



IMPROVING COMMERCIAL REIMBURSEMENT FOR COMMUNITY HEALTH CENTERS

Case Studies and Recommendations for New York



FALL 2007

ACKNOWLEDGMENTS

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The project's advisory committee devoted time, energy, and insight into this project. Members included Feygele Jacobs, Julio Bellber, Elizabeth Swain, Kate Breslin, Neil Calman, John Rugge, and Wendy Stark. Kathy Shure of the New York State Department of Health, Roger Schwartz of the National Association of Community Health Centers, Inc., David Selig of Community Care Network of Virginia, and Ralph Silber of the Community Health Center Network serving Oakland, California, also provided valuable insights.

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ABOUT THE RCHN COMMUNITY HEALTH FOUNDATION

The RCHN Community Health Foundation (RCHN CHF) which was founded in October 2005, is a not-for-profit operating foundation whose purpose is to support community health centers through strategic investment, advocacy, education and research. The only foundation in the country dedicated to community health centers, RCHN CHF builds on a 40-year commitment to the provision of accessible, high-quality community-based health care services for underserved, medically vulnerable populations. RCHN CHF is led by Julio Bellber, president and CEO, a nationally-renowned leader of the health center movement.

ABOUT CHCANYS

The Community Health Care Association of New York State (CHCANYS) is a 36-year-old nonprofit association of federally-funded Community Health Centers (CHCs) in New York State. Its 50+ members provide primary health care for more than 1 million vulnerable New Yorkers, regardless of their ability to pay. CHCANYS' mission is to advocate for the expansion of community-based primary health care access and resources throughout New York State. It provides extensive technical assistance to its CHC members, so that they can have the most positive and sustained impact on public health. Finally, as a HRSA-designated Primary Care Association, it plays many other public health roles, including providing leadership in promoting primary care, and quality, cost-effective models, and work to foster emergency preparedness and the adoption of health information technology.

ABOUT MANATT HEALTH SOLUTIONS

Manatt Health Solutions (MHS) is an interdisciplinary policy and business advisory division of Manatt, Phelps & Phillips, LLP, one of the nation's premier law and consulting firms. MHS helps clients develop and implement strategies to address their greatest challenges, improve performance and position themselves for long-term sustainability and growth.

ABOUT RSM McGLADREY

RSM McGladrey is the fifth-largest provider of accounting, consulting and business advisory services in the United States, with a targeted focus on middle-market companies. For over thirty years, the Healthcare Services Team of RSM McGladrey has been committed to nurturing the development of strong and successful community health centers nationwide. Through specialized knowledge in the strategic, operational and financial issues facing community health centers, RSM provides guidance to organizations seeking to maximize financial performance, respond to regulatory requirements, improve service delivery and respond to changes in technology.

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EXECUTIVE SUMMARY

Background

Federally Qualified Health Centers, known as FQHCs or Community Health Centers (CHCs), provide a “medical home” where patients receive preventive care, primary care, and chronic disease management. CHCs are driven by mission and legal mandate to offer their services regardless of ability to pay. While fulfilling their historic mission to serve the uninsured and underserved communities, some CHCs across New York also serve large numbers of patients with private, commercial insurance. Nearly one-half million patient visits – approximately 15 percent of all visits to CHCs in New York State in 2004 – were provided to patients with commercial insurance coverage. For some CHCs, the proportion of patient visits covered by commercial insurance is between one-third and one-half. For many commercially insured patients living in rural or underserved areas, CHCs offer the only point of access to primary care. Other commercially insured patients are making CHCs their provider of choice because of their reputation for outstanding, culturally competent primary care and the wide scope of services they provide.

For this study, in-depth analyses of six CHC networks across New York State with high proportions of commercially-insured patients were conducted to examine their experiences with commercial and public payers. The executive management of each CHC participated in a structured interview. In addition, each participating CHC provided extensive data related to its finances, operations, and quality of care.

Case Study Findings

CHCs receive significantly lower reimbursement rates from private insurers compared with those from public payers. On average, commercial payment rates per visit are \$38 less than Medicaid fee-for-service rates and \$17 less than Medicare rates. Compared to the costs of providing medical services, the rates of payment from commercial insurers are inadequate to cover the cost of care. On average, without co-insurance or co-payments, the CHCs lose \$41 on each medical visit they provide to a patient with commercial insurance. Accounting for the enabling services that CHCs provide in addition to medical services, the shortfall in commercial payments is even more severe. Collectively, the six CHCs in this study lost more than \$5.8 million dollars in 2006 on the care they provided to commercially insured patients; the total losses for all CHCs across the state are even more substantial.

While Medicaid and Medicare payments are also below the cost of care, they come much closer to covering the costs of caring for patients.

CHCs contract with numerous commercial payers and face large administrative burdens managing many different contracts. These include individual physician credentialing, preauthorization requirements, managing multiple networks of specialists, and managing formularies. Despite recognizing the administrative burdens these contracts present, most CHCs have continued to sign additional contracts in order to provide continuity of care and a stable medical home for their patients.

CHCs report lacking bargaining power compared to commercial plans, and CHCs rarely negotiate rates with commercial payers. Instead, CHCs reported that they are presented with commercial contracts on a “take it or leave it” basis. Every CHC interviewed believed that they have insufficient volumes to secure negotiating leverage with plans. CHCs in urban areas, in particular, reported that plans have wide networks of primary care providers, do not “need” CHCs to be in their networks, and can simply set whatever rates they desire. CHCs also attribute their lack of leverage to a lack of good data. Plans rarely provide comprehensive, patient-specific and aggregate data to the CHCs. Many CHCs lack the health information technology (health IT) capacity that would support the information capture and data analysis needed to negotiate with plans.

Without negotiating rates, CHCs cannot explain how their commercial rates are set by plans. The commercial rate-setting process is a “black box;” rates are simply set unilaterally by the plans, and payment policies are usually unpublished. Quality-of-care incentives in managed care contracts are rare, based on mysterious formulas, and generate only modest payments for some CHCs. CHCs report that some of their commercial managed care contracts contain quality incentives or pay-for-performance mechanisms. However, these incentives are not standardized across different plans and there is significant confusion regarding how they work and which plans examine which measures. Commercial plans only rarely provide CHCs with performance data or benchmark comparisons.

CHCs are efficient, low-cost, well-managed providers of primary care. The CHCs in this study generally meet or exceed national benchmarks in terms of productivity and cost control. Their medical costs per encounter as well as their total costs per user are generally lower than the national averages for CHCs, despite the expense of operating in New York. CHCs have implemented a wide range of management strategies to address the commercial payment shortfall, but the benefits of these strategies are largely exhausted.

Recommendations

CHCs are an integral part of the state’s primary care infrastructure, often being the main point of access to care for an array of vulnerable patient populations. However, the ability of some CHCs to continue fulfilling this role is severely jeopardized by low reimbursement rates from commercial insurance plans. While Medicaid and Medicare payments cover greater percentages of the actual cost of providing care, payments from commercial plans are falling far short of meeting these costs. Inadequate commercial reimbursements threaten the viability of CHCs as a major source of care for the uninsured. Unless this gap in reimbursement rates is corrected, the ability of CHCs to keep their doors open to all patients, regardless of insurance source, is at risk.

While there are no “magic bullets” to rectify this gap in reimbursement rates, we recommend a variety of strategies to improve commercial reimbursement for CHCs. Taken individually, it is unlikely that any of the following strategies will be enough to fill the commercial reimbursement gap for CHCs. When grouped together, however, these strategies can improve the situation for CHCs:

1. Require the inclusion of CHCs in commercial insurance provider networks and ensure adequate compensation to cover federally mandated services.

2. Create a unified incentive fund to reward CHCs that provide superior quality of care and establish uniform methods for measuring care and administering these funds.
3. Establish community reinvestment strategies to fill the gaps in commercial payments to CHCs.
4. Support the ability of CHCs to create more effective business partnerships with commercial plans through investment in health information technology (health IT).

I. INTRODUCTION AND BACKGROUND

Federally Qualified Health Centers,¹ also known as FQHCs or Community Health Centers (CHCs), provide a “medical home” where patients receive preventive care, primary care, and chronic disease management. In New York State, they provide comprehensive, community-based health care and supportive services to over one million residents. CHCs have been described as “one-stop shopping” providers of care and are statutorily mandated to provide a wide range of health services to their patients. Federal law requires, for example, that CHCs provide preventive health services, including prenatal and perinatal services; well-child services; immunizations; screenings for cancer, elevated blood lead levels, communicable diseases, and cholesterol; pediatric eye, ear, and dental screenings and voluntary family planning services. CHCs must provide access to after-hours care, and must have on-site or under arrangement lab and radiological services, emergency care, pharmacy, and referrals to specialty care. In addition, CHCs must provide for a range of enabling services that are of particular importance for underserved populations, including outreach and transportation, case management and if necessary, translation services.²

CHCs’ comprehensive model repeatedly has been shown to provide high-quality and cost-effective care that reduces the number of hospitalizations and emergency department visits, and reduces costly care by specialists. One analysis examined medical records of CHC patients and found that CHC quality of care was comparable to or better than care delivered elsewhere, as measured by reduced hospitalizations and emergency department visits, higher vaccination rates, and higher cancer screening rates.³ Another study assessed primary care performance by type of provider, and found that CHCs’ patients were nearly 20 percent less likely to use emergency departments and 11 percent less likely to be hospitalized for ambulatory care sensitive (ACS) conditions compared with patients using office-based physicians or hospital-based practices.⁴ Other studies found that CHCs produce significant savings for payers compared with private physicians,^{5,6} and provide higher quality care at a significantly lower cost than other primary care or ambulatory care settings.⁷

¹ According to the National Association of Community Health Centers, FQHCs are “non-profit, consumer-directed health care corporations that provide comprehensive primary and preventive health care services and either (1) receive grants under the U.S. Public Health Service Act (i.e., Community Health Centers, Migrant Health Programs, Health Care for the Homeless Programs, Health Care in Public Housing Programs, Indian Tribal Health Centers, Urban Indian Centers) or (2) do not receive federal PHSA grants, but meet the standards for funding.” See <http://www.nachc.com/about/>.

² 42 U.S.C. § 254b(b).

³ Hicks LS, et al. “The Quality of Chronic Disease Care in US Community Health Centers.” November/December 2006 *Health Affairs* 25(6): 1713-1723.

⁴ Falik M, Needleman J, Herbert R, et al. “Comparative Effectiveness of Health Centers as Regular Source of Care.” January – March 2006 *Journal of Ambulatory Care Management* 29(1):24-35.

⁵ Proser M. “Deserving the Spotlight: Health Centers Provide High-Quality and Cost-Effective Care.” October-December 2005 *Journal of Ambulatory Care Management* 28(4):321-330.

⁶ McRae T. and Stampfly R. “An Evaluation of the Cost Effectiveness of Federally Qualified Health Centers Operating in Michigan.” October 2006, Institute for Health Care Studies at Michigan State University.

⁷ National Association of Community Health Centers, The Robert Graham Center, and Capital Link. “Access Granted: The Primary Care Payoff,” 2007, available at <http://www.cq.com/flatfiles/editorialFiles/healthBeat/reference/NACHCReport.pdf> [accessed August 9, 2007].

CHCs share a common mission: to provide health care to anyone who needs it, regardless of income or insurance status. While rooted in both the culture and clinical care model of CHCs, this mission is also reflected in federal law, which conditions federal funds for CHCs on assurances that “no patient will be denied health care services due to an individual’s inability to pay.”⁸ According to the Institute of Medicine, CHCs are an integral part of the “core health care safety net.” In many communities in New York State, CHCs are the main or only provider of care to the uninsured, the publicly insured and residents of medically underserved areas.

While fulfilling their historic mission to provide care to the underserved, some CHCs across New York also serve large numbers of patients with private, commercial insurance. Nearly one-half million patient visits – approximately 15 percent of all visits to CHCs in New York State in 2004 – were provided to patients with commercial insurance coverage. For some CHCs, the proportion of patient visits covered by commercial insurance is between one-third and one-half. For many commercially insured patients living in rural or underserved areas, CHCs offer the only point of access to primary care. Other commercially insured patients are making CHCs their provider of choice because of their reputation for outstanding, culturally competent primary care and the wide scope of services they provide.

Preserving a mix of public, private and self-pay patients within CHCs protects against a two-tiered health system divided into the “haves” and “have-nots.” Yet, CHCs report a wide gap in the reimbursement rates they receive from private insurers and those from public payers.⁹ Medicaid payments, according to federal law, must cover the cost of care including costs that stem from federal requirements. This reimbursement requirement is unique to CHCs and reflects the importance of ensuring adequate support to sustain the full range of mandated CHC services. Medicare payments, while capped, also come close to covering the cost of care for most visits. In contrast, private payers tend to reimburse CHCs at much lower rates; reimbursement from commercial insurers covers only 57 percent of costs.¹⁰

The discrepancy in payment levels between public and private payers places an unexpected burden on taxpayers: Medicaid and Medicare are paying higher rates linked to actual costs while commercial health insurers are not. The payment gap is placing some essential, high-quality CHCs in fiscal jeopardy and compromising their missions. Ironically, inadequate commercial reimbursements means that CHCs cannot afford to serve commercially insured patients if they wish to remain financially viable.

⁸ 42 U.S.C. § 254b(k)(3)(G)(iii)(I).

⁹ National Association of Community Health Centers, *The Safety Net on the Edge*, Washington, DC, 2005.

¹⁰ *Ibid.*

II. METHODOLOGY

In-depth analyses of six CHC networks across New York State were conducted to examine their experiences with commercial and public payers. The executive management of each CHC participated in a structured interview. In addition, each participating CHC provided extensive audited (as well as other third party verified) data related to their finances, operations, and quality of care.¹¹ Profiles of the participating CHCs follow.

The selected CHCs have high proportions of patients with commercial insurance and are geographically dispersed across New York State in urban, suburban, and rural locations. Collectively, the six networks provided nearly a quarter million visits to commercially insured patients in 2004, approximately half of all the visits (489,477) that were provided to commercially insured patients by all the CHCs in New York State that year. The case study networks had an average of 40 percent of patient visits covered by commercial insurance in 2004.

While the health centers in this study serve especially large proportions of patients with commercial insurance, other centers across the state also serve patients with commercial coverage. On average, 15% of the visits provide by CHCs throughout the State were to patients with commercial insurance. That percentage has remained stable over the past three years, as patient visits overall have increased. Given the nearly one-half million visits provided by CHCs to the commercially-insured in New York State, under-reimbursement by commercial insurance plans has a substantial and adverse financial impact on CHCs statewide.

Table 1. Commercial Insurance Visits and Total Visits, New York State CHCs – 2004

CHC Network	Commercial Visits	Total Visits	Percent Commercial Visits
Callen-Lorde CHC	7,651	36,340	21%
Family Health Network of Central New York	19,313	50,277	38%
Hudson Headwaters Health Network	87,825	184,801	48%
Institute for Family Health*	101,288	253,191	40%
Northwest Buffalo CHC	12,002	35,342	34%
Oak Orchard CHC	20,937	64,325	33%
Total: 6 Case Studies	249,016	624,276	40%
Total: New York State	489,477	3,164,935	15%

* Includes data from the recently acquired Mid-Hudson Family Health Institute sites.

¹¹ Financial and utilization data analyses for this report were conducted by RSM McGladrey, one of the nation's leading professional services firms providing accounting, tax and business consulting with a dedicated group specializing in community health centers.

III. CASE STUDIES: COMMUNITY HEALTH CENTER PROFILES

Callen-Lorde Community Health Center is New York City's only primary health care center dedicated to meeting the health care needs of the lesbian, gay, bisexual and transgender (LGBT) communities and people living with HIV/AIDS regardless of any patient's ability to pay. Callen-Lorde welcomes all patients, regardless of sexual orientation. Callen-Lorde dates back over 35 years to 1971. In 1998, Callen-Lorde opened its modern, state-of-the-art 27,000-square-foot health center in the Chelsea neighborhood of Manhattan. Serving all of New York City, it is the first LGBT organization in the nation to be designated a Federally Qualified Health Center. Callen-Lorde offers primary and specialty medical services, including a continuum of HIV/AIDS care, mental health services, case management, and HOTT (Health Outreach To Teens) – New York State's only comprehensive program for the health and mental health care of LGBT, homeless and other street youth.

Family Health Network of Central NY (FHN), established in 1972, operates a network of medical and dental centers, school-based clinics, and obstetrics and gynecology services in Cortland and Cayuga counties. In these rural areas of south central New York, its five health centers are located in health professional shortage areas – areas that, for reason of income or geography, individuals and families have difficulty accessing care. Patients come to FHN centers from eight different counties, and occasionally from as far away as Pennsylvania. FHN is the main source of care in three of the five communities served, and the only source of sliding scale adjustments for low-income individuals and families in the Cortland County region.

Hudson Headwaters Health Network (HHHN) took root in the 1970s, a time when basic health care was vanishing in the Adirondack Region of New York State. Starting with a single health center established in Chestertown, HHHN has grown into a sprawling system including 12 health centers. HHHN provides care to the residents and visitors of a region more than twice the size of Rhode Island, 3,700 square miles in four counties of the Adirondack/Lake George/Glens Falls area in upstate New York. Most of its patients live in communities where no other basic health services are available. In its mountain service area, HHHN is the doctor for each of the school districts, the health officer for local towns, the doctor for area summer camps, and the medical director for many assisted living and long-term care facilities. HHHN serves a disproportionately elderly, isolated population.

Institute for Family Health (IFH) (formerly the Institute for Urban Family Health) has grown to be among the largest CHC networks in New York State. Starting with a single location in the Bronx in 1983, IFH is composed today of 27 health delivery sites: 16 CHCs, 8 homeless health care sites, 1 school-based clinic, 2 community mental health centers, and 2 family medicine residency training programs. In its Manhattan sites, many patients come from local neighborhoods, while others travel from surrounding neighborhoods and boroughs. They represent a diverse spectrum of economic and social backgrounds, from the middle class and the working poor, to welfare recipients and the homeless. They come from many ethnic backgrounds, and a wide variety of cultures. In the Bronx, IFH serves the Morrisania, Mt. Hope, Tremont, and Parkchester neighborhoods – all of which are Health Professional Shortage Areas. Many of its Bronx patients are African-American or Hispanic; many receive public assistance; and more than half are women. In 2007, IFH assumed responsibility for the former Mid-Hudson

Family Health Institute's seven sites, extending its reach into rural sections of the Hudson Valley in Ulster and Dutchess counties.

Northwest Buffalo Community Health Center, established in 1987, now operates at two sites serving Erie County. The suburban Hamburg site exclusively provides obstetric services and serves mainly commercially insured patients. The Hamburg site also draws patients from as far away as Pennsylvania because it is distinct in providing obstetric services to publicly insured and uninsured patients. The Lawn Avenue site is located next to an inner-city housing project and serves a mixture of patients with commercial insurance, Medicaid and Medicare. Many of its privately insured patients are unionized, lower income or retired workers.

Oak Orchard Community Health Center was originally founded by the University of Rochester as a migrant health project in 1966. Oak Orchard has grown and now operates three stationary facilities plus two mobile health units. It is the only CHC serving the rural areas of Orleans, Genesee, and Wyoming counties, all of which are federally designated as medically underserved areas. The largest site, in Brockport, occupies a facility built in 1995 and provides family medicine, pediatrics, and gynecology. The second site, in Albion, occupies a dedicated facility built for Oak Orchard in 1991 and provides family medicine. The third site is an OB/GYN office.

IV. CASE STUDY FINDINGS

CHCs serve growing numbers of patients, produce more patient visits each year, and have expanded their networks.

Consistent with national trends, all of the CHCs studied have grown over the years to serve more patients and deliver more patient visits. With its recent acquisition of the Mid-Hudson Family Health Institute, IFH has grown over time from 1 site to 27. The FHN started with 3 sites and now operates 5 medical sites, 1 dental site, and 4 school-based sites. Oak Orchard started with a mobile unit in a migrant field and now operates 3 stationary sites as well as two mobile units. HHHN provides service in more than 30 diverse settings, having begun with a single location.

Among the CHCs described in this report, total patient visits have increased by approximately 8% on average over the past two years. Likewise, their total number of users has increased by approximately 9% on average over the past two years.

Figure 1.

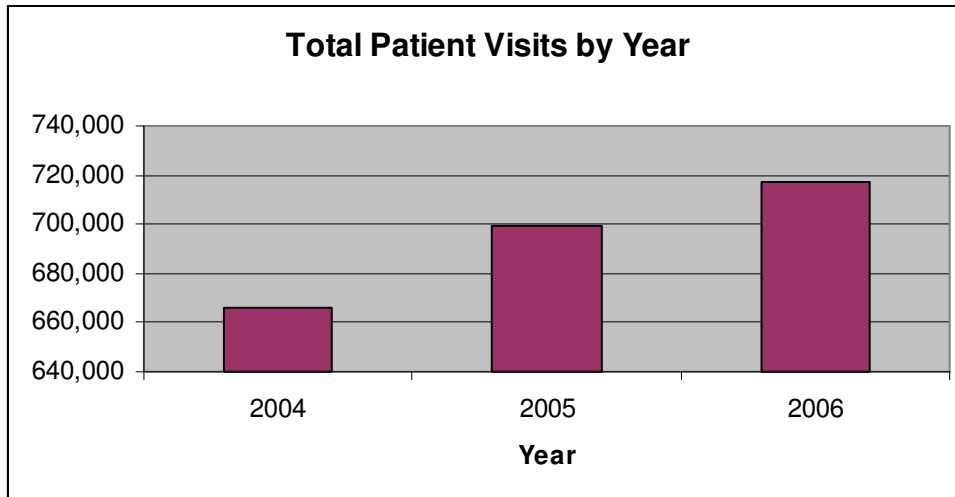


Table 2. Total Patient Visits by Year

CHC Network	<u>2004</u>	<u>2005</u>	<u>2006</u>
Callen-Lorde	36,340	41,719	44,764
FHN*	62,080	67,473	69,277
HHHN*	214,828	236,931	246,990
IFH**	253,191	250,987	251,616
Northwest Buffalo	35,342	37,185	40,478
Oak Orchard	64,325	64,902	64,143
Total Patient Visits by Year	666,106	699,197	717,268
<i>Percent Change from Previous Year</i>		5%	3%
<i>Percent Increase from 2004</i>			8%

* All figures provided by RSM McGladrey. Figures for FHN and HHHN shown here include off-site visits.

**Includes Mid-Hudson sites.

Figure 2.

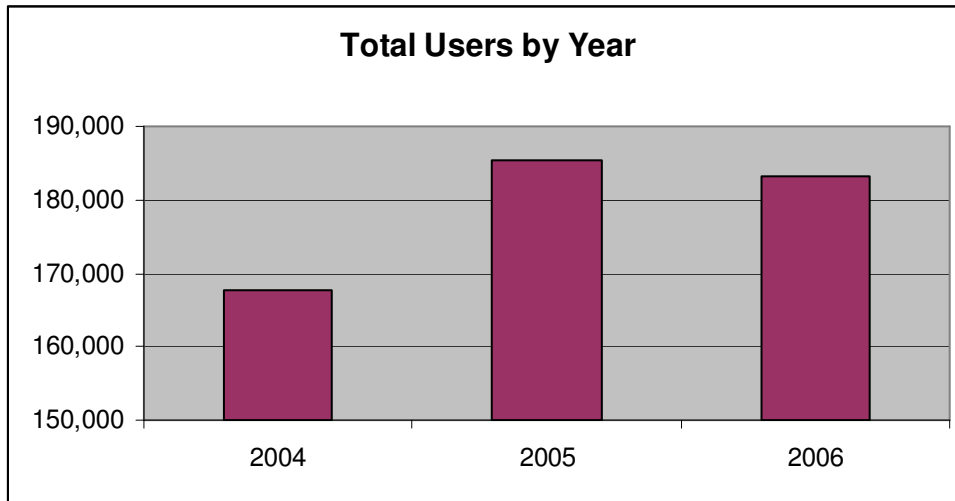


Table 3. Total Users by Year

CHC Network	<u>2004</u>	<u>2005</u>	<u>2006</u>
Callen-Lorde	9,322	11,076	11,171
FHN	15,982	16,476	17,254
HHHN	51,532	56,903	55,938
IFH*	67,118	76,331	73,612
Northwest Buffalo	8,317	8,870	9,316
Oak Orchard	15,321	15,827	15,997
Total Users by Year	167,592	185,483	183,288
<i>Percent Change from Previous Year</i>		11%	-1%
<i>Percent Increase from 2004</i>			9%

*Includes Mid-Hudson sites.

CHCs provide enriched primary care with supportive services. All patients, including the commercially insured, utilize and benefit from this enhanced delivery model. The intensity of services delivered during medical visits is consistent regardless of the patient’s payer source.

CHCs provide a wide range of services. All provide preventive and primary care to adults and children. Collectively, the CHCs provide, on-site or through arrangements with other providers, HIV/AIDS testing and treatment, pediatrics/adolescent care, urgent care, obstetrics and gynecology, dental care, optical care, and behavioral health care. Some CHCs also provide on-site imaging (e.g., radiology, ultrasound, and mammography), laboratory services, and pharmacy, including the 340b prescription drug benefit program which offers prescription medications at a reduced fee.

In addition to their medical services, CHCs provide an enriched model of primary care that includes many supportive services. By law, CHCs are required to provide enabling services that

facilitate care and improve outcomes, but also increase costs.¹² These services can include transportation, social work, case management, nutrition, outreach and patient/community education, translation/interpretation, and eligibility assistance/insurance enrollment.

When analyzing the scope and intensity of services provided at an FQHC, the types of procedures performed, as captured by the practice management system through billing codes, are commonly reviewed. Office visits are spread across 10 procedure types, varying in intensity depending upon whether the patient is new or an existing patient of the facility as well as the complexity of the actual visit performed. Relative value units, or RVUs, are used to capture the intensity of services between the 10 procedure types – the higher the RVU, the more intense the service. Table four indicates that the intensity of medical service is consistent regardless of payer type and that CHCs provide the same level of service to patients with different insurance coverage status.

Table 4. Intensity of Medical Service: Avg. Relative Value Unit per Visit by Payer, 2006

CHC Network	Medicaid FFS	Medicaid MC	Medicare	Commercial	Self-Pay
Callen-Lorde	1.94	1.78	1.96	1.88	1.84
FHN	1.60	1.57	1.62	1.53	1.45
HHHN	1.74	1.71	1.84	1.76	1.68
IFH*	1.91	1.86	2.06	1.92	1.76
NW Buffalo	N/A**	N/A	N/A	N/A	N/A
Oak Orchard	1.85	1.87	1.93	1.82	1.70
Total Average	1.82	1.75	1.88	1.77	1.71

* Excludes Mid-Hudson Family Health Institute.

**Northwest Buffalo does not use a reliable RVU tool at this time.

CHCs are needed providers that serve a broad range of vulnerable populations. Because of geography or patient population demographics, CHCs can be the main or sole provider of primary care.

In rural areas, CHCs can be the only or main point of access to primary care. HHHN is among the few primary care providers serving the rural north country area, including the counties of Warren, Hamilton, and Essex. As the only CHC in its service area, Oak Orchard has primary responsibility for serving patients with Medicaid and no insurance, who are not well-served by private physicians. Physician retirements and the difficulties of attracting new physicians to its rural area make Oak Orchard an increasingly critical provider of primary care. Similarly, FHN’s patients are described primarily as living in rural areas, “white”, and as having low income levels; some have limited education and low literacy levels. In three of FHN’s rural sites, it is the only medical provider in its service area and is the main provider accepting Medicaid and uninsured patients at a fourth location.

In urban areas, patients choose to receive care at CHCs for various reasons. For example, Callen-Lorde’s unique dedication to the lesbian, gay, bisexual, and transgender (LGBT) community attracts large numbers of commercially insured patients. While primary care options in Manhattan are numerous, LGBT patients often face discrimination in the mainstream medical

¹² 42 U.S.C. § 254b(b).

community, and as a result, do not receive adequate or timely medical care. The sensitive, caring and nonjudgmental environment at Callen-Lorde makes it a provider of choice for patients with private health insurance coverage. Also, in the lower Manhattan area, IFH attracts many young entry-level professionals in the arts and other industries who choose the CHC environment.

In addition to serving low income and uninsured patients, some CHCs serve large numbers of patients with commercial insurance. CHCs with substantial numbers of commercially insured patients are located in rural, suburban, and urban areas across New York State.

Figure 3.

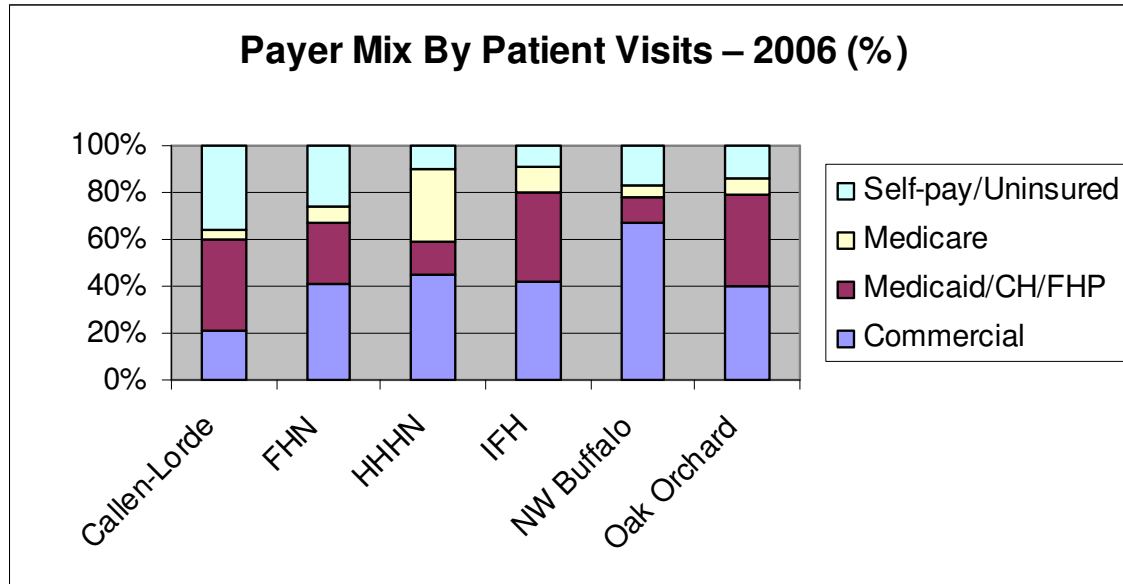


Table 5. Payer Mix By Patient Visits – 2006

CHC Network	Commercial (%)	Medicaid/CH/FHP (%)	Medicare (%)	Self-pay/Uninsured (%)
Callen-Lorde	21	39	4	36
FHN	41	26	7	26
HHHN	45	14	31	10
IFH*	42	38	11	9
Northwest Buffalo	66	11	5	17
Oak Orchard	40	39	7	14

* The relatively low percentage of self-pay/uninsured patients at IFH reflects that Mid-Hudson Family Health Institute was not an FQHC prior to its acquisition in 2007 and thus did not receive federal grant funds.

Commercial reimbursement rates are significantly lower than Medicaid and Medicare reimbursement rates. On average, commercial payment rates per visit are \$38 less than Medicaid FFS rates and \$17 less than Medicare rates.

Table 6. Average Net Revenue per Visit by Payer, CHC Case Studies, 2006

Payer	Average Net Revenue per Visit (\$)
Medicaid FFS	111.90
Medicaid MC*	86.03
Medicare	90.27
Commercial	73.72
Self-Pay	32.98
Average	79.23

* CHCs also receive a “wrap-around” payment for the difference between Medicaid managed care and Medicaid fee-for-service payments and Medicare managed care and Medicare fee-for-service payments.

Compared to the costs of providing medical services, the rates of payment from commercial insurers are inadequate to cover the cost of care.

On average, without co-insurance or co-payments, the CHCs lose \$41 on each medical visit they provide to a patient with commercial insurance. Accounting for the enabling services that CHCs provide in addition to medical services, the shortfall in commercial payments is even more severe. Collectively, the CHCs analyzed in this study lost more than \$5.8 million dollars in 2006 on the care they provided to commercially insured patients.

Table 7. Average Costs and Commercial Reimbursements for Case Study Sites – 2006

	Average per Visit (\$)*
Medical Cost	115.04
Commercial Reimbursement	73.72
Per Visit Loss for Medical Services	(41.32)
Total Cost	129.09
Commercial Reimbursement	73.72
Per Visit Loss	(55.37)

* Excludes Mid-Hudson Family Health Institute.

Table 8. Financial Losses Attributed to Serving Commercially Insured Patients, 2006

CHC Network	Losses on Commercial Patients (\$)
Callen-Lorde	(583,018)
FHN	(402,963)
HHHN	(2,398,092)
IFH*	(1,800,937)
Northwest Buffalo	(357,804)
Oak Orchard	(266,878)
Combined Total	(5,809,692)

* Includes Mid-Hudson Family Health Institute data.

Medicaid and Medicare payments are also below the cost of care, but come much closer to covering the costs of caring for patients.

Table 9. Average Reimbursement Versus Medical and Total Costs by Payer, 2006

	Commercial (\$)	Medicaid FFS (\$)	Medicare (\$)
Average reimbursement per visit	73.72	111.90	90.27
Co-insurance/co-pay	14.74*	3.00	18.05*
Total reimbursement per visit	88.46	114.90	108.32
Average medical cost per visit	115.04	115.04	115.04
Profit/(Loss) for <i>medical services</i>	(26.58)	(0.14)	(6.72)
Average total cost per visit	129.09	129.09	129.09
Profit/(Loss) for <i>total services</i>	(40.63)	(14.19)	(20.77)

*Estimated at 20% of the payment amount.

CHCs contract with numerous commercial payers and face large administrative burdens managing many different contracts. These substantial administrative burdens include individual physician credentialing, preauthorization requirements, and managing formularies.

IFH has contracts with 35 commercial payers. Such large numbers of contracts are common: Callen-Lorde has 21; FHN has 16; Oak Orchard has 12; Northwest Buffalo has 11; and HHHN has 9.

Despite recognizing the administrative burdens these contracts present, most CHCs have continued to sign additional contracts in order to provide continuity of care and a stable medical home for their patients. According to IFH, its patients are loyal, and 80 percent of its patients have seen their primary care provider within the last year. When these patients have their insurance coverage switched by their employers, IFH seeks new contracts in order to allow patients to remain “in-network” and continue using IFH as their medical home.

In addition to their formal contracts, CHCs accept patients with all types of commercial insurance and report a significant amount of “courtesy billing.” Northwest Buffalo, for example, reports that they have dealt with 98 different plans within the past year and a half. Similarly, HHHN reports having sent bills to over 1,000 different addresses because it is a primary source of care not only for year-round residents but also for vacationers and summer camp residents who may have insurance from different regions.

Not surprisingly, CHCs report that it is difficult to navigate among so many contracts with different terms and conditions. According to IFH,

Plans decide what type of provider they’ll reimburse for different procedures. So, for example, one plan does not reimburse a family doctor for putting in an IUD [intrauterine device]. Another plan will reimburse the family doctor for the

insertion, but not for the IUD itself; they'll only reimburse the IUD if obtained by the patient through a pharmacy. A third plan will say only an OB/GYN [obstetrician or gynecologist] can insert an IUD and get paid for it.

IFH continues,

We have been declined for many ancillary services we provide based on policies that do not seem to be written anywhere that we can find them. You can call for every little case, but the person who answers the phone won't know anyway because each company has so many different types of plans and there are different rules for each plan.

CHCs report lacking bargaining power in their relationships with commercial plans. CHCs rarely have the opportunity to negotiate rates with commercial payers and are instead presented with fixed rates and contract terms.

Rate negotiations between CHCs and commercial insurers are exceptionally rare. Instead, CHCs reported that they are presented with commercial contracts on a “take it or leave it” basis. New fee schedules and administrative changes are mailed out from plans with a notice that the provider is assumed to accept them unless they notify the plan in 60 to 90 days that they have chosen to terminate their participation.

Every CHC interviewed believed that they have insufficient volume to secure any leverage against the plans. CHCs in urban areas, in particular, reported that plans have wide networks of primary care providers, do not “need” CHCs to be in their networks, and can simply set whatever rates they desire. Northwest Buffalo reported that “between us and the other CHC in Buffalo, we have less than 20,000 patients in the area. We even have a ranking member of a major payer on our board but we still have no leverage.” CHCs also attribute their lack of leverage to a lack of good data; plans only rarely provide CHCs with performance data or benchmark comparisons, as discussed further below.

In rare instances, CHCs in rural areas reported having tried to negotiate better rates. The Mid-Hudson Family Health Institute, for example, has taken one of the more aggressive stances and has tried to improve commercial reimbursements. HHHN is also engaging in efforts to negotiate rate increases with several of their commercial payers. However, neither Mid-Hudson nor HHHN could report having had much success in these negotiations. Mid-Hudson reported having particularly acute difficulties negotiating with larger national health plans. In one instance, Mid-Hudson was able to negotiate a contract with a plan’s local representative and secured an agreement in writing but then found that the agreement would not be honored by the national company. After considering legal action, the expense and burden of dealing with this plan led Mid-Hudson to cancel the contract with that payer. Other CHCs also reported that larger national plans are generally more difficult to do business with and that locally-based plans tend to act more collaboratively even though they do not pay any better.

Occasionally, CHCs will attempt to negotiate on issues other than reimbursement rates. For example, some CHCs report unsuccessful efforts to secure facility-based contracts in lieu of individual physician contracts with plans and to streamline the physician credentialing process.

The requirement to individually credential each physician often means that months can pass when CHCs cannot get paid for services provided by a new physician. Others reported negotiating on issues such as FQHC compliance language and electronic claims submissions. Oak Orchard was able to convince one plan to pay for a nutritionist.

Finally, few CHCs have the health IT infrastructure necessary to independently capture and analyze data necessary to support contract negotiations. While IFH implemented a fully-integrated electronic health record and practice management system in 2002, most CHCs reported having limited information technology capabilities. Practice management systems were often cited as rigid and inadequate to meet the Center's data needs. According to one, "our practice management systems aren't as robust as the payer systems or the systems that hospitals and large groups use. We have no data outside of own little world." Similarly, while all CHC's expressed the desire to implement Electronic Medical Records (EMRs) to improve the capture and analysis of clinical information, few have the capital resources necessary to acquire and sustain them. Callen-Lorde installed an EMR in 1998 but has not been able to afford maintaining it and installing system upgrades, so it is of limited value. Currently, HHHN, FHN, Oak Orchard and Northwest Buffalo lack EMRs. Were health IT capabilities enhanced at CHCs, it could facilitate their increased participation in quality improvement and incentive programs, and perhaps increase negotiation leverage.

The commercial rate-setting process is a "black box"; rates are simply set unilaterally by the plans, and payment policies are usually unpublished.

Without negotiating rates, CHCs cannot explain how their commercial rates are set by plans. Various theories were advanced, but no CHC knew for sure how their commercial reimbursement rates are established. They report that their contracts do not always include specific rates and that payment policies are unpublished. Instead, contracts may refer to "usual and customary" Medicare rates for their region with some further rate adjustment. According to CHCs, contracts tend to be on automatic renewals without annual rate negotiations or adjustments. The executive director of Northwest Buffalo reported that there had been no commercial rate increase in the 18 months that he had been at the center.

Quality-of-care incentives in managed care contracts are rare, based on mysterious formulas, and generate only minimal payments for some CHCs.

CHCs report that some of their commercial managed care contracts contain quality incentives or pay-for-performance mechanisms. However, these incentives are not standardized across different plans and there is significant confusion regarding how they work and which plans examine which measures. As a result, CHCs cannot modify their clinical practices to maximize these payments. Usually, the CHCs reported that they do not actively apply for these payments; Callen-Lorde, for example, reported that occasional small payments are received automatically "out of the blue." Northwest Buffalo reported that one payer occasionally conducts chart reviews while another plan processes payments on the basis of claims data. IFH reports having received small bonus payments but states that

"No one knows how they measure them or why we are getting them. The formulas are very complicated and the amount received is not large enough to

drive any practice changes. The plans do the calculations and small amounts of money just arrive every now and then.”

The sums received through these programs are modest enough that most CHCs interviewed could not quantify their amounts. Some limited exceptions exist. FHN reported receiving approximately \$50,000 a year in quality incentives from one plan that does provide explicit criteria. Oak Orchard would like to participate in a new diabetes/asthma program that one plan is offering – and could get upwards of \$4,000 for participating – but the administrative burden for participation is too high and the center does not have the staff or the means to participate, noting that “the support staff time required would be too much to be worth it.” In essence, these payments serve as rewards rather than incentives that drive changes in practice behaviors.

CHCs have sometimes benefited from the savings they generate for plans, but commercial insurers have largely cancelled incentive programs.

IFH reported having once been involved in a “partnership plan” with Oxford. Under the Plan, Oxford established a special pool of funds and then distributed among providers any funds that were not spent due to reductions in specialty and emergency care. For IFH, the program generated approximately \$600,000 annually. Eventually, Oxford cancelled this program and IFH believes it is unlikely that plans will reinstate similar programs because “why would plans pay more for what they already get for free – high quality comprehensive health care?” CHCs will deliver consistently high quality primary care regardless of incentive programs and accordingly plans have no reason to reward providers who help them achieve savings.

Commercial plans only rarely provide CHCs with performance data or benchmark comparisons.

Occasionally, plans provide such information. Northwest Buffalo, for example, cited one more collaborative payer that provides them with statistical data about diagnosis and treatment patterns and provides benchmarks against other providers. HHHN has received useful information from only one of its commercial payers. IFH reported receiving data from one payer on utilization relative to peers but said these reports are inaccurate and not useful. Mid-Hudson has received data from a few of its payers. Oak Orchard also reported that they sporadically receive performance data but that it is often inaccurate and not useful. Callen-Lorde reported that they never receive any data on their performance from their commercial payers.

Commercial plans are slower to pay submitted claims than Medicaid or Medicare and sometimes decline claims for technical reasons.

CHCs generally reported that commercial payers typically take 45-60 days to pay claims, which is nearly twice as long as their experiences with Medicaid and Medicare. One CHC, however, reported having their claims from all payers paid within four to six weeks. In addition, all CHCs reported that a significant portion of their submitted claims are returned to them for editing/recoding and resubmission, which requires substantial staff time and effort. However, very few claims result in denials of payment that require formal appeals.

CHCs have not dropped commercial contracts and rarely decline to contract with plans.

CHCs have not cancelled contracts with commercial payers other than in one instance by Mid-Hudson. Although they have considered doing so, commitments to their patients and missions have precluded CHCs from cancelling contracts. Occasionally, CHCs such as Oak Orchard reported having declined to accept a contract because the reimbursement rates offered to them were too low. When CHCs declined to accept a contract, the plans did not counter-offer with higher reimbursement rates.

Panel closures are also rare.

In July 2006, Callen-Lorde closed five commercial panels representing 50 percent of their commercial patient volume as part of a deliberate effort to alter their payer mix and reduce their proportion of commercial reimbursements. Callen-Lorde also subsequently closed a sixth panel in April 2007. When closing panels, Callen-Lorde used an active referral program to ensure that patients were connected to another source of primary care, usually a private physician practice. Panel closures cost Callen-Lorde some goodwill within their patient community, yet they maintain the panel closures were a financial necessity to preserve their fundamental mission.

Oak Orchard reported closing their commercial panels for family medicine because of capacity constraints. The family medicine physicians at Oak Orchard were fully-utilized and could not handle additional patients. Unless Oak Orchard can attract more primary care providers to their rural region, the capacity shortage will continue. Mid-Hudson also temporarily closed some panels but is in the process of reopening them.

Other CHCs report considering closing panels but have not actually done so.

CHCs are efficient, low-cost, well-managed providers of primary care. CHCs have implemented a wide range of management strategies to address the commercial payment shortfall, but the benefits of these strategies are largely exhausted.

The CHCs in this study generally meet or exceed national benchmarks in terms of productivity and cost control. Their medical costs per encounter as well as their total costs per user are generally lower than the national averages for CHCs, despite the expense of operating in New York.

Table 10. Productivity and Efficiency Measures, Case Studies Versus National Benchmarks, 2005

	Callen-Lorde*	FHN	HHHN	IFH**	Northwest Buffalo	Oak Orchard
<i>Team Productivity</i>						
Actual	2,473	4,280	4,766	4,152	3,533	4,287
Ntl. Avg.	4,312	4,312	4,312	4,312	4,312	4,312
<i>Medical Cost per Medical Encounter</i>						
Actual	210	92	85	158	105	78
Ntl. Avg.	111	111	111	111	111	111
<i>Total Cost per Total User</i>						
Actual	899	351	452	465	437	379
Ntl. Avg.	515	515	515	515	515	515

*Callen-Lorde's results reflect the high acuity of its patient population and its specialty practice serving patients with HIV/AIDS. ** Excludes Mid-Hudson Family Health Institute data.

CHCs have been unable to directly address the revenue shortfalls in commercial reimbursements. Instead, many have applied various “band-aids” and attempted to fill the gaps with other revenue sources. Efforts to enhance revenues have included such steps as improving billing practices, vigorously pursuing self-pay collections such as co-pays, fundraising, and investing in revenue cycle teams. Others have implemented expense-reduction strategies such as hiring freezes, limiting salary increases, eliminating services such as physical therapy, and reducing hours of operation. While these measures have provided some financial relief, none of them directly address the fundamental issue of low reimbursement rates. These strategies alone cannot solve the growing fiscal crisis faced by CHCs with large numbers of commercial patients.

V. RECOMMENDATIONS

Policymakers in New York State have identified reimbursement reform and strengthened primary care as top priorities in transforming the state's health care system. CHCs are an integral part of the state's primary care infrastructure, often being the main point of access to care for an array of vulnerable patient populations. However, the ability of some CHCs to continue fulfilling this role is severely jeopardized by low reimbursement rates from commercial insurance plans. While Medicaid and Medicare are covering most of the cost of providing care, payments from commercial plans are falling far short of meeting these costs. Unless this gap in reimbursement rates is corrected, the ability of CHCs to keep their doors open to all patients regardless of insurance source is at risk.

While there are no “magic bullets” to rectify this gap in reimbursement rates, we recommend a variety of strategies to improve commercial reimbursement for CHCs. Taken individually, it is unlikely that any of the following strategies will be enough to fill the commercial reimbursement gap for CHCs. When grouped together, however, these strategies can improve the situation for CHCs:

1. Require the inclusion of CHCs in commercial insurance provider networks and ensure adequate compensation to cover federally mandated services.

New York State currently requires that health maintenance organizations (HMOs) have “adequate” provider networks.¹³ A variety of factors are considered in determining the adequacy of a provider network, and a key focus is on accessibility. A network must contain a sufficient number and mix of providers capable of meeting the diverse and comprehensive needs of enrollee populations. Networks must include geographically accessible providers of both primary and specialty care. Most notably, HMOs must have a minimum of three primary care providers accessible within reasonable travel and distance time standards. Networks are reviewed annually by the State to ensure that this standard is being met. While several CHCs operating in rural areas noted that their sites were often the only provider of primary care in the region, inquiries to the regulating agency indicated that adequacy of primary care capacity had not been found to be a problem for New York's HMOs. New York would benefit from closer examination of the standards used to determine adequacy of provider networks to better understand the source of this discrepancy.

While such an examination is important to a limited number of rural providers, it is inadequate to address the problem more broadly. New York's Medicaid managed care program has implemented more targeted policies to both ensure patients' continued access to the enriched delivery model of CHCs and to support the financial viability of CHCs themselves. Under New York's Medicaid Managed Care program, managed care organizations operating in mandatory counties must contract with at least one CHC operating in their service areas. This requirement stems from CMS approval of the implementation of New York's Section 1115 Waiver program, the Partnership Plan.¹⁴ A key underlying concern is that managed care organizations have

¹³ N.Y. Pub. Health Law § 4403(5)(a).

¹⁴ See Chapter 18 of the “New York State Operational Protocol for the Partnership Plan” available at http://www.health.state.ny.us/health_care/managed_care/partner/operatio/. This requirement also is incorporated in

adequate networks to provide appropriate choices of providers capable of offering clinical and enabling services to vulnerable populations and meet the needs of recipients in their service area. An exemption from this mandatory contracting requirement exists, provided a managed care organization can demonstrate that it has adequate capacity and the ability to provide comparable services that CHCs offer; any exemption request is subject to CMS approval. The goals that have driven this policy are worthy of consideration in the commercial environment, as well.

A statutory requirement mandating the inclusion of CHCs in HMO provider networks would bolster the negotiating leverage of CHCs to demand adequate rates. At present, CHCs perceive that plans are indifferent to their inclusion in networks. If CHCs were a required component of network adequacy, CHCs, especially those in rural areas, could negotiate on a more level playing field with commercial HMOs. Exemptions to such a new statutory requirement would be made in areas without any CHCs.

A second Medicaid policy worthy of consideration in the commercial context is “wrap-around” reimbursement. Currently, Medicaid funds are provided to “wrap-around” Medicaid managed care plan reimbursement rates, ensuring CHCs are fully reimbursed for their care. This policy stems from requirements under federal law that CHCs receive adequate Medicaid reimbursement to cover the cost of the wide range of services provided by CHCs.¹⁵ New York should consider similar requirements that would ensure commercial rates are adequate to reimburse for the full range of federally mandated services. This could be accomplished through creation of a “wrap-around” pool.

The regulatory rationale for such requirements is compelling: without such protections, public funds intended to enable CHCs to serve uninsured and publicly insured populations will be at risk of being diverted to fill the gaps created by inadequate commercial rates. In other words, without regulation, commercial payers have every incentive to become “free riders,” and the public good created by government investment in CHCs will be undermined.

2. Create a unified incentive fund to reward CHCs that provide superior quality of care and establish uniform methods for measuring care and administering these funds.

CHCs should receive a share of the savings that they produce for commercial payers as a result of their excellent care and success in reducing hospitalizations and the costly use of specialists. This does not currently happen. HHHN, for example, was provided data by one commercial plan that documented the savings HHHN had produced because they effectively manage their chronically ill patients, provide some specialty services in-house, and effectively prevent unnecessary hospitalizations. According to the plan’s own data, the average cost per patient for 2005 was \$2,452 and the cost per patient for HHHN was \$2,128. HHHN saved this plan \$342 per patient, based on the difference between HHHN’s cost and the average cost per patient for the plan. Yet, none of these savings were returned to HHHN.

the New York State Medicaid Managed Care and Family Health Plus Model Contract available at http://www.health.state.ny.us/health_care/managed_care/docs/medicaid_managed_care_and_family_health_plus_model_contract.pdf. See Section 21, pages 10-11.

¹⁵ 42 U.S.C. § 1396a(bb)(5)

The CHCs interviewed for this study repeatedly cited a lack of standardized quality measures across different plans. CHCs also reported significant confusion regarding how they work. It does not appear that, as structured, these incentives are effective at influencing behaviors and bringing out desired performance improvements.

In Spring 2005, New York State statutorily established a new “Pay for Performance” program to promote patient safety, quality of care and cost effectiveness by rewarding hospitals, physicians and clinics that provide high quality care. Subsequently, a broad-based workgroup developed consensus on clinical ambulatory and inpatient measures necessary and appropriate to achieve improvement in quality demonstration programs. Using these measures, four demonstration projects are scheduled to begin in various regions of the state. Each multi-payer collaborative demonstration will apply a common set of measures to participating providers and aggregate performance data as necessary across payers. Within each demonstration, providers who exceed performance benchmarks will receive cash payments. These demonstrations deserve careful scrutiny and, if successful, should be expanded and modified to support CHCs that consistently provide high quality care and achieve satisfactory patient outcomes.

3. Establish community reinvestment strategies to fill the gaps in commercial payments to CHCs.

New York State has historically relied upon dedicated funding pools to ensure the provision of necessary health services. A similar strategy could be deployed to address the failure of commercial insurers to adequately reimburse community health centers. New York State should establish a reinvestment mechanism that directs profits from commercial payers for the purpose of financially stabilizing CHCs.

Currently, numerous bills are under consideration by the Legislature that would require reinvestment of HMO and health insurer profits in the health care delivery system. Citing the fact that “many health insurers and health maintenance organizations incur substantial profits and have excess reserves while health care providers in general struggle financially,” Senate Bill 6056 would require that health insurers and HMOs provide funds to improve provision of health services, improve quality of care, workforce, infrastructure, and efficiency.¹⁶ A second bill would apply a percentage of the profits of for-profit health insurers to establish a community health care investment fund that would make grants to address health care disparities and access to health care.¹⁷ Another bill under consideration would require for-profit insurers and for-profit HMOs to provide funds for reinvestment in health information technology in the suburban area around New York City.¹⁸ Yet another bill would set aside “one and one-half percent of the aggregate of all healthcare related premiums and back office charges” to provide assistance to hospitals to upgrade their technology and modernize their infrastructure.¹⁹ Given the documented inadequacy of commercial payments to CHCs, such reinvestment programs should

¹⁶ S.B. 6056, 230th Ann. Leg. Sess., Reg. Sess., (N.Y. 2007) (Hannon), and Assemb. B. 8074, 230th Ann. Leg. Sess., Reg. Sess., (N.Y. 2007) (Bradley) (pending).

¹⁷ S.B. 4795, 230th Ann. Leg. Sess., Reg. Sess., (N.Y. 2007) (Sampson) (pending).

¹⁸ S.B. 4016, 230th Ann. Leg. Sess., Reg. Sess., (N.Y. 2007) (Morahan), and Assemb. B. 6509, 230th Ann. Leg. Sess., Reg. Sess., (N.Y. 2007) (Paulin) (pending).

¹⁹ S.B. 4600, 230th Ann. Leg. Sess., Reg. Sess., (N.Y. 2007) (Young) (pending).

be modified to provide directed fiscal support to CHCs which are a critical component of the state's primary care delivery system.

4. Support CHCs in creating more effective business partnerships with commercial plans and strengthen their ability to do so through investment in health information technology (health IT).

Until recently, the CHCs have not generally followed strong business practices in their dealings with commercial payers. For the most part, CHCs have not attempted to negotiate adequate rates with their commercial payers and have simply accepted the rates dictated to them, with no understanding of how those rates were calculated. While CHCs are motivated first and foremost by their mission to serve their patients, there can be no mission without adequate financial margins to support the provision of high quality care and continual reinvestments in their care management systems. CHCs must take responsibility for being credible negotiators at the bargaining table. Having had some success with negotiating on issues other than payments, CHCs must be just as strenuous in insisting on adequate reimbursement rates.

To enable CHCs to be better negotiators, they need the data, systems and tools to increase their negotiating leverage. For example, CHCs are often hampered by the failure of plans to provide patient-specific and aggregate-level data and handicapped by a lack of information to facilitate their negotiating position. Support for the implementation of health information technologies (health IT) such as electronic medical records (EMRs) will significantly strengthen their ability to manage care as well as their ability to generate data necessary to prove the benefits and savings that they produce for commercial payers. EMRs have also been shown to decrease the costs and administrative time associated with billing and other administrative functions. EMRs will help prepare CHCs for meaningful participation in quality-based reimbursement. Likewise, CHCs must systematically strengthen their use of proper billing codes to reflect the actual care being delivered and ensure that appropriate payments are not lost due to poor billing practices. Initiatives to support CHC acquisition and implementation of HIT will enhance the ability of CHCs to improve business practices and negotiate favorably with commercial payers.