

Teaching Health Centers Can Meet Objectives for State Medicaid Innovation

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Medicaid Expansion and 1115 Demonstration Waivers

Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve innovative demonstration projects that are likely to assist in promoting the objectives of the Medicaid program.¹ The purpose of these demonstrations, which give states additional flexibility to design and improve these programs, is to demonstrate and evaluate state-specific policy approaches to better serving their Medicaid populations.

More than a year ago, the Department of Health and Human Services and the Centers for Medicare & Medicaid Services (CMS) issued a letter to governors affirming the federal government's partnership with states to improve the integrity and effectiveness of the Medicaid program for low-income beneficiaries.¹ Traditional Medicaid approaches have not always been effective at eliminating barriers to access, and lack adequate focus on a goal of achieving long-term health and economic independence.¹ Section 1115 demonstration projects present an opportunity for states to pursue innovations that go beyond routine medical care, focusing on evidence-based interventions, including directing Medicaid funds toward workforce development, to enhance access to high-quality, cost-effective care.²

In this article, we propose that community health centers (CHCs) can meet many of the objectives of state-level Medicaid innovations. The CHC mission is to provide affordable care for lower-income and medically underserved populations in urban and rural communities.³ Studies consistently show that CHCs improve the health status of individuals and the communities where they are located.⁴ CHCs

often deploy interdisciplinary teams to provide comprehensive services, including dental, vision, behavioral health care, pharmacy, as well as transportation and financial advice, which typically are not provided by health care facilities or covered by health insurance.

CHCs rely on a mix of funding to cover their cost, including Medicare, Medicaid, private insurance, and patient payments. Other revenues come from competitively awarded Health Resources & Services Administration (HRSA) grants, other grants, and contracts with state, local, and private sources. In fiscal year (FY) 2015, 43% of CHC revenue came from Medicaid, and federal grants accounted for 22%.⁴ Affordable Care Act funding of CHCs has been previously described.⁵ In FY 2018, the HRSA CHC program supports nearly 1400 grantees, providing care to 27 million patients. The HRSA FY 2018 budget provides \$3.86 billion in mandatory resources, and \$1.6 billion in discretionary funding, an increase of more than \$300 million over the prior year.⁶

CHCs face difficulties in recruiting the primary care workforce to meet needed growth, and many currently are unable to accommodate additional patients even prior to demand increases under Medicaid expansion.^{7,8} One approach to CHC expansion is for teaching health centers (THCs) to train the necessary health care workforce.⁵ Given this, state Medicaid support of THC programs will be essential.

We propose that a state Medicaid demonstration of the recently described Mega THC paradigm⁵ would meet the goals of the Section 1115 waiver. A recently published detailed description of the Mega THC documented how this paradigm would maximize quality, increase access, and minimize cost for Medicaid,⁵ achieving many of the goals of Section 1115 demonstrations (BOX 1).⁵ We review key components of the Mega THC, with description of features designed to address Section 1115 goals, and discuss the structure and benefits of a proposed CHC/Mega THC State Medicaid demonstration project.

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BOX 1 Reforms Designed to Promote Medicaid's Objectives

- Improve access to high-quality, person-centered services that produce positive health outcomes for individuals
- Promote efficiencies that ensure the Medicaid program's sustainability for beneficiaries over the long term
- Support coordinated strategies to address certain health determinants that promote upward mobility, greater independence, and improved quality of life among individuals
- Strengthen beneficiary engagement in their personal health care plan, including incentive structures that promote responsible decision-making
- Enhance alignment between Medicaid policies and commercial health insurance products to facilitate smoother beneficiary transition
- Advance innovative delivery system and payment models to strengthen network capacity and drive greater value for the Medicaid program

BOX 2 Community Health Center/Mega Teaching Health Center Medicaid Cost Savings

- Use of senior residents and supervisory faculty as primary care physicians for patients in the CHC Hub, funded by Medicaid graduate medical education support
- Nonphysician health professions students and faculty to provide primary care in neighborhood clinics
- Decreased hospital admissions and emergency department visits for conditions that can be treated in ambulatory care settings enabled by improved continuity, comprehensiveness, and extended hours
- Decreased hospital readmissions resulting from coordinated care and improved care transitions
- Decreased laboratory and imaging costs resulting from mandated teaching of appropriate resource utilization
- Decreased fragmentation of care through effective access to and utilization of consultations
- Malpractice liability protection for CHC physicians under the Federal Tort Claims Act
- Reduced CHC expenditures on pharmaceuticals through the federal Drug Pricing Program
- Effective chronic disease management and prevention through PCMH practices
- Provision of integrated dental and behavioral health services
- Recent electronic health record and PCMH development
- Elimination of billing costs and administrative cost for managed care, through global payment via an ACO
- Global payment and ACO incentives promoting cost-effective care
- Reduced "churning" of providers with change of coverage
- Reduced nursing home admissions due to increased provider access

Key Components of Mega THC

Key components of the Mega THC include diverse primary care physicians and other health professionals, effective communication and teamwork in outreach clinics, and fully interprofessional education. Another important structural aspect is the partnership with academic health centers for inpatient and ambulatory subspecialty care. Finally, we propose an emphasis on team care to address mental health and addiction, and social determinants of health.

The proposed approach requires CHCs to serve substantially larger numbers of Medicaid patients. Major expansion of CHCs, facilitated by THC in partnership with regional affiliated teaching hospitals, could substantially increase Medicaid beneficiaries' access to cost-effective care. CHC expansion cannot succeed without developing these CHC-academic health center partnerships to supplement the currently deficient CHC primary care workforce pipeline that limits the potential of CHCs and provides a demonstration model for unique CHC-affiliated community outreach sites to enhance access to care, while containing costs. The potential CHC/Mega THC contribution to cost control for the Medicaid program is shown in BOX 2, and provides the basis for this budget-neutral state Medicaid demonstration.

Primary Care Outreach Clinics

Outreach clinics, located in underserved urban areas and small rural communities, are a key component of the CHC/Mega THC paradigm. Nurse practitioner (NP) and/or physician assistant (PA) students and their faculty could staff neighborhood clinic teams in collaborative practice. Teams could include

pharmacists, social workers, community and home health workers, and primary care technician (PCT) students and their faculty. Care in this collaborative practice model is coordinated with a hub THC.

These clinics could utilize PCTs⁹ to expand the impact and reach of patient care teams by providing basic preventive care and treating minor illness and stable chronic disease care in rural and other resource-deprived communities. Utilizing a practice model employed by emergency medical technicians and the US military, PCTs would collaborate with a supervising primary care NP or PA in the outreach clinic, and via remote technology with primary care physicians in the hub THC. This model of oversight, use of mobile technology, clinical algorithms, real-time documentation, and instant online consultation could extend the deficient ranks of primary care physicians in underserved urban and rural areas.

Abbreviations: CHC, community health center; PCMH, patient-centered medical home; ACO, accountable care organization.

Having these health professionals work and live in the community may contribute to enhancing the viability of Critical Access Hospitals and help improve rural health.¹⁰

CHC and Academic Medical Center Partnerships

CHC and academic medical center partnerships (CHAMPs) could merge the primary care expertise of CHCs with the medical technology, inpatient care, and subspecialty expertise of academic medical centers.¹¹ CHAMP THC's would offer patients access to high-quality subspecialty care from the teaching hospital partner through telemedicine consults and imaging, laboratory tests, and inpatient care.

The care of Medicaid beneficiaries in this partnership would be reimbursed by a global payment to a Medicaid CHAMP Accountable Care Organization,^{12,13} with all care for Medicaid patients covered by a risk-adjusted, prospective global payment. Cost of care and patient satisfaction would be compared with a matched population of managed-care Medicaid patients in the region as part of the Medicaid demonstration project.

Mega THC's also provide additional interprofessional team care features, including care for opioid dependence, which has been especially devastating to rural areas,¹⁰ where access to mental health and addiction treatment is limited, and where CHCs are beginning to fill this gap.¹⁴ Further development of this demonstration could help address the opioid epidemic under a "hub and spoke" model already used in Vermont, and recommended by the PEW Charitable Trusts' Substance Use Prevention and Treatment Initiative.^{15,16} The limited access to dental hygienists and other dental care also could be addressed by THC's by using trainees with faculty supervision. Impaired dental health has significant health impact, and is an obstacle to employment. Many veterans, particularly those in rural areas, are not receiving the dental and oral health care they need, and several CHCs have identified veterans as a priority population for oral health services.¹⁷ Finally, Mega THC's can train medical social workers as part of the medical team to address social determinants of health, including housing, diet, transportation, and legal services.

Implementation

In addition to the proposed design and financing of the Medicaid delivery system, the demonstration projects would address transition of a CHC to a CHC/Mega THC, including funding of trainees,

faculty, and program administration. To facilitate this transition, a state would select a major urban and rural CHC by November 2018, with an existing or newly formed relationship with an academic medical center to form a CHAMP Accountable Care Organization.¹¹ The selected CHCs would serve as pilot centers in a 5-year Mega THC State Demonstration Project. The resident physicians to train in the Mega THC hub would begin the hospital component of their training in July 2019, and subsequently pursue their continuity ambulatory training at the Mega THC,¹⁸ which would concurrently develop affiliated neighborhood and rural outreach clinics. As of July 2021, the Mega THC's would have developed all resources necessary to be fully functional, expanding its Medicaid service base in the hub and affiliated clinics, and being ready for the full participation of third-year THC residents and the nonphysician health professional students and their faculty.

At each THC hub, up to 12 primary care residents (4 per supervising faculty member in family medicine, internal medicine, and pediatrics)¹⁸ would receive salary and benefits support from the demonstration project. State Medicaid programs also would support administrative costs and teaching time of the faculty members who supervise the trainees, and the salary and benefits of advanced practice nurses, physician assistants, behavioral health, dental, and pharmacy faculty working at the Mega THC hub and its outreach clinics. Finally, state Medicaid funding would support the resident physicians' inpatient rotations.

In the Mega THC, faculty would have academic appointments in their respective departments. Faculty would share program oversight with CHC board members.^{11,18} State Medicaid funds would flow to a consortium for distribution to teaching hospitals and THC's.¹¹

Substantial funding would be needed to expand facilities for hub and affiliated community outreach clinic CHC activities. Funding by the federal CHC facility budget could be supplemented by community sources, and potentially from nonprofit AMC partners that are required to give back to their community. Supporting CHC expansion could be an attractive option for hospitals since CHCs reduce emergency department visits, especially when they offer after-hours access.

Looking Ahead

THC's currently are struggling with limited federal support, and lack prospects for expansion.⁵ If CHCs are to reach their potential as a resource for the Medicaid program, they must have an expanded

pipeline of health care professionals produced by the Mega THC. Establishing Mega THC de novo, or expanding existing THC, would allow selected states to demonstrate the efficacy of this approach for Medicaid patients, leading to implementation by other states, as part of a Section 1115 waiver. Thus, this initiative represents an opportunity for states to lead the way in reforming Medicaid to better serve their Medicaid beneficiaries.

A continuing challenge will be the logistics of accommodating changes in coverage as financial circumstances of beneficiaries change. This results in as many as 40% of Medicaid enrollees moving between Medicaid and marketplace coverage within a year of enrolling in the program.¹⁹ CHCs can accommodate the patients caught in this “churning” effect, since, if these patients receive care at a CHC, a change in primary care physician will not be necessary.

Another continuing challenge would be the high percentage of Medicaid’s highest-needs beneficiaries who have dual enrollment with Medicare. The 22% of Medicaid enrollees who qualify—based on age or disability—for dual enrollment account for more than half of all Medicaid expenditures.¹⁹ Improving their access to care, especially in rural areas, reducing preventable emergency department encounters and hospital and nursing home admissions, and increasing cost efficiency for these dual-enrolled individuals should be major factors in controlling costs and facilitating the budget neutral aspect of this state Medicaid demonstration. The cost efficiencies outlined in box 2 will contribute to budget neutrality when CHC/Mega THC enrollees’ cost is compared with that of Medicare-managed care beneficiaries.

A proposal made almost 5 years ago suggested that directing some Medicaid funding toward the state’s greatest health care workforce needs could address deficient health care access.²⁰ While a few states have pursued this strategy, we propose that specifically directing Medicaid support toward Mega THCs could address more directly the objectives established for state Medicaid innovations via the Section 1115 waiver. The proposed partnership between Medicaid and graduate medical education would contribute to long-term health and independence of Medicaid beneficiaries.

Poverty may be both a cause and an effect of impaired health, and a missing link in the effort to lift people out of poverty may be the absence of high-quality, cost-effective, accessible health care. Pursuit of regular care and health maintenance can contribute to the achievement of economic independence.

References

1. Medicaid.gov. About Section 1115 Demonstrations. <https://www.medicaid.gov/medicaid/section-1115-demo/about-1115/index.html>. Accessed May 14, 2018.
2. Rockey PH, Rieselbach RE, Neuhausen K, et al. States can transform their health care workforce. *J Grad Med Educ*. 2014;6(4):805–808.
3. Rosenbaum S. Reinventing a classic: community health centers and the newly insured. In: Hall MA, Rosenbaum S, eds. *The Health Care “Safety Net” in a Post-Reform World*. New Brunswick, NJ: Rutgers University Press; 2012:67–90.
4. Shin P. The health care safety net: community health centers’ vital role. July 2016. <https://www.nihcm.org/categories/the-health-safety-net-community-health-centers-vital-role>. Accessed May 14, 2018.
5. Rieselbach RE, Epperly T, Friedman A, et al. A new community health center/academic medicine partnership for medicaid cost control, powered by the mega teaching health center. *Acad Med*. 2018;93(3):406–413.
6. Simmons Farber A. NACHC Statement on the FY 2018 Omnibus Appropriations. <http://www.nachc.org/news/nachc-statement-on-the-2018-omnibus-legislation-passed-by-congress>. Accessed May 14, 2018.
7. Rieselbach R, Shin P, Nycz G, et al. Mega teaching health centers: A new model to power CHCs. *Health Affairs*. <https://www.healthaffairs.org/doi/10.1377/hblog20161013.057067/full>. Accessed May 14, 2018.
8. Chokshi DA, Chang JE, Wilson RM. Health reform and the changing safety net in the United States. *N Engl J Med*. 2016;375(18):1790–1796.
9. Kellermann AL, Saultz JW, Mehrotra A, et al. Primary care technicians: a solution to the primary care workforce gap. *Health Aff (Millwood)*. 2013;32(11):1893–1898.
10. Iglehart JK. The challenging quest to improve rural health care. *N Engl J Med*. 2018;378(5):473–479.
11. Rieselbach RE, Crouse BJ, Neuhausen K, et al. Academic medicine: a key partner in strengthening the primary care infrastructure via teaching health centers. *Acad Med*. 2013;88(12):1835–1843.
12. Rieselbach RE, Kellermann AL. A model health care delivery system for Medicaid. *N Engl J Med*. 2011;364(26):2476–2478.
13. Stine N, Chokshi D, Knudsen J, et al. How America’s Largest Safety-Net Health System Built A High-Performing Medicare ACO. *Health Affairs*. <https://www.healthaffairs.org/doi/10.1377/hblog20171106.437941/full>. Accessed May 14, 2018.
14. National Association of Community Health Centers. Rising to the challenge: community health centers are making substance use disorder treatment more accessible than ever. <http://www.nachc.org/wp-content/>

- uploads/2018/03/NACHC_PI_2018_WEB_v1.pdf. Accessed May 14, 2018.
15. Comprehensive Addiction and Recovery Act of 2016. Pub L No. 114–198. 130 Stat 695.
 16. The Pew Charitable Trusts' Substance Use Prevention and Treatment Initiative. Substance use disorder treatment and prevention policy recommendation for the State of Wisconsin. <http://www.hamilton-consulting.com/wp-content/uploads/2018/01/FINAL-Wisconsin-Recommendations-FOR-DISTRIBUTION-1.5.18.pdf>. Accessed May 14, 2018.
 17. Engstrom K. Serving the oral health needs of our nation's military heroes. National Association of Community Health Centers. <http://www.nachc.org/wp-content/uploads/2018/02/Serving-the-Oral-Health-Needs-of-Our-Nations-Military-Heroes.pdf>. Accessed May 14, 2018.
 18. Rieselbach RE, Crouse BJ, Frohna JG. Teaching primary care in community health centers: Addressing the workforce crisis for the underserved. *Ann Intern Med*. 2010;152(2):118–122.
 19. Mann C, Osius E. Medicaid's new role in the health care system. *JAMA*. 2015;314(4):343–344.
 20. Spero JC, Fraher EP, Ricketts TC, et al. GME in the United States: a review of state initiatives. The Cecil G. Sheps Center for Health Services Research. University of North Carolina at Chapel Hill. September 2013. <http://www.shepscenter.unc.edu/product/gme-in-the-united-states-a-review-of-state-initiatives>. Accessed May 14, 2018.



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