centers; Figures adjusted to exclude health centers that were considered non-comparable for purposes of productivity analysis. Texas and National comparison data are from the 2006 UDS.

With few exceptions, provider productivity must become a priority issue for the health centers in order to reduce costs, reduce the amount of time the patient spends at the health center to see a provider, and improve overall financial performance. However, it is important to note that productivity improvements alone will not be nearly enough to meet the tremendous unmet demand for primary care in Harris County. After accounting for increased capacity attributable to productivity improvements and recently completed service and site expansions, the County still faces an estimated unmet primary care demand for uninsured individuals below 200% FPL of more than 600,000 visits.[1]

FQHCs may need help reaching national clinical quality benchmarks. The federal agency (the Health Resources and Services Administration, or "HRSA") that houses the Bureau of Primary Health Care (BPHC) has adopted a set of 12 nationally-standardized clinical core measures as the basis for an Agency-wide quality improvement initiative for grantee delivery sites that provide clinical care and/or provide referrals for clinical care. BPHC selected a subset of four new clinical measures from these HRSA core measures: 1) appropriate childhood immunizations; 2) cervical cancer screening; 3) blood pressure control; and 4) diabetes control. Current Harris County quality measure reporting suggests that health centers may need assistance in developing protocols to meet the quality expectations.

Primary care safety net providers are facing significant physician shortages, exacerbated by ongoing contract problems, the new Baylor hospital, and limited and difficult access to

[1] HMA analysis of health center data compared to national productivity standards and recently completed estimates of unmet primary care demand in Harris County. *See* "Safety Net Primary Care Demand and Supply Analysis (April 2007)," Harris County Healthcare Alliance, St. Luke's Episcopal Health Charities, University of Texas School of Public Health (UTSPH).

specialty care. Frequent provider turnover and difficulty recruiting provider staff was frequently cited as one of the largest barriers to improving productivity in the health centers. Many health centers identified lengthy periods of time during which they were without a medical director or other key provider. Many also spoke of extreme difficulty recruiting providers.

Despite recent improvements, access to specialty care remains a significant problem for Harris County uninsured. Access to specialty care for the uninsured in Harris County is a tremendous challenge, as it is almost everywhere across the country. The impact of a lack of specialty care access ripples through the primary care safety net and affects both patients who need specialty care and the providers who struggle daily to get it for them. Earlier this year, the Harris County Hospital District completed negotiations with the FQHCs to allow direct access to HCHD's specialty referral center, rather than sending patients through HCHD's primary care system or emergency room. This should result in a reduction in the number of "wasted" primary and specialty care visits and also result in a much-improved process for patients seeking access to HCHD specialists. However, it is not expected to significantly impact the overall need for specialty care in the community.

Long-Term Vision

To address the challenges discussed above and create an environment to support a meaningful expansion in primary care capacity, HMA recommends a long-term vision for the provision of primary (and limited specialty) care in the county. The model structure envisions four to five FQHC entities, in rational geographic service areas, with multiple locations per FQHC organization, to serve the community:

- Each health center location should be large enough to achieve meaningful economies of scale, attract and retain physician and other provider staff, and support the array of wrap-around services that FQHCs must provide.
- Additional "niche" providers may continue to serve their communities and provide the population-specific, culturally appropriate services they are best able to provide; and
- Each service area should develop a "specialty center" for FQHC patients under the umbrella of the FQHC entity, to allow for cost-based reimbursement.

Figure 1 depicts the model structure when fully phased in:

Figure 1: Harris County FQHC System Model Structure

NW 4 Health Centers Specialty Center	**NE** 5 Health Centers Specialty Center
SW 4 Health Centers Specialty Center	**SE** 3 Health Centers Specialty Center

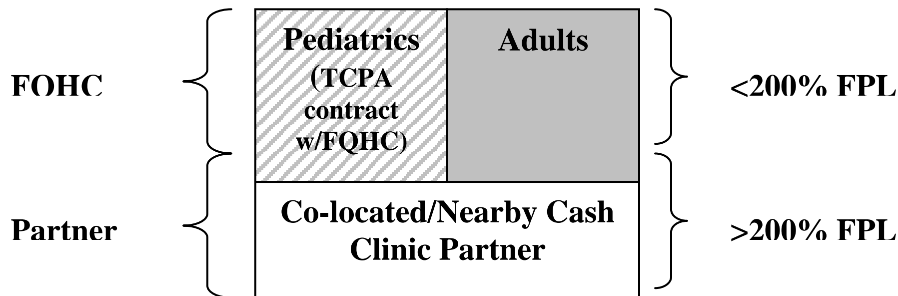
Within each FQHC rational service area (for purposes of calculating demand we have relied on a quadrant diagram but do not necessarily expect FQHC rational service areas to follow quadrant boundaries), the model organizational structure for the core health centers would ideally have several components, though variations on the model structure assumed.

- As they do now, the FQHC would serve *primarily* individuals below 200% FPL and would give patients above 200% FPL the option of getting care on a cash basis from a co-located or nearby clinic operated by a hospital partner or staffed by hospital-affiliated private practice physicians. This provides a more affordable option for this segment of the population.[2]
- Within the FQHC entity, pediatrics would ideally be provided through formal partnership arrangements with Texas Children's Pediatric Associates. This partnership arrangement could take several forms. For example, the FQHC could contract with TCPA physicians to provide pediatricians within the FQHC. Alternatively, a TCPA clinic could become a pediatric satellite site of an FQHC, operating under the management and governance of the FQHC.

[2] FQHCs are required to charge patients above 200% FPL full charges for services rendered. As a result, patients above 200% FPL frequently face charges near or well above $100 for routine care at an FQHC.

Figure 2 illustrates the model structure of each health center. The actual configuration of individual health centers may vary, depending on individual arrangements with TCPA, hospital partners and other partner organizations.

Figure 2: Model Organizational Structure



Recommendations

The recommendations in this report are intended to strengthen and build capacity in Harris County's primary care safety net in the near term while moving toward the long-term vision outlined above. The recommendations are also intended to build the organizational capacity of individual providers while strengthening the fabric of the primary care safety net system as a whole.

Key recommendations for strengthening the primary care safety net include:

- The philanthropic community must recognize the need for long-term support of Harris County's primary care safety net and make targeted, long-term investments that incentivize providers to merge while improving performance and quality of care.
- The management and oversight of the strategic long-term vision should be housed within the Harris County Healthcare Alliance and led by an independent project manager. The project manager should also be the point person for measuring the results of the coordinated long-term vision.
- The community should develop and nurture strategic partnerships between Texas Children's Pediatric Associates and FQHCs.
- FQHCs should create regional specialty care centers to serve Harris County.
- The community should work with the state to create a local Medicaid expansion for parents using unmatched tax dollars.

Key recommendations for building the organizational capacity of individual health centers include the following:

- Providers and funders must make provider clinical quality, productivity, eligibility and customer service a priority.
- The FQHCs must place a substantial focus on outreach and marketing, both individually and collectively.
- Health Centers should put in place policies and procedures to ensure they are getting infants and mothers back after delivery.
- Providers and funders must ensure clinical benchmarks are consistently improving.
- The health centers should establish and formalize "mentorship" arrangements among FQHC leadership and among board members of FQHCs.
- The health centers should advocate for the establishment of a prospective payment system (PPS) reimbursement methodology under SCHIP for FQHCs and Look-Alikes.[3]
- The health centers should evaluate a joint recruitment strategy as well as a joint-contracting arrangement for FQHCs , and other safety net providers, to contract with large organized medical groups.

It is important not to underestimate the magnitude of the changes required at both the individual organization and system levels to achieve the outcomes suggested by the long-term vision. They will require a coordinated, well-planned effort that is supported by not only the health centers, but also the philanthropic community, other providers, and key political officials at the local and especially national level.

[3] Look-Alikes are health centers that meet all federal FQHC requirements but do not receive Section 330 grant funding and are ineligible for certain other FQHC benefits. Both FQHCs and Look-Alikes are entitled to cost-based reimbursement under Medicaid and Medicare, however.

Purpose

Health Management Associates (HMA) was engaged by the Harris County Healthcare Alliance (the Alliance) to conduct a strategic assessment of primary care capacity in the county. The assessment included two components: individual "feedback reports" to each of the 13 health centers included in the "target group" identified by the Alliance, and a system-level analysis of the Harris County primary care safety net. The target group included the following health centers:

Federally Qualified Health Centers (FQHCs):
Houston Community Health Centers (Denver Harbor)
El Centro de Corazon
Good Neighbor Community Health Center
Healthcare for the Homeless – Houston
Legacy Community Health Services
Pasadena Community Health Center
South Central Houston Community Health Center
Spring Branch Community Health Center

Other Safety Net Health Centers:
Ibn Sina
San Jose Clinic
Hope (Asian American Health Coalition)
Planned Parenthood
Texas Children's Pediatric Associates Project Medical Home[4]

The individual feedback reports were intended to provide health centers with an assessment of their current operations and capacity for growth, as well as specific recommendations with respect to governance, operations, information technology (IT), finance and quality. Each individual assessment also included key staffing, productivity, cost, quality and other benchmarks to allow the health center to compare itself to its peers in Harris County, Texas and to national benchmarks.

The purpose of this report is to present our findings and recommendations for the primary care safety net as a whole, including the identification of strengths, weaknesses and opportunities for expanding capacity through strategic partnerships and improved efficiency. An additional component of this analysis

[4] Because of their unique structure and role, Texas Children's Pediatric Associates did not participate in the detailed site visit portion of this project, but did participate in several meetings with HMA and submit modified data.

is the identification of additional financial resources, particularly federal resources, that Harris County may be able to draw on to help offset the cost of caring for its large and growing population of uninsured.

Based on our findings, this report also describes a long-term vision for expanding primary care capacity in Harris County that is based on FQHC growth, consolidation and the development of several strategic partnerships to improve financial performance and better serve Houston's medically underserved populations. When fully phased in, the model reduces the estimated unmet need for low income uninsured primary care visits by approximately half. The proposed vision, comes with a significant price tag, however, roughly tripling the support required from third-party sources (including the philanthropic community and other non-federal funding sources) but providing nearly seven times the number of uninsured primary care visits as are currently being provided by the FQHCs.

The analysis in this report and the individual health center feedback reports is based on day-long site visits to each of the health centers in the target group and extensive data collection and analysis. HMA also conducted meetings with dozens of community stakeholders, including health center board members, leadership and staff; foundations; health policy researchers; and representatives from the Harris County Hospital District (HCHD), the Harris County Department of Public Health and Environmental Services (HCPHES) and the City of Houston Department of Health and Human Services. (See Appendix D for a complete list of individuals interviewed for this report.)

Overview of the Problem

Harris County Uninsured

While Texas has the highest rate of uninsured persons of any state in the nation (24% versus 16% nationally),[5] uninsured rates in Harris County are far worse than the statewide figure. Data from the U.S. Census Bureau's Current Population Survey indicate that nearly one in three persons (30.4%) in Harris County under the age of 65 are uninsured, a total of more than one million uninsured countywide.[6] Several factors contribute to this extremely high uninsured rate:

- **Low public insurance coverage rates for adults**. Texas ranks 49th among all states in its Medicaid coverage levels for parents.[7] In addition, Texas currently offers no public insurance coverage for childless adults. Fifteen states currently have such programs, funded either through state funds, federal funds or a combination of both.[8]

Table 2: Income Eligibility for Medicaid/SCHIP by Eligibility Category (Annual Income as a Percent of Federal Poverty Level, 2008)

	Texas	National	Texas Rank
Working Parents	28%	63%	49
Non-Working Parents	13%	41%	49

Source: "Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles;" data based on a national survey conducted by the Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, January 2008.

- **Low Medicaid eligibility threshold for children**. While Texas' public coverage eligibility levels for children are comparable to those seen across the nation, it is important, for purposes of this report, to distinguish between children covered by the Medicaid program and those covered by the State Children's Health Insurance Program (SCHIP). Compared to other states in the region, Texas' income limits for children under Medicaid is relatively low (ranging from 100% of FPL for children ages 6 -19 to 185% FPL for infants), thereby shifting coverage for many children to the stand-alone SCHIP

[5] Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2006 and 2007 Current Population Survey (CPS: Annual Social and Economic Supplements)), accessed at http://www.statehealthfacts.org.
[6] "The State of Health: Houston/Harris County, Texas, 2007," Houston Department of Health and Human Services, Harris County Public Health and Environmental Services, Harris County Healthcare Alliance, MHMRA of Harris County, Harris County Hospital District.
[7] "Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles;" data based on a national survey conducted by the Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, January 2008.
[8] Analysis by Beth Waldman of Bailit Health Purchasing, LLC, prepared for the California Working Committee, April 2007.

program. In contrast, Oklahoma covers all children up to 185% FPL under its Medicaid and Medicaid-expansion SCHIP program. Louisiana covers all children up to 200% FPL under Medicaid and will cover children between 201% and 250% FPL under a separate SCHIP program beginning in June 2008.

Table 3. Texas Medicaid and SCHIP Eligibility by Age and FPL

Children	0 – 100% FPL	101 – 133% FPL	134 – 185% FPL	186 – 200% FPL
< 1 year	MEDICAID	MEDICAID	MEDICAID	SCHIP
Age 1-5	MEDICAID	MEDICAID	SCHIP	SCHIP
Age 6-19	MEDICAID	SCHIP	SCHIP	SCHIP

Source: State Health Facts, Kaiser Commission on Medicaid and the Uninsured (www. statehealthfacts.org)

This has important implications for FQHCs in Texas, which are required by federal law to be reimbursed under a cost-based prospective payment system (PPS) for Medicaid. There is no similar requirement under SCHIP and, as a result, SCHIP reimbursement to FQHCs is far less generous than Medicaid.[9]

- **High numbers of undocumented and non-citizens**. The undocumented and other non-citizens comprise a significant minority of the uninsured in Harris County. While precise figures are not available, the Harris County Hospital District estimated that about 20 percent of the patients seen within its system in 2005 were undocumented immigrants. Medical care for these patients, however, comprised only 14 percent of the system's total operating costs in 2005.[10]

- **Concentration of workers in small firms that do not offer health insurance**. In 2003, Texas ranked 48th in the nation in percentage of residents having employment-based health coverage (52.4%).[11] In 2002, 63 percent of U.S. low-wage workers in private businesses with fewer than 10 employees did not receive health insurance coverage through their employer; in Texas, 73 percent did not.[12] The Texas Department of Insurance (TDI) identified several

[9] The SCHIP authorizing legislation (P.L. 105-33) allowed states to establish their SCHIP programs as Medicaid expansion programs under Title XIX of the Social Security Act or as stand-alone programs under the newly created Title XXI of the Social Security Act (or they could build a hybrid program). States that chose the Title XIX option are required to reimburse FQHCs under the cost-based PPS system. States utilizing the Title XIX option have no such requirement. According to the Kaiser Family Foundation, 14 states have Medicaid expansions, 19 states have stand-alone programs and 18 have hybrid programs (as of June 2007, see http://www.statehealthfacts.org. As a result, Harris County FQHCs may receive $150 or more for a Medicaid visit, while the same visit under SCHIP may pay between $20 and $90, depending on the service.

[10] Preston, Julia, "Texas Hospitals Reflect Debate on Immigration," *New York Times* (July 18, 2006).

[11] U.S. Census Bureau, "Health Insurance Historical Tables," Table HI-4, "Health Insurance Coverage Status and Type of Coverage by State—All People: 1987 to 2003."

[12] U.S Department of Health and Human Services, Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends, *2002 Medical Expenditure Panel Survey-Insurance Component*, Table II.A.2.

factors that partly explain Texas' lower rate of employment-sponsored insurance. They note that Texans are more likely to work in retail and service industries that are less likely to offer health insurance through the workplace. A relatively smaller percentage of Texans work in the manufacturing sector, where employers are more likely to provide health benefits. In addition, TDI found that most insurers and employers in the state have provisions that exclude part-time, contract and seasonal workers from insurance coverage.[13]

Current Efforts to Expand Coverage

Several initiatives at the state and local level are currently underway and, if implemented successfully, will extend affordable coverage options to many who currently do not have such options. One of the initiatives is a local three-share program in Houston that should have a positive impact on safety net providers. The net impact on the safety net of a state Medicaid Section 1115 waiver proposal is less clear.

- *Three-share program.* In March, 2008, the Texas Health and Human Services Commission (HHSC) awarded a $700,000 grant to the Harris County Healthcare Alliance to serve as the fiduciary agent for communities in the Texas Communities Healthcare Coalition (Houston, Galveston, Dallas and El Paso) to establish "three-share programs." The three-share model provides low-cost insurance (or insurance-like) coverage to low-income working families by dividing program costs between the employer, the employee and a government entity (via a public subsidy). The Texas Communities Healthcare Coalition plans to make coverage available to 45,000 individuals who currently lack coverage across the state, including 5,000 in Houston.[14]
- *Section 1115 Medicaid waiver*. In April, HHSC sent a Texas health care reform waiver request to the U.S. Department of Health and Human Services' Centers for Medicare & Medicaid Services (CMS). In his cover letter, Texas Governor Rick Perry said the plan seeks to "transform health care in Texas by providing more people with insurance, reducing reliance on expensive emergency room visits for basic care, and making it easier for the working poor to buy into employer-sponsored health coverage." The centerpiece of the waiver proposal is the creation of a Health Opportunity Pool (HOP) Trust Fund, which will combine a portion of current disproportionate share hospital (DSH) and upper payment limit (UPL) funds, state general revenue funds, and other federal and non-federal funds. The HOP will be used to:

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[13] Texas Department of Insurance, *Working Together for a Healthy Texas: Texas State Planning Grant* (Austin, Texas, September 2004), p. 15.
[14] *In Touch,* Texas Health and Human Services Coalition, May/June 2008.

- o enroll certain groups of children not currently eligible for Medicaid or SCHIP in the state's SCHIP program (Year 1);
- o provide grants to reduce uncompensated care costs and improve coordination of care for the indigent (Year 1); and
- o implement a premium support program for uninsured adults below 200% of the federal poverty level (FPL) to support the purchase of employer-sponsored or individual insurance. Subsidies would be phased in and would initially cover parents up to 133% FPL and childless adults up to 100% FPL (Year 3).

While many of the waiver details remain to be worked out, many large public and other safety net hospitals in the state have expressed concern about the principal financing mechanisms for the HOP. The waiver proposes a so-called "DSH swap" in which the state transfers a portion of the hospitals' DSH payments into the HOP. In exchange, the hospitals are to be reimbursed under a new DRG system and see reductions in their uncompensated care burden as a result of expanded coverage. For other safety net providers, including the FQHCs and other primary care providers, any increase in coverage levels is likely to be viewed as largely positive (though coverage via the SCHIP program would result in below-cost reimbursement for FQHCs), as would the availability of new grant funds to support care coordination and infrastructure development. However, any program that takes significant resources from the public system may adversely impact availability of specialty care and diagnostic tests, which would directly affect access to care for vulnerable populations.

Harris County Safety Net

Like many communities, the Harris County safety net is comprised of a loosely organized group of providers, including the public hospital system, private hospitals and some physicians, FQHCs and other safety net clinics. Private safety net providers have historically relied heavily on the support of Houston's philanthropic community and have also engaged in limited collaborative efforts – often through Gateway to Care, the Harris County Healthcare Alliance, or predecessor organizations -- to support each other and lessen duplication where possible. The Harris County safety net has also benefited from the presence of two major medical schools – The UT Medical School at Houston and Baylor College of Medicine – which have historically staffed the Hospital District Clinics as well as providing limited staffing for some of the FQHCs.

Harris County Hospital District. The Harris County Hospital District is one of the nation's largest public hospital systems and is comprised of two large general

hospitals and a rehabilitation hospital, which saw a combined 242,000 admissions, 11,000 births and 154,000 ER visits in 2007.[15] In 1966 the Hospital District, in cooperation with Baylor College of Medicine, created the Community Health Care Program to provide primary care access close to patients' homes. The program currently operates 11 community-based health centers (which saw approximately 470,000 medical encounters in 2007), an HIV clinic and seven school-based health centers. Uninsured residents of Harris County may access clinic and other HCHD services by qualifying for a "Gold Card," based on their residency and household income.

The District is governed by a nine-member board of managers appointed by the Harris County Commissioners Court. The medical staff for the District hospitals and clinics are provided through a contractual arrangement with the Baylor College of Medicine and the University of Texas at Houston School of Medicine, jointly doing business as Affiliated Medical Services (AMS). In recent years, this contractual relationship has become somewhat strained. As is the case in other public systems across the country, the medical schools are advocating for greater resources while the District is seeking greater accountability and a higher service level from the medical schools. The contract has been under negotiation for the past two years. Our understanding is that the contract currently under negotiation includes principles used by other systems and medical schools, including independently verified Relative Value Units (RVUs) and other mechanisms, to create more transparency in the relationship.

Private Hospitals. Private hospitals are a critical component of the Harris County safety net, providing more than $1 billion in uncompensated care in 2006.[16] Many of these hospitals have undertaken significant efforts to expand primary care capacity. The Memorial Hermann Healthcare System has established cash clinics near two of its hospital emergency rooms and has opened several new school-based health centers. Texas Children's Pediatric Associates provides primary care services to children through more than 40 locations. Most of these locations serve primarily privately insured children, but four sites have been designated as "Project Medical Home" health centers. These health centers were specifically designed and located based on an analysis of emergency room (ER) patient zip code origin data that indicated high numbers of children from certain regions of the county were presenting in the ER with primary care or primary care treatable

[15] Harris County Hospital District web site (www.hchdonline.com/about/census.htm), accessed May 29, 2008.

[16] Texas Department of State Health Services, Center for Health Statistics, Charity Care Charges and Selected Financial Data for Acute Care Texas Hospitals, 2006. Uncompensated care = bad debt charges plus charity care charges.

conditions. Methodist Hospital continues to support its family practice residency program after separating from the Baylor College of Medicine several years ago. The program staffs the Denver Harbor Community Health Center and is a valuable training program for future physicians in Harris County.

Harris County Department of Public Health and Environmental Services. The Harris County Department of Public Health and Environmental Services (HCPHES) provides preventive health services at six locations throughout the county. Services include immunizations, well-child visits, family planning, prenatal care, dental services for children and pregnant women, and HIV screening. In 2007, HCPHES provided nearly 34,000 medical encounters[17] and more than 3,000 dental encounters.

Houston Department of Health and Human Services. Through its Neighborhood Services Division, the Houston Department of Health and Human Services provides preventive health services at seven clinics throughout the city. Services include immunizations, well-child visits, family planning, prenatal care and dental services for children and pregnant women. The Department has recently begun an effort to co-locate and coordinate services with FQHCs and the Hospital District, transferring prenatal services to those providers while focusing on its core public health mission. In 2007, the DHHS clinics saw more than 78,000 medical encounters.[18]

Federally Qualified Health Centers. Harris County currently has eight private FQHCs operating out of 13 sites, and one public homeless FQHC operated by the Harris County Hospital District. In 2007, the FQHCs (excluding the HCHD Homeless program) provided approximately 73,000 primary care visits[19] and 11,000 dental visits. For additional information on these health centers, please see Appendices A-C.

Other Safety Net Providers. Harris County is home to several other safety net health centers that see patients on a sliding fee scale basis. These include two health centers operated by the Ibn Sina Foundation, the Asian American Health Coalition (dba Hope Community Health Center), four Planned Parenthood clinics and the San Jose Clinic. Collectively, these health centers saw nearly 50,000 primary care visits in 2007. For additional information on these health centers, please see Appendices A-C.

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[17] Includes family planning, prenatal and child health program encounters; excludes nurse-only visits, immunizations and other visits that did not include a face-to-face encounter with a medical provider.
[18] Ibid.
[19] Excludes specialty visits and visits that did not entail a face-to-face encounter with a medical provider (e.g., lab-only, pharmacy-only visits).

The history and evolution of the Harris County safety net – particularly over the last five to six years – is unique and important to understand, both as a backdrop to evaluating the current capacity within the system and in assessing options for building additional capacity. Of particular importance to this study is the evolution of Harris County's FQHCs. Unlike many urban communities that took advantage of generous federal funding in the 1980s and 1990s for community health centers, Houston (and other Texas urban centers) elected not to pursue these funds except for one or two sites. As a result, Houston had only one FQHC by the year 2000. Recognizing the tremendous need for primary care access points, the Gateway to Care organization was formed, largely through the support of a federal Community Access Program (CAP) grant.

Gateway's early efforts focused on building the infrastructure for and nurturing the development of community health centers. They worked with the Texas Department of Health to attain federal Medically Underserved Area/Medically Underserved Population (MUA/MUP) designations for underserved areas of the county – a pre-requisite for receiving Section 330 funding – and identified and worked with community-based clinics and other organizations rooted in Houston's neighborhoods to prepare them to apply for FQHC designation. These efforts were bolstered in 2003 by the creation of the Texas Incubator Program, a state-run program designed to support the President's New Access Point Initiative by providing support to organizations seeking to apply for FQHC or Look-Alike designation. Since its inception, the Incubator Program has provided nearly $6 million in support to Harris County health center projects, which is roughly one-fourth of all Incubator funds distributed statewide.[20] These efforts were also generously supported by Houston's philanthropic community, which contributed millions of dollars into the development and start-up of the health centers.

By most accounts, these early efforts were a success. Houston saw unprecedented growth in its number of FQHCs, increasing from one in 2000 to a peak of 10 in 2006. Since 2006, however, one FQHC has gone out of business (it later reopened under the auspices of another FQHC) and another lost its 330 grant, which was subsequently transferred to another FQHC after a competitive bidding process. The rapid proliferation and subsequent rapid downfall of a handful of these organizations points to some vulnerabilities in Harris County's FQHC network that are important to understand as one considers next steps.

[20] Harris County Healthcare Alliance analysis of data provided by the Texas DSHS FQHC Incubator Program, June 2008.

At a time when the federal Bureau of Primary Health Care was pushing consolidation and horizontal integration of health centers and the creation of integrated service development initiatives (ISDIs)[21] to improve efficiencies and reduce duplication, Harris County was pursuing a more traditional development plan for its FQHCs, one rooted in small, typically parochial, community-based organizations. This approach has many strengths; most notably, it fosters the development of health centers that are truly of and for the community. From the standpoint of sustainability and community need, however, this model presents several challenges. First, the model employed by Houston, while successful in bringing grant dollars into the community, was not based on a strategic assessment of overall community need and resources to ensure that health centers were placed in the areas of greatest need and run by organizations that had the greatest chance of success. Second, small, community-based clinics often have difficulties achieving the scale and level of sophistication needed to be financially sustainable. By applying for FQHC designation so late, Harris County's FQHCs receive Section 330 grants that are limited to $650,000 annually.[22] In contrast, most of the nation's large, established FQHCs receive several millions of dollars in federal grant funds annually, largely because initial funding was designed to underwrite the actual cost of providing uninsured care. In Houston, the challenges faced by new health centers are exacerbated by the extremely difficult payer environment.

At the same time Harris County was developing and nurturing its fledgling FQHCs, the safety net community was also going through a rigorous period of self-examination, which culminated in the issuance of several reports that generated a significant amount of controversy a well as some action. The first of these reports, issued in 2004 by the Lewin Group on behalf of Save Our ERs, recommended a significant restructuring of the current safety net system into a "Coordinated Community Health System" (CCHS). The CCHS included a county-wide coordinated network of primary, specialty and urgent care clinics (including 5 new FQHCs and 9 Look-Alikes, each able to see 50,000 visits annually); significant improvements in IT connectivity and coordination,

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[21] The Integrated Service Development Initiative program is a federal health center-focused grant that funds implementation of joint practice management systems and electronic health records (EHRs) across centers in a single area and health center collaborations to form integrated delivery systems designed to increase health center efficiency and effectiveness. ISDI was the culmination of several earlier efforts by the Bureau to encourage the development of integrated delivery systems, that would allow health centers to successfully participate in managed care as well as integrate administrative, clinical, IT and financial functions.

[22] Health centers can apply for additional funding to support expanded medical capacity. In addition, the majority of New Access Point grants are also awarded to existing health centers.

including a web-based patient referral system, and a consolidated city-county health department.

Later that year, a separate report was issued by the Greater Houston Partnership's Public Health Task Force.[23] This 19-member task force made several recommendations to address issues of fragmentation, inadequate supply of primary care and growing numbers of uninsured. Specifically, it recommended that Houston/Harris County:

- create a comprehensive, integrated public health delivery system with control over and accountability for the full continuum of services currently provided through the existing five public agencies (HCHD, HCPHES, MHMRA[24], Houston DHHS and the Harris County Psychiatric Center);
  develop a community health information network to link the integrated public health delivery system with private providers;
- build capacity in community-based outpatient sites to provide preventive, primary and specialty care; and
- increase the number of insured residents through a variety of public, private, employer-sponsored, and hybrid insurance programs.

Since the issuance of these reports, Houston and Harris County have taken several steps to address the reports' recommendations. As described above, Harris County has significantly expanded its community-based primary care capacity through the creation of several new FQHCs. Efforts to expand coverage are also underway via the newly announced three-share program in Houston. While efforts to create a single public health agency and otherwise reduce fragmentation in the system have fallen short of stated goals, these efforts eventually led to the creation of the Harris County Healthcare Alliance, which was formed to act as "a coordinating vehicle for providers of indigent care to facilitate service efficient delivery and to bring in additional resources to support indigent healthcare costs."[25]

Despite these efforts, recent data continue to show a significant gap between primary care need and primary care provided in the county. Recent reports also describe an overwhelmed trauma/emergency system in Harris County that is due in large part to patients seeking care in the emergency room for primary care or primary care-treatable conditions.[26] Harris County is in a similar position to

[23] Greater Houston Partnership Public Health Task Force Final Report, 2004.
[24] Mental Health Mental Retardation Authority of Harris County
[25] Harris County Healthcare Alliance web site (accessed May 29, 2008 at http://www.hchalliance.org)
[26] *After-Hours Urgent Care Market Assessment for Harris County: A Study of Harris County Emergency Department Use,* prepared for the Harris County Healthcare Alliance by Clarus Healthcare Consulting, July

many urban centers around the country. Barring significant health reform at the federal level, the safety net in Harris County will continue to struggle to keep pace with the needs of the uninsured. Indeed, in many respects, Harris County faces a situation that is even more challenging than that faced by other urban areas, due to the Texas policy environment and the relative youth of the region's health centers. Significant change at the system level is needed to maximize the ability of the safety net to meet current and future demand.

2007. See also *Access to Primary Care and Hospital Emergency Room Use: Evidence from Houston, Texas,* UT School of Public Health, 10/03/07 draft.

Current Safety Net Capacity and Capacity for Growth

Current Supply and Demand

As part of our analysis, HMA developed a dynamic model to estimate the current capacity of the target group health centers, as well as the capacity given various assumptions about health center growth and performance. These findings were compared against recent estimates of unmet demand for primary care visits in Harris County by quadrant[27] to estimate the remaining unmet need under three near-term scenarios:

- *Current state.* The current state estimates are based on actual CY 2007 data reported to us by the health centers, with minor adjustments for data inaccuracies (Table 4).
- *Current state at optimal productivity.* These estimates assume no changes to the current physical plant or provider staffing levels at the health centers (Table 5). Additional capacity is estimated using two widely accepted annual productivity standards for primary care physicians: the current FQHC national median physician productivity (3,676 visits)[28] and 4,200 visits, which is the federal expectation published by the Health Resources and Services Administration. All health centers exceeded the federal productivity expectation for mid-level providers (2,100 visits)[29] and most exceeded the national median (2,810 visits). In the instances where this was not the case, we also estimated the additional capacity created by raising mid-level productivity to this level.
- *Future state.* These estimates build on the optimal productivity estimates and also include expansions currently planned by the health centers that, in the opinion of the authors, can reasonably expect to be implemented within the next 1-2 years. These expansions include the addition or acquisition of additional sites, expanded hours (e.g., evening or weekend hours), or the addition of providers.

[27] Safety Net Primary Care Demand and Supply Analysis (April 2007), Harris County Healthcare Alliance, St. Luke's Episcopal Health Charities, UTSPH.
[28] 2006 Uniform Data Set (UDS) national rollup.
[29] Mid-level providers include nurse practitioners, physician assistants and certified nurse midwives.

Table 4 below details the number of primary care visits provided in 2007 by the Harris County FQHCs, other target group clinics and public providers (HCHD, HCPHES and City of Houston).

Table 4: Harris County Primary Care Safety Net Encounters* (2007)

Health Center	Primary Care Encounters	Specialty Encounters	Total Medical Encounters	Dental Encounters
FQHCs	72,895	2,535	75,430	11,346
Other Target Group	84,843	3,043	87,886	10,808
HCHD Clinics	429,086	41,710	470,796	37,207
City of Houston	78,581	0	78,581	-
HCPHES	33,811	0	33,811	3,066
Total	**699,216**	**47,288**	**746,504**	**62,427**

Sources: 2007 UDS data for FQHCs and comparable data provided by non-FQHC providers. Note: the City of Houston provides dental services but did not provide dental encounters for this report.
* Encounters exclude non-provider visits.

Table 5 illustrates the estimated impact on unmet need if the FQHCs, other target group health centers and HCHD clinics were to operate at two widely accepted standards for provider productivity. Data collected for this analysis indicate that the FQHCs and, to a lesser degree, the HCHD clinics, are currently falling short of the federal expectation of 4,200 visits per physician per year. However, productivity improvements alone will fill only a small portion of the current gap in primary care supply and demand. The data are presented against both the estimated unmet demand by all uninsured in Harris County and the uninsured below 200% FPL. While FQHCs predominantly serve those below 200% FPL, approximately 13% of Harris County FQHC patients have incomes above 200% FPL and another 17% did not report their income.

Table 5: Estimated Excess Capacity Through Productivity Improvements (2007)

	Below 200% FPL	**Total**
Uninsured Unmet Demand*	769,431	1,454,076
Excess Capacity in Current State at National Median for:		
HCHD	33,497	33,497
FQHC	16,355	16,355
Other Safety Net Providers**	8,155	8,155
Remaining Unmet Demand < 200% FPL	**711,424**	**1,396,069**
Excess Capacity in Current State at 4,200 Standard for:		
HCHD	78,625	78,625
FQHC	22,696	22,696
Other Safety Net Providers**	11,905	11,905
Remaining Unmet Demand < 200% FPL	**656,205**	**1,340,850**

*Safety Net Primary Care Demand and Supply Analysis (April 2007), Harris County Healthcare Alliance, St. Luke's Episcopal Health Charities, UTSPH.

**We did not have sufficient data to estimate excess capacity in the city and county clinics, nor do these clinics provide comprehensive primary care.

For the FQHCs, the model also estimates the additional revenue and costs that would be generated by the additional visits (Table 6) based on current reimbursement rates and payer mix. (Additional scenarios were also modeled using the Texas and national average payer mix.) Because the FQHCs are currently operating below capacity, additional costs include only those variable costs that would be incurred as a result of the added volume, primarily lab and pharmaceutical costs. In instances where health center support staffing levels[30] were insufficient to support additional volume, costs also include the estimated costs of adding appropriate staff. Additional revenues are estimated based on each health center's current payer mix, as well as at the state and national median payer mix.

Table 6. Estimated Financial Impact of Productivity Improvements (FQHCs only)

	At National Median	**At 4,200 Visits/Year**
Additional encounters:		
Physician	13,570	19,910
Midlevel	2,786	2,786
Dental	7,624	7,624
Total additional encounters	23,980	30,320
Revenue from additional encounters at:		
Current Payor Mix	$1,178,873	$1,487,720
Texas Payor Mix	$1,732,300	$2,178,185
National Payor Mix	$2,254,320	$2,832,514
Support staff FTE needs (at national median staffing ratios)		
Direct Medical Support	1.70	1.70
Direct Dental Support	3.15	3.15
Patient Support (front office)	3.59	3.59
Total Support staff needs	8.44	8.44
Additional Costs at Capacity	$910,320	$1,097,532
Net revenue at:		
Current Payor Mix	$268,553	$390,189
Texas Statewide Payor Mix	$821,981	$1,080,653
National Payor Mix	$1,344,000	$1,734,982

Almost all health centers in the target group also noted that they are actively discussing expansion of their sites or services. These expansion plans were at varying stages – from mere discussions about potential expansion, to fully-formulated business plans with secured financing that are ready for

[30] Support staffing ratios were evaluated against 2006 UDS median staffing ratios for direct medical support and patient support.

implementation. For purposes of this analysis, we have broken these expansion plans into two categories, those that are currently in the process of implementation (or have been implemented within the last several months and are, therefore, not reflected in the 2007 data collected for this analysis), and expansion plans that we reasonably expected to be implemented within the next 1-2 years. These future expansions (and any other proposed expansions) should be viewed and evaluated in the context of the overall recommendations and visions outlined in this report.

Expansions in the former category include Ibn Sina, which recently expanded hours at its Southwest Houston clinic to 9 p.m. five days/week and Saturday from 9 a.m. to 1 p.m. The health center expects to see an additional 3,000 visits in 2008 due to the expanded hours. In addition, Good Neighbor recently moved into new, more expansive clinical space, and Denver Harbor is transitioning into new space as this report is being written. Denver Harbor's current location will continue to be utilized for health center administration and dental services. Table 7 below details estimated expanded capacity attributable to the Good Neighbor and Denver Harbor expansions.

Table 7: Current Expansions

Good Neighbor

Additional Capacity Maximizing New Space			
Add'l Primary Care Medical Encounters at National Median		Add'l Midlevel Capacity	Add'l Dental Encounters at National Median
National Median	At 4,200	Based current productivity	National Median
12,181	**14,801**	**5,284**	**4,548**

Denver Harbor

Additional Capacity Maximizing New Space			
Add'l Primary Care Medical Encounters at National Median		Add'l Midlevel Capacity	Add'l Dental Encounters at National Median
National Median	At 4,200		National Median
11,107	**13,832**		**3,283**

In addition to the above expansions, several providers have plans to expand their sites or services within the next several years. These include a significant

reconfiguration of clinical space at South Central's main location, which is expected to add as many as 3 to 4 dental operatories and an additional 6 to 8 exam rooms for medical and behavioral health services. Future growth plans also include a new Planned Parenthood flagship facility, which is expected to open in late 2009 and will have the capacity to provide approximately 28,000 visits, as well as two additional Planned Parenthood satellites, which will have the capacity to see approximately 5,500 visits each.

Potential to "Transfer" Services from HCPHES/HDHS to Other Providers

HMA was also asked to estimate the volume of primary care visits that could realistically be transferred from either the City of Houston Department of Health and Human Services clinics or the Harris County Public Health and Environmental Services clinics to another provider. These services primarily include family planning and maternal and child health services funded through Title X of the Public Health Service Act, and Titles V (Maternal and Child Health Grant), and XX (Social Services Block Grant) of the Social Security Act, as well as prenatal services provided through Medicaid and the SCHIP Perinatal program. FQHCs and other health centers are eligible providers (either directly or via subcontract with a primary contractor) under all of these programs. Only one of the target group health centers is currently providing Title XX services, while several are providing some Title V services.

Title V. As a result of the Omnibus Budget Reconciliation Act of 1981, the Maternal and Child Health Block Grant was added as Title V of the Social Security Act. In Texas, approximately 70 state and local health entities provide preventive health care services to women and children. Those eligible for Title V services are female Harris County residents whose income is at or below 185 percent FPIG and who are not eligible for Medicaid.

Title X. Title X of the Public Health Services Act is the only federal legislation that relates solely to family planning, including medical, educational, and social services training and research. Title X funding can be used to support payment for clinic facilities, staff salaries, utilities, medical and office supplies, equipment, and travel, as well as for direct medical services. The Texas Department of State Health Services contracts with health care agencies across the state that provide comprehensive family planning services.

Title XX. Title XX of the Social Security Act contains the Social Services Block Grant. The Texas Department of State Health Services annually allocates these limited dollars to contractor agencies across Texas. Benefits

are those family planning services (including pregnancy testing, birth control, gynecological exams and miscellaneous gynecological procedures) delivered by contractor agencies.

As noted above, the Houston Department of Health and Human Services has begun to transfer much of its prenatal care to other providers, including HCHD and private FQHCs, while focusing on its core public health mission. The city has engaged in co-location agreements with several FQHCs and the HCHD and has also provided training to these providers on Title V administration. In the clinics where co-location has occurred, the city has seen its volume of Title V and Title XIX (which includes SCHIP Perinatal) drop significantly.

The Harris County Department of Public Health and Environmental Services continues to provide substantial amounts of prenatal services (12,700 visits in 2007), in addition to child health and family planning services and dental. However, they have also seen patient base drop by 5.1% over the last two years (from 9,541 unduplicated users in 2005, to 9,057 unduplicated users in 2007), which may be attributable in part to the creation of the SCHIP perinatal program.

Should the city and county choose to completely eliminate their provision of prenatal care, there is currently not enough capacity within the FQHCs or other target group clinics to absorb all of it, though over time it could reasonably be absorbed. It is important to note, however, that as long as the SCHIP perinatal program reimburses at rates that fall well below cost, the financial incentive for FQHCs to absorb this population is indirect. They will lose money on the prenatal care, but will have the opportunity to care for Medicaid-covered newborns. It is also important to note that, while the city-health center co-location strategy does appear to have resulted in some reduction in service duplication, it has also encountered some logistical and other problems that must be addressed if the strategy is to be expanded. Health centers with co-located clinics reported problems with inconvenient and inflexible building hours that prevented them from offering services on evenings and weekends. They also reported concerns related to the "stigma" of receiving services at a city clinic building and instances of patient confusion related to multiple entities providing similar services in the same building.

Harris County Safety Net – Challenges and Opportunities

Challenges

The above analysis of primary care supply and demand brings to light several important challenges facing primary care safety net providers in Harris County.

The Texas policy/payer environment makes the FQHC business model extremely difficult. While FQHCs receive cost-based reimbursement from Medicare and Medicaid, Texas' current Medicaid coverage levels, combined with large numbers of undocumented immigrants and other non-citizens, make the FQHC business model extremely difficult to sustain. Nationally, FQHCs see a payer mix that is approximately 36% Medicaid and 40% uninsured. In Texas, FQHCs see a payer mix that is approximately 24% Medicaid and 59% uninsured. These payer mix issues are compounded in Harris County due to the relative youth and small scale of the FQHCs (see discussion below). On average, approximately 16% of the patients seen in Harris County's FQHCs have Medicaid coverage, while 72% are uninsured.

Several recent policy changes have improved the payer environment in Texas. Most notably the Women's Health Waiver Program and the SCHIP Perinatal Program have created an opportunity for FQHCs and other safety net primary care providers to attract patients with a payer source. However, as noted earlier, the SCHIP Perinatal Program does not pay FQHC cost based PPS rates and currently reimburses providers at less than cost. The Women's Health Program reimburses FQHCs at their PPS rate for up to three visits annually.[31] Targeted, strategic philanthropic support will be needed on a long-term basis to build a sustainable model. Finally, unlike other counties and municipalities, neither Houston nor Harris County provides direct taxpayer support to safety net providers outside of the public system. In contrast, communities such as Kansas City, Missouri, Cincinnati, Ohio and Montgomery, Alabama provide significant tax levy support to public and private providers that comprise their local safety nets.

Small, developing FQHCs need help reaching national benchmarks and strong incentives to encourage performance, improved quality and growth to scale. Relative to their peers around the nation, Harris County's FQHCs are extremely young and small and, as a result, most are struggling to reach national performance standards. Table 8 shows the Harris County FQHC productivity compared to Texas and the nation. (See Appendix A for a more detailed table, by individual health center.) Productivity measures for the other target group health centers and the HCHD

[31] Texas Association of Community Health Centers, "Texas Update," October 2007.

clinics are also shown. As a group, the FQHCs fall below the 25th percentile for physician productivity, while the HCHD clinics are close to the 50th percentile, though still well below the federal expectation of 4,200 visits per provider per year. The other target group clinics are quite productive, exceeding the national 75th percentile. Within the FQHCs, physician productivity ranged from 1,742 to 4,679; however, only one FQHC exceeded the federal expectation of 4,200 visits.

Table 8: Annual Harris County Provider Productivity (2007) versus National Benchmarks

							National Percentiles (2006)		
	FQHCs	Other Target Group	HCHD Clinics	Texas Mean	National Mean	HRSA Expectation	25th	Median	75th
Physician Productivity	3,009	4,289	3,528	4,114	3,846	4,200	3,080	3,676	4,261
Mid-level Productivity	3,358	3,786	4,251	3,045	2,879	2,100	2,262	2,810	3,358
Dentist Productivity	1,398	1,847	3,251	2,651	2,702	NA	1,996	2,525	3,089

Sources: 2007 UDS data for FQHCs and comparable 2007 data provided by non-FQHC health centers; Figures adjusted to exclude health centers that were considered non-comparable for purposes of productivity analysis. Texas and National comparison data are from the 2006 UDS.

The vast majority of providers are currently meeting or exceeding national expectations for mid-level productivity. While dental was not a specific focus of this report, it is important to note that dental productivity in the FQHCs and other target group health centers is well below the 25th percentile. Specific strategies for improving dental productivity were addressed in many of the individual health center feedback reports. Almost without exception, provider productivity must become a priority issue for the health centers in order to reduce costs, improve patient through-put time and improve overall financial performance. However, as the above analysis indicates, productivity improvements alone will not be enough to meet the tremendous unmet demand for primary care in Harris County.

As noted above, Harris County's FQHCs face an extremely challenging payer mix. However, it is clear from both the data and information gathered through site visits that the health centers have had widely varying levels of success in enrolling eligible patients in coverage. To a large degree, payer mix is directly correlated with the eligibility policies and procedures employed by each health center as well as the priority placed on eligibility by the health center board and leadership. Indeed, while the mean FQHC payer mix among the FQHCs is 16% Medicaid, actual figures ranged from less than 2% to nearly 30% within the individual health centers.

FQHCs may need help reaching national clinical quality benchmarks. The federal agency (the Health Resources and Services Administration, or "HRSA") that houses the Bureau of Primary Health Care (BPHC) has adopted a set of 12 nationally-standardized clinical core measures as the basis for an Agency-wide quality improvement initiative for grantee delivery sites that provide clinical care and/or provide referrals for clinical care. These measures encompass six key areas that cut across multiple bureaus, programs, and health service delivery grantees: HIV, pre-natal and perinatal care, immunizations, cancer, cardiovascular hypertension, and diabetes.

BPHC selected a subset of four new clinical measures from these HRSA core measures. The four new health center measures are: 1) appropriate childhood immunizations; 2) cervical cancer screening; 3) blood pressure control; and 4) diabetes control. They include both process and outcome measures: childhood immunization and cervical cancer screening as process measures, and blood pressure and diabetes control as outcome measures. Through the annual UDS, health centers will be asked to report on their overall patient populations for the process measures as well as on the racial and ethnic subgroups within that population for the outcome measures. These new measures augment clinical quality measure reporting already underway in health centers including entry into prenatal care, and birth weight. A sample of reported indicators is below for FQHCs only (non-FQHCs are not required to report on these indicators):

Table 9: Sample Clinical Indicators: 2007 Harris County

	Harris County 2007 UDS	Texas (2006)	National Mean (2006)	National Percentiles (2006)		
				25th	Median	75th
Screening and Prevention						
Percent of patients tested for HIV	**6.11%**	3.34%	3.02%	0.00%	0.67%	3.71%
Mammograms per female patient aged 45+	**NA**	8.60%	10.60%	0.00%	0.03%	10.06%
Pap smears per female patient aged 15+	**18.39%**	22.22%	22.12%	11.04%	17.30%	25.88%
Family planning per female patient 15-44 yrs	**10.39%**	21.44%	20.00%	6.46%	12.55%	21.10%
Perinatal Care						
Percent prenatal teen patients (<20 yrs)	**20.54%**	18.69%	18.59%	14.29%	18.69%	23.65%
Percent newborns below normal birth weight	**10.44%**	6.16%	7.69%	3.62%	6.26%	10.10%
Percent late entry prenatal care (after 12 wks)	**46.53%**	49.78%	35.84%	20.02%	31.58%	41.29%

Source: 2007 Uniform Data Set (UDS)

The current Harris County quality indicator reporting suggests that health centers may need assistance in developing and implementing clinical protocols to meet the clinical quality expectations.

Primary care safety net providers are facing significant physician shortages, exacerbated by ongoing contract problems, the new Baylor hospital, and limited and difficult access to

specialty care. Frequent provider turnover and difficulty recruiting provider staff was frequently cited as one of the largest barriers to improving productivity in the health centers. Many health centers identified lengthy periods of time during which they were without a medical director or other key provider. Many also spoke of extreme difficulty recruiting providers. Issues cited included competition with the medical center, reluctance among providers to work in small clinics where they have few if any professional peers with whom to consult (and share call), language issues and the difficult work environment in the health centers. In addition, the very limited access to specialty care was also cited as a challenge in recruiting and retaining primary care providers (exacerbated in small practice settings).

Despite recent improvements, access to specialty care remains a significant problem for Harris County uninsured. Access to specialty care for the uninsured in Harris County is a tremendous challenge, as it is almost everywhere across the country. The impact of a lack of specialty care access ripples through the primary care safety net and affects both patients who need specialty care and the providers who struggle daily to get it for them. The target group health centers in this study reported accessing specialty care through a patchwork approach that included the hospital district, networks of specialty providers pieced together by the individual health centers, and the specialty services offered by the San Jose Clinic.

In recent years, Harris County has undertaken several efforts to address this issue. Gateway to Care, supported initially through CAP funds and subsequently through local philanthropic funds, established a voluntary provider network modeled on the "Project Access" program.[32] The Gateway to Care Provider Health Network program has 31 hospitals and 445 physicians enrolled. Approximately two-thirds of these physicians are specialists and the rest are primary care providers. Since the program began accepting referrals in November 2005, it has referred 1,015 patients to network providers. An additional 4,440 patients were determined to be ineligible for Gateway Network services (due to income, Gold Card eligibility, or other reasons), but received services from the Gateway Network's Navigator program to help them access services for which they are eligible.

Earlier this year, the Harris County Hospital District (HCHD) completed negotiations with the FQHCs to allow the health centers to directly access

[32] Project Access originated in Ashville, North Carolina in the mid-1990s and has since been replicated in more than 50 communities around the country. The model recruits physicians and other providers to commit to provide a set number of uninsured visits (or see a set number of uninsured patients). Referral coordinators screen referral requests and manage the referral process.

HCHD's specialty referral center, rather than sending patients through HCHD's primary care system to access specialty care. As of the writing of this report, all FQHCs in the county with one exception have signed a Memorandum of Understanding with the Hospital District agreeing to certain terms in exchange for direct access. Referrals are reviewed by HCHD against a set of clinical criteria to ensure that the visit is necessary and that pre-requisite tests have been completed prior to the visit. This should result in a reduction in the number of "wasted" specialty visits; it should also result in a much-improved process for patients seeking access to HCHD specialists. However, it is not expected to significantly impact the overall need for specialty care in the community.

Harris County Safety Net – Long-term Vision

To address the challenges discussed above and create an environment to support a meaningful expansion in primary care capacity, HMA recommends a long-term vision for the provision of primary (and limited specialty) care in the county. Implementing this long-term vision will require restructuring the existing primary care safety net in order to achieve significant efficiencies and economies of scale and overall improvements in quality of care, operations, and customer service. The following sections outline the components of the long-term vision. Each of the recommendations at the end of this report are designed to move the primary care safety net toward the implementation of this vision, while simultaneously improving the performance of individual health centers and the climate in which they operate.

Model Structure for Harris County Primary Care Safety Net

The model structure envisions four to five FQHC entities, in rational geographic service areas, with multiple health center locations, to serve the community. Because of federal guidance governing how FQHC service areas are defined, the actual service areas of the FQHCs may not precisely (or even closely) align with Harris County's quadrants, but for purposes of analysis and description, we reference the quadrant model because this has historically been the geographic structure used to measure unmet demand for services in the county. The model assumes the following:

- Each health center location is large enough (e.g., no less than 8 FTE providers per site) to achieve meaningful economies of scale, attract and retain physician and other provider staff, and support the full array of wrap-around services that FQHCs are required to provide, though variations on this model may be considered, as financially feasible and appropriate to the needs of the community.

- Additional "niche" providers may continue to serve their communities and provide the population-specific, culturally appropriate services they are best able to provide (e.g., Healthcare for the Homeless, Planned Parenthood, Hope, San Jose, Ibn Sina).
- Each service area includes a "specialty center" under the umbrella of the FQHC entity, to allow for cost-based reimbursement. According to recent statements made by HRSA officials, other FQHCs (including "niche" FQHCs) may be able to refer into the specialty center as well. The presence of the specialty center will also "free up" some access to HCHD specialty care for non-FQHC health centers, thereby increasing overall capacity for specialty care in the community (see Recommendations section below).

Figure 3 below depicts the model structure when fully phased in.

Figure 3: Harris County FQHC System Model Structure

NW 4 Health Centers Specialty Center	**NE** 5 Health Centers Specialty Center
SW 4 Health Centers Specialty Center	**SE** 3 Health Centers Specialty Center

(Note: For purposes of calculating demand we have relied on a quadrant diagram but do not necessarily expect FQHC rational service areas to follow quadrant boundaries.)

Within each FQHC rational service area, the model organizational structure for the core health centers would *ideally* have several components, though variations on the model structure are assumed and discussed below:

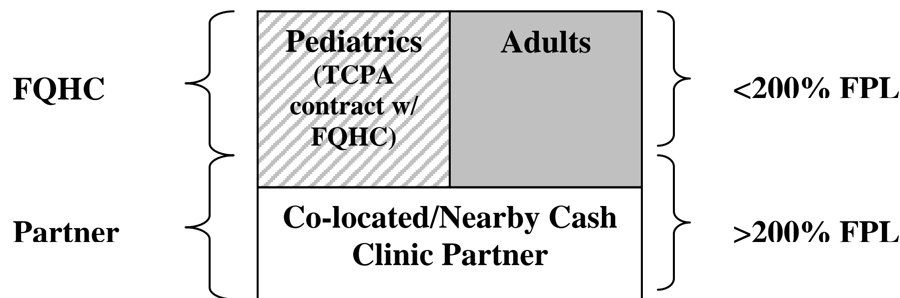
- As they do now, each FQHC would serve *primarily* individuals below 200% FPL and would give patients above 200% FPL the option of getting care on a cash basis from a co-located or nearby clinic operated by a hospital partner or staffed by hospital-affiliated private practice physicians. This model recognizes that FQHCs alone will not be able to meet the entire demand from the uninsured. The establishment of formal relationships with hospital or other partners for this population also creates a more affordable option for uninsured individuals above 200% FPL (see Recommendations section below for detailed discussion).[33]

[33] FQHCs are required to charge patients above 200% FPL full charges for services rendered. As a result, patients above 200% FPL frequently face charges near or well above $100 routine care at an FQHC.

- Within the FQHC entity, pediatrics would ideally be provided through formal partnership arrangements with Texas Children's Pediatric Associates (see Recommendations section below for detailed discussion). This partnership arrangement could take several forms. For example, the FQHC could contract with TCPA physicians to provide pediatricians within the FQHC. Alternatively, a TCPA clinic could become a pediatric satellite site of an FQHC, operating under the management and governance of the FQHC.

Figure 4 below illustrates the model organizational structure of each health center. The actual configuration of individual health centers may vary, depending on individual arrangements with TCPA, hospital partners and other partner organizations.

Figure 4: Model Organizational Structure



Financial Model

HMA developed a model to provide a high-level estimate of the cost and impact (measured as a percent of uninsured primary care visit need met) of the model structure under two scenarios. The full model is designed to illustrate the maximum scale we believe can be achieved given the starting point and the current policy environment in Harris County. The scaled-back model is designed to effectively hold philanthropic and other non-federal grants at close-to-current levels to illustrate the impact of better-targeting these investments. The scaled-back model may also be viewed as an interim step toward implementation of the full model. Both versions of the model assume the following:

- Existing capacity, including capacity gained from achieving productivity standards and from recently implemented expansions, is rolled into the model structure (i.e., the model is not additive of current or near-term planned capacity).
- Health centers are meeting the federal productivity expectation of 4,200 visits per full-time physician per year.

- The payer mix is set at slightly better than the average Texas payer mix for FQHCs. This is an aggressive assumption and one that depends heavily on establishing strong partnerships/contractual arrangements with Texas Children's Pediatric Associates, as well as significant improvements in health center eligibility processes, outreach and customer service. The full model estimates approximately 200,000 Medicaid *visits* in the FQHCs, while the scaled back model estimates approximately 81,000 Medicaid *visits*. Both of these estimates appear reasonable in the context of total Medicaid enrollment in the county, which stands at approximately 475,000 individuals.[34] The likelihood of achieving this payer mix is also enhanced if Harris County is able to persuade the state to implement a local or regional Medicaid coverage expansion for adults. Each of these issues is discussed in detail in the recommendations section below.
- The fully loaded cost per medical visit is estimated at approximately the national median of $134.[35] This is significantly lower than the current Harris County FQHC average cost per visit of approximately $156 and assumes that the health centers are able to achieve significant economies of scale and improvement in productivity.
- Medicaid and Medicare payment per visit are estimated at $165 and $115, respectively, which is roughly the average of the 2007 rates the health centers received, adjusted for inflation.
- The current level of Section 330 grant funding flowing to the health centers continues at current levels in the scaled back model (approximately $6 million). The model assumes that no grant dollars are lost as a result of consolidation. The full model assumes an additional $3 million in federal expanded medical capacity (EMC) or new access point (NAP) grant dollars flow to the county, which is a reasonable expectation given the scale of growth contemplated by the model, assuming a continuation of EMC and NAP opportunities.
- Capital costs are not included in the calculations. The model assumes capital required to build and equip health centers would be provided through a combination of federal Community Development Block Grant funds, capital campaigns organized by the health centers or a third party, and financing. Dental services are also excluded from the model. Significant growth in

[34] Texas Health and Human Services Commission, Texas Medicaid Enrollment Statistics, Medicaid Enrollment by County (November 2007).
[35] 2006 UDS, adjusted for inflation based on the Texas growth rate in costs/medical visit. Allowance added for enabling services, pharmaceuticals and lab/x-ray.

dental services would require additional outside resources, which would likely be disproportionately larger than those required for medical services because dental services are costly and typically have a less favorable payer mix, unless the dental strategy is heavily focused on pediatrics.

The following table outlines the model input under two scenarios, full implementation and a scaled back model.

Table 10: Model Input

Input	**Full Model**	**Scaled Back Model**
Unmet Demand (<200% FPL) after productivity improvements (see Table 5)	656,205	656,205
Additional Capacity from current/near term expansions (see Table 7)	36,917	36,917
Remaining unmet demand (<200% FPL)	*619,288*	*619,288*
Staffing and Productivity		
Physician providers/site	10	8
Productivity (visits/year)	4,200	4,200
Number of sites		
NW Quadrant	4	2
NE Quadrant	5	2
SW Quadrant	4	2
SE Quadrant	3	2
Payer Mix (Net Revenue per Encounter)		
Medicaid ($165)	30%	30%
SCHIP ($50)	5%	5%
Medicare ($115)	7%	7%
Private/Other ($100)	5%	5%
Self-Pay ($25)	53%	53%
Section 330 Grant Revenue	$9,000,000	$6,000,000
Cost/Visit		
Total cost/medical encounter	$134	$134

The following table summarizes the model output at full implementation. The output indicates that the FQHCs, under the model structure, can make significant inroads toward meeting the unmet demand for primary care for the uninsured, covering approximately 49% of the current gap in uninsured primary care visits for patients below 200% FPL. Contrary to the findings in earlier studies, however, our model does not predict that the FQHCs can become self-sufficient without severely limiting the number of uninsured patients they see, which is inconsistent with federal regulations governing FQHCs and is inconsistent with the policy goal of improving access to care for the uninsured.

At full capacity (see Table 11) the model still requires substantial and ongoing outside financial support to counteract the effects of the large numbers of uninsured. The estimated level of annual support needed is roughly three times the current level. The value provided by these dollars (as measured by philanthropic dollars per uninsured medical visit provided), however, is much greater than under the current philanthropic model ($165 per visit currently versus $79 per visit new model) because the dollars are targeted toward efficient health centers that are aggressively maximizing other revenue sources. Under both models, patient services revenues comprise approximately 58% of total revenue, which would place Harris County FQHCs between the 50th and 75th percentile nationally on this metric.

Outside revenue (including philanthropic dollars and other non-federal grants) make up between 25% (scaled back model) and 31% (full model) of total revenues, which is well below the current level in Harris County (39%, adjusted to exclude outliers) but still above the national mean of 21%.

Table 11: Model Results – Full Capacity

	NW Quadrant	NE Quadrant	SW Quadrant	SE Quadrant	Total Harris County
Encounters					
Medicaid	50,400	63,000	50,400	37,800	201,600
SCHIP	8,400	10,500	8,400	6,300	33,600
Medicare	11,760	14,700	11,760	8,820	47,040
Private/Other	8,400	10,500	8,400	6,300	33,600
Self-Pay	89,040	111,300	89,040	66,780	356,160
Total Encounters	**168,000**	**210,000**	**168,000**	**126,000**	**672,000**
Total Revenue ($ millions)	**$15.4**	**$18.7**	**$15.4**	**$12.1**	**$61.6**
Total Costs ($ millions)	**$22.5**	**$28.1**	**$22.5**	**$16.8**	**$89.9**
Net Income Before Philanthropic/Other Grants ($ millions)	**($7.1)**	**($9.4)**	**($7.1)**	**($4.7)**	**($28.3)**
Add Philanthropic/Other Grants ($ millions)	**$7.1**	**$9.4**	**$7.1**	**$4.7**	**$28.3**
Net Income After Philanthropic/Other Grants ($ millions)	**$0**	**$0**	**$0**	**$0**	**$0**

The scaled back model (see Table 12 below) effectively holds annual philanthropic and other non-federal contributions near their current level to illustrate the impact of targeting these investments. This model provides more than 2.5 times the current number of uninsured primary care visits but meets only 15% of the total unmet need. However, as with the full model, the value of each philanthropic dollar is much greater than under the current state ($165 per uninsured visit versus $63 per visit new model).[36]

Table 12: Model Results – Scaled Back Model

	NW Quadrant	NE Quadrant	SW Quadrant	SE Quadrant	Total Harris County
Encounters					
Medicaid	20,160	20,160	20,160	20,160	80,640
SCHIP	3,360	3,360	3,360	3,360	13,440
Medicare	4,704	4,704	4,704	4,704	18,816
Private/Other	3,360	3,360	3,360	3,360	13,440
Self-Pay	35,616	35,616	35,616	35,616	142,464
Total Encounters	**67,200**	**67,200**	**67,200**	**67,200**	**268,800**
Total Revenue ($ millions)	**$6.8**	**$6.8**	**$6.8**	**$6.8**	**$27.0**
Total Costs ($ millions)	**$9.0**	**$9.0**	**$9.0**	**$9.0**	**$36.0**
Net Income Before Philanthropic/Other Grants ($ millions)	**($2.2)**	**($2.2)**	**($2.2)**	**($2.2)**	**($8.9)**
Add Philanthropic/Other Grants ($ millions)	**$2.2**	**$2.2**	**$2.2**	**$2.2**	**$8.9**
Net Income After Philanthropic/Other Grants ($ millions)	**$0**	**$0**	**$0**	**$0**	**$0**

It is important not to underestimate the magnitude of the changes required at both the individual organization and system level to achieve the outcomes suggested by the models above. They will require a coordinated, well-planned effort that is supported by not only the health centers, but also the philanthropic community, business community, other providers, and key political officials at the local, state and national levels.

[36] Because other payers, including Medicare and SCHIP pay below full cost, outside grant dollars effectively subsidize these payers. As overall volume grows, more grant dollars must be "diverted" to subsidize these payers as well as the uninsured.

Recommendations

The recommendations in this report are intended to strengthen and build capacity in Harris County's primary care safety net in the near term while moving toward the long-term vision outlined above. The recommendations are also intended to build the organizational capacity of individual providers while also strengthening the fabric of the primary care safety net system as a whole. Therefore, this section is structured around identifying short, mid and long term goals for strengthening the safety net system and building organizational capacity.

Strengthening the Safety Net System

Short-term Recommendations

The philanthropic community must recognize the need for long-term support of Harris County's primary care safety net and make targeted, long-term investments that incentivize providers to merge while improving performance and quality of care. The philanthropic community in Harris County was instrumental in the creation of the FQHCs that currently serve the county, and it continues to provide generous support to the FQHCs and other primary care safety net providers. Indeed, Houston's FQHCs rely on philanthropic and other non-federal grant dollars for, on average, approximately 39% of their operating funds, compared to approximately 21% nationally and 27% across the state of Texas. In 2007, non-federal grants/contributions provided approximately $8.6 million in funding for FQHCs in Harris County;[37] these FQHCs provided approximately 52,000 uninsured primary care visits resulting in an average contribution per visit of $165.[38]

The findings in this report indicate the need for a substantial and long-term commitment from the philanthropic community in order to assure the long-term viability of the primary care safety net. However, working collaboratively, the philanthropic community has the opportunity to be a driving force in ensuring both the growth and stability of the safety net by carefully targeting its dollars. Specifically, HMA recommends that the philanthropic community work together to create funding opportunities that encourage FQHCs to merge in order to:

- create economies of scale;
- consolidate administrative functions and technology;
- improve financial performance;

[37] 2007 UDS reports; includes all non-federal grants, not only local philanthropic dollars.
[38] Primary care visits only; excludes specialty and dental visits.

- monitor clinical measures reported to the BPHC on annual UDS to achieve established benchmarks;
- consolidate physical facilities where it makes sense to do so
- maximize revenue sources; and
- improve horizontal and vertical integration.

If the philanthropic community agrees to the model structure outlined in this report, a specific funding opportunity should be created that would pilot the model in at least one quadrant of the county and would ideally include the following components:

- a specific size requirement (expressed either in terms of provider FTEs, patients or visits) such that providers would be strongly incentivized to seek out merger opportunities. The opportunity could also award incentive points to organizations that come together to submit a strong joint proposal;
- a requirement that the applicant enter into formal partnership arrangements with TCPA or another pediatric practice to ensure they will be able to generate sufficient pediatric volumes to maintain a strong payer mix. This could be achieved through a variety of different models, including contracting with TCPA to provide physicians on-site at the FQHC, or taking over a TCPA facility as a pediatric satellite facility under the management and governance of the FQHC;
- a preference that the applicant have a formal arrangement with a hospital partner or another provider, such as private practice physicians, for the care of higher income (>200% FPL) uninsured adults on a cash basis at the patient's option; and
- a requirement that the applicant achieve minimum productivity, clinical and financial benchmarks with a further requirement that the grantee meet more aggressive benchmarks over the course of the grant period.[39]

The data analysis and site visits conducted for this project revealed several potential merger scenarios based on criteria including geography, complementary strengths of the individual health centers, and discussions already underway within the health centers and among potential partner organizations. It is important to note that merging two or more health centers is a complex process at all levels. Organizational policies, procedures and cultures

[39] In addition to the clinical quality indicators discussed in this report, the Bureau of Primary Health Care has announced it will begin monitoring several existing and new financial indicators: total cost per total patient, medical cost per medical encounter, change in net assets to expense ratio, working capital to monthly expense ratio, long term debt to equity ratio.

must be aligned; a single governance structure must be created; and federal approval must be attained. These issues are discussed in more detail in the "Next Steps" section below.

The management and oversight of the strategic long-term vision should be housed within the Harris County Healthcare Alliance and led by an independent project manager. The project manager should also be the point person for monitoring the results of the coordinated long-term vision. The project manager function should be filled by an individual who understands the policy environment at the local, state and national level, can maneuver within the parameters of the Harris County-wide vision, but also understands FQHC governance, operations and finance. The project manager should have experience working with and an understanding of complex federal regulations. The project manager function should also be filled by someone who can build trust among the health centers and help health centers work through the process of merging operations and cultures. HMA believes the Harris County Healthcare Alliance is the organization that is best suited to house the project manager function for this effort. The Alliance currently fills a complementary role of serving as a catalyst for change within the safety net and has the existing infrastructure and relationships to coordinate this complex undertaking and carry out the strategic vision.

Philanthropic funding decisions should be consistent with and move the primary care safety net toward achieving the long-term vision. In addition to the coordinated philanthropic effort described above, all other health center-related funding decisions made by the local philanthropic community should be consistent with and further the implementation of the agreed-upon vision. In other words, while this report certainly envisions that the funders will continue to make a variety of grants, both large and small, to health centers and other entities critical to the safety net, each of these funding decisions should help further the implementation of the shared long-term vision.

The community must develop and nurture strategic partnerships between Texas Children's Pediatric Associates and FQHCs. In the absence of a significant Medicaid coverage expansion, primary care safety net providers must attract more children with Medicaid coverage in order to maintain a sustainable payer mix. At the same time, many pediatric providers struggle with the complexity of treating pediatric patients who have wide-ranging social needs and could benefit from the array of wrap-around services offered by FQHCs. And, unlike FQHCs, private pediatric providers do not receive enhanced Medicaid reimbursement that is intended to cover the costs of such services.

One of the core components of the long-term vision outlined in this report is a strategic partnership between Texas Children's Pediatric Associates (TCPA) and one or more FQHCs. In 2007, the TCPA Project Medical Home health centers saw approximately 22,000 Medicaid visits. If these visits were brought under the umbrella of the FQHCs (assuming no other changes), the average Harris County FQHC payer mix would improve from 16% Medicaid to more than 30% Medicaid. This recommendation echoes an earlier report commissioned by the Alliance, which found that children had the highest proportion of emergency room visits for non-emergent and primary care treatable conditions and recommended that FQHCs provide walk-in urgent care services specifically targeted to children.[40]

Based on preliminary discussions with TCPA and other stakeholders, HMA understands there is a mutual interest in pursuing a formal relationship between TCPA and one or more FQHCs. These partnerships could be structured to meet the individual needs of the health center and TCPA. For example, the arrangement could be structured so that TCPA physicians provide services at one or more FQHC sites. Alternatively, a new or existing TCPA location could become a pediatric satellite site of an FQHC. Under either scenario, the patients reap the benefits of receiving excellent care provided by TCPA providers, the FQHC reaps the benefits of the TCPA "gold standard," and both partners see the financial benefit of the FQHC's cost-based reimbursement.

The FQHCs should also develop relationships with the school-based health centers (SBHCs) operated by HCHD and Memorial Hermann to ensure that those patients are linked to a full-service, year-round primary care home. Developing these linkages between the SBHCs and FQHCs will also maximize the revenue coming into the community for these patients. This strategy could take several forms, ranging from formal/informal referral relationships to a sub-contract relationship with one or more FQHCs to operate the SBHCs.

The community should nurture development of partnership arrangements between the FQHCs and hospital partners or hospital-affiliated private physicians to operate cash clinics targeted toward higher income uninsured. FQHCs are required to charge full charges to uninsured patients with incomes above 200% FPL, making them often a more expensive option for this population, in many cases, than other settings. At the same time, FQHCs are required by law to serve all patients, regardless of ability to pay. The model structure outlined in this report incorporates a hospital

[40] *After-Hours Urgent Care Market Assessment for Harris County: A Study of Harris County Emergency Department Use,* prepared for the Harris County Healthcare Alliance by Clarus Healthcare Consulting, July 2007

partner – ideally co-located with each health center site – that would offer a low-cost alternative for these patients. At least one hospital system in Harris County is already operating several cash clinics, and is open to exploring extension of this model. Additional hospital systems should be approached as well. While the ideal structure would be a hospital cash clinic that is co-located with each health center site, alternatives to this model should also be considered, including partnerships with hospital-affiliated private practice physicians or physician groups that may be currently operating clinics that are serving this population. They could be co-located in or near the existing FQHC sites.

FQHCs should create regional specialty care centers to serve Harris County. While the FQHC program has traditionally focused on primary care, a handful of health centers have successfully integrated limited specialty care into their health centers. A prototype of this model was established in 1988 by the Shasta Community Health Center (SCHC) in Redding, California and continues to thrive after twenty years of operation. The model features paid specialty physician services delivered through a community clinic already serving the target population. The clinic leverages FQHC reimbursement for MediCal and Medicare beneficiaries who require specialty care, and maintains a sliding fee scale for payment from those who are uninsured. In 2006, 30 specialists saw patients in the following specialties: cardiology, endocrinology, ENT, gastroenterology, neurology, neurosurgery, orthodontia, orthopedics, pediatric subspecialties, podiatry, rheumatology and urology.

Interest has been growing among other health centers to replicate this model and in 2007 the federal government issued a draft Policy Information Notice (PIN) providing formal guidance on the inclusion of limited specialty care within an FQHC's approved scope of services.[41] The long-term vision outlined for Harris County includes a specialty center to serve each region of the county. Each center would be physically housed by one FQHC, though other FQHCs could refer to it (including niche FQHCs), with federal approval. Current guidance indicates that the federal government is unlikely at this point to allow referrals from non-FQHCs to the specialty center. In the interim, the specialty centers should relieve some of the pressure on HCHD specialists and specialists practicing at other safety net clinics, including San Jose and Ibn Sina, freeing up those specialists to see non- FQHC patients (see recommendation below).

HCHD should open up its specialty care Memorandum of Understanding (MOU) to non-FQHC health centers that agree to comply with HCHD's criteria and processes. According to HCHD officials, all FQHCs in Harris County (with one exception)

[41] Draft PIN 2007-xx, Specialty Services and Health Centers' Scope of Project.

have signed the new specialty care MOU, which allows the FQHCs to refer directly to the Hospital District's specialty referral center. Patients referred by the FQHCs must have a HCHD Gold Card and do not receive expedited Gold Card processing (see next recommendation, below). Health Centers must also ensure that patients have met all clinical pre-requisites for the specialty visit; labs and diagnostics must be provided outside of the HCHD system.[42]

HMA recommends that HCHD offer the specialty care MOU to non-FQHC health centers, including Look-alikes and other primary care safety net providers that agree to comply with HCHD's criteria and processes, as well as to Harris County patients of non-Harris County FQHCs (e.g., Fort Bend). Many of these patients are likely accessing HCHD specialty care now, either through the emergency department (ED) or through a duplicative visit to an HCHD primary care provider. Allowing these patients to access HCHD specialty services through an MOU with their primary care provider would enhance access for these patients while also maximizing the utility of each HCHD specialty visit.

Harris County's public health agencies should accelerate development and implementation of the Quad-Agency eligibility system and authorize FQHCs and other community-based providers to qualify individuals for appropriate programs, including the HCHD Gold Card. For several years, representatives from the "Quad Agencies" (HCHD, HCPHES, Houston DHS and MHMRA) have been working on the implementation of an eligibility system ("Medicaider") that would enable the agencies to share eligibility information and qualify patients for 41 benefit programs, including the HCHD Gold Card, Medicaid, SCHIP, Titles V, X and XX and a variety of other programs. The system streamlines benefit applications and aligns criteria and processes but does not require the city and county to collect the additional information required for Gold Card eligibility unless it is determined that the individual has a need for HCHD services. The agencies are putting in place an audit/oversight process to monitor the quality of eligibility determinations and for training purposes.

This system is expected to "go live" in January 2009 and is an important advancement for both the public agencies and for patients, who should notice a significant reduction in their paperwork and documentation burden when they seek services from public providers. The system will also be an important data repository and a key milestone in what will hopefully be future efforts to share

[42] Note, HCHD staff indicated that exceptions will be made to this provision on a case by case basis, but that the provision was intended to ensure that health centers were not substituting HCHD lab and diagnostic services for services currently provided through affiliations with other hospitals and non-hospital providers.

data and consolidate data collection among the agencies. Therefore, every effort should be made to accelerate its implementation.

HMA further recommends that the system be taken a step further to allow other providers – including FQHCs and other safety net providers -- to qualify individuals for appropriate assistance programs, including the HCHD Gold Card. HMA understands that initial discussions toward this end have begun and will continue in earnest after the Quad Agencies complete their implementation early next year. In the interim, HCHD could expand its placement of Gold Card eligibility workers located in the health centers so that each health center had an eligibility worker on-site several days per week. The current Gold Card eligibility process requires an individual to meet with an on-site or out-stationed Gold Card eligibility worker and present the required documentation prior to receiving a primary or specialty care appointment. Patients often have to make several return visits to the eligibility worker to complete the documentation process, and this process often comes after the patient has gone through a separate eligibility process at another public or private provider. In the near term, other public providers will be able to determine Gold Card eligibility via the Quad Agency system. In the longer term, this service should be extended to FQHCs and other community based providers who meet the other terms and conditions of the HCHD specialty care MOU.

The health centers should accelerate adoption of a common electronic medical record (EMR) system for Harris County's private primary care safety net providers. Most FQHCs and several other health centers in the county are currently participating in Gateway to Care's effort to evaluate and jointly purchase an EMR system. While not a federal requirement, HRSA has made funding available for implementation of EMR systems in FQHCs, as this effort is of critical importance as health centers look to improve the delivery of high quality care in an efficient manner. It takes on an even higher level of importance when viewed in the context of the long-term vision outlined here, as the adoption of multiple EMR systems could greatly hamper the ability of the health centers to integrate and share data. According to discussions with health center leadership, at least one FQHC is actively working with the Texas Primary Care Association and may pursue purchasing an EMR through TPCA. Several other organizations noted that, while they are participating in the Gateway to Care EMR evaluation and purchasing process, they were not confident that the process would ultimately lead to a product that meets their needs in a timeframe that meets their needs.

Health centers cited several problems with the purchase and implementation of the BCA practice management system through Gateway that they hope can be

avoided in the EMR purchase and implementation. Specifically, while most health centers believe the BCA system has the power and functionality they need, many cited problems with implementation attributed to a lack of direct access to BCA support (BCA deals directly with Gateway), that led to an unsuccessful training model and an agreement that limited the ability to customize the system for individual health center needs, These issues must be addressed as the EMR process moves forward, and the health centers must be able to feel confident that they are getting the best system for the best price and in a timeframe that allows them to meet their other goals and obligations.

HCHD, the University of Texas and Baylor should accelerate adoption of a new faculty contract that is transparent and provides adequate resources dedicated to primary and specialty care. Even under the aggressive long-term strategy outlined in this report, HCHD will continue to be the backbone of the Harris County primary care safety net and will likely continue to provide the bulk of specialty care services for uninsured patients in the county. The contract is currently being re-negotiated. The future stability of the Harris County safety net is dependent on developing a contract that provides adequate resources to both attract and retain providers.

Leadership within the community health programs at both Baylor and UT noted difficulty in recruiting and retaining primary care providers due in large part to what they believed were insufficient starting salaries. In addition, the new contract should include provisions to ensure that the medical schools are held accountable for providing the level of care for the uninsured they commit to provide. HMA understands that the contract will be using an relative value unit (RVU) based methodology to track and account for care provided. Independent validation and verification of claims should be a key component of this system. Finally, the contract should be transparent, such that HCHD can be certain that taxpayer dollars are being used to support those services deemed to be the highest priority.

The community should conduct a comprehensive inventory of available city and county clinic space. Both the city and county health departments have seen their patient volumes decline within the last several years as the result of a conscious strategy to shift primary care services to other providers (City) and as a result of changes in policy (e.g., the SCHIP perinatal program) that have opened up additional care options for patients. As a result, the health departments have unused space that could be utilized by other providers if the circumstances were right. Indeed, the city has entered into several arrangements recently with FQHCs and HCHD

to provide space for primary care services in their health center and multi-service center buildings.

HMA recommends that a comprehensive inventory of available city and county clinic space be conducted. Factors that should be part of the inventory include the location of the space, hours the space is open (and flexibility to extend/change those hours), clinical "readiness" of the space, safety, and availability of parking and mass transit. While there may not be sufficient space available to house one of the large health center locations outlined in the model structure, available space may provide a good interim/transition solution to accommodate health center growth.

Mid/Long-term Recommendations

The community should work with the state to create a local Medicaid expansion for parents using unmatched tax levy dollars. Based on discussions with HCHD officials and a consultant who is knowledgeable about Medicaid financing strategies in Harris County and the rest of Texas, HMA understands there is currently approximately $70 million in Harris County tax levy funds that are not being used to draw down federal Medicaid match. The Section 1115 Medicaid waiver proposal currently before CMS would use an estimated $40 million of those dollars for the creation of a Medically Needy program and for other purposes, leaving approximately $30 million remaining. At the Texas Medicaid matching rate of 60%, $30 million in local funds yields $45 million in federal funds for a total of $75 million.

HMA recommends that Harris County work with the state to utilize its currently unmatched tax dollars to create a regional coverage expansion for parents above current Medicaid coverage levels. Using a rough calculation, $75 million could provide coverage to approximately 18,000 parents. In addition to requiring state action and approval, the expansion would require federal approval of the use of regional income disregards (which requires a waiver of Medicaid's "state-wideness" requirement).[43] Such an approach has been proposed by the State of Louisiana and is currently under review by the federal government, but has not yet been approved or replicated. While this program would not require any state funds, significant state support would be required to develop the required Medicaid state plan amendment and navigate the federal approval process.

[43] See Section 1902(a)(1) of the Social Security Act.

Build Organizational Capacity

Short-term Recommendations

Providers and funders must make provider productivity a priority. Almost without exception, the FQHCs fall far below national benchmarks for physician productivity (though most are meeting or exceeding benchmarks for mid-level productivity). While many of the health centers have struggled to recruit and retain providers, which has adversely affected productivity, other issues faced by the health centers, including language barriers and the complex needs of the patients, are comparable to those faced by health centers everywhere. Productivity improvements alone will not fill the current gap in primary care supply and demand, but Harris County's health centers must make provider productivity a priority in order to maximize their current resources and reduce cost per visit. All health center leadership, staff and board members should be aware of the federal productivity expectations and how their health center compares to the expectation and other health centers.

The model structure assumes that the FQHCs are operating at the productivity expectation and are thus able to significantly reduce their overall cost per visit. In the interim, the philanthropic community could also create incentives to increase productivity by directly linking funding levels to encounters. For example, funding levels could be set based on a factor of each provider's Medicaid encounter rate (or equivalent for non-FQHCs); the factor could vary based on the health center's productivity relative to established benchmarks.

Providers and funders should make eligibility and customer service a priority. Data collected and site visits conducted as part of this study indicate a clear distinction between providers who have placed a priority on eligibility determination and those that have not. Among Houston's "traditional" FQHCs, which have a tremendous financial incentive to identify every patient eligible for Medicaid coverage, Medicaid rates range from one percent of patients to nearly 30 percent of patients. FQHC requirements mandate that health centers maximize revenues but do not specify how health centers must meet this requirement. While some health centers worked aggressively to screen and enroll patients in coverage programs, others cited cultural and other reasons (e.g., fear of being branded as a "government clinic," cultural opposition to public insurance) for relaxing eligibility screening. In order to reach a level of long-term financial sustainability, Harris County's safety net providers (with the exception of those who do not bill insurance) must make every effort to screen all patients for coverage and enroll eligible patients in coverage programs. At a minimum, these efforts should include:

- educating patients on the importance of insurance for both their own well-being and the financial future of the health center;
- verifying each patient's insurance prior to each visit, and screening uninsured patients at regular intervals for eligibility for public coverage; and
- verifying each patient's insurance at the time a bill is produced.

HMA understands that there have been initial discussions between the health centers and the Quad Agencies (HCHD, Houston DHS, HCPHES and MHMRA) regarding extending access to the soon-to-be-implemented "Medicaider" eligibility system. As noted above, HMA recommends that every effort be made to accelerate implementation of this system by the public agencies and extension of the system to private primary care safety net providers.

At the same time, the health centers must also work aggressively to improve customer service in order to attract a wide patient base. Many of the health centers in the target group had very attractive clinic buildings with safe, plentiful parking and large, comfortable waiting areas. Several health centers had less inviting space and were in the process of developing plans to either renovate their current space or relocate to new space.

The biggest customer service issue identified during the site visits to the target group health centers was the patient "through-put" time. Most health centers stated that on a typical day, their patients spend approximately 2 hours in the health center from the time they check in to the time they leave. Several health centers were able to pinpoint the sources of log-jams within their patient flow (e.g., log-jams at front desk checking in, patients arriving late, inadequate provisions for walk-in patients, inadequate utilization of medical assistants) and were working to address them. Other health centers could not identify the root of the problem and may require a detailed patient flow analysis that was beyond the scope of this engagement.

Health Centers should put in place policies and procedures to ensure they are getting infants and mothers back after delivery. Health centers should provide a follow-up appointment prior to delivery and educate women about what to expect upon discharge from the hospital. According to health center staff, it is common practice for HCHD staff to require new mothers to set up an infant follow-up appointment within the Hospital District system unless they are fully convinced another appointment already exists. Retaining these newborns is critical for improving the payer mix of the health centers, as most of these children will be covered by Medicaid or SCHIP. Similarly, the health centers should educate

patients and emphasize the importance of returning for a postpartum visit within weeks of delivery.

Health Centers should place a substantial focus on outreach and marketing. Most of the health centers in the target group – including both FQHCs and non-FQHCs – stated that they had same-day or one to two day appointment availability for both new and returning patients. Several health centers also noted that low provider productivity was largely a factor of the health center simply not having enough patients. These statements stand out in sharp contrast to recent reports indicating an overcrowded ED system and vast unmet primary care demand, especially among the uninsured. This phenomenon is likely attributable to several factors, including the youth and size of many of the health centers, lack of outreach into the community; perceptions that wait times are too long and that patients are required to fill out lots of paperwork; and in some cases, cultural and lifestyle factors that undervalue or make it difficult to obtain preventive and/or primary care.

The FQHCs must, both individually and collectively, aggressively market themselves to the community. As the model structure evolves, this marketing approach should also evolve to create a "brand name" image for the FQHC system.

Providers and funders must ensure key clinical benchmarks are continually improving. HRSA has adopted a set of 12 nationally-standardized clinical core measures as the basis for an Agency-wide quality improvement initiative for grantee delivery sites that provide clinical care and/or provide referrals for clinical care. These measures encompass six key areas that cut across multiple bureaus, programs, and health service delivery grantees: HIV, pre-natal and perinatal care, immunizations, cancer, cardiovascular hypertension, and diabetes.

BPHC (the oversight agency for FQHCs) selected a subset of four new clinical measures from these HRSA core measures. The four new health center measures are: 1) appropriate childhood immunizations; 2) cervical cancer screening; 3) blood pressure control; and 4) diabetes control. They include both process and outcome measures: childhood immunization and cervical cancer screening as process measures, and blood pressure and diabetes control as outcome measures. Through the annual UDS, health centers will be asked to report on their overall patient populations for the process measures as well as on the racial and ethnic subgroups within that population for the outcome measures. These new measures augment clinical quality measure reporting already underway in health centers including entry into prenatal care, and birth weight.

Current Harris County quality measure reporting suggests that health centers may need assistance in developing and implementing the clinical protocols to meet the clinical quality expectations. These criteria should be monitored and reviewed as part of the funding process. They also speak to the need to accelerate the evaluation and adoption of a single EMR system for Harris County's FQHCs (see recommendation above).

In addition, the Bureau of Primary Health Care is embarking on a year-long process to communicate to grantees about the new clinical indicators and to provide training. For CY 2008, the annual UDS trainings will include additional sessions focused specifically on the four new clinical measures and the sampling and data collection methodology for UDS reporting. All FQHCs in Harris County should actively participate in one or more of these sessions. More information about the UDS reporting requirements for these measures is available online at: http://www.bphc.hrsa.gov/uds/2008manual/.

Health centers should establish and formalize "mentorship" arrangements among FQHC leadership and among board members of FQHCs. FQHCs are subject to a wide array of federal requirements prescribing how they governed, who they must serve and the services they must provide. Even well-established FQHCs frequently struggle with the complexity of these requirements. Houston's FQHCs face another layer of difficulty, given their relative youth and the Texas policy environment in which they operate.

Though vehicles for formal and informal collaboration exist through Gateway to Care and the Harris County Healthcare Alliance, many individuals interviewed for this study spoke of a dearth of opportunities for mentorship, particularly with respect to FQHC policy, finance, operations and how to be an excellent Medical Director. HMA's analysis of health center operations indicates that FQHC finance expertise is a particular area of need, as is expertise in the Chief Medical Officer position. Some expertise is likely available locally, while other expertise (specifically expertise related to FQHC requirements) may require outside talent. Several FQHCs also expressed strong interest in bringing in specific expertise from the outside to address issues and concerns facing that particular health center. These issues have been addressed in the individual health center feedback reports.

Mid/Long-term Recommendations

The Alliance should advocate for the establishment of a PPS reimbursement methodology under SCHIP for FQHCs and Look-Alikes. In the fall of 2007, Senate and House negotiators reached a compromise on SCHIP reauthorization language that included a PPS payment methodology for FQHCs (and Look Alikes) under

stand-alone SCHIP programs.[44] The compromise legislation was vetoed by the President; as a result, states operating stand-alone SCHIP programs are not required to use the cost-based PPS methodology and frequently reimburse providers at a fraction of actual cost. In the absence of a federal requirement to do so, Texas SCHIP (including the SCHIP perinatal program) should reimburse FQHCs under the Medicaid PPS or alternative PPS methodology. Without such a provision, Section 330 grant dollars and philanthropic dollars must effectively be used to subsidize insured patients rather than cover the costs of the uninsured. Indeed, some FQHCs reported that they believed they were better off treating the patient as self-pay than enrolling the patient in the SCHIP perinatal program because sliding fee scale payments actually exceeded SCHIP reimbursement in at least some cases. At Texas' current SCHIP federal match rate of 72%, the state would receive approximately $2.50 in federal funds for every dollar it spends on enhanced reimbursement.

Health centers should evaluate a joint recruitment and/or joint-contracting arrangement between the FQHCs, and other safety net providers as appropriate, which may include contracting with large organized medical groups, including the two local medical schools. Most of the FQHCs and other health centers in the target group cited provider recruitment and retention as a major issue and ongoing concern. Many of the health centers currently have – or have recently experienced – provider vacancies, including vacancies in their medical director positions. These vacancies make it more difficult to meet productivity goals and establish the continuity needed to continuously improve productivity and quality of care.

Several factors were cited as the reason health centers were having difficulty recruiting and retaining providers:

- ***Non-competitive salaries***. The health centers noted that they have difficulty meeting the increasing salary demands of experienced and even new providers. Competition from the medical center, particularly for mid-level providers, was also often cited.
- ***Difficult work environment/lack of back-up and support***. Perhaps the most often cited reason for difficulty in recruiting and retaining providers was the work environment. Safety net primary care health centers – including both FQHCs and other providers – can be stressful working environments due to the complex needs of the patients, difficulties in obtaining specialty referrals and other factors. In Harris County, the youth and small size of the health centers also make for a challenging work environment, as

[44] See House Amdt. to Senate Amdt. to H.R. 976

providers in small health centers may find themselves with few or no professional colleagues in the workplace and little back-up support for after hours call coverage.

- ***Language barriers***. Many of the health centers in the target group serve a population that primarily speaks languages other than English. In many instances the health centers have been unable to recruit and retain providers that speak the languages of the patient population and meet the other requirements for the job, forcing the health centers to rely very heavily on medical assistants and other staff as translators for the providers.

Some of these issues will be addressed through the growth and consolidation of the health centers. However, HMA recommends that the health centers work together to explore the pros, cons and feasibility of a joint recruitment and/or joint contracting strategy.

A joint recruitment strategy would entail consolidating recruitment efforts on behalf of all FQHCs (and other health centers) to collectively address the provider shortage. This could initially start with health centers sharing information around retention and benefit packages, assisting each other in times of provider shortages (locum tenens) and providing an incentive for Medical Directors to meet on a regular basis. A fully integrated recruitment strategy could include a common retention and benefit package, network level credentialing and re-credentialing, jointly sponsored CME activities and the identification of clinical administrative functions that could be performed centrally and not duplicated at the individual health center level.

A joint contracting strategy would involve health centers contracting with one or more organized medical groups for physician and mid-level providers. This could include a contract with one or both of the local medical schools (either via the current AMS contract or through a separate vehicle) or other organized medical groups. Such an arrangement would help the health centers more effectively compete for providers and would provide a mechanism for call coverage and other back-up support. It is important to emphasize that current law precludes FQHCs from accessing federal tort protection via the Federal Tort Claims Act (FTCA) if they contract with a group practice for provider services. Hence, the benefits of this strategy must be weighed against the loss of FTCA coverage. In some joint contracting arrangements, the medical group absorbs this coverage. In other arrangements, the contract is structured such that the medical providers are effectively FQHC employees with some portion of their time devoted to other commitments of the group practice (e.g., as faculty).

Conclusion and Next Steps

Table 13 outlines, at a high level, the steps that will need to be taken over the next year to advance the long-term vision outlined in this report. Of course, buy-in and support from all stakeholders, including the health centers, hospital partners, funders and political and business leaders will be critical and their input must drive the specific decisions behind each of these steps. As described in the recommendations, the realization of this vision will also require the efforts of a strong, independent project manager to both coordinate and measure the impact of the strategy.

Table 13: Next Steps/Timeline

Task	Aug. 08	Sept. 08	Oct. 08	Nov. 08	Dec. 08	Jan. 09	Feb. 09	Mar. 09	Apr. 09	May 09	June 09	Jul. 09
Secure buy in from health centers on long term vision and mergers	■	■	■	■	■							
Secure buy in from TCPA, hospital partners and private physicians, and other stakeholders re long-term vision.	■	■	■	■	■							
Reach agreement among key funders re long-term vision.	■	■	■	■	■							
Recruit and hire project manager.						■						
Establish project steering committee, which should include representatives from the health centers, hospital partners, TCPA, funders and the business community.						■	■					
Inventory available city and county clinical space.						■	■					
Develop specific criteria for supporting and funding pilot site(s).								■	■			
Issue RFP for pilot(s) under model structure.										■		
Ongoing discussions with key political officials (e.g., congressional representatives) re long term vision						■	■	■	■	■	■	■
Health centers apply for BPHC's New Access Point and Expanded Medical Capacity funding as appropriate.					■	■	■	■	■			
Ongoing technical support/mentoring for health centers	■	■	■	■	■	■	■	■	■	■	■	■