



# Issues Brief

# 3

NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS, INC.®

## Strategies for Maintaining Network Development: *Lessons Learned from the Community Integrated Services Initiative*

**This issues brief concentrates on midcourse changes in network development as the networks are challenged by external and internal developments. It discusses four major issue areas:**

- ♦ **The initial goals.**
- ♦ **The external and internal challenges that induced change.**
- ♦ **The strategies to assure success when faced by these challenges.**
- ♦ **Strategies for attaining network sustainability.**

### PREFACE

This Issues Brief is one of three representing some of the lessons learned from the Community Integrated Services Initiative, a program jointly sponsored by the National Association of Community Health Centers, Inc. (NACHC) and the W.K. Kellogg Foundation. The three briefs are:

- ♦ Strategies for Early Network Development
- ♦ Building Trust Among Network Partners Through Communication and Leadership
- ♦ Strategies for Maintaining Network Development

The briefs were written by Ann Zuvekas, DPA, and Lea Nolan, MA, of The George Washington University's Center for Health Services Research and Policy, who evaluated the Initiative to identify factors that contribute to the creation and sustainability of successful networks. For more information about development of health service delivery networks for providing care to underserved communities, contact

Malvise Scott, Corporate Vice President, at NACHC, 202/659-8008.

The briefs may be obtained at the NACHC website [www.nachc.com](http://www.nachc.com).

The ten networks receiving funding from the Community Integrated Services Initiative (CISI) offer lessons for other safety-net health service providers in the early stages of network development. CISI is a program jointly sponsored by the National Association of Community Health Centers, Inc. (NACHC) and the W.K. Kellogg Foundation, created to establish community health center-driven integrated health service delivery networks and/or health plans for the underserved. The program has provided \$4.2 million in matching grant funds to support early-stage development activities within these networks and to identify factors that contribute to the creation and sustainability of successful networks.

To set the context, we begin with a brief description of the CSI networks.

## THE CISI NETWORKS

The CISI grants were awarded to networks of federally funded Community/Migrant Health Centers, Health Care for the Homeless Programs, Centers for the Residents of Public Housing, and State and Regional Primary Care Associations; in some cases they included other safety-net providers. Four one-year grants began in 1998 and six in 1999. Exhibit 1 gives an overview of the ten networks.

### EXHIBIT 1 COMMUNITY INTEGRATED SERVICES INITIATIVE GRANTEES

Cohort	Grantee	Service Area	Type of Network
<b>COHORT I</b>	New Mexico Integrated Services Network	Statewide-urban and rural	Horizontal - 10 FQHCs
	Providers of Health Care for the Homeless	New York City's five boroughs	Horizontal - 6 agencies serving the homeless
	Southern Ohio Health Services Network	Rural Cincinnati area	Vertical - CHC, multi-specialty group, 2 non-profit hospital systems
	Central Valley Health Network	18 rural counties in California's Central Valley	Horizontal - 10 FQHCs
<b>COHORT II</b>	Alabama Community Health Care Network	Statewide - urban and rural	Horizontal - 9 FQHCs
	Alliance of Chicago Community Health Centers	North side of Chicago	Horizontal - 6 FQHCs
	Community Integrated Services Network of Pennsylvania	Statewide except Philadelphia	Horizontal - 19 FQHCs, 1 rural health clinic
	Montana Network	Regional, partners' service areas	Horizontal - 6 FQHCs
	Northern Michigan Health Services Community Integrated Services Initiative	15 communities surrounding partners	Horizontal - 17 FQHCs, 1 non-profit HMO
	Vulnerable Population Managed Care Integrated Services Partnership Network	Six urban and rural Indiana counties	Vertical - CHC and 2 hospital systems

## THE INITIAL GOALS

As shown in their initial applications for CISI grants, all ten networks included in their goals some form of readiness for managed care, ranging from building a managed care negotiating network to developing a full-risk Medicare product. In part this emphasis on managed care stemmed from the grant's requirements that the networks address managed care as a primary purpose, and in part the emphasis was a reflection of the health care environment's continuing preference for risk contracting, especially for Medicaid beneficiaries.

All the CISI grantees initially saw managed care as both an opportunity and a threat. That is, in some way the networks were to assist in contracting for managed care to help the members generate surpluses to be used for care to the uninsured, to maintain or increase market share, and to improve access and quality of care. Most of the networks also sought to assist in improved care and practice management and, in some cases, shared services such as purchasing or personnel.

**A**ll the CISI grantees initially saw managed care as both an opportunity and a threat.

In general, networks' goals can be divided into two types: 1) *a managed care network*, and 2) *a practice management network*.

- ♦ ***A managed care network*** can be on a continuum from an entity that negotiated managed care contracts on behalf of individual provider institutions, to an entity that accepts some financial risk itself, to a full-risk managed care organization. New Mexico's and Michigan's goals largely were those of developing a managed care network (See Exhibit 2).<sup>1</sup>
- ♦ ***A practice management network*** examines and improves its members' readiness for managed care, as well as develops services to improve the members' clinical, management, and financial performance with or without managed care. Ohio's and Illinois's goals largely were those of a practice management network.
- ♦ ***A mixed model*** has goals that include both a managed care network and a practice management network. New York's, California's, Alabama's, Pennsylvania's, Montana's, and Indiana's goals were a mix of the managed care network and the practice management network.

---

<sup>1</sup> As Exhibit 2 shows, the networks had broad goals that somewhat included both types of networks. This discussion is a summary that attempts to place those goals into categories.

**EXHIBIT 2  
NETWORKS' ORIGINAL GOALS**

<b>Grantee</b>	<b>Original Goals</b>
New Mexico Integrated Services Network	<ul style="list-style-type: none"> <li>♦ Contract as single entity for Medicaid, Medicare, and commercial lives</li> <li>♦ Assume risk either through capitation or withhold pools</li> <li>♦ Develop shared services</li> <li>♦ Create a seamless delivery system</li> <li>♦ Contract for medical, dental, behavioral health, ancillary and enabling services</li> </ul>
Providers of Health Care for the Homeless (New York)	<ul style="list-style-type: none"> <li>♦ Respond to New York State's 1115 waiver (attempt to exempt homeless people from mandatory managed care)</li> <li>♦ Build a managed care negotiating network</li> <li>♦ Establish actuarial categories and payment methodologies for caring for the homeless</li> <li>♦ Market members' services to MCOs</li> <li>♦ Build information systems capabilities toward coordinating care to the homeless</li> </ul>
Southern Ohio Health Services Network	<ul style="list-style-type: none"> <li>♦ Build a coordinated delivery system</li> <li>♦ Prepare for mandatory Medicaid managed care</li> </ul>
Central Valley Health Network (California)	<ul style="list-style-type: none"> <li>♦ Create an IPA of primary care centers</li> <li>♦ Integrate billing, quality assurance, utilization review, clinical protocols</li> <li>♦ Organize or partner with organization with Knox Keene license to provide prepaid health services</li> </ul>
Alabama Community Health Care Network	<ul style="list-style-type: none"> <li>♦ Negotiate group managed care and other payer contracts</li> <li>♦ Achieve cost/administrative efficiencies through group purchasing and practice management</li> <li>♦ Expand capacity and enter areas of state without FQHC presence</li> <li>♦ Improve clinical outcomes and management effectiveness</li> <li>♦ Obtain and implement statewide Medicaid contract, and commercial and Medicare contracts</li> <li>♦ Hire staff and relocate network offices</li> <li>♦ Be fully operational and expand number of patients seen by members</li> </ul>
Alliance of Chicago Community Health Centers	<ul style="list-style-type: none"> <li>♦ Attain a more formal structure that will allow for negotiation and joint contracts, procurement of loans, and acquisition of capital resources</li> <li>♦ Complete preparations for joint managed care contracting</li> <li>♦ Implement an information system to track utilization data for clinical management, needs assessment, and planning</li> <li>♦ Hire staff to coordinate and standardize activities across network</li> <li>♦ Develop a more formal understanding of the relationships with potential hospital partners</li> </ul>
Community Integrated Services Network of Pennsylvania	<ul style="list-style-type: none"> <li>♦ Enter into risk arrangements with at least three HMOs for Medicaid and at least one Medicare arrangement</li> <li>♦ Establish partnerships with specialists and hospitals and other providers</li> <li>♦ Develop resources to monitor and manage clinical activities to promote economic discipline and assure quality of care (MIS, case management, risk assessment, and clinical guidelines)</li> <li>♦ Conduct feasibility study on formation of a licensed HMO</li> </ul>
Montana Network	<ul style="list-style-type: none"> <li>♦ Determine whether formal incorporation is needed and be ready to execute corporate or partnership agreements</li> <li>♦ Achieve a central reporting system and data collection/dissemination entity for MIS, financial and clinical/QA</li> <li>♦ Assess potential for reasonable acceptance of risk</li> </ul>
Northern Michigan Health Services Community Integrated Services Initiative	<ul style="list-style-type: none"> <li>♦ Create a negotiating network to provide managed care to the Medicare population</li> <li>♦ Fully contract the network</li> <li>♦ Establish systems to accept and manage Medicare members</li> <li>♦ Complete staff training at both the plan and center levels</li> <li>♦ Negotiate Medicare rates with HCFA</li> <li>♦ Submit application to obtain the state's approval on the product</li> </ul>
Vulnerable Population Managed Care Integrated Services Partnership Network (Indiana)	<ul style="list-style-type: none"> <li>♦ Develop partnership mission statement and secure ongoing partner commitment to mission</li> <li>♦ Gather, assess, and analyze additional information on: market place, interest of additional partners, details of partners' operating systems, Medicaid MCOs</li> <li>♦ Develop preliminary network design</li> <li>♦ Test and/or validate preliminary design with partners and stakeholders</li> <li>♦ Finalize design based on test/validation information</li> <li>♦ Solicit additional potential partners</li> <li>♦ Develop broad initial implementation in 6 counties</li> <li>♦ Secure year two financing for implementation</li> </ul>

All the CISI networks reported that, in hindsight, many of the goals they set prior to obtaining the grant were too ambitious to achieve in the 12-month CISI grant period. Both external and internal conditions pushed them toward revised goals and strategies to continue their network development.

## THE EXTERNAL AND INTERNAL CHALLENGES THAT INDUCED CHANGE

As networks develop objectives, create business plans, and begin implementation of their initial goals, they face external and internal challenges that often in move them toward revised goals and strategies.

### *External Challenges*

The major external challenges that the CISI networks faced were: 1) changes in Medicaid managed care programs (and, in one case Medicare managed care); 2) refusal of Managed Care Organizations (MCOs) to negotiate with the networks; 3) development of local hospital-based networks; and 4) turnover of MCOs' and state Medicaid programs' staff.

- ♦ ***Change in Medicaid managed care programs*** was the most serious challenge to the CISI networks. Since one of the major impetuses for the networks' development was the threat and opportunity of mandatory managed care for Medicaid beneficiaries, state delays or pullbacks from these mandates tended to remove the urgency of network development. For example, New York's decision to postpone inclusion of homeless persons in its mandate for managed care reduced the urgency of the CISI network's progress. In Alabama, based on the state's negative experience in risk contracting with a failed MCO pilot project in Mobile, the state postponed Medicaid risk contracting indefinitely, as did Illinois for Chicago and Ohio for the Cincinnati area.

Similarly, changes in the federal Medicare program for risk contracting, which occurred largely as the result of interpretation of the 1997

Balanced Budget Act, greatly reduced the opportunities for the Michigan network to pursue Medicare risk contracts as companions to its Medicaid contract.

- ♦ ***Refusal of MCOs to negotiate with the networks*** was a major challenge in New Mexico and Pennsylvania. Since the MCOs already had contracts with individual members of the networks, they initially saw little reason to either renegotiate those contracts or to contract directly with the networks.
- ♦ ***Development of local hospital-based networks*** in potentially direct competition with the CISI CHC-based networks that covered a broader geographic area left the CHC network members uncertain about where their affiliations and loyalties should lie. This was a particular issue in Montana and New Mexico. The CHCs especially felt the pull to affiliate with the local hospital-based networks when the hospitals had traditionally been their back-up institutions for inpatient and emergency care.
- ♦ ***Turnover of MCOs' and state Medicaid programs' staff*** became problematic as the networks in New Mexico and Pennsylvania sought to demonstrate their value as contractors who could deliver high-quality and efficient care. In New Mexico, the Directors of Provider Relations at two of the three plans with state Medicaid contracts resigned in the midst of talks with the network. At the third plan the staff member responsible for drafting a single contract for network members went on maternity leave and was thus inaccessible.

### *Internal Challenges*

In addition to the above external challenges, the networks found themselves dealing with internal network conditions that were largely not visible when the initial goals were articulated: 1) enormous variation in partners' understanding of and readiness for risk-based managed care; 2) members' attention and interest focused elsewhere; 3) time requirements for network development; 4) turnover

of network staff; and 5) members' needs for practice management.

- ◆ **Variation in partners' understanding of and readiness for risk-based managed care** resulted in protracted discussions about the degree of risk to accept, as well as the terms of managed care contracts that were acceptable. This issue surfaced in all the CISI networks. Partners often had confidence in their own organizations' ability to manage care and costs, but not necessarily in their partners' capacity to do so.
- ◆ **Members' attention and interest focused elsewhere** meant they had limited capacity to invest in the networks' development. Many CHCs are thinly staffed at the management level, which means that their leaders are often occupied with other, non-network, tasks. This was particularly apparent in networks with large proportions of rural centers such as Montana, New Mexico, and Pennsylvania. Networks that involved hospital partners, such as Indiana and Ohio, found it difficult to keep the attention of hospital participants whose institutions were also dealing with mergers, construction programs, and reduced payments for services. Retaining the hospitals' involvement was a particular challenge when the possibility of mandated Medicaid managed care faded.
- ◆ **Time requirements for network development** often exceeded that anticipated by the members when they initially committed to the network. Since the additional time requirements, reported by all the CISI networks, made it difficult to maintain the partners' interest, the additional time required exacerbated the challenge of members' attention being focused elsewhere.
- ◆ **Turnover of network staff** was a serious challenge in Alabama, Illinois, and New Mexico, since activities conducted by those staff members were largely suspended while new staff members were recruited and integrated into the network. The issue seemed to be particularly acute for those positions where the networks were competing for staff with MCOs, especially for medical directors and clinical coordinators.

- ◆ **Members' needs for practice management services** tended to draw the networks away from risk-based managed care toward provision of services such as development of protocols, medical records, and common information systems. Alabama is an example of the challenge to develop common information systems: of nine members, only three used the same software, four were seeking new software, one had just purchased a new system different from the software being used by the three, and one had its own proprietary system developed over time.

As we would expect, the external and internal challenges often interacted. For example, as states postponed or withdrew the probability of mandating Medicaid managed care, the challenge of maintaining partners' interests and willingness to spend the requisite time in network development and activities became larger.

We next turn to strategies that can be used to assure network success in the face of such challenges, using lessons drawn from the CISI experiences.

## STRATEGIES TO ASSURE SUCCESS WHEN FACED BY THESE CHALLENGES

The above external and internal challenges are indeed serious. The strategies that can be employed to meet them fall into six main categories:

- ◆ Use retreats and strategic planning sessions combined with education of partners.
- ◆ Develop pilot projects.
- ◆ Maintain time pressures and demonstrate results.
- ◆ Involve senior administrators.
- ◆ Move aggressively into being a practice management network.
- ◆ Include advocacy as a network function. Exhibit 3 shows the relationships between the challenges and strategies for meeting them.

**EXHIBIT 3  
CHALLENGES AND STRATEGIES FOR MEETING THEM**

CHALLENGES	STRATEGIES					
	Retreats & education	Pilot projects	Time pressures & results	Senior administrators	Practice management	Advocacy
Changes in Medicaid managed care		X	X		X	X
Refusals of MCOs to negotiate		X			X	X
Development of local hospital-based networks	X	X			X	
Turnover of MCOs' staff		X			X	X
Variation in readiness for managed care	X					
Members' attention focused elsewhere	X		X	X	X	
Time required	X		X	X	X	X
Turnover of network staff			X	X	X	X
Members' needs for practice management			X	X	X	X

***Use Retreats and Strategic Planning Sessions Combined with Education of Partners.***

Attaining consensus on the degree of financial risk that the network and/or its partners will accept can be addressed through a series of retreats or strategic planning meetings that combine trust building with education to increase members' sophistication about managed care. Network members often need more sophisticated understanding of managed care, its varieties, arrangements, and demands. Like the CISI networks, organizations may find that, although they first assume that every partner understands managed care, this may not be the case. Progress on networks' design and development can be

delayed until all members are equally familiar with the issues necessary to make decisions.

In New York, a series of retreats facilitated by consultants helped to establish goals and plans that could be implemented under several possible scenarios of the state's Medicaid managed care policies. The sessions had a large component of education about managed care. When New Mexico's network became stuck on whether members would accept provider contracts negotiated by the network, it used a series of strategic planning meetings, or retreats, to assure that all members' voices were heard, all issues aired, and that the group could move forward with common purpose.

Using a facilitator is often critical to the success of

these retreats or strategic planning sessions. A facilitator is particularly important as a neutral party in the network's initial trust-building phases or later, if the partnership becomes stuck on an issue or mired in distrust.<sup>2</sup> In the case of California, the outside facilitator was so adept that she became the network's Executive Director.

### ***Develop Pilot Projects.***

If state Medicaid managed care policy is potentially unfavorable to the network partners or the people they serve, one strategy is to propose to the state a pilot project that will implement managed care in ways benefiting the network providers and their patients. This is the strategy being pursued by Ohio. While New York explored some possibilities of pilot projects, in the end they did not work out.

Believing Medicaid managed care to be an opportunity, the Southern Ohio CISI network was disappointed when the state decided not to mandate enrollment in rural areas. In effect the state was abandoning its prior decision to roll out mandatory Medicaid managed care in multiple areas after its inception in Dayton. The CISI network is working to propose a pilot project in its service area to show that managed care can work in rural areas.

In New York, the network's providers of health care for homeless persons had initially come together as advocates for the homeless, especially seeking to exempt homeless persons from mandatory enrollment in managed care. As they formed the network, the partners initially decided to follow a two-pronged approach. They would continue to advocate that homeless people be exempt from the managed care requirement. They also explored ways to participate as a group in managed care through improved efficiencies, better clinical management, and development of a more continuous system of care among levels of providers and locations. Recognizing that exclusion of the homeless from mandatory enrollment in managed care was likely time-limited and, based on their experiences

of working together, the network negotiated with the state to develop a pilot project both to stress care management and also to develop techniques and information for the successful transition of homeless patients into managed care. For example, they are proposing to develop actuarial rates for homeless persons, since neither the state nor the network's members have good information on the utilization rates and costs of homeless persons. Similarly, the pilot will work to develop payment methodologies.

### ***Maintain Time Pressures and Demonstrate Results.***

Networks, like other human organizations, often find that they work best under pressure and with short deadlines. As the impetus of states mandating Medicaid managed care stalls, networks can discover that participation in joint activities wanes. In addition, since network development is extremely time-consuming and arduous, far beyond what members anticipated when they initiated the networks,<sup>3</sup> partners' focus may shift to their individual institutions rather than on the needs of the network.

One strategy for maintaining the time pressure is to use external deadlines. A good source of these deadlines is the requirements of potential or actual funding sources. This might be, for example, the deadline for submission of proposals. Or a funder might require a maximum grant period and/or interim work plans and deadlines. In the case of CISI, the grant period was one year, a fact that was used by a number of network leaders to spur members' efforts in network development. Another source of external timelines might be opportunities for advocacy, which might include deadlines such as dates of public hearings or public budget submissions.

Another strategy is to establish internal timelines for accomplishing decisions and tasks. In particular, resolving not to revisit old decisions can keep the group moving forward, as both California and Indiana discovered.

---

2 See Issues Brief #2 *Building Trust Among Network Partners Through Communication and Leadership*.

---

3 See Issues Brief #1 *Strategies for Early Network Development: Lessons Learned from the Community Integrated Services Initiative*.

Whether the time pressures are externally or internally generated or — as is most likely — a combination of the two, achievement of results provides positive reinforcement of members' efforts and underscores the value of joint actions. These achievements can be small and symbolic, such as agreement over a logo, as in Alabama and California, or they can be more substantive, such as completion of analyses of members' costs or quality improvement processes. The CISI networks found that these early or mid-term victories were more likely to be in the area of practice management than in risk-based managed care contracting.

### ***Involve Senior Administrators.***

Capturing and holding the attention of members' senior administrators is a key to network success, since they — in conjunction with their boards of directors on whom the administrators have great influence — set the priorities for their organizations. They can make things happen. Having top administrators articulate the importance of the networks and their expectations of success helps to generate their subordinates' enthusiasm and effective commitment of their institutions.

Generally, in networks with health centers as partners, the centers send their executive directors or CEOs to network board meetings. The strategy of including senior administrators becomes more difficult to implement in the case of larger health centers and, especially, hospitals. Keeping the interest of hospital executives proved to be difficult for CISI's two vertically integrated networks, in Indiana and Ohio. The networks used separate meetings with senior executives, cajoling, and internal marketing to keep their interest.

### ***Move Aggressively into Being a Practice Management Network.***

Perhaps the most promising strategy to pursue when faced with the above external and internal challenges is that of "practice management". This all-encompassing term can include many functions, some of them directed at clinical management (e.g., the development of protocols for high-risk patients),

others at administrative matters (e.g., helping to improve productivity), and still others at a combination of clinical and administrative matters (e.g., managing a pharmacy benefit, developing an information system capable of tracking patients through multiple providers). All of the CISI networks pursued some forms of practice management strategies. The following illustrate the breadth of their activities:

- ♦ Pennsylvania has worked on case management, protocol development, and provider incentive compensation plans.
- ♦ Chicago concentrated on health education and improving medical records.
- ♦ Ohio stressed asthma protocols and management of pharmacy through prescribing guidelines.
- ♦ Montana bought the services of a financial consultant to examine and suggest improvements in centers' cost structures.

Often the practice management efforts were new and creative solutions to issues that had been raised in the networks' initial stages. For example, several networks had planned to develop information systems to support the additional data needs of managed care. However, they found significant barriers in locating the expertise for such systems, the high cost of hardware and the resulting reluctance of members to make such large investments, and the long time required to design, acquire, and implement a common system. Several networks, notably Illinois, Montana, and Pennsylvania, are continuing with the development of data capacity to augment, not supplant, their members' management information systems. Pennsylvania is doing so through a web-based reporting system.

Although in some cases the network slowed or tabled its plans for becoming a managed care network (e.g., Alabama, California, Chicago), in other cases the practice management network coexisted with managed care activities. For example, Pennsylvania was able to negotiate a contract with a major MCO. Montana also assisted its members in developing local managed care plans by helping them to come together with hospitals and other

providers. New York is also working on a Medicaid pilot project for homeless persons.

One caution arises in the development of a practice management network: if partners' managers and employees come to identify shared systems or services with centralization, then their fears for their continued employment — and for the community identity that health centers cherish — may lead to foot-dragging and noncooperation. Each partner needs to feel that the sharing will result in stronger health centers and better care for underserved and vulnerable populations.<sup>4</sup>

A second consideration is the role of primary care associations in providing shared services, technical assistance, and training. As appropriate, networks with a primary care association sharing the same catchment area will want to carefully delineate the roles and activities of each to avoid conflict and reduce costs.

### ***Include Advocacy as a Network Function.***

Although community health centers have a long history of advocacy on behalf of medically underserved and disadvantaged people, the networks must make deliberate decisions if they are to take on this function. Two of the CISI networks saw advocacy as one of their major functions and galvanized support for the network through active advocacy. The California network became a regional spokesperson for the underserved on a par with other regional networks in the state; it was specifically recognized as such by the state primary care association. The New York network began as an advocate for homeless persons when the state planned to include them in Medicaid mandated managed care, and it continued to be active in advocacy.

As with practice management activities, networks need to define their roles in advocacy in relation to

their appropriate primary care associations. There needs to be clear understanding of who will do what, so that conflicts either do not arise or else are dealt with promptly and expeditiously.

Using a mix of the above strategies, the CISI networks were able to accomplish a great deal during their grant periods, even though their achievements often required modification of their initial goals.

## **STRATEGIES FOR ASSURING NETWORK SUSTAINABILITY**

Clearly, one of the major issues facing developing networks is the question of sustainability once the initial grant is ended. Although they may well be concerned about their survival, network participants need to recognize that they have already done the major work of nurturing a network through its early developmental stages, which are time-consuming and expensive.

Once the networks are in place, they can take advantage of opportunities as they arise. Among the sources of funds are: 1) other grants; 2) charging for their services; 3) using a portion of managed care premiums; 4) charging a fee or percentage on group purchases; 5) capital calls from existing members; and 6) expanding to include new partners.

♦ ***Other grants.*** Funds are available from multiple sources, sometimes for specific programs (e.g., improving diabetes care, enrolling children in state child health insurance programs) and sometimes for general network support.

Sources of grants include local foundations and corporations, the traditional foundations specializing in health care (especially the W.K. Kellogg Foundation and The Robert Wood Johnson Foundation), and relatively new foundations established when not-for-profit organizations such as Blue Cross/Blue Shield plans and hospitals converted to for-profit status. California has especially been blessed with the establishment of these new foundations.

<sup>4</sup> See Issues Brief #1 *Strategies for Early Network Development* on the involvement of middle managers in network development and Issues Brief #2 *Building Trust Among Network Partners Through Communication and Leadership*.

Government agencies are also sources. Several of the CISI grantees have received funds from the Bureau of Primary Health Care's ISDI grants. As this paper is being drafted, the Congress is considering legislation to allow direct funding of practice management networks that are controlled by Section 330-funded health centers. Grants for special purposes, such as telemedicine, are available from other government bureaus and agencies.

- ◆ **Charging for their services.** The practice management services offered by networks have value, and, as such, are potentially marketable to members or others for a fee. This might be for management information systems, managed care readiness reviews, or technical assistance in such areas as reengineering. Managed Care Organizations may be willing to pay for services like credentialing of providers.

All these avenues are being explored by the CISI networks. They have found that one of the biggest challenges is defining the value — and thus the price — for their services.

- ◆ **Using a portion of managed care premiums.** If the networks contract with payors, such as Medicaid, or with MCOs, then the networks can use a percentage or flat fee of the premiums to support their own managed care activities.
- ◆ **Charging a fee or percentage on group purchases.** Networks that engage in group purchasing or shared services of products (e.g., employee benefits, laboratory tests) or services (e.g., consultants who work with partners on patient

flow in their organizations) may charge a portion of the savings resulting from higher purchasing volumes than each member could generate on its own.

- ◆ **Capital calls from existing members.** Often networks begin with each member contributing a fixed amount of capital, which may vary by size of the member's organization. As networks develop, they can return to this source of funding. Since the CISI grants required local matching funds, capital calls were sources of those matches.
- ◆ **Expanding to include new partners.** Networks can also increase their available resources through expansion. This growth may be to other health centers or to organizations with deeper pockets, such as hospitals.<sup>5</sup>

Development of additional funding is challenging for networks but can be done, as evidenced by the continued existence and thriving of a number of community health center-affiliated networks.

\* \* \*

As the above discussion demonstrates, start-up networks can learn a great deal from the experiences of the ten CISI grantees. Further information is available from NACHC (see Preface).

---

5 Including hospitals as partners raises a number of issues from both legal and business perspectives. See *Legal Considerations in Health Center Network Development*, available at [www.bphc.hrsa.dhhs.gov/CHC/ISDI/RefDocs/HTML/programinfo.htm](http://www.bphc.hrsa.dhhs.gov/CHC/ISDI/RefDocs/HTML/programinfo.htm) under "Legal Guidance".

*Publication of this issues brief was supported by the  
W.K. Kellogg Foundation.*



**National Association of Community Health Centers, Inc.**

1330 New Hampshire Avenue, N.W.

Suite 122

Washington, DC 20036

(202) 659-8008

Fax: (202) 659-8515

Website: [www.nachc.com](http://www.nachc.com)