## IMPLEMENTING HEALTH REFORM

# Community Health Centers

The Affordable Care Act includes $11 billion in new funding to significantly expand the reach of federally qualified health centers, known as community health centers. The bulk of the funding – $9.5 billion – will be used to fund new health centers and to expand patient capacity at existing centers. Over the next 5 years, that funding is expected to double community health center capacity to about 40 million patients. The first $1 billion in funding is being distributed this year.

Dr. Gary Wiltz, who runs a network of community health centers in rural Louisiana, explains how the new funding and other provisions of the ACA will impact primary care in underserved areas.

**RHEUMATOLOGY NEWS:** The ACA would help expand services to an additional 20 million patients. Will that begin to address the need for primary care services in underserved areas?

**Dr. Wiltz:** I think it most definitely will. The community health center network has long been advocating for expansion to try to meet the needs of about 60 million people whom we consider disenfranchised because they don't have a regular source of medical care or a medical home.

This funding, if it's fully implemented, will help us to get close to 40 million patients by 2015. We'll have the largest network of primary care providers in the nation. Along with that funding, there is a tripling of funding for the National Health Service Corps, which also will help to address the shortage of primary care providers. But we're certainly not going to solve all of the nation's ills. I think if we continue to invest in building capacity and getting folks good primary, comprehensive preventive care where they live, we can solve some of these problems by getting them out of the emergency department.

**RN:** Where are the greatest unmet needs?

**Dr. Wiltz:** One of the things we see a lot in our practice is that people go without care because they don't have insurance. They come in for just acute, episodic care and they do it in the emergency department. They'll seek care in that setting, which is the most expensive care they can get. If you don't have a payer source, it's very difficult to navigate the system. Even if you have insurance, a lot of people don't know how to navigate the system. That's why we want to be their medical home. What we attempt to do is provide a wide array of services in one place.

**'If residents train in our community health centers, then they will have the skill sets to do what we do.'**

DR. WILTZ

**RN:** The ACA also includes funding to develop medical residency programs at community health centers. What is the advantage of offering training through health centers?

**Dr. Wiltz:** A few years ago, the National Association of Community Health Centers (NACHC) came up with the idea of "growing our own." I'm an internist, and when I was a resident, there was a lot of the emphasis placed on hospital-based medicine. Outpatient primary care clinics were an afterthought. It wasn't until I got into a community health center setting that I recognized that that's really where you can make a difference. If residents train in our community health centers, then they will have the skill sets to do what we do: provide primary care in a setting with lots of uninsured patients who lack resources. So we came up with the idea of NACHC U. We started with a dental school. Now it's spread to a medical school model. The natural progression was to offer a residency training program. So in the ACA, lawmakers included a provision that's specific to teaching in community health centers. In the last round of funding, several centers received funds. The hope is that we will spread that as time goes on. This introduces residents to primary care where the needs are the greatest. But most importantly, it increases the number of primary care residencies.

**RN:** Community health centers have been touted as models for providing high-quality, low-cost primary care. What lessons can physicians outside of that system apply to their own practice?

**Dr. Wiltz:** There's no one magic bullet, so the private sector and the public sector have to work together. Wherever we can collaborate, we want to collaborate. Concerned physicians can get involved in the community to promote good health. For example, they can work with local food stores to make sure patients have healthy choices or improve the places where people go to exercise. But we have the advantage in community health centers because we have resources to bring to bear that you wouldn't have ordinarily in a private practice. We can provide services in one place and offer discounted prices for medications. I have a lot of colleagues who want to be a part of this solution. But the ultimate step will be if those uninsured people have a payer source; then they can be seen by for primary care. ■

*DR. WILTZ is CEO of Teche Action Clinic, a network of seven community health centers based in Franklin, La. He is also the treasurer and a member of the executive committee of the NACHC.*

*–Interview by Mary Ellen Schneider*

# Quality Reporting Payouts Were $234 Million in 2009

BY ALICIA AULT

FROM THE CENTERS FOR MEDICARE AND MEDICAID SERVICES

About $234 million in bonuses under the Physician Quality Reporting System and $148 million in incentives for ePrescribing were paid out in 2009, according to the Centers for Medicare and Medicaid Services.

Participation in the now-voluntary PQRS has grown 50% per year since the program started in 2007 and currently includes one in five eligible health care professionals. In 2009, some 210,000 physicians and other eligible health care professionals participated, but just 119,804 clinicians reported data in a manner consistent with the necessary criteria for incentive payouts, the CMS said.

**The average payment per professional was $1,956 and the average payment per practice was $18,525, according to the CMS.**

Emergency medicine physicians had the highest rate of satisfactory reporting, the CMS said. In 2009, 31,000 reported on at least one quality measure and 79% received an incentive payment.

"Although participation in our pay-for-reporting programs is optional now, it should be regarded as imperative in terms of medical professionals' shared goal of improving quality of care and patient safety," CMS Administrator Donald Berwick said in a statement.

The average payment per professional was $1,956 and the average payment per practice was $18,525, according to the CMS.

Payments, which were sent in the fall of 2010, were equal to 2% of total estimated charges under Medicare Part B.

Physicians and health professionals could report on 194 measures. The three most frequently reported quality measures were performing electrocardiograms in the emergency department to diagnose chest pain; using electronic health records to organize and manage care; and working with diabetics to control blood glucose levels.

Some of the notable improvements since the program's inception included a near doubling of the number of physicians reporting that they had talked with diabetic patients about eye-related complications – 93% in 2009 as compared to 52% in 2007.

Also, beta-blockers were recommended to patients with left ventricular systolic dysfunction by 95% of reporting physicians in 2009, as compared to 64% in 2007.

The PQRS program will remain voluntary until 2015, when the Medicare program will start withholding payments for lack of participation.

The first year of the ePrescribing program was 2009. That year, 48,354 physicians received an ePrescribing incentive payment, with an average payment of $3,000 per individual and $14,501 per practice.

The deadline for participation in the ePrescribing program is much sooner than that for the PQRS program. Physicians will see pay reductions beginning in 2012 if they don't participate in ePrescribing.

For more information on how to participate in the PQRS program, visit www.cms.gov/PQRS/. ■

## INDEX OF ADVERTISERS